STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275035	A. Building B. Wing	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Missoula Health & Rehabilitation Center	3018 Rattlesnake Dr Missoula, MT 59802

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48261 Based on observations and interviews, the facility failed to ensure residents' catheter bags were covered for maintaining resident dignity, for 2 (#s 29 & 132) of 3 sampled residents for dignity and catheter concerns. Findings include: During an observation and interview, on 2/14/24 at 8:01 p.m., resident #132 was sitting in her room. A catheter bag was attached to her wheelchair armrest, and the catheter bag was uncovered. Resident #132 stated she just had Valentine's dinner with her husband. Resident #132 stated her catheter bag had not been covered since her arrival to the facility, which was back on 2/5/24. During an interview on 2/14/24 at 8:10 p.m., staff member G stated she was not sure why catheter bags were not covered. Staff member G stated the CNAs were responsible for emptying the catheter bags and placing covers on the catheter bags. During an interview on 2/14/24 at 8:21 p.m., staff member A stated the staff should have been placing covers on the catheter bags, and catheter bag covers were available for staff use. During an observation on 2/15/24 at 8:15 a.m., resident #29 was lying in bed sleeping. A catheter bag was hanging from the end of his bed, by the entrance to the room. The catheter bag did not have a dignity cover over it. Resident #29 was not responsive at the time of the observation. Due to the location of the catheter bag, residents, family, or anyone entering the room to see resident #29 or his roommate, would be able to see the catheter bag with urine in it.

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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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48261 Based on observations, interviews, and record review, the facility failed to ensure residents had knowledge of the grievance process and access to grievance forms to file a grievance, to include anonymously; and, the facility failed to ensure all grievances were investigated, resolved, and that residents were made aware of the outcome of the grievance, for 2 (#s 11 and 20) of 19 sampled residents. Findings include: During an observation and interview on 2/12/24 at 1:15 p.m., resident #13 verbally notified the CNAs that she did not like the lunch served and to take it away. Resident #13 stated she was upset the food was not edible. Resident #13 stated she had reported her grievances verbally several times (and on this day) to staff and management, but nothing was ever done. She continued to receive the foods she did not want. Resident #13 stated another resident repeatedly entered her room and took her things. She stated the facility did not do anything about that either. Resident #13 stated, It's been going on for months (lack of follow up of grievance concerns) and no one does anything. She stole my shoes last night, and staff had to get them back from her. It happens all the time, and all they say is they are trying to find her a new home. That's not my problem, I've lost so much stuff to her stealing. Grievances just go unanswered. Resident #13 stated she did not know how to access a grievance form to file a grievance. Resident #13 stated she had verbally notified many people (of her grievances), including staff member C and the kitchen, but they did not have a grievance form to complete. Resident #13 stated no one ever came back to tell her what a plan was to address her concerns. During an interview on 2/12/24 at 1:16 p.m., resident #20 stated she did not know how to file a grievance or where to locate grievance forms in the event she needed one. During an interview on 2/12/24 at 1:17 p.m., staff member F stated he did not know where to get grievance forms, or what to do, when a resident had a complaint or grievance. Staff member F stated, Let me get my DON, because I just don't know. During an interview on 2/12/24 at 1:20 p.m., staff member B stated grievances are given to staff member C, and she addresses them. Staff member B stated, Well usually they (staff) just go get [staff member C], if there was a grievance concern. Staff member B showed the surveyor a box at the nursing station, located on the wall, where grievance forms would be kept. No forms were available in the box as it was empty. In addition, the grievance box at the nurses' station was not accessible to residents unless they asked a staff member to retrieve the form. Due to this, obtaining and submitting an anonymous grievance would be difficult. Staff member B took the surveyor the South Hall, to another grievance form box, by where the survey results book was kept. Staff member B stated there was a grievance box there as well, but that box was now missing. Staff member B stated the residents could file a grievance during resident council, and staff member C filled a form out for those complaints or grievances. Staff member B stated most grievances at resident council were about food. Staff member B stated, residents who did not attend resident council could ask a staff member for a grievance form. There was no process in place for a resident to file a grievance anonymously. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/24 at 2:04 p.m., staff member Q, R, S, and T were at the nursing station. The staff were unable to explain where grievance forms were located. Staff member T stated, if a resident had a grievance, If it's abuse, we tell [staff member A]. Staff member Q, R, and S did not have an answer for what they would do if a resident had a grievance. During an interview on 2/15/24 at 9:04 a.m., resident #11 stated she did not know how to file a grievance or where to locate forms to file a grievance. Resident #11 stated she just told staff member C when she was not happy. A review of the facility's policy, Grievance Procedure, dated November 2016, showed: - .4. Staff are trained at orientation and periodically on the Center's grievance procedure, including: - .d. What to do with grievances. - .e. When to put a grievance in writing. - .5. The Center makes Grievance Forms and this policy readily available to residents, family members, representatives, visitors, and staff members. - .10. The person with the grievance has the right to a written decision regarding his/her grievance.

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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. 41952 Based on observation, interview, and record review, the facility failed to review and revise care plan interventions, and identify beneficial interventions, to prevent a resident from wandering into other residents' personal space and rooms, and taking or destroying their belongings, for 1 (#24) of 19 sampled residents. Findings include: During an observation on 2/14/24 at 5:55 p.m., resident #24 was wandering around other residents who were gathering for dinner, and she was blocking their paths. Several other residents were showing signs of irritation by resident #24 being in their personal space. Another resident faked pushing her walker into resident #24 when she stopped in front of her. Another resident visibly froze in place, backed up, and went around resident #24, to not cross paths with her. During an observation on 2/14/24 at 7:32 p.m., resident #24 was wandering and went to the exit door by the nursing station. Staff member W then put resident #24 to bed. Staff member W attempted to leave the room. Resident #24 sat up in bed and started reaching for things. Staff member W turned on the light as she re-entered the room and closed the door. There was no alert stop signs on the resident room doors in use on the North or South Halls (with residents residing in them), as to deter resident #24 from entering the other rooms. During an interview on 2/14/24 at 7:58 p.m., staff member W stated resident #24 would already be wandering by the time her shift started at 2:00 p.m. Staff member W stated resident #24 wandered throughout the facility but was generally able to be redirected. Staff member W stated the alert stop signs were given to residents who had issues with resident #24 going into their room or taking things. Staff member W stated, if the alert stop sign was in use, it will slow resident #24 down because resident #24 would pick at the sign, but she would still attempt to enter the room, and staff would intervene if they witnessed her trying to enter a room. Staff member W stated she would try different interventions when she was on shift, in between care sessions for other residents, such as sitting with resident #24, coloring, or watching television. Resident #24 had a very short attention span. Staff member W was not sure if these interventions were care planned for #24, or if there were interventions that worked for resident #24. During an observation on 2/15/24 at 10:05 a.m., resident #24 was wearing the same clothing as the day prior, which was a blue Rugrats sweatshirt, grey pants, and purple and pink striped fuzzy socks. Resident #24 was walking to the common area, where three other residents were seated. Resident #24 was hovering over a male resident touching his walker, then she went to a female resident and started rummaging through her walker basket. Resident #24 grabbed the handle of another resident's wheelchair, and the resident yelled at resident #24. Three facility employees walked past the common area during the observation and did not intervene with resident #24's behavior. Resident #24 proceeded to go down the South Hall, carrying a decoration, and looking into different resident rooms. Staff member N came down the hall, saw resident #24, who was close to the end of the hall, and started calling her name. Resident #24 did not notice Staff member N calling her as she leaned into another resident's room that did not have an alert stop sign on the door. Staff member N caught up to resident #24 as she went to the exit door. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/15/24 at 10:43 a.m., staff member C stated the interdisciplinary team reviewed behaviors, and resident #24 was reviewed for her behaviors when incidents occurred. Staff member C stated resident #24 needed a memory care unit, and she had been attempting placement for four to six months as the resident's behavior's had progressed. Staff member C stated resident #24's medications had been reviewed, and she had been placed on a toileting plan, but this did not change the wandering behavior. Staff member C stated there were residents that would seek out resident #24 if they were upset, because they had incidents with her, but resident #24 could not understand or respond. Staff member C stated the alert stop signs were for residents who had an incident with resident #24 going into their room. Staff member C stated #24's care plan was generalized for keeping resident #24 out of other resident's rooms because the facility did not put information for other residents on her care plan. Review of the facility grievances from December 2023 through February 2024 showed: - On 2/12/24 resident #24 wandered into a resident's room and took a pair of her shoes. Staff witnessed the other resident chase resident #24 down the hall to get the shoes back. The facility re-educated the resident to use the alert stop sign and press her call light when resident #24 came to her room. - On 12/1/23 resident #24 went into another resident's room when the resident in the room had a visitor, and #24 destroyed the puzzle they had worked on. The facility gave an alert stop sign to the resident for the door, and then told the resident to press the call light if resident #24 wandered into the room again. Review of a facility reported incident, which occurred on 2/3/24, showed resident #24 wandered into two different resident rooms, on two facility halls. In one room, she tore up two bags of briefs. Resident #24 entered the other resident's room and was touching his leg boot. The report showed resident #24's care plan was reviewed, and resident #24 would be redirected by staff if attempting to go in other resident rooms and staff would provide 1:1 activities. Review of resident #24's care plan, last updated 5/13/24, showed: - Resident #24 displayed multiple behaviors, to include being in others personal space, entering their rooms, getting into their bed, taking or destroying items, and pushing residents in their wheelchairs. - Interventions included placement of the alert stop signs on doors as appropriate, and to redirect resident #24 when in the personal space of another resident or entering their room.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48261 Based on observations, interviews, and record review, the facility failed to provide necessary services to maintain grooming for 1 (#13) of 19 sampled residents. Findings include: During an observation and interview on 2/12/24 at 1:15 p.m., resident #13 was in her room. Resident #13 appeared disheveled, with hair unbrushed, and long facial hair growing into a beard on her lower jaw and down her neck. Resident #13 stated, No one offered to assist me with my whiskers, so they just grow. Resident #13 stated she brushed her own hair and had not had a chance to brush it that morning. Resident #13 stated, I would love to get rid of this thing (beard), it's awful masculine isn't it. During an interview on 2/12/24 at 2:00 p.m., staff member F stated the CNAs should be offering shaving during bath days. During an interview on 2/12/24 at 2:10 p.m., staff member R stated, I suppose I should offer (assistance with shaving). I've only worked here a couple of shifts. I'm a traveler. During an interview on 2/12/24 at 2:20 p.m., staff member E stated, Well we were focused more on incontinence and showers, but we should start more on shaving too. During an interview on 2/13/24 at 3:18 p.m., NF3 stated she had visited resident #13 and noted her beard was long and thick. During an observation and interview on 2/14/24 at 10:40 a.m., resident #13 received a shower without complaint or refusals, and she was shaved. Resident #13 returned to her room and stated, It's awesome. I feel like new. A review of the facility's policy, CNA Competency, Assisting with a Shower or Bath, dated July 2014, showed: - . 22. Assist with hair care or other grooming needs.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 50245 Based on observations, interviews, and record review, the facility failed to provide the necessary services for a resident related to scheduling medical appointments, communication, and continuity of care, for the resident's catheter care and services, and catheter changes, received at a specialized Urology clinic, for 1 (#8) of 19 sampled residents. Findings include: During an interview on 2/12/24 at 2:18 p.m., staff member B stated resident #8 required monthly catheter changes with the [Urology Clinic]. A record review of Resident #8's physician communications, showed a physician's fax, dated 7/1/22. The fax included a physician's order for monthly catheter changes for #8. No new physician orders concerning biweekly catheter changes were noted in the resident's EHR. During an interview and record review, on 2/13/24 at 9:26 a.m., staff member B reviewed the monthly appointment calendar with the surveyor. It was identified there was no monthly [Urology Clinic] appointment on the calendar for resident #8, for catheter care and services. Staff member B reported the [Urology Clinic] scheduled the appointments. During an observation, interview, and record review, on 2/13/24 at 3:36 p.m. staff member B showed an appointment had been scheduled for resident #8 for catheter services. Staff member B made no reference to the appointment that was missing during the review earlier that morning, and the new appointment for resident #8 was scheduled for 2/15/24. Review of the audit trail of appointments showed appointments were made by staff member N. Staff member B stated staff member N made (resident) appointments. During an interview on 2/14/24 at 8:51 a.m., staff member N stated she only made one appointment yesterday (1/13/24) for #8, but the facility made the appointments monthly for #8, for catheter services. During an interview and record review on 2/14/24 at 9:56 a.m., NF2 stated the facility made the appointments for resident #8's catheter services and changes. NF2 stated the next appointment for resident #8 was scheduled for 2/15/24. This appointment was scheduled by the facility on 2/13/24, after the surveyor asked staff member B about #8's next appointment. NF2, and the surveyor, reviewed the resident's [Urology Clinic] appointment note from 12/20/23, and it showed the resident's catheter changes were now biweekly, not monthly. During resident #8's record review, a [Urology Clinic] note, dated 1/18/24, also referenced biweekly catheter changes. NF2 stated she had concerns regarding resident #8 being left alone at his appointments and only being sent with an SBAR communication form, from the facility. Resident #8 had a BIMS of 4. The BIMS scale ranges from 0 to 15. Scores 0 to 7 are categorized as severely cognitively impaired. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/15/24 at 9:17 a.m., staff member O reported, Residents can be left alone at appointments if they say they are okay. Staff member O stated, another employee was utilized if two appointments were scheduled at the same time. Staff member O stated he made appointments most of the time, but staff member N would help sometimes. Record review of a fax sent to the [Urology Clinic], on 12/17/23, requested the facility's transport to make an appointment for resident #8. Record review of a facility Transportation policy, updated November 2016, showed, If staff is to assist a resident in coordinating transportation and he/she is unable to leave the Community without superivsion, staff needs to make arrangements for an escort to accompany the resident. Record review of a resident list, provided by the faciility, for residents who needed supervision at appointments, which was not dated, showed resident #8 required supervision for appointments. Record review of resident #8's EHR reflected gaps in communication two times, and the documentation from the facility to the [Urology clinic] in the past 3 months. These included: a. The first gap in communication and documentation showed four nursing notes referring to follow up with the [Urology clinic], and only one fax to the [Urology clinic], dated 12/17/23, regarding resident #8's catheter and the catheter was frequently leaking. Per the documentation in the nursing notes, resident #8 had a catheter leaking for the past three months. b. The 2nd gap in communication and documentation, included one progress note, dated 1/18/24, which addressed the [Urology clinic] catheter change for resident #8. This documented note was a late entry, created on 2/13/24 at 9:37 a.m., by staff member B. There were no other notes regarding a catheter change in the past three months.

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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** 48261 Based on observations, interviews, and record review, the facility failed to ensure medication error rates were under 5% for 4 (#s 1, 16, 29, & 132) residents, of 4 residents sampled for medication. The calculated medication error rate was 17.86%. Findings include: 1. During an observation on [DATE] at 8:22 a.m., staff member E administered the following medication to resident #132: - Cefuroxime (Cefin) axetil oral: cut in half 2. During an observation and interview on [DATE] at 8:45 a.m., staff member E stated resident #29 received his medications crushed in applesauce, or he would spit them out because he could not swallow them. Staff member E prepared to enter the room to administer the following medication, but the surveyor intervened: - Aspirin 325 mg expired on [DATE] - Metoprolol succinate ER 50 mg crushed During an interview on [DATE] at 8:50 a.m., staff member E stated, We (nurses) always give his (resident #29) medications crushed because he will spit them out if we don't. All the nurses do it that way. I know we can split them and sometimes we will quarter the pill, but he still spits it out, so we crush it. The surveyor requested staff member B to re-evaluate the medications for resident #29, prior to administering, to ensure accuracy. During an interview on [DATE] at 9:01 a.m., staff member B stated the nurses should never crush or cut up an extended release medication like metoprolol succinate ER. Staff member B went down to the nurses cart and educated staff member E to not crush or cut up extended release medications, and to contact the doctor for an alternate medication, if resident #29 could not swallow the medication whole. During an interview on [DATE] at 11:10 a.m., staff member B stated, I just don't see the medication issues until I work the cart. Then I see the red flags, but I've only worked the cart one time in recent months. Staffing has been a mess so that was what I worked on. 3. During an observation and interview on [DATE] at 11:12 a.m., staff member J administered the following medication to resident #16: - Sinemet ,d+[DATE] mg. Staff member J walked out of the room while resident #16 still had medication in his mouth and had not swallowed it. Resident #16 was observed swishing the pills around in his mouth and continued to drink water to swallow the medication, after staff member J left the room. Staff member J stated she should have stayed in the room, but she thought he had swallowed the pills. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:15 a.m., resident #16 stated he, . had a little bit of a hard time with hard pills and some food when I try to swallow them. Resident #16 stated he had received Speech Therapy services in the past but was not currently receiving assistance for his swallowing. During an interview on [DATE] at 11:37 a.m., staff member P stated resident #16, . needs a little bit of help with his water and pills. During an interview on [DATE] at 11:40 a.m., staff member B stated resident #16 would need to go to the dining room if he was having difficulty swallowing. Staff member B stated resident #16 had eaten in the dining room with his partner in the past but had stopped coming to the dining room after his partner died . Staff member B stated she would be going to see him and tell him she was ordering a swallow evaluation, and he would need to return to the dining room for meals. 4. During an observation on [DATE] at 12:07 p.m., staff member B entered the blood sugar reading for resident #1 in the EHR, which was 237, and then changed the blood sugar to 227, after the surveyor questioned the accuracy of the result. Staff member B prepared insulin for resident #1. Staff member B stated she was drawing up four units of insulin. She then decided not to administer the medication, due to the concern for low blood sugar, if resident #1 did not eat his lunch. The surveyor noted the the syringe did not hold four units of insulin, and this was discussed with staff member B. Staff member B then placed the insulin syringe in the top drawer of the medication cart, without a label. During an observation and interview on [DATE] at 1:02 p.m., staff member B stated she was going to administer the insulin drawn up at 12:07 p.m., to resident #1. Staff member B retrieved the unlabeled syringe from the top drawer of her medication cart, which had been put there prior, without verifying the dose or blood sugar, and showed the volume in the syringe to the surveyor. The surveyor noted the insulin amount was not the required dosage ordered by the physician, as it was under four units, and staff member B was notified of this. Staff member B then threw away the syringe and drew up a new syringe of four units of insulin. A review of the facility's policy, Oral Medications That Should Not Be Crushed or Altered, no date, showed the following medications should not be crushed or altered: - Cefin - Metoprolol Succinate ER A review of the facility's policy, Medication Administration Subcutaneous Insulin, dated ,d+[DATE], showed: - . e. Hold insulin syringe with correct calibration in view (at eye level) and withdraw ordered insulin . A review of the facility's policy, Medication Administration General Guidelines, dated ,d+[DATE], showed: - . 4. Medications are to be administered at the time they are prepared . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 8. No expired medication will be administered to a resident .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275035	A. Building B. Wing	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Missoula Health & Rehabilitation Center	3018 Rattlesnake Dr Missoula, MT 59802

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48261 Based on observations, interviews, and record review, the facility failed to remove expired items for disposal for one medication room and two medication carts; and properly store food items used for medication administration, keeping it off the floor, in one medication room. These failures increased the risk of expired items being or food being used, when stored unsafely, for resident care, if taken from the identified medication room and carts. Findings include: 1. During an observation on 2/13/24 at 10:43 a.m., with staff member B, in the medication room, the following items were found: - One case of Prostat packets, on the floor. - One case of individual serving, vanilla pudding cups, on the floor. - One case of individual applesauce cups, on the floor. 2. Stock of multi-resident use medications: - Senna, two bottles, expired 12/20 - Senna, four bottles, expired 7/20 - Omeprazole, one bottle, expired 11/18 - Milk of magnesia, one bottle, expired 5/19 - Ferrous Gluconate, expired 1/24 - Fleet pads, opened 7/24/20 - Slow-release Iron, expired 12/23 - Two Sodium Chloride 0.9% 250 mL bags, expired 11/30/23 During an interview on 2/13/24 at 10:45 a.m., staff member B stated she was not aware of the expired medications. Staff member B stated the pharmacy was responsible for checking of expiration dates. Staff member B stated she tried to get into the medication room to also check out dates, monthly, but had not done so in several months. During an observation on 2/13/24 at 12:15 p.m., staff member E had the following items on the medication cart: - Aspirin, 81 mg, expired 1/24 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Multivitamin expired 1/24 During an observation on 2/13/24 at 11:55 a.m., staff member F had the following item on the medication cart: - Metrix blood glucose test strips, bottle of 50 strips, expired 5/31/23 Review of the facility's procedure, Did you Know The Steps to Perform an Internal Expired Med Inventory Audit?, no date, reflected: - . Enact a system to regularly check meds for correct expiration dates and to remove expired drugs. - Perform this internal inventory inspection at least monthly .

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 41952 Based on observations, interviews, and record review, the facility failed to ensure kitchen staff followed safe hygiene practices and properly check temperatures of food for serving. This had the potential to effect any residents that consumed the food prepared by the kitchen. Findings include: During a kitchen observation on 2/12/24 at 1:30 p.m., four staff were in the kitchen cleaning and prepping for the next meal. Only one staff member had a baseball hat on, which was covering her hair. The other staff did not have hair or beard nets on to cover facial/head hair. During an observation and interview on 2/14/24 at 11:24 a.m., staff member U had a hair net on her head, but it was not covering two long braids, and she was wearing two long, dangling earrings. Staff member U was leaning over the tray line taking the temperature of the prepared foods. Staff member U took the temperature of the pureed broccoli. The thermometer showed 92.4 degrees, and she documented 94 degrees on the temperature log. When the temperature documented was questioned, staff member U stated she may have hit the button and accidently took the temperature in Celsius instead of Fahrenheit. Staff member U rechecked the pureed broccoli, and she documented 129.9 degrees, but she did not check the other foods. During an interview on 2/15/24 at 10:40 a.m., staff member U stated she took the temperature and documented lunch meal on 2/14/24, using a Celsius setting, by accident. She stated she should have rechecked the temperature in Fahrenheit to make sure it was within range. Staff member U stated hairnets should be on in the kitchen and staff should not be wearing dangling jewelry, but acknowledged she had worn long earrings and was not wearing her hairnet correctly the day before (2/14/24). During an interview on 2/15/24 at 10:43 a.m., staff member D stated food temperatures should be taken and documented in Fahrenheit. Review of the facility temperature logs, for 2/12/24 through 2/14/24, showed the lunch temperatures on 2/14/24 were lower than the rest of the meals for cooked food. The retaken broccoli temperature of 129.9 degrees Farenheit was below the required holding temperature of 135 degrees Fahrenheit for vegetables.

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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. 48261 Based on observations, interviews, and record review, the facility failed to maintain infection control hand hygiene practices and for cleaning of communal equipment, for 2 (#s 1 and 4) for 19 sampled residents. Findings include: 1. During an observation and interview on 2/13/24 at 9:10 a.m., staff member F performed hand hygiene as he entered resident #1's room. Staff member F changed the left foot dressing for resident #1. Staff member F removed the dirty bandages from three wounds on the resident's left foot, cleansed the wounds with saline, and placed new bandages, without performing hand hygiene or glove changes during any of the steps moving from a clean to a soiled task. Staff member F then placed a new bandage to a wound on the resident's right foot stump. No hand hygiene was performed until staff member F was exiting the room. Upon exiting, staff member F stated he knew he had missed hand hygiene steps and glove changes. 2. During an observation on 2/13/24 at 11:27 a.m., staff member E completed a blood sugar check for resident #4. After checking the blood sugar, staff member E failed to complete hand hygiene, before leaving the resident's room, and prior to returning to the medication cart. 3. During an observation on 2/14/24 at 11:55 a.m., staff member J checked the blood sugar for resident #4. After testing resident #4's blood sugar, staff member J wiped the glucometer with a Sani-cloth Bleach disposable wipe. Staff member J then tossed the glucometer into a basket with the supplies used to check blood sugars for residents through-out the building. The Sani-Cloth Bleach Wipes showed a four-minute wet contact time was necessary. Staff member J stated she was not aware of the wet contact times or dry times for the Sani-Cloth wipes, and she came from [Country name] where they do things differently. Staff member J stated she did not have training on wet contact times or of dry times for safe use of cleaning supplies such as the Sani-Cloth Bleach wipes. During an interview on 2/14/24 at 12:30 p.m., staff member K stated she had no training or knowledge on wet contact times or dry times for cleaning products. During an interview on 2/14/24 at 12:35 p.m., staff member L stated she had no knowledge or training on wet contact times or dry times for cleaning products. 4. During an observation and interview on 2/14/24 at 5:45 p.m., staff member B pricked the finger of resident #1 and squeezed some blood out, but stated she was unable to get enough blood from the prick. Staff member B reached into the basket that held extra alcohol pads and obtained a new alcohol pad and lancet with the gloves on that were used to attempt the first prick. Staff member B repeated the test and wiped the glucometer at the cart. Staff member B placed the blood sugar check supplies basket in the cart drawer. When asked about contamination of the supplies in the basket, staff member B stated, Yes, I know I contaminated it all. Sorry, I am just stressed. I'll clean it later. Staff member B proceeded to continue medication pass. A review of the facility's Sani-Cloth Bleach Germicidal Disposable wipes packaging showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- . Cleaning Procedure: All blood and other bodily fluids must be thoroughly cleaned from surfaces and objects before disinfection by the germicide wipe. Open, unfold, and use first germicide wipe to remove heavy soil . - . Contact Time: Use second germicide wipe to thoroughly wet surface. Allow to remain wet one minute, let air dry. Although efficacy at a one-minute contact time has been shown to be adequate against HIV-1/HBV/HVC, this time is not sufficient for all organisms listed on this label. Therefore, a four-minute wet contact time must be used for TB and pathogenic fungi . 41952 During an interview on 2/14/24 at 3:50 p.m., staff members M and J stated they had things to work on and were reeducating facility staff on reusable equipment cleaning product dry times. Staff member M stated if facility staff could not find the dry time on the sanitation wipes, the highest dry time in the facility was ten minutes, and they should default to that time. Staff members M and J stated they did not have any kind of audits when staff did wound care, pericare, or catheter care for infection control and hand hygiene practices. Staff member J showed weekly checklists she conducted for infection control. The checklists showed environmental items to review. The only staff task was hand hygiene, but just had a checkmark it was done, not who was observed, or what task was being completed. Staff member J stated she made sure she observed one staff member, and the checkmark meant there were no issues with the hand hygiene. Staff member J stated if there was an issue it would be handled in the moment and would not be formally documented. Staff member M stated facility managers had resident rooms assigned, which they would observe during rounds. Staff member M stated, if cares were being provided at the time managers were observing, the managers were to stay and watch. Then the managers would report any issues during the daily meetings.