STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675336	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirkland Court Health and Rehabilitation Center	1601 Kirkland Dr Amarillo, TX 79106

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 48161 Based on observation, record review, and interview, the facility failed to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being for 3 of 7 anonymous residents reviewed for quality of life. The facility failed to ensure 3 of the 7 anonymous residents interviewed received adequate notification of activities. The facility failed to ensure activities that were provided met residents' needs or desires. This failure placed residents at risk of boredom and a decline in their quality of life. Findings included: During an observation on 04/24/2024 at 9:56 AM, the AD was coloring in the dining room with two female residents. During an interview on 04/24/2024 at 10:00 AM, the AD stated that Resident Council was scheduled to meet that day at 2:00 PM and that surveyor could meet with residents during that time. An observation on 04/24/2024 at 10:30 AM of Activity Calendar did not reflect Resident Council Meeting at 2:00 PM. Bingo was scheduled at 2:00 PM. During an interview on 04/24/2024 at 10:37 AM, anonymous resident stated that the AD offered her to join the coloring activity but stated that she wasn't able to color due to her right hand having a contracture from a stroke. The resident stated that the AD does not offer any other activity other than coloring. The anonymous resident also stated that the calendar she received monthly is too small to read. In an Anonymous interview on 04/24/2024 at 2:00 PM, 3 of 7 residents stated that activities in the facility were not engaging, and that coloring was the primary activity. The residents also stated that the activities were not followed according to the monthly calendar. The residents went on to state that the calendar was hard to read due to the font being too small to read. (continued on next page)

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/24/2024 at 3:00 PM revealed a bulletin board in the dining room that was blank and not being utilized. During an interview on 04/25/24 at 10:16 AM, the AD stated that the calendar she gave to the residents to hang on their bathroom door. The AD said she does not utilize the bulletin board in the dining room to announce activities. The AD stated that she printed coloring pages and colored with the residents and believed that they enjoyed that activity. During an interview on 04/26/2024 at 9:45 AM, CNA C stated that the residents did not have engaging activities and that the AD would color with the residents instead of doing stimulating activities. CNA C stated that the activities that were provided were not beneficial and were degrading to the residents. An observation and interview on 04/26/2024 at 9:47 AM, in an anonymous resident's room, revealed a calendar on the bathroom door with small font. The anonymous resident stated that the AD only provided coloring pages for activities and the calendar does not reflect what activities were actually provided. The anonymous resident said that she had a hard time seeing the activities on the calendar provided. During an interview on 04/26/24 at 10:10 AM, the DON stated that the ADM was responsible Wfor ensuring the AD was doing engaging activities with residents and that a possible negative outcome for not having engaging activities would be a lack of stimulation for the residents. During an observation on 04/26/2024 at 2:00 PM, the AD was coloring in the dining room with one female resident. Record Review of Resident Rights Policy dated 1/2008. An elderly individual may participate in activities of social, religious, and community groups. Request for Activity Policy was requested but was not provided before exit.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 48161 Based on interview and record review, the facility failed to ensure the activities program was directed by a qualified professional. The facility failed to ensure the AD was qualified to serve as the director of the activities program. This failure placed residents at risk of not having stimulating, engaging activities that are beneficial and meaningful to the residents. Findings included: During an interview on 04/24/2024 at 10:10 AM, the AD said she had worked at the facility for about 6 months and had not taken the classes yet to be certified. The AD said she was waiting on the facility to pay for the classes. During an interview on 04/25/2024 at 11:00 AM, the ADM stated that she was aware of the AD not being certified and that it was a deficiency. The ADM had no answer to a possible negative outcome for uncertified staff. During an interview on 04/26/2024 at 8:20 AM, the ADON stated that she was aware that the AD was not certified and a possible negative outcome for not having a certified AD would be that the AD would not have the training that was needed to provide stimulating activities. During an interview on 04/26/2024 at 9:45 AM, CNA C stated that a possible negative outcome for not having a certified AD would be that resident's activities would not be beneficial to the residents. During an interview on 04/26/2024 at 10:10 AM, the DON said that the ADM was responsible to ensure the AD was trained and that a possible negative outcome of the AD not being certified would be that the AD wouldn't be able to identify the resident's needs. Record review on 04/26/2024 of the AD's personnel file revealed the AD was hired on October 20, 2023. There were no trainings with regards to Activities and no certification in the personnel file On 04/26/2024, a policy regarding Activities/certified staff was requested but was not provided before exit.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48161 Based on observation, interview, and record review, the facility failed to assess residents for risk of entrapment from bed rails prior to installation, review the risks and benefits of bed rails, and obtain informed consent prior to installation of bed rails with residents or their resident representatives for 1 of 13 (Resident #12) residents reviewed for quality of care in that: The facility failed to ensure Resident #12 did not have (2) one-quarter bed rails, on both sides of his bed with no documentation of physician orders, consent, or a safety assessment prior to installation. This failure could place residents at risk of injury, hindering residents from getting out of bed, and/or cause a decline in resident's ability to engage in activities of daily living. Findings included: Record Review of Resident #12's Face Sheet revealed that a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included but not limited to muscle weakness, Vascular Dementia, muscle wasting and atrophy, and neuroleptic induced parkinsonism. Record Review of Resident #12's Quarterly MDS assessment dated [DATE] revealed Resident #12 had a BIMS score of 11 indicating that resident was moderately impaired. The MDS revealed that resident was independent in sit to stand and bed to chair transfer with supervision/touch assistance in dressing. Record Review of Resident #12's Care plan dated 2/26/2024 revealed the following with no documentation relating to side/bed rail use. Focus: Impaired Cognitive function/Dementia Interventions: Cue, reorient and supervise as needed. Focus: ADL Self Care Performance deficit related to confusion Interventions: Resident is able to reposition himself in bed. Focus: Elopement Risk/Impaired safety awareness Interventions: Reorientation strategies such as signs, pictures, memory boxes Record Review of Resident #12's clinical record revealed no physician orders for bed rails. Record Review of Resident #12's clinical record under Assessments revealed no documentation of bed rail safety assessment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #12's clinical record for bed rail consents revealed no documentation of a signed bed rail consent. Observation on 04/24/2024 at 10:42AM of Resident #12's bed revealed (2) one-quarter bed rails on both sides of the bed. In an interview on 04/24/2024 at 10:42 AM, Resident #12 stated that he liked the bed rails as they help him reposition. Resident #12 had no concerns relating to the bed rails. During an interview/observation on 04/26/2024 at 8:20 AM, the ADON verified that Resident #12 had 1/4 bed rails. The ADON stated that due to the size of the bedrails, there should be in the resident's record the following: physician orders, bed rail consent, bed rail assessment and interventions relating to bed rails in the resident's care plan. The ADON stated that a possible negative outcome for having bedrails without proper assessing would be that the resident could get hurt. During an interview on 04/26/2024 at 9:45 AM, CNA C stated residents with bed rails on their beds should have orders, assessments, and bed rails should be noted in their care plan. CNA C stated that the possible negative outcome for having bedrails on the bed without assessing the resident first would be that the resident could hurt themselves or be restrained. During an interview on 04/26/2024 at 10:10 AM, the DON said residents with bed rails on their beds should be properly evaluated prior to utilizing the bed rails so staff would know the resident's limitations and if the bed rails were a help or a danger to the resident. Record Review of facility's policy titled Proper Use of Side Rails dated 12/2016 revealed the following: .The use of side rails as an assistive device will be addressed in the resident care plan An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks . Facility staff, in conjunction with the Attending physician, will assess and document the residents risk for injury .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 47854 Based on observation, interview, and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical well-being for 1 of 5 staff reviewed for nursing services. The facility failed to ensure the following: -LVN A used proper technique when providing wound care. -LVN A used proper technique when providing incontinent care. -LVN A used proper technique when administering medications via gastrotomy tube. This failure had the potential to affect residents receiving wound care and incontinent care by exposing them to infections resulting in poor healing, increased tissue damage, and deterioration in their wounds and health often resulting in IV antibiotic therapy and even hospitalization . This failure had the potential to affect residents with gastrostomy tubes by interfering with the efficacy of the therapeutic level of medications. Findings include: Observation on 04/25/24 at 08:49 AM revealed LVN A administering medication via peg tube to Resident #48, LVN asked investigator if she should put the crushed pill in with some liquid. Investigator replied, what does your policy say?. LVN stated that she was told to place dry crushed pill into tube and then add fluid after. LVN A proceeded to mix medication with small amounts of water to administer medications via gastrostomy tube. Medications were not going down the tube, due to the resident receiving his bolus feeding before medication administration. LVN A stated, This has never happened before, could this be because I gave him his feeding first? In an interview on 04/25/24 at 10:27 AM LVN A was asked if she has had training for administering medications via peg tube and she stated Here, in this facility? No!. LVN A was asked what a negative outcome would be for not having adequate training in gastrotomy care such as medication administration, LVN A stated, medication errors. In an interview on 04/25/24 at 10:43 AM DON was asked if nursing staff received checkoffs in gastrostomy tube care and medication administration. DON stated that HR would have those documents. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/25/24 02:32 PM of wound care and incontinent care performed by CNA E and LVN A for revealed that resident had a bowel movement and needed to be cleaned before wound care was performed. HH was performed and gloves were put on by both CNA E and LVN A at the beginning of the incontinent care. Resident was turned to her right side towards CNA E. LVN A proceeded to remove the wound dressing and then begun to clean the back side of the resident and LVN A took a clean wipe and wiped resident in a back to front motion. Once all the stool was cleaned from the resident LVN A never removed gloves or performed HH before touching the resident, residents' gown, or the baby doll the resident was holding. LVN A then proceeded to remove gloves and perform HH and then continued with wound care of the wound to resident's coccyx. LVN A cleaned the wound, but never removed her gloves or performed HH before starting to place collagen into the wound with her gloved hand that LVN A cleaned the wound with. LVN A placed the dressing onto the wound. In an interview on 04/25/24 at 03:01 PM LVN A was asked why she did not perform HH or perform a glove change after performing incontinent care for resident before touch items. LVN stated, I did, didn't I? I thought I did. LVN A was asked what a negative outcome of not performing HH and glove changes would be, LVN stated infection control. LVN A was asked why HH, and a glove change didn't happen in between the dirty and clean portion of wound care for the resident. LVN A stated, I thought I did., and stated that a negative outcome would be increase chance of infection. In an interview on 04/26/24 at 09:07 AM ADON was asked what a negative outcome was for not performing HH during incontinent care, wound care treatments. ADON stated that when these procedures are not performed correctly there is an increased risk for infection to the residents. In an interview on 04/26/24 at 09:34 AM with DON was asked what a negative outcome was for not performing HH during incontinent care, and wound care treatments. DON stated that it could lead to an increased risk for infection and complications to the residents. A Request was made on 04/26/2024 at 09:24 AM with BOM for competency checkoffs for LVN A, BOM stated that there were no checkoffs for LVN A. BOM stated, The facility doesn't have checkoffs for staff. Record review of LVN A's personal file revealed that LVN A had an Annual Training on 04/23/2024. The document revealed that there was a training but a not a return demonstration of competency performed. Record review of facility provided policy titled, Administering Medications, revised April 2019, stated the following: .2. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. .29. New personnel authorized to administer medications are not permitted to prepare or administer medications until they have been oriented to the medication administration system used by the facility. 30. The charge nurse mush accompany new nursing personnel on their medication rounds for a minimum of three (3) days to ensure established procedures are followed and proper resident identification methods are learned. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No policy for medication administration via gastrotomy tube was provided by facility. Record review of the facility provided policy titled, Perineal care/Incontinent care, revised on 07/0/2016, stated that following: .8. For female patient/resident: . .11. Clean anal area by first wiping off excessive fecal material with toilet paper or disposable wipes (for females, wash by wiping from vagina toward anus with one stroke). Discard soiled wipes. 12. Cleanse skin with incontinent wipe or perineal cleanser and cloths until skin is clear of fecal material. 13. Wash hands, don gloves. 14. apply moisture barrier if needed. 15. Reapply appropriate incontinence brief/undergarment. Record review of the facility provided policy titled, Wound Care, revised October 2010, stated the following: 2. Wash and dry your hands thoroughly. .4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves. .7. Use no-touch technique. Use sterile tongue blades and applicators to remove ointments or creams from their containers. .16. Discard disposable items into the designated container. Wash and dry your hand thoroughly. .23. Wash and dry your hands thoroughly. Record review of facility provided policy titled, Handwashing/Hand Hygiene, revised August 2019, stated the following: 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to the other personnel, resident, and visitors. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .b. Before and after direct contact with residents; c. Before preparing or handling medications; d. Before performing any non-surgical invasive procedures; .g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin' j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.; .m. After removing gloves; .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854 Based on observation, interview and record review, the facility failed to ensure residents were free of any significant medication errors for one of 13 (Resident #10) residents reviewed for pharmacy services. -The facility failed to ensure LVN B did not administer insulin to Resident #10 that belonged to another resident. This failure could place residents who receive insulin medications at an increased risk for complications such as increased blood glucose levels, change in cognition, and an exacerbation of symptoms and disease process. Findings include: Observation on [DATE] at 11:39 AM of medication administration performed by LVN B to Resident #10. Revealed LVN B was asked to confirm open date on insulin pen, which also had another resident's name on it. LVN B confirmed that the open date was still valid, and the insulin was not expired. Pen was cleaned with alcohol and a new needle was placed on pen. Novolog 10 units to the RLQ was administered Resident #10. LVN B went back to the medication cart realizing that the Novolog belonged to another resident. There was no adverse reaction since it was the same medication, and the correct dosage was provided to Resident #10. LVN B was asked how long she had been working in the facility, she stated that day, [DATE], was her first day in a while. In an interview on [DATE] at 11:43 AM with LVN B stated that she would give investigator a copy of the report once the appropriate individuals were contacted and a medication error report was completed. Resident, MD, family member, were contacted, and DON was made aware of medication error. LVN B was sent home for the remainder of shift. Record review of Resident #10's face sheet, dated [DATE], revealed a [AGE] year-old male, who was admitted to the facility on [DATE], with the following diagnosis: Type 1 diabetes mellitus with diabetic neuropathy, chronic obstructive pulmonary disease, unspecified, end stage renal disease, anemia in chronic kidney disease, hypertension, dependence on renal dialysis, presence of cardiac pacemaker, peripheral vascular disease, hyperlipidemia (high cholesterol), congestive heart failure, major depressive disorder, generalized anxiety, disorder, difficulty in walking. Record review of Resident #10's MDS assessment, dated [DATE], revealed that Resident #10 had a BIMS (Brief Interview for Mental Status) of 12, which indicates a moderate cognitive impairment, and a functionality of partial assistance needed for showering, lower body dressing, and putting on/takin off footwear. Supervision or touching assistance for upper body dressing and toileting, and setup or clean-up assistance for eating, and oral hygiene. Resident #10 does receive dialysis secondary to end stage renal disease. Record review of Resident #10's care plan, dated [DATE], revealed that Resident #10 was insulin dependent. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions . .Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Record review of Resident #10's active physicians orders, dated [DATE], revealed that resident is on NovoLOG Injection Solution 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 0 - 200 = 0; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401+ = 10 units Give 10 units notify nurse practitioner. , subcutaneously before meals for blood sugar Interview on [DATE] at 01:44 PM with ADON was asked what a negative outcome would be for a medication error of the wrong medication or medication that belongs to another resident would be. ADON stated that the resident's medication that was used put that resident at risk for not having enough medication, and it could be fatal giving the wrong medication. Interview on ,d+[DATE] at 09:34 AM with DON was asked what a negative outcome would be for a significant medication error would be. DON stated that it could lead to resident injury and complications for that resident. Record review of thefacility provided policy titled, Administering Medications, dated revised [DATE], revealed the following: .2. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. .5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: . .9. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: a. Checking identification band; b. Checking photograph attached to medical record; and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47854 Based on observation, interview, and record review, it was determined the facility failed to ensure drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 of 2 medication carts reviewed for medication storage. The facility failed to prevent the following: -1 loose pill was found in medication cart for Hall 300 and part of Hall 200, -medication cart for Hall 300 and part of Hall 200 had 3 insulins with no open dates located on medications. -3 insulin medications were found in Hall 100 & and part of 200 Hall's medication cart that were past their expiration dates. -LVN A left 2 bubble packs of medication on top of the medication cart and left them unattended while she administered medications to a resident. -LVN B did not lock her medication cart while going into a resident's room to administer a medication. The facility's failure placed residents receiving medication at risk for drug diversion, drug overdose, and accidental or intentional administration to the wrong resident. Findings include: Observation on 04/24/24 at 8:37 AM of the medication cart for Hall 100 and part of 200 Hall revealed, Insulin Glarigin with an open date of 03/24 (according to manufacture insulin expires 28 days after opening), Insulin Aspart with an open date of 03/13/2024 (according to manufacture insulin expires 28 days after opening), and Amelog Solostar with an open date of 03/12/2024 (according to manufacture insulin expires 28 days after opening). Insulins were available for possible use. Observation on 04/24/24 at 09:20 AM of the medication cart for 300 and part of 200 halls revealed Novolog insulin pen with no resident's name or open date on medication, and 2 Lantus medications did not have an open date on the bottles. 1 loose pill was found in bottom of medication drawer. The pill was not identified by LVN A. Observation on 04/24/24 at 11:40 AM of medication cart for Hall 100 and part of 200 Hall revealed it was left unlocked and unattended while LVN B administered medication to resident in his room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/24/24 at 11:44 AM with LVN B was asked what a negative outcome would be for leaving medication cart unlocked and unattended. LVN B stated that another resident could get into the cart and take medications. Observation on 04/25/24 at 09:05 AM of mediation cart on 200 Hall revealed it was left unattended with 2 bubble packs of medication left on top of medication cart, while LVN A administered medication to a Resident. Observation on 04/25/24 at 09:19 AM of mediation cart on 200 Hall revealed 2 bubble packs still left on top of medication cart unattended. In an interview on 04/25/24 at 09:20 AM LVN A was asked what a negative outcome of leaving medications unattended. LVN A stated that another resident could walk by and take medications. In an interview on 04/26/24 at 09:07 AM ADON was asked what a negative outcome would be for administering expired medications and leaving the medication cart unlocked and leaving medications out unattended. ADON stated that by leaving the medication cart unlocked anyone can get into the cart and could lead to an adverse reaction. ADON also stated that by leaving medication unattended could also lead to an adverse reaction to a resident and could be serious. In an interview on 04/26/24 at 09:34 AM DON stated that a negative outcome for administering an expired medications could lead to resident injury and complications for the resident and the expired medications would not be effective or even dangerous. DON was asked what a negative outcome would be for not locking medication cart and leaving medications out to where residents could get to them. DON stated that any resident that was not cognitively intact could get into the cart and take medications that do not belong to them and could lead to a resident injury or complication. Record review of the facility provided policy titled, Security of Medication cart, revised April 2007, revealed the following: 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. .4. Medication carts must be securely locked at all times when out of the nurse's view Record review of facility provided policy titled, Administering Medications, revised April 2019, revealed the following: .12. The expiration/beyond use date on the medication label is checking prior to administering, When opening a multi-does container, the date opened is recorded on the container. .19. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48491 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure freezer items were properly stored, labeled and dated. 2. The facility failed to ensure walk-in refrigerator items were stored, labeled, and dated. 3. The facility failed to ensure pantry foods were properly stored, labeled, and dated. These failures could place residents who ate food served by the kitchen at risk of food-borne illness. Findings include: Observation of the walk-in pantry on 04/24/24 at 8:16 AM revealed the following: 1. (1) Package of turkey gravy mix, opened and sealed in a Ziploc storage bag, with no label or date. 2. (2) Boxes of oatmeal creme pies, 1 opened and the other sealed, with no label or date. 3. (2) cereal boxes, not sealed and open to air with no date or label. 4. (5) cereal bowls covered in plastic wrap with no date or label. 5. (7) loaves of bread were unopened and in their original packages with no date or label, (1) loaf opened and in original package, with no date or label. Observation of the walk-in refrigerator on 04/24/24 at 8:25 AM revealed the following: 1. (1) partially used loaf of what looked like raisin bread, in original package, with no date or label. 2. (7) bags of hamburger buns, in original package, with no date or label. 3. (1) bag of what appeared to be shredded purple cabbage with no date or label. 4. (1) bag of shredded carrots, no date or label. 5. (11) bags of a yellow substance which may have been liquid eggs, with no date or label. 6. (2) packages of ham in a bucket, both sealed, with no label or date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. (2) packages of what appeared to be chili with no date or label. 8. (2) boxes of individually wrapped packages of margarine with no date or label. Observation of the freezer on 04/24/24 at 8:40 AM revealed the following: 1. (2) large packages of meat in a tray with no date or label. In an interview on 04/26/24 at 9:35 AM, Cook G stated that a possible negative outcome for not having labeled and dated food in walk in refrigerator, pantry, and freezers would be that the food would not be servable and that the facility policy states that everything must be dated and labeled. In an interview on 04/26/24 at 9:40 AM, Cook F stated that a possible negative outcome for not having everything in the kitchen labeled and dated would be that they would not know what the food item was or if it was outdated, and they do not want to use bad food because that would be bad. In an interview on 04/26/24 at 10:00 AM, DM stated that a possible negative outcome for not having food dated and labeled would be that residents could get sick and that everything must have a label and a date. She went on to state that leftovers must be dated as well and that they are only good for 3 days after the date and then they must be thrown out. Record review of the facility-provided policy dated October 2009 titled Food Safety in Receiving and Storage: General Food Storage Guidelines stated in part: .Refrigerated, ready to eat foods are properly covered, labeled, dated with a use-by date, and refrigerated immediately. [NAME] them clearly to indicate the date by which the food shall be consumed or discarded.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47854 48161 Based on interview and record review, the facility failed to electronically submit to CMS complete and accurate direct care staffing information, including information, for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specification established by CMS for 1 of 4 FY quarters (FY Quarter 1 2024 (October 1-December 31)) reviewed for administration. The facility failed to submit staffing data to CMS for FY Quarter 1 (October 1-December 31). This failure could place residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment. Findings included: Review of the CMS PBJ report for CMS for FY Quarter 1 (October 1-December 31) indicated the facility had failed to submit data for the quarter triggered. In an interview on 04/24/24 at 9:30 AM, ADM stated that IT Corp was responsible for uploading the PBJ. In a phone interview on 4/26/24 at 9:44 AM, IT Corp stated that the PBJ was not uploaded due to human error. He stated that he oversaw fifteen buildings and that he missed 1 and it was that facility. He stated he sent all the documents to the ADM. Review of the facility's undated policy, and titled Staffing stated in part: .Direct care staffing information per day (including agency and contract staff) is submitted to the CMS payroll-based journal system on the schedule specified by CMS, but no less than once a quarter. 48491

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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** 47854 Based on observation, interview, and record review, the facility failed to 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. The facility failed to prevent the following: -LVN B did not perform HH before performing blood sugar check. -LVN B did not perform HH before or after donning or doffing gloves to administer insulin to resident. -LVN A did not perform HH before preparing medication for resident. -LVN A did not clean bedside table before setting up medication administration for a resident with a gastrotomy tube. -CNA D did not perform HH or glove change after cleaning resident during incontinent care. -LVN A did not perform HH during incontinent care or wound care of resident. These deficient practices have the potential to affect all residents in the facility by exposing them to care that could lead to the spread of viral infections, secondary infections, and communicable diseases. Findings include: Observation on 04/24/24 at 11:34 AM revealed blood glucose check was performed by LVN B for resident. HH was not performed before donning gloves to perform the fingerstick, no HH performed after the removal of gloves after fingerstick. Observation on 04/24/24 at 11:39 AM of medication administration for a subcutaneous injection performed LVN B, revealed HH was not performed before donning gloves for the medication administration or after the gloves were removed after the administration of the injectable medication. Observation on 04/25/24 at 08:49 AM of medication preparation for resident who received medication via gastrotomy tube, revealed no HH was performed by LVN A before the prep of peg tube medications and the donning of gloves. There was a glove change in between the preparation of liquid meds and pills that needed to be crushed. No HH was performed after the removal of gloves and taking medications into room. No cleaning of bed side table was performed before the setting up meds on resident's bedside table. Observation on 04/25/24 at 01:58 PM of incontinent care with CNA D and CNA C for resident. Revealed CNA D cleaned residents bottom and did not perform hand hygiene or a glove change before touching the clean brief or draw sheet of resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/25/24 at 2:12 PM CNA D was asked what a negative outcome would be for not performing HH or glove change from a dirty to clean area of incontinent care. CNA D stated the spread of infection. Observation on 04/25/24 at 02:32 PM of incontinent care performed by CNA E and LVN A for resident. Revealed that resident had a BM and needed to be cleaned before wound care to a Stage 3 wound to the coccyx. HH was performed at the beginning of incontinent care. Resident was turned to her right side towards CNA E. LVN A proceeded to clean the back side of the resident and LVN A took a cleaning wipe and wiped resident in a back to front motion. Once all of the stool was cleaned from the resident LVN A never removed gloves or performed HH before touching the resident, residents' gown, or the baby doll the resident was holding. LVN A then proceeded to remove gloves and perform HH and then continued with wound care of the wound to resident's coccyx. LVN A cleaned the wound, but never removed her gloves or performed HH before starting to place collagen into the wound or placing the dressing onto the wound. In an interview on 04/25/24 at 03:01 PM LVN A was asked why she did not perform HH or perform a glove change after performing incontinent care for resident. LVN A stated, I did, didn't I? I thought I did. LVN A was asked what a negative outcome of no performing HH and glove changes would be LVN A stated infection control. LVN A was asked why HH, and a glove change didn't happen in between the dirty and clean portion of wound care for the resident. LVN A stated, I thought I did., and stated that a negative outcome would be increase change of infection. In an interview on 04/26/24 at 09:07 AM with ADON was asked what a negative outcome was for not performing HH during incontinent care, wound care treatments. ADON stated that when these procedures are not performed correctly there is an increased risk for infection to the residents. In an interview on 04/26/24 at 09:34 AM DON was asked what a negative outcome was for not performing HH during incontinent care, and wound care treatments. DON stated that it could lead to an increased risk for infection and complications to the residents. No policy for medication administration via gastrotomy tube was provided by facility. Record review of facility provided policy titled, Perineal care/Incontinent care, revised on 07/0/2016, stated that following: .8. For female patient/resident: . .11. Clean anal area by first wiping off excessive fecal material with toilet paper or disposable wipes (for females, wash by wiping from vagina toward anus with one stroke). Discard soiled wipes. 12. Cleanse skin with incontinent wipe or perineal cleanser and cloths until skin is clear of fecal material. 13. Wash hands, don gloves. 14. apply moisture barrier if needed. 15. Reapply appropriate incontinence brief/undergarment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility provided policy titled, Wound Care, revised October 2010, stated the following: 2. Wash and dry your hands thoroughly. .4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves. .7. Use no-touch technique. Use sterile tongue blades and applicators to remove ointments or creams from their containers. .16. Discard disposable items into the designated container. Wash and dry your hand thoroughly. .23. Wash and dry your hands thoroughly. Record review of the facility provided policy titled, Handwashing/Hand Hygiene, revised August 2019, stated the following: 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to the other personnel, resident, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .b. Before and after direct contact with residents; c. Before preparing or handling medications; d. Before performing any non-surgical invasive procedures; .g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin' j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.; .m. After removing gloves; . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility provided policy titled, Subcutaneous Injections, revised March 2011, revealed the following: Steps in the procedure. 1. Perform hand antisepsis 2. Put on gloves. . 17. Remove gloves and [NAME] in designated container, perform hand antisepsis. 18. Clean the bedside stand and/or overbed table. Return the overbed table to its proper position. 19. Wash and dry your hands thoroughly.