| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 375256 | A. Building<br>B. Wing | 01/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Meadowlake Estates | 959 Southwest 107th Street<br>Oklahoma City, OK 73139 |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45583<br><br>Based on record review and interview, the facility failed to ensure MDS entry tracking was completed per RAI guidelines for one (#45) of 27 sampled residents who were reviewed for resident assessments.<br><br>ADON #1 identified 111 residents resided in the facility.<br><br>Findings:<br><br>A Resident Assessment policy, revised 01/12/20, read in parts, Purpose: To enter this assessment data into a computerized format that will be transmitted to the Center for Medicare/Medicaid Services (CMS). The policy also read, Tracking records .will be transmitted electronically, in a CMS specified format.<br><br>Resident #45's MDS list documented a discharge return anticipated on 05/19/23. It documented a quarterly assessment dated [DATE].<br><br>There was no entry tracking record.<br><br>On 12/31/24 at 10:42 a.m., the clinical reimbursement specialist stated the resident went to the hospital and did need an entry. They stated the RAI was not followed. |

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

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

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389<br><br>Based on record review and interview, the facility failed to ensure resident assessments were accurately coded for one (#111) of 27 sampled residents reviewed for resident assessments.<br><br>ADON #1 identified 111 residents resided in the facility.<br><br>Findings:<br><br>A Resident Assessment policy, revised [DATE], read in part, Each individual who completes a portion of the assessment will sign to certify the accuracy of that portion of the assessment.<br><br>Resident #111 had diagnoses which included history of seizures and history of traumatic brain injury.<br><br>A Nurse Note, dated [DATE], documented at 5:25 p.m., Resident #111 coded, CPR was started, emergency personnel arrived, and eventually restored Resident #111's pulse. It documented Resident #111 transferred from the facility to the hospital. The note was electronically signed by the DON on [DATE].<br><br>A Transfer Form, dated [DATE], documented Resident #111's blood pressure was ,d+[DATE], pulse 68, respirations 18, oxygen 95 percent, and the resident was transferred to the hospital.<br><br>Resident #111's hospital record, dated [DATE], documented after consultation with GI, the resident's family had elected comfort measures only at the hospital.<br><br>A Resident Assessment, dated [DATE], documented Resident #111 had died in the facility.<br><br>On [DATE] at 9:39 a.m., the DON stated they had closed out the nurse note for Resident #111 on [DATE]. They stated the nurse who had written it worked on the weekends. They stated it appeared Resident #111 coded, CPR was started, and emergency personal took over and restored the resident's pulse. They stated the resident was transferred to the hospital.<br><br>On [DATE] at 9:46 a.m., the DON reviewed the resident assessment dated [DATE] and stated they were not sure of the reason it was marked death in the facility. They stated the staff member who filled out the assessment no longer worked for the facility. The DON stated the resident did not die at the facility and the assessment was coded incorrectly.<br><br>On [DATE] at 2:09 p.m., the DON stated Resident #111 expired at the hospital.<br><br>On [DATE] at 2:11 p.m., the DON stated the resident assessment was not coded correctly.<br><br>48344 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>35389<br><br>Based on observation, record review and interview, the facility failed to provide incontinent care in a manner to prevent UTI's for one (#42) of four sampled residents observed during incontinent care.<br><br>The DON identified 67 incontinent residents resided in the facility.<br><br>Findings:<br><br>A Perineal Care/Incontinent Care policy, effective 04/2012, read in parts, Staff will perform perineal/incontinent care with each bath and after each incontinent episode .Clean groin using sweeping motion .For female .Separate labia and wash downward .then downward on each side of the labia using a different peri wipe with each stroke .Wash downward toward the base of the vaginal opening .Remove gloves and wash hands or alcohol gel and re-glove hands .Turn resident on side facing staff. Roll soiled brief/incontinent pad and apply clean brief and/or incontinent pad. Turn resident away from staff. (ONLY USE ONE WIPE PER SWIPE) .Clean outer hip of buttocks going upwards towards back .Clean anal area with upward motion .Remove gloves and wash hands with alcohol gel.<br><br>Resident #42 had diagnoses which included UTI.<br><br>A Physician Order, dated 12/17/24, documented culture urine one time only.<br><br>An Admission Resident Assessment, dated 12/18/24, documented Resident #42 had moderate cognitive impairment, was always incontinent of bowel and bladder and required substantial/maximal assistance for toilet hygiene.<br><br>Urine culture laboratory results, final release 12/21/24, documented Escherichia Coli was detected low.<br><br>A Physician Order, dated 12/22/24, documented ertapenem (antibiotic) one gram intramuscular every morning shift for seven days for a diagnoses of UTI.<br><br>On 12/27/24 at 6:10 a.m., CNA #1 entered Resident #42's room, placed a disposable brief on the bedside table, donned gloves and adjusted the resident's bed.<br><br>On 12/27/24 at 6:12 a.m., CNA #1 removed the resident's linens, unlatched the disposable brief, obtained several disposable wipes, and wiped the resident's peri area front to back removing a small amount of bowel. Resident #42 was rolled to their right side, there was a large amount of bowel observed in the brief and had leaked out of the brief onto the non disposable pad. CNA #1 removed the disposable pad and rolled the non disposable pad and draw sheet under the resident. CNA #1 provided peri care, placed a clean disposable pad under the resident, rolled the resident to the left side, and pulled the soiled linens out from under the resident. CNA #1 started to attach the clean brief. There was a brown substance remaining on Resident #42's peri area.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/27/24 at 6:16 a.m., CNA #1 was asked to observe Resident #42's front peri area and identify if the resident still had bowel present. CNA #1 opened the brief and stated, It's like pee I think. CNA #1 wiped the resident several more times and started to close the resident's brief. A brown substance was observed on the new brief. The CNA did not offer a response when asked about it.<br><br>On 12/27/24 at 6:21 a.m., CNA #1 obtained a new disposable brief from the cart on Hall 200.<br><br>On 12/27/24 at 6:23 a.m., CNA #1 turned Resident #42 to their right side, and cleaned additional brown bowel off of the resident using several disposable wipes.<br><br>On 12/27/24 at 6:25 a.m., CNA #1 removed the soiled brief, placed a new brief under Resident #42 and attached the brief. CNA #1 was asked to observe the resident's right thigh. There was a brown circular substance on the resident's right leg. CNA #1 stated, It wasn't BM, it looks like rice cake. CNA #1 removed the substance from Resident #42's leg.<br><br>On 12/27/24 at 6:30 a.m., CNA #1 stated incontinent care was to be provided every two hours. CNA #1 was asked how they ensured incontinent care was complete before placing a clean brief. CNA #1 stated, We had some mistakes. CNA #1 stated Resident #42 was not completely clean. CNA #1 stated staff were to keep wiping until the resident was clean.<br><br>On 12/27/24 at 6:40 a.m., LPN #1 stated they let staff know what residents were incontinent. They stated staff were to complete first round checks on everyone. They stated incontinent care was to be provided every two hours.<br><br>On 12/27/24 at 6:41 a.m., LPN #1 stated staff were supposed to visualize the resident to ensure they were clean before placing a new brief. LPN #1 stated there had been times they observed incontinent care and had to remind staff a resident was not completely clean.<br><br>On 12/31/24 at 2:34 p.m., the DON stated staff were to provide incontinent care by wiping from the perineum to the rectum using one wipe per swipe. They stated staff were to turn the resident, clean all areas of the buttock, remove gloves, perform hand hygiene, and apply new gloves before placing a new brief.<br><br>On 12/31/24 at 2:37 p.m., the DON stated staff should be able to visually tell all urine and feces was removed prior to placing a clean brief on a resident. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>48344<br><br>Based on observation, record review, and interview, the facility failed to ensure oxygen was administered as ordered and a concentrator had a filter and was dust free for one (#1) of one sampled resident reviewed for respiratory care.<br><br>The DON identified 24 residents who received oxygen therapy in the facility.<br><br>Findings:<br><br>The OXYGEN THERAPY, CONCENTRATOR INITIATION policy, revised 01/12/20, read in part, The licensed staff will provide the prescribed amount of oxygen therapy to the residents as prescribed by physician and according to practice guidelines.<br><br>Resident #1 had a diagnosis of chronic obstructive pulmonary disease.<br><br>A physician's order, dated 12/27/24, documented oxygen 2 liters per minute inhalation every shift via nasal cannula, may remove for ADLs.<br><br>On 12/30/24 at 11:58 a.m., Resident #1 was observed receiving oxygen via a nasal cannula. The concentrator vent had extreme dust build up.<br><br>On 01/02/25 at 11:33 a.m., Resident #1 was observed receiving oxygen via a nasal cannula at 3 liters per minute.<br><br>On 01/02/25 at 1:32 p.m., RN #1 reviewed Resident #1's oxygen order. They stated the resident was to receive 2 liters oxygen per minute inhalation.<br><br>On 01/02/25 at 1:35 p.m., RN #1 stated maintenance personnel took care of the filters on the oxygen concentrators.<br><br>01/02/25 at 1:39 p.m., RN #1 observed Resident #1's concentrator. They stated it was set at 3 liters per minute. They stated the concentrator vent had a lot of dust build up. They stated the concentrator was not cleaned in a while.<br><br>On 01/02/25 at 1:41 p.m., RN #1 stated Resident #1 did not receive the correct oxygen as ordered. RN #1 adjusted the oxygen to 2 liters per minute.<br><br>01/02/25 at 1:51 p.m., the regional maintenance director stated they checked concentrator cords and filters. They stated they were not sure how often concentrators were cleaned, but could be quarterly.<br><br>01/02/25 at 2:11 p.m., the maintenance director and regional maintenance director observed Resident #1's concentrator. They stated there was dust build up and the filter was missing from the vent.<br><br>On 01/02/25 at 2:14 p.m., the DON stated oxygen should be administered as ordered.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 51977 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701<br><br>Based on observation and interview, the facility failed to ensure a outdated medication was removed from stock for one of one medication storage observation.<br><br>ADON #1 identified 111 residents resided in the facility and 111 residents were administered medications by the nursing staff.<br><br>Findings:<br><br>A medication storage policy, dated ,d+[DATE], read in part, Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock.<br><br>On [DATE] at 11:02 a.m., a magnesium chloride with calcium bottle was observed to be expired. The best by date was ,d+[DATE].<br><br>On [DATE] at 11:03 a.m., ACMA #2 stated someone was supposed to check the expiration dates and rotate the stock. They identified the best by date to be ,d+[DATE] and stated the medication would not be appropriate to use.<br><br>On [DATE] at 11:13 a.m., CMA #3 stated they checked the medications last on [DATE]. They stated they were surprised to know that something was expired. They stated they rotated the stock by putting the new medications at the back and moving the older medications to the front to be used first. They stated the magnesium may have been one that had fallen behind or under the cart and they did not look to see if it was good or not. They stated, As far as I know they look at any expiration dates before they dispense to the residents. CMA #3 stated the magnesium had already been opened so maybe someone took it off their cart. CMA #3 stated, I don't know why it would be up their and open.<br><br>On [DATE] at 11:15 a.m., a vitamin E bottle with an expiration date of ,d+[DATE] was observed in the back of the rotation to be used last, while the vitamin E to be used first had an expiration date of ,d+[DATE].<br><br>On [DATE] at 11:15 a.m., CMA #3 stated they did not know why it would be arranged like that, but it was not in correct rotation order.<br><br>On [DATE] at 2:15 p.m., the DON stated the medications were supposed to be rotated to prevent medications from being able to expire. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389<br><br>Based on observation, record review and interview, the facility failed to ensure:<br><br>a. raw meat items were stored in a manner to prevent cross contamination;<br><br>b. dented cans were removed from circulation in the dry storage;<br><br>c. leftover food items were discarded within the appropriate timeframe;<br><br>d. food items in the refrigerator were stored in a sealed container;<br><br>e. expired food items were removed from circulation; and<br><br>f. food items were appropriately dated and labeled during the kitchen observation.<br><br>The DON identified 106 residents received services from the kitchen.<br><br>Findings:<br><br>A Use of Leftovers policy, dated [DATE], read in parts, Leftovers will be properly handled and used . Leftovers should be covered, labeled, dated and stored appropriately .Unless otherwise indicated on package, leftover food is used within 72 hours or discarded.<br><br>A Food Storage policy, dated [DATE], read in parts, Storeroom .Air-tight containers or bags are used for all opened packages of food. All containers are accurately labeled with the item and date opened .All stock is rotated with each new order received using a First In, First Out system .Canned and dry foods without expiration dates are used within six months of delivery .All foods are covered, labeled and dated. Defrosting meat, eggs and milk shakes are labeled with date pulled for thawing .Any item out of the original case must be properly secured and labeled.<br><br>A General Food Preparation and Handling policy, dated [DATE], read in part, Questionable foods (from broken packages, swollen cans, food with abnormal appearance or odor) are not served.<br><br>On [DATE] at 10:18 a.m., the dry storage area was observed in the kitchen. There was one 111 oz can of light red kidney beans with a large dent in the back of the can. There was one six lb 6.5 oz can of diced tomatoes in tomato juice with a small dent in the edge of the can toward the top.<br><br>On [DATE] at 10:26 a.m., the CDM removed the can of beans and stated it needed to go away. The CDM stated because the can was dented, it was possibly in the seam and it should not be in here.<br><br>On [DATE] at 10:28 a.m., the CDM stated if staff identified a canned good that had been damaged they would bring it to the CDM so it would be returned to the company or disposed of. The CDM observed the dent in the can of tomatoes and stated since the dent was not in the seam, it was OK.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On [DATE] at 10:46 a.m., two 6.63 lb cans of pumpkin were observed, one with a large dent in the side, and one with a smaller dent in the top edge of the can. The CDM stated, We aren't using them. The CDM stated they were definitely in the seams.<br><br>On [DATE] at 10:48 a.m., a one gallon container of salad dressing was observed in the dry storage with a best by date of [DATE]. The CDM stated the best by date had elapsed by a couple of days.<br><br>On [DATE] at 10:54 a.m., the reach in cooler was observed to have a white plastic container with an original label of cottage cheese and a handwritten label on blue tape that read tartar sauce [DATE].<br><br>On [DATE] at 10:55 a.m., the DON stated the facility would keep tartar sauce after they made it until the next day. They stated, Yeah it should have been thrown away.<br><br>On [DATE] at 10:59 a.m., a large clear bag containing grated Parmesan cheese, open date [DATE], was observed to be open to air in the reach in cooler. The CDM stated the bags sometimes opened when they moved them. They stated it was supposed to be closed.<br><br>On [DATE] at 11:01 a.m., there were ten unlabeled cups of a dark material located in the walk in cooler. The CDM stated it was the minced and moist snack for today. They stated it looks like chocolate pudding. The CDM was asked how floor staff would know what was in the cups. The CDM stated neither of the kitchen staff members could write English, so they would ask the CDM or the cook to write it on the containers before they went out to the floor. The CDM began labeling the items.<br><br>On [DATE] at 11:05 a.m., a box of chocolate health shakes with directions keep frozen on the box was observed in the walk in cooler. The box did not contain a date the box was pulled from the freezer and placed in the cooler. The CDM stated they did not know the date the shakes were moved into the cooler. They stated staff should have put a pull date on the box.<br><br>On [DATE] at 11:09 a.m., a large metal cookie sheet was observed on the bottom shelf of the middle rack in the walk in cooler. There were five long pieces of raw meet thawing on the rack. Two of the pieces of meat were labeled ground beef and were hanging over the edges of the pan. The CDM stated the purpose of the tray was if the items leaked, they would not go onto the floor. The CDM stated the meat should have been in a single layer. The CDM stated the pork should have been on one tray and the beef on the other.<br><br>On [DATE] at 11:15 a.m., the other three pieces of raw meat were observed for a label. The only label observed was butcher's block with a yellow sticky note with a pull date of [DATE] written on it. The CDM stated it was pork loin. When asked how they knew what the meat was without a label, the CDM stated the facility only got pork loin and pork butt that looked similar. They stated there was a new staff member who pulled the meat before they left and were still in training.<br><br>On [DATE] at 11:29 a.m., the CDM stated the facility used the first in first out method for rotating stock in the kitchen. The CDM stated staff were to date food items when they came in. They stated staff would also date items when they opened them.<br><br>On [DATE] at 11:30 a.m., the CDM stated left over items that had been served out of could be kept for 24 hours. They stated items such as cheeses, staff would use the date on the package. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389<br><br>Based on observation, record review, and interview, the facility failed to:<br><br>a. provide incontinent care in a manner which prevented cross contamination for two (#33 and #42) of four sampled residents observed during incontinent care;<br><br>b. handle linens in a manner which prevented cross contamination for one (#42) of four sampled residents observed during incontinent care;<br><br>c. ensure proper PPE was worn in a room with a COVID-19 positive resident for three (#46, 55 and #89) of three sampled residents observed with COVID-19;<br><br>d. ensure the same PPE was not worn when assisting two different residents with COVID-19 in the same room for two (#46 and #55) of three sampled residents observed with COVID-19; and<br><br>e. medications were not handled with bare hands.<br><br>The DON identified 67 incontinent residents and four Covid-19 positive residents resided in the facility. ADON #1 identified 111 residents resided in the facility.<br><br>Findings:<br><br>A Perineal Care/Incontinent Care policy, effective 04/2012, read in parts, Staff will perform perineal/incontinent care with each bath and after each incontinent episode .Clean groin using sweeping motion .For female .Separate labia and wash downward .then downward on each side of the labia using a different peri wipe with each stroke .Wash downward toward the base of the vaginal opening .Remove gloves and wash hands or alcohol gel and re-glove hands .Turn resident on side facing staff. Roll soiled brief/incontinent pad and apply clean brief and/or incontinent pad. Turn resident away from staff. (ONLY USE ONE WIPE PER SWIPE) .Clean outer hip of buttocks going upwards towards back .Clean anal area with upward motion .Remove gloves and wash hands with alcohol gel .<br><br>A Glove Use policy, reviewed 01/2022, read in parts, Gloves are worn when .Touching blood or body fluids, except sweat .Touching urine, stool .Handling items or environmental surfaces soiled with blood or body fluids .Gloves are changed between residents .Gloves are changed if contaminated with blood or body fluids before touching other parts of the same resident .Hands are washed immediately after gloves are removed, before contact with another resident or the environment .Hands are washed or decontaminated prior to donning gloves.<br><br>A COVID-19 policy, revised 08/2023, read in parts, COVID-19 PPE .The required PPE for COVID-19 isolation rooms when providing care or services to a COVID-19 positive resident suspected of having COVID-19, staff should wear an N95, face shield or goggles, gown, and gloves.<br><br>A Medication Administration policy, dated 01/2024, read in part, Hands are washed with soap and water and gloves applied before administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications.<br><br>(continued on next page) |

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| | 375256 | A. Building<br>B. Wing | 01/06/2025 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A Laundry and Linen Services policy, undated, read in part, All facility staff should handle all used laundry as potentially contaminated and use appropriate precautions .Used laundry should be handled with gowns and gloves to prevent personal clothing from getting contaminated .All contaminated laundry should be bagged in the area it was used prior to transporting to the laundry area.<br><br>1. Resident #33 had diagnoses that included lack of history of cerebral infarct, lack of coordination, and muscle weakness.<br><br>An Admission Resident Assessment, dated 11/14/23, documented Resident #33 required max assist with toileting and dressing.<br><br>On 12/27/24 at 6:01 a.m., CNA #6 entered Resident #33's room to answer the call light.<br><br>On 12/27/24 at 6:05 a.m., CNA #6 returned to Resident #33's room with brief, wipes, and trash bags. CNA #6 applied gloves, pulled the resident's covers down, and opened the resident's brief. The resident's peri area was cleaned front to back with multiple wipes. Resident #33 was then rolled to their right side and dark liquid bowel was continuously flowing from their anus. CNA #6 continued to clean the resident until the bowel movement was cleaned up. CNA #6's hair kept falling into the brief and touching the resident while care was being provided.<br><br>On 12/27/24 at 6:08 a.m., CNA #6 proceeded to move Resident #33's pillow and quilt wearing the same gloves that was used during incontinent care. The CNA then removed their gloves and the remaining personal items were removed from the resident's bed.<br><br>On 12/27/24 at 6:12 a.m., CNA #6 left the resident's room to get different bedding.<br><br>On 12/27/24 at 6:17 a.m., CNA #6 returned to Resident 33's room with bedding. The CNA donned new gloves and cream was applied to Resident 33's buttocks. The CNAs gloves were then changed and dirty linens were bagged.<br><br>On 12/27/24 at 6:24 a.m., CNA #6 completed the bed change and returned personal items to the resident's bed. The call cord was attached to the resident's blanket and dirty laundry and trash were removed from room.<br><br>On 12/27/24 at 6:28 a.m., CNA #6 took the linens and trash to bins in the soiled utility and washed their hands.<br><br>On 12/27/24 at 6:31 a.m., CNA #6 stated they had on new gloves when they moved the pillow and quilt, and their hair was usually tied back. They stated they were supposed to change gloves at least three times with a bowel movement and after the third time, they were to wash their hands. The CNA stated residents were to be checked and changed every two hours because most of the residents could not use the call system for assistance.<br><br>2. Resident #42 had diagnoses which included UTI.<br><br>An Admission Resident Assessment, dated 12/18/24, documented Resident #42 had moderate cognitive impairment, was always incontinent of bowel and bladder and required substantial/maximal assistance for toilet hygiene.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/27/24 at 6:10 a.m., CNA #1 entered Resident #42's room, placed a disposable brief on the bedside table, donned gloves, and adjusted the resident's bed.<br><br>On 12/27/24 at 6:12 a.m., CNA #1 removed the resident's linens, unlatched the disposable brief, obtained several disposable wipes, and wiped the resident's peri area front to back removing a small amount of bowel. Resident #42 was rolled to their right side, there was a large amount of bowel observed in the brief and had leaked out of the brief onto the non disposable pad. CNA #1 removed the disposable pad and rolled the non disposable pad and draw sheet under the resident. CNA #1 provided peri care, placed a clean disposable pad under the resident, rolled the resident to the left side, and pulled the soiled linens out from under the resident and threw them on the floor. CNA #1 did not change their gloves or wash/sanitize their hands when going from dirty to clean. Bowel was observed on the non disposable pad and draw sheet that were laying on the floor. CNA #1 started to attach the clean brief. There was a brown substance observed remaining on Resident #42's peri area.<br><br>On 12/27/24 at 6:16 a.m., CNA #1 was asked to observe Resident #42's front peri area and identify if the resident still had bowel present. CNA #1 opened the brief and stated, It's like pee I think. CNA #1 went through several drawers in the resident's room with the same gloved hands used during incontinent care and obtained another package of disposable wipes. CNA #1 wiped the resident several more times and started to close the resident's brief. There was brown substance observed on the new brief. The CNA did not offer a response when asked about it.<br><br>On 12/27/24 at 6:18 a.m., CNA #1 again went through several drawers in the room, lowered Resident #42's bed, covered the resident with a blanket, pulled a trash bag off a roll of trash bags, and sat the roll on the resident's bedside table with the same gloved hands used during incontinent care.<br><br>On 12/27/24 at 6:20 a.m., CNA #1, with the same gloved hands placed the soiled linens from the floor in the trash bag, obtained the bag of trash from the trash can, tied it shut, opened the resident's door to the hallway with the same gloved hands used during incontinent care. Once out in the hall, CNA #1 removed the glove on their right hand, tossed the soiled items in the appropriate barrels, removed their left glove and threw it away.<br><br>On 12/27/24 at 6:21 a.m., CNA #1 sanitized their hands and obtained a new disposable brief from the cart on hall 200.<br><br>On 12/27/24 at 6:22 a.m., CNA #1 entered Resident #42's room and donned gloves. ADON #1 also entered the room and picked up the roll of trash bags CNA #1 had previously touched with contaminated gloves with gloved hands hands. ADON #1 placed a trash bag in the trash can.<br><br>On 12/27/24 at 6:23 a.m., CNA #1 adjusted the bed, turned Resident #42 to their right side, and cleaned additional brown bowel off of the resident using several disposable wipes, and rolled the soiled brief under the resident.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/27/24 at 6:25 a.m., CNA #1 removed the soiled brief, placed a new brief under Resident #42 and attached the brief. The CNA did not change their gloves or wash/sanitize their hands when going from dirty to clean. CNA #1 was asked to observe the resident's right thigh. There was a brown circular substance on the resident's right leg. CNA #1 stated, It wasn't BM, it looks like rice cake. CNA #1 removed the substance from Resident #1's leg. CNA #1 adjusted Resident #42's bed, covered them with a blanket, moved the resident's bedside table, glasses, television, and placed the roll of trash bags in their right pants pocket with the same gloved hands used during incontinent care.<br><br>On 12/27/24 at 6:28 a.m., CNA #1 opened the door to the hall with the same gloved hands used during incontinent care, took the trash to the soiled utility room on the hall, removed their right glove, opened the door, placed the items in the trash, and washed their hands with soap and water.<br><br>On 12/27/24 at 6:30 a.m., CNA #1 stated incontinent care was to be provided every two hours.<br><br>On 12/27/24 at 6:31 a.m., CNA #1 stated staff were to make sure soiled linens were bagged before leaving the resident's room. They stated the soiled linens would be placed in the soiled linen container. CNA #1 stated they sanitized their hands every time they came out of a room. They stated by the second resident, they would wash their hands. CNA #1 stated they did not know if that was the facility's policy, but it was their policy.<br><br>On 12/27/24 at 6:32 a.m., CNA #1 stated they were supposed to change gloves every time they came out of a room and between residents. CNA #1 stated they were supposed to change gloves between everything.<br><br>On 12/27/24 at 6:40 a.m., LPN #1 stated they let staff know what residents were incontinent. They stated staff were to complete first round checks on everyone. They stated incontinent care was to be provided every two hours.<br><br>On 12/27/24 at 6:42 a.m., LPN #1 stated staff were to either place soiled linens directly in the soiled linen container, or bag them and then place them in the container. LPN #1 stated they had seen it done both ways.<br><br>On 12/27/24 at 6:44 a.m., LPN #1 stated staff were to sanitize their hands after every interaction with a resident. They stated staff were to wash their hands after they had used sanitizer twice.<br><br>On 12/27/24 at 6:45 a.m., LPN #1 stated anytime staff were dealing with something dirty, they had to change their gloves before touching something clean. They stated staff were to change gloves between residents, and were not supposed to wear gloves in the hall. They stated a lot of staff did wear gloves in the hall when transporting trash.<br><br>On 12/31/24 at 2:32 p.m., the DON stated staff were to wash their hands prior to providing care and after care. They stated staff were supposed to wash their hands between care if they had to go from dirty to clean.<br><br>On 12/31/24 at 2:33 p.m., the DON stated anytime staff went from dirty to clean they should change their gloves. The DON stated soiled linens should be placed in a bag and placed in the hopper room. They stated they should never be on the floor.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/31/24 at 2:34 p.m., the DON stated staff were to provide incontinent care by wiping from the perineum to the rectum using one wipe per swipe. They stated staff were to turn the resident, clean all areas of the buttock, remove gloves, perform hand hygiene, and apply new gloves before placing a new brief.<br><br>3. Resident #89 had diagnoses which included COVID-19.<br><br>COVID-19 testing logs documented Resident #89 tested positive for COVID-19 on 12/17/24.<br><br>On 12/26/24 at 1:52 p.m., CMA #4 was observed placing the lid of a meal tray on the counter in Resident #89's room. CMA #4 did not have a gown, gloves, face shield, or N95 mask on while in the COVID-19 room. CMA #4 only had a standard face mask on. CMA #4 exited the room with a standard face mask on. CMA #4 stated they were delivering the meal tray to Resident #89. CMA #4 was asked to explain the COVID-19 sign on the outside of Resident #89's door. They stated, You are supposed to gown up. They stated they did not put a gown on before entering Resident #89's room. The red COVID-19 sign documented use PPE when caring for patient with COVID-19 or suspected COVID-19. It documented PPE must be donned correctly before entering patient area.<br><br>4. Resident #46 had diagnoses which included COVID-19.<br><br>COVID-19 testing logs documented Resident #46 tested positive for COVID-19 on 12/23/24.<br><br>A Physician Order, dated 12/23/24, documented isolation full transmission based precautions every shift, droplet precautions along with gown, gloves, N95 mask, and face shield or goggles.<br><br>5. Resident #55 had diagnoses which included COVID-19.<br><br>COVID-19 testing logs documented Resident #55 tested positive for COVID-19 on 12/23/24.<br><br>A Physician Order, dated 12/23/24, documented isolation full transmission based precautions every shift, droplet precautions along with gown, gloves, N95 mask, and face shield or goggles.<br><br>On 12/26/24 at 12:20 p.m., CNA #5 was observed wearing two standard face masks. They donned a gown and gloves and entered room [ROOM NUMBER] where Resident #46 and #55 resided. CNA #5 did not have a N95 face mask or a face shield/goggles before entering the COVID-19 positive room. CNA #5 adjusted Resident #55's bed, rolled the resident to the right side, and placed a pillow under the resident's back. Resident #55 did not like the position so CNA #5 went to the right side of the bed, rolled the resident further to the right using the draw sheet, and placed a pillow behind their back. CNA #5 adjusted the resident's bed to the low position, pushed the bed to the wall, and lifted the head of the bed until the resident was comfortable. CNA #5 pulled the trash bag out of Resident #55's trash container, tied it shut, and placed another bag in the trash can.<br><br>On 12/26/24 at 12:23 p.m., CNA #5 changed their gloves, walked over to Resident #46 with the same gown and masks used during care of Resident #55, picked up linens off of the resident's floor, placed them in a trash bag, and removed their gloves.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/26/24 at 12:30 p.m., CNA #5 walked over to Resident #55 with the same masks and gown on, adjusted the resident's bed and handed Resident #55 a box of tissues with their bare hands. CNA #5 then washed their hands with soap and water and stated, I'm going to have to get a new gown since I'm taking care of [Resident #46] OK. CNA #5 removed their gown, placed it in the trash can, and tried to hand Resident #55 their TV remote. The resident did not take the remote. CNA #5 then handed Resident #55 their call light and bed control with their bare hands wearing no gown.<br><br>On 12/26/24 at 12:34 p.m., CNA #5 entered room [ROOM NUMBER] with a new gown on and donned a pair of gloves at the door in the room. CNA #5 still had two regular face masks on and no face shield.<br><br>On 12/26/24 at 12:35 p.m., CNA #5 handed Resident #55 their bed remote on request and changed their gloves. CNA #5 got a washcloth off the counter in the room, wet it, and walked over to Resident #46, sat in a chair next to the resident and washed their face and hands off with the washcloth. CNA #5 lifted the resident's head with the bed controller and offered the resident a drink of water with a straw. CNA #5 wiped down Resident #46's bedside table with a disposable wipe and lowered the resident's head back down.<br><br>On 12/26/24 at 12:38 p.m., CNA #5 removed their gown and gloves, moved over to Resident #55 and moved their bedside table without a gown or gloves on. CNA #5 donned a pair of gloves, wiped off items on the bedside table with a wet wipe, handed Resident #55 their phone wearing just the two regular face masks and gloves. CNA #5 then wet a rag and wiped something off the resident's floor.<br><br>On 12/26/24 at 12:44 p.m., CNA #5 washed their hands with soap and water, took the soiled linens and trash out of room [ROOM NUMBER] and placed them in the soiled utility room on hall 200. CNA #5 was still wearing both of the standard non disposable face masks.<br><br>On 12/26/24 at 12:45 p.m., CNA #5 stated staff were to gown and glove before going into a COVID-19 positive room. They stated they were to use a new gown between residents. They stated they did the best they could. They stated there were a lot of needs in the COVID-19 rooms. They stated they tried to make sure the linens and areas were clean to try to stop the process of infection by changing the linens. CNA #5 stated they tried to change their gloves and gown between Resident #55 and #46, but Resident #55 was needy. CNA #5 stated they usually did not wear the same masks in and out of a COVID-19 positive room, but they did today. They stated they should have worn a N95 mask. CNA #5 stated they place COVID-19 soiled items in the regular bin on the hall as instructed.<br><br>On 12/27/24 at 6:02 a.m. the call light in room [ROOM NUMBER] activated. CNA #1 donned a gown, gloves, N95 mask and face shield, and stated all of the PPE items were needed to enter a COVID-19 room. As CNA #1 approached room [ROOM NUMBER], CNA #3 was exiting and did not need anything. CNA #1 removed their PPE and disposed of it.<br><br>On 12/27/24 at 6:50 a.m., LPN #1 stated complete PPE, a gown, N95 mask, face shield/goggles, and gloves were to be worn in COVID-19 rooms.<br><br>On 12/27/24 at 6:54 a.m., LPN #1 stated if staff were caring for two residents in a COVID-19 room, they should change PPE between residents.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/30/24 at 12:28 p.m., the DON stated staff were to wear a N95 mask, face shield, gown, and gloves to enter a COVID-19 room. The DON stated the trash from a COVID-19 room was to be placed in the regular trash in the resident's room.<br><br>On 12/31/24 at 2:37 p.m., the DON stated staff were to switch out all PPE, wash their hands, and completely change out their PPE when caring for two residents in a COVID-19 room.<br><br>6. On 01/03/25 at 7:47 a.m., RN #1 was observed popping an unidentified pill from the blister pack that was removed from the secondary lock box inside the medication cart into their bare hands. The pill was then placed into a medication cup. Their nails had red fingernail polish on them.<br><br>On 01/03/25 at 7:53 a.m., RN #1 stated the policy was to put gloves on, then get the medications out of the cart and give them to the resident, come out, then wash or sanitize their hands again.<br><br>On 01/03/25 at 7:56 a.m., RN #1 stated they did not put gloves on before touching the medication. They stated the purpose of the gloves was as a safety precaution and gloves were to be used for everything.<br><br>49701 |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>35389<br><br>Based on observation and interview, the facility failed to ensure the walk in freezer was in safe operating condition.<br><br>The DON identified 106 residents received services from the kitchen.<br><br>Findings:<br><br>On 12/31/24 at 11:20 a.m. the walk in cooler located in the kitchen was observed to have an internal temperature of 34.7 degrees.<br><br>On 12/31/24 at 11:21 a.m., the walk in freezer entrance was observed inside the walk in cooler. There was an accumulation of ice buildup observed on the doorway of the freezer. While standing outside the entrance door of the freezer, light was observed from inside the freezer with the door closed as far as it would go. Ice accumulation was observed on the upper section of the freezer door all the way down the inner part of the doorframe where the door should seal. Icicles varying in size were observed on the underside of the three level green metal shelving located inside the freezer. There was a clump of ice, larger than the size of a softball, located on the middle shelf. There was ice observed covering the floor of the entrance to the freezer. The CDM stated it was supposed to have a heater on the door, but because it was old, the facility had people out looking at it in the past. The CDM stated it had been a process that had been going on for at least a year. The CDM stated they would come in every couple of weeks or so and use a hammer on the ice so the door would shut all the way.<br><br>On 12/31/24 at 11:27 a.m., the CDM stated the last time the freezer was worked on was last month.<br><br>On 12/31/24 at 1:57 p.m., the DON stated they were unable to locate a maintenance policy for the kitchen equipment. |