STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415014	A. BUILDING _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE BARKER NURSING CENTER	54 BARKER AVENUE WARREN, RI 02885

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted at Grace Barker Nursing Center from 2/3/2025 through 2/5/2025 to determine compliance with 42 CFR. Part 483, requirements for Long Term Care Facilities. State licensure and emergency preparedness surveys were also conducted at this facility. Deficiencies were identified as a result of this survey.	F 000	The filing of this Plan of Correction (POC) does not constitute that the deficiencies alleged did in fact exist, rather this POC is filed as evidence of the facility's continuing commitment to high quality resident care in full compliance with state and federal regulations. Completion date for optimal compliance with the POC will be March 7, 2025.	March 7, 2025 (03/07/2025)
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide services that meet professional standards of practice for 1 of 1 resident observed relative to wound care, Resident ID #23. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, "...The physician is responsible for directing medical treatment, Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients..." Record review revealed the resident was	F 658	**As a Plan of Correction (POC) for Tag F 658:** a) Resident ID#23 is currently receiving care for skin impairments according to professional standards. b) Residents that reside in the facility who have skin impairments have the potential to be affected by this finding. We have reviewed their care and made any needed corrections. c) We have educated the nursing staff on the importance of following physician orders, especially as to the frequency of treatments. We have instructed them on ensuring that their documentation is accurate related to the treatments completed. We have further educated the nurses on the need to document any skin impairments, to report impairments to the provider and to obtain, implement and accurately document treatment orders. The nurses are to check their Treatment Administration Records at the end of each shift for completeness and accuracy. They are to report any incomplete treatments to the charge nurse for further follow up. We have	March 7, 2025 (03/07/2025)

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

Administrator 02/25/2025

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

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F 658	Continued From page 1 admitted to the facility with diagnoses including, but not limited to, dementia and skin cancer. Record review revealed a physician's order dated 1/6/2025, to cleanse the open area to the left side of the face with normal saline (NS), pat dry, apply A&D ointment (a treatment used to treat minor skin irritations), followed by a non-adhesive pad and a transparent dressing, once daily. Review of the Treatment Administration Record (TAR) revealed the treatment order was signed off as completed on 2/3 and 2/4/2025. During a surveyor observation of the resident on 2/5/2025 at 3:09 PM, the dressing to the left side of his/her face revealed the initials "EJS" with a date of "2/3." During a surveyor observation of the resident on 2/5/2025 at 3:13 PM in the presence of Registered Nurse, Staff A, she acknowledged the dressing to his/her face was dated 2/3, with the initials "EJS." Staff A removed the dressing to the resident's face and the wound bed was observed to be approximately 1.5 centimeters (cm) x 1.5 cm and there was a light yellow drainage observed in the wound bed and on the dressing. During a surveyor interview on 2/5/2025 at 3:10 PM with Licensed Practical Nurse (LPN), Staff B, he revealed that he worked on the evening of 2/3/2025, but he did not work on 2/4/2025. Additionally, he confirmed that the initials "EJS" were his initials and that he completed the dressing change on 2/3/2025. During a surveyor interview on 2/5/2025 at 3:13 PM with Staff A, she acknowledged although the	F 658	developed an audit tool to monitor compliance with this plan. d) The Director of Nursing (DNS)/ designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 6 months; at which time, we will determine the need/frequency to continue formal audits.	

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F 658	Continued From page 2 TAR indicates that the treatment to the resident's face was signed off as completed on 2/4/2025 by LPN, Staff C, the dressing was dated 2/3/2025 with Staff B's initials, indicating that the treatment was not completed on 2/4/2025. During a surveyor observation of the resident on 2/5/2025 at 3:29 PM in the presence of Staff A and Staff B, they acknowledged the resident had a dressing on his/her right elbow with a date of "2/1." Additionally, when Staff B removed the resident's elbow dressing, a bruise was noted with an approximate size of 4.5 cm x 4.5 cm and a small, scabbed area was adjacent to the bruise. Record review failed to reveal evidence of a physician's order for a treatment to the right elbow. Further review failed to reveal evidence of any documentation indicating a skin impairment to the resident's right elbow. During a surveyor interview with the Director of Nursing Services on 2/5/2025 at the time of the observation, she revealed that she was not aware of the bruise and scab to the resident's elbow. Additionally, she revealed staff should have notified the resident's physician and obtained a treatment order for the right elbow. Further, she could not provide evidence that the dressing to the left side of the resident's was completed, as ordered on 2/4/2025.	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy	F 695	**As a POC for Tag F695:** a) Resident ID#13 is currently receiving appropriate respiratory treatment as needed.	March 7, 2025 (03/07/2025)

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F 695	Continued From page 3 care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, it has been determined that the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 3 residents reviewed with a respiratory illness, Resident ID #13. Findings are as follows: Review of an undated facility policy titled, "Practice for Change in Condition" states in part, "...Suspected Respiratory Illness...follow physician orders...test as ordered...follow order set for [positive] + virus...follow respiratory event orders...all other respiratory illness follow respiratory event and order set...document..." Record review revealed Resident ID #13 was readmitted to the facility with a diagnosis including, but not limited to, asthma. Record review of a chest x-ray completed on 1/28/2025 indicated the resident had pneumonia. Record review of the physician's orders revealed an order, with a start date of 1/29/2025 for Levaquin (an antibiotic prescribed to treat infections), 500 mg daily for 10 days. Record review failed to reveal evidence that a "Respiratory Event" document was completed for the resident once s/he was diagnosed with	F 695	b) Residents who have respiratory conditions have the potential to be impacted by this finding. We have reviewed their orders and plans of care and made any needed updates or corrections. c) We have provided education to the nurses on the need to implement the in-house protocol related to changes in respiratory conditions so that proper provider notification is made, and necessary orders are obtained and implemented. We have also retrained the nurses on the necessary orders required as standards of care for respiratory illness to ensure notifications and orders have been put in place as a double check of the protocol implementation. This is to be followed during the morning meeting when changes in conditions are to be reviewed, and care plans updated to reflect the change in respiratory status. The resident is also to be followed weekly in risk meetings to ensure order and care plans are being followed and/or updated during the episode of respiratory illness. We have devised an audit tool to monitor our progress with this plan. d) The DNS/designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 6 months; at which time, we will determine the need/frequency to continue formal audits.	

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F 695	Continued From page 4 pneumonia. Additional review of the record failed to reveal any order sets to follow for the resident, per facility policy. During a surveyor interview on 2/4/2025 at 11:38 AM with Registered Nurse, Staff E, she acknowledged that a "Respiratory Event" document was not completed for the resident when s/he was diagnosed with pneumonia on 1/28/2025, as per the facility's policy. Staff E revealed that a "Respiratory Event" document triggers for physician orders that include; obtaining a temperature, oxygen saturation levels, to assess lung sounds every shift and to document the findings in the progress notes until the antibiotics are completed. Record review of a "Respiratory Event" document completed by Staff E on 2/4/2025, after it was brought to her attention by the surveyor, indicates the following physician's orders: - obtain oxygen saturation levels, temperature, and lung sounds every shift and document under progress notes. Additional record review failed to reveal evidence that a care plan was developed for pneumonia. During a surveyor interview on 2/4/2025 at 12:26 PM with Registered Nurse, Staff F, she acknowledged that a care plan had not developed for the resident relative to his/her diagnosis of pneumonia. " During a surveyor interview on 2/4/2025 at 12:03 PM with the Director of Nursing Services (DNS), she revealed that the "Respiratory Event" document should have been completed for the	F 695		

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F 695	Continued From page 5 resident when s/he was diagnosed with pneumonia and that s/he should have had his/her temperature, oxygen saturation level and lung sounds assessed every shift. Additionally, the DNS acknowledged that a care plan was not developed for pneumonia.	F 695		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to provide the appropriate treatment and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 4 residents reviewed with a diagnosis of dementia, Resident ID #23. Findings are as follows: Record review revealed the resident was admitted to the facility with a diagnosis including, but not limited to, dementia. Record review of a Quarterly Minimum Data Set Assessment dated 11/29/2024, revealed a Brief Interview for Mental Status score of 0 out of 15, indicating s/he has severe cognitive impairment. Record review revealed a physician's order dated 8/2/2024, to administer Trazodone (a medication	F 744	**As a POC for Tag F744:** a) Residents ID#23 is currently receiving appropriate dementia care. b) Residents with dementia have the potential to be affected by this finding. We have reviewed their plans of care and made any needed updates or revisions. c) We have reviewed standard medication administration times for residents with dementia to ensure that medications intended to provide relief of targeted symptoms are scheduled to be given within the appropriate time frames to coincide with the targeted activity. We have provided education to the nurses regarding dementia care and the use of medication intended to address targeted symptoms. We have also provided education to the nurses and the nurse aides on using care planned approaches with residents with dementia. We have further stressed to the nurse aids the need to report any symptoms affecting the resident's comfort and well-being during care (and at other times), so that follow up as indicated (which may include PRN medication) can be provided. We have developed an audit tool to monitor for compliance with this plan.	March 7, 2025 (03/07/2025)

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F 744	Continued From page 6 prescribed to treat depression and other conditions determined by health care providers) 25 milligrams (mg) by mouth prior to morning care. Further review revealed the Trazodone is scheduled to be administered between 7:00 AM to 9:00 AM daily. Record review revealed a physician's order dated 1/17/2025 for Trazodone 25 mg by mouth every 8 hours PRN (as needed) for restlessness, anxiety, irritability, or inconsolable crying. During a surveyor observation of the resident on 2/4/2025 at approximately 11:00 AM, s/he was observed lying in his/her bed quietly with his/her eyes closed. Nursing Assistant (NA), Staff G, was observed entering the resident's room shortly after and drew the curtain closed. At 11:15 AM, the resident was overheard crying and sobbing in his/her room while Staff G was assisting the resident. Staff G opened the curtain, the resident was now observed sitting in a shower chair (a chair used to transport residents and shower them in) crying and sobbing. Record review of the Medication Administration Record (MAR) revealed the resident received his/her standing order for Trazodone 25 mg at 8:03 AM on 2/4/2025. Further review of the MAR failed to reveal evidence that the resident received a PRN dose of Trazodone on 2/4/2025 for his/her crying. During a surveyor interview on 2/5/2025 at 2:34 PM with Registered Nurse (RN), Staff E and RN, Staff A, they revealed that they both worked during the day on 2/4/2025. Additionally, both Staff A and Staff E revealed that they were not made aware that the resident was crying that	F 744	d) The DNS/designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee for no less than 6 months, at which time, we will determine the need/frequency to continue formal audits.	

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F 744	Continued From page 7 morning. If they had been made aware, they would have administered the resident his/her PRN Trazodone. During a surveyor interview on 2/5/2025 at 3:39 PM with Staff G, she revealed that she provided morning care for the resident on 2/4/2025 and that the resident was crying out during care, she tried to console the resident but s/he would not stop crying. Staff G further revealed that she did not notify any of the nurses that the resident was crying, because this was common behavior for the resident. During a surveyor interview on 2/5/2025 at 2:54 PM with the Director of Nursing Services, she revealed that she would have expected the NA to notify the nurse when the resident was crying so that the resident could have received his/her PRN Trazodone, as ordered.	F 744		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880	**As a POC for Tag F880:** a) The glucometers for residents ID#52 and 48 are being cleaned according to infection control protocol. Dressing changes for resident ID #179 are being done according to infection control principles. The inhaler belonging to resident ID #278 is being maintained to prevent the spread of pathogens. Education was provided to the identified staff members in a timely manner once the issues were identified. b) Residents who reside in the facility have the potential to be affected by non-adherence to infection control practices. We have retrained and are carefully monitoring staff members relative to infection control practices.	March 7, 2025 (03/07/2025)

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F 880	Continued From page 8 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880	c) We have reviewed infection control principles with the nurses and CMTs and the need to apply them in daily practice. We have specifically provided education for them on the proper cleaning and sanitizing of glucometers. We have reviewed infection control protocols especially related to dressing changes, the use of gloves and hand hygiene with the nurses. We have instructed the nurses and CMTs about the need to follow contact precautions as related to items brought into a precaution room from the medication and/or treatment cart. We will make frequent infection control rounds to ensure compliance. We have devised an audit tool to monitor our achievement with this plan. d) The DNS/designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI committee for no less than 6 months; at which time we will determine the need/frequency to continue formal audits.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 9 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary environment, and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 residents observed during the use of a glucose meter to obtain a blood sugar, Resident ID #s 52 and 48, for 1 of 1 resident observed during a dressing change, Resident ID #179 and for 1 of 1 resident receiving an inhaler, Resident ID #278. Findings are as follows: 1. Review of the facility's policy titled "CLEANING AND DISINFECTING THE [glucose] METER", provided to the surveyor on 2/5/2025, revealed two disposable wipes are needed for the meter, one wipe for cleaning and the second wipe for disinfecting the meter. 1a. Record review revealed Resident ID #52 was admitted to the facility with a diagnosis including, but not limited to, diabetes. Record review revealed a physician's order dated	F 880		

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F 880	Continued From page 10 6/25/2024 to administer Admelog SoloStar insulin per the sliding scale, before meals and at bedtime. During a surveyor observation on 2/4/2025 at 11:02 AM revealed Licensed Practical Nurse (LPN), Staff D using the glucose meter to obtain the resident's blood sugar. Staff D then placed the used meter on top of the treatment cart without cleaning and disinfecting the glucose meter. Staff D removed her gloves and performed hand hygiene and then touched the used glucose meter again. Staff D continued to touch multiple items and surfaces including the treatment cart, computer, the computer mouse and a set of keys prior to cleaning the meter. Further observation revealed Staff D cleaned the glucose meter using only 1 disposable wipe and not 2, per the facility's policy. Additionally, Staff D failed to clean and disinfect the top of the treatment cart, the computer, the computer mouse, and keys. 1b. Record review revealed Resident ID #48 was admitted to the facility with a diagnosis including, but not limited to, diabetes. Record review revealed a physician's order dated 4/24/2024 to obtain a fingerstick blood sugar (FSBS) twice daily, 6:00 AM and 12:00 PM. During a surveyor observation on 2/4/2025 at 11:16 AM revealed LPN, Staff D using the glucose meter to obtain the resident's FSBS. Staff D then placed the used meter on top of the treatment cart without cleaning and disinfecting the glucose meter. Staff D removed her gloves and performed hand hygiene and then touched the used glucose meter again. Staff D continued to touch multiple items and surfaces including the	F 880		

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F 880	Continued From page 11 treatment cart, computer, the computer mouse. Further observation revealed Staff D cleaned the glucose meter using only 1 disposable wipe and not 2, per the facility's policy. Additionally, Staff D failed to clean and disinfect the top of the treatment cart, the computer, the computer mouse. During a surveyor interview on 2/5/2025 at 12:36 PM with the Education Coordinator, she revealed that she would have expected Staff D to follow the facility policy and use 2 disposable wipes to clean and disinfect the glucose meter. She further revealed that she would have expected Staff D to disinfect the glucose meter after obtaining the resident's blood sugar and to disinfect the top of the medication cart, the computer and the computer mouse after handling the used glucose meter. 2. Review of the facility document titled, "Competency Validation for A Clean Dressing Change" revealed the following procedure actions which include, but are not limited to: -wash hands and don (put on) disposable clean gloves -remove old dressing -dispose the soiled dressing in a waterproof bag -clean the area as per the physician's order, discard contaminated material into the waterproof bag -remove gloves and perform hand hygiene -prepare sterile or clean dressing supplies as	F 880		

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	415014	A. BUILDING _____ B. WING _____	02/05/2025

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F 880	Continued From page 12 appropriate -don clean gloves -apply dressing and fasten the dressing a. Record review revealed Resident ID #179 was admitted to the facility with diagnoses including, but not limited to, stroke, gastrostomy tube (g-tube, a tube that is inserted into the stomach through the abdominal wall to provide nutritional support, medication and hydration) and two stage 4 ulcers (the most serious pressure ulcer that extends below the subcutaneous fat into deep tissues, including muscle, tendons, and ligaments) to the coccyx and left ankle. Record review revealed a physician's order dated 12/2/2024 to cleanse the area around the G-tube site and to change the dressing daily and as needed. During a surveyor observation of the dressing change on 2/5/2025 at 9:55 AM with LPN, Staff D, she removed the old dressing from the G-tube site then with the same used gloves, she proceeded to clean the g-tube site with Normal Saline (NS), dried the skin and then applied the drainage gauze dressing. Staff D failed to remove the used gloves and perform hand hygiene after removing the old g-tube dressing and prior to applying the new treatment and dressing. b. Record review for Resident ID #179 revealed a physician's order dated 1/22/2025, to cleanse the stage 4 left lateral ankle wound with NS, pat dry, apply collagen (treatment that promotes wound healing), then apply Hydrofera blue (absorbent dressing) moistened with NS, and cover the area	F 880		

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F 880	Continued From page 13 with a bordered gauze dressing daily. During a surveyor observation of of the dressing change with Staff D on 2/5/2025 at 10:05 AM, she removed the old dressing, which had a small amount of yellow and green drainage, from the resident's left ankle. While wearing the same used gloves, she proceeded to clean the wound with NS, pat the wound dry, apply the collagen and the Hydrofera blue, and lastly apply the bordered gauze dressing to the wound. Staff D failed to remove the used gloves and perform hand hygiene after cleaning the wound and prior to applying the new treatment and dressing. c. Record review for Resident ID #179 revealed a physician's order dated 1/22/2025, to cleanse the coccyx wound with NS, pat dry, apply collagen, then apply Hydrofera blue moistened with NS, and cover the area with a foam dressing daily. During a surveyor observation of the dressing change with Staff D on 2/5/2025 at 10:14 AM, she cleansed the wound with NS, patted the wound dry and did not change her gloves or perform hand hygiene before applying the collagen, Hydrofera blue treatments, or the foam dressing to the wound. During a surveyor interview on 2/5/2025 at 12:08 PM with the Director of Nursing Services (DNS), she acknowledged that Staff D should have removed her gloves and washed her hands after she removed the old dressings from the g-tube site and the left ankle. The DNS further revealed that Staff D should have removed her gloves and washed her hands after cleaning the g-tube site, left ankle, and coccyx wounds and before applying a new treatment and dressing.	F 880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 14 3. During the medication administration pass on 2/2/2025 at 11:08 AM with Medication Technician, Staff I, she was observed preparing to administer Resident ID #268 his/her inhaler. A sign was observed affixed to the wall outside of the resident's room, indicating the resident's roommate was on Contact Precautions (a means to prevent transmission of infections through direct contact by wearing personal protective equipment such as a gown and gloves when performing care). Staff I donned a gown and gloves and proceeded to enter the resident's room with his/her inhaler to administer the medication. Staff I administered the inhaler and then placed the inhaler on the only bureau in the room. She then removed her gown and gloves, removed the inhaler from the bureau, exited the room and placed the inhaler on top of the medication cart. Staff I performed hand hygiene, then removed the inhaler from the top of the cart and placed the inhaler in its box and into the med cart drawer, without disinfecting the inhaler and without disinfecting the medication cart. During a surveyor interview immediately following the observation with Staff I, she revealed that she should have placed a barrier down prior to placing the resident's inhaler on the bureau. Additionally, she acknowledged she should have cleaned the inhaler prior to returning it to the cart. During a surveyor interview on 2/4/2025 at approximately 12:00 PM with the DNS, she revealed that Staff I should have used a barrier prior to placing the inhaler down on the resident's bureau. Additionally, she acknowledged that Staff I should have disinfected the inhaler prior to placing it back to the cart.	F 880		

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Center for Health Facilities and Regulation on 2/3/2025. The facility was found to be in compliance with 42 CFR §483.73 related to Emergency Preparedness. No Emergency Preparedness deficiencies were identified during the survey. Capacity: 82 Census: 82	E 000		

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

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

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K 000	INITIAL COMMENTS The annual Federal Life Safety Code survey was conducted by the State Survey Agency. Grace Barker Nursing Center was surveyed pursuant to the National Fire Protection Association 101 Life Safety Code, 2012 Edition as referenced in 42 CFR 483.90 (a - d) Physical Environment. Life safety code deficiencies were identified. Capacity: 82 Census: 82	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9, 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined that the facility failed to maintain their emergency lighting systems in accordance with National Fire Protection Association (NFPA) 99 2012 Edition and NFPA 101 2012 Edition. This deficient practice has the potential to impact 82 of 82 residents as well as an indeterminable number of staff and visitors. Findings are as follows: A surveyor observation in the presence of the Maintenance Director on 2/5/2025 at approximately 9:15 AM, revealed that the facility failed to install a battery backup emergency	K 291	**As a POC for Life Safety Code (LSC) Tag K291:** a) No residents were mentioned in this citation. b) 82 of 82 residents and an indeterminate number of staff and visitors have the potential to be affected by this finding. c) We have installed emergency battery backup lighting in the basement electrical room where the generator transfer switch is located. The battery is to be maintained and tested at intervals as required to ensure proper functioning. We will maintain a supply of replacement batteries. We have provided training to our maintenance director on the importance of ensuring that the emergency back-up lighting is functional. We have developed a fire safety check list to monitor our compliance with this plan. d) The Administrator/ designee is responsible for implementing this plan. The fire safety check list will be utilized on a routine basis and the results shared with the QAPI committee for no less than 3 months; at which time, we will determine the need/frequency to continue formal fire safety checks.	March 7, 2025 (03/07/2025)

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

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K 291	Continued From page 1 lighting unit in the basement electrical room where the generator transfer switch is located. During a surveyor interview with the Maintenance Director immediately following the above observation, he acknowledged that the basement electrical room, where the generator transfer switch is located, lacked a battery backup emergency lighting unit, as required.	K 291		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review, surveyor observation, and staff interview, it has been determined that the facility failed to maintain a minimum of an 18-inch clearance between the deflector of the ceiling-mounted sprinkler head and the top of	K 353	**As a POC for LSC Tag K353:** a) No residents were identified in this finding. b) 82 0f 82 residents and an indeterminate number of staff and visitors have the potential to be affected by this citation. c) We have provided training to relevant staff regarding the need to ensure that there is an 18- inch gap between the ceiling sprinklers and the top height of storage in the clean linen room as well as other areas of storage. We have marked the 18-inch limit with a visual reminder. Our maintenance director will make inspections to ensure that stored items do not exceed the 18- inch limit between the ceiling sprinklers. We have devised a fire safety check list to monitor our compliance with this plan. d) The Administrator/ designee is responsible for implementing this plan. The fire safety checklist will be utilized on a routine basis and the results shared with the QAPI committee monthly. We will review our progress with the QAPI committee for no less than 3 months at which time, we will determine the need/frequency to continue the fire safety checklist.	March 7, 2025 (03/07/2025)

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K 353	Continued From page 2 storage in accordance with the National Fire Protection Association (NFPA) 13 2010 Edition section 8.5.6.1 and NFPA 101 2012 Edition. This deficient practice has the potential to impact 82 of 82 residents, as well as an undetermined number of visitors and staff. Findings are as follows: Record review of the NFPA 13 Standard for the Installation of Sprinkler Systems, 2010 Edition states in part, "...8.5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 8.5.5.2.1 Continuous or noncontinuous obstruction less than or equal to 18 inches (457 millimeter) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 8.5.5.2." A surveyor observation on 2/5/2025 at approximately 9:45 AM during the life safety tour in the presence of the Maintenance Director, failed to reveal the facility maintained the required 18-inch minimum clearance between the combustible storage and the sprinkler heads in the clean linen storage room. During a surveyor interview immediately following the above observation with the Maintenance Director, he acknowledged the facility failed to maintain the required 18-inch minimum clearance between the combustible storage and the ceiling mounted sprinkler heads in sprinkler heads in the storage room.	K 353		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage	K 923	**As a POC for LSC Tag K923:** a) No residents were identified in this finding.	March 7, 2025 (03/07/2025)

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K 923	Continued From page 3 Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined that the facility	K 923	b) 82 of 82 residents and an indeterminate number of staff and visitors have the potential to be affected. c) We have provided training to staff regarding the safety implications of improperly stored oxygen cylinders and the need for them to be placed on a proper stand or cart when in use and/or when in storage. We have ensured that we have enough carts/and proper stands to accommodate each cylinder. Our maintenance director will conduct inspections to ensure oxygen is being stored safely. We have devised a check list to monitor our compliance with this plan. d) The Administrator/Designee is responsible for implementing this plan. The fire safety check list will be utilized on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/frequency to continue use of the fire safety checklist.	

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K 923	Continued From page 4 failed to maintain oxygen cylinders in accordance with National Fire Protection Association (NFPA) 99, 2012 Edition. This deficient practice has the potential to impact 82 of 82 residents, as well as an indeterminable number of staff and visitors. Findings are as follows: Review of NFPA 99, 2012 edition, states in part: 11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures: (1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device. (2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them. (3) Cylinders shall be protected from tampering by unauthorized individuals. (4) Cylinders or cylinder valves shall not be repaired, painted, or altered. (5) Safety relief devices in valves or cylinders shall not be tampered with. (6) Valve outlets clogged with ice shall be thawed with warm- not boiling - water. (7) A torch flame shall not be permitted, under any circumstances, to contact a cylinder, cylinder valve, or safety device.	K 923		

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K 923	Continued From page 5 (8) Sparks and flame shall be kept away from cylinders. (9) Even if they are empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them. (10) Large cylinders (exceeding size E) and containers larger than 45 kg (100 lbs.) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1. (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. Surveyor observations made during the Life Safety Tour on 2/5/2025 at approximately 9:25 AM, in the presence of the Maintenance Director, revealed the oxygen storage room failed to have cylinders stored in a proper stand or cart. During a surveyor interview with the Maintenance Director, immediately following the above observation, he acknowledged that the facility failed to store portable oxygen cylinders in an approved stand or cart, as required.	K 923		