| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265810 | A. BUILDING _____ B. WING _____ | 12/04/2024 |

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| F 607 SS=E | Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii)<br><br>§483.12(b) The facility must develop and implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br><br>§483.12(b)(4) Establish coordination with the QAPI program required under §483.75.<br><br>§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.<br><br>§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.<br><br>§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, facility staff failed to check the Employee Disqualification List ((EDL) a list of individuals who have been determined to have abused or neglected a resident or misappropriated funds or property belonging to a resident) and/or criminal | F 607 | | |

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

Lori White — LNHA — 12/24/24

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.

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| F 607 | Continued From page 1<br>background check (CBC), prior to hire in accordance with their facility policy for eight employee (Certified Nurse Aide (CNA) I, Licensed Practical Nurse (LPN) J, receptionist K, Social Services Director, Certified Medication Technician (CMT) L, housekeeper N, Nurse Aide (NA) B, and Food Service Manager) out of ten sampled employees. Facility staff failed to develop an abuse and neglect policy that directed staff to check the NA registry for all employees, prior to hire, for seven employees (CNA I, LPN J, Receptionist K, Social services director, CMT L, housekeeper N, and NA B) out of 10 employees. The facility census was 53.<br><br>1. Review of the Facility's Background Screening Investigations, dated March 2019, showed the director of personnel, or designee, conducts background checks, reference checks and criminal conviction checks (including fingerprinting as may be required by state law) on all potential direct access employees and contractors. Background and criminal checks are initiated within two days of an offer of employment or contract agreement, and completed prior to employment.<br><br>Review of the Facility's Credentialing of Nursing Service Personnel, dated May 2019, showed:<br><br>-Nursing personnel requiring a license/certification are not permitted to perform direct resident care services until all licensing/background checks have been completed;<br>-Upon obtaining the applicants informed consent to conducting a license/certification/background investigation, the director of nursing services, or designee, will: | F 607 | | |

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| F 607 | Continued From page 2<br>-Contact the facility's authorized vendor/service organization to perform a background check in accordance with current state law and facility policy;<br>-A copy of all documents obtained during the verification and background check are filed in the employee's personnel file. Such records are filed in accordance with current federal and state law and facility policy to protect the confidentiality of information.<br><br>2. Review of CNA I's personnel record showed the employee hire date of 12/27/23. The personnel record did not contain documentation staff completed a CBC or EDL check prior to his/her hire date.<br><br>3. Review of LPN J's personnel record showed the employee with a hire date of 05/22/24. The personnel record did not contain documentation staff completed a EDL check prior to his/her hire date.<br><br>4. Review of Receptionist K's personnel record showed the employee with a hire date of 04/23/24. The personnel record did not contain documentation staff completed a CBC or EDL check prior to his/her hire date.<br><br>5. Review of Social Services Director's personnel record showed the employee with a hire date of 10/29/24. The personnel record did not contain documentation staff completed a CBC or EDL check prior to his/her hire date.<br><br>6. Review of CMT L's personnel record showed the employee with a hire date of 06/12/24. The personnel record did not contain documentation staff completed a CBC or EDL check prior to | F 607 | | |

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| F 607 | Continued From page 3<br>his/her hire date.<br><br>7. Review of Housekeeping N's personnel record showed the employee with a hire date of 02/08/24. The personnel record did not contain documentation staff completed a CBC or EDL check prior to his/her hire date.<br><br>8. Review of NA B's personnel record showed the employee with a hire date of 06/03/24. The personnel record did not contain documentation staff completed a CBC or EDL check prior to his/her hire date.<br><br>9. Review of Food Service Manager's personnel record showed the employee with a hire date of 07/10/24. The personnel record did not contain documentation staff completed a CBC or EDL check prior to his/her hire date.<br><br>10. During an interview on 12/03/24 at 2:50 P.M., the Business Office Manager (BOM) said he/she is responsible for doing EDL and CBC checks for new employees. He/She said six months ago his/her processes changed. He/She said the facility was shorthanded and employees were "pushed through" the hiring process without back ground screenings prior to hire. He/She said he/she was initiating the paperwork during their orientation. He/She said new employee screenings are supposed to be initiated before the employee steps foot in the building. He/She said the employees are in the building before the checks come back. He/She said he/she is not sure where the missing background checks are. He/She said he/she does do yearly chart audits. He/She said he/she does background screenings when missing background checks are found during those audits. | F 607 | | |

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| F 607 | Continued From page 4<br><br>During an interview on 12/03/24 at 3:17 P.M., the Director of Nursing (DON) said EDL and CBC checks should be done prior to hire. He/She said it is the responsibility of the BOM to ensure those checks are completed. He/She said those checks are important because they keep residents safe from people who have been committed of abuse and neglect. He/She said he/she was not aware the BOM was not running background checks on new employees prior to hiring them.<br><br>During an interview on 12/03/24 at 4:10 P.M., the administrator said the BOM is responsible for checking background screenings. He/She said it is his/her expectation that the CBC and EDL checkes are completed prior to hire. He/She said he/she was not aware the BOM wasn't conducting background screenings prior to hire.<br><br>11. Review of the facility's policies showed staff did not provide a policy to direct staff to check the NA registry on all employees prior to hire.<br><br>12. Review of CNA I's personnel record showed the employee with a hire date of 12/27/23. The personnel record did not contain documentation staff completed a NA Registry check prior to his/her hire date.<br><br>13. Review of LPN J's personnel record showed the employee with a hire date of 05/22/24. The personnel record did not contain documentation staff completed a NA Registry check prior to LPN J's hire date.<br><br>14. Review of Receptionist K's personnel record showed the employee with a hire date of 04/23/24. The personnel record did not contain | F 607 | | |

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| F 607 | Continued From page 5<br>documentation staff completed a NA Registry check prior to Receptionist K's hire date.<br><br>15. Review of Social Services Director's personnel record showed the employee with a hire date of 10/29/24. The personnel record did not contain documentation staff completed a NA Registry check prior to Social Services Director's hire date.<br><br>16. Review of CMT L's personnel record showed the employee with a hire date of 06/12/24. The personnel record did not contain documentation staff completed a NA Registry check prior to CMT L's hire date.<br><br>17. Review of Housekeeping N's personnel record showed the employee with a hire date of 02/08/24. The personnel record did not contain documentation staff completed a NA Registry check prior to Housekeeping N's hire date.<br><br>18. Review of NA B's personnel record showed the employee with a hire date of 06/03/24. The personnel record did not contain documentation staff completed a NA Registry check prior toNA B's hire date.<br><br>19. During an interview on 12/03/24 at 2:50 P.M., the BOM said he/she is responsible for running the NA registry checks. He/She said he/she is aware he/she was supposed to run the NA registry checks prior to hire. He/She said he/she was not sure why the staff members did not have the NA Registry checks done prior to hire. He/She said he/she thought the NA registry was only ran to check if an employee was certified. He/She said he/she was not aware it was to check for federal indicators (a marker given by the federal | F 607 | | |

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| F 607 | Continued From page 6<br>government to individuals who have committed abuse and/or neglect) against the staff member.<br><br>During an interview on 12/03/24 at 3:17 P.M., the DON said NA registry checks should be done prior to hire. He/She said the BOM is in charge of ensuring all checks are done prior to hire. He/She said he/she knows that it is important to have them done prior so that residents are not exposed to any employees who may cause them harm. He/She was not aware that the NA registry checks were not being done prior to hire.<br><br>During an interview on 12/03/24 at 4:10 P.M., the Administrator said the BOM is responsible for checking the NA registry prior to hire on all employees. He/She said he/she was not aware the facility's policy did not direct staff to check all employees prior to hire. He/She said it is his/her expectation that staff check all employees prior to hire. He/She said he/she had instructed the BOM to do checks on all staff prior to hire and he/she was not aware that the BOM was not doing the checks. | F 607 | | |
| F 623 SS=C | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or | F 623 | | |

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| F 623 | Continued From page 7<br>discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), | F 623 | | |

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| F 623 | Continued From page 8<br>and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of | F 623 | | |

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| F 623 | Continued From page 9 | F 623 | | |

the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, facility staff failed to notify the Ombudsman (a resident advocate) for four residents (Resident #25, #34, #38, and #54) out of four sampled resident who transfered to the hospital. The facility's census was 53.

1. Review of the facility policies showed the facility did not have a policy for Ombudsman notification.

2. Review of Resident #25's medical record showed the resident transferred to the hospital on 10/15/24 and readmitted to the facility on 10/22/24. The medical record did not contain documentation staff notified the Ombudsman of the resident's transfer to the hospital.

3. Review of Resident #34's medical record showed the resident transferred to the hospital on 10/31/24 and readmitted to the facility on 11/06/24. The medical record did not contain documentation staff notified the Ombudsman of the resident's transfer to the hospital.

4. Review of Resident #38's medical record showed the resident discharged to the hospital on 08/12/24 and readmitted to the facility on 08/20/24. The record did not contain documentation staff notified the Ombudsman of the resident's transfer to the hospital.

5. Review of Resident 54's medical record

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| F 623 | Continued From page 10<br>showed the resident discharged to the hospital on 11/07/24 and readmitted to the facility on 11/13/24. The record did not contain documentation staff notified the Ombudsman of the resident's transfer to the hospital.<br><br>6. During an interview on 12/04/24 at 10:10 A.M., the Social Services Director said he/she was not aware of the process for Ombudsman notification of transfered and discharged residents. He/She said he/she does not handle this task.<br><br>During an interview on 12/04/24 at 4:00 P.M., the Administrator said the Ombudsman notification should be sent monthly and she was the one who did that task but hasn't had time to do it. | F 623 | | |
| F 625 SS=C | Notice of Bed Hold Policy Before/Upon Trnsfr<br>CFR(s): 483.15(d)(1)(2)<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and<br>(iv) The information specified in paragraph (e)(1) | F 625 | | |

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| F 625 | Continued From page 11<br>of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, facility staff failed to provide written information to the resident and/or the resident's representative of the facility's bed hold policy at the time of transfer to the hospital for four residents (Resident #25, #34, #38, and #54) out of 14 sampled residents. The facility's census was 53.<br><br>1. Review of the facility's Bed Holds policy, dated March 2022, showed the facility shall inform residents upon admission and prior to a transfer for hospitalization or therapeutic leave of the bed-hold policy.<br><br>2. Review of Resident #25's medical record showed the resident discharged from the facility on 10/15/24 and readmitted to the facility on 10/22/24. The record did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy.<br><br>3. Review of Resident #34's medical record showed the resident discharged from the facility on 10/31/24 and readmitted to the facility on 11/06/24. The record did not contain written documentation staff notified the resident or the resident's responsible party of the facility's | F 625 | | |

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| F 625 | Continued From page 12<br>bed-hold policy.<br><br>4. Review of Resident #38's medical record showed the resident discharged from the facility on 08/12/24 and readmitted to the facility on 08/20/24. The record did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy.<br><br>5. Review of Resident 54's medical record showed the resident discharged from the facility on 11/07/24 and readmitted to the facility on 11/13/24. The record did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy.<br><br>6. During an interview on 12//24 at 10:15 A.M., the Social Services Director (SSD) said he/she knows this is supposed to be done, but to their knowledge the charge nurse does it. The SSD said the nurse would give it to him/her to upload. The SSD said he/she has not completed any bed holds for any residents upon transfer or discharge.<br><br>During an interview on 12/24 at 11:03 A.M., the Administrator said "We are supposed to do bed holds, but it is not happening." The facility found that the last SSD had not been doing this, and the new SSD needs to be trained. | F 625 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered | F 656 | | |

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| F 656 | Continued From page 13<br>care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged | F 656 | | |

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| F 656 | Continued From page 14<br>by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and interview, facility staff failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet resident's needs for three residents (Resident #20, #49, and #56) out of 14 sampled residents.The facility census was 53.<br><br>1. Review of the facility's Comprehensive Care Plans policy, September 2022, showed:<br><br>-It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment;<br>-The comprehensive care plan will be developed within 7 days after the completion of the comprehensive Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff used to assess the care needs of the resident, assessment.<br><br>2. Review of Resident #20's admission MDS, dated 11/15/24, showed staff assessed the resident as follows:<br><br>-Admitted on 11/06/24;<br>-Cognitivly impaired;<br>-Diagnoses of Cancer, Cerebrovascular accident (CVA), Transient Ischemic attack (TIA), or Stroke; | F 656 | | |

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| F 656 | Continued From page 15<br>-Care Area Triggers: Delirium, cognitive loss/dementia, communication, urinary incontinence/indwelling catheter, behavioral symptoms, falls, dental care, pressure ulcer, psychotropic drug use, and pain,<br><br>Review of the resident's medical record showed the record did not contain documentation of a comprehensive person-centered care plan for the resident, to provide directions for the resident's delirium, cognitive loss/dementia, communication, urinary incontinence/indwelling catheter, behavioral symptoms, dental care, pressure ulcer, psychotropic drug use, and pain.<br><br>During an interview on 12/04/24 at 8:52 A.M., the MDS/Care Plan Coordinator said the resident's comprehensive care plan should have been completed 21 days after admission, but unsure why this residents comprehensive was not completed.<br><br>3. Review of Resident #49's admission MDS, dated 11/01/24, showed staff assessed the resident as follows:<br><br>-Admitted on 10/22/24;<br>-Moderate cognitive impairment;<br>-Diagnoses: Renal failure, Thyroid disorder, Dementia, and Parkinson's;<br>-Care Area Triggers: Delirium, Cognitive loss, communication, activities of daily living (ADL) care, urinary incontinence/indwelling catheter, psychosocial well-being, mood state, behavioral symptoms, activities, falls, nutritional status, dehydration/fluid maintenance, pressure ulcer, and pain.<br><br>Review of the resident's medical record showed | F 656 | | |

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| F 656 | Continued From page 16<br>the record did not contain documentation of a comprehensive person-centered care plan for the resident, to provide directions for the resident's communication deficits, ADL care, urinary catheter, psychosocial well-being, mood and behavioral symptoms, nutritional status, dehydration/fluid maintenance, pressure ulcer, and pain.<br><br>During an interview on 12/04/24 at 8:53 A.M., the MDS/Care Plan Coordinator said the resident's comprehensive care plan should have been completed 21 days after admission, but he/she must have just overlooked it.<br><br>4. Review of Resident #56's discharge MDS, dated 09/21/24, showed staff assessed the resident as follows:<br><br>-Admitted on 09/16/24 from an acute hospital;<br>-Discharged 09/21/24 to an acute hospital with return anticipated;<br>-Moderate cognitive impairment;<br>-Diagnoses: Obstructive uropathy (blocked urine flow), Diabetes Mellitus, Right hip dislocation,<br>-Care Area Triggers: Cognitive loss, visual function, activities of daily living (ADL) care, urinary incontinence/indwelling catheter, psychosocial well-being, falls, nutritional status, dehydration/fluid maintenance, dental care, pressure ulcer, and pain,<br><br>Review of the resident's medical record showed staff documented the resident returned to the facility on 09/23/24. The record did not contain documentation of a comprehensive person-centered care plan for the resident, to provide directions for the resident's visual deficits, ADL care, urinary catheter, psychosocial | F 656 | | |

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| F 656 | Continued From page 17<br>well-being, falls, dental care, and pain.<br><br>During an interview on 12/04/24 at 8:54 A.M., the MDS/Care Plan Coordinator said the resident's comprehensive care plan should have been completed in October, and he/she must have just overlooked it.<br><br>5. During an interview on 12/04/24 at 3:50 P.M., the Director of Nursing (DON) said the MDS coordinator is responsible for the completion of care plans. The DON said he/she and MDS review all the care plans together. The DON said she does not have a good reason for the care plans not being done or updated.<br><br>During an interview on 12/04/24 at 4:50 P.M., the Administrator said comprehensive care plans are compeleted by MDS coordinator. The administrator said he/she does not have a reason why any of the care plans have not been done or updated, but the DON should monitor that they are. | F 656 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, facility staff failed to safely transfer two | F 689 | | |

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| F 689 | Continued From page 18 | F 689 | | |

residents (Resident #14 and #52) of two sampled residents via mechanical lift, in a manner to prevent accidents. The facility's census was 53.

1. Review of the facility's policy titled, "Using a Mechanical Lift Machine", dated July 2017, showed staff were directed as follows:

-At least two nursing assistants are needed to safely move a resident with a mechanical lift;
-Staff must be trained and demonstrate competency using the specific machines or devices used in the facility;
-Gently support the resident as he or she is moved, but do not support any weight;
-The policy did not contain direction for position of the base legs during the transfer.

2. Review of Resident #14's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/14/24 showed staff assessed the resident as severe cognitive impairment and dependent on staff for transfers from chair to bed/bed to chair.

Review of the resident's care plan, dated 10/30/24, showed two staff are to asssit the resident with the mechanical lift for transfers.

Observation on 12/03/24 at 10:12 A.M., showed Certified Nursing Aide (CNA) E and Nuring Assistant (NA) B attached the resident's sling to the mechanical lift. NA B raised the resident from his/her wheelchair with the legs in the opened position of the mechanical lift, while CNA E removed the wheelchair from behind the resident. CNA E left the room to gather additional supplies, leaving the resident suspended in the sling without two staff support for three minutes. CNA

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| F 689 | Continued From page 19<br>E returned to the resident's room, closed the legs of the mechanical lift, pushed the lift to the resident's bed, and lowered the resident to the bed.<br><br>During an interview on 12/03/24 at 10:35 A.M., CNA E said two staff should perform mechanical lift transfers, with one person controlling the lift and the other to guide the resident in the sling to ensure safety and prevent falls or the machine tipping over. The CNA said he/she should have lowered the resident back to the chair prior to leaving the room, for safety, and since only one staff was left with him/her in the room. The CNA said he/she was taught the legs of the mechanical lift should be closed when pushing the resident with the lift for better maneuvering, and to keep staff from tripping over each other.<br><br>During an interview on 12/03/24 at 10:47 A.M., NA B said two staff should perform mechanical lift transfers, with one person controlling the lift and the other to guide the resident in the sling. The NA said the legs of the mechanical lift should be opened when pushing the resident with the lift for balance and resident safety. The NA said the resident could have fallen while left "dangling in the air", but he/she was unsure of what to do since he/she was left alone with the resident.<br><br>3. Review of Resident #52's significant change MDS, dated 11/12/24, showed staff assessed the resident as severe cognitive impairment and dependent on staff for transfers from chair to bed/bed to chair.<br><br>Review of the resident's care plan, dated 12/02/24, showed two staff are to asssit the resident with the mechanical lift for transfers. | F 689 | | |

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| F 689 | Continued From page 20<br><br>Observation on 12/01/24 at 12:07 P.M., showed CNA E widened the legs of the mechanical lift to accommodate the resident's wheelchair. CNA E and CNA F attached the resident's sling to the mechanical lift. CNA E raised the resident from the wheelchair in the sling using the mechanical lift, while CNA F removed the chair from behind the resident. CNA E closed the legs of the lift, pushed the lift to the resident's bed, and lowered the resident to the bed.<br><br>During an interview on 12/03/24 at 10:35 A.M., CNA E said he/she was taught the legs of the mechanical lift should be closed when pushing the resident with the lift for better maneuvering, and to keep staff from tripping over each other.<br><br>Observation on 12/02/24 at 8:11 A.M., showed NA C widened the legs of the mechanical lift to accommodate the resident's wheelchair. NA C and NA D attached the resident's sling to the lift. NA D raised the resident from the wheelchair in the sling using the mechanical lift, while NA C removed the chair from behind the resident. NA D closed the legs of the lift, pushed the lift to the resident's bed, and lowered the resident to the bed.<br><br>During an interview on 12/02/24 at 2:39 P.M., NA C said two staff should always perform mechanical lift transfers, with one person who locks the wheel/controls the lift and the other person to guide the resident in the sling while in the air. The NA said the legs of the mechanical lift should be opened when pushing the resident with the lift for balance and safety. The NA said when he/she realized that NA D was pushing the resident in the lift with the legs closed, it was too | F 689 | | |

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| F 689 | Continued From page 21<br>late for him/her to intervene.<br><br>During an interview on 12/04/24 at 10:55 A.M., the Director of Nursing (DON) said NA C and NA D have received training on how to transfer a resident with a mechanical lift.<br><br>4. During an interview on 12/04/24 at 3:42 P.M., the DON said two staff are required to transfer a resident via a mechanical lift to ensure resident safety and prevent falls, and one person should always guide the resident in the sling. The DON said it is not appropriate or safe to leave a resident suspended in the sling in the air. He/She said the legs of the mechanical lift should be opened to ensure stability of the lift when pushing a resident. | F 689 | | |
| F 700 SS=E | Bedrails<br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. | F 700 | | |

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| F 700 | Continued From page 22<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, facility staff failed to accurately assess the use of side rails for three residents (Resident #2, #49, and #52), and failed to complete an entrapment risk assessment for five residents (Resident #1, #2, #49, #52, and #106), out of 14 sampled residents. The facility census was 53.<br><br>1. Review of the facility's policies showed staff did not provide a policy for Entrapment Risk Assessments.<br><br>Review of the facility's Proper use of Side Rails Policy, dated 09/2022, showed:<br><br>-Examples of bedrails include, but are not limited to side rails, bed side rails, safety rails, grab bars, and assist bars;<br>-The resident assessment must assess the resident's risk from using bed rails such as entrapment;<br>-The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself;<br>-A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon significant change in status, or a change in the type of bed/mattress/rail.<br><br>2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated | F 700 | | |

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| F 700 | Continued From page 23 | F 700 | | |

assessment tool, dated 11/27/24, showed staff assessed the resident as:

-Re-admitted on 10/01/24;
-Severe cognitive impairment;
-Impairment on one side of upper extremity (shoulder, elbow, wrist, hand);
-Required substantial/moderate assist from staff to roll left and right, sitting to lying in bed, lying to sitting on side of bed, and dependent for transfers from bed to chair.

Review of the resident's side rail use assessment, dated 10/29/24, showed staff documented the resident used grab bars to assist with cares and to turn side to side.

Review of the resident's medical record showed the record did not contain an entrapment risk assessment for use of side rails/grab bars.

Observation on 12/03/24 at 8:33 A.M., showed the resident in bed with grab bars to both sides of the bed in the upright position.

3. Review of Resident #2's Quarterly MDS, dated 09/23/24, showed staff assessed the resident as:

-Severe cognitive impairment;
-Required partial/moderate assist from staff to roll left and right;
-Required substantial/maximum assist from staff from sitting to lying in bed and for lying to sitting on side of bed, and dependent of staff for transfers from bed to chair.

Review of the resident's side rail use assessment, dated 09/22/24, showed staff documented the resident did not use side rails or

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| F 700 | Continued From page 24<br>assistive devices such as grab bars.<br><br>Review of the resident's medical record showed the record did not contain an entrapment risk assessment.<br><br>Observation on 12/01/24 at 2:04 P.M., showed the resident in bed with bilateral hand rails in upright position.<br><br>Observation on 12/02/24 at 1:33 P.M., showed the resident in bed with bilateral u-bars in upright position.<br><br>Observation on 12/03/24 at 10:25 A.M., showed the resident in bed with bilateral u-bars in upright position.<br><br>During an interview on 12/04/24 at 3:13 P.M., the MDS/Care plan Coordinator said the resident's side rail use assessment was incorrect, but knows resident uses u-bars. The charge nurses are responsible to complete the assessment.<br><br>4. Review of Resident #49's Admission MDS, dated 11/01/24, showed staff assessed the resident as:<br><br>-Moderate cognitive impairment;<br>-Required partial/moderate assist from staff to roll left and right and from sitting to lying and lying to sitting on side of bed;<br>-Required dependent assist from staff for transfers from bed to chair.<br><br>Review of the resident's side rail use assessment dated 10/22/24, showed staff documented the resident did not use side rails or assistive devices such as grab bars. | F 700 | | |

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| F 700 | Continued From page 25<br><br>Review of the resident's medical record showed the record did not contain an entrapment risk assessment for use of side rails.<br><br>Observation on 12/01/24 at 2:28 P.M., showed the resident in bed with bilateral grab bars in upright position.<br><br>Observation on 12/02/24 at 1:28 P.M., showed the resident in bed with bilateral grab bars in upright position.<br><br>Observation on 12/04/24 at 09:08 A.M., showed the resident in bed with bilateral grab bars in upright position.<br><br>During an interview on 12/04/24 at 3:13 P.M., the MDS/Care plan Coordinator said the resident's side rail use assessment was incorrect, but knows resident uses grab bars.<br><br>5. Review of Resident #52's admission MDS, dated 10/09/24, showed staff assessed the resident as:<br><br>-Moderate cognitive impairment;<br>-Impairment on one side of upper extremity (shoulder, elbow, wrist, hand);<br>-Required substantial/maximum assist from staff to roll left and right, sitting to lying in bed, dependent for lying to sitting on side of bed and transfers from bed to chair.<br><br>Review of the resident's side rail use assessment dated 10/03/24, showed staff documented the resident did not use side rails or assistive devices such as grab bars. | F 700 | | |

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| F 700 | Continued From page 26 | F 700 | | |

Review of the resident's medical record showed the record did not contain an entrapment risk assessment for use of side rails/grab bars.

Observation on 12/01/24 at 12:07 P.M., showed the resident held the grab bar on each side of the bed when assisted by staff to roll left and right during care.

Observation on 12/02/24 at 8:11 A.M., showed the resident in bed with grab bars to both sides of the bed in the upright position.

During an interview on 12/04/24 at 8:50 A.M., the MDS/Care plan Coordinator said the resident's side rail use assessment was incorrect. The charge nurses are responsible to complete the side rail use assessment.

6. Review of Resident #106's admission MDS, dated 11/27/24, showed staff assessed the resident as:

-Severe cognitive impairment;
-Required partial/moderate assist from staff to roll left and right, sitting to lying in bed, lying to sitting on side of bed, and substantial/maximum assist with transfers from bed to chair.

Review of the resident's side rail use assessment, dated 11/18/24, showed staff documented the resident used half side rails per family request.

Review of the resident's medical record showed the record did not contain an entrapment risk assessment for use of side rails.

Observation on 12/01/24 at 11:00 A.M., showed

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| F 700 | Continued From page 27 | F 700 | | |

the resident in bed with grab bars to both sides of the bed in the upright position.

Observation on 12/03/24 at 8:30 A.M., showed the resident in bed with grab bars to both sides of the bed in the upright position.

During an interview on 12/04/24 at 8:50 A.M., the MDS/Care plan Coordinator said he/she could not find documentation that the maintenance staff completed the bed safety measurements.

7. During an interview on 12/04/24 at 8:50 A.M., the MDS/Care plan Coordinator said nurses do the side rail and entrapment assessment and maintenance does the measurements of the side rails monthly. He/She said he/she is unsure if the resident is supposed to be in the bed during entrapment measurements.

During an interview on 12/04/24 at 9:00 A.M., Maintenance said he/she does entrapment measurements monthly. He/She said he/she measures without the resident in the bed. He/She agrees that the gaps between side rail and mattress would be different measurements with the resident laying in the bed. He/She said that he/she is unsure if he has read anything that stated that the resident needed to be in the bed for the measurements.

During an interview on 12/04/24 at 3:08 P.M., Licensed Practical Nurse (LPN) J said bed rail assessments are done upon admission and quarterly. He/She said he/she is not sure who completes them quarterly.

During an interview on 12/04/24 at 4:00 P.M., the Director of Nursing (DON) said maintenance and

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| F 700 | Continued From page 28<br>nursing get together and make sure that the side rail assessment and entrapment measurements are done. He/She said the side rail assessment is part of the admission process or it is completed if a family member asks for side rails. He/She said it is the admitting nurses responsible to complete the side rail assessment. He/She said maintenance is responsible for doing entrapment measurements, but he/she is unsure how often or if the resident should be in the bed during the measurements.<br><br>During an interview on 12/04/24 at 4:25 P.M., the Administrator said that side rail assessment is done quarterly by a nurse. He/She said maintenance does entrapment measurements monthly or with change of a new bed. He/She assumes the resident should be in the bed during measurements since that's what the diagram shows. He/She said the DON and ADON is responsible for monitoring to ensure assessments are being done. | F 700 | | |

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| F 700 | Continued From page 29 | F 700 | | |
| F 727 SS=E | Surveyor: Savage, Jade<br>RN 8 Hrs/7 days/Wk, Full Time DON<br>CFR(s): 483.35(b)(1)-(3)<br><br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, facility staff failed to provide the services of a Registered Nurse (RN) for at least eight consecutive hours per day, seven days per week. The facility's census was 53.<br><br>1. Review of the facility's Nursing Services Registered Nurse Policy, dated October 2022, showed it is the intent of the facility to comply with RN staffing requirements, and the facility will | F 727 | | |

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| F 727 | Continued From page 30<br>utilize the services of a Registered Nurse for at least eight consecutive hours per day, seven days per week.<br><br>2. Review of the facility's time-keeping records for consecutive hours worked by an RN for August 2024, showed:<br><br>-Saturday, 08/17/24: 7.55 hours;<br>-Sunday, 08/18/24: 7.9 hours.<br><br>Review of the facility's time-keeping records for consecutive hours worked by an RN for September 2024, showed:<br><br>-Sunday, 09/01/24: 7.83 hours;<br>-Saturday, 09/07/24: 7.6 hours;<br>-Sunday, 09/08/24: seven hours;<br>-Sunday, 09/29/24: did not show a RN in the building.<br><br>Review of the facility's time-keeping records for consecutive hours worked by an RN for October 2024, showed:<br><br>-Saturday, 10/05/24: 4.87 hours;<br>-Saturday, 10/19/24: 6.83 hours;<br>-Saturday, 10/26/24: 6.52 hours.<br><br>During an interview on 12/04/24 at 3:36 P.M., the Director of Nursing (DON) said his/her expectation is for staff to provide eight consecutive hours of RN coverage every day including the weekends, and he/she usually fills in if there is no RN scheduled or if someone called in. The DON said some of the days with less than eight hours of RN coverage on the weekends were likely due to a lunch break, and he/she did not have an explanation for why there was no RN | F 727 | | |

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| F 727 | Continued From page 31<br>coverage on 09/29/24.<br><br>During an interview on 12/04/24 at 4:09 P.M., the administrator said there should be an RN at the facility for eight consecutive hours per day, seven days per week. The administrator said he/she realized that there were days where the facility staff did not meet the eight consecutive hours requirement for RN coverage, and he/she did not have an explanation for why there was no RN coverage on 09/29/24. | F 727 | | |
| F 732 SS=C | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors. | F 732 | | |

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| F 732 | Continued From page 32<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Reviewed AT<br><br>Based on observation, interview, and record review, facility staff failed to post the required nurse staffing information on a daily basis, which included the facility name, current date, resident census, total number of staff and the actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift. Facility staff failed to keep the required daily staffing records for 18 months. The facility's census was 53.<br><br>1.Review of the facility's policy titled, "Nurse Staffing Posting", dated September 2022, showed:<br><br>-The facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents;<br>-It is the policy of the facility to make nurse staffing information readily available in a readable format to resident and visitors at any given time;<br>-The facility will post the Nurse Staffing sheet at the beginning of each shift; | F 732 | | |

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| F 732 | Continued From page 33<br>-A copy of the schedule will be available to all supervisors to ensure the information posted is up-to-date and current;<br>-The information shall reflect staff absences on that shift due to call-outs and illness, and after the start of each shift, actual hours will be updated to reflect such;<br>- Nursing schedules and posting information will be maintained in the Human Resources Department for review for a minimum of 18 months or as required by State law, whichever is greater.<br><br>Review of the facility's records showed the facility did not retain nurse staff posting for:<br><br>-January 2024;<br>-February 2024;<br>-03/01/24 through 03/14/24;<br>-April 2024;<br>-05/01/24, 05/04/24, 05/05/24, 05/09/24 through 05/15/24, 05/17/24 through 05/21/24, and 05/23/24 through 05/29/24;<br>-06/03/24, 06/06/24 through 06/14/24, 06/18/24 through 06/20/24, 06/25/24, 06/27/24, and 06/28/24;<br>-07/06/24, 07/07/24, and 07/12/24 through 07/31/24;<br>-08/01/24 through 08/15/24, and 08/20/24 through 08/26/24;<br>-09/13/24 through 09/15/24, 09/18/24, and 09/23/24;<br>-10/02/24, 10/07/24, and 10/28/24.<br><br>2. Observation on Sunday, 12/01/24 at 9:20 A.M., showed the daily nurse staff posting, dated Friday, 11/22/24.<br><br>3. During an interview on 12/04/24 at 10:47 A.M., | F 732 | | |

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| F 732 | Continued From page 34<br>the Director of Nursing (DON) said the postings should be retained for 18 months. He/She said he/she started working at the facility in April and did not know the process for retaining the staff posting sheets prior to that or why the sheets from January through March were missing. The DON said he/she was not sure why the sheets from 07/01/24 through 07/31/24 were missing either. The DON said at one point, he/she, the administrator, and Assistant Director of Nursing (ADON) shared the responsibility to post the daily Nurse Staffing sheet, but currently, the administrator is responsible to post it on weekdays, and the ADON prepares the ones for Saturday and Sunday ahead of time and directs the weekend charge nurse to post on the weekends.<br><br>During an interview on 12/04/24 at 10:50 A.M., the ADON said he/she prepares and prints the Nurse Staffing sheets with hall assignments on Fridays for the weekends, and gives the sheets to the charge nurse to post on the weekends.<br><br>During an interview on 12/04/24 at 4:09 P.M., the administrator said the ADON ensures the daily staff posting is printed, and the charge nurse posts it at the beginning of the shift, but he/she was not sure anyone updates the posting with call-outs or illnesses. The administrator said the daily postings for January through April were not being completed because the facility only had an interim DON and did not have enough staff to keep up with it. The administrator said he/she did not know why the Nurse Staffing sheets were not posted daily from 11/23/24 through 11/30/24. | F 732 | | |
| F 759 SS=D | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) | F 759 | | |

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| F 759 | Continued From page 35<br><br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, facility staff failed to maintain a medication error rate of less than 5% out of 27 opportunities observed, seven errors occurred, resulting in a 25.93% error rate, which affected two residents (Resident #16, and #36). The facility census was 53.<br><br>1. Review of the Facility's Administering Medications policy, dated 12/2012, showed:<br><br>-Medications must be administered in accordance with the orders including any required time frame;<br>-Individual administering the medication must check to verify right time;<br>-The Expiration/beyond use date on the medication label must be checked prior to administering, when opening a multi-dose container, the date opened shall be recorded on the container;<br><br>Review of the Facility's Medication Errors policy, dated 04/2017, showed:<br><br>-A "medication error" is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles or the professional providing services;<br>-Example of medication error includes wrong time | F 759 | | |

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| F 759 | Continued From page 36<br>and/or failure to follow manufacturer instructions and/or accepted professional standards.<br><br>2. Review of the Resident #16's physician's order sheets (POS), dated December 2024, showed the directed staff to adminster:<br><br>-Fiasp (Rapid-acting insulin) inject 25 units subcutaneously (SQ) (under the skin)with meals;<br>-Fiasp inject per sliding scale for a blood sugar of 301-350 inject five units SQ;<br>-Tresiba (Long-acting insulin) inject 65 units SQ with meals.<br><br>Observation on 12/02/24 at 10:22 A.M., showed Certified Medication Tech (CMT) O prepared and administered Fiasp 30 units and Tresiba 65 units SQ to the resident. The resident's Fiasp and Tresiba insulin pens did not contain an open or beyond use date.<br><br>During an interview on 12/02/24 at 10:31 A.M., Certified Medication Technician (CMT) O said insulins pens are supposed to be dated when opened. He/She said whoever opens the insulin pen is responsible for making sure resident name and open date is on the pen. He/She said he/she thinks insulin expires after 30 days of being open, but he/she usually has to ask the nurse for sure. He/She said if insulin pens are not dated and he/she has questions about when they were opened or doubts, he/she will go talk with the charge nurse or converse with the other CMT's to see when they were opened. He/She the risk of not dating insulin pens is not knowing how long it's been opened, and it could affect the overall effectiveness of the insulin. He/She said that residents normally going through about one insulin pen a week, so they usually don't expire. | F 759 | | |

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| F 759 | Continued From page 37 | F 759 | | |

3. Review of Resident #36's POS, dated December 2024, showed staff are directed to administer medications between 0600-1100 A.M.:

-ProFe (treat low iron) 391.3 (180 fe) milligrams (mg) daily in the morning between 0700-1100 A.M.;
-Pioglitazone (treat diabetes) 30mg one time a day between 0600-1100 A.M.;
-Metoprolol Succinate (treat high blood pressure) 25 mg in the morning between 0700-1100 A.M.;
-Furosemide (diuretic) 20mg one time a day between 0600-1100 A.M.;
-Glimepiride (treat diabetes) 2mg in the morning between 0700-1100 A.M.

Observation on 12/02/24 at 12:10 A.M., showed CMT O administered Profe, Pioglitazone, Metoprolol, Furosemide, and Glimepiride to the resident. One hour and 10 minutes after the allotted timeframe.

During an interview on 12/02/24 at 12:15 A.M., CMT O said he/she normally gives the resident his/her morning medications during breakfast but said the resident left the dining room before he/she could give them to the resident and then he/she forgot to go back later. He/She said when he/she gives medications late he/she usually puts a progress note in chart and then watches the other medication to make sure they are not given to close together.

4. During an interview on 12/02/24 at 4:03 P.M., License Practical Nurse (LPN) G said if a CMT has a medication error he/she would expect them to report it to charge nurse. He/She said if he/she

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| F 759 | Continued From page 38<br>is notified about a medication error then the physician would be contacted along with the Director of Nursing (DON), resident family, and possible pharmacy to see if anything needed to be done. He/she said there should be a progress note in the chart under risk management for a medication error and there are steps to follow. He/She agreed that administering medications late and given undated insulin is a medication error. He/She said he/she was not informed about any medication errors today.<br><br>During an interview on 12/04/24 at 3:53 P.M., the DON said when a medication error occurs that it needs to be reported to the charge nurse, DON, notify family, physician and obtain any orders. He/She said administering undated insulin and administering medications late are considered medication errors to him/her because it violates the nine rights of administration. He/She expects a progress note to be in the chart.<br><br>During an interview on 12/04/24 at 4:25 P.M., the Administrator said when a medication error occurs the charge nurse should be notified along with the doctor and family member. He/She said administering undated insulin and administering medications late would be considered a medication error. He/She expects there to be a progress note in the chart. | F 759 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary | F 761 | | |

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| F 761 | Continued From page 39<br>instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, facility staff failed to store medications in a safe and effective manner when staff failed to properly label, and/or discard expired insulin medications from two of two sampled medication carts. The facility census was 53.<br><br>1. Review of the facility's policy titled, "Administering Medications," dated 12/2012, showed the expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container.<br><br>2. Observation on 12/01/24 at 9:26 A.M., showed the 100/200 hall medication cart contained two | F 761 | | |

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| F 761 | Continued From page 40<br>Lantus insulin Pens opened and undated.<br><br>During an interview on 12/01/24 at 9:30 A.M., Certified Medication Technician (CMT) P said insulin pens are usually only good for 28 days. He/She said the person opening the insulin pen is responsible for putting the open date on the pen. He/She said the risk of not having an open date is you don't know when it expires, and insulin may not be effective if it is expired.<br><br>3. Observation on 12/01/24 at 9:49 A.M., showed the 300/400 hall medication cart contained:<br><br>-Six Lantus insulin pens opened and undated;<br>-Three Novolog insulin pens opened and undated;<br>-One Novolin insulin pen opened and undated;<br>-One Glargine insulin pen opened and undated;<br>-One Aspart insulin pen opened and undated;<br>-One Fiasp insulin pen opened and undated;<br>-One Tresiba insulin pen opened and undated.<br><br>4. During an interview on 12/01/24 at 09:55 A.M., CMT Q said there is no explanation why the insulin pens are not dated. He/She said he/she always works, and the residents take their insulin so frequently they go through one pen a week or less. He/She said insulin pens usually expire 28 days after opening. He/She said the person opening the insulin is responsible for dating the pen with the open date. He/She said the risk of not dating the pens is the insulin may not be effective if you do not know when it expires.<br><br>During an interview on 12/04/24 at 3:06 P.M., Licensed Practical Nurse (LPN) J said whoever opens the insulin pens should be dating it with the open date. He/She "thinks" insulin pens are good | F 761 | | |

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| F 761 | Continued From page 41<br>for 60 days after opening. He/She said the risk for not dating insulin pens when opened is you don't know when it expires, and the insulin may not be effective.<br><br>During an interview on 12/04/24 at 3:53 P.M., the Director of Nursing (DON) said insulin pens should be labeled with the pharmacy label and open date when opened. He/She said the person opening the pen is responsible for putting the open date on the pen. He/She said most insulin pens are good for 28 days after opening. He/She said if insulin pens are not dated then you don't know how long it has been opened and risk the insulin losses effectiveness. He/She said the Assistant Director of Nursing (ADON) and the DON should be monitoring if insulin pens are being dated. He/She said he/she was not aware there were several insulin pens opened with no dates on them.<br><br>During an interview on 12/24/24 at 4:25 P.M., the administrator said insulin pens should be dated when opened. He/She said whoever opens the insulin pen is responsible for dating it. He/She is unsure when insulin pens expire. He/She said the ADON and DON should be monitoring the pens. He/She is unsure of the risks of having opened and undated insulin pens. | F 761 | | |
| F 800 SS=E | Provided Diet Meets Needs of Each Resident<br>CFR(s): 483.60<br><br>§483.60 Food and nutrition services.<br>The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. | F 800 | | |

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| F 800 | Continued From page 42<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility staff failed to provide each resident with a nourishing, palatable, well-balanced diet to meet their daily nutritional and special dietary needs, when staff failed to follow recipes. The facility census was 53.<br><br>1. Review of the facility's Standardized Recipes policy, revised April 2007, showed staff were directed to use only tested, standardized recipes to prepare foods. Review showed standardized recipes will be adjusted to the number of portions required for a meal.<br><br>Review of the facility's standardized recipe for 52 servings of shepherd's pie showed staff were directed to include 16 pounds of ground beef, one and one-eighth of a #10 (approximately seven pounds) can of tomatoes and one gallon plus one cup of potatoes. Review showed the recipe also included peas and carrots. Review showed a three inch by three inch wide long portion was equal to one serving.<br><br>Observation on 12/02/24 at 11:36 A.M., showed dietary staff served the residents a #8 scoop (four ounces) of shepherd's pie for the noon meal. Observation showed the shepherd's pie contained more potatoes than ground beef and did not contain tomatoes. Observation showed the shepherd's pie was runny in consistency.<br><br>During an interview on 12/02/24 at 11:42 A.M., the Dietary Supervisor (DS) said staff used about eight pounds of beef and forgot to add tomatoes. The DS said staff used enough peas, carrots and potatoes for 52 servings. The DS said he/she | F 800 | | |

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| F 800 | Continued From page 43<br>reduced the amount of beef so there would not be a lot of left overs which would go to waste.<br><br>During an interview on 12/02/24 at 11:47 A.M., the Registered Dietician (RD) said he/she would expect staff to follow the standardized recipes. The RD said he/she was not aware staff only used half of the beef called for in the recipe. The RD said shepherd's pie should be firm and served as a three inch by three inch wide long portion, not a four ounce scoop. The RD said he/she did not know if a four ounce scoop was the same as a three inch by three inch wide long portion . | F 800 | | |
| F 801 SS=C | Qualified Dietary Staff<br>CFR(s): 483.60(a)(1)(2)<br><br>§483.60(a) Staffing<br>The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.<br><br>This includes:<br>§483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-<br>(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by | F 801 | | |

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| F 801 | Continued From page 44<br>an appropriate national accreditation organization recognized for this purpose.<br>(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.<br>(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.<br>(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.<br><br>§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.<br>(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-<br>(A) A certified dietary manager; or<br>(B) A certified food service manager; or<br>(C) Has similar national certification for food service management and safety from a national certifying body; or<br>D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of | F 801 | | |

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| F 801 | Continued From page 45<br>higher learning; or<br>(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and<br>(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and<br>(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility staff failed to designate a person to serve as the Director of Food and Nutrition Services with the appropriate qualifications, when the facility did not employ a qualified dietitian or other clinically qualified nutrition professional full-time. The facility census was 53.<br><br>1. Review of the facility Food Services Manager policy, updated 9/28/22, showed the director of food and nutrition services must at a minimum meet one of the following qualifications:<br><br>-A certified dietary manger (CDM);<br>-A certified food service manager;<br>-Has two or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management. | F 801 | | |

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| F 801 | Continued From page 46<br>During an interview on 12/02/24 at 10:26 A.M., the Dietary Supervisor (DS) said he/she did not have any dietary manager training. The DS said he/she had worked in hotels and restaurants prior to starting at the facility. The DS said he/she was aware of the Certified Dietary Manager requirement and the administrator was working to get him/her certified. The DS said he/she had a food handlers card but he/she had never received any formal food service training. The DS said he/she started as a cook about six months ago and assumed the DS position about two months ago.<br><br>During an interview on 12/04/24 at 11:05 A.M., the Human Resources (HR) Manager said the DS was hired as a cook on 07/10/24 and assumed the DS role on 09/03/24. The HR manager said he/she was aware the DS did not have previous experience in a nursing facility. The HR manager said he/she was aware of the CDM requirement but did not know the certification was required upon hire. The HR manager said the DS was in his/her 90-day probation period. The HR manager said he/she did not know if the DS was enrolled in any training.<br><br>During an interview on 12/04/24 at 2:30 P.M., the administrator said he/she was responsible for ensuring the dietary manager had proper training and qualifications. The administrator said he/she thought the dietary manager could complete training after hired to the position and did not realize the dietary manager had to have dietary manager qualifications when hired. The administrator said the DS was enrolled in a food service manager course through the facility food service vendor but had not received a course date yet. | F 801 | | |

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| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, facility staff failed to store food in a manner to prevent potential contamination and outdated use. Facility staff failed to store ice scoops in a manner to prevent contamination and failed cover resident meals in a manner to prevent contamination. Facility staff failed to maintain the ice machine drain air gap. The census was 53.<br><br>1. Review of the facility's Food Receiving and Sorage policy, revised July 2014, showed:<br><br>-Food in desiganted dry storage areas shall be kept off the floor at least 18 inches;<br>-All foods stored in the refrigerator or freezer will | F 812 | | |

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| F 812 | Continued From page 48<br>be covered, labeled and dated with a "use by" date;<br>-Other opened containers must be dated and sealed or covered during storage;<br>-Dry foods that are stored in bins will be removed from original packaging, labeled and dated.<br><br>2. Observation on 12/01/24 at 9:29 A.M., showed the kitchen refrigerator #1 door contained a sign which read "Record open and use by dates on all open items. Follow use by manufacturer's date or seven days". Observation showed the refrigerator contained:<br><br>-One container of parmesan cheese opened and undated;<br>-One container with chopped garlic open to the air, opened and undated;<br>-An unlabeled and undated container with a yellow substance;<br>-Bottles of Caesar and Italian dressing, opened and undated;<br>-A bottle of ketchup, opened and undated;<br>-A metal container of lettuce leaves open to the air and undated;<br>-A container of chopped onions open to the air and undated;<br>-Two cartons of grape juice, opened and undated;<br>-Two cartons of orange juice, opened and undated;<br>-One 64oz bottle of apple juice, opened and undated;<br>-One gallon bottle of enchilada sauce, opened and undated;<br>-One bottle of salsa, opened and undated.<br><br>3. Observation on 12/01/2024 at 9:33 A.M., showed the kitchen refrigerator #2 contained food debris on the bottom shelf and two opened pieces | F 812 | | |

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| F 812 | Continued From page 49<br>of ham wrapped in plastic, which were dated 11/21.<br><br>4. Observation on 12/01/24 at 9:45 A.M., showed the kitchen freezer #1 contained:<br><br>-Abox of pizza dough open to the air and undated;<br>-A box of dinner rolls open to the air and undated;<br>-A bag of breadsticks open to the air and undated;<br>-A bag of hashbrown patties open to the air and undated;<br>-A bag of cubed potatoes open to the air and undated;<br>-A bag of french fries open to the air and undated.<br><br>5. Observation on 12/01/24 at 9:47 A.M., showed the kitchen freezer #2 door contained a sign which read "Label and date before putting items in fridge or freezer". Observation showed the freezer contained:<br><br>-A box of square cod patties with frost, open and undated;<br>-A box of unbreaded raw beef steaks, open and undated;<br>-A box of fajita flavored chicken strips, open and undated;<br>-A box of cookie dough, open and undated;<br>-A box of pork loin steak fritters, open and undated.<br><br>6. Observation on 12/01/24 at 9:50 A.M , showed the dry storage room contained:<br><br>-A package of egg noodles open to the air;<br>-A package of spaghetti noodles, open and undated; | F 812 | | |

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| F 812 | Continued From page 50<br>-A box of parboiled rice, on the floor, open and undated;<br>-A bag of oatmeal on the floor, open and undated;<br>-A salt storage container which contained an aluminum bowl.<br><br>Observation on 12/02/24 at 10:44 A.M., showed the dry goods storage area contained a bulk storage bin which contained flour. Observation showed a metal bowl was stored in the bin with the flour.<br><br>7. Observation on 12/01/24 at 9:55 A.M., showed under the cooks prep table contained a box of pancake mix with a scoop inside.<br><br>8. Observation on 12/02/24 at 10:31 A.M., showed the shelves behind the serving line contained:<br><br>-A bin of frosted flakes, undated;<br>-A bin of puffed coco cereal, dated 9/30;<br>-A bin of fruit loops, undated.<br><br>During an interview on 12/01/24 at 9:55 A.M., The Dietary Manager (DM) said all dietary staff were responsible to label and date items when opened, and prior to storing. The DM said he/she was responsible to double check and ensure opened items were resealed and labeled/dated. The DM said scoops should not be left inside containers to prevent risk of bacteria growth.<br><br>During an interview on 12/02/24 at 12:19 P.M., the Registered Dietician (RD) said food labeling/dating, and kitchen cleanliness have been issues lately and he/she was working with staff to resolve. | F 812 | | |

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| F 812 | Continued From page 51 | F 812 | | |

10. Observation on 12/01/14 at 12:45 P.M., showed staff served the noon meal. Observation showed the cooler uncovered contained ice with the ice-scoop inside.

11. Observation on 12/02/24 at 11:49 A.M., showed an unidentified staff member prepared drinks for residents in the dining room and placed the ice scoop into an uncovered cooler which contained ice after after each drink.

12. Observation on 12/02/24 at 11:59 A.M., showed shower Aide T used the ice scoop to remove ice from the cooler and placed the ice scoop back into the cooler with ice.

During an interview on 12/02/24 at 11:59 A.M., Shower Aide T said he/she helped with lunch everyday. He/She said the ice scoop should go back in the scoop holder and should not be stored in the ice.

13. Observation on 12/02/24 at 12:11 P.M., showed Nurse Aide (NA) D used a ice scoop to remove ice from the dining room cooler and placed the ice scoop back into the cooler with ice. Observation showed NA D served the drink to a resident. NA D then removed the scoop from the ice, prepared another resident drink, and returned the scoop to the ice bin.

During an interview on 12/02/24 at 12:12 P.M., NA D said the ice scoop should "probably not" go in cooler but he/she was not sure where it should go. NA D said he/she helped with lunch daily.

14. Observation on 12/02/24 at 12:11 P.M., showed Housekeeper N removed the ice scoop from the ice, placed ice in a cup and returned the

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| F 812 | Continued From page 52<br>scoop to the ice.<br><br>During an interview on 12/02/24 at 12:15 P.M., Housekeeper N said the ice scoop should go back in the container next to the cooler. Housekeeper N said the ice scoop should not be stored in the ice.<br><br>15. Observation on 12/03/24 at 8:09 A.M., showed an unidentified staff member prepared drinks for residents in the dining room and placed the ice scoop into an uncovered cooler which contained ice after after each drink.<br><br>During an interview on 12/04/24 at 1:00 P.M., the DM said dietary staff were responsible for ensuring the ice scoop was not stored in the ice.<br><br>16. Observation on 12/02/24 at 12:15 P.M., showed staff delivered two metal carts to the hallway near the nurse's station. Observation showed the meal plates were covered with plastic lids which contained a hole in the center, which exposed the food. Observation showed the cart remained in the hallway as staff delivered the meal trays to residents.<br><br>Observation on 12/03/24 at 12:25 P.M., showed an open metal cart which contained five resident hall trays sat in the main hallway on the 100-hall side of the nurse's station. Observation showed the meal plates were covered with plastic covers, which contained a hole in the center. Observation showed five resident trays contained small cups of pudding and potato salad which were not covered. Observation showed the cart was not attended by staff.<br><br>During an interview on 12/02/24 at 12:19 P.M., | F 812 | | |

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| F 812 | Continued From page 53<br>the Registered Dietician (RD) said the hall trays were being covered with lids for cold items and the lids should not have a hole in them.<br><br>During an interview on 12/04/24 at 1:00 P.M., the DM said the servers were responsible for ensuring food was covered before being placed on delivery carts. The DM said the plate covers should not have holes. The DM said he/she was not aware meal carts were being left in the hall with uncovered food items.<br><br>17. Observation on 12/02/24 10:33 A.M., showed the ice machine drain ran to an open floor drain, sat below the finished floor level and did not contain an air gap.<br><br>During an interview on 12/04/24 at 1:00 P.M., the DM said he/she was not familiar with the ice machine air gap requirement.<br><br>During an interview on 12/04/24 at 11:30 A.M., the plant supervisor said he/she had never looked at the ice machine drain so he/she didn't realize there was not an air gap.<br><br>During an interview on 12/04/24 at 2:30 P.M., the administrator said the DM and dietary staff were responsible for food storage. The administrator said dietary and nursing staff were responsible for ensuring food was covered when being delivered to resident rooms. The administrator said anyone serving drinks or using the ice scoop was responsible for not storing the scoop in the ice. The administrator said the DM and Plant Supervisor were responsible for the ice machine air gap. The administrator said the RD has been working with newer kitchen staff on ome of the issues noted. | F 812 | | |

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| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to: | F 880 | | |

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| F 880 | Continued From page 55<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, facility staff failed to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems to inhibit the growth of waterborne pathogens and reduce the risk of an outbreak of Legionnaire's Disease (a serious type of pneumonia (lung infection) caused by Legionella bacteria, which places all residents of the facility at risk of exposure which could lead to illness. Facility staff failed to ensure the two-step | F 880 | | |

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| F 880 | Continued From page 56<br>purified protein derivative (PPD) (skin test for Tuberculosis (TB)) was completed for six employees (Certified Nurse aide (CNA) I, Licensed practical nurse (LPN) J, Receptionist K, transporter M, Housekeeper N, and nurse aide (NA) B) out of ten sampled employees. Staff failed to perform hand hygiene and/or wash hands to prevent the spread of infection during perineal care for four residents (Resident #9, #14, #38, and #52) of four sampled residents. Failed to implement the Enhanced Barrier Precautions (EBP) policy when they did not educate, or alert staff of residents who required EBP, and failed to place appropriate personal protective equipment (PPE) in close proximity for three (Resident #14, #38, and #52) of three sampled residents. The facility census was 53.<br><br>1. Review of the Centers for Medicare and Medicaid Services (CMS) Quality, Safety and Oversight (QSO) 17-30, dated 06/02/17 and revised on 07/06/18, showed:<br><br>The bacterium Legionella can cause a serious type of pneumonia called Legionnaire's Disease in persons at risk. Those at risk include persons who are at least 50 years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as showerheads, cooling towers, hot tubs, and decorative fountains.<br><br>Facilities must have water management plans | F 880 | | |

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| F 880 | Continued From page 57<br>and documentation that, at a minimum, ensure each facility:<br><br>-Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system;<br>-Develops and implements a water management program that considers the ASHRAE industry standard and the CDC toolkit;<br>-Specifies testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained.<br><br>Review of the facility's Risk Management Plan for Legionella Control, reviewed 10/08/24, showed the plan contained a policy template which was not modified to reflect the facility's water system. Review showed the plan did not contain:<br><br>-Facility specific policies related to water management;<br>-A description of the facility's water system;<br>-Facility specific areas identified as at risk for Legionella growth;<br>-Control measures to include acceptable ranges;<br>-Corrective actions to take if control measures are out of range.<br><br>Review of Appendix B of the Legionella control plan showed the Appendix contained 30 questions which provided a description of the facility water system. The Appendix did not contain information related to areas identified as risk areas. The Appendix did not contain information related to control measures or | F 880 | | |

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| F 880 | Continued From page 58<br>corrective actions.<br><br>During an interview on 12/04/24 at 10:55 A.M., the Housekeeping supervisor said his/her staff flushes toilets and runs water in vacant rooms every couple of days. The housekeeping supervisor said the Plant Supervisor brought up the need to run the water periodically but the Plant Supervisor never provided guidance on four shower rooms which were being used for storage. The housekeeping supervisor said he/she did not know the last time the unused showers were flushed.<br><br>During an interview on 12/04/24 at 11:30 A.M., the Plant Supervisor said he/she read the Legionella control plan briefly when he/she started work at the facility. The Plant Supervisor said he/she was not familiar with what should be included in the Legionella control plan. The Plant Supervisor said he/she did not know if the plan identified specific risk areas of the facility water system. The Plant Supervisor said he/she believed the four showers and two bathtubs which were not being used would probably be high risk areas. The Plant Supervisor said he/she did not know if the plan addressed low use areas. The Plant Supervisor said he/she had spoken with housekeeping about flushing low use resident room sinks and toilets.<br><br>During an interview on 12/04/24 at 1:45 P.M., the administrator said maintenance staff were responsible for implementing the Legionella control plan. The administrator said he/she had reviewed the plan but was not very knowledgeable of the contents. The administrator said Appendix B contained facility specifics. The administrator said Appendix B did not contain | F 880 | | |

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| F 880 | Continued From page 59<br>facility specific risk areas, control measures or corrective actions.<br><br>2. Review of the Facility's Employee Screening for Tuberculosis, dated 12/2016, showed:<br><br>-Each newly hired employee will be screened for TB infection and disease after an employment offer has been made prior to the employee's duty assignment;<br>-The initial TB testing will be a two-step Tuberculin skin test (TST);<br>-If the reaction to the first skin test is negative, the facility will administer a second skin test not before 7 days and no later than 21 days after the first test. The employee may begin duty assignments after the first skin test (if negative) unless prohibited by state regulation.<br><br>Review of the Center for Disease Control and Prevention's, Clinical Testing Guidance for TB: TB Skin Tests, dated May 14, 2024, showed:<br><br>-Two-Step testing;<br>-If the first skin test is negative, a second TB skin test should be done one to three weeks later;<br>-The skin test reaction should be read between 48-72 hours after administration by a health care worker trained to read TB skin results.<br><br>3. Review of CNA I's employee file showed a hire date of 12/27/23. Review showed the employees file did not contain documentation the first or second step PPD as completed.<br><br>4. Review of LPN J's employee file showed a hire date of 05/22/24. Review showed the employee's file did not contain documentation the first or | F 880 | | |

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| F 880 | Continued From page 60<br>second step PPD as completed.<br><br>5. Review of Receptionist K's employee file showed a hire date of 04/23/24. Review showed the employee's file did not contain documentation the first or second step PPD as completed.<br><br>6. Review of Transporter M's employee file showed a hire date of 05/15/24. Review showed the employee's file did not contain documentation the first or second step PPD as completed.<br><br>7. Review of Housekeeper N's employee file showed a hire date of 02/08/24. Review showed the employee's file did not contain documentation the first or second step PPD as completed.<br><br>8. Review of NA B's employee file showed a hire date of 06/03/24. Review showed the employee's file did not contain documentation the first or second step PPD as completed.<br><br>9. During an interview on 12/02/24 at 2:50 P.M., the business office manager (BOM) said the director of nursing (DON) and the assistant director of nursing (ADON) are responsible for ensuring the two-step TB's are completed on all new hires. He/She said at new employee orientation he/she has the new employees file out the TB documentation and then either the DON or ADON will administer the first step. He/She said it is the DON's job to keep track of the documentation and ensure the employee completes the TB testing. He/She said all employees should have the first step TB done and read before they come in contact with the residents. He/She is not sure why there are staff members who did not get the two step TB's completed timely. | F 880 | | |

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| F 880 | Continued From page 61<br><br>During an interview on 12/02/24 at 3:17 P.M., the DON said all new employees need a two-step TB. He/She said the first step should be given and read before staff come in contact with residents. The second step should be done one to three weeks after the first step is completed. He/She said TB's should be read 48-72 hours after administration. He/She said TB's are started at new employee orientation by either the ADON, Charge nurse, or himself/her/self. He/She is responsible for ensuring the TB's are completed timely. He/She tracks them on a spreadsheet. He/She said he/she is not sure why there are employees without two-step TB's completed.<br><br>During an interview on 12/02/24 at 4:10 P.M., the administrator said the DON, with the help of the ADON, is responsible for ensuring two-step TB's are completed on all new hires. He/She said after conducting audits in September he/she was made aware that there were staff members who did not have a two-step TB. He/She said he/she thought they had all been fixed and was not sure why there were still staff members who were uncorrected.<br><br>10. Review of the facility's Hand Hygiene policy, dated May 2021 showed:<br><br>-Alcohol-based hand rub with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating and after using the restroom;<br>-The use of gloves does not replace hand hygiene. If your task require gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. | F 880 | | |

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| F 880 | Continued From page 62 | F 880 | | |

11. Review of Resident #9's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated , showed staff assessed the resident as follows:

-Cognitively impaired;
-Required substantial/maximum assist from staff with toileting, bathing, and personal hygiene.

Observation on 12/01/24 at 3:10 P.M., showed NA A entered the resident's room to provide perineal care. NA A applied his/her gloves, removed the residents soiled brief and wiped the resident's perineal area front and back. With the same soiled gloves, NA A placed a clean brief, clean clothes, and covered the resident with their blanket. NA A removed the gloves and left the room without preforming hand hygiene.

During an interview on 12/01/24 at 3:45 P.M., NA A said he/she forgot to change his/her gloves after they removed the dirty items. He/She said they are to wash hands before and after care.

12. Review of Resident #14's quarterly MDS, dated 10/14/24, showed staff assessed the resident as follows:

-Severe cognitive impairment;
-Required substantial/maximum assist from staff with personal hygiene, and dependent with toileting.

Observation on 12/03/24 at 10:13 A.M., showed CNA E entered the resident's room to provide care. CNA E applied his/her gloves and provided peri-care. CNA E changed his/her gloves,

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| F 880 | Continued From page 63 | F 880 | | |

cleaned the bowel movement from the resident's buttock, changed gloves, placed a clean brief and disposable pad underneath the resident, removed gloves, and took the trash from the room. The CNA did not perform hand hygiene before or in between gloves changes during peri-care to prevent the spread of infection.

During an interview on 12/03/24 at 10:35 A.M., CNA E said he/she should have sanitized or wash his/her hands prior to applying gloves, and after each glove change, but did not, because he/she was nervous and in a rush.

13. Review of Resident #38's Quarterly MDS, dated 09/18/24 showed staff assessed the resident as follows:

-Moderate cognitive impairment;
-Required substantial/maximal assist from staff with personal hygiene and toileting.

Observation on 12/02/24 at 3:31 P.M., showed CNA R entered the resident's room to provide catheter care. CNA R washed hands, and applied gloves. CNA R cleaned the resident's catheter and peri area. With the same soiled gloves, the CNA rolled the resident and applied new brief underneath resident. CNA R changed his/her gloves, latched the resident's brief and adjusted the blankets. The CNA did not perform appropriate hand hygiene in between gloves changes during peri-care to prevent the spread of infection.

During an interview on 12/02/24 at 3:45 P.M., CNA R said he/she should have washed hands between glove changes, but he/she was nervous. He/She said not washing hands between gloves

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| F 880 | Continued From page 64<br>changes is a risk for infection.<br><br>14. Review of Resident #52's significant change MDS, dated 11/12/24, showed staff assessed the resident as follows:<br><br>-Severe cognitive impairment;<br>-Required substantial/maximum assist from staff with personal hygiene, and dependent with toileting.<br><br>Observation on 12/01/24 at 12:07 P.M., showed CNA E entered the resident's room to provide care and applied gloves. CNA E provided peri-care, changed gloves, and cleaned the bowel movement from the resident's buttock.With the same soiled gloves, CNA E open the dresser drawer and removed a clean brief, changed gloves, placed the brief underneath the resident, covered the resident, and took the trash from the room. CNA E did not perform appropriate hand hygiene before or in between gloves changes during peri-care to prevent the spread of infection.<br><br>15. During an interview on 12/04/24 at 3:36 P.M., the DON said staff should perform hand hygiene when they enter a resident's room and prior to putting gloves on. The DON said staff should perform hand hygiene after each glove change, wash hands between dirty and clean tasks, and prior to leaving the resident's room. The DON said staff may use hand sanitizer up to three times, then he/she should wash his/her hands with soap and water.<br><br>During an interview on 12/04/24 at 4:30 P.M., the administrator said staff are expected to wash their hands when they enter the room and exit the | F 880 | | |

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| F 880 | Continued From page 65<br>room. Staff should hand sanitize between glove changes or wash hands if they are visibly soiled. Gloves should be changed between dirty task to clean task.<br><br>16. Review of the facility's Enhanced Barrier Precautions policy, dated September 2022 showed:<br><br>-All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions;<br>-Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident are activities that require the use of gown and gloves;<br>-An order for enhances barrier precautions will be obtained for residents with any of the following:<br>-Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO;<br>-Infection or colonization with any resistant organisms targeted by the CDC and epidemiologically important MDRO when contact precaution do not apply.<br><br>17. Review of Resident #14's quarterly MDS, dated 10/14/24, showed staff assessed the resident as severe cognitive impairment, and had one stage three (full thickness tissue loss) pressure ulcer. | F 880 | | |

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| F 880 | Continued From page 66<br>Observation on 12/01/24 at 11:48 A.M., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room.<br><br>Observation on 12/02/24 at 9:57 A.M., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room. LPN H and NA C performed incontinence care and wound care to the resident. NA C did not wear a gown when he/she performed incontinence care. The NA did not use appropriate PPE as an EBP during cares.<br><br>During an interview on 12/02/24 at 10:16 A.M., NA C said he/she did not know what EBP was or that a gown was required when performing incontinence care with the resident.<br><br>During an interview on 12/02/24 at 10:18 A.M., LPN H said extra PPE should be used with cares for residents with an open wound to protect the residents and staff from cross contamination. The LPN said the charge nurse notifies the NAs and CNAs during shift report of residents who require extra PPE, which requires the NAs/CNAs to wear at least a gown and gloves with incontinence care. The LPN said he/she should have ensured the NA wore a gown when he/she assisted him/her to provide incontinence care to the resident.<br><br>Observation on 12/03/24 at 10:16 A.M., showed a sign on the resident's door to alert staff on the use of EBP. NA B and CNA E entered the resident's room and did not wear a gown when they transferred the resident via mechanical lift and performed incontinence care. | F 880 | | |

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| F 880 | Continued From page 67 | F 880 | | |

During an interview on 12/03/24 at 10:35 A.M, CNA E said he/she should have worn a gown when he/she transferred the resident via mechanical lift and performed incontinence care since he/she was in contact with the resident's wound. The CNA said he/she was in a rush and forgot to go get a gown.

During an interview on 12/03/24 at 10:47 A.M., NA B said he/she did not realize there was an EBP sign on the resident's room door, and he/she did not know to wear a gown when he/she transferred the resident via mechanical lift and performed incontinence care.

18. Review of Resident #38's Quarterly MDS, dated 09/18/24 showed staff assessed the resident as follows:

-Moderate cognitive impairment;
-Indwelling catheter.

Observation on 12/02/24 at 3:31 P.M., showed the CNA R entered the resident's room with EBP sign on resident's door, washed hands, and applied gloves. CNA R performed catheter care to resident, removed gloves, and sanitized hands. The CNA did not wear a a gown when he/she performed catheter care.

During an interview on 12/02/24 at 3:45 P.M., CNA R said the EBP sign was just put on resident's door today. He/She said he/she was not informed about it at the beginning of his/her shift, but usually the sign means that the resident has a sickness. He/She said he/she is unsure why resident has one on the door today.

19. Review of Resident #52's significant change

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| F 880 | Continued From page 68<br>MDS, dated 11/12/24, showed staff assessed the resident as severe cognitive impairment, and had one unstageable (wound depth is undetermined due to being covered with necrotic tissue) pressure ulcer.<br><br>Observation on 12/01/24 at 12:07 P.M., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room.<br><br>Observation on 12/02/24 at 9:39 A.M., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room. NA C did not wear a gown when he/she assisted LPN H to hold and reposition the resident's leg while LPN H performed wound care to the resident's leg.<br><br>During an interview on 12/02/24 at 10:16 A.M., NA C said he/she did not know what EBP was or that a gown was required when he/she assisted to reposition the resident during wound care.<br><br>During an interview on 12/02/24 at 10:18 A.M., LPN H said the NA did not need to wear a gown since the NA was not the one who performed the wound care to the resident.<br><br>During an interview on 12/04/24 at 3:36 P.M., the DON said the NA should have worn gown and gloves to protect him/herself, whether he/she was directly involved with the wound care, or not.<br><br>Observation on 12/02/24 at 1:11 P.M., showed a sign on the resident's door to alert staff on the use of EBP. LPN G and NA C entered the resident's room and did not wear a gown when they transferred the resident via mechanical lift | F 880 | | |

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| F 880 | Continued From page 69<br>and performed incontinence care.<br><br>During an interview on 12/02/24 at 1:28 P.M., LPN G said he/she saw a sign on the resident's room door but he/she did not read it. The LPN said he/she had not received an in-service/training on EBP but would personally wear gloves and maybe a gown if he/she performed a treatment for a resident with an infected wound with drainage, or a urinary catheter. The LPN said he/she was not sure where to find extra PPE but he/she would ask staff or search for them if needed.<br><br>During an interview on 12/04/24 at 3:36 P.M., the DON said he/she had not yet in-serviced all staff on the use of EBP but had begun packaging kits with extra PPE (gloves, gown, mask, and trash bags) for use on each hall. The DON said he/she recently had signs placed on doors for residents with a catheter or wound, that alert staff to wear at least a gown and gloves when they provide transfers, wound care, catheter care, incontinence care for that resident. The DON said not everyone is aware of where the extra PPE kits are stored.<br><br>During an interview on 12/04/24 at 4:31 P.M., the Administrator said staff should wash hands before placing PPE on, and after it is discarded, wash hands again. The administrator said EBP has been process that the facility is still rolling it out. She said implementation and education has fallen through the cracks, there has been some education, but staff need more. The administrator said if staff see signs, and don't know what it means, they should ask their charge nurse or DON. | F 880 | | |

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| A4003 | 19 CSR 30-85.042(3) Operator/Administrator Responsibilities<br><br>The operator shall be responsible to assure compliance with all applicable laws and rules. The administrator shall be fully authorized and empowered to make decisions regarding the operation of the facility and shall be held responsible for the actions of all employees. The administrator ' s responsibilities shall include the oversight of residents to assure that they receive appropriate nursing and medical care. II/III<br><br>This regulation is not met as evidenced by:<br>Class III<br><br>Based on interview and record review, facility staff failed to check the Employee Disqualification List (EDL) (a list of individuals who have been determined to have abused or neglected a resident or misappropriated funds or property belonging to a resident) on a quarterly basis to ensure employees of the facility had not been added to the EDL since the initial check, in accordance with state specific regulation for nine (Certified Nurse Aide (CNA) I, Licensed Practical Nurse (LPN) J, receptionist K, Certified Medication Technician (CMT) L, transporter M, housekeeper N, Director of Nursing (DON), Nurse Aide (NA) B, and Food Service Manager) out of ten sampled staff. The facility census was 53.<br><br>1. Review of the facility's policies showed staff did not provide a policy for quarterly EDL checks.<br><br>2. Review of CNA I's personnel records, showed a hire date of 12/27/23. The personnel record did not contain documentation the facility completed the EDL check since June, 2024. | A4003 | | |

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| A4003 | Continued From page 1<br><br>3. Review of LPN J's personnel records, showed a hire date of 05/22/24. The personnel record did not contain documentation the facility completed the EDL check since June, 2024.<br><br>4. Review of Receptionist K's personnel records, showed a hire date of 04/23/24. The personnel record did not contain documentation the facility completed the EDL check since June, 2024.<br><br>5. Review of CMT L's personnel records, showed a hire date of 06/12/24. The personnel record did not contain documentation the facility completed the EDL check since June, 2024.<br><br>6. Review of Transporter M's personnel records, showed a hire date of 05/15/24. The personnel record did not contain documentation the facility completed the EDL check since June, 2024.<br><br>7. Review of Housekeeper N's personnel records, showed a hire date of 02/08/24. The personnel record did not contain documentation the facility completed the EDL check since June, 2024.<br><br>8. Review of DON's personnel records, showed a hire date of 04/08/24. The personnel record did not contain documentation the facility completed the EDL check since June, 2024.<br><br>9. Review of NA B's personnel records, showed a hire date of 06/03/24. The personnel record did not contain documentation the facility completed the EDL check since June, 2024.<br><br>10. Review of Food Service Manager's personnel records, showed a hire date of 07/10/24. The personnel record did not contain documentation the facility completed the EDL check since July, 2024. | A4003 | | |

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| A4003 | Continued From page 2<br><br>11. During an interview on 12/02/24 at 2:50 P.M., the business office manager (BOM) said he/she is responsible for doing quarterly EDL checks. He/She said he/she has not done a quarterly since June. He/She said he/she was having issues with logging into the system to check EDL's. He/She said he/she just put in a help ticket that day. He/She said he/she knows EDL checks are important to keep residents safe from staff who may be on the EDL list and have abuse and neglect crimes against them.<br><br>During an interview on 12/02/24 at 3:17 P.M., the DON said the BOM is responsible for all EDL checks. He/She said he/she knows EDL checks are important to ensure employees who have comminted abuse and neglect are not in the building with their residents. He/She was not aware the BOM was not checking the quarterly EDL's.<br><br>During an interview on 12/02/24 at 4:10 P.M., the administrator said the BOM is responsible for checking quarterly EDL's. He/She last spoke with the BOM in June about the quarterly EDL's. He/She said at that time the BOM was not doing the quartlery checks but siad she was going to start. He/She was not aware the BOM did not do quarterlys after the June EDL checks. | A4003 | | |
| A4018 | 19 CSR 30-85.042(18)(A) Criminal History -Facility Policy/Procedure<br><br>The facility must develop and implement written policies and procedures which require that persons hired for any position which is to have contact with any patient or resident have been informed of their responsibility to disclose their | A4018 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 01339A | A. BUILDING: _____ B. WING _____ | 12/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STONEBRIDGE ADAMS STREET | 1024 ADAMS STREET JEFFERSON CITY, MO 65101 |

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| A4018 | Continued From page 3<br>prior criminal history to the facility as required by section 660.317.5, RSMo. The facility-<br>(A) Shall also develop and implement policies and procedures which ensure that the facility does not knowingly hire, after August 28, 1997, any person who has or may have contact with a patient or resident, who has been convicted of, plead guilty or nolo contendere to, in this state or any other state, or has been found guilty of any A or B felony violation of Chapter 565, 566 or 569, RSMo, or any violation of subsection 3 of section 198.070, RSMo, or of section 568.020, RSMo, unless the person has been granted a good cause waiver by the division; II/III<br><br>This regulation is not met as evidenced by:<br>Class III<br>Refer to F607 | A4018 | | |
| A4040 | 19 CSR 30-85.042(35)(B) SNF RN-Day Shift, LPN/RN eve/nights<br><br>Licensed Nursing Requirements; Skilled Nursing Facility.<br>(B) A registered nurse shall be on duty in the facility on the day shift. Either a licensed practical nurse (LPN) or a registered professional nurse (RN) shall be on duty in the facility on both the evening and night shifts. II<br><br>This regulation is not met as evidenced by:<br>Class II<br>Refer to F727 | A4040 | | |
| A4064 | 19 CSR 30-85.042(55) Medication Storage<br><br>Facilities shall store all external and internal medications at appropriate temperatures in a | A4064 | | |

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| A4064 | Continued From page 4<br>safe, clean place and in an orderly manner apart from foodstuffs and dangerous chemicals. A facility shall secure all medications, including those refrigerated, behind at least one (1) locked door or cabinet. Facilities shall store containers of discontinued medication separately from current medications. II/III<br><br>This regulation is not met as evidenced by:<br>Class III<br>Refer to F761 | A4064 | | |
| A4074 | 19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave<br><br>Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II<br><br>This regulation is not met as evidenced by:<br>Class III<br>Refer to F700 & F689 | A4074 | | |
| A4086 | 19 CSR 30-85.042(77) Infection Control/Communicable Disease<br><br>Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State | A4086 | | |

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| A4086 | Continued From page 5<br>Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II<br><br>This regulation is not met as evidenced by:<br>Class II<br>Refer to F880 | A4086 | | |
| A5014 | 19 CSR 30-85.052(14) Personnel Sufficient, Trained<br><br>There shall be sufficient personnel properly trained in their duties to assure adequate preparation and serving of food. II<br><br>This regulation is not met as evidenced by:<br>Class II<br>Refer to F801 | A5014 | | |
| A7015 | 19 CSR 30-87.030(13) Food-Protected, Temp, Need to Contact DHSS<br><br>At all times, including while being stored, prepared, displayed, served or transported to or from the facility, food shall be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage and overhead leakage or overhead drippage from condensation. The temperature of potentially hazardous food shall be forty-five degrees Fahrenheit (45°F) or below or one hundred forty degrees Fahrenheit (140°F) or above at all times, except as otherwise provided in this section. In the event of a fire, flood, power outage or similar event that might result in the contamination of food, or that might prevent potentially hazardous food from being held at required temperatures, the person in | A7015 | | |

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| A7015 | Continued From page 6<br>charge shall immediately contact the Department of Health and Senior Services (the department). Upon receiving notice of this occurrence, the department shall take whatever action that it deems necessary to protect the residents. II/III<br><br>This regulation is not met as evidenced by:<br>Class II<br><br>Please refer to F812 | A7015 | | |
| A7017 | 19 CSR 30-87.030(15) Food-Stored Above the Floor, Protected<br><br>Containers of food shall be stored above the floor in a manner that protects the food from splash and other contamination and that permits easy cleaning of the storage area, except that metal pressurized beverage containers, and cased food packaged in cans, glass or other waterproof containers need not be elevated when the food container is not exposed to floor moisture; and containers may be stored on dollies, racks or pallets, provided the equipment is easily movable. III<br><br>This regulation is not met as evidenced by:<br>Class III<br><br>Please refer to F812 | A7017 | | |
| A7042 | 19 CSR 30-87.030(40) Ice Store/Dispense, No Contamination, Air Gap<br><br>Ice shall be dispensed only with scoops, tongs or other ice-dispensing utensils or through automatic self-service, ice-dispensing equipment. Ice-dispensing utensils shall be stored on a clean surface or in the ice with the dispensing utensil ' s | A7042 | | |

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| A7042 | Continued From page 7<br>handle extended out of the ice. Between uses, ice transfer receptacles shall be stored in a way that protects them from contamination. Ice storage bins shall be drained through an air gap. III<br><br>This regulation is not met as evidenced by:<br>Class III<br><br>Please refer to F812 | A7042 | | |

# PLAN OF CORRECTION

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| **Provider/Supplier Name:** | StoneBridge Adams Street |
| **Street Address, City, Zip:** | 1024 Adams Street, Jefferson City, MO 65101 |
| **Date of Survey:** | 12/1/2024 |

| **PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER** | 265810 |
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| ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETION DATE |
|---|---|---|
| | This Plan of Correction is submitted as required under State and Federal Law. The submission of the Plan of Correction does not constitute an admission on the part of Stonebridge Adams Street as to the accuracy of the surveyors' findings nor the conclusion drawn from those findings. Submission of the Plan of Correction does not constitute an admission on the part of Stonebridge Adams Street that the findings constitute a deficiency, or that the scope and severity determinations are correct.<br><br>The Plan of Correction is intended to constitute the facility's credible letter alleging compliance of the facility.<br><br>Compliance has been and will be achieved no later than the Plan of Correction, 1/10/2025. Compliance will be maintained as provided in the Plan of Correction. | |
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| F607 | The facility shall achieve ongoing compliance with F-607 by ensuring that:<br><br>1. All current staff have FCSR, or CBC, and the review of EDL was completed on 12/5/24.<br>2. Inservice held on 12/9/2024, CBC, EDL, CNA registry review, nursing licensure verification and pre-hire checklists (policy titled: "Background Screening Investigations, Instructions for New Hire Background Screening, Criminal Background Checks & Employment Verifications") with the HR/BOM and DON.<br><br>Review of completion of pre-hire checklist and background screenings will be completed one time monthly for 3 months until compliance is consistently achieved according to facility policy and practice.<br><br>The above corrective actions will be reported monthly to and reviewed by the QAPI committee for 3 months or until substantial compliance has been achieved.<br><br>To be monitored by the administrator. | 12/9/24 |
| | The facility shall achieve ongoing compliance with F-623 by ensuring that monthly e-mail or fax notification of facility discharges is completed. | |

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| F623 | 1. SSD and/or designee were educated on F-623 - Notice requirements prior to a discharge, and facility policy titled “Transfers and Discharges (including AMA)”<br>2. SSD and/or designee have demonstrated competency in the above processes.<br><br>Monthly review of discharges and verification of notification to the ombudsman will be one time monthly for 3 months until compliance is consistently achieved according to facility policy and practice.<br><br>The above corrective actions will be reported monthly to and reviewed by the QAPI committee for 3 months or until substantial compliance has been achieved.<br><br>To be monitored by the administrator. | 12/9/24 |
| F625 | The facility shall achieve ongoing compliance with F-625 by ensuring that bed hold notifications are completed per policy on all discharges by:<br><br>1. SSD, and all nurses and nursing leadership- were re-educated on the policy titled, “Bed Holds” and proper procedure for discharge notifications.<br>2. All appropriate staff have demonstrated competency in the above processes.<br><br>Daily review of discharges daily for 5 days, 3 times a week for 1 week, and weekly for 2 weeks until compliance is consistently achieved according to facility policy and practice.<br><br>The above corrective actions will be reported monthly to and reviewed by the QAPI committee for 3 months or until substantial compliance has been achieved.<br><br>To be monitored by the administrator. | 1/10/25 |
| F656 | The facility will maintain ongoing compliance with F-656 by ensuring that the care plan will be consistent with the resident’s care, treatment, and preferences:<br><br>1. Resident #20, #49, and #56 - have had person centered care plans updated and completed in accordance with physician orders and current care and services.<br><br>All other resident care plans have been reviewed for adherence to their completion schedule. All other resident care plans are in compliance with scheduling compliance.<br><br>Care plan updates are reviewed during daily morning meeting Monday through Friday; the Risk Meeting; Care Plan Meetings and on an as needed basis to make appropriate changes.<br><br>The MDS Coordinator completed re-education with Administrator and the Regional Clinical Operations Nurse on 12/10/2024. Education included but was not limited to completion of care plan and timeline for completion and measurable objectives to meet needs. | 12/10/24 |

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| | The above corrective actions will be reported monthly to and reviewed by the QAPI committee for 3 months or until substantial compliance has been achieved.<br><br>To be monitored by the Administrator. | |
| F689 | The facility shall achieve ongoing compliance with F-689 by ensuring that all resident environments remain free from accidents as much as possible and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>1. All CNA's involved in the care of Resident's #14, and #52 have been educated on how each resident's person-centered care plans for them.<br>2. All nursing staff were re-educated on 12-12-2024 regarding resident transfers, equipment usage and safety procedures. Education consisted of small groups or one on one lecture, review of policy and return demonstration with competency verification.<br>3. The Director of Nursing or his/her designee will do an audit of hoyer transfers three (3) times a week for four (4) weeks. Any non-compliance will result in re-education and follow-up to comply with the requirements.<br><br>The above corrective actions will be reported monthly to and reviewed by the QAPI committee for 3 months or until substantial compliance has been achieved.<br><br>To be monitored by the administrator. | 1/10/25 |
| F700 | The facility will maintain ongoing compliance with F-700 by ensuring that residents are assessed for use of side rails or transfer bars and entrapment risk per policy.<br><br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the previous elements.<br><br>1. Maintenance Director, DON and all nurses were re-educated on policy 12/14/2024 related to entrapment and side rails assessments, equipment usage and safety procedures.<br>2. Side rail assessments on Residents #2, 49 and 52 have been reviews and/or completed. Entrapment risk assessments on Residents #1, 2, 49, 52, and 106 have been reviewed and/or completed.<br>3. Entrapment risk assessments have been reviewed and completed per policy for all current residents.<br><br>The DON and Maintenance Director and/or designee will do a daily review of new admissions for the appropriate use of assist bar assessments and entrapment risk assessments. This will be completed on an ongoing basis.<br><br>The above corrective actions will be reported monthly to and reviewed by the QAPI committee for 3 months or until substantial compliance has been achieved. | 1/10/25 |

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| | To be monitored by the Administrator. | |
| F727 | The facility will maintain ongoing compliance with F-727 by ensuring that RN coverage of 8 consecutive hours daily is achieved, 7 days a week.<br><br>Daily staffing review to be completed by the DON or designee for review of required staffing for the upcoming week's schedule.<br><br>The DON and/or RN designee will be assigned to the building to appropriately staff any laps in coverage that may arise following the review.<br><br>The above corrective actions will be reported monthly to and reviewed by the QAPI committee for 3 months or until substantial compliance has been achieved.<br><br>To be monitored by the Administrator. | 12/5/24 |
| F732 | The facility will maintain ongoing compliance with F-732 by ensuring that nurse staffing is posted daily.<br><br>Daily staffing review to be completed by DON and/or designee and will be posted at the nurse's station by DON and/or assigned charge nurse.<br><br>Daily staffing documentation will be retained for 18 months by the DON and/or designee.<br><br>The above corrective actions will be reported monthly to and reviewed by the QAPI committee for 3 months or until substantial compliance has been achieved.<br><br>To be monitored by the Administrator. | 12/5/24 |
| F759 | The facility will maintain ongoing compliance with F-759 by ensuring that medication error rates are less than 5% by:<br><br>1. All nurses and CMT's were re-educated by the DON on the following:<br><br>A. All nurses and CMT's were re-educated using the "Administering Medications" and "Storage of Medications" and "Change of Condition" policies.<br><br>DON/designee will conduct daily audits of medication administration daily for 7 days, 5 times a week for 1 week, 2 times a week for 4 weeks and as needed until substantial compliance has been achieved.<br><br>The above corrective actions will be reported monthly to and reviewed by the QAPI committee for 3 months or until substantial compliance has been achieved.<br><br>To be monitored by the Administrator. | 1/10/25 |
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| F761 | The facility will maintain ongoing compliance with F-761 by ensuring that medication and biologicals are stored and labeled in a safe and effective manner by:<br><br>1. Medication and biologics in medication carts, treatment carts, crash carts and medication storage rooms have been labeled and stored according to policy.<br>2. All nurses and CMT's were re-educated using the "Administering Medications" and "Storage of Medications" policies.<br><br>Nursing staff (CMT's and Nurses) were re-educated by the DON on medication storage and handling.<br><br>DON/designee will conduct audits of medication and treatment carts and storage areas for appropriate storage 2 times a week for 4 weeks, then 2 times monthly for 2 months or until substantial compliance has been achieved.<br><br>The above corrective actions will be reported monthly to and reviewed by the QAPI committee for 3 months or until substantial compliance has been achieved.<br><br>To be monitored by the Administrator. | 1/10/25 |
| F800 | The facility will maintain ongoing compliance with F-800 by ensuring that facility staff will provide nourishing, palatable, and a well balanced diet to meet the daily nutritional requirements and special dietary needs of the residents.<br><br>1. The dietary manager has been re-educated on the standardized recipes policy.<br>2. The dietician or designee has re-educated all dietary staff on diet spreadsheets and portion sizing.<br><br>Dietary Manager will conduct audits recipe use and accuracy and portion sizing daily for 7 days and then 3 times weekly for 2 weeks or until substantial compliance has been achieved.<br><br>The above corrective actions will be reported monthly to and reviewed by the QAPI committee for 3 months or until substantial compliance has been achieved<br><br>To be monitored by the Administrator. | 1/10/25 |
| F801 | The facility will maintain ongoing compliance with F-801 by ensuring that the dietary manager meets the appropriate qualifications by:<br><br>1. Dietary manager is enrolled in the ServSafe Manager Course. Course completion will be monitored by the Registered Dietitian.<br><br>To be monitored by the Administrator | 12/11/24 |
| | The facility will maintain continued compliance with F-812 by ensuring that foods are labeled and dated, sealed appropriately, ice machine drain air gap is appropriate, ice scoops are stored | |

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| F812 | and used appropriately during meal service, and meals are covered appropriately to prevent contamination.<br><br>The ice machine drain gap has been adjusted.<br><br>The Dietician will re-educate dining staff on:<br><br>1. Labeling and dating food to include food storage to prevent contamination and outdated use<br>2. Hand hygiene and safe food handling during meal service related to ice scoop usage and storage<br>3. Meal service and plate presentation to prevent contamination.<br><br>Dietary Manager will conduct audits of food storage and labeling, meal service procedures, daily for 7 days and then 3 times weekly for 2 weeks or until substantial compliance has been achieved.<br><br>The above corrective actions will be reported monthly to and reviewed by the QAPI committee for 3 months or until substantial compliance has been achieved.<br><br>To be monitored by the Administrator. | 1/10/25 |
| F880 | The facility will maintain ongoing compliance with F-880 by ensuring that Legionella Water Management Plan, TB testing procedures, hand washing procedures, and EBP are in use appropriately.<br><br>1. Members of the Water Management Team (Legionella Team) including Maintenance Director, Infection Preventionist, DON, and Administrator have been re-educated on water management plan, testing and implementation of plan by regional nurse on 12/23/24. Inservice using policy titled, “Water Management Policy” was reviewed by all members of the Risk team on 12/20/2024.<br>2. Legionella assessment was updated to reflect areas of concern specific to this facility for review.<br>3. Regional Director of Operations will be responsible for correcting and monitoring the Water Management Policy.<br>4. Water Management Team will monitor toilets, sinks, tubs and showers in empty room and rooms that aren’t frequently used.<br>5. DON and BOM/HR were re-educated on “Tuberculosis Infection Control Program”, “Tuberculosis Employee Screening” policies by regional nurse on 12/23/24<br>6. All direct care staff, CNA’s, CMT’s and nurses- were re-educated on peri-care procedures and hand hygiene by the DON on 12/12/24.<br>7. All direct care staff of residents #9, 38 and 52 have been educated on peri care hand hygiene specific to each resident.<br>8. All clinical staff will be re-educated on EBP, signage verified and location of PPE by the DON or designee. Residents #14, 38 and 52 have PPE for EBP placed in close proximity to each resident’s room. | 1/10/25 |

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| A4003 | The facility shall achieve ongoing compliance with A4003 by ensuring that:<br><br>1. All current staff and have FCSR, or CBC, and the review of EDL was completed on 12/5/24.<br>2. Inservice held on 12/9/2024, CBC, EDL, CNA registry review, nursing licensure verification and pre-hire checklists with the HR/BOM and DON.<br><br>Review of completion of pre-hire checklist and background screenings will be completed one time monthly for 3 months | 12/9/24 |

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| | The Director of Nursing, Infection Preventionist and/or designee will conduct audits to include the following but not limited to perineal care, TB program compliance of staff, hand hygiene, EBP compliance, Legionella program compliance 2 times a week for 2 weeks, then 1 time a week for 4 weeks and then monthly until substantial compliance is achieved and ongoing.<br><br>The above corrective actions will be reported monthly to and reviewed by the QAPI committee for 3 months or until substantial compliance has been achieved.<br><br>Compliance has been and will be achieved no later than the Plan of Correction completion date.<br><br>This will be monitored by the Director of Nursing and the Administrator. | |
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| | until compliance is consistently achieved according to facility policy and practice.<br><br>The above corrective actions will be reported monthly to and reviewed by the QAPI committee for 3 months or until substantial compliance has been achieved.<br><br>To be monitored by the administrator. | |
| A4018 | See F607 | 12/9/24 |
| A4040 | See F727 | 12/5/24 |
| A4064 | See F761 | 1/10/25 |
| A4074 | See F700 & F689 | 1/10/25 |
| A4086 | See F880 | 1/10/25 |
| A5014 | See F801 | 12/11/24 |
| A7015 | See F812 | 1/10/25 |
| A7017 | See F812 | 1/10/25 |
| A7042 | See F812 | 1/10/25 |

**The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.**