STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265325	A. Building B. Wing	10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens North	4401 Parker Road Black Jack, MO 63033

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07342 Based on record review, interview and review of facility policies and procedures, the facility failed to ensure that two (Resident (R)72 and R247) of 31 sampled residents were informed and provided written information to formulate an advance directive. Findings include: 1. Review of R72'a Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab revealed R72 had diagnoses of type II diabetes, peripheral vascular disease, non-pressure chronic ulcer, gangrene, and moderate protein calorie malnutrition. The resident was admitted on [DATE]. Further review of the EMR revealed a Code Status Form under the Miscellaneous tab labeled Advance Directive dated [DATE]. Review of R72's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] in the electronic medical record (EMR) under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R72 was cognitively intact. An interview with the Social Services Director (SSD) on [DATE] at 3:00 PM revealed that the facility did not have a signed advance directive or even a notice that an advance directive was offered. An interview with the Administrator on [DATE] at 3:45 PM indicated she was not aware of the problem with R72; however, the facility was working on a quality improvement plan for advance directives. Further review of the quality improvement plan on [DATE] at 4:30 PM revealed no documentation of a quality improvement plan related to advanced directives was available. An interview with R72 on [DATE] at 4:45 PM revealed that she had not been asked about an advance directive for two years or since she broke her leg and went to the hospital. 20243 2. Record review of R247's Code Status Form, found in the Advanced Directives tab under resident documents in the EMR, revealed the resident had an admitted [DATE] and had elected to receive cardiopulmonary resuscitation (CPR) and that 911 would be called. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 2:40 PM, the SSD stated that the facility gave paperwork to residents or family members on admission and that she would look for R 247's Advanced Directives documentation. In an interview on [DATE] at 12:15 PM, the Administrator stated that advanced directives paperwork could not be found for R247. Facility policy review of an undated facility document titled Advance Directives Policy provided by the facility on paper revealed the facility policy was: 1.Upon admission, identify the resident has an advance directive and if not determine if the resident wishes to formulate an advance directive. A resident has the option to execute an advance directive but will not be required to do so. The facility will not discriminate against a resident based on whether he or she has executed an advance directive. 2. At the resident's request, the facility will provide written examples of advance directives to include, but not limited to a Living will, a directive to the attending physician, a durable power of attorney or health care. a medical power of attorney, a pre-existing medical order for do not resuscitate (DNR), or other document directing the resident's health care. 3. Facility staff will provide the resident and/or resident representative with a copy of this policy to implement an advance directive. (Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements are met.). The facility will identify the primary decision-maker (e.g., assess the resident's decision-making capacity and identify or arrange for an appropriate legal representative for the resident assessed as unable to make relevant health care decisions) has not followed their procedure.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on interviews, record review, and review of facility policy, the facility failed to provide a baseline care plan within 48 hours of admission for one resident (Resident (R)100) of one resident reviewed for base line care plans out of 31 sampled residents. Findings include: Review of R100's Face Sheet located in the resident's electronic medical record (EMR) in the section titled Face Sheet revealed the resident was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, anxiety, psychotic disturbances, chronic pain, and generalized osteoarthritis. Review of R100's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/08/23 located in the resident's EMR section titled Resident Assessment Instrument (RAI) revealed the resident had a Brief Interview of Mental Status (BIMS) score 14 out of 15 indicating the resident's cognition was intact. The MDS documented the resident had an unsteady gait but could stabilize with assistance and utilized a walker and cane for mobility. The MDS documented the resident sustained a fall after admission to the facility. Review of R100's Care Plans located in the resident's EMR section titled Care Plans failed to reveal a baseline care plan for R100. During an interview on 10/03/23 at 4:00 PM R100 revealed the resident stated she did not remember receiving or signing a care plan that discussed her care issues with interventions within 48 hours of her admission to the facility. During an interview on 10/04/23 at 11:45 AM Licensed Practical Nurse (LPN) 3 revealed the base line care plans were completed by the unit nurses. LPN3 revealed care plans were revised/updated by the IDT teams. LPN3 was unable to provide a copy of the baseline care plan for R100. During an interview on 10/05/23 at 12:49 PM, the Unit Manager (UM) and the MDS nurse revealed the floor nurse was responsible for baseline care plans that should have been maintained in the EMR. They revealed the baseline care plan was not separated from regular care plans. Neither the UM nor MDS nurse were sure if the resident or resident's responsible party received a copy of baseline care plans within 48 hours of admission. The MDS nurse stated that she and social services worked together in handling the baseline care plans. The facility was unable to provide a copy of the baseline care for this resident. Review of facility policy titled Care Plan Conference, Interdisciplinary, with a revision date 05/21, read in part . The admission care plan is initiated by a nurse or interdisciplinary (IDT) member within 48 hours of admission .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 16752 Based on record review, interview, and review of facility policy, the facility failed to ensure that care plans for one (Resident (R)96) was revised to reflect palliative services from a sampled 31 residents. Finding include: Review of R96's Resident Face Sheet located in the resident electronic medical records (EMR) section titled Face Sheet revealed the resident was admitted to the facility 12/16/22 with diagnoses that included acute kidney failure, pressure ulcers of the sacrum, diabetes mellitus type II, cerebral infarct with hemiplegia, hemiparesis, and dysphagia. Review of R96's monthly Physicians Orders located in the resident's EMR section titled Orders revealed the resident started to receive palliative services on 07/20/23. Review of R96's Resident's Progress Notes located in the resident's EMR section titled Documents revealed a note dated 07/20/23 that the resident was evaluated and admitted to palliative services. During an interview on 10/04/23 at 12:00 PM Licensed Practical Nurse (LPN)5 revealed that palliative services provided the care plan for the resident. However, she was unsure if the facility's care plan included that the resident was receiving palliative services. During an interview on 10/05/23 at 1:14 PM the Unit Manager (UM) revealed the resident's palliative services should have been included in the resident's care plan; and this was the responsibility of the Minimum Data Set (MDS) nurse. The UM reviewed the resident's care plan and confirmed it did not include that the resident was on palliative services. Review of the facility's policy titled Care Plans, Interdisciplinary, with a revision date 05/22, read in part . The care plan coordinator or the appropriate discipline updates the resident's care plan using the proper procedure for entering and discontinuing items .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 22409 Based on observation, interview, and record review, the facility failed to follow physician's orders and their policy by failing to ensure one resident's gastrostomy tube (g-tube, a tube inserted through the belly that brings nutrition directly to the stomach) feeding infused at the prescribed rate. In addition, the facility failed to ensure staff recorded a date/time on the package of a g-tube declogger (used to declog a g-tube) of when it was opened, and failed to ensure staff were aware of how long the g-tube declogger could be used prior to discarding it. The facility identified six residents with g-tubes. Four were sampled and problems were identified with one. (Resident # 1). The census was 138. Review of the facility Enteral Nutrition /Tube Feeding policy, dated 2014, showed: -Guideline: Enteral Nutrition (EN, a way of delivering nutrition directly to the stomach or small intestine) may be substituted for individuals who have an intact gastrointestinal tract but are unable or unwilling to take food by mouth in amounts that will support adequate nutrition. Examples are individuals with neurological disorders (strokes, head and neck trauma or surgery), cancer, and individuals with difficulty swallowing or ingesting adequate amounts of food, and gastrointestinal obstructions. Enteral feedings provide nutrients and fluids using the gastrointestinal tract. Enteral feedings can be used to supplement oral intake or can provide all of an individual's nutritional needs; -Procedure: -The choice of the EN depends on the medical and nutritional needs of the individual as assessed by the Registered Dietician (RD) and physician; -Enteral feedings supply nutrients directly to the stomach via a very small diameter, flexible feeding tube; -Continuous drip: Requires a pump and is appropriate for individuals who do not tolerate larger volumes of Tube Feeding (TF, a medical device used to provide nutrition) infusions. The TF is usually infused for a total of 18 to 24 hours; -Open System: TF product must be opened and poured into a tube feeding bag prior to administration; -EN feeding orders should include: formula - brand and formula name, route of feeding, administration method, strength, number of calories per day and the amount of water flushes per 24 hours; -If the individual is to be a continuous feeding, divide the total milliliters (ml) of enteral feeding by 24. This will be the rate per hour that the enteral formula is to be administered; -Monitoring of the individual's actual intake and tolerance of tube feeding is important to ensure that nutritional goals are met and maintained. Monitoring of the individual with tube feedings is an interdisciplinary team effort and includes EN is being delivered as ordered by physician; (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The RD should assist the health care community with the development of guidelines, procedures and/or protocols regarding EN. Review of Resident #1's, quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/9/23, showed: -Makes Self Understood: Rarely/never understood; -Ability to Understand Others: Rarely/never understood; -Total dependence of one person required for bed mobility, dressing, eating, toilet use, personal hygiene and bathing; -Total dependence of 2 (+) persons required for transfers; -Diagnoses of Alzheimer's disease, aphasia (inability to speak), stroke, dementia, and hemiplegia/hemiparesis (partial or total paralysis of one side of the body/weakness of one side of the body); -Feeding Tube: 51% or more of total calories received through a feeding tube. Review of the resident's care plan, located in the electronic health care record (EHR), showed: -Problem: Nutritional status. -Approach(s): Administer g-tube feeding as ordered. RD follow-up as needed. Maintain NPO (nothing by mouth) status. Review of the resident's physician's order sheet (POS), located in the EHR, showed: -Diet: NPO; -Enteral Feeding: Nepro (formula) 1.8 continuous feeding at 50 ml per hour (ml/hour) continuous; -G-Tube Flush: 125 ml of water every two hours; -G-Tube Size: 18 french; -No order regarding g-tube decloggers. Observation on 9/29/23 at 8:51 A.M., showed the resident lay in bed with Nepro TF infusing via a g-tube feeding pump at 60 ml/hour. Observation inside the resident's top drawer of his/her chest of drawers showed an opened, undated, g-tube declogger (used to unclog a g-tube). The inside of the package had small flecks of brown material indicating it had been used. The opened package containing the declogger was marked at that time by the surveyor. That was the only declogger observed in the drawer. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/2/23 at 9:32 A.M., and 11:30 A.M., showed the resident lay in bed with Nepro TF infusing at 60 ml/hour. Observation of the resident's top drawer of his/her chest of drawers showed the same opened and marked package containing the g-tube declogger. This was the only declogger observed in the drawer. During an interview on 10/2/23 at 112:50 A.M., Licensed Practical Nurse (LPN) 6 said he/she is an agency nurse. He/She did not know if the facility had a policy as to how long a g-tube declogger could be used prior to being discarded. He/She thought it should be discarded within three to five days after being opened. The package should be dated and timed when opened so staff would know when to discard it. Observation on 10/2/23 at 2:05 P.M., showed the resident sat in a chair in his/her room after being transferred from the bed to the chair. Certified Nursing Assistant (CNA) 3 left the room to find the nurse to turn the resident's tube feeding back on. A few minutes later, LPN 7 entered the room, reconnected the tube feeding and turned the tube feeding pump back on. The tube feeding rate was still set at 60 ml/hour. During an interview, the nurse said nurses work 12 hour shifts. Nurses are responsible to ensure tube feeding rates are set per physician's orders. He/She left to check the physician orders. He/She returned and said 60 ml/hour was not the correct tube feeding rate, and he/she re-set the tube feeding rate to 50 ml/hour. The nurse observed the tube feeding declogger in the resident's top drawer. He/She confirmed the package had been opened, and was undated. He/She was an agency nurse so he/she did not know what the facility's policy was for discarding a g-tube declogger after being opened. He/She thought it would not be used for more than three days to a week after opening. If the package was not dated when opened, you would not know when to discard it. During an interview on 10/2/23 at 2:55 P.M., the Director of Nurses said nurses work 12 hour shifts. Both the day and night shift nurses were responsible to ensure tube feedings were infusing at the rate ordered by the physician. The facility did not have a policy for g-tube decloggers. Staff should write the date and time on the package when it was opened. She thought a g-tube declogger should be discarded no longer than 24 hours after the package was opened and the declogger had been used. MO00223682

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15189 Based on observation, record review, interviews, and facility policy review, the facility failed to promptly intervene when a resident's respiratory equipment was missing for one (Resident (R) 34) of three residents reviewed for respiratory care/oxygen of 31 sample residents. Findings include: Review of R34's electronic Face Sheet located in the Face Sheet tab of the electronic medical record (EMR) revealed R34 was admitted to the facility on [DATE] with diagnoses that included obstructive sleep apnea. Review of R34's electronic Active Orders located in the Orders tab of the EMR revealed R34 had the following physician's order dated 08/05/23 for bilevel positive airway pressure (BiPAP), a respiratory treatment used during sleep to treat obstructive sleep apnea every evening and night shift. 08/05/23: Wash CPAP [Continuous Positive Airway Pressure]/BiPAP mask/tubing/humidifier chamber with warm soapy water. Air dry. Once a day on Sun. During observation and interview with R34 on 10/03/23 at 9:15 AM a BiPAP machine was observed on R34's bedside table. When asked if the BiPAP was currently being utilized the resident stated that the BiPAP equipment was cleaned on Sunday (10/01/23) and the mask had been missing since that time. The resident further stated that the BiPAP had not been used during sleep on 10/01/23 or 10/02/23. During an interview on 10/03/23 at 9:47 AM Licensed Practical Nurse (LPN) 3, who identified herself as the charge nurse on R34's unit, revealed that she was not aware that R34's BiPAP face mask had been missing since 10/01/23. Interview with the Director of Nursing (DON) on 10/04/23 at 8:48 AM confirmed that R34's BiPAP mask had been missing since 10/01/23, but she had not been notified. The DON stated that R34's daughter and primary care physician (PCP) were notified. The DON stated the PCP gave an order at that time to do oxygen saturation checks on R34 every 2 hours while sleeping until the resident's BIPAP mask was replaced. The DON confirmed that the company for the BiPAP machine had also been contacted for replacement of R34's BiPAP mask. Review of the Nursing Policy and Procedure Manual entitled CPAP/Bi-Level Respiratory Care, revised on 07/21, revealed procedures for cleaning that included: WEEKLY: Wash mask, tubing and humidifier chamber in mild soapy water, rinse and allow to air dry.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36383 Based on observations, interviews, record review, and policy review, the facility failed to ensure: 1. the high temperature dish machine met proper temperatures and 2. the staff maintained a clean kitchen including items in the storage areas for all 133 residents who received meals from the kitchen. These failures had the potential to lead to food-borne illness among all facility residents. Findings include: 1.Observations during the initial tour of the kitchen on 10/02/23 beginning at 9:31 AM with the Food Service Director (FSD) revealed: The hot water dishwasher temperatures of Wash was 152 Fahrenheit (F), the Rinse was 154 F, and the Final Rinse was 190F. At 9:35 AM, Dietary Aide (DA) 1 loaded another batch of dirty dishes onto the conveyor belt and dishwasher temperatures registered at Wash 130F, Rinse 156F, and Final Rinse of 190F. On 10/02/23 at 9:36 AM, DA1 placed another load of dirty bowls from breakfast onto the conveyor belt with the FSD observing. The dishwasher gauges measured the following temperatures: Wash 128F, Rinse 148F and Final Rinse of 191F. The FSD stated that she did not know why the dishwasher temperatures were low and said that she was leaving the kitchen to contact their dishwasher service technician. The plaque on the dishwasher displayed required temperatures of Wash 150F, Rinse 160F and Final Rinse of 180F. On 10/02/23 at 9:44 AM, the FSD returned to the kitchen and told DA1 not to wash any more dishes until the dishwasher reached the correct temperature. In an interview on 10/02/23 at 9:54 AM, the FSD stated that she were not aware that the dishwasher temperature for the Wash and Final Rinse were not reaching the proper temperatures. In an interview on 10/02/23 at 10:24 AM, DA2, who worked at the facility as a dishwasher for one year, stated that he talked to maintenance about a month ago about dishwater temperatures not being met. DA2 stated, One side of the knobs are not moving or the temps [temperatures] were not heating up. The Final Rinse was the only side that worked or heated up. In an interview on 10/02/23 at 10:29 AM, DA3, who worked at the facility as a dishwasher for three years, stated the dishwasher Wash cycle normally gets to 120F and that is the highest . the final rinse is normally fine. In an interview on 10/02/23 at 10:42 AM, the Registered Dietician (RD), facility's dietician for [AGE] years, stated that she was not aware of any dishwashing issues until that morning. The RD stated that the FSD called the dishwasher technician and industrial chemical company. The RD added that it was odd that the final rinse is meeting temps but not the wash and rinse were not. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 10/02/23 at 10:49 AM, the FSD stated that they do not audit the dishwasher machine temperatures because they depend on the staff to tell them if the dishwasher was malfunctioning. The FSD stated that staff had not informed maintenance of the low wash and rinse temperatures. The FSD said that the dishwasher should be running at proper temperatures to ensure all germs are killed and that the dishes are cleaned and sanitized. In an interview on 10/02/23 at 1:48 PM, the Maintenance Director (MD) stated that the dishwasher was serviced last week for a converter belt issue and not a temperature issue. The MD stated the dishwasher was a high temp dishwasher and this was the first time he heard that the required temperatures were not met. The MD stated that they do not conduct audits of the dishwasher because expect their staff to report problems to management or their supervisor. In an interview on 10/02/23 at 12:01 PM, the Service Technician (ST) stated the dishwasher was now working and he noticed the wash tank temperature was extremely low because there was no voltage. ST said that he simply turned on the breaker and everything was now working. ST confirmed the proper dishwashing temperatures were the following: 150F for Wash 160F for Rinse 180F for Final Rinse. Review of the owner's manual for the dishwasher machine entitled Maintenance; Dishwashing; Gleaning - [NAME] c44 Instruction Manual shows required dishwashing temperatures as the following: 150F for Wash, 160F for Rinse, and 180F for Final Rinse. 2. During the initial visit to the kitchen on 10/02/23 at 9:10 AM with the FSD observations revealed: The storage room floor contained dirty tiny pieces of paper, sticky-like substances, and a plastic bag on the floor. The debris and substances were embedded onto the floor and under the storage racks. Large white bins of brown sugar, white sugar, white flour, grits, and oats were unlabeled and undated. The corners of the bins contained a buildup of grease and tiny crumbs. Fruit flies were flying around the sticky areas. The recipe shelf above the cook's food preparation area contained greasy crumbs and sticky substances. During a subsequent visit to the kitchen on 10/03/23 at 8:19 AM, observations with FSD revealed: Garbage can at the right of the sink where employees wash their hands was covered with sticky black substances with patches of a white substance embedded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In the storage closet next to the dish machine area, dirty plates (15), large serving trays (4), large rectangular lids (10), bin of scoops and silverware, and metal oven racks were observed. The deep freezer in the storage room across the hall from the kitchen needed defrosting and contained two inches of old ice, Unlabeled traditional stuffing mix and a rice bin covered with what appeared to be dirt were observed in the storage area across from the kitchen Black substance that appeared to be mold covered the large surfaces of two large rectangular plastic cutting boards. The cutting boards were observed in the storage closet next to the dish machine area in the kitchen. In an interview on 10/04/23 at 3:03 PM, the Administrator stated, kitchen food safety is important and it is expected the staff to know proper temps. And if dishwasher temperatures are not working, it is expected for the staff to notify [FSD] or Maintenance. Also, the Administrator stated that the expectation for kitchen staff was to provide clean and sanitized dishes to the facility's residents and proper dishwasher temperatures at all cycles. Review of the facility's Sanitation/Infection Control policy, dated August 2010, revealed Monitor that the dishwashing machine is maintaining operating guidelines for wash, rinse, and final rinse temperatures. Check each item as it comes out of the dishwashing machine for soiled items. Run dirty items through again until they are clean. the Dining Services staff shall maintain the operation of the dishwashing machine according to established procedure and manufacturer guidelines posted or contained in this guideline to ensure effective cleaning and sanitizing of all tableware and equipment used in the preparation and service of food . In addition, all dishwashing machines should be operated according to manufacturer recommendation. Tableware, utensils, and pots and pans should be cleaned and sanitized in either a high temperature dishwashing machine that uses hot water, or a chemical-sanitizing dishwashing machine that uses a chemical sanitizing solution.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265325	A. Building B. Wing	10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens North	4401 Parker Road Black Jack, MO 63033

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on record review, interview and review of facility policy, the facility Quality Assurance Performance Improvement (QAPI) program failed to identify problems with the admission process in that Advance Directives were not offered to two (Residents (R)247 and R333) from a sampled 31 residents. Findings include: 1. Review of R247's Resident Face Sheet located in the resident's electronic medical records (EMR) section titled Face Sheet revealed the resident was admitted to the facility 12/29/22 with diagnoses that included non-Alzheimer's dementia, diabetes type II, coronary artery disease, congestive heart failure, benign prostate hyperplasia, anxiety disorder and depression. Review of R247's Advance Directives located in the resident's EMR section titled Documents revealed the resident did not have an Advance Directive. 2. Review of R333 Resident Face Sheet located in the resident's electronic medical record (EMR) section titled Face Sheet revealed the resident was admitted to the facility 10/16/20 with diagnoses that included diabetes mellitus type II, peripheral vascular disease, anxiety disorder, chronic pain syndrome, necrotizing fasciitis, and protein calorie malnutrition. Review R333 Advance Directive located in the resident's EMR in the section titled Documents revealed the resident did not have an Advance Directive. An interview with the Administrator on 10/05/23 at 4:36 PM revealed she was recently hired in this position but had [AGE] years' experience. The Administrator stated that she attended the QAPI meeting in September 2023. The Administrator stated that she noticed there was a problem with the Advance Directives not being offered to the residents on admission. The Administrator stated she asked social services to conduct an audit of the Advance Directives missing from the admission packet. The Administrator also stated that she had developed her audit tool to reveal the residents admitted to the facility to see if they had an Advance Directive. The audit tool was reviewed with the Administrator and identified that the tool failed to identify which residents had missing Advance Directives. The Administrator was unable to describe what corrective action would be taken. Review of a facility policy titled Quality Assurance Performance Improvement (QAPI) Program with an effective date November 2017 reads in part . The community's QAPI process focuses on systems and processes rather than individual. The emphasis is on recognizing inconsistencies and system defects.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 20243 Based on observation, interviews, review of manufacturer's instructions, policy review, and review of Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to train and ensure staff, including agency nurses, disinfected multi-use glucometers with an EPA registered disinfectant and removed used gloves for one of one resident observed receiving a fingerstick (Resident (R) 22) out of 39 residents receiving blood sugar monitoring. This failure increased the likelihood of transmission of blood-borne pathogens to residents receiving blood sugar monitoring. Findings include: During an observation on 10/05/23 at 8:12 AM, Registered Nurse (RN)1 approached the medication cart stating that the cart surface was clean from previous use. RN1 donned gloves gathered supplies and a glucometer. RN1 approached the resident, cleaned the resident's finger with an alcohol prep, allowed it to dry, and performed the fingerstick. She then touched the test strip with a drop of blood and read the results. RN1 then gathered the supplies, alcohol prep, used lancet, glucometer, and the test strip bottle with her contaminated gloves. On 10/05/23 at 8:15 AM, immediately following the observation, when asked about disinfecting the glucometer prior to performing the fingerstick RN1 stated that the glucometer was clean. When asked how she could be sure it was clean she stated that she could not be sure. When asked about removing the supplies with her contaminated gloves and contaminating the test strip bottle, RN1 stated she should have removed her gloves. RN1 stated she had been trained to clean the glucometer before and after each use but acknowledged she failed to clean the glucometer before using on R22. In an interview with Licensed Practical Nurse (LPN) 2 on 10/05/23 at 4:05 PM, LPN2 stated that she cleans the glucometer with alcohol or Sani-wipes. LPN2 added she cleans the glucometer before, after, and in-between each resident. LPN2 stated that she uses Sani-wipes (EPA registered disinfectant) first then alcohol pads. LPN2 stated that she did not receive any training on how to perform glucometer disinfection at the facility. During an interview on 10/05/23 at 4:15 PM with LPN1, located on the 400/500 unit, LPN1 stated use alcohol prep pad [to disinfect the glucometer] . that might not be their policy because I don't know all of their policies because I'm agency; we go by what we've been taught at other facilities. When asked how many times she has worked in the facility, LPN1 stated I've worked here maybe five or six times; usually do day or night shift; they don't do that orientation [disinfecting the glucometer] with us, and they don't tell us before we start doing Accu-Checks what the policy is. In an interview on 10/05/23 at 5:00 PM, the Staff Development Nurse/Unit Manager stated she completes orientation for new and agency staff. She stated that there should be two glucometers on each unit for the nurses to alternate use while waiting for the glucometer to dry after disinfection She stated that she would cleanse a glucometer with a wipe from a purple top canister (Sani-Wipe) and wait two minutes. She stated she would disinfect the glucometer before and after use. The Staff Development Nurse/Unit Manager further stated that glucometer disinfection was not covered in orientation unless the staff members asked about it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Orientation for New and Contract Staff training packet, provided by the facility, revealed no training related to glucometer cleaning and disinfection. Review of the CDC guidelines, retrieved from https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html, revealed The Centers for Disease Control and Prevention (CDC) has become increasingly concerned about the risks for transmitting hepatitis B virus (HBV) and other infectious diseases during assisted blood glucose (blood sugar) monitoring and insulin administration. CDC is alerting all persons who assist others with blood glucose monitoring and/or insulin administration of the following infection control requirements: Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared . Review of the facility policy titled, Blood Glucose Monitors (Equipment Cleaning), revised February 2021, revealed Purpose: To prevent the spread of blood borne pathogens. Policy: Equipment used to obtain blood glucose results (blood glucose monitoring devices) that are used for more than one resident will be cleansed before and after each use. Procedure: A container of Oxivir TB will be stored in each treatment cart. Before and after the testing procedure, the nurse will cleanse the monitor with the Oxivir TB. Review of the EVENCARE ProView Blood Glucose Monitoring System manufacturer's instructions, provided by the facility, revealed that The EVENCARE ProView Meter should be cleaned and disinfected between each patient .Disinfection Instructions . the meter must be disinfected between patient uses by wiping it with a CaviWipes towelette or EPA-registered disinfecting wipe in between tests and be cleaned prior to disinfecting. The Disinfection process reduces the risk of transmitting infectious diseases if it is performed properly. 36383