STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525718	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WI Veterans Home Moses Hall	210 Cumberlidge Ave King, WI 54946

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50988 Based on observation, staff interview, and record review, the facility did not ensure a call light was within reach for 1 resident (R) (R118) of 35 sampled residents. On 3/17/25, R118 did not have a call light within reach. Findings include: The facility's Member Rounds policy, dated 1/7/25, indicates call lights should be within reach. From 3/17/25 to 3/19/25, Surveyor reviewed R118's medical record. R118 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's dementia, chronic obstructive pulmonary disease, and adult failure to thrive. R118's Minimum Data Set (MDS) assessment, dated 2/25/25, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R118 had moderately impaired cognition. R118's risk for falls care plan indicated R118 was at risk for falls due to a screening evaluation and several predisposing factors. The care plan contained an intervention (dated 12/16/22) to remind R118 to be safe and call for assistance. On 3/17/25 at 10:25 AM, Surveyor observed R118 in a recliner with a pressure sensitive pad alarm. R118 did not have a call light within reach and was unable to call for assistance. Surveyor noted R118's call light was wrapped around a trapezius bar positioned above R118's bed. On 3/17/25 at 10:34 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who observed R118's call light. LPN-E verified R118's call light was not within reach and R118 was unable to call for assistance. On 3/18/25 at 2:51 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated residents should have call lights within reach.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on observation, staff and resident interview, and record review, the facility did not ensure the provision of care and treatment to prevent urinary tract infections (UTIs) for 1 resident (R) (R54) of 3 sampled residents. Staff did not provide suprapubic catheter (a tube that drains urine from the bladder through a small incision in the abdomen) site care for R54. Findings include: The facility did not provide a policy related to suprapubic catheter site care. From 3/17/25 to 3/19/25, Surveyor reviewed R54's medical record. R54 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease and chronic kidney disease. R54's Minimum Data Set (MDS) assessment, dated 1/8/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R54 had moderate cognitive impairment. R54 had a Power of Attorney for Healthcare (POAHC) who was responsible for R54's healthcare decisions. R54's medical record indicated R54 had a suprapubic urinary catheter due to urinary retention as a result of an atonic bladder (a condition where the bladder muscles don't contract which makes it hard to urinate). R54's medical record did not contain an order or indicate routine suprapubic catheter site care was provided to prevent UTIs. R54's medical record indicated R54's suprapubic catheter was changed monthly as ordered by the physician. On 3/17/25 at 11:12 AM, Surveyor interviewed R54 who indicated R54 experienced frequent UTIs at the end of summer in 2024. R54 indicated those have gotten better more recently. On 3/19/25 at 8:56 AM, Surveyor observed Certified Nursing Assistant (CNA)-I empty R54's catheter drainage bag. CNA-I indicated R54's catheter site care was provided by night (NOC) shift staff. On 3/19/25 at 10:56 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated nurses completed suprapubic catheter care. DON-B verified R54's medical record did not contain documentation that suprapubic catheter site care was completed. DON-B was unsure if the facility had a policy specific to suprapubic catheter care. On 3/19/25 at 12:53 PM, Surveyor interviewed DON-B who indicated DON-B searched suprapubic catheter care and the results indicated suprapubic catheter site care should be completed twice daily. DON-B indicated the handwriting on the below mentioned document was DON-B's handwriting from the search. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/25, Surveyor reviewed an email to DON-B, dated 3/19/25, that indicated the facility had a policy that indicated staff should cleanse suprapubic catheter sites with insertion and removal (when catheter tubing is changed). The email indicated the policy for catheter changes referenced another policy that only addressed routine perineal care with a Foley catheter (a tube inserted in the bladder through the urethra (natural tube through which urine normally exits body)). Handwriting on the email indicated to wash the site with warm soapy water, secure the catheter, and wipe down primal to distal with morning and evening care, and report any redness. On 3/19/25 at 1:55 PM, Surveyor interviewed DON-B who indicated DON-B could not provide documentation that R54 received suprapubic catheter site care. DON-B verified suprapubic catheter site care should have been completed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff and resident interview and record review, the facility did not provide the necessary respiratory care and services for 1 resident (R) (R147) of 2 residents reviewed for oxygen therapy. R147 did not have a physician order for oxygen therapy. Findings include: The facility's Oxygen Therapy policy, revised 10/2/24, indicates: A provider's order is required for extended oxygen use .Orders must indicate the liter flow rate and if delivery is to be continuous or on demand . Humidification bottle shall be replaced as needed; bottles shall be labeled with date opened and shall be discarded no later than 30 days from labeled date .Nasal cannula (NC) shall be replaced at least weekly and when visibly soiled or contaminated .Filters on concentrator units shall be cleaned weekly in warm, soapy water and allowed to air dry prior to replacing .1) When oxygen is ordered, each oxygen delivery device should be labeled with an identification band/label that includes the member's name, facility, room number, and oxygen order .4) When oxygen is discontinued or no longer used, discard all supplies .5) Replace NC/masks weekly Sundays on night shift and when visibly soiled or .6) Once per month, Certified Nursing Assistants (CNAs) replace in-use extension tubing on Sunday night shift when replacing NC/masks . Concentrator unit: .10) Record oxygen administration and member's response in the electronic health record . 13) If in use, replace humidification bottle as needed and no later than 30 days since last replaced. When placing a new bottle, indicate date of opening on bottle with a permanent marker .14) When oxygen is no longer needed or discontinued power unit off, remove oxygen supplies from member .Remove unit from member's room . From 3/17/25 to 3/19/25, Surveyor reviewed R147's medical record. R147 was admitted to the facility on [DATE] and had diagnoses including chronic diastolic (congestive) heart failure, obstructive sleep apnea, and type 2 diabetes mellitus with diabetic chronic kidney disease. R147's Minimum Data Set (MDS) assessment, dated 2/12/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R147 had intact cognition. R147's medical record did not include physician orders or a care plan for oxygen therapy. On 3/17/25 at 10:23 AM, Surveyor observed R147 with oxygen running at 6 liters per minute (LPM) via nasal cannula connected to an oxygen concentrator. Surveyor noted R147's tubing and humidifier canister were not dated. Surveyor interviewed R147 who indicated R147 needed oxygen and had used oxygen for a while. On 3/18/25 at 1:11 PM, Surveyor interviewed Respiratory Therapist (RT)-J who reviewed R147's medical record and confirmed R147 did not have an order for oxygen even though R147 was known to use oxygen. RT-J indicated a resident on oxygen therapy should have orders for the dose, route, and pulse oximetry parameters. RT-J indicated CNAs were responsible for changing oxygen tubing once per week. On 3/18/25 at 1:20 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R147 did not have an order or care plan for oxygen therapy. DON-B indicated R147 should have an oxygen order and care plan. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 2:15 PM, DON-B provided Surveyor with a written physician order for R147 (dated 9/17/24) for oxygen 1-2 liters to keep saturation above 88%. DON-B indicated the order dropped off R147's physician orders but should not have.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility was not free of significant medication errors for 2 residents (R) (R54 and R170) of 11 sampled residents. R54 received five extra doses of baclofen (a medication used to treat muscle spasms) on 1/15/25 and 1/16/25 due to a transcription error. R54 experienced overdose symptoms that required emergency transport and admission to the hospital on 1/17/25. R170 was administered double the ordered dose of long-acting insulin on 3/1/25 and 3/2/25. Findings include: The facility's Medication Administration policy, revised 2/6/25, indicates: .All medications shall be administered following the seven rights of administration. Right: Medication, Dose, Member, Route, Time, Documentation, Indication .Orders and administration instructions shall be followed at all times .Medication errors shall be reported immediately to the Registered Nurse (RN) . The facility's Orders Management policy, revised 5/1/24, indicates: .The RN is responsible to review the member's plan of care to address revisions needed based on prescribed orders. Orders transcribed in the electronic health record by anyone other than a nurse shall require RN review for accuracy and confirmation prior to administration. Orders from other than the Primary Care Physician (PCP)/designee shall be reviewed and verified with the PCP/designee .Order clarifications shall be documented in the clinical record. Holding orders shall require an end date or duration. Hold orders without an end date or duration shall be clarified with the provider and discontinued, requiring a new provider's order to restart. All orders shall be addressed and processed promptly unless clarification is needed; those needing clarification shall be addressed timely for processing. All transcription errors shall be promptly reported to the RN .When transcribing orders, the prescriber shall always be identified as the ordering provider . 1. On 3/17/25, Surveyor reviewed R54's medical record. R54 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease and chronic kidney disease. R54's Minimum Data Set (MDS) assessment, dated 1/8/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R54 had moderate cognitive impairment. R54 had a Power of Attorney for Healthcare (POAHC) who was responsible for R54's healthcare decisions. R54's medical record indicated R54 was transferred to the hospital on 1/17/25 and readmitted to the facility on [DATE]. An Order note, dated 1/14/25 at 4:59 PM, indicated baclofen 10 milligrams (mg) four times daily (QID) exceeded the usual frequency of one to three times per day. An Administration note by Licensed Practical Nurse (LPN)-F, dated 1/14/25 at 5:05 PM, indicated there was a duplicate order. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A Respiratory Therapy note, dated 1/16/25 at 2:00 PM, indicated R54 was extremely drowsy during nebulizer treatments. The Respiratory Therapist reported the information to an RN. An Administration note by LPN-F, dated 1/16/25 at 8:43 PM, indicated R54 was unable to safely take a medication due to lethargy. A Notification note, dated 1/16/25 at 10:11 PM, indicated the on-call physician was notified of a medication error at 9:40 PM. The physician instructed staff to hold baclofen until R54 was alert and monitor R54 overnight. The note indicated R54's POAHC was notified of the medication error and monitoring order. An Incident note, dated 1/16/25 at 10:15 PM, indicated a new order was received on 1/14/25 to increase baclofen 10 mg from three times daily (TID) to QID; however, the TID order was not discontinued and an order to administer baclofen 10 mg QID was added. The error was found in the evening on 1/16/25. R54's vital signs were within normal limits, however, R54 exhibited increased fatigue and weakness. A note, dated 1/17/25 at 12:30 AM, indicated R54 was assessed by an RN. Adverse effects from the medication error were unknown at that time because R54 was sleeping soundly and slept through the assessment. R54's respiratory rate was even, shallow, and unlabored with no concerns. A Health Status note, dated 1/17/25 at 6:51 AM, indicated an RN was called to R54's room at approximately 5:25 AM because R54's legs were shaking. The RN observed R54 in bed and noted both lower legs were shaking with the left leg shaking more than the right. R54's arms could not extend and R54's fists were clenched. R54 was confused, answered only yes or no, and had a delayed response to questions. The on-call physician (who was already aware of the medication error) was notified and requested staff administer carbidopa/levodopa (a medication used to treat Parkinson's disease symptoms of stiff joints and movement), however, R54 was too sleepy to use a straw or swallow. The on-call physician instructed staff to send R54 to the emergency room (ER). R54 left the facility with Emergency Medical Services (EMS) at approximately 6:10 AM. The RN was unable to obtain vital signs due to R54's condition. ER physician notes, dated 1/17/25, indicated R54 was alert and had tremors of both lower legs with stiffness. R54 was sedate but responded to painful and loud verbal stimuli. R54 was conversant upon EMS' arrival at the facility but was sedate and tremulous upon arrival at the ER. The ER physician discussed the case with Poison Control and obtained additional blood levels based on Poison Control's recommendations. The levels were reassuring and R54's condition appeared to be an accidental baclofen overdose. A hospital history and physical note, dated 1/17/25, indicated there was difficulty assessing R54's neurological status at the time of admission to the hospital from the ER. R54 appeared uncomfortable. R54's eyes were open, however, R54 did not follow commands, moaned incomprehensible words, and did not answer questions. R54's arms were stiff with mild tremors. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 3/19/25 at 10:15 AM, Surveyor interviewed Medical Director (MD)-G via phone. MD-G indicated MD-G was aware of the baclofen medication error within 24 hours if not the same day. MD-G indicated the on-call physician was immediately notified when the error was discovered. MD-G indicated MD-G would have issued the same orders as the on-call physician. MD-G indicated when R54's baclofen order was increased by a specialty physician, the nurse should have entered the order in R54's medical record correctly by discontinuing the previous baclofen TID order or should have questioned the physician with any concerns. MD-G indicated the medication error led to R54's hospitalization and indicated the most severe outcomes of a baclofen overdose are mild respiratory distress, sedation, and cognitive changes. MD-G indicated the quantity of baclofen R54 received for the short period of time was not life-threatening but could cause cognitive changes. MD-G participated in the facility's improvement process to determine the cause of the error and reeducate staff in collaboration with the pharmacy. MD-G indicated R54's medical record should have triggered an alert when the order was entered because both the TID and QID orders together exceeded the standard dosing. MD-G indicated standard dosing for baclofen should not exceed 80 mg total per day. MD-G indicated the medication error put (R54) close to that. On 3/19/25 at 10:34 AM, Surveyor again interviewed MD-G via phone. MD-G indicated R54's medical record did generate an alert (see note above) and MD-G believed the pharmacy discontinued the TID order from their end. Surveyor reviewed R54's January 2025 medication administration record (MAR) which contained the following orders: ~ Baclofen 10 mg TID: ordered 9/4/24 and discontinued 1/16/25 at 8:36 PM - received all scheduled doses in January as ordered (at 6:30 AM, 10:30 AM and 6:30 PM) with the following exceptions: no signature on 1/14/25 for the 10:30 AM dose, the 1/14/25 6:30 PM dose was held, no signature on 1/16/25 for the 6:30 PM dose. ~ Baclofen 10 mg QID: ordered 1/14/25 at 3:00 PM and discontinued 1/21/25 at 11:58 AM - received all scheduled doses as ordered (6:30 AM, 10:30 AM, 2:30 PM and 6:30 PM) with the following exceptions: the 6:30 PM dose was documented as refused on 1/16/25. All doses thereafter were not administered because R54 was hospitalized . Based on the above information, R54's MAR indicated R54 received double doses of baclofen (a total of 20 mg each time) on 1/15/25 at 6:30 AM, 10:30 AM, and 6:30 PM and on 1/16/25 at 6:30 AM and 10:30 AM for a total of five double doses. On 3/19/25 at 10:49 AM, Surveyor interviewed Director of Nursing (DON)-B. Immediately after discovering the error, DON-B indicated the facility re-educated all nurses regarding the transcription process and provided one-on-one education to the RN who transcribed R54's baclofen order incorrectly. DON-B indicated LPN-F reported the duplicate order to the RN on 1/14/25 and the RN indicated the RN would take care of it but got distracted. DON-B indicated the facility conducted informal audits of orders following R54's medication error but had no documentation of the audits. DON-B indicated no medication errors had occurred since then. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 3/19/25, Surveyor reviewed the facility's investigation for the medication error which contained a Record of Conversation/Notice, dated 1/25/25, that indicated RN-H was counseled regarding failure to discontinue a duplicate order for a medication which resulted in a medication overdose and hospitalization . The investigation did not indicate a process change was implemented to prevent additional errors and did not contain audits to determine if any other residents were affected. On 3/19/25 at 1:51 PM, Surveyor interviewed DON-B who indicated the process change implemented in response to the medication error is to have staff enter the ordering physician's name with the order unless the PCP is the ordering provider. DON-B verified the process change did not really fix the root cause of the medication error. DON-B indicated the education provided to staff was on the process change plus the overall transcription process. 50479 2. From 3/17/25 to 3/19/25, Surveyor reviewed R170's medical record. R170 was admitted to the facility on [DATE] and had diagnosis of type 2 diabetes mellitus. R170's most recent MDS assessment, dated 2/3/25, indicated R170 had moderate cognitive impairment. On 3/17/25 at 10:21 AM, Surveyor interviewed R170 who indicated R170 had unpredictable fluctuations in R170's blood glucose levels since admission to the facility. On 3/19/25, Surveyor reviewed R170's MAR which included the following long-acting insulin orders: ~ Lantus SoloStar Subcutaneous Solution Pen-injector 100 units/milliliter (ml) (insulin glargine) Inject 14 units subcutaneously at bedtime for diabetes type 2. When pen is completed, please refer to Semglee order. Have RN initiate Semglee order and discontinue Lantus (ordered and started 1/27/25; discontinued 2/7/25). ~ Semglee Subcutaneous Solution Pen-injector 100 units/ml (insulin glargine-yfgn) Inject 14 units subcutaneously at bedtime for diabetes type 2 (ordered 1/27/25; started 1/29/25; discontinued 3/3/25). ~ Lantus SoloStar Subcutaneous Solution Pen-injector 100 units/ml (insulin glargine) Inject 12 units subcutaneously at bedtime for diabetes type 2. When pen is completed, please refer to Semglee order. Have RN initiate Semglee order and discontinue Lantus (ordered and started 2/7/25 for indefinite). R170's medical record indicated R170 was to transition from Lantus SoloStar to Semglee when R170's home supply of Lantus SoloStar was exhausted. The order for Semglee was entered and held from 1/27/25 to 1/29/25. On 3/1/25, Semglee was started but Lantus SoloStar was not discontinued. On 3/1/25 at 6:30 PM, R170 received 14 units of Semglee (insulin glargine-yfgn) and 12 units of Lantus (insulin glargine). On 3/2/25 at 2:30 AM, R170 had an episode of asymptomatic hypoglycemia (low blood sugar). R170's continuous glucose monitoring device alarmed for a blood glucose of 78. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 3/2/25 at 6:30 PM, R170 received 14 units of Semglee (insulin glargine-yfgn) and 12 units of Lantus (insulin glargine). On 3/3/25 at 4:36 AM, R170 had an episode of asymptomatic hypoglycemia. R170's continuous glucose monitoring device alarmed for a blood glucose of 78. On 3/19/25 at 1:54 PM, Surveyor interviewed DON-B who indicated there was not an investigation for the insulin error and staff were not interviewed following the error. DON-B indicated staff education was not completed and a process change(s) was not implemented to prevent similar medication errors.

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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. 45942 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 more than 4 of the 176 residents residing in the facility. Food items for resident consumption were not appropriately labeled and/or were beyond the discard date. Equipment in the main kitchen was not in clean condition and/or covered. Findings include: On 3/17/25 at 9:20 AM, Surveyor interviewed Dietary Manager (DM)-K who stated the facility follows the Federal Food Code. Food Labeling/Storage: The 2022 FDA Food Code documents at 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking: .(B) Except as specified in (E)-(G) of this section, refrigerated, ready-to-eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. During an initial kitchen tour that began at 9:20 AM on 3/17/25, Surveyor noted an item in the cooler labeled tater tot casserole with a prepped date of 12/12/23, a pulled date of 12/13/23, and no use-by date. Surveyor noted an item in the freezer labeled gluten free (GF) hot dog bun (single) dated 2/12 with no year or use-by date. Surveyor also noted an open box of turkey breasts dated 9/25/22 with no use-by date. On 3/17/25 at 9:20 AM, Surveyor interviewed DM-K who confirmed the tater tot casserole, hot dog bun, and turkey breasts were past their expiration dates and should have been discarded. 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525718	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WI Veterans Home Moses Hall	210 Cumberlidge Ave King, WI 54946

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 2022 FDA Food Code documents at 4-602.13 Nonfood-Contact Surfaces: Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residue. The 2022 FDA Food Code documents at 4-903.11 Equipment, utensils, linens, and single-service and single-use articles: (a) Except as specified in (d) of this section, cleaned equipment and utensils, laundered linens, and single-service and single-use articles shall be stored: (1) in a clean, dry location; (2) where they are not exposed to splash, dust, or other contamination; and (3) at least 15 centimeters (cm) (6 inches) above the floor. (b) Clean equipment and utensils shall be stored as specified under (a) of this section and shall be stored: (1) in a self-draining position that allows air drying; and (2) covered or inverted. During an initial tour of the kitchen that began at 9:20 AM on 3/17/25, Surveyor observed a coffee dispensing machine and noted dried coffee ground-like debris on the interior compartment. Surveyor also noted a cleaning sign off log posted on the exterior of the dispenser. The cleaning log indicated the coffee dispenser should be cleaned weekly on Fridays and was last cleaned on 1/10/25. On 3/17/25 at 9:20 AM, Surveyor interviewed DM-K who confirmed the coffee dispenser should be cleaned weekly on Fridays. DM-K acknowledged the dried debris on the interior of the dispenser and verified the last time staff indicated it was cleaned was on 1/10/25. During a follow-up tour of the kitchen that began at 12:01 PM on 3/18/25, Surveyor noted the coffee dispenser appeared to have been cleaned and the cleaning log contained a date of 3/17/25. On 3/17/25 at 9:20 AM, Surveyor observed three standing mixers in the main kitchen. The mixers were not in use and were not covered. Surveyor also observed a vertical cutter mixer (VCM) and 5+ VCM disc blades that were hung on the wall. The VCM and disc blades were not covered. On 3/17/25 at 9:20 AM, Surveyor interviewed DM-K who stated the three stand mixers, the VCM, and the blades are not covered when not in use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525718	A. Building B. Wing	03/19/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50988 Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 2 residents (R) (R79 and R72) of 3 sampled residents. R79 was on enhanced barrier precautions (EBP). On 3/18/25, Licensed Practical Nurse (LPN)-D did not wear a gown during catheter care for R79. R72 was on EBP. On 3/8/25, LPN-D did not wear a gown while administering medications via gastrostomy tube (G-tube) to R72. Finding includes: The facility's Transmission-Based Precautions policy, dated 4/11/24, indicates: Enhanced Barrier Precautions (EBP): For members with novel or targeted multidrug-resistant organism (MDRO) infections, indwelling medical devices and wounds, including as part of a public health containment response. This type of precaution falls between standard and contact precautions and requires gown and glove use for certain members during specific high-contact member care activities that have been found to be at increased risk for MDRO transmission .Residents with device care or use: central line, urinary catheters, feeding tubes, tracheostomy/ventilator . 1. From 3/17/25 to 3/19/25, Surveyor reviewed R79's medical record. R79 was admitted to the facility on [DATE] and had diagnoses including diabetes and disorder of the bladder. R79 had an indwelling urinary catheter. R79's Minimum Data Set (MDS) assessment, dated 2/10/25, had a Brief Interview for Mental Status (BIMS) score of 15 of 15 which indicated R79 was not cognitively impaired. On 3/18/25 at 11:50 AM, Surveyor observed LPN-D empty R79's Foley catheter bag without wearing a gown. Surveyor interviewed LPN-D who verified LPN-D should have worn a gown when emptying R79's catheter bag per the facility's EBP policy. LPN-D verified R79 was on EBP. 2. From 3/17/25 to 3/19/25, Surveyor reviewed R72's medical record. R72 was admitted to the facility on [DATE] and had diagnoses including dysphagia, chronic obstructive pulmonary disease, and heart failure. R72 had a G-tube. R72's MDS assessment, dated 12/26/24, had a BIMS score of 15 out of 15 which indicated R72 was not cognitively impaired. On 3/18/25 at 11:56 AM, Surveyor observed LPN-D administer medication to R72 via G-tube without wearing a gown. Surveyor interviewed LPN-D who verified LPN-D should have won a gown when administering medication to R72 per the facility's EBP policy. LPN-D verified R72 was on EBP. On 3/18/25 at 2:53 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R79 and R72 were on EBP and LPN-D should have worn a gown during high-contact resident cares. DON-B indicated emptying a catheter bag and administering medication via G-tube were considered high-contact resident cares.