STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265091	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camdenton Windsor Estates	2042 N Business Route 5 Camdenton, MO 65020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, facility staff failed to ensure residents' personal information was protected when staff left the computer screen open in public areas for four residents (Resident #12, #18, #32, and #34) out of eleven sampled residents. Facility staff failed to protect residents' privacy when staff failed to provide privacy during perineal care for one resident (Resident #17) out of three sampled residents and during medication administration by feeding tube for one resident (Resident #202) out of one sampled resident. The facility's census was 46. 1. Review of the facility's policies showed staff did not provide a policy for privacy. Review of the facility's policy titled, Resident Rights, undated, showed each resident has the right to privacy and confidentiality. 2. Observation on 04/08/25 at 8:40 A.M., showed Certified Medication Technician (CMT) A left the computer screen open and unattended with Resident #32 medication information visible in the hallway. Observation showed residents and staff walked by the cart. Observation on 04/08/25 at 8:42 A.M., showed CMT A left the computer screen open and unattended with Resident #34 medication information visible in the hallway. Observation showed residents and staff walked by the cart. Observation on 04/08/25 at 8:55 A.M., showed CMT A left the computer screen open and unattended with Resident #12 medication information visible in the hallway. Observation showed residents and staff walked by the cart. Observation on 04/08/25 at 10:45 A.M., showed CMT A left the computer screen open and unattended with Resident #18 medication information visible in the hallway. Observation showed residents and staff walked by the cart. During an interview on 04/09/25 at 10:08 A.M., CMT A said computer screens should be minimized when away from the cart. He/She said when screens are left open other staff or residents can see the information on the screen, and it is a risk for privacy. He/She said he/she just forgot to minimize the screen when he/she walked away. During an interview on 04/10/25 at 01:26 P.M., Director of Nursing (DON) said when staff walk away from their computer the screen should be minimized. He/She said it is a violation of privacy and it is no one else business about that resident what is on the screen. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/25 at 2:30 P.M., the administrator said when staff is away from the chart the computer screen should be minimized. He/She said no other staff or residents should see other residents' information. He/She said it is a violation of privacy. 3. Review of Resident #17's quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 01/08/25 showed staff assessed the resident as follows: -Cognitively Intact; -Dependent on staff for dressing and toileting hygiene; -Substantial/maximal assistance on staff for personal hygiene. Review of the resident's care plan, dated 03/14/25, showed staff are directed to assist the resident with transfers, dressing, toileting, and personal hygiene. Observation on 04/09/25 at 9:20 A.M., showed Certified Nursing Assistant (CNA) C and Nursing Assistant (NA) B transferred the resident from his/her chair to bed, and provided perineal care to the resident with the resident's roommate in his/her wheelchair facing the resident. CNA C and NA B did not pull the privacy curtain between the residents to provide privacy during perineal care. During an interview on 04/09/25 at 9:50 A.M., NA B said he/she should have pulled the curtain between the residents for privacy. He/She said he/she didn't even think about it at the time. During an interview on 04/09/25 at 10:26 A.M., CNA C said he/she didn't even realize the roommate was in the room until he/she came on the other side of the bed afterwards. He/She said he/she should have pulled the curtain for privacy. 3. Review of Resident #202's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -Required a feeding tube; -Diagnosis of traumatic brain injury. Observation on 04/09/25 at 11:45 A.M., showed Licensed Practical Nurse (LPN) D enter the resident's room to administer medication by feeding tube. Observation showed the LPN did not close the curtain to the outside parking lot and exposed the residents abdomen. During an interview on 04/10/25 at 08:40 A.M., LPN D said he/she did not need to close the curtain because the window was a one way view and people could not see in from the outside During an interview on 04/10/25 at 08:47 A.M., the Maintenance Director said he/she was not aware of any one-way windows or films used on the facility windows. During an interview on 04/10/25 at 02:20 P.M., the administrator said he/she was not aware of any one-way window films or windows used at the facility and would expect staff to close the room curtains to provide privacy during care. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/25 at 01:26 P.M., Director of Nursing (DON) said during care curtains should be pulled for privacy. He/She said this includes curtains by the window or in between residents. During an interview on 04/10/25 at 2:30 P.M., the administrator said he/she would expect staff to close the door and pull the curtains for all care provided to the residents to maintain their privacy. He/She said the DON is responsible to ensure nursing staff provide privacy.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to provide written information to the resident and/or the resident's representative of the bed hold policy at the time of transfer to the hospital for three residents (Resident #12, #42, and #47) out of three sampled residents. The facility's census was 47. 1. Review of the facility's Bed Hold Policy Guidelines, undated, showed the facility will notify all residents, and/or representative of the bed hold policy guidelines. This notification shall be given upon admission to the facility, at the time of transfer to the hospital or leave; at the time of non-covered therapeutic leave. 2. Review of Resident #12's medical record showed the resident discharged from the facility on 12/18/24 and readmitted to the facility on [DATE]. Review showed the resident discharged from the facility of 02/21/25 and readmitted to the facility on [DATE]. The medical record did not contain documentation staff issued a bed hold or reviewed upon discharge on [DATE] or 02/21/25. 3. Review of Resident #42's medical record showed the resident discharged from the facility on 03/16/25 and readmitted to the facility on [DATE]. The medical record did not contain documentation staff issued a bed hold or reviewed upon discharge on [DATE]. 4. Review of Resident #47's medical record showed the resident discharged from the facility on 12/02/24 and readmitted to the facility on [DATE]. The medical record did not contain documentation staff issued a bed hold or reviewed upon discharge on [DATE]. 5. During an interview on 04/10/25 at 08:40 A.M., Licensed Practical Nurse (LPN) D said he/she does not do anything with bed holds. During an interview on 04/10/25 at 1:25 PM., the Director of Nursing (DON) said bed hold should be sent with the resident when they go out. The charge nurse or whoever is initiating the transfer is responsible. The DON said she believes the previous business office manager was going to up date the form, and they never got another one so it just hasn't been being done. During an interview on 04/10/25 at 2:40 P.M., the administrator said the nurses are responsible to give upon transfer out of the facility. She said she is not sure why its not being done. The expectation is for it to be done at the time the resident is sent out for leave, and no one responsible for follow up on the process, but will be someone assigned.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to notify the Central Office Medical Review Unit (COMRU) or the state mental health authority of a change in condition Level I Preadmission Screening and Resident Review (PASRR) evaluation and determination after admission for one resident (Resident #18) of one sampled resident, when the resident was diagnosed with a new mental disorder and later experienced a significant change in his/her functional status. The facility's census was 46. 1. Review of the facility's policies showed it did not contain a policy to address the PASRR screening and referral process. 2. Review of Resident #18's electronic medical record (EMR) showed the resident admitted to the facility on [DATE] with diagnoses of Huntington's Disease and Depression (other than bipolar). He/She received a new diagnosis of schizoaffective disorder (a mental health condition with symptoms such as hallucinations and delusions, and mood disorder) on 06/10/24. Review of the resident's Significant Change Minimum Data Set (MDS), a federally mandated assessment, dated 03/18/25, showed staff assessed the resident as follows: -Mild cognitive impairment; -Not evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition; -Received antipsychotic medications on a routine basis only. Review of the resident's care plan, updated 04/01/25, showed staff assessed the resident at risk for inadequately being able to meet his/her own needs due to cognitive deficits caused from Huntington's and Schizoaffective disorder. The resident received antipsychotic medications for diagnosis of Huntington's Disease, Schizoaffective disorder, and Persistent mood disorder. Review of the resident's EMR did not contain documentation staff completed or submitted a change in status PASRR to COMRU. During an interview on 04/08/25 at 11:24 A.M., the MDS Coordinator said he/she has been responsible for the past seven months to complete and submit PASRRs prior to a resident's admission to the facility. He/She said he/she completed a significant change MDS for the resident about a month prior and he/she was not aware of the requirement to update COMRU with a significant change PASRR. During an interview on 04/10/25 11:38 AM the MDS Coordinator said facility staff follow federal and state policies regarding PASRR. He/She said the resident currently has a diagnosis of schizoaffective disorder which is a mental illness diagnosis, but he/she was not aware he/she needed to send an update to COMRU. During an interview on 04/10/25 at 2:36 P.M., the administrator said he/she knew very little about the PASRR process, facility staff follows state and federal requirements for PASRR, and the MDS Coordinator is currently responsible to complete residents' PASRRs. He/She said if a significant change (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASRR was required to be sent to COMRU he/she expects the MDS Coordinator to send the update as required.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to maintain professional standards of practice when staff failed to notify the physician and follow up with pharmacy when medications were unavailable for three (Resident #10, #12, and #201) out of three sampled residents. Facility staff failed to document the correct dose of medication for two (Resident #12 and #32) out of eight sampled residents. Staff failed to document the weight for one resident (Resident #40) weekly per physician orders. Staff failed to document weight and food intake for one resident (Resident #18) of one sampled resident with a history of significant weight loss. The facility census was 47. 1. Review of the facility's policies showed staff did not provide a policy for physicians orders. Review of the facility's telephone order policy, undated and the medication error policy, undated, showed the policies did not contain direction or guidance for unavailable or ommited medications. Review of the facility's condition change policy, undated, showed the policy did not contain direction or guidance for notification of the physician when medication is unavailable or omitted. 2. Review of Resident #10's Significant Change of Status Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/03/25 showed the staff assessed the resident as cognitively intact. Review of the Physician Order Sheet (POS), dated April 2025, showed: -Fluticasone propionate (anti-inflammatory and hayfever medication) spray, 50 mircrograms (mcg) twice a day; -The order did not contain number of sprays or to which nostril; -The POS did not contain an order to allow the resident to self administer the medication. Review of the resident's Medication Administration Record (MAR), dated March 2025, showed staff documented the fluticasone was unavailable on 03/26/25-03/28/25, 03/30/25 and 03/31/25. Review of the resident's MAR, dated April 2025, showed staff documented the fluticasone was unavailable from 04/01/25 through 04/09/25. Review of the nurse notes, dated 03/01/25 through 04/09/25 showed staff did not document contact with the physician or the pharmacy when the resident did not recieve his/her medication. During an interview on 04/07/25 at 10:13 A.M., the resident said he/she had been out of his/her nasal spray for a long time now. He/She said that when at home he/she was taking two sprays to each nostril twice a day but at the facility they told her it was one spray to each nostril twice a day. He/She said he/she ran out of the medication and the pharmacy won't fill it because he/she ran out too soon. The resident said that the staff keep the medication in the medication cart but gives the spray to her to give it to him/herself. During interview on 04/09/25 at 10:08 A.M., Certified Medication Techinition (CMT) A said the resident's nasal spray has been sent off for refill but insurance has not refilled it. He/She said the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident knows he/she is only supposed to use one spray each nostril, but he/she says he/she needs two sprays and that's probably why insurance hasn't refilled it because its to soon. 3. Review of Resident #12's Quarterly MDS, dated [DATE] showed the staff assessed the resident as cognitively impaired. Review of the resident's POS, dated April 2025, showed and order for fluoxetine (an antidepressant) 10 milligrams (mg) once daily; Review of the resident's MAR, dated April 2025, showed staff documented the fluticasone was unavailable from 04/05/25 through 04/08/25. Review of the nurse notes, dated 03/01/25 through 04/09/25, showed staff did not document contact with the physician or the pharmacy when the resident did not recieve his/her medication. During interview on 04/09/25 at 10:08 A.M., CMT A said the resident's Fluoxetine has been ordered, but he/she is not sure why its not here yet. He/She said when medications aren't available for a few days he/she tells the evening CMT and that CMT will call pharmacy or let the charge nurse know. 4. Review of Resident #201's admission MDS, dated [DATE], showed staff assessed the resident as cognitively intact and admitted on [DATE]. Review of the resident's POS, dated April 2025, showed a physician order on 03/21/25 for the following: -Alendronate (used to treat weak/thin bones) 35 mg weekly on Mondays; -Meloxicam (used to treat symptoms of arthritis) 15 mg daily; Review of the resident's MAR, dated March 2025, showed staff documented the following: -Alendronate as unavailable on 03/24/25 and 03/31/25; -Meloxicam as unavailable 03/21/25 through 03/31/25. Review of the resident's MAR, dated April 2025, showed staff documented the meloxicam as unavailable 04/01/25 through 04/08/25. Review of the nurse notes, dated 03/01/25 through 04/09/25, showed staff did not document contact with the physician or the pharmacy when the resident did not recieve his/her medication. 5. During an interview on 04/10/25 at 1:13 P.M., the Director of Nursing (DON) said when a medication is unavailable, the CMT is to write a note and let the DON know. If it is an over the counter (OTC) medication, he/she would go to a local store and pick it up. If the medication is a prescription, then the CMT can check the emergency supply and pull from that. If the medication is not in the emergency supply, the CMT is to notify the charge nurse. The resident should not go longer than a few days without the medication. The nurse should be calling the pharmacy to follow up and notify the DON and physician. Until yesterday, the CMT's were doing their own chart audits but now the nurse will be double checking with the CMT. He/She said he/she was not aware of the medications missing. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Missing medication could cause harm or potentially death of a resident if missing. During an interview on 04/10/25 at 2:20 P.M., the Corporate Nurse said that staff should document the unavailable medication, notify the nurse, physician and DON of the medication and document any adverse effects of missing medications. During an interview on 04/10/25 at 2:20 P.M., the Administrator said CMT's should pull medications from the emergency supply if the medication is unavailable and would need to defer to nursing for the rest of the procedure. He/She said that the physician should be notified right away of any medication is out to avoid any adverse reactions. 6. Review of Resident #12's Significant Change MDS, dated [DATE], showed staff documented the resident diagnosis of Hypertension (high blood pressure). Review of the resident's POS, dated 02/10/25, showed an order for Diltiazem (medicine used to treat high blood pressure) 240 mg, one capsule daily. Observation on 04/08/25 at 8:55 A.M., showed CMT A administered Diltiazem 180mg to the resident. During an interview on 04/09/25 at 10:08 A.M., CMT A said the resident was previously on 180mg and the order must not have gotten followed through to get that changed and the correct card put in the medication cart. He/She said there is a lot of risks if the resident is not receiving the correct dosage of medication as prescribed depending on the medication. 7. Review of Resident #32's admission MDS, dated [DATE], showed staff documented the resident diagnosis of Arthritis (a condition characterized by joint inflammation, causing pain, swelling, stiffness, and limited movement). Review of the resident's POS, dated 03/12/25, showed an order for Vitamin D3 (for bone and muscle strength, immune function, and healthy skin) 1,250 mcg, one tablet daily on Tuesday and Friday. Observation on 04/08/25 at 08:40 A.M., showed CMT A administered Vitamin D3 50mcg to the resident. During an interview on 04/09/25 at 10:08 A.M., CMT A said he/she noticed the incorrect dosage of Vitamin D3 was given after the observation. He/She said he/she was unsure how long the resident had been getting the incorrect dosage. During an interview on 04/10/25 at 1:35 P.M., the DON said staff should verify medication with the physician's order to ensure the correct dosage is given. He/She said there are a lot of risks to the residents regarding medication errors depending on the type of medication that was given incorrectly. 8. Review of the facility's Weight and Height Measurement policy, dated 03/2012, showed residents are weighed on admission and monthly unless ordered by the attending physician to monitor the resident's condition. 9. Review of Resident #40's admission MDS, dated [DATE], showed staff assessed the resident as follows: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-admitted [DATE]; -Cognitively intact; -Dependent on staff for mobility, and transfers. Review of the resident's POS, dated 03/2025, showed an order for weekly weights times four weeks. Once A Day on Mon. Review of the resident's care plan, reviewed/revised 03/29/25, showed weigh the resident weekly or as ordered by PCP (primary care physician). Review of the resident's medical record, dated 03/17/25 through 04/10/25, showed the record did not contain a weight for the resident. During an interview on 04/07/25 at 12:31 P.M., the resident said he/she has not been weighed since he/she arrived to the facility, because he/she has not got out of bed since admitted to the facility. During an interview on 04/10/25 at 11:07 A.M., Licensed Practial Nurse (LPN) D said facility policy is that residents are weighed on admit, weekly for four weeks, then monthly on the first of the month. He/She said the nurses and CNAs are responsible to obtain resident weights, but he/she is not sure if anyone is designated to verify all the monthly weights are obtained and documented. During an interview on 04/10/25 at 12:06 P.M., the MDS Coordinator said residents are weighed on admit, weekly for four weeks, then monthly, unless other directions such as daily. He/She said the charge nurse is responsible to tell the CNAs which residents need to be weighed, and the monthly weights should be obtained within the first five days of each month. During an interview on 04/10/25 at 2:58 P.M., Certififed Nurse Assistant (CNA) G said the CNAs are responsible to weigh residents when directed by the charge nurse at beginning of each shift, document the weight on paper and give to the nurse to calculate the difference between the resident and the chair they were weighed in. He/She said residents are weighed at different intervals such as monthly, weekly, or daily, and the nurse usually tells the CNAs who needs to be weighed and when. During an interview on 04/10/25 at 12:29 P.M., the DON said residents should be weighed on admit, weekly for four weeks, then monthly, and if ordered otherwise by physician. 10. Review of the facility's policy titled, Weight and Height Measurement, dated 03/2012, showed residents are weighed on admission and monthly unless ordered by the attending physician to monitor the resident's condition. 11. Review of Resident # 18's Significant Change in Status (SCSA) MDS, dated [DATE], showed staff assessed the resident as: -Mild cognitive impairment; -Received nutrition via tube feeding and a mechanically altered diet; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Received hospice care. Review of the resident's care plan, updated 3/18/25, showed the resident's goal is to maintain his/her current weight or possibly gain weight through the next assessment, and staff were directed: -Monitor and record weights as ordered by the physician, report weights to the resident; -Resident required nutrition through a feeding tube; -Resident can be expected to lose weight due to his/her terminal condition; -Resident at risk for altered nutritional status, chooses to have a pureed diet using a divided plate, follow diet recommendations as ordered. Review of the resident's progress notes, dated 03/04/25 through 03/31/25, showed: -On 03/14/25, the RD documented resident returned to facility on 03/12/25, received a puree diet supplemented with 90 cc Boost three times daily and enteral (tube) feeding, February 2025 weight 176 lbs, (a 1% loss in one month, and 2% loss in three months). Recommend weekly weights for four weeks to closely monitor with addition of enteral feeding, will continue to monitor and follow up as needed; -On 03/16/25, the RD documented recommend weekly weights for four weeks to closely monitor with addition of enteral feeding. Review of the resident's POS, dated 03/01/25 through 04/07/25, showed: -Weigh monthly unless otherwise indicated; -Boost 90 cc at meal pass due to weight loss/nutritional supplement with Meals, effective 11/11/24; -Jevity 1.5 Cal liquid, give 300 ml bolus three times a day after meals if less than 50% of meal consumed, effective 3/31/25. Review of the resident's electronic medical record (EMR), dated 04/09/25, did not contain documentation of weekly weights and did not contain documentation of the resident's daily food intake. During an interview on 04/08/25 at 2:38 P.M., LPN D said he/she thinks the Certified Nurses Aides (CNAs) document the resident's meal intake in the electronic chart, but they just tell the nurse if the resident ate his/her meal or not. During an interview on 04/09/25 at 12:35 P.M., CNA G said staff assist the resident with meals in the dining room and verbally tell the charge nurse how much the resident ate. He/She said the CNAs have not been instructed to document the resident's meal intake, and do not report his/her fluid intake because the resident has a feeding tube. During an interview on 04/10/25 at 11:07 A.M., LPN D said the resident had a feeding tube placed in March and should have at least one weight documented after his/her readmission in March. He/She said facility policy is residents are weighed on admit and the nurse and CNA are responsible to weigh (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents as ordered. He/She said the DON is responsible to communicate recommendations from the RD to the nurses, and he/she was not aware the RD wanted the resident weighed weekly for four weeks after tube feeding started. During an interview on 04/10/25 at 12:06 P.M., the MDS Coordinator said charge nurse is responsible to tell the CNAs which residents need to be weighed, and the monthly weights should be obtained within the first five days of each month. He/She said the resident should have had a documented weight after admission in March. He/She said the DON follows up on recommendations from the RD. He/She said there was no system in place to document the resident's percentage of food intake. During an interview on 04/10/25 at 12:29 P.M., the DON said he/she expected staff to weigh the resident after he/she re-admitted to the facility, and he/she probably should have been weighed weekly especially with the feeding peg tube. He/She said he/she is responsible to ensure the recommendations from the RD gets implemented, and just missed the weight recommendations on 03/14/25 and 03/16/25. He/She said there is not currently a charting system in place to document the resident's meal consumption. During an interview on 04/10/25 at 2:36 P.M., the administrator said each resident should be weighed on admit. He/She said the resident opted to have a feeding tube placed to enhance his/her weight, and staff should have obtained the resident's weight after he/she re-admitted to the facility to monitor for any increased or decreased weight. He/She said the RD consults with residents monthly, sends his/her report to the administrator, who gives the report to the DON and dietary manager for follow up as recommended. He/She said there is not currently a charting system in place to document the resident's meal consumption, so he/she expects the CNA that assists the resident to eat to report the resident's food intake to the charge nurse after each meal. During an interview on 04/10/25 at 2:58 P.M., CNA G said the CNAs are responsible to weigh residents when directed by the charge nurse at beginning of each shift, document the weight on paper and give to the nurse to calculate the difference between the resident and the chair they were weighed in. He/She said residents are weighed at different intervals such as monthly, weekly, or daily, and the nurse usually tells the CNAs who needs to be weighed and when. During an interview on 04/11/25 at 9:03 A.M., the resident's physician said he/she would expect staff to weigh the resident when he/she re-admitted to the facility to have a new baseline weight after the hospitalization and would expect staff to follow the RD's recommendations for additional weights for monitoring.

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. Based on interview and record review, the facility staff failed to ensure the activities program was directed by a qualified professional. The census was 46. 1. Review of the facility's Role of the Activity Recreational Services policy, dated March 2012, showed the activity program must be directed by a qualified professional (Activity Director) who is directly responsible to the Administrator. During an interview on 04/09/25 at 9:14 A.M., the activity director said he/she was not certified and did not know he/she should be certified. He/She looked into it a while ago but the facility changed management and believes it fell through the cracks. During an interview on 04/10/25 at 1:13 P.M., the Director of Nursing (DON) said he/she is not sure if the Activity Director is certified and tries to keep to his/her department. During an interview on 04/10/25 at 2:20 P.M., the Administrator said the activity director is not certified and became aware he/she was not certified in August and is aware of the requirement to have them certified. He/She did not have an answer on why the Activity Director is not certified.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to ensure residents' environment remained free of accident hazards when staff failed to ensure resident's did not retain smoking materials while in the facility for six residents (Resident #10, #23, #26, #29, #34, and #40) out of six sampled residents as directed in the facility policy. The facility census was 46. 1. Review of the facility's Resident Smoking Policy, dated 12/2016, showed the policy will cover all types of smoking devices such as: -Cigarettes, tobacco, pipes, cigars (requiring matches or fire to light); -Electronic or vapor smoking replacement devices (require batteries that could cause resident damage); -Chewing tobacco; -Residents may not have or keep smoking materials in room, Smoking materials include; cigarettes, pipes, electronic or e-cigarettes, chewing tobacco, cigars, matches; -Smoking shall not be permitted in the living/sleeping area or inside the facility. Review of the facility's admission Packet, Resident Rules and Regulations, showed residents may not retain matches or lighters. 2. Review of Resident #10's Significant Change of Status (SCSA) Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/03/25, showed staff assessed the resident as cognitively intact and used tobacco. Observation on 04/08/25 at 11:35 A.M., showed the resident exit the facility to the designated smoke area. He/She removed a lighter from his/her walker and lit his/her cigarette. During an interview on 04/07/25 at 10:53 A.M., the resident said he/she goes in and out to smoke whenever he/she likes to. He/She said they are supposed to turn in their lighters after each break. 3. Review of Resident #23's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact. Observation on 4/07/25 at 11:38 A.M., showed the resident with one pack of cigarettes and lighter in coat pocket. During an interview on 04/07/25 at 11:38 A.M., the resident said he keeps his smoking material with him. He/She said he/she can go outside at any time to smoke. Observation on 04/09/25 at 1:16 P.M., showed the resident in his/her room with a vape (a device used for inhaling vapor containing nicotine and flavoring) in hand up by mouth. Resident covered vape and put in coat pocket. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #26's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact. Observation on 4/07/25 at 11:00 A.M., showed the resident had one electronic vape laying in nightstand next to bed and one pack of cigarettes in three drawer organizer in his/her room. During an interview on 04/07/25 at 11:00 A.M., resident said he/she vapes outside. He/She said he/she charges the vape when he/she comes inside from vaping. Resident said he/she charges the vape in his/her room with a charger connected to his/her laptop. He/She said from time to time he/she will smoke a cigarette, but usually vapes. Observation on 04/08/25 at 2:15 P.M., showed one electronic vape on nightstand and one pack of cigarettes in the drawer organizer in the resident's room. Observation on 04/09/25 at 8:38 A.M., showed one electronic vape laid on nightstand and one pack of cigarettes in the drawer organizer in the resident's room. 5. Review of Resident #29's Annual MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment and used tobacco. Observation on 04/07/25 at 11:55 A.M., showed the resident with a pack of cigarettes inside the cup holder attached to his/her wheelchair, as he/she propelled down the hallway to the dining room. Observation on 04/08/25 at 8:30 A.M., showed the resident in the dining room with a lighter and a pack of cigarettes inside the cup holder attached to his/her wheelchair. Observation 04/08/25 at 2:07 P.M., showed the resident in front of the nurses' station with a lighter and a pack of cigarettes inside the cup holder attached to his/her wheelchair. Observation on 04/09/25 at 8:23 A.M., showed the resident in the dining room with a lighter and a pack of cigarettes inside the cup holder attached to his/her wheelchair. During an interview on 04/10/25 at 11:04 A.M., Licensed Practical Nurse (LPN) D said the resident keeps his/her smoking materials with him/her. 6. Review of Resident #34's admission MDS, dated [DATE], showed staff assessed the resident as cognitively intact and used tobacco. Review of the resident's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact. Observation on 04/08/25 at 11:35 A.M., showed the resident exit the facility to the smoke area. He/She removed a lighter from his/her jacket and lit his/her cigarette. During an interview on 04/07/25 at 11:18 A.M., the resident said he/she goes outside to smoke whenever he/she wants to. He/She said he/she does not turn in his/her smoking materials to include his/her lighter. 7. Review of Resident #40's admission MDS, dated [DATE], showed staff assessed the resident as (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitively intact and current tobacco use. Observation on 04/07/25 at 12:30 P.M., showed the resident in bed with a vape on his/her bedside table. During an interview on 04/07/25 at 12:31 P.M., the resident said he/she does vape, but has not get out of bed since he/she admitted to the facility. The resident said they have to go outside to vape. Observation on 04/09/25 at 9:20 A.M., showed the resident in bed with a vape on his/her bedside table. 8. During an interview on 04/10/25 at 12:16 P.M., Certified Nurse Aide (CNA) G said all residents are independent smokers. He/She said residents are supposed to give their smoking materials back at the nurses station when they come back inside from smoking. He/She said this includes lighters, cigarettes, and electronic vapes. He/She said residents should only smoke or vape outside. He/She said residents should not charge vapes in their room. He/She said it is a fire hazard for the residents to keep smoking materials on themselves. During an interview on 04/10/25 at 12:06 P.M., LPN D said independent smokers are able to keep their smoking materials on them including their lighter and cigarettes. He/She said he/she is unaware of any residents who currently vape. He/She said he/she has not seen any chargers for vapes or has never been asked to charge a vape. During an interivew on 04/10/25 at 1:45 P.M., the Director of Nursing (DON) said residents are supposed to give smoking material back at the nurses station when they come back in from smoking. He/She said this includes cigarettes, lighters, and vapes. He/She said he/she was not aware that residents are keeping smoking materials on them or vaping inside the facility. He/She said this is a fire hazard for resident to keep smoking materials on them or charge vapes inside of room. He/She said it is all staff's responsibility to check if residents has smoking materials on them and if they find smoking materials staff should go to the charge nurse. During an interivew on 04/10/25 at 2:30 P.M., the administrator said smoking materials should be kept at the nurses station. He/She said this includes cigerattes, lighters, and vapes. He/She said he/she was absolutely not aware that residents are keeping smoking materials on themselves or that vapes were being charged in resident rooms. He/She said resident keeping smoking materials on themselves and charging vapes inside of rooms is a fire hazard. He/She said the residents are their own people and are aware of the policy when they were admitted and they should obey the policy. He/She said staff should monitor for smoking materials and if found they should be taken to the nurses station.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, facility staff failed to provide appropriate respiratory care and services, when they did not ensure oxygen delivery at the prescribed flow rate for one resident (Resident #6), and did not change oxygen tubing or properly clean and maintain oxygen concentrators for five (Resident #4, #6, #17, #19, and #26) out of five sampled residents. The facility census was 46. 1. Review of the facility's Oxygen Administration policy, undated, showed staff are directed as follows: -Set the flow meter to the rate ordered by the physician. -At regular intervals, check and clean oxygen equipment, masks, tubing and cannula. -Place cannula tubing in plastic bag attached to concentrator when tubing is not in use. -Change tubing per cleaning guidelines. 2. Review of Resident #4's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/01/25, showed staff assessed the resident as follows: -Mild cognitive impairment; -Required oxygen therapy; -Diagnosis of Chronic Obstructive Pulmonary Disease (COPD, a condition caused by damage to the airways or other parts of the lung). Review of the resident's physician order sheet (POS), dated 02/18/25, showed staff are directed to change the oxygen tube monthly on the first day of the month. Observation on 04/07/25 at 10:45 A.M., showed the resident in bed with oxygen via nasal cannula in place. Observation showed the oxygen tube dated 03/01/25. Observation on 04/08/25 at 3:00 P.M., showed the resident in bed with oxygen via nasal cannula in place. Observation showed the oxygen tube dated 03/01/25. 3. Review of Resident #6 admission MDS, dated [DATE], showed staff assessed the resident as follows: -Moderate cognitive impairment; -Diagnosis of Emphysema (a progressive, chronic lung disease characterized by the damage and enlargement of the tiny air sacs (alveoli) in the lungs, leading to reduced lung function and shortness of breath). Review of the resident's POS, dated 02/18/25, showed staff are directed to change the oxygen tube monthly on the first day of the month. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's POS, dated 02/25/25, showed an order for Oxygen two Liters (L) per minute per nasal cannula continuous Observation on 04/07/25 at 10:00 A.M., showed the resident in bed with oxygen via nasal cannula in place. Observation showed the oxygen tube dated 03/01/25. Observation showed the resident's oxygen concentrator set at five liters per minute. Observation on 04/08/25 at 2:05 P.M., showed the resident in bed with oxygen via nasal cannula in place. Observation showed the oxygen tube dated 03/01/25. Observation showed the resident's oxygen concentrator set at five liters per minute. Observation on 04/09/25 at 2:00 P.M., showed the resident in bed with oxygen via nasal cannula in place. Observation showed the oxygen tube dated 03/01/25 and 04/08/25. Observation showed the resident's oxygen concentrator set at five liters per minute. Observation on 04/10/25 at 10:00 A.M., showed the resident in bed with oxygen via nasal cannula in place. Oxygen tubing dated 03/01/25 and 04/08/25. Observation showed the resident's oxygen concentrator set at five liters per minute. During an interview on 04/10/25 at 12:15 P.M., Licensed Practical Nurse (LPN) D said the nurse should check oxygen settings every shift. He/She said he/she was not sure why the resident's oxygen is set to five liters, and does not remember what it should be, but knows it's not to be that high. LPN D said there are many potential risks to the flow rate being too high, and it should be set for what the physician ordered. During an interview on 04/10/25 at 1:45 P.M., the Director of Nursing (DON) said every staff who walks into a room for a resident with continuous oxygen, is responsible to check the rate on the concentrator, aides can check and tell charge nurse if there is a concern. The DON said he/she is not sure why the residents oxygen is set at five liters, but it shouldn't be. The DON said if there was ever a need for a higher amount than ordered, staff should contact the doctor and document it. During an interview on 04/10/25 at 2:45 P.M., the administrator said the charge nurse is responsible to check the flow rate for oxygen. 4. Review of Resident #17's Annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Diagnosis COPD; -Required oxygen therapy. Review of the resident's POS, dated 02/18/25, showed staff are directed to change the oxygen tube monthly on the first day of the month. Observation on 04/07/25 at 10:42 A.M., showed the resident in bed with oxygen via nasal cannula in place. Observation showed the oxygen tube dated 03/01/25. Observation on 04/08/25 at 09:21 A.M., showed the resident in bed with oxygen via nasal cannula in (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	place. Observation showed the oxygen tube dated 03/01/25. 5. Review of Resident #19's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact, received oxygen therapy and diagnosis of dependence on supplemental oxygen. Review of the resident's POS, dated 03/08/25 through 04/08/25, showed: -Change the oxygen tube monthly on the first Monday of the month; -Weekly concentrator cleaning. Special Instructions: Wipe down concentrator with disinfectant wipes allow to dry. Cleanse filter with soap and water and allow to dry. Observation on 04/07/25 at 10:50 A.M., showed the resident in bed with oxygen via nasal cannula in place. Observation showed the oxygen tube dated 03/01/25. Observation on 04/08/25 at 8:45 A.M., showed the resident in his/her wheelchair and received oxygen via nasal cannula from a portable oxygen tank. The oxygen tubing was undated. Observation on 04/08/25 at 2:13 P.M., showed the resident in bed with oxygen via nasal cannula in place. The oxygen tubing was undated, and the concentrator with scattered dried debris and dried brownish/red substance behind the flow rate display. Observation on 04/09/25 at 8:32 A.M., showed the oxygen concentrator with scattered debris and dried brownish/red substance behind the flow rate display, the black filter on the back covered with white debris and hair strands. Observation on 04/10/25 at 8:46 A.M., showed the oxygen concentrator with scattered debris and dried brownish/red substance behind the flow rate display, the black filter on the back covered with white debris and hair strands. During an interview on 04/09/25 at 08:36 A.M., the resident said the concentrator could use some cleaning. During an interview on 04/10/25 at 11:23 A.M., LPN D said the night shift nurse is responsible to change the resident's oxygen tubing per the schedule on the POS. He/She said the night nurse is also responsible to clean the concentrator, but he/she was unsure of the schedule. 6. Review of Resident #26's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Diagnosis COPD. Review of the resident's POS, dated 02/18/25, showed staff are directed to change the nebulizer tube monthly on the first day of the month. Observation on 04/07/25 at 10:44 A.M., showed nebulizer tube laid on the resident's nightstand and dated 03/01/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/08/25 at 2:15 P.M., showed nebulizer tube laid on the resident's nightstand and dated 03/01/25. Observation on 04/09/25 at 08:30 A.M., showed nebulizer tube laid on the resident's nightstand and dated 03/01/25. During an interview on 04/10/25 at 12:06 P.M., LPN D said the night shift nurse is in charge of changing nebulizer tubing. He/She said he/she is not sure how often it is scheduled to change. He/She said he/she will change the tubing if he/she finds it on the floor or sees that it hasn't been changed in over a month. During an interview on 04/10/25 at 1:50 P.M., the DON said oxygen and nebulizer tubing should be changed at the beginning of the month by the night shift nurse. He/She said he/she asks the night nurse if its been done and just goes with that, but he/she said he/she should probably be checking it his/herself to ensure its being done. During an interview on 04/10/25 at 2:30 P.M., the administrator said oxygen and nebulizer tubing should be changed on the first day of the month by the night shift nurse. He/She said it is the DON's responsibility to ensure its getting done.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to provide the services of a Registered Nurse (RN), for at least eight consecutive hours per day, seven days a week. The facility census was 46. 1. Review of the Facility Assessment tool, dated 12/13/24, showed the facility is to provide one RN Director of Nursing (DON) full time and one RN or Licensed Practical Nurse (LPN) for each shift. The assessment does not contain direction for use of an RN eight consecutive hours per day, seven days a week. Review of the facility's RN staff schedule, dated December 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building on Monday, December 30, 2024. Review of the facility's RN staff schedule, dated January 2025, showed the facility did not have an RN, eight consecutive hours a day, in the building on Monday, January 13, 2025. Review of the facility's RN staff schedule, dated February 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building on Monday, February 3, 2025. During an interview on 04/10/25 at 1:13 P.M., the DON said he/she counts him/herself as RN coverage when they are in the building. He/she said they recently hired an RN that works weekends and is the weekend RN coverage. He/She was aware there were days there was not an RN in the building, but he/she was working a lot of hours and did remain on-call 24 hours a day. The DON said if they needed a day off, they would ensure there was two LPN's in the building. He/She said the days there was no RN in the building, the residents in the building at the time did not have any needs that required RN oversight or potential interventions. During an interview on 04/10/25 at 2:20 P.M., the Administrator said the facility should have an RN in the facility at least eight consecutive hours daily. He/She said if the facility has no RN, the DON will cover those hours. The Administrator said that the DON and him/her are responsible to ensure there is RN coverage in the building, but the DON was working a lot of hours to cover as a floor nurse and took very few days off. He/She did not know there was days without an RN in the building at least eight hours on three different days.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to ensure residents remained free from unnecessary medications when they did not ensure a 14-day stop date for the as needed use of a psychotropic medication (a drug that affects behavior, mood, thoughts, or perception) or provide a rationale for the continued use of the medication for one resident (Resident #18), and did not implement the physician's order for a gradual dose reduction (GDR) for a psychotropic medication for one resident (Resident #19) out of four sampled residents. The facility's census was 46. 1. Review of the facility's policies showed it did not contain a policy to address Psychotropic Medication Use or the Medication Regimen Review (MRR) process. 2. Review of Resident #18's Significant Change of Status (SCSA) Minimum Data Set (MDS), a federally mandated assessment, dated 03/18/25, showed staff assessed the resident as follows: -Mild cognitive impairment; -Diagnoses of depression, schizoaffective disorder (symptoms such as hallucinations and delusions, and mood disorder); -Did not receive antianxiety medications in the seven-day review period; -Received hospice care. Review of the resident's Physician Order Sheet (POS), dated 03/01/25 through 04/07/25, showed an order for Lorazepam (psychotropic medication used to treat anxiety) 0.5 milligram (mg), one tablet by mouth every four hours as needed for schizoaffective disorder, effective 03/26/25. The order did not contain a stop date. Review of the resident's Medication Administration Record (MAR), dated 03/13/25 through 04/08/25, showed staff did not document the resident received the as needed Lorazepam. During an interview on 04/10/25 at 11:38 A.M., the MDS Coordinator said as needed psychotropic medications should have a stop date of 14 days whether the resident is under the care of hospice care or not, unless the physician states otherwise. He/She said the night shift nurse should be responsible to double check the orders, but he/she was not sure anyone was assigned the responsibility. He/She said he/she was not sure why the resident's Lorazepam order did not have a stop date, other than the order just got overlooked by staff. During an interview on 04/10/25 at 12:29 P.M., the Director of Nursing (DON) said as needed psychotropic medications should have a stop date of 14 days unless the physician documents otherwise, whether the resident is under the care of hospice or not. He/She said the nurse who received the order is responsible to ensure a stop date is obtained, and the pharmacist checks monthly as well. He/She said the resident's Lorazepam order just got missed, and it was ultimately his/her responsibility to audit and ensure as needed psychotropic orders have a stop date. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/10/25 at 2:36 P.M., the administrator said as needed psychotropic medications should have a stop date of two weeks. He/She said the nurses are responsible to obtain a stop date on the order and the DON should ensure it gets done. 2. Review of Resident #19's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact; -Diagnoses of anxiety disorder and depression; -Received antidepressant medications with indication noted; -Date of last attempted GDR not documented. Review of the resident's care plan, updated 03/17/25, showed staff documented the resident received antidepressant medication for depression, will be prescribed the lowest effective dose of medication, and the pharmacy consultant will review the medications. Review of the resident's POS, dated 04/01/25 through 04/09/25, showed an order for Amitriptyline (psychotropic medication used to treat depression) 25 mg tablet, three times daily for depression at 6:00 A.M.-10:00 A.M., 11:00 A.M. to 1:00 P.M., and 2:00 P.M. to 6:00 P.M, with an effective 10/01/24. Review of the resident's monthly MRR, dated 12/27/24, showed: -On 12/18/24, the pharmacist documented recommendation to the physician the resident's Amitriptyline 25 mg three times a day is due for review. Please consider a GDR on Amitriptyline 25 mg to at bedtime. -01/23/25, the physician signed the recommendation and documented I accept the recommendation above. Please implement as written. Review of the resident's monthly MRR, dated 01/29/25, showed the pharmacist documented in his/her report to the nursing staff see pharm consult regarding Amitriptyline 25 mg at bedtime per the physician. Review of the resident's MAR, dated 01/29/25 through 01/31/25, showed staff documented they adminstered the Amitriptyline 25 mg three times daily from 01/29/25 through 01/31/25. Staff did not implement the physician's order for Amitriptyline 25 mg to be administered at bedtime. Review of the resident's monthly MRR, dated 02/27/25, showed the pharmacist documented see pharm consult regarding Amitriptyline to 25 mg at bedtime per the physician. Review of the resident's MAR, dated February 2025, showed staff documented they adminstered the Amitriptyline 25 mg three times daily. Staff did not implement the physician's order for Amitriptyline 25 mg to be administered at bedtime. Review of the resident's monthly MRR, dated 03/27/25, the pharmacist documented see pharm consult (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regarding Amitriptyline to 25 mg at bedtime per the physician. Review of the resident's MAR, dated March 2025, showed staff documented they adminstered the Amitriptyline 25 mg three times daily from 03/01/25 through 03/31/25. Staff did not implement the physician's order for Amitriptyline 25 mg to be administered at bedtime. Review of the resident's MAR, dated 04/01/25 through 04/09/25, showed staff documented they adminstered the Amitriptyline 25 mg three times daily from 04/01/25 through 04/09/25. Staff did not implement the order for Amitriptyline 25mg to be administered at bedtime. During an interview on 04/10/25 at 11:38 A.M., the MDS Coordinator said the DON was responsible to implement the order from the physician in January, and he/she did not think there was a system in place for anyone else to double check. During an interview on 04/10/25 at 12:29 P.M., the DON said he/she is responsible to follow up on the pharmacist's recommendations to the physician and to ensure the physician's response is acted on and any orders are implemented. The DON said he/she overlooked the Amitriptyline order from the physician in January, and did not realize the pharmacist was referring to the same order in his/her report on 01/29/25, 02/27/25, and 03/27/25. The DON said depending on the resident, medications ordered to be given at bedtime are scheduled between 6:00 P.M. and 12:00 A.M. During an interview on 04/10/25 at 2:36 P.M., the administrator said he/she was not sure about the MRR process but is aware the pharmacist does a routine review and sends a report to the DON for follow up.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to maintain a medication error rate of less than 5% out of 38 opportunities observed, two errors occurred, resulting in a 5.26% error rate, which effected two residents (Resident #12 and #32) out of eight sampled residents. The facility census was 46. 1. Review of the Facility's Medication Administration policy, undated, showed: -Medication are given to benefit a resident's health as ordered by the physician; -Read label three times before administering the medications: -First when comparing the label with the medication sheet; -Second when setting up the medication; -Third when preparing to administer the medication to the resident. 2. Review of Resident #12's Significant Change MDS, dated [DATE], showed staff documented the resident diagnosis of Hypertension. Review of the resident's physician's order sheets (POS), dated 02/10/25, showed an order for Diltiazem (medicine used to treat high blood pressure) 240 milligram (mg), one capsule daily. Observation on 04/08/25 at 8:55 A.M., showed Certified Medication Technician (CMT) A administered Diltiazem 180mg to the resident. During an interview on 04/09/25 at 10:08 A.M., CMT A said he/she was not sure how he/she did not catch the medication error until now. He/She said the resident was previously on 180mg and the order must not have gotten followed through to get that changed and the correct card put in the medication cart. He/She said there is a lot of risks if the resident is not receiving the correct dosage of medication as prescribed depending on the medication. He/She said he/she would go inform charge nurse about medication error. 3. Review of Resident #32's admission MDS, dated [DATE], showed staff documented the resident diagnosis of arthritis. Review of the resident's physician's order sheets (POS), dated 03/12/25, showed an order for Vitamin D3 (for bone and muscle strength, immune function, and healthy skin) 1,250 micrograms (MCG), one tablet daily on Tuesday and Friday. Observation on 04/08/25 at 08:40 A.M., showed CMT A administered Vitamin D3 50mcg to the resident. During an interview on 04/09/25 at 10:08 A.M., CMT A said he/she noticed the incorrect dosage of Vitamin D3 was given after the observation. He/She said he/she was unsure how long the resident had been getting the incorrect dosage. 4. During an interview on 04/10/25 at 1:35 P.M., the Director of Nursing (DON) said staff should (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	verify medication with the physician's order to ensure the correct dosage is given. He/She said there are a lot of risks to the residents regarding medication errors depending on the type of medication that was given incorrectly.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility staff failed to serve food in accordance with the nutritionally calculated recipes and menus to three residents who received pureed diets. The facility census was 46. 1. Review of the facility's Food Preparation and Distribution policy, dated April 2011, showed recipes should be followed on each item prepared. Review of the facility's Week 4, Day 25 lunch menu showed residents who received pureed meals were to receive a #6 (five and one third ounces) scoop of pureed ham, a #8 (four ounces) scoop of candied sweet potatoes, a #12 (two and two thirds ounces) scoop of buttered spinach and a #16 (two ounces) scoop of dinner roll. Review of the facility's standardized recipes showed they did not contain a recipe for pureed mixed peas and carrots. Review of the facility's standardized recipe for pureed ham showed staff were instructed to prepare five servings by processing five, 4.5 ounce servings of ham and a slurry of water and food thickener. Observation on 04/09/25 at 12:09 P.M., showed [NAME] J added 4 slices of ham, which were not weighed, and an unmeasured amount of hot water to a food processor. Observation showed [NAME] J did not add thickener. [NAME] J pureed the ham and water and divided the ham among three plates which set on the counter. Observation on 04/09/25 at 12:12 P.M., showed [NAME] J added two unmeasured dessert cups of mixed peas and carrots to the food processor. [NAME] J pureed the peas and carrots and divided the vegetables among three plates, which sat on the counter. Observation showed the peas and carrots were not divided evenly among the three plates. Observation showed [NAME] J did not prepare or serve pureed potatoes or bread. During an interview on 04/09/25 at 12:21 P.M., [NAME] J said they did not have any candied sweet potatoes, so they served baked sweet potato fries as an alternative. [NAME] J said he/she could not locate a recipe for mixed peas and carrots. [NAME] J said residents who receive pureed meals cannot have bread or potato fries since they don't puree well. [NAME] J said residents who receive pureed meals can have mashed potatoes. [NAME] J said he/she never pureed bread or potato fries, and he/she tended to give extra vegetables or meat as a substitute. [NAME] J said the residents were to receive three ounces of meat and three ounces of vegetables. [NAME] J said he/she used four, three-ounce slices of ham and did not measure the amount of peas and carrots. [NAME] J said he/she believed he/she was giving the residents 25% more meat and vegetables than the menu indicated. During an interview on 04/10/25 at 11:15 A.M., the Dietary manager (DM) said cooks have a daily menu and recipes, and they should be followed. The DM said kitchen staff were using a pureed bread mix, but it was on back order. The DM said residents receiving pureed meals should have received a starch (potato) as the menu indicated. The DM said he/she was not aware staff were not following recipes or menus. The DM said he/she is also serving as the activities director so his/her DM role is not 100%. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/10/25 at 1:10 P.M., the administrator said cooks were responsible for following all menus and recipes unless approved substitutions were made. The administrator said the DM was responsible for ensuring kitchen staff followed menus and recipes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility staff failed to store food in a manner to prevent potential contamination and outdated use and failed to maintain frozen foods at a temperature to keep the food frozen solid. Facility staff failed to maintain and serve pureed food items at temperatures adequate to prevent food borne illness. Facility staff failed to perform hand hygiene as often as necessary, using approved techniques, to prevent cross-contamination. These failures have the potential to affect all residents. The facility census was 46. 1. Review of the facility's food service policies showed they did not contain policies related to food storage. Review of the Record of Cooler and Freezer Temperatures, dated April 2025, which was mounted on the front of three-part freezer showed staff recorded the temepratures as: -04/01 morning freezer temperature recorded as seven; -04/02 morning freezer temperature recorded as eight; -04/03 morning freezer temperature recorded as seven; -04/04 morning freezer temperature recorded as five, afternoon temperature recorded as seven; -04/05 morning freezer temperature recorded as four; -04/08 morning freezer temperature recorded as five; -04/09 morning freezer temperature recorded as 10; -04/10 morning freezer temperature recorded as nine. Observation on 04/07/25 at 9:52 A.M. showed the reach in refrigerator contained: -One opened five-pound container of cottage cheese with a best by date of 3/30/25; -One opened five-pound container of cottage cheeses with a best by date of 4/6/25; -One unopened five-pound container of cottage cheese with a best by date of 3/30/25; -One plastic container of lemon and lime wedges, undated; -An aluminum baking sheet on the bottom shelf with saturated pieces of cardboard stuck to it. Observation on 04/07/25 at 10:00 A.M showed the three-door freezer contained a large area of dried purple substance along the bottom shelf/base. Observation on 04/07/25 10:04 A.M., showed the cook's refrigerator contained: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A one gallon container of tuna salad, opened and undated; -A one gallon container of Pasta salad with cheese, opened and undated. Observation on 04/08/25 at 2:10 P.M., showed the milk refrigerator contained an opened container of coffee creamer with a best by date of 07/07/24. Observation on 04/08/25 at 2:20 P.M., showed the cooks refrigerator contained: -A plastic container labeled carrots, dated 4/4; -A plastic container labeled Italian veggies, with a use by date of 4/6; -A ten-pound container of hard-boiled eggs, dated 3/30 and was partially open to the air; -A plastic container labeled Philly cheese steak, dated 4/3/25; -A plastic container labeled peas, dated 4/4; -A five-pound container of cottage cheese, which was opened and undated and had a best by date of 03/30/25; -A five-pound container of pasta salad, opened and undated; -A five-pound container of tuna salad, opened and undated; -A plastic bag of lettuce, undated. Observation on 04/08/25 at 2:26 P.M., showed the three-door freezer contained a digital external thermometer which indicated a temperature of nine degrees Fahrenheit (F), Observation showed a calibrated digital thermometer placed in the freezer for five minutes indicated a temperature of 13 degrees F. Observation showed a package of cinnamon rolls stored on the bottom shelf were soft to firm with pressure. Observation on 04/09/25 at 8:14 A.M., showed the three-door freezer external thermometer indicated a temperature of 4 degrees F. Observation showed a package of cinnamon rolls stored on the bottom shelf were soft to firm with pressure. Observation on 04/09/25 at 11:06 A.M., showed the three-door freezer external thermometer indicated a temperature of six degrees F. Observation showed the freezer contained a large bag of french fries, a package of cinnamon rolls and a plastic bag of whipped topping which were soft to firm with pressure. Observation on 04/09/25 at 12:32 P.M., showed the external temperature of the three-door freezer indicated five degrees F. During an interview on 04/07/25 at 9:54 A.M., [NAME] K said kitchen staff were responsible to date items when opened and refrigerated cottage cheese is good for two days after opened. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/07/25 at 9:58 A.M., Dietary Aide (DA) L said he/she did not know who placed the items in the refrigerator. DA L said kitchen staff should date items before placing in the refrigerator. During an interview on 04/07/25 at 10:02 A.M., the Dietary Manager (DM) said the purple stuff was from dragon fruit that was stored in the freezer, and must have spilled without staff noticing. The DM said he/she thought staff used the dragon fruit over the weekend. The DM said there was a weekly cleaning schedule for the larger items in the kitchen, but he/she expected staff would have cleaned the spill when they removed the dragon fruit from the freezer. During an interview on 04/10/25 at 9:40 A.M., [NAME] J said the freezer temperature averaged seven degrees F. [NAME] J said he/she did not know what the temperature should be but the freezer tiems should be frozen solid. During an interview on 04/10/25 at 11:15 A.M., the DM said opened food items should be labeled and dated with a three-day discard date. The DM said the freezer temperature should be between negative twenty and zero degrees F in order to keep all items frozen solid. The DM said he/she did not know the freezer temperatures were not zero or below. 2. Review of the facility's Food Preparation and Distribution policy, dated April 2011, showed recipes should be followed on each item prepared. Review of the facility's standardized recipe for pureed ham showed staff were instructed to reheat the pureed item to a minimum temperature of 165 degrees F or higher for 15 seconds. Hold at minimum required temperature or higher for service. Observation on 04/09/25 at 12:09 P.M., showed [NAME] J prepared pureed ham and mixed peas and carrots for three residents who receive pureed meals. Observation showed [NAME] J plated the pureed items and left the plated items on a kitchen counter. Observation at 12:28 P.M., showed [NAME] J placed a plate with pureed items in the microwave for 30 seconds. Observation showed the temperature of the pureed ham was 145 degrees F and did not reach 165 degrees F. Observation showed the pureed items were served to a resident. During an interview on 04/09/25 at 12:28 P.M., [NAME] J said he/she placed pureed items in the microwave for 30 seconds to ensure the foods were brought up to a temperature of 140 degrees F. [NAME] J said he/she did not usually look at the reheating directions on the recipe because he/she thought 140 degrees F was the proper temperature. During an interview 0n 04/10/25 at 11:15 A.M., the DM said all cooks should follow the standardized recipes which included reheating instructions. The DM said he/she was not aware staff were not following recipes. 3. Review of the facility's Handwashing policy, dated April 2011, showed the policy did not contain guidance on when staff should wash hands. Review of the facility's Hand Washing Procedure, which was posted next to the kitchen hand washing sink, showed staff were to wash hands after handling soiled rags, cans, or cleaning material. Review showed the procedure did not contain guidance related to soiled kitchen wares. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/09/25 at 10:49 A.M., showed DA M prewashed soiled kitchen wares and loaded the wares on a dish rack. DA M ran the spoiled wares through the dish machine, removed a rack of clean wares and handled clean silverware and did not wash his/her hands. Observation showed DA M returned to soiled side of the dish machine, removed gloves, donned new gloves and did not wash hands. Observation showed DA M placed dirty silverware in a sanitizer bucket, loaded a dish rack with dirty dishes, handled soiled water pitchers with straws, cleaned a service cart and pushed a rack of soiled wares into the dish machine. Observation showed DA M then removed clean wares which were placed on a drying rack and did not wash his/her hands. During an interview on 04/09/25 at 11:18 A.M., DA M said he/she should change gloves whenever changing from the soiled side to the clean side of the dish machine. DA M said he/she changed gloves most of the time, but he/she just forgot. DA M said he/she should wash hands when changing gloves and he/she did not know why he/she did not wash his/her hands. During an interview on 04/10/25 at 11:15 A.M., the DM said staff should wash hands and change gloves between dirty and clean tasks. The DM said staff should wash hands and change gloves after handling soiled kitchen wares. The DM said he/she was responsible for ensuring staff washed hands before donning clean gloves. The DM said he/she was not aware DA M was not washing his/her hands when required. The DM said he/she is also serving as the activities director so he/she is only performing kitchen related duties about 75% of the time. During an interview on 04/10/25 at 1:10 P.M., the administrator said the cooks were responsible for labeling and dating all left over food items with a three day, use by date. The administrator said the freezer temperature should be at zero degrees F or less and the cooks and DM were responsible for checking the temperature log to ensure correct temperatures were maintained. The administrator said items stored in the freezer should be frozen solid. The administrator said staff should follow the standardized recipes including portion sizes and reheating instructions. The administrator said all staff are responsible for washing hands after completing any dirty task and before donning clean gloves.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections when staff failed to implement the Enhanced Barrier Precautions (EBP) Policy when they did not properly educate or alert staff of residents who required EBP during wound care for three (Resident #8, #18, and #19) of three sampled residents, failed to properly clean and disinfect glucometer (a device for monitoring blood sugars) and provide a barrier for the glucometer and insulin supplies for six residents (Resident #16, #17, #18, #21, #37, and #203) out of six sampled residents. Staff failed to perform proper hand hygiene during blood sugar checks and insulin administration for five residents (Resident # 16, #17, #18, #21, and #37) out of six sampled residents and failed to perform appropriate hand hygiene during toilet hygiene for two residents (resident #12 and #17) of three sampled resident and tracheostomy, catheter and feeding tube care for one (Resident #202) of one sampled resident in a manner to prevent the spread of infection. The facility census was 46. 1. Review of the facility's policy titled, Enhanced Barrier Precautions to Infection Control Guidance, dated 03/2024, showed the purpose is to prevent broader transmission of multidrug-resistance organisms (MDRO) and to help protect patients with chronic wounds and indwelling devices. EBP should be implemented for the period of their stay or until wounds have resolved or indwelling medical devices have been removed. Residents with a wound, regardless of their MDRO status, residents with an indwelling medical device including urinary catheter, feeding tube, tracheostomy/ventilator regardless of their MDRO status. Use EBP when providing high-contact resident care activities such as performing wound care, caring for or using an indwelling medical device. Gloves and gown are required when conducting high-contact resident care activities listed above. 2. Review of Resident #8's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 03/10/25, showed staff assessed the resident as cognitively intact, and had one venous ulcer (a wound on the leg or ankle caused by abnormal or damaged veins) present. Review of the resident's care plan, updated 04/01/25, showed: -EBP is required to be free from infections due to a wound; -An EBP identifier will be hung outside the resident's door to let staff know they need to utilize a gown, gloves when performing high-contact cares; -Staff will perform hand hygiene, put on Personal Protective Equipment (PPE), enter the room and perform necessary cares, remove PPE, perform hand hygiene, and exit the room taking all trash/linens with them. -Cleanse wound to Left outer ankle with wound cleanser and apply dry bordered dressing daily. Observation on 04/09/25 at 1:14 P.M., showed the resident's room did not contain a sign to alert staff on the use of EBP. Observation on 04/09/25 at 1:15 P.M., showed Licensed Practical Nurse (LPN) E provided wound care to the resident and did not wear a gown when he/she performed wound care to the resident's leg. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/09/25 at 1:40 P.M., LPN E said he/she did not think the resident required EBP precautions, and did not think he/she needed to wear a gown during wound care since the resident's wound was very tiny and without drainage. 3. Review of Resident #18's Significant Change MDS, dated [DATE], showed staff assessed the resident as moderate cognitive impairment, and uses a feeding tube for nutrition. Review of the resident's care plan, updated 04/01/25, showed: -EBP is required to be free from infections due to an opening in the resident's abdomen from a PEG tube (feeding tube placed directly into the stomach through the abdominal wall) placement; -An EBP identifier will be hung outside the resident's door to let staff know they need to utilize a gown, gloves when performing high-contact cares; -Staff will perform hand hygiene, put on PPE, enter the room and perform necessary cares, remove PPE, perform hand hygiene, and exit the room taking all trash/linens with them. -Cleanse area around PEG tube site with wound cleanser and apply split gauze dressing daily. Observation on 04/08/25 at 02:40 P.M., showed the resident's room did not contain a sign to alert staff on the use of EBP. Observation on 04/08/25 at 02:40 P.M., showed LPN D entered the resident room to assess and provide wound care to the residents PEG tube site on his/her abdomen. Observation showed the LPN did not wear a gown and provided the treatment. During an interview on 04/09/25 at 1:32 P.M., LPN D said there should be a sign on the resident's door to alert staff to use EBP and since the resident has a feeding tube. He/She said he/she should have worn a gown during the wound care to the resident's PEG tube site, but he/she did not think about it at the time. Observation on 04/09/25 at 9:15 A.M., showed the resident's room did not contain a sign to alert staff on the use of EBP. Observation on 04/09/25 at 9:16 A.M., showed LPN E entered the residents room to provide wound care. The LPN did not wear a gown when he/she provided wound care to the resident's PEG tube site. During an interview on 04/09/25 at 1:40 P.M., LPN E said there should be a sign on the resident's door to alert staff to use EBP since the resident has a feeding tube. LPN E said he/she should have worn gown when he/she provided wound care to the resident's PEG tube site, and he/she was not sure why he/she did not wear a gown. 4. Review of Resident #19's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact, and had one venous ulcer present. Review of the resident's care plan, updated 03/17/25, showed: -EBP is required to be free from infections due to a wound on the resident's left leg; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An EBP identifier will be hung outside the resident's door to let staff know they need to utilize a gown, gloves when performing high-contact cares; -Staff will perform hand hygiene, put on PPE, enter the room and perform necessary cares, remove PPE, perform hand hygiene, and exit the room taking all trash/linens with them. Observation on 04/09/25 at 9:22 A.M., showed a sign on the resident's door to alert staff to use EBP. Observation on 04/09/25 at 9:23 A.M., showed LPN E entered the residents room to provide wound care. The LPN did not wear a gown when he/she provided wound care to the resident's leg wound. During an interview on 04/09/25 at 1:40 P.M., LPN E said he/she was not sure why he/she did not wear a gown when he/she provided wound care to the resident's leg. 5. During an interview on 04/10/25 at 1:58 P.M., the Director of Nursing (DON) said he/she educated staff on residents who require the use of EBP, to wear gown and gloves when doing wound care for those residents and he/she expects all the nurses to use EBP when they provide care to a wound or device such as a PEG tube. The DON said he/she was responsible to ensure alert signs were placed on the door for resident #8 and #18. During an interview on 04/10/25 at 2:36 P.M., the administrator said if a resident required EBP, there should be a caution sign on the resident's door to alert staff. He/She said he/she expects staff to use EBP during wound care, the charge nurse to ensure the nurse aides use appropriate EBP, and the DON to ensure the nurses use appropriate EBP. 6. Review of the facility's Blood Glucometer Disinfecting policy, undated, showed staff were directed to: -Wash hands; -Put on gloves; -Provide a clean field in which to place the glucose meter (a paper towel works well for this); -Clean the blood glucose meter prior to using with approved wipes with 10% bleach or comparable product, place on clean field and let air dry according to manufacturer's directions. -Removed gloves; -Wash Hands. Review of the facility's Blood Glucose Monitoring policy, undated, showed staff were directed to place equipment on a clean surface (such as clean towel). 7. Review of Resident #16's medical record showed the resident admitted to the facility on [DATE] with a diagnosis of diabetes. Observation on 04/08/25 at 11:15 A.M., showed Certified Medication Technician (CMT) A did not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	perform hand hygiene, applied gloves, obtained a blood sample and placed the glucometer on top of the medication cart without a barrier. The CMT disposed the glucose strip, removed his/her gloves, and did not perform hand hygiene. CMT A drew up insulin from insulin vial and laid the open needle on top of medication cart without a barrier and did not perform hand hygiene. Observation showed CMT A applied gloves, administered insulin, removed gloves, cleaned glucose meter with an alcohol prep pad, and did not perform hand hygiene. 8. Review of Resident #17's medical record showed the resident admitted to the facility on [DATE] with a diagnosis of diabetes. Observation on 04/08/25 at 10:55 A.M., showed CMT A did not perform hand hygiene, applied gloves, obtained a blood sample and placed the glucometer on resident's bedside table without a barrier, disposed of the glucose strip, removed his/her gloves, cleaned the glucose meter with an alcohol prep pad, and did not perform hand hygiene. 9.Review of Resident #18's medical record showed the resident admitted to the facility on [DATE]. Observation on 04/08/25 at 10:45 A.M., showed CMT A did not perform hand hygiene, applied gloves, obtained a blood sample and placed the glucometer on residents' blankets without a barrier. Observation showed the CMT disposed of the glucose strip, removed his/her gloves, cleaned glucose meter with an alcohol prep pad. 10. Review of Resident #21's medical record showed the resident admitted to the facility on [DATE] with a diagnosis of diabetes. Observation on 04/08/25 at 10:58 A.M., showed CMT A did not perform hand hygiene, applied gloves, obtained blood sample and placed glucometer on the residents' blankets without a barrier. Observation showed CMT A disposed the glucose strip, removed gloves, and cleaned the glucose meter with an alcohol prep pad. CMT A drew up insulin from insulin vial and laid the open needle on top of medication cart without a barrier, did not perform hand hygiene, applied gloves, administered insulin, and removed gloves. 11.Review of Resident #37's medical record showed the resident admitted to the facility on [DATE] with a diagnosis of diabetes. Observation on 04/08/25 at 10:52 A.M., showed CMT A did not perform hand hygiene, applied gloves, obtained a blood sample and placed the glucometer on residents blankets without a barrier. Observation showed the CMT disposed of the glucose strip, removed his/her gloves, and cleaned glucose meter with an alcohol prep pad. 12. Review of Resident #203's medical record showed the resident admitted to the facility on [DATE] with a diagnosis of diabetes. Observation on 04/08/25 at 11:09 A.M., CMT A did not perform hand hygiene, drew up insulin from insulin vial and laid the open needle on top of medication cart without a barrier. Observation showed the CMT removed a medication pill from the container and placed into medication cup on top of medication cart. CMT A applied gloves, obtained blood sample and placed the glucometer on top of medication cart without a barrier. CMT A administered insulin, removed gloves, gave medication to resident, sanitized hands, removed glucose strip with a Kleenex and disposed of it. The CMT did not clean (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	glucose meter. During an interview on 04/09/25 at 10:08 A.M., CMT A said he/she should have sanitized his/her hands more in between gloves changes. He/She said he/she shouldn't lay the glucometer down anywhere with blood on the strip due to risk of contamination and said the other CMT has mentioned that using a paper plate as a barrier is a good idea, but he/she just doesn't think about it. He/She said he/she was always taught to just use an alcohol prep wipe to clean the meter between residents and was never told differently. He/She said he/she shouldn't set an open needle on top of the medication care because of risk of contamination or an accidental needle stick. 13. During an interview on 04/10/25 at 1:41 P.M., the Director of Nursing (DON) said the glucometers should be cleaned with disinfecting wipes in the bottom of the medication cart. He/She said alcohol prep wipes are not acceptable cleaning method. He/She said laying the glucometer on residents' blankets or on top of unclean medication cart is not acceptable and there should be a barrier to prevent contamination. He/She said there should never be an open needle on top of medication cart due to risk of contamination or a needle stick. He/She said staff should be sanitizing or handing hands in between gloves changes. During an interview on 04/10/25 at 2:30 P.M., the administrator said he/she is unsure of the glucometer cleaning process. He/she said it is not acceptable to place an open needle on top of medication cart or lay the glucometer on residents blankets due to risk of blood borne pathogen and contamination. 14. Review of the facility's Handwashing policy, undated, showed the policy did not contain direction for when to perform hand hygiene. Review of the facility's Enteral feeding tube policy, undated, showed the policy did not contain direction for when to perform hand hygiene. Review of the facility's Perineal Care policy, undated, directed staff to perform perineal care, remove gloves, wash hands and position the resident. Review of the facility's Catheter care policy, undated showed staff are directed to: -Wash hands and apply gloves; -Change the position of the washcloth with each cleansing stroke; -Remove gloves and wash hands; -Position the resident; -Wash hands. 15. Review of Resident #12's Significant Change of Status (SCSA) MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent on staff for toilet and personal hygiene; -Required substantial or maximum assistance of staff for toilet transfers; -Diagnosis of stroke and renal failure. Observation on 04/09/25 at 08:50 A.M., showed Nurse Aide (NA) I and Certified Nurse Aide (CNA) H entered room to assist the resident and applied gloves. NA I and CNA H assisted the resident to the toilet. CNA H removed the soiled pants from the resident and NA I removed the soiled brief. With the same soiled gloves, CNA H placed clean pants on the resident and NA I places a clean brief on the resident. CNA H cleaned the resident's peri. With the same soiled glove NA I pulled up the residents clean brief and pants. With the same soiled gloves, CNA H handed the resident's hairbrush to NA I, NA I touched the wheelchair, the bed linens, placed a blanket on the resident's lap, and braided the residents hair. During an interview on 04/09/25 at 9:02 A.M., CNA H said staff should always wash their hands between dirty and clean stuff. He/She said he/she should have performed hand hygiene after removing the soiled pants and putting new clean pants on and before touching the resident's hairbrush. CNA H said hand hygiene would prevent the clean items from becoming dirty and just forgot. During an interview on 04/09/25 at 09:12 A.M., NA I said he/she has only been with the facility since January and currently in classes. He/She said that he/she didn't think about the need to change his/her gloves between touching the soiled brief and clean brief and before touching clean items in the room to include brushing the resident's hair. 16. Review of Resident #17's quarterly MDS, dated [DATE] showed staff assessed the resident as follows: -Cognitively Intact; -Dependent on staff for dressing and toileting hygiene; -Substantial/maximal assistance on staff for personal hygiene. Observation on 04/09/25 at 9:20 A.M., showed CNA C and NA B entered residents' room with gown and gloves on. CNA C removed residents soiled shorts. CNA C removed his/her gloves, did not perform hand hygiene and applied new gloves. CNA C provided peri care, removed his/her soiled gloves and applied new gloves. CNA C applied cream to buttock. With the same soiled gloves, CNA C placed a drawsheet underneath resident. NA B wiped bowel movement from residents' leg and lower back, and removed the soiled linens from the bed. With the same soiled gloves, NA B touched the residents' blankets, resident oxygen tubing and the bed remote. With the same soiled gloves, CNA C placed the resident's oxygen on. CNA C and NA B removed their gloves and gown, did not perform hand hygiene and walked out of the room. During an interview on 04/09/25 at 9:50 A.M., NA B said he/sheshould have changed gloves more often and washed her hands before touching blankets, oxygen tubing, or bed remote and before leaving the room. He/she said not washing hands is a risk for infection and contamination. During an interview on 04/09/25 at 10:08 A.M., CNA C said he/she should have changed his/her gloves (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	more often and performed hand hygiene between glove changes. He/She said he/she should not have touched oxygen tubing with soiled gloves. He/She said he/she should have washed hands before leaving the room, but states that he/she knew he/she was going to the shower room afterwards. He/She said not performing hand hygiene is a risk of contamination. 17. Review of Resident #202's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -Dependent on staff for all care; -Had a tracheostomy (tube inserted into the windpipe for breathing); -Had a feeding tube (tube inserted into the stomach for hydration and artificial nutrition administration); -Had an indwelling catheter (tube inserted into the bladder to drain urine); -Diagnosis of traumatic brain injury. Observation on 04/08/25 at 02:09 P.M., showed LPN D enter the resident room to provide tracheostomy care, feeding tube care and catheter care. Observation showed the nurse set up a barrier and placed down supplies to perform tracheostomy care, applied sterile gloves, and provided tracjeostomy care. The LPN removed his/her gloves, applied clean gloves and applied a clean dressing to the tracheostomy site without performing hand hygiene. The LPN removed his/her gloves, gathered wet cloths and clean dressing for feeding tube care. The LPN did not wash his/her hands and applied gloves. The LPN used a wet cloth to wipe down the soiled feeding tube, used the same portion of the cloth over the same area of the tube multiple times and applied a clean dressing. The LPN removed his/her gloves, applied clean gloves, cleansed around the catheter site, cleansed the tubing with a warm cloth, used the same portion of the cloth over the same area multiple times, applied a clean dressing, and did not perform hand hygiene between catheter site cleaning and application of a clean dressing. During an interview on 04/08/25 at 2:31, LPN D said he/she did not wash or sanitize between glove changed because he/she did not want to risk touching his/her gown or ruin the clean field. He/She said he/she is aware he/she used the same portion of the wipe on the difficult areas to clean off the tubing, but moved to a clean portion once the difficult areas were clean. Hand hygiene helps decrease the risk of spreading infection and bacteria. 18. During an interview on 04/10/25 at 01:13 P.M., the DON said hand hygiene should be performed before care and after care, between glove changes, and between dirty and clean tasks. He/She said gloves are not to be considered a barrier that will prevent transmission of germs. He/She said gloves should be changed between different areas of the body. The DON said he/she does spot checks on the staff and interviews residents about staff performance. He/She did not know staff were performing inadequate hand hygiene during cares. During an interview on 04/10/25 at 02:20 P.M., the Administrator said he/she would expect staff to perform hand hygiene between glove changes, between dirty and clean tasks and when care is completed. He/She said staff are trained by electronic inservice company and monthly and tasks such as hand hygiene are monitored by the DON. He/She was not aware staff performed inappropriate hand hygiene (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during cares.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, facility staff failed to designate one or more individuals with specialized training in Infection Prevention and Control (IPC) as the Infection Preventionist (IP) for the facility's Infection Prevention and Control Program. The facility's census was 46. 1. Review of the facility's policy titled, Infection Prevention and Control Program, dated 08/2024, showed the IP is qualified to conduct IPC activities as a result of education, training and experience. He/she will complete the Centers for Disease Control and Prevention (CDC) Long Term Care Infection Preventionist module. 2. During an interview 04/09/25 at 1:53 P.M., the Director of Nursing (DON) said the facility does not currently have a qualified IP. He/She said a nurse was recently hired to be the facility's IP but the nurse is not certified, and he/she was not aware the IP needed to be certified. During an interview on 04/10/25 at 2:36 P.M., the administrator said he/she was not aware the IP needed to be certified. He/she said a nurse was recently hired to be the facility's IP but the nurse is not certified.