STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366106	A. Building B. Wing	05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens of Fairfax Health Care Center	9014 Cedar Ave Cleveland, OH 44106

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on observation, record review, and interview the facility failed to ensure call lights were within reach and accessible for residents. This affected one resident (Resident #46) of two residents (Resident #12 and #46) reviewed for call light placement. Findings Include: Review of the medical record for Resident #46 revealed an admitted [DATE]. Diagnoses included but were not limited to cerebral infarction due to unspecified occlusion or stenosis of right posterior cerebral artery, type II diabetes mellitus and adult failure to thrive. Review of the 04/08/23 quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #46 revealed a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment. Resident #46 required extensive assist of one for bed mobility, transfer, walk in room, locomotion off unit, dressing, toileting, personal hygiene, and supervision of one for locomotion on unit, and eating. Resident #46 was noted to frequently be incontinent of bladder. Review of the 04/20/23 revised care plan for Resident #46 revealed she was at high risk for falls related to decline in functional ability with impulsiveness. One of the goals listed for Resident #46 was to be free of falls through the review date. Interventions included staff to be sure Resident #46's call light was within reach and to encourage Resident #46 to use it for assistance as needed. Resident #46 was also noted to need prompt assistance with all requests for assistance. A phone interview on 05/07/23 at 10:03 A.M. with Resident #46's son revealed he was concerned about her call light not being within reach as he had previously observed the call light not being in reach on more than one occasion. Observation on 05/09/23 at 9:44 A.M. revealed Resident #46 sitting on the side of her bed with the call light on the floor on the opposite side of the bed. Interview at the time of the observation with Licensed Practical Nurse (LPN) #219 confirmed the call light was not within Resident #46's reach.

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 38522 Based on record review, facility policy review, personnel file review and interview, the facility failed to implement the screening component of their abuse policy and procedure to ensure all potential new hires were checked against the state Nurse Aide Registry (NAR) to ensure no employee had findings concerning abuse, neglect, exploitation or misappropriation of residents' property. The facility also retained staff after 30 days when background check results were not received. This affected six out of 14 employees whose personnel files were reviewed and had the potential to affect all 45 residents in the facility. Findings Include: Review of 14 personnel records on 05/10/23 starting at 12:29 P.M. with Human Resource Coordinator (HRC) #202 revealed the following concerns: a. Review of State tested Nursing Assistant (STNA) #218's personnel file revealed a re-hire date of 04/11/23. The file contained no evidence of STNA #218 being checked against the NAR and no evidence background checks had been completed upon re-hire. b. Review of Dietary Aide (DA) #204's personnel file revealed a hire date of 02/10/23. The file contained no evidence of DA #204 being checked against the NAR on hire. c. Review of Licensed Practical Nurse (LPN) #219's personnel file revealed a hire date of 05/31/22. LPN #219's NAR check was completed on 04/20/23. d. Review of STNA #211's personnel file revealed a re-hire date of 05/21/22. STNA #211's NAR check was completed on 06/18/22. e. Review of Unit Secretary (US) #206's personnel file revealed a hire date of 06/10/22. The file contained no evidence background checks had been received. f. Review of STNA #217's personnel file revealed a hire date of 04/07/23. The file contained no evidence background checks had been received. Interview on 05/10/23 at 12:29 P.M. with HRC #202 verified the above background and NAR checks were not completed on or before each employee's date of hire to ensure no employee had a finding concerning abuse, neglect, exploitation or misappropriation of residents' property. HRC #202 verified US #206 and STNA #217 continued to work at the facility even as 30 days had passed and their background check results had still not been received by the facility. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy, Abuse, Neglect and Misappropriation, revised 09/29/22 revealed as part of the employment screening process, Ohio's NAR portal was used to confirm a STNA's eligibility to work in a long-term care setting. As part of the employment screening process, the Ohio Board of Nursing was used to confirm as nurse's eligibility to work in a long-term care setting. Once a conditional offer of employment was given to a potential employee, he/she would be provided with information to attain a criminal background check at the individual's expense. Potential employees were encouraged to complete this process as soon as possible, preferably prior to the start of orientation. [Facility name] must receive results of this check prior to the completion of one month of employment. New hires must stop working after one month until [facility name] received the results from the background check.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on record review, self-reported incident (SRI) review, policy review and interview, the facility failed to report an allegation of potential abuse related to an injury of unknown origin as required. This affected one resident (Resident #29) of four residents (Residents #26, #29, #35, and #147) reviewed for abuse. The facility census was 45. Findings Include: Review of the medical record for Resident #29 revealed an admitted [DATE]. Diagnoses included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, adult failure to thrive and osteoarthritis. Review of 02/22/23 quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #29 revealed a Brief Interview of Mental Status (BIMS) score of 03 which indicated severe cognitive impairment. Resident #29 required supervision of one for bed mobility, transfer, walking in room, dressing, eating, toileting, and personal hygiene. Resident #29 was noted to use a cane and wheelchair for mobility. Review of Resident #29's care plan revealed she has limited physical mobility related to stroke and weakness. Interventions included provide supportive care and assistance with mobility as needed. Review of the 12/13/22 nursing progress note with time stamp of 3:40 P.M. revealed Resident #29 was noted to have four plus edema to her right hand. Resident #29's physician was called and an order for x-ray of her right hand was obtained. Review of the 12/14/23 radiology report for Resident #29 revealed acute metacarpal fractures of the fourth and fifth finger on her right hand. Review of 12/14/22 nursing progress note with time stamp of 10:15 A.M. revealed the nurse received the x-ray results for Resident #29 which listed findings of fracture to Resident #29's right fourth and fifth finger. At 9:20 A.M. Resident #29's physician was notified of the x-rays results and an order was received to splint both fingers and schedule an orthopedic appointment. Review of the 12/14/22 facility form titled Self-Reported Incident Form for SRI #230161 revealed staff became aware of the swelling on Resident #29's right hand on 12/13/22 at 12:30 P.M. The Administrator was noted to have been notified of the incident on 12/14/22 at 10:00 A.M. Under the area of, whether serious bodily injury occurred, if known, the response indicated was yes, fracture of two fingers. Review of the SRI form reported to the state agency revealed the injury of unknown origin involving Resident #29 was reported on 12/14/22 at 5:37 P.M. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 09/29/22 revised facility policy called: Abuse, Neglect and Misappropriation revealed the policy indicated all staff members no matter their discipline or their department were required to immediately report no later than two hours after forming the suspicion if the events that cause suspicion result in serious bodily injury, or no later than 24 hours if the events that causes suspicion do not result in serious bodily injury. Interview on 5/9/23 at 4:27 P.M. with the Administrator confirmed the staff became aware of the injury of unknown origin on 12/13/22 on 12:30 P.M., he was not made of aware of the incident until 12/14/22 at 10:00 A.M., and the state agency reporting form was not filed until 12/14/23 at 5:37 P.M. This deficiency is an example of continued noncompliance from the complaint survey completed 04/20/23.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on record review, self-reported incident (SRI) review, policy review and interview, the facility failed to conduct a thorough investigation related to and injury of unknown origin for Resident #29 and an allegation of alleged sexual abuse for Resident #35. This affected two (Resident #29 and #35) of four residents (#26, #29, #35 and #147) reviewed for abuse. Findings Include: 1. Review of the medical record for Resident #29 revealed an admitted [DATE]. Diagnoses included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, adult failure to thrive and osteoarthritis. Review of the [DATE] quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #29 revealed a Brief Interview of Mental Status (BIMS) score of 03 which indicated severe cognitive impairment. Resident #29 required supervision of one for bed mobility, transfer, walking in room, dressing, eating, toileting, and personal hygiene. Resident #29 was noted to use a cane and wheelchair for mobility. Review of Resident #29's care plan revealed she has limited physical mobility related to stroke and weakness. Interventions included provide supportive care, assistance with mobility as needed. Review of the [DATE] nursing progress note with time stamp of 3:40 P.M. revealed Resident #29 was noted to have four plus edema to her right hand. Resident #29's physician was called and an order for x-ray of her right hand was obtained. Review of the [DATE] radiology report for Resident #29 revealed acute metacarpal fractures of the fourth and fifth finger on her right hand. Review of the [DATE] nursing progress note with time stamp of 10:15 A.M. revealed the nurse received the x-ray results for Resident #29 which listed findings of fracture to Resident #29's right fourth and fifth finger. At 9:20 A.M. Resident #29's physician was notified of the x-ray results and an order was received to splint both fingers and schedule an orthopedic appointment. Review of the facility investigation file regarding the Self-Reported Incident (SRI) #230161 revealed a facility form titled Self-Reported Incident Form and a printed copy of the self- reported incident report form filed with the state agency. No written resident or staff witness statements were found in the file. Interview on [DATE] at 4:27 P.M. with the Administrator confirmed he did not have further documentation of staff or resident interviews following the discovery of the injury of unknown origin for Resident #29 to add to the SRI #230161 investigation file. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the [DATE] revised facility policy called: Abuse, Neglect and Misappropriation revealed the facility would thoroughly investigate suspicious bruising of residents, injuries or patterns that resembled abuse. The facility would use video, photographs, witness statements, staffing patterns, interviews with residents, staff, and visitors to investigate allegations of abuse, neglect, or misappropriation. 37096 2. Review of the medical record for Resident #35 revealed an admitted [DATE] Diagnosis included dementia, chronic kidney disease, and heart failure. Review of the quarterly MDS assessment dated [DATE] revealed Resident #35 had impaired cognition and required extensive assistance of one staff for bed mobility, dressing, toilet use and hygiene. The assessment indicated Resident #35 had verbal behaviors directed at others. Review of the progress notes dated [DATE] at 2:25 P.M. revealed the housekeeping staff reported to the nurse that Resident #35 stated her privates hurt. The Housekeeping staff questioned Resident #35 and she stated she had sex last night with her husband. Her husband was deceased . Review of the self-reported incident (SRI) dated [DATE] and timed 2:45 P.M. revealed an alleged incident of sexual abuse occurred on [DATE]. The housekeeper reported it to the Director of Nursing (DON). The social worker interviewed the resident, a cognitive test was administered, staff that worked the night of the occurrence were interviewed. Review of the facility investigation dated [DATE] revealed one statement from the housekeeper that reported the incident. The investigation lacked evidence of the social worker's interview with Resident #35 and statements from staff that worked the night of the occurrence. There was no evidence that residents were interviewed. Interview on [DATE] at 4:30 P.M. with the Administrator revealed a full investigation was conducted. Staff and residents were interviewed. The Administrator was unaware of the missing statements and indicated he would try to locate them. As of [DATE] at 3:00 P.M., after several request throughout the survey, the Administrator did not provide staff and/or resident interviews. Review of the facility policy titled Abuse, Neglect, and Misappropriation, revised [DATE] revealed the facility would thoroughly investigate any evidence of suspected abuse, neglect, or misappropriation of property. The facility would use video, photographs, witness statements, staffing patterns, interviews with residents, staff, and visitors to investigate allegations of abuse, neglect, or misappropriation.

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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** 37096 Based on record review and interview the facility failed to develop a baseline care plan. This affected one resident (Resident #148) of three residents reviewed for new admissions. Findings Include: Review of the medical record for Resident #148 revealed an admitted [DATE]. Diagnoses included heart disease, gout, osteoarthritis, repeated falls, and retention of urine. Review of the baseline assessment, dated 05/02/23 revealed Resident #148 experienced confusion, had a history of falls, an unsteady gait, poor balance, and was impulsive. Resident #148 used a walker. Review of the baseline care plan dated 05/03/23 revealed information regarding nutritional risk. The care plan did not include information regarding falls, unsteady gait, confusion, impulsiveness or urinary retention. Interview on 05/09/23 at 1:13 P.M. with Licensed Practical Nurse (LPN) #225 verified the baseline care only included Resident #148 had a nutrition risk and the care plan was not complete. LPN #225 stated she started the care plan but forgot to complete the care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on record review, observation and interview the facility failed to provide nail care for residents unable to carry out activities of daily living (ADLs) without assistance. This affected three (Residents #2, #8, and #26) of four residents reviewed for ADLs. Findings Include: 1. Review of the medical record for Resident #8 revealed an admitted [DATE]. Diagnoses included type II diabetes, heart disease, chronic kidney disease, blindness of one eye, and glaucoma. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 03/31/23, revealed Resident #8 had impaired cognition and required extensive assistance with bed mobility, limited assistance with transfers, total dependence for dressing and personal hygiene. Review of the plan of care dated 05/03/23 revealed Resident #8 had a self-care performance deficit related to blindness. Intervention included one person assistance for personal hygiene, bathing, and dressing. Observation on 05/07/23 at 3:27 P.M. of Resident #8's fingernails revealed they were long. Observation and interview on 05/08/23 at 9:54 A.M. with Licensed Practical Nurse (LPN) #225 confirmed Resident #8's fingernails were long. It was also noted and confirmed with LPN #225 there was debris under Resident #8's fingernails. LPN #225 said Resident #8 ate with her fingers. LPN #225 verified Resident #8 required total dependence from staff for personal hygiene. 2. Review of the medical record for Resident #2 revealed an admitted [DATE]. Diagnoses included seizures, paranoid schizophrenia, and alcohol abuse. Review of the plan of care dated 01/30/23 revealed Resident #2 had a self-care performance deficit related to mood disorder. Interventions included supervision for bathing and dressing. Resident #2 was independent with toileting and bed mobility. Review of the quarterly MDS 3.0 assessment, dated 02/22/23 revealed Resident #2 had intact cognition and required supervision with bed mobility, transfers, dressing and personal hygiene. Observation on 05/07/23 at 10:50 A.M. of Resident #2 revealed his fingernails were long. Interview with Resident #2 at the time of the observations revealed he would cut his nails if staff provided clippers. Resident #2 stated he preferred his nails a short length. Observation and interview on 05/08/23 at 10:01 A.M. with Licensed Practical Nurse (LPN) #225 confirmed Resident #2's fingernails were long. LPN #225 stated nail care was provided twice weekly on shower days. Review of the facility's undated policy titled Resident Care Protocol: Nail Care, revealed nail care was to be provided during shower/baths and as needed. 38522 3. Review of Resident #26's medical record revealed an admitted [DATE] and diagnoses including type two diabetes, cerebral infarction, chronic obstructive pulmonary disease, schizoaffective disorder bipolar type, major depressive disorder and anxiety. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #26's physician's orders revealed an order dated 12/16/22 for nursing to cut fingernails monthly and as needed. Monitor for signs and symptoms of infection. Review of Resident #26's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he was cognitively intact, had delusions and did not reject care. Resident #26 was totally dependent on one staff member for personal hygiene. Review of Resident #26's Medication Administration Records (MARs) for April 2023 and May 2023 (through 05/08/23) revealed no evidence Resident #26's nail care had been completed. Review of nurses' notes from 12/09/22 to 05/07/22 revealed no documentation related to nail care. Observation on 05/07/23 at 12:34 P.M. of Resident #26 revealed his fingernails were long and dirty. Interview on 05/07/23 at 12:34 P.M. with Resident #26 revealed his nails were long, yellow and dirty. Resident #26 stated his nails were last cleaned and trimmed two weeks ago but staff used to provide nail care weekly. Resident #26 was not able to say when staff stopped providing weekly nail care. Observation on 05/08/23 at 9:51 A.M. with Licensed Practical Nurse (LPN) #225 and one other surveyor revealed Resident #26 was in bed and his nails remained long, yellow and dirty. Interview on 05/08/23 at 9:51 A.M. with LPN #225 verified Resident #26's nails were not acceptable and needed to be cut and cleaned. LPN #225 stated nail care was to be done with Resident #26's baths twice a week. Review of the undated policy, Resident Care Protocol: Nail Care, revealed nail care was to be performed during the bath and as needed. Record and report your actions and any unusual observations in the chart.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on record review and interview the facility failed to provide Resident #8's restorative nursing program for ambulation and lower extremity exercises as ordered by the physician and as recommended upon discharge from physical therapy. This affected one (Resident #8) of two residents reviewed for physical therapy. Finding Include: Review of the medical record for Resident #8 revealed an admitted [DATE]. Diagnoses included type II diabetes, heart disease, chronic kidney disease, blindness of one eye, and glaucoma. Review of the quarterly Minimum Data Set 3.0 assessment, dated 03/31/22, revealed Resident #8 had impaired cognition and required extensive assistance from staff for bed mobility, transfers and ambulation. Review of the plan of care dated 05/03/23 revealed Resident #8 had a self-care performance deficit related to blindness. Intervention included one a person assist for personal hygiene, bathing, and dressing. Review of the physician orders dated 02/17/23 revealed an order to refer Resident #8 to a restorative nursing program for ambulation and lower extremity exercises. Review of Resident #8's physical therapy discharge summary dated 02/20/23 revealed a recommendation to establish a restorative ambulation program that included walking 30 feet with a forward wheeled walker with the assist of one person. In addition, a restorative range of motion program that included bilateral lower extremity exercises was recommended. Interview on 05/09/23 at 11:10 A.M. with Licensed Practical Nurse (LPN) #225 revealed Resident #8 was not a restorative nursing program for ambulation or lower extremity exercises. LPN #225 stated she never received the paperwork from therapy services. Review of the facility's Restorative Nursing Policy, revised 12/19/20 revealed the purpose was to maintain a maximum functional level for all residents, prevent deterioration from the resident's current level of functioning, prevent deformities, immobility, and contractures or to reverse these conditions.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on interview, record review and policy review, the facility failed to provide appropriate catheter care and monitoring. This affected one resident (Resident #44) of one resident reviewed for catheter care. The facility census was 45 residents. Findings Include: Review of Resident #44's medical record revealed an admitted [DATE] and diagnoses including acute kidney failure, chronic obstructive pulmonary disease, osteoarthritis, adult failure to thrive and gout. Review of Resident #44's bowel and bladder program screener dated 08/02/22 revealed a score of 19 indicating Resident #44 was a good candidate for retraining. Review of Resident #44's hospital paperwork revealed a urinary catheter was placed prior to his readmission to the facility on [DATE]. Review of a readmission bowel and bladder program screener dated 03/19/23 indicated Resident #44 scored a nine and was a candidate for scheduled toileting. The readmission bowel and bladder program screener did not mention a urinary catheter was in place. Review of Resident #44's historical physician's orders revealed an order dated 03/20/23 to empty urinary catheter each shift; document color, clarity and odor of urine if less than 10 cubic centimeters (cc) of urine notify medical doctor (MD). No order for catheter care was noted. Review of a significant change minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #44 was moderately cognitively intact, was totally dependent on one staff for toileting and had an indwelling urinary catheter. Resident #44 was always continent of bladder and frequently incontinent of bowel. Review of Resident #44's physician's orders as of 05/07/23 revealed an order dated 03/31/23 to document color, clarity and odor of urine if less than 10 cc of urine notify MD; an order dated 04/25/23 to check tubing for kinks with check and change each shift; an order dated 04/25/23 for check placement of urinary catheter measure every shift, red marker line or Foley, if past line and leaking check with [hospice company] for interventions. Review of Resident #44's medication administration records (MARs) and treatment administration records (TARs) revealed no evidence of catheter care being provided from 03/01/23 through 05/07/23. Review of Resident #44's Kardex (care card) did not mention cleaning the urinary catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's care plan dated 04/11/23 revealed he had an indwelling urinary catheter due to benign prostatic hyperplasia. Listed interventions included position catheter bag and tubing below the level of the bladder and away from entrance room door; check placement of Foley measure every shift, red marker line on Foley, if past line and leaking check with hospice services for interventions; check tubing for kinks with check and change each shift; monitor and document output per facility policy; monitor for sign/symptom on urination and frequency; monitor/document for pain/discomfort due to catheter; monitor/record/report to MD for signs/symptoms of urinary tract infection (UTI): pain, burning, blood tinged urine, cloudliness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns. The care plan lacked instruction regarding cleaning Resident #44's catheter or providing routine catheter care. Interview on 05/07/23 at 1:11 P.M. with Resident #44 revealed he did not know how long he had had his urinary catheter. Resident #44 stated staff cleaned the catheter some days but not every day. Interview on 05/08/23 at 7:52 A.M. with Licensed Practical Nurse (LPN) #219 verified Resident #44 did not have an order for catheter care to be completed. LPN #219 stated catheter care should be done per shift or two to three times daily and confirmed Resident #44's electronic medical record did not have evidence catheter care was being completed routinely. Interview on 05/09/23 at 7:12 A.M. with State tested Nursing Assistant (STNA) #218 revealed catheter care was done on Resident #44 daily and charted in Point of Care (POC). STNA #218 was asked to show the POC documentation. STNA #218 showed POC interface for Resident #44 which prompted STNAs to document continence but did not prompt staff to complete catheter care three times daily. Review of the facility policy, Urinary Catheterization, dated 12/28/22 revealed the interval between catheter changes would be determined by the individual resident's needs. Cleansing the meatal surface during daily bathing was appropriate. The periurethral area should not be cleaned with antiseptics in residents with indwelling urinary catheters.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on record review, interview and policy review, the facility failed to obtain dialysis orders and ensure the dialysis care plan included individualized interventions which accurately reflected the care needs of the resident. This affected one of one resident (Resident #12) reviewed for dialysis. The facility identified two residents (Residents #2 and #12) receiving dialysis. Findings Include: Review of the medical record for Resident #12 revealed an admitted [DATE]. Diagnoses included but were not limited to dementia, end stage renal disease and chronic combined systolic (congestive) and diastolic heart failure. Review of the 03/14/23 quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #12 revealed a Brief Interview of Mental Status (BIMS) score of 09 which indicated Resident #12 was moderately cognitively impaired. Review of activities of daily living (ADLs) section of the MDS assessment revealed Resident #12 required extensive assist of one staff for bed mobility, total dependence of two staff for transfer, total dependence of one staff for locomotion on and off the unit, dressing, toileting, personal hygiene, and bathing. Resident #12 was noted to receive dialysis. Review of Resident 12's dialysis care plan initiated on 02/12/20 with a last reviewed date of 02/17/20 revealed Resident #12 needed dialysis due to renal failure. Interventions included check and change dressing daily at access site (chest). Document any changes, drainage, bleeding prior to leaving and upon return. Check for bruit and thrill prior to going and upon return and on non-dialysis days and every shift. Review of the current physician orders for Resident #12 did not reveal orders related to dialysis appointments, care, or monitoring. Review of the Medication Administration Records and Treatment Administration Records for April 2023 and May 2023 did not reveal directions or documentation of care provided to Resident #12's Perma catheter (special intravenous line in to the blood vessel in neck or upper chest just under the collar bone. This type of catheter is used for dialysis treatment). Interview on 05/08/23 at 9:00 A.M. with Licensed Practical Nurse (LPN) #219 confirmed Resident #12 did not have physician orders for dialysis. Observation on 05/10/23 at 9:56 A.M. revealed Resident #12 dressed and staff assisting her to be ready for transport to her dialysis appointment. Resident #12 was observed to have a Perma catheter covered with a bandage on the upper right side of her chest. The Perma catheter would not require staff to check for bruit and thrill prior to and upon return from dialysis as indicated in the care plan. Interview on 05/10/23 at 9:57 A.M. with LPN #232 revealed staff were to monitor Resident #12's dialysis port located on her upper right chest for bleeding or any signs of infection. LPN #232 confirmed there were no orders in place regarding care of the Perma catheter. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 12/19/19 revised facility policy called; Policy for Provision of Dialysis Care revealed the facility would provide ongoing provision of assessment, care planning and provision of care. There must be a coordinated plan for dialysis treatment developed with input from both the nursing home and dialysis facility. This required more frequent and increased observations and monitoring for the resident before and after dialysis treatments.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 38522 Based on interview and record review the facility failed to ensure a Registered Nurse (RN) was on-site eight hours a day, seven days a week as required. This had the potential to affect all 45 residents in the facility. Findings Include: 1. Review of posted staffing sheets from 04/01/23 to 05/06/23 revealed a RN was not in the facility on 04/01/23, 04/02/23, 04/03/23, 04/06/23, 04/07/23, 04/08/23, 04/09/23, 04/10/23, 04/13/23, 04/14/23, 04/15/23, 04/16/23, 04/17/23, 04/20/23, 04/21/23, 04/22/23, 04/23/23, 04/27/23, 04/28/23, 04/29/23 and 05/06/23. Interview on 05/09/23 at 9:14 A.M. with Scheduler #220 verified the identified dates did not meet the required eight hours of RN coverage as required. 2. Review of the staffing schedules for 04/30/23 to 05/06/23 with Scheduler #220 on 05/09/23 at 12:05 P.M. revealed the facility did not have an RN onsite on any shift on 05/06/23. Interview on 05/09/23 at 4:31 P.M. with the Administrator revealed if RN #235 was not working the facility tried to obtain an RN through a staffing agency but at times, staffing was tight. The Administrator was made aware at the time of the interview the facility did not have an RN onsite in the facility as required on 05/06/23.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on interview, record review and policy review, the facility failed to ensure pharmacy medication recommendations were timely addressed and followed up upon. This affected one resident (Resident #41) of five residents reviewed for unnecessary medications. The facility census was 45 residents. Findings Include: Review of Resident #41's medical record revealed an admitted [DATE] and diagnoses including bipolar disorder, current episode manic severe with psychotic features, unspecified dementia, unspecified severity without behavioral disturbance, major depressive disorder, insomnia, history of COVID-19 and other specified mental disorders due to known physiological condition. Review of Resident #41's quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #41 was cognitively impaired and received antipsychotics and antidepressants. Review of a pharmacy medication recommendation for Resident #41 dated 07/22/22 revealed if not recently obtained and if indicated would you consider adding a comprehensive metabolic panel (CMP) and lipid panel to an upcoming set of lab draws to monitor his medication regimen. The document was blank, unsigned and no physician response was provided. Review of a pharmacy medication recommendation for Resident #41 dated 02/22/23 revealed if not recently obtained and if indicated would you consider adding a CMP and lipid panel to an upcoming set of lab draws to monitor his medication regimen. The document was blank, unsigned and no physician response was provided. Review of a pharmacy medication recommendation for Resident #41 dated 04/25/23 revealed if not recently obtained and if indicated would you consider adding a CMP and lipid panel to an upcoming set of lab draws to monitor his medication regimen. The document was blank, unsigned and no physician response was provided. Interview on 05/10/23 at 10:16 A.M. with the Director of Nursing (DON) revealed Licensed Practical Nurse (LPN) #225 would send pharmacy medication recommendations to the physician to be signed and they were placed in the chart after that. The DON indicated she did not think this process was being done. The DON confirmed pharmacy medication recommendations were to be addressed immediately and verified Resident #41's medication recommendations for 07/22/22, 02/22/23 and 04/25/23 had not been addressed as the same request was continuing to be made from the pharmacy. Review of the facility policy, Medication Monitoring, revised 12/28/22 revealed the policy lacked information on how the physician would address pharmacy medication recommendations and did not provide a time frame that medication recommendations would be addressed within.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on record review, interview and policy review, the facility failed to ensure monitoring for medication effects and potential adverse consequences was completed for residents who were receiving psychotropic medications. This affected four residents (#2, #8, #11 and #41) out of five residents reviewed for unnecessary medications. The facility census was 45 residents. Findings Include: 1. Review of Resident #11's medical record revealed an admitted [DATE] and diagnoses including type two diabetes, schizophrenia, anemia, hypertension and hypertension. Review of Resident #11's plan of care dated 11/25/20 revealed she used lexapro and trazodone. Interventions listed included: administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness each shift and monitor/document/report as needed (PRN) adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in activities of daily living ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, nausea/vomiting, dry mouth and dry eyes. Review of Resident #11's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #11 was cognitively intact and received antipsychotic and antidepressant medications. Review of Resident #11's May 2023 physician's orders revealed an order dated 10/14/21 for lexapro (antidepressant) tablet 10 milligram (mg) once a day and an order dated 03/29/23 for trazodone hydrochloride (antidepressant) 50 mg by mouth at bedtime. No order was noted regarding monitoring behaviors or side effects for Resident #11's antidepressants. Review of Resident #11's Medication Administration Records (MARs) and Treatment Administration Records (TARs) from March 2023 through 05/08/23 revealed no evidence of behavior or medication side effect monitoring relative to antidepressant use. Review of Resident #11's nurses' notes from 06/01/22 to 05/08/23 revealed no evidence of behavior or medication side effect monitoring relative to antidepressant use. Interview on 05/09/23 at 11:17 A.M. with the Director of Nursing (DON) revealed she expected nursing staff would monitor for side effects and signs/symptoms of depression but no formal order was put into the medical record for monitoring antidepressants. Interview on 05/09/23 at 1:39 P.M. with Licensed Practical Nurse (LPN) #225 revealed nursing staff documented monitoring for antidepressant medication side effects and resident behaviors on the TAR. LPN #225 verified no such monitoring had been in place for Resident #11 prior to 05/09/23. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #41's medical record revealed an admitted [DATE] and diagnoses including bipolar disorder, current episode manic severe with psychotic features, unspecified dementia, unspecified severity without behavioral disturbance, major depressive disorder, insomnia, history of COVID-19 and other specified mental disorders due to known physiological condition. Review of Resident #41's plan of care dated 05/05/21 revealed he used trazodone related to depression and insomnia. Interventions listed included: administer trazodone as ordered by physician. Monitor/document side effects and effectiveness each shift and monitor/document/report as needed (PRN) adverse reactions to trazodone: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in activities of daily living ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, nausea/vomiting, dry mouth and dry eyes. No care plan was noted for use of venlafaxine. Review of Resident #41's quarterly MDS 3.0 assessment dated [DATE] revealed Resident #41 was cognitively impaired and received antipsychotics and antidepressants. Review of Resident #41's May 2023 physician's orders as of 05/08/23 revealed an order dated 10/15/21 for venlafaxine hydrochloride (antidepressant) extended release capsule 24 hour 75 mg one time a day for antidepressant; an order dated 10/15/21 for ziprasidone hydrochloride (antipsychotic) capsule 80 mg give by mouth one time a day for depression and an order dated 02/18/23 for trazodone hydrochloride (antidepressant) tablet 150 mg give 100 mg by mouth one time a day for depression and give 100 mg by mouth before bed. No order was noted regarding monitoring behaviors or side for Resident #41's antidepressants. Review of Resident #41's MARs and TARs from March 202 effects 3 through 05/08/23 revealed no evidence of monitoring for side effects or behaviors related to antidepressant use. Review of Resident #41's nurses notes from 03/11/22 to 05/08/23 revealed no evidence of monitoring for side effects or behaviors related to antidepressant use. Interview on 05/09/23 at 1:12 P.M. with the DON verified no behavior or side effect monitoring was in place for Resident #41's antidepressants. Interview on 05/09/23 at 1:39 P.M. with LPN #225 revealed nursing staff documented monitoring for antidepressant medication side effects and resident behaviors on the TAR. LPN #225 verified no such monitoring had been in place for Resident #41 prior to 05/09/23. Review of the facility policy, Medication Monitoring, revised 12/28/22 revealed residents who used psychotropic drugs received behavioral interventions unless clinically contraindicated. 37096 3. Review of the medical record for Resident #8 revealed an admitted [DATE]. Diagnoses included type II diabetes, heart disease, chronic kidney disease, blindness of one eye, and glaucoma. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 03/31/22 revealed Resident #8 had impaired cognition and mild depression. The assessment indicated Resident #8 received an antidepressant. Review of the plan of care dated 05/03/23 revealed Resident #8 received an antidepressant related to a diagnosis of depression. Interventions included administering antidepressant medication, monitoring and documenting side effects every shift. Review of physician orders for May 2023 revealed an order to administer Lexapro 15 milligram (mg), (an antidepressant) daily. Review of the medical record revealed no evidence of monitoring for signs and symptoms of depression or side effects. Interview on 05/09/23 at 11:10 A.M. with Licensed Practical Nurse (LPN) #225 confirmed Resident #8 received Lexapro daily. LPN #335 monitoring for signs and symptoms of depression was completed on an as needed basis. LPN #225 stated Resident #8 was stable on her depression medication. 4. Review of the medical record for Resident #2 revealed an admitted [DATE]. Diagnoses included seizures, paranoid schizophrenia, and alcohol abuse. Review of the plan of care dated 01/30/23 revealed Resident #2 used an antipsychotic medication related to mood disorder. Interventions included administering antipsychotic medication and monitoring for adverse reactions of medication. Review of the quarterly MDS 3.0 assessment, dated 02/22/23 revealed Resident #2 had intact cognition and no behaviors. The assessment identified Resident #2 received an antipsychotic medication. Review of physician orders for May 2023 revealed an order to administer Zyprexa (antipsychotic)10 milligram (mg) daily. Review of the Medication Administration Record (MAR) for May 2023 revealed an entry for monitoring antipsychotic medication twice daily. The entry read to monitor for dry mouth, constipation, blurred vision, confusion, difficulty urinating, hypotension, dark urine, yellow skin, lethargy, drooling, agitation, restlessness, and involuntary movement of the mouth and tongue. Instructions read to document N if monitored and none of the above symptoms were observed. Document Y if monitored and any of the above symptoms were observed. The data tracking revealed Resident #2 was monitored twice daily. The data did not indicate a N or Y for symptoms observed. Interview on 05/09/23 at 11:10 A.M. with Licensed Practical Nurse (LPN) #225 confirmed Resident #2 received Zyprexa daily. LPN #225 was unaware the data tracking did not indicate whether Resident #2 had an indicated symptom. Review of the polity titled Medication Monitoring, revised 12/28/22 revealed each resident receiving a psychotropic agent was monitored for episodes of behaviors, side effects, appropriateness of drug selection and dosage, and potential for gradual dose reduction.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38522 Based on observation, interview and record review the facility failed to ensure food was served at safe and appetizing temperatures. This affected 44 residents receiving food from the kitchen. Resident #25 was ordered nothing-by-mouth. The facility census was 45. Findings Include: Review of the Fall/Winter Week Two menu for Monday corresponding to 05/08/23 revealed the meal to be served for lunch included Salisbury steak, garlic mashed potatoes, stewed tomatoes, wheat bread, margarine, coconut cream pie and beverage of choice. Observation on 05/08/23 at 11:37 A.M. revealed [NAME] #209 was taking temperatures for lunch tray service with the facility's self-calibrating electronic thermometer. Food temperatures obtained were as follows: sour cream (on ice) 33.5 degrees Fahrenheit (F); Salisbury steak, 203 degrees F; baked potato, 191 degrees F; stewed tomatoes, 173 degrees F; and mashed potatoes 196 degrees F. Trayline started 11:46 A.M. At 12:03 P.M. staff started making trays for the two carts for the first floor and a test tray was requested. The test tray was made at 12:22 P.M., on the cart at 12:23 P.M. and left the kitchen at 12:24 P.M. The carts arrived on the floor at 12:24 P.M. and trays began to be passed at 12:25 P.M. The test tray was sampled at 12:49 P.M. with Dietary Manager (DM) #200 and Assistant Dietary Manager (ADM) #205. Temperatures were taken with the facility's self-calibrating electronic thermometer with temperatures as follows: Salisbury steak, 128.1 degrees F; potato, 124.5 degrees F; tomatoes, 109.5 degrees F and lemon curd dessert, 50 degrees F. DM #200 and ADM #205 stated the potatoes were cold to touch and the tomatoes were also cold. ADM #205 stated the tomatoes should have been served in a disher to better retain heat but the facility did not have enough dishers for service. DM #200 and ADM #205 verified the potato and tomatoes were not at a palatable temperature and indicated the ideal temperature for point of service was 135 to 140 degrees F which the test tray did not meet.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 38522 Based on observation, interview and policy review, the facility failed to ensure pureed foods were prepared in a manner that preserved nutritional value. This affected five residents (Residents #6, #15, #16, #24 and #34) receiving a pureed diet. The facility census was 45. Findings Include: Review of the Fall/Winter Week Two menu for Monday corresponding to 05/08/23 revealed the meal to be served for lunch included Salisbury steak, garlic mashed potatoes, stewed tomatoes, wheat bread, margarine, coconut cream pie and beverage of choice. Observation on 05/08/23 starting at 10:56 A.M. with [NAME] #209 revealed she was making pureed stewed tomatoes for the lunch meal. [NAME] #209 indicated she needed six purees but would make seven portions. [NAME] #209 then stated she needed four purees so would make five portions. [NAME] #209 put five #8-scoops of stewed tomatoes into the food processor along with 2/3 cup of vegetable broth and 1/2 cup of thickener. [NAME] #209 blended the product then added another 1/2 cup of broth. Interview with [NAME] #209 during the observation revealed she followed the 'extremely thick' guidance on the Resource thicken-up sheet posted on the wall. [NAME] #209 was asked if there was a recipe she followed and she stated there was a book with it but confirmed it was not out during the observation. Interview on 05/08/23 at 11:06 A.M. with Dietary Manager (DM) #200 revealed there was no recipe book. Observation on 05/08/23 at 11:08 A.M. revealed [NAME] #209 placed five Salisbury steaks in the food processor with 1/2 cup broth and 3/4 cup thickener also for the lunch meal. [NAME] #209 blended the product then added another 4 ounces of broth; blended again then and added a little less than 1/2 cup of broth. [NAME] #209 and the surveyor tasted the food which was chunky and [NAME] #209 continued to blend the food and added 1/4 cup of broth. Interview on 05/08/23 at 11:26 A.M. with Assistant Dietary Manager (ADM) #205 revealed for pureed foods, staff were to look at the thickener guidance posted on the wall. ADM #205 stated the dietitian never gave them any further breakdown to follow. ADM #205 agreed the purees had a high amount of thickener and were not appropriate nor nutritionally adequate. Interview on 05/09/23 at 1:49 P.M. with Registered Dietitian (RD) #241 revealed she had not been asked by the facility to work on the menu and had no culinary responsibilities. Review of the document, Resource Thicken Up Instant Food and Drink Thickener dated 2019 revealed for eight servings, for mildly-thick consistency add a half-cup to 2/3 cup of thickener; for moderately-thick consistency add 2/3 cup to 3/4 cup of thickener and for extremely thick consistency, add 3/4 cup to one cup of thickener. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy, Puree Food Preparation Policy, no date, revealed the facility would prepare food products in a way that conserved nutrient value of the product. Products should be nutrient dense and in the appropriate size as specified by the recipe and menu spreadsheet. Add three ounces of cooked meat for every three tablespoons of added thickener. An equivalency table indicated per two ounces of cooked meat portion, two to four tablespoons hot liquid and one tablespoon of thickener was to be added. Review of the facility diet list as of 05/08/23 revealed five residents received a pureed diet, Residents #6, #15, #16, #24 and #34.

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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. 38522 Based on observation, interview and record review the facility failed to ensure a clean and sanitary kitchen. This affected 44 residents receiving food from the kitchen. Resident #25 was ordered nothing-by-mouth. The facility census was 45. Findings Include: Observation of the kitchen on 05/07/23 from 8:54 A.M. to 9:45 A.M. with [NAME] #209 revealed the following concerns: The walk-in cooler lacked an internal thermometer. On the shelves, two bags of shredded mozzarella cheese, a lemon meringue pie and a strawberry cream pie did not have dates on them. On the bread cart, four loaves of bread had a use by date of 04/24/23 and two loaves of bread had a use by date of 05/02/23. Buns and wraps were present but also undated. On a pull cart, three packs of ham were undated. In the freezer, a bag of unidentifiable meat was not dated and had a lot of ice buildup. On the shelf, 11 pans of macaroni and cheese lacked a date. There was also no internal thermometer inside the freezer. In the dry stock room, cans did not have a date received to ensure appropriate rotating. A bottle of lemon juice was noted with an expiration date of 12/03/21. In the second-floor refrigerator, a container of potato salad was noted dated 03/11/23. An internal thermometer was present but broken. A red-gray material covered the bottom of the refrigerator. On the shelf, three halves of peanut butter and jelly sandwiches were present but lacked dates. Interview with [NAME] #209 verified the above areas of concern at the time of observation. [NAME] #209 stated the pans of macaroni and cheese were made 05/04/23 and confirmed the pans should have had the date made written on them. [NAME] #209 indicated all foods should have a date on them when pulled such as the ham or when received such as the cans in the stock room. [NAME] #209 agreed the second floor refrigerator was not clean and reiterated all foods under refrigeration should have a date on them. Review of the facility policy, Food Receiving and Storage, dated December 2008 revealed refrigerators must have working thermometers and be monitored for temperature according to state-specific guidelines. Food services or other designated staff would maintain clean food storage areas at all times. All foods stored in the refrigerator or freezer would be covered, labeled and dated (use by date).

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 38522 Based on interview, record review and review of the Payroll Based Journal (PBJ) staffing data report, the facility failed to ensure consistent submission of information as required. This had the potential to affect all 45 residents in the facility. Findings Include: Review of the facility's Payroll Based Journal (PBJ) staffing data report for Quarter Three of 2022 (covering 04/01/22 to 06/30/22) revealed no staffing data was submitted by the facility for the quarter. Review of facility documentation for submission of PBJ data revealed the last data the facility submitted was on 05/12/22 for the dates 01/01/22 to 03/31/22. No more recent submission information was available for review. Interview on 05/08/23 at 4:26 P.M. with Human Resource Coordinator (HRC) #202 verified the facility last submitted PBJ data on 05/12/22. HRC #202 indicated she had been working in the facility on a part-time basis since October 2022 and had staffing data for November 2022 however did not have any evidence of submission.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on observation, record review and interview the facility failed to ensure a clean and sanitary laundry service, privacy curtains were changed when visibly dirty, a comprehensive legionella program, and yearly screening for tuberculosis. This affected all 45 residents residing at the facility. Findings Include: 1. Observation on 05/10/23 at 10:29 A.M. with Building Manager #226 revealed in the soiled area of the laundry processing area there were two large washing machines and one smaller washing machine. The smaller washing machine had clothing inside. An attempt to open the door of the smaller washing machine revealed it would not open. The tops of both large washers had sticky liquid spills, and dust. Interview at the time of the observation with Building Manager #226 revealed he was unsure how long the small washer had not been in service nor how long the clothes locked inside had been there. Further observation of the clean side of the laundry processing area revealed a bath robe and additional clothing items on hangers hanging from a metal pipe just below the ceiling. A wheeled cart that held additional clothing items on hangers, and unorganized, unfolded clothing items on the bottom of the cart. The cart also had folded blankets sitting on top. On the floor, in front and to the right of the cart were numerous clear plastic bags full of clothing items. Some of the bags were open and overflowing with the contents spilling onto the floor. An interview at the time of the observation with Maintenance Director #226 revealed the items on the cart were ready to be returned to the residents and the bags on the floor were clean resident clothing items and mismatched socks that needed to be sorted. An additional observation in the clean laundry area revealed a large table that had a laminate cover with uneven edges exposing the particle board beneath the top of the table and a brown, sticky dried liquid spill located just in front of the clean, folded blankets and washcloths. Observation in the entrance to the clean and dirty laundry rooms revealed the flooring was in disrepair with broken, uneven pieces of cement. Multiple areas of drywall in the clean laundry area were observed to have gouges and missing pieces. Interview at the time of the observation with Maintenance Director #226 confirmed the sticky spill, indicated the items on the table were overflow items, and confirmed the flooring was uneven and there were areas of disrepair in the drywall as it was an older building. Review of the undated facility policy titled Quality Assessment and Assurance Program revealed functions of the quality assessment and assurance program were to: evaluate care delivery to resident in accordance to established regulations and rules, quality indicators, quality measures, professional standards and facility based criteria, identify any quality deficiencies that deviate from the established regulations and rules, and assess the overall environment as it related to the comfort, safety and infection control of residents. It was the responsibility of all department heads to assure the quality assessment and assurance program was followed at all times. 2. Observation on 05/07/23 at 10:10 A.M. of Resident #26's privacy curtain revealed numerous unidentifiable dark spots on the bottom section of the curtain. Interview at the time of the observation with Resident #26 revealed the curtain had not been changed in at least the last six months. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 05/09/23 at 9:52 A.M. in Resident #26's room revealed unidentified soiling in multiple spots on the privacy curtain on both sides. Interview at the time of the observation with Building Manager #226 confirmed the observation. Observation on 05/09/23 at 9:56 A.M. in Resident #6's room revealed numerous unidentified brown spots on the lower section of the privacy curtain. Interview at the time of the observation with Building Manager #226 confirmed the observation. Interview on 05/10/23 at 1:03 P.M. with Housekeeper #237 revealed there was not a specific frequency for washing the privacy curtains. Review of the 02/22/16 facility policy titled [NAME] Place Environmental Services Housekeeping Procedures revealed it provided no information for staff regarding cleaning frequency or changing of privacy curtains. 38522 3. Review of the facility's legionella environmental assessment form dated 02/25/20 revealed the facility had municipal water and did not monitor incoming water parameters, such as disinfectant or temperature. Only hot water temperatures were measured at the point of use. Review of the facility's water management plan, no date, revealed cold water was distributed directly to the water fountain in the lobby area, ice machine in the kitchen and faucets in resident rooms and tub rooms. Cold water was heated to 120 degrees Fahrenheit (F) by a water heater. A diagram was noted on a sheet titled, How to Monitor Your Control Measures and indicated to check temperatures (marked by a red c in a pentagon) at the kitchen appliances, water heater (#1, #2), water heater (#3 kitchen), sinks/showers (floors one and two) at both the cold water distribution and the hot water distribution points and after receiving water from the municipality. The plan indicated the facility would complete yearly testing of their water supply and follow the water management program. Review of a water testing request form dated 03/04/20 revealed four water samples were taken to be tested for legionella. Results dated 03/12/20 indicated no legionella was detected. No further water testing results were available for review. Review of the facility water temperature log book revealed water temperatures were done quarterly for 18 resident rooms sampled in the morning and again in the afternoon. For 2023, temperatures were obtained on 03/14/23 and 05/10/23. Interview on 05/15/23 at 8:51 A.M. with Building Manager (BMA) #226 revealed hot water temperatures were collected quarterly. When asked about what the facility did for vacant rooms, such as the 2-south wing, BMA #226 stated he ran the hot water and flushed the toilets in those rooms monthly but did not document this practice. BMA #226 stated the 2-south wing had been closed since 12/31/22. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Follow-up interviews on 05/15/23 at 9:11 A.M. and 9:55 A.M. with BMA #226 revealed he moved hot water temperatures from monthly to quarterly due to not having enough help. BMA #226 verified the water management plan and legionella policy were incomplete and did not match as hot water temperatures were being taken from resident rooms, not in shower rooms or other areas identified on the water management plan. BMA #226 confirmed the provided documentation did not address water in rooms not in use nor provide a timeframe for this monitoring and documentation. Review of the facility policy, Legionella, no date identified risks within the facility including: hot and cold-water storage tanks, water heaters, expansion tanks, water filters, electronic and manual faucets, showerheads and hoses, eyewash stations, ice machines, decorative fountains and cooling towers. The policy did not indicate what the facility would monitor or provide a frequency for monitoring to minimize the risk of legionella. 4. Review of 14 personnel records on 05/10/23 starting at 12:29 P.M. with Human Resource Coordinator (HRC) #202 revealed the following concerns: a. Review of State tested Nursing Assistant (STNA) #231's personnel file revealed a date of hire of 02/15/80. The file did not contain evidence an annual tuberculosis (TB) questionnaire had been completed with the most recent questionnaire available dated 05/12/22. Interview on 05/10/23 at 12:29 P.M. with HRC #202 verified she did not have an annual TB questionnaire for STNA #231. b. Review of STNA #223's personnel file revealed a date of hire of 04/29/94. The file did not contain evidence an annual TB questionnaire had been completed with the most recent questionnaire available dated 03/10/22. Interview on 05/10/23 at 12:29 P.M. with HRC #202 verified she did not have an annual TB questionnaire for STNA #223. c. Review of STNA #201's personnel file revealed a date of hire of 06/02/14. The file did not contain evidence an annual TB questionnaire had been completed. Interview on 05/10/23 at 12:29 P.M. with HRC #202 verified she did not have an annual TB questionnaire for STNA #201. d. Review of Dietary Aide (DA) #204's personnel file revealed a date of hire of 02/10/23. The file did not contain evidence an initial TB test had been completed. Interview on 05/10/23 at 12:29 P.M. with HRC #202 verified she did not have evidence of an initial TB test completed for DA #204. e. Review of STNA #217's personnel file revealed a date of hire of 04/07/23. The file did not contain evidence an initial TB test had been completed. Interview on 05/10/23 at 12:29 P.M. with HRC #202 verified she did not have evidence of an initial TB test completed for STNA #217. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy, TB Testing for New Employees, dated 12/28/22 revealed all new employees not having documentation of a two-step TB skin test within the last year before start of employment shall receive a two-step TB skin test upon employment and must have one negative test result prior to resident contact. All employees shall answer the questionnaire annually thereafter.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 45442 Based on record review and staff interview, the facility failed to implement a comprehensive antibiotic stewardship program. This had the potential to affect all 45 residents residing at the facility including Residents (#9, #15, #23, #27, #39 and #40) who received antibiotics between March 2023 and May 2023. Findings Include: Interview on 05/09/23 at 9:24 A.M. with the Director of Nursing (DON) revealed the facility kept a log of resident infections in a notebook which was tracked by type of organism, type of antibiotic used and mapped by room to identify potential patterns. If a physician ordered an antibiotic prior to obtaining culture and sensitivity results, the nurse wrote a progress note that McGreer's criteria (antibiotic surveillance definitions specific for benchmarking appropriate antibiotic usage) had not been met and the physician was notified. When an antibiotic was started prior to obtaining the culture and sensitivity results, and the lab results indicated the current antibiotic was an inappropriate antibiotic, the physician was notified. The DON stated the medical director had been made aware of concerns related to antibiotics being ordered prior to identification of the organism but had declined to address this with other physicians. Follow up interview on 05/10/23 at 12:14 P.M. with the DON revealed each physician had a notebook with information regarding their residents. Results of culture and sensitivity reports were placed in the physician notebooks. The DON indicated she did not speak directly with the physicians regarding the results including when the culture and sensitivity results indicated the antibiotic currently in use was not sensitive to the bacteria identified. The DON was unsure if the physicians reviewed the antibiotic information in the notebook for their residents. The DON stated the physicians did not meet to discuss antibiotic stewardship and indicated a team approach would be better at ensuring appropriate antibiotic stewardship was achieved. Review of the facility infection control log for the months of March 2023 through May 2023 revealed eight residents (Residents #9, #15, #19, #23, #27, #39, #40, and #46), received antibiotics. Review of the monthly medical director reports revealed the Medical Director checked off a box indicating he was reviewing the monthly infection control logs. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the 09/01/18 facility policy titled Antibiotic Stewardship Policy revealed since antibiotics were frequently over and inappropriately prescribed, an effort to decrease or eliminate inappropriate use could make a big impact on resident safety and the reduction of adverse events. Antibiotic stewardship consisted of coordinated interventions aimed at treating infections while promoting appropriate antibiotic use. Further review of the policy revealed the facility was to have physician, nursing, and pharmacy leads responsible for promoting and overseeing antibiotic stewardship activities. Regular feedback on antibiotic use and resistance to prescribing clinicians, nursing staff and other relevant staff. The Antibiotic Stewardship Team (AST) was to monitor antibiotic use and other data to ensure that the policies and procedures of the Antibiotic Stewardship Policy were followed and refined as needed and would include, at minimum, the Medical Director, the Director of Nursing, and the consultant pharmacist. The policy indicated providers were to use the McGreer criteria when considering initiation of antibiotics. Consistent with these criteria, the standardized suspected urinary tract infection (UTI) Situation Background Assessment and Recommendations (SBAR) form would be used for all residents suspected of having a UTI. The completed form should be provided to or information communicated with the provider. The medical director and medical staff were to perform quality of care functions including, but not limited to review of minutes of the facility's Quality Assessment and Assurance Committee meeting for minutes for items which needed medical consideration, further investigation or new policies and procedures.

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F 0944 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 37096 Based on interview and review of the facility's Quality Assurance and Performance Improvement (QAPI) Program, the facility failed to provide mandatory staff training on the facility's QAPI program. This had the potential to affect all 45 residents residing in the facility. Findings Include: Review of the facility's QAPI program for 2022 and 2023 revealed initiatives that included: Resident tuberculosis base line testing and documentation, COVID vaccine documentation, and code status posting policy upon admission. There was no evidence of mandatory staff training on the facility's QAPI program initiatives that included the goals and various elements of the program, how the facility intended to implement the program, and how to communicate concerns or opportunities for improvement. Interview on 05/15/23 at 12:27 P.M. with the Director of Nursing (DON) verified the facility had not provided the mandatory training to staff on the QAPI program. Review of the facility policy titled Quality Assessment and Assurance Program, undated revealed it was the responsibility of the quality assurance committee to inform any department and services of specific quality assessments or assurance activities.