STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366288	A. Building B. Wing	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Nursing Healthcare LLC	3434 State Route 132 Amelia, OH 45102

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure residents were dressed in a dignified manner. This affected one (Resident #195) of 12 residents reviewed for dignity. The census was 41. Findings include: Review of the medical record for Resident #195 an admitted [DATE] with a diagnosis of heart failure. Review of admission nursing note dated 05/26/22 revealed Resident #195 was admitted to the facility for a five-day respite stay. Review of the admission nursing assessment dated [DATE] revealed Resident #195 was alert and oriented to person but was not checked as oriented to place, time, or situation. The resident was able to express herself verbally in an appropriate manner. Review of baseline care plan dated 05/26/22 revealed Resident #195 preferred to choose which clothes she would wear for the day. Review of nursing note dated 05/30/22 revealed Resident #195's daughter reported the clothes brought into the facility on the day of admission were missing. Observation on 05/31/22 at 10:40 A.M. revealed Resident #195 was sitting in her wheelchair, with her door open. Resident #195 could be seen from the hallway and was wearing a short nightshirt, which barely covered her peri area. Resident #195 was tugging at the bottom of the nightshirt trying to cover herself. Interview on 05/31/22 at 10:40 A.M. with Resident #195 confirmed she didn't have any pants and she was embarrassed because the nightshirt did not cover her upper thighs. Resident #195 further confirmed she was new to the facility, and thought her family had brought in some clothes for her to wear but they hadn't been provided to her yet. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/31/22 at 12:18 P.M. with State tested Nursing Assistant (STNA) #261 confirmed she assisted Resident #195 with getting dressed that morning but the only clothing available was nightshirts. STNA #261 further confirmed Resident #195 was wearing a nightshirt which barely covered her peri area. Interview on 05/31/22 at 12:19 P.M. with Licensed Practical Nurse (LPN) #245 confirmed Resident #195 was wearing a nightshirt which did not appropriately cover her. LPN #245 further confirmed he heard the resident's clothes were missing and he thought management was conducting a search for them. Interview on 06/01/22 at 3:58 P.M. with the Director of Nursing (DON) confirmed Resident #195 was initially admitted for a respite stay but the resident and her family decided she would stay at the facility long-term. The DON further confirmed the facility had a supply of clothing available in the lost and found which could have been used for Resident #195 so she could have had appropriate clothing to wear. The DON further confirmed it was not appropriate for the resident to be uncovered and exposed when her preference was to wear clothing. Review of the facility policy titled, Quality of Life - Dignity, dated August 2009, revealed residents shall be encouraged and assisted to dress in their own clothes rather than in hospital gowns.

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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** 39703 Based on record review, observation, resident interview, staff interview, and review of facility policy, the facility failed to ensure residents were bathed according to their preference. This affected one resident (#7) of 12 residents reviewed for bathing preferences. The census was 41. Findings include: Review of the medical record for Resident #7 revealed an admitted [DATE] with a diagnosis of end stage renal disease (ESRD.) Review of the Minimum Data Set (MDS) for Resident #7 dated 05/16/22 revealed the resident was cognitively impaired and required extensive assistance of one to two staff with activities of daily living (ADLs). Review of MDS for Resident #7 dated 09/02/21 revealed resident was coded as very important for the question in section F of the MDS: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Review of the care plan for Resident #7 dated 04/19/21 revealed the resident had an ADL self-care performance deficit related to tibial plateau fracture, fibula fracture, diabetes, weakness, and non-weight bearing status. The resident required staff assistance to complete ADL tasks daily. Fluctuations were expected related to diagnoses and the resident was at risk for decline in physical function. Interventions included the resident should be bathed/showered two times per week, staff should avoid scrubbing and should pat dry sensitive skin, and provide a bed bath when a shower cannot be tolerated. Review of bathing records for Resident #7 for May 2022 revealed resident was out of the facility on 05/06/22 through 05/09/22. Further review of records revealed the resident received a bed bath on 05/02/22, 05/11/22/, 05/19/22, and 05/31/22. Observation on 05/31/22 at 9:35 A.M. revealed Resident #7 had a functioning shower in his room. Interview on 05/31/22 at 9:35 A.M. Resident #7 confirmed he preferred to take a shower, but the aides told him he wasn't allowed to take a shower and they gave him regular bed baths instead. Interview on 05/31/22 at 9:45 A.M. with State tested Nursing Assistant (STNA) #253 confirmed Resident #7 had a functioning shower in his room but the facility used the central shower room for residents who got showers. STNA #253 confirmed Resident #7 was not permitted to take showers and the nightshift aides gave him bed baths. Interview on 06/01/22 at 12:00 P.M. with Registered Nurse (RN) #223 confirmed there was no clinical contraindication to Resident #7 receiving showers as opposed to bed baths. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Shower-Tub Bath, dated October 2010, revealed the facility would provide showers or tub baths to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on record review, observations and staff interview, the facility failed to implement a physician ordered intervention for a speciality cushion to a residents wheelchair to promote healing of a pressure ulcer. This affected one (#44) of three residents reviewed for pressure ulcers. The facility census was 41. Findings include: Medical record review for Resident #44 revealed an admitted [DATE]. Diagnoses included hemorrhage of cerebrum, loss of consciousness unspecified, pneumonia, dementia, and chronic heart failure. Resident #44 received hospice services. Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 was cognitively impaired and required extensive assistance of two staff for transfers and bed mobility. Review of nurse note date 05/22/22 at 1:15 P.M. revealed Resident #44 was noted to have a open area/pressure ulcer to right inner coccyx measuring 1.0 centimeter by 0.5 centimeter. New orders included hydrocolloid dressing for three days and monitoring of wound on weekly wound rounds. Review of nurse's notes dated 05/26/22 at 6:06 P.M. revealed the physician ordered a specialty wheelchair cushion. Review of nurse's notes dated 06/01/22 at 12:35 P.M. revealed the family representative was notified of the specialty wheelchair cushion to assist with skin healing. The family representative was in agreement to implement the specialty wheelchair cushion. Observation on 05/31/22 from 12:22 P.M. through 4:30 P.M., Resident #44 was observed sitting in a wheelchair in the hallway near the unit nurse station. The wheelchair did not have the specialty wheelchair cushion in place. Observation on 06/01/22 at 8:55 A.M. revealed the resident in the wheelchair in her room with no specialty wheelchair cushion in place. Interview on 06/01/22 at 9:00 A.M., State tested Nurse Aide, (STNA) #217 verified Resident #44 did not have the specialty wheelchair cushion in the wheelchair. STNA #217 stated the specialty wheelchair cushion was delivered earlier in the week. STNA #217 stated the cushion was too thick and would not fit in the resident's wheelchair. STNA #217 did not report the concern to the nurse managers. STNA #217 went to the resident's closet and showed the surveyor the specialty cushion. STNA #217 returned the specialty cushion to the resident's closet. Interview on 06/01 at 2:20 P.M., Licensed Practical Nurse (LPN) #219 verified Resident #44 should have had the specialty wheelchair cushion to prevent further skin breakdown. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/02/22 at 8:00 A.M. revealed Resident #44 was in bed. The wheelchair was at bedside with no specialty wheelchair cushion in the wheelchair. Interview on 06/02/22 at 8:05 A.M. with STNA #217 verified the specialty wheelchair cushion was not in the wheelchair.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on medical record review, observation, resident and staff interview, and review of facility policy, the facility failed to ensure residents oxygen tubing was dated when changed. Additionally, the facility failed to ensure a resident had physician's orders for oxygen administration. This affected two (#7 and #44) of three residents reviewed for oxygen administration. The census was 41. Findings include: 1. Review of the medical record for Resident #7 revealed an admitted [DATE] with a diagnosis of end stage renal disease (ESRD). Review of the Minimum Data Set (MDS) for Resident #7 revealed resident was cognitively impaired and required extensive assistance of two staff with activities of daily living. Review of the May 2022 monthly physician orders for Resident #7 revealed there were no orders for oxygen administration. Review of the care plan for Resident #7 initiated 08/26/21 revealed it contained no documentation regarding the use of oxygen. Review of the May 2022 Treatment Administration Record (TAR) and Medication Administration Record (MAR) for Resident #7 revealed it did not include documentation regarding oxygen administration. Observation on 05/31/22 at 10:04 A.M. revealed Resident #7 had an oxygen concentrator in his room with oxygen tubing with a nasal cannula which was not dated. Resident #7 was not receiving oxygen. Interview on 05/31/22 at 10:04 A.M. with Resident #7 confirmed he occasionally used oxygen when he felt short of breath. Resident #7 confirmed he was unsure how often the tubing was changed or how much oxygen he was supposed to receive. Interview on 05/31/22 at 10:06 A.M. with State tested Nursing Assistant (STNA) #253 confirmed Resident #7's oxygen tubing was undated and tubing was supposed to be changed every Friday. Observation on 06/01/22 at 12:01 P.M. revealed Resident #7 was receiving oxygen per nasal cannula with the oxygen concentrator set at three liters. The oxygen tubing was not dated. Interview on 06/01/22 at 12:01 P.M. with Registered Nurse (RN) #223 confirmed Resident #7's oxygen tubing was not dated. RN #223 further confirmed Resident #7 did not have a physician's order for the use of oxygen and she was unsure of the correct liters per minute for oxygen administration for Resident #7. Review of the facility policy titled Oxygen Administration dated October 2010 revealed prior to oxygen administration the nurse should verify that there is a physician's order for the procedure. The facility would ensure oxygen was administered in accordance with professional standards of practice. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44083 2. Record review revealed Resident #44 was admitted on [DATE] with diagnosis of hemorrhage of cerebrum, loss of consciousness unspecified, pneumonia, dementia, and chronic heart failure. Resident #44 received hospice services. Review of the Significant Change Minimum Data Set, (MDS), dated [DATE] revealed Resident #44 was cognitively impaired and required extensive assistance of two staff for care. Review of current physician orders revealed continuous oxygen at 3.5 milliliters via nasal cannula and change oxygen tubing every week on Sunday night shift and as needed. Observation on 05/31 22 at 12:24 P.M. and on 06/01/22 at 2:49 P.M. revealed Resident #44 was receiving oxygen via nasal cannula and the oxygen tubing was not dated. Interview on 06/01/22 at 2:50 P.M. with Licensed Practical Nurse (LPN) #219 verified Resident #44 oxygen tubing was not dated and was unable to determine when the oxygen tubing was last changed. LPN #219 stated the oxygen should have been changed and dated on Sunday, 05/29/22.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, observation, staff interview, and review of facility policy, the facility failed to ensure proper documentation of administration of controlled substances and accounting for controlled substance medications. This affected two (#15 and #20) of nine facility-identified residents with controlled substances stored on the Primrose Unit medication cart. The facility also failed to administer a residents medications (Ativan and Lyrica) as ordered. This affected one (#195) out of three residents reviewed for medication administration. The census was 41. Findings include: 1. Review of the medical record for Resident #15 revealed an admitted [DATE] with a diagnoses of generalized anxiety disorder and chronic pain syndrome. Review of the June 2022 monthly physician orders for Resident #15 revealed an order dated 01/19/22 for Ativan twice daily at 9:00 A.M. and 9:00 P.M. Resident #15 also had an order dated 05/03/21 for hydrocodone twice daily at 9:00 A.M. for pain. Review of the controlled substance sheets for Resident #15's Ativan and hydrocodone revealed the 9:00 A.M. doses of the medications for 06/01/22 had not been signed out by the nurse. Observation on 06/01/22 at 9:40 A.M. with Licensed Practical Nurse (LPN) #219 of the Primrose Unit medication cart controlled substance medication drawer revealed there were five Ativan tablets in the cart for Resident #15 but the controlled substance sheet for Resident #15's Ativan indicated there should be six Ativan tablets remaining. Interview on 06/01/22 at 9:40 A.M. with LPN #219 confirmed she had administered tablet #6 to Resident #15 on 06/01/22 at approximately 9:00 A.M. but had not signed when she pulled the medication for administration. Observation on 06/01/22 at 9:41 A.M. with LPN #219 of the Primrose Unit medication cart controlled substance medication drawer revealed there was an empty card of hydrocodone tablets for Resident #15 with no tablets remaining. The controlled substance sheet for Resident #15's hydrocodone indicated there should be one hydrocodone tablets remaining. Interview on 06/01/22 at 9:41 A.M. with LPN #219 confirmed she had administered tablet #1 to Resident #15 on 06/01/22 at approximately 9:00 A.M. but had not signed when she pulled the medication for administration. 2. Review of the medical record for Resident #20 revealed an admitted [DATE] with a diagnosis of panic disorder. Review of the June 2022 monthly physician orders for Resident #20 revealed an order dated 12/08/21 for Ativan twice daily at 9:00 A.M. and 9:00 P.M. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the controlled substance sheets for Resident #20's Ativan revealed the 9:00 A.M. doses of the medication for 06/01/22 had not been signed out by the nurse. Observation on 06/01/22 at 9:42 A.M. with LPN #219 of the Primrose Unit medication cart controlled substance medication drawer revealed there were 20 Ativan tablets remaining for Resident #20 with no tablets remaining. The controlled substance sheet for Resident #20's Ativan indicated there should be 21 Ativan tablets remaining. Interview on 06/01/22 at 9:42 A.M. with LPN #219 confirmed she had administered tablet #21 to Resident #20 on 06/01/22 at approximately 9:00 A.M. but had not signed when she pulled the medication for administration. Review of the facility policy titled Controlled Substance undated revealed the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. Review of the facility policy titled Administering Medications dated April 2019 revealed the individual administering the medication initials the resident's Medication Administration Record (MAR) on the appropriate spot after giving each medication and before administering the next one. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: the date and time the medication was administered, the dosage, the route of administration, the signature and title of the person administering the drug. 3. Review of the medical record for Resident #195 revealed an admitted [DATE] with diagnoses including heart failure and anxiety disorder. Review of the admitting physician orders for Resident #195 dated 05/26/22 revealed orders for resident to receive a routine dose of Ativan at 9:00 P.M. and a routine dose of Lyrica at 9:00 P.M. Review of the May 2022 MAR for Resident #195 revealed resident's Ativan and Lyrica were not documented as administered or refused on 05/28/22 at 9:00 P.M. Review of the controlled substance sheets for Resident #195 for Ativan and Lyrica revealed medications were not signed out for 05/28/22 at 9:00 P.M. Review of nurse progress notes for Resident #195 dated 05/28/22 revealed the notes were silent regarding rationale for Ativan and Lyrica not being administered as ordered. Interview on 06/01/22 at 5:00 P.M. with Regional Nurse (RN) #268 confirmed Resident #195's MAR, controlled substance sheets and nurse progress note dated 05/28/22 showed resident was not administered her 9:00 P.M. doses of Ativan and Lyrica on 05/28/22. Review of the facility policy titled Administering Medications dated April 2019 revealed medications are administered in a safe and timely manner, and as prescribed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, observation, staff interview, and review of facility policy, the facility failed to timely discard expired medications. This affected two (#195 and #15) residents with expired medications observed in the medication carts and had the potential to affect all 41 residents residing in the facility who could potentially receive expired stock medications. The census was 41. Findings include: 1. Observation on 06/01/22 at 9:15 A.M. with Licensed Practical Nurse (LPN) #219 revealed the B Side medication room refrigerator contained two open vial of tuberculin testing solution dated upon opening with dates of 03/30/22 and 04/12/22. Interview on 06/01/22 at 9:15 A.M. with LPN #219 confirmed the TB test solution was expired and should have been discarded. 2. Review of the medical record for Resident #40 revealed an admitted [DATE] with a diagnosis of glaucoma Review of the June 2022 monthly physician orders for Resident #40 revealed an order dated 02/08/21 for Brimonidine Tartrate Solution eye drops to left eye two times a day. Observation on 06/01/22 at 9:16 A.M. with LPN #219 revealed the B side medication room contained an unopened bottle of Brimonidine Tartrate eye drops for Resident #40 with a manufacturer's expiration date of 05/23/22. Interview on 06/01/22 at 9:16 A.M. with LPN #219 confirmed the B side medication room contained an unopened bottle of Brimonidine Tartrate eye drops for Resident #40 with a manufacturer's expiration date of 05/23/22. LPN #219 confirmed the medication was expired and should have been discarded. 3. Review of the medical record for Resident #15 revealed an admitted [DATE] with a diagnosis of angina pectoris. Review of the June 2022 monthly physician orders for Resident #15 revealed an order dated 02/08/21 for nitroglycerin tablet sublingual as needed for chest pain. Observation on 06/01/22 at 9:29 A.M. of the Primrose Unit medication cart with LPN #219 revealed the cart contained a bottle of nitroglycerin tablets for Resident #15 with a manufacturer's expiration date of February 2022. Interview on 06/01/22 at 9:29 A.M. with LPN #219 confirmed the Primrose Unit medication contained a bottle of nitroglycerin tablets for Resident #15 with a manufacturer's expiration date of February 2022. LPN #219 confirmed the nitroglycerin tablets for Resident #15 were expired and should have been discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Observation on 06/02/22 at 7:35 A.M. of the Lilac Unit medication cart with LPN #258 revealed the cart contained a bottle of house stock sodium bicarbonate tablets with a manufacturer's expiration date of January 2022 and a bottle of magnesium oxide tablets with a manufacturer's expiration date of March 2022. Interview on 06/02/22 at 7:35 A.M. with LPN #258 revealed the cart contained a bottle of house stock sodium bicarbonate tablets with a manufacturer's expiration date of January 2022 and a bottle of magnesium oxide tablets with a manufacturer's expiration date of March 2022. Review of the facility policy titled Storage of Medications dated April 2019 revealed discontinued, outdated, or deteriorated drugs or biological's are returned to the dispensing pharmacy or destroyed.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 44083 Based on observations, staff interviews, review of a meal spreadsheet and policy review, the facility failed to provide qualified staff to ensure meals were provided as ordered by the physician. This had the potential to affect all 41 residents residing in the facility. The facility census was 41. Findings include: Review of lunch menu spreadsheet dated 06/01/22 revealed a puree diet was to have a #16 scoop portion of puree bread. There was no diet planned for mechanical soft diets. Observation on 06/01/22 from 11:00 A.M. to 11:15 A.M. , revealed [NAME] #228 preparing puree foods, and no puree bread was prepared. The 06/01/22 lunch spreadsheet was observed on the counter. [NAME] #228 did not review the spreadsheet when pureeing the food. Interview on 06/01/22 at 11:15 A.M. [NAME] #228 stated she did not normally made puree bread and did not know the amount of meat portion or foods to prepared for mechanical soft diets. [NAME] #228 stated she just received new spreadsheets from the Interim Dietary Manger #275 and had not been trained on the spreadsheets. [NAME] #228 stated the Interim Dietary Manger #275 visits the facility one time a week to order food and has not seen Registered Dietitian, (RD) #271. [NAME] #228 states she works five to seven days a week as she is the only cook. [NAME] #228 stated she did not contact Dietary Manager #275 regarding meal and diet preparation, food substitutions, or portion control because she did not have time. [NAME] #228 stated she did not have RD #271's contact information. Interview on 06/01/22 at 1:18 P.M. RD #271 revealed she is contracted one day a month and a diet technician visits the facility for clinical duties one time a week. RD #271 verified the Dietary Manager #275 is not employed at the facility full time. RD #271 stated Dietary Manager #275 places food orders and was to provide new spreadsheets last week. RD #271 revealed her monthly audit, completed 05/21/22, recommended the cook to contact the RD before making substitutions, and to follow the spreadsheets for meal preparation. Observation during survey of dates 05/31/22, 06/01/22 and 06/02/22 from 8:00 A.M. through 4:00 P.M. revealed the Dietary Manger #275 and the RD #271 were not in the facility. Interview on 06/02/22 at 9:00 A.M. the Administrator verified the facility has had no full time employed RD and/or full-time certified Dietary Manager since 05/13/22. The Administrator stated current RD #271 is not employed full time and the Interim Dietary Manager #275 is not employed full time at the facility. The Administrator stated the current certified Dietary Manger #275 is at the facility one day a week to place the food order and verified the facility requires full time Dietary Manger. The facility confirmed all 41 residents residing in the facility receive their meals from the kitchen. Review of the policy titled Food and Nutrition Services, dated October 2017, revealed the Dietitian will assess the resident nutritional needs and a diet will be based on this assessment. Each resident will be provided a well-balanced diet that meets the national dietary needs.

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	366288	A. Building B. Wing	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Nursing Healthcare LLC	3434 State Route 132 Amelia, OH 45102

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on observations, staff and resident interviews, review of a spreadsheet and policy review, the facility failed to ensure sufficient and trained dietary staff to meet residents' dietary needs. This had the potential to affect all 41 residents residing in the facility who received meals from the kitchen. The facility census was 41. Findings include: Review of the dietary schedule revealed no dinner cook was scheduled on 05/31/22 and 06/01/22. Interview on 05/31/22 at 4:45 P.M. Housekeeper #231 revealed she was pulled to assist in the kitchen for the meal. Housekeeper #231 stated she had not worked in the kitchen for [AGE] years. Observation on 06/01/22 at 1:30 P.M. revealed the dishwasher washer was not meeting temperature standards and the Administrator instructed Dietary Aide #243 to clean and sanitize the dishes in the three-sink method. Interview on 06/01/22 at 3:30 P.M. with Dietary Aide #243 stated she was not going to clean the dishes by the three-sink method because she did not have enough time. Dietary Aide #243 stated there was no one else in the kitchen. Dietary Aide #243 stated there was no cook scheduled to cook dinner. Dietary Aide #243 verified there were many meals in which the menu was changed due to untrained staff asked to do dietary positions. Dietary Aide #243 verified there had been no Dietary Manager employed for several weeks. Observation on 06/01/22 at 4:30 P.M. revealed a dish rack of pots and pans in the dish machine and lunch plates in a rack on the clean side of the dish machine. Interview on 06/01/22 at 4:31 P.M. Dietary Aide #243 verified she had no time to wash the lunch plates and pans from lunch by the three-sink method and washed the pans and plates through the improper functioning dish machine. Dietary Aide #243 stated there had been no cook in the kitchen preparing dinner. Dietary Aide #243 verified dinner meals were to be delivered starting at 5:00 P.M. Observation at 5:45 P.M. on 06/01/22 revealed five staff in the kitchen plating food for residents. There was no qualified cook preparing or plating the resident meals. On the spread sheet, the meal was written as a chicken wrap, cucumber tomato salad and fruit cup. The observed meal served to the residents was a chicken wrap, cottage cheese, mandarin oranges, cookies, and yogurt. Activity Director #262 was observed to not follow the spreadsheet for portion control. The Administrator prepared puree food without following the spreadsheet for puree foods and did not use the correct scoop sizes per the spreadsheet. There was no Dietary Manager or Registered Dietitian present in the kitchen. Review of meal service times revealed the dinner meal was to begin service at 5:00 P.M. and at 5:15 P.M. for the Primrose unit. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 06/02/22 at 8:30 A.M. with Residents #13 and #3, who resided on Primrose Unit, revealed the dinner meal on 06/01/22 had not been served until after 6:00 P.M. and were hungry. Residents #13 and #3 stated the meals are often late, especially on the weekends. Interview on 06/02/22 at 9:00 A.M. the Administrator verified the spreadsheet was not followed for the dinner meal on 06/01/22. The Administrator stated there was no substitution list completed and the Registered Dietitian was not contacted prior to the meal being planned or served. The Administrator verified the dietary staffing was being supplemented by staff who have not been recently trained. The Administrator verified the diner meal of 06/01/22 was served late. The facility confirmed all 41 residents residing in the facility receive their meals from the kitchen. Review of the policy titled, Prevention Foodborne Illness-Employee Hygiene and Sanitary Practices, dated October 2017, revealed all employees who handle, prepare or serve food will be trained in the practices of safe food handling. All employees will demonstrate knowledge prior to working with food or serving food to residents.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44083 Based on record review, observation and staff , the facility failed to provide puree and mechanical soft diets as planned by a Registered Dietitian. This had the potential to affect two (#19 and #245) residents with orders for a puree diet, and six (#8, #10, #24, #41, #44 and #195) residents with orders for a mechanical soft diet. The facility census was 41. Findings include: Review of the spreadsheet for lunch meal of 06/01/22 revealed there was no menu plan for mechanical soft diets. The puree diet was to include a puree bread portion of a number 16 scoop and the meat portion of a number eight scoop. Observation on 06/01/22 from 11:00 A.M. to 11:35 A.M., revealed [NAME] #228 preparing puree foods, and no puree bread was prepared. The 06/01/22 lunch spreadsheet was present on the counter. [NAME] #228 did not review the spreadsheet when pureeing the food. [NAME] #228 had the incorrect food portion number 16 scoop in the puree meat. There was a number eight portion scoop for the mechanical meat. Interview on 06/01/22 at 11:15 A.M. [NAME] #228 stated she did not normally make puree bread and did not know the amount of meat portion for the mechanical meat or foods to prepare for mechanical soft diet because it was not on the spreadsheet. [NAME] #228 stated she received new spreadsheets from the Interim Dietary Manger #275 and had not been trained on the spreadsheets. [NAME] #228 stated she had no reference sheet available to convert measurements and weights of food into scoop portion sizes. [NAME] #228 confirmed there are currently two (#19 and #245) residents with orders for a puree diet, and six (#8, #10, #24, #41, #44 and #195) residents with orders for a mechanical soft diet. Review of policy titled Kitchen Weights and Measures dated April 2007, revealed the staff will be trained in weights and measures, utensil use and size conversions of weight measures. Signs and posters explaining utensil measurement will be displayed for reference.

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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. 44083 Based on observations, staff interview, review of the dish machine log and policy review the facility failed to label foods, sanitize dishes and store ice machine scoop in a sanitary manner. This had the potential to affect all 41 residents residing in the facility who received food from the kitchen. The facility census was 41. Findings include: Observation on 05/31/22 at 8:45 A.M. revealed in the dry storage room, an undated bag of macaroni. In the refrigerator walk in, macaroni salad and two bags of chopped lettuce were undated. The lettuce appeared to be wet and had a brown colored appearance. In the reach in refrigerator, thawed meat was in an undated box. The ice machine scoop was directly on top of the ice machine, lying on the wet surface. The ice scoop holder was hanging onto the ice machine, attached on one side. The ice scoop had several cracked areas and had brown debris in the cracked areas. Interview on 05/31 at 8:50 A.M., Dietary Aide #202 verified the lettuce needed discarded and the macaroni salad was undated. Dietary Aide #202 verified the ice scoop holder had been broken, could not hold the ice scoop to drain and needed cleaned. Observation on 06/01/22 at 9:20 A.M. revealed the high temperature dish machine wash temperature peaked at 145 degrees Fahrenheit. The dish machine log dated 06/01/22, revealed the dish machine wash temperature was 150 degrees Fahrenheit during breakfast meal dish washing. The dish machine log dated May 2022 revealed the dish machine wash cycle was always above 150 degrees Fahrenheit. The dish machine log revealed the minimum wash temperature should be 150 degrees Fahrenheit. Interview on 06/01/22 at 9:22 A.M., Dietary Aide #202 stated the dish machine wash temperature runs low many days due to resident bathing times and laundry usage. Dietary Aide #202 verified the wash cycle should be 150 degrees Fahrenheit. Dietary Aide #202 stated she has not washed dishes in the three-sink when the wash cycle was below 150 degrees Fahrenheit. Observation on 06/01/22 at 11:15 P.M. revealed the dishwasher wash temperature was 140 to 145 degrees Fahrenheit. Interview on 06/01/22 at 11:20 A.M., the surveyor alerted the Administrator the dish machine wash temperature was 140 to 145 degrees Fahrenheit. Observation on 06/01/22 at 1:30 P.M. revealed the dishwasher was not meeting washing temperature standards and the Administrator instructed Dietary Aide #243 to clean and sanitize the dishes in the three-sink method. Interview on 06/01/22 at 3:30 P.M. with Dietary Aide #243 stated she was not going to clean the dishes by the three-sink method because she did not have enough time. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 06/01/22 at 4:30 P.M. revealed a dish rack of pots and pans in the dish machine and lunch plates in a rack on the clean side of the dish machine. Interview on 06/01/22 at 4:31 P.M. Dietary Aide #243 verified she had no time to wash the lunch plates and pans from lunch by the three-sink method and washed the pans and plates in the improper functioning dish machine. The facility confirmed all 41 residents residing in the facility receive their meals from the kitchen. Review of the policy titled Dishwasher Machine Use, dated March 2010, revealed high temperature dish machine must maintain the wash solution temperature of 150 degrees Fahrenheit. Review of policy titled Sanitation dated October 2008, revealed ice machine storage containers will be clean, and in good repair. Review of policy titled Food Receiving and Storage dated October 2017 revealed, dry foods will be labeled, and foods stored in the refrigerator will be dated and discarded within seven days from preparation date.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, observation, staff interview, and review of manufacturers guidelines, the facility failed to properly clean and sanitize blood glucose meters after use. This affected four (#22, #19, #7, and #14) of four residents observed for blood glucose monitoring. The census was 41. Findings include: Review of the medical record for Resident #22 revealed an admitted [DATE] with a diagnosis of diabetes mellitus (DM). Review of the medical record for Resident #196 revealed an admitted [DATE] with a diagnosis of DM. Review of the medical record for Resident #7 revealed an admitted [DATE] with a diagnosis of DM. Review of the medical record for Resident #14 revealed an admitted [DATE] with a diagnosis of DM Observation on 06/01/22 at 11:44 A.M. revealed Licensed Practical Nurse (LPN) #258 checked Resident #22's blood sugar with a glucose meter. After the procedure, LPN #258 wiped the meter with an alcohol pad. Continued observation at 11:49 A.M. revealed LPN #258 proceeded to check Resident #196's blood sugar with the same portable glucose meter used for Resident #22. After the procedure, LPN #258 wiped the meter with an alcohol pad. Interview on 06/01/22 at 11:52 A.M. LPN #258 confirmed she cleansed the glucose meter with an alcohol pad after use for Resident #22 and #196. LPN #258 further confirmed if she did not have bleach wipes available, she used alcohol pads instead. Observation on 06/01/22 at 12:01 P.M. revealed Registered Nurse (RN) #223 checked Resident #7's blood sugar with a portable glucose meter. After the procedure, RN #223 wiped the meter with an alcohol pad. Continued observation at 12:10 P.M. revealed RN #223 checked Resident #14's blood sugar with the same portable glucose meter used for Resident #7. After the procedure, RN #223 wiped the meter with an alcohol pad. Interview on 06/01/22 at 12:10 P.M. RN #223 confirmed she cleansed the glucose meter with an alcohol pad after use for Resident #7 and #14. RN #223 confirmed she usually used alcohol pads to clean the glucose meter. Review of manufacturer's guidelines for the glucose meter, undated, revealed the meter should be cleaned and disinfected with a commercially available Environmental Protection Agency (EPA)-approved disinfectant detergent or germicidal wipe.