STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275132	A. Building B. Wing	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitefish Care and Rehabilitation	1305 E 7th St Whitefish, MT 59937

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 44769 Based on interview and record review, the facility failed to protect residents from neglect of care for 5 (#s 71, 80, 102, 105, & 107); failed to protect residents from verbal abuse for 4 (#s 10, 14, 33, & 59) of 9 sampled residents and resulted in a resident feeling terrified, and other residents feeling deameaned and upset; and failed to protect residents from another resident of the opposite sex who displayed inappropriate sexual touching, for 1 (#29), and the behavior affected 2 (#s 10 and 18), of 4 sampled residents. Findings include: 1. A review of a facility reported incident, reported to the State Survey Agency, dated 6/28/22, showed, Resident (resident #10) was told she had pretend pain by shift nurse and nurse taped a rock to her arm. No injuries were sustained and no need for medical treatment. Resident did state she is terrified of this nurse. [sic] A review of a facility document titled, Roommate Interview, listing resident #16 and dated, 6/29/22, showed, Do you feel afraid because of the way your roommate was treated? I am not afraid. I know my roommate (resident #10) is afraid. I know [NF3] says some weird things. We try to keep our door closed so we don't hear anything. A review of a facility document titled, Staff Interview, listing staff member M, and dated 6/29/22, showed, Do you have any concerns with the professionalism of nursing staff? Well [NF3] makes a gurgling noise and says 'it's them.' She talks a lot about Nazis and Illuminati's. [sic] During an interview on 3/1/23 at 4:01 p.m., resident #10 stated, when she requested pain medication from NF3, NF3 told her, she was having pain because the Nazi's were coming here. NF3 then stated, listen to me and she would make a gurgling sound, like a demonic sound, when she breathed. I was terrified, I don't think I've ever been that scared in my life. She taped a flat crystal on my arm and said it would get rid of the Nazi's, which would get rid of my pain. I was terrified of her. I would lie awake at two a.m. because I was afraid she would come back. 2. A review of a facility reported incident, reported to the State Survey Agency, dated 11/3/22, showed, NF4 was verbally abusive to resident #10 and, the incident was substantiated by the facility. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility document titled, Alleged Resident Physical or Verbal Abuse Incident Report, with a date of alleged incident of 11/3/22, listed resident #10 as resident, and NF4 as alleged perpetrator. Under the heading Verbal Abuse other was checked and showed, yelled at resident and wouldnt listen. [sic] A review of a facility document, titled, Grievance/Concern Form, from resident #10, and dated 11/3/22, showed: Aide has been rude, yells at me, will not listen . During an interview on 3/1/23 at 3:56 p.m., resident #10 stated [NF4] had a really smart mouth. My roommate [Resident #16] was trying to tell [NF4] something when she was getting her up out of bed. I told [NF4], [Resident #16] was trying to tell her something and to let her talk. [NF4] then yelled at me, to stop talking to her because she was getting distracted and she might hurt my roommate, and that if she did hurt my roommate, it would be my fault. 45447 3. Review of a facility reported incident, dated, 2/21/23, showed: There were multiple reports that CNA (staff member N) was not answering call lights and that a resident was left wet (resident #71), and one was left on a bed pan (resident #80). Review of the facility's investigation interview with resident #71, dated 2/21/23, showed resident #71 stated: I turned my call light (on) because my brief was soaked and I wanted to be changed, The CNA (staff member N) didn't come into my room for a while and then she came in, turned my light off and left without changing me or saying she would be back. I am very upset with how that happened and I do not like to sit in my briefs being saturated [sic]. During an interview on 2/28/23 at 8:12 a.m., resident #71 was calling and asking for help to a passing staff member, who did not go into the resident's room. Resident #71 spoke to the surveyor, appearing anxious and quick in speech, asking for help, and repeatedly stating she needed help to get more tea. Resident #71 could not articulate what happened during the incident with staff member N, as she appeared fixated on getting help. Review of the facility's investigation interview with resident #80, dated 2/21/23, showed resident #80 stated: My call light was turned on and I waited for almost 45 minutes, until a CNA came into my room asking what I needed and ended up turning my call light off and saying she would be back but never came back. I sat in my saturated brief for almost 3 hours, until another CNA came and cleaned me up. Review of the facility's investigation interview with staff member N, dated 2/21/23, showed staff member N stated: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I told [Resident #80] to call me when she was ready to get off the bed pan. I peeked around the corner and didn't see her light yet. Resident #80 was unavailable to interview during the survey. During an interview on 3/1/23 at 11:50 a.m., staff member A stated after learning about the allegation against staff member N's neglect of changing resident #s 71 and 80, on 2/21/23, staff member A went bed to bed to check all the residents. Staff member A stated the facility substantiated the allegation against staff member N, and the staff member was terminated. Staff member A stated she felt staff member N did not have a resource to help her due to staffing issues. Staff member A stated she felt the facility needed to move away from the current culture where departments were not supporting each other. 4. Review of a facility reported incident, dated 2/21/23, showed: [Staff member Z] was verbally abusive towards a few residents. [Staff member Z] was demanding that [Resident #33], [Resident #59], and [Resident #14] go back to their rooms because of the covid outbreak status, each resident was being compliant with wearing a mask and being six feet apart, but [Staff member Z] still told them to go back to their rooms, making them visibly upset. During an interview on 2/28/23 at 8:46 a.m., resident #33 stated during an incident with staff member Z on 2/21/23, staff member Z poked her finger on resident #33's chest, and told the resident, with a yelling tone of voice, to go back to the resident's room. Resident #33 stated staff member Z made the resident feel, like a little kid, and was, demeaning. Resident #33 stated she was not fearful and felt safe at the facility, but did not like what happened, and almost wanted to leave the facility. Resident #s 14 and 59 were unable to be interviewed during the survey due to cognition status and availability. During an interview on 3/1/23 at 12:02 p.m., staff member A stated the verbal abuse allegation towards staff member Z was substantiated at the facility. Staff member A stated she thought staff member Z's approach towards the residents during the incident was inappropriate, and was a customer service issue, as staff member Z primarily helped in the kitchen. Staff member A stated she felt staff member Z was undereducated on the proper COVID-19 precautions for residents. Staff member A stated, I should have educated her (staff member Z) more. When staff are undereducated, it blows up on us (the facility). I should have made sure she (Staff member Z) was comfortable (with the expectations). We need to talk about this in QAPI and implement a skills checklist. 45448 5. Review of a Facility Reported Incident, reported to the State Survey Agency, dated 4/18/22, showed resident #18 reported to nursing staff, resident #29 entered her room, exposed his penis, and she told him to get out. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility investigative file for the incident, which occurred on 4/16/22 or 4/17/22, showed the facility investigation substantiated the allegation of resident-to-resident abuse. The facility investigation also identified resident #10 had experienced abuse by resident #29. Resident #29 had entered resident #10's room and grabbed her breast. During an interview on 3/1/23 at 3:30 p.m., resident #18 said resident #29 had entered her room and showed her his penis. Resident #18 said she thought he was, nuts, and told him to leave. Resident #29 left the room right away, and he had never bothered her again. Resident #18 said she was not afraid of resident #29, and had no concerns for her safety in the facility. During and interview on 3/1/23 at 3:54 p.m., resident #10 said resident #29 had entered her room and grabbed her breast. Resident #29 told resident #10 he thought women liked it. Resident #10 said she told resident #29 to stop, she did not appreciate it, and if he ever did it again, she would, take him out. Resident #10 said the facility staff talked to resident #29, and now resident #29 spent his time with the men, eating and doing activities. Resident #10 said she told the nurse what had happened, and it was not a big deal. Resident #10 said resident #29 had never bothered her again and did not speak to her. Resident #10 said she was not afraid of resident #29, and did not have any concerns about her safety while she was in the facility. During an interview on 3/1/23 at 4:38 p.m., staff member A said she was not working at the facility at the time of the incident. Staff member A said the facility had initiated 15-minute watches for resident #29. Resident #29 was also instructed he was no longer able to enter a lady's room, unless invited, and he would not be allowed to dine at a ladies table at this time. Staff were educated on abuse and QAPI discussed the incident. Staff member A said she was not aware of any further incidents between resident #29 and any other female residents residing in the facility. Record review of resident #29's care plan, with an initiation date of 4/20/22, and a revision date of 10/28/22, showed: .Focus: Resident exhibiting difficulty with behavioral issues as evidenced by showing his genitals to another lady resident. Goal: Will response to redirection with episode through the review date Interventions: Notify MD if prn medication not effective, Notify SS (social services) prn, Refer to Psych Consult . [sic]. A request was made to the facility for resident #29's Psychological Consult, the document was not provided by the end of the survey.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45447 Based on interview and record review, the facility failed to ensure new admission MDS assessments were completed for 2 (#s 71 & 72) of 2 sampled residents. Findings include: During an interview on 3/1/23 at 11:37 a.m., staff member D stated the MDS assessments for residents #71 and #72 were not completed. Staff member D stated she would update the care plan based on what was completed on the MDS. Staff member D stated resident #71's anxiety interventions, and resident #72's ulcer interventions, should have been updated on their care plans. Staff member D stated she had not completed the MDS's because she has had a lack of time, and often had to work as a nurse providing care. Review of resident #72's EMR, on 2/28/23, showed the resident was admitted on [DATE]. The resident's EMR showed the MDS was due on 2/16/23 and was 'In Progress.' Review of resident #71's EMR, on 2/28/23, showed the resident was admitted on [DATE]. The resident's EMR showed the MDS was due on 2/22/23 and was 'In Progress.' A review of the facility's policy, MDS 3.0 Completion, dated 10/8/22, reflected: Policy: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan . 2. Types of OBRA Assessments: a. Entry Tracking i. Complete and submit with every entry into the facility no later than entry date +7 calendar days . b. Admission Assessment - completed within 14 days of admission .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40068 Based on observation, interview, and record review, the facility failed to initiate a contact precautions care plan for a resident with Clostridioides Difficile (C. diff) infection for 1 (#21); failed to initiate a behavioral health care plan for 1 (#15); and failed to implement a care planned intervention for 1 (#29) resident who exhibited sexually inappropriate behavior which affected #10 and 18, of 4 sampled residents. Findings include: 1. During an observation on 2/28/23 at 8:31 a.m., resident #21 had a sign outside her door for contact precautions. Review of a nurse progress note for resident #21, dated 2/3/23 showed, Resident arrived in w/c via Van accompanied by facility transporter. Her son followed her over and was also present. Resident is incontinent of bladder. Also incontinent of bowels at the moment due to diarrhea r/t c-diff infection. Contact isolation precautions in place. During an interview on 2/28/23 at 4:07 p.m., staff member D stated resident #21 had the proper sign outside of her room to show she was on contact precautions for C. diff. Review of resident #21's care plan did not show any information regarding the resident being on precautions for C. diff, despite being admitted to the facility with C. diff, and continuing to have symptoms of C. diff. 2. Review of resident #15's nursing progress notes, dated 2/21/23, showed, Resident had two episodes of yelling at staff this shift. This afternoon resident asked staff sitting at nurse's station for a clipboard. Staff searched for an extra clipboard and were unsuccessful at finding one. Resident became angry and yelled. Again this evening, while nursing staff were doing report, resident interrupted and asked staff to make a phone call for him. Resident was told that after report, assistance would be given to him. He became angry and yelled and cursed at staff. Review of resident #15's NP progress notes, dated 2/14/23, showed, He is walking around the facility with his walker. He reports he is doing well. He does have a hx of encephalopathy with bouts of behavior changes. He is at his normal mh (mental health) baseline. During an interview on 3/1/23 at 2:50 p.m., staff member L stated her and staff member D were in charge of implementing and updating care plans. Staff member L stated if a resident was having behavioral health issues, nursing staff let her know, and she implemented a care plan for behavioral health. Staff member L also attended the residents' care plan meetings. Staff member L stated she was not aware of resident #15 having any behaviors. Review of resident #15's care plan did not show any information regarding his behavioral health needs. 45448 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of a Facility Reported Incident, reported to the State Survey Agency, dated 4/18/22, showed resident #18 reported to nursing staff, resident #29 entered her room, exposed his penis. The facility investigation also identified resident #10 had experienced abuse by resident #29. Resident #29 had entered resident #10's room and grabbed her breast. During an interview on 3/1/23 at 3:30 p.m., resident #18 said resident #29 had entered her room and showed her his penis. Resident #18 said she thought he was, nuts, and told him to leave. During and interview on 3/1/23 at 3:54 p.m., resident #10 said resident #29 had entered her room and grabbed her breast. Resident #29 told resident #10 he thought women liked it. Resident #10 said she told resident #29 to stop, she did not appreciate it, and if he ever did it again, she would, take him out. Record review of resident #29's care plan, with an initiation date of 4/20/22, and a revision date of 10/28/22, showed: .Focus: Resident exhibiting difficulty with behavioral issues as evidenced by showing his genitals to another lady resident. Goal: Will response to redirection with episode through the review date Interventions: Notify MD if prn medication not effective, Notify SS (social services) prn, Refer to Psych Consult . [sic]. The care plan failed to show individualized interventions for how staff were to ensure protection of other residents related to sexual abuse.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44769 Based on interview and record review, the facility failed to update or revise the comprehensive care plan for a resident involved in a resident-to-resident altercation, for 1 (#222) of 2 sampled residents. Findings include: A review of a facility reported incident, reported to the State Survey Agency, dated 12/6/22, showed, resident #222 had thrown root beer, hot cocoa, and a half full urinal at resident #41. A review of resident #222's care plan failed to show an updated focus, goal, or intervention showing the resident was aggressive towards another resident or could become aggressive, and the resident potentially could have harmed another resident with hot liquids. During an interview on 3/2/23 at 10:30 a.m., staff member L stated the facility did not update resident #222's care plan after the incident involving him and resident #41. A review of resident #222's progress notes in the EHR, failed to show aggressive behaviors, prior to this incident. A review of a facility policy, titled, Comprehensive Care Plans, with a revised date of 9/16/22, showed: . 6. The comprehensive care plan will include measurable objectives and time frames to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 40068 Based on observation, interview, and record review, the facility staff failed to follow professional standards of practice when caring for residents with Clostridioides Difficile Infection (C. diff) for 2 (#s 21, and 76) of 2 sampled residents. Findings include: During an observation on 2/28/23 at 8:31 a.m., resident #s 21 and 76 both had signs on the outside their door for airborne and contact precautions. During an observation on 2/28/23 at 8:32 a.m., resident #21 had a strong, foul-smelling odor. She was wearing a brief and had a chuck pad under her. She appeared very lethargic. During an observation and interview on 2/28/23 at 8:53 a.m., staff member O was in the hallway passing medications to the residents. She stated she only worked at the facility PRN. She stated she did not know why resident #s 21 and 76 had an airborne sign and contact precaution sign outside their door. Staff member O stated she assumed it was just for the covid outbreak. Staff member O stated she knew resident #76 used to have C. diff, but did not have it anymore, therefore the sign should have been taken down. During an observation on 2/28/23 at 8:46 a.m., resident #76 had what appeared to be loose stool smeared on her bedroom floor coming from the bathroom. During an interview on 2/28/23 at 3:08 p.m., staff member B stated the infection preventionist walked out on 2/27/23. Staff member B stated staff member D was now the infection preventionist for the facility as of that day. Staff member B stated she was aware of one resident in the facility with C. diff, but could not remember who it was. During an interview on 2/28/23 at 3:28 p.m., staff member D stated she was aware that resident #76 had C. diff. She stated resident #76 was diagnosed with C. diff on 1/14/23, before she was admitted to the facility. Staff member D stated the resident was put on contact precautions as soon as she entered the facility. Staff member D stated the facility would notify the nurse on the resident's unit, and would expect the nurse would pass on the contact precaution information and specifics to the rest of the staff. Staff member D stated she was not sure if the resident still had active C. diff. She stated the resident would be taken off contact precautions for C. diff after the resident had formed stool for 48 hours, and the facility did not retest if a resident had C. diff in the past six weeks. Staff member D stated she was not aware of resident #21 having any signs or symptoms of C. diff, and did not think she was on precautions for C. diff. Staff member D stated the nursing staff was supposed to report any signs and symptoms to her. Review of a nurse progress note for resident #21, dated 2/3/23 showed, Resident arrived in w/c via Van accompanied by facility transporter. Her son followed her over and was also present .Resident is incontinent of bladder. Also incontinent of bowels at the moment due to diarrhea r/t c-diff infection. Contact isolation precautions in place. Review of a MD communication note for resident #21, dated 2/13/23, showed, Completed ABX for C-diff. Remains lethargic family recommending labs get obtained. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nursing progress note, Infection note, for resident #21, dated 2/25/23, showed, C. diff test ordered, awaiting collection. Resident having diarrhea and lethargic behavior. Will continue to monitor. Review of resident #76's Hospital Discharge paperwork, dated 1/30/23 showed: 1/11: readmitted to inpatient for right lobar PNA. Completed antibiotic course, weaned down to room air. Developed C-difficile colitis on 1/14, started PO vancomycin (completed 10 days), PO metronidazole added 1/18 (to complete 1/28). Review of nursing progress notes for resident #76, dated 2/11/23. showed, Resident having loose stools with strong odor. Droplet precautions continue. During an interview on 2/28/23 at 4:07 p.m., staff member D stated resident #s 21 and 76 now had the proper signs outside their room door to show they were on contact precautions for C. diff. Staff member D stated resident #21 had orders for a C. diff test, and were waiting for the results. Resident #76 still had loose stool, and therefore should still be on precautions for C. diff. During an observation on 3/1/23 at 7:58 a.m., resident #76 was eating breakfast in the dining room, sitting in her wheelchair, and sitting across from another resident. During an observation on 3/2/23 at 8:43 a.m., resident #76 was in the dining room eating breakfast at a table with another resident. During an observation and interview on 3/1/23 at 8:34 a.m., staff member I donned a gown and entered resident #21's room with her breakfast tray. Staff member I rearranged items on her bed side table and set the breakfast tray down. Staff member I doffed the gown and exited resident #21's room. Staff member I used hand sanitizer and continued passing trays. Staff member I did not wash her hands with soap and water. Staff member I stated she did not know why the resident was on contact precautions, other than for covid, and was not told if the resident had any other illness. Review of the facility's Infection Log for 2/2023 did not show resident #76 had C. diff. Resident #21's C. diff was dated 2/5/23, and stated she was on isolation precautions. Review of a facility policy titled, Management of C. Difficile Infection, dated 9/28/22, showed: .C. diff is a bacterium that causes diarrhea a colitis. It is shed in feces and is spread by direct contact with contaminated objects or the hands of persons who have touched a contaminated object . 5. General principles related to contact precautions for C. difficile: a. All staff to wear gloves and a gown upon entry into the resident's room and while providing care for the resident with C. difficile infection. b. Hand hygiene shall be preformed by handwashing with soap and water in accordance with facility policy for hand hygiene. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Maintain on contact precautions for the duration of illness, but no less than 48 hours after diarrhea has resolved .7. Testing considerations: .c. Repeat testing (within 7 days) during the same episode of diarrhea is not recommended . e. After treatment, repeat testing is not recommended if the resident's symptoms have resolved. Do not test to detect cure, as residents may remain positive for equal to or greater than 6 weeks. f. A reoccurrence of symptoms following successful treatment and diarrhea cessation should be assessed by repeat testing .11. Surveillance: a. The Infection Preventionist shall conduct surveillance activities related to C. difficile based on the facility's infection control risk assessment and antibiotic stewardship program.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45447 Based on interview and record review, the facility failed to implement interventions to identify and prevent a Stage III pressure ulcer from forming for 1 (#72) of 2 sampled residents. Findings include: During an interview on 2/28/23 at 9:00 a.m., resident #72 stated she had a pressure sore on her left ankle that formed while she was at the facility. Resident #72 stated she used to have to wear a boot on her left leg because she broke her leg, and the wound was caused by the boot. Resident #72 could not remember when the sore had formed. Resident #72 stated she did not want a nurse to uncover her wound at the time of the interview, due to some pain, and wanting to rest. During an interview on 2/28/23 at 3:10 p.m., staff member O stated she worked all over the facility, and was not sure whether or not resident #72 was in the facility. Staff member O stated she was not sure if resident #72 had any pressure sores. Staff member O stated skin checks were completed on every resident, and the nurses should have been checking the resident head to toe. Staff member O stated some residents showered themselves, and she would expect those residents to tell her if they had a wound. Staff member O stated if a resident had a boot on, it should come off in the shower, and the skin underneath should have been looked at. Staff member O stated the facility had a wound care nurse. During an interview on 2/28/23 at 3:20 p.m., staff member AA stated she provided wound care to the residents in the facility, and resident #72 had a wound on her left ankle from her brace that she had on, upon admission, on 2/9/23. Staff member AA stated she had not seen the wound at that time. Staff member AA stated if she was doing a skin check, she would take the resident's boot off to look at the skin. Staff member AA stated CNAs report and document abnormal skin issues on the shower sheets after showers. Staff member AA stated resident #72's pressure sore was discovered over the weekend on 2/25/23. Staff member AA did not answer why the wound was not discovered before 2/25/23 during wound checks. During an interview on 3/1/23 at 11:37 a.m., staff member D stated resident #72's Admission MDS was supposed to be completed by 2/16/23, and she had just learned of the resident's leg injury on 2/28/23. Staff member D stated she was supposed to update the care plan with information on the residents left leg injury but did not have the time to complete the MDS, or the care plan, due to needing to work on the floor as a nurse. Review of resident #72's MDS, with an ARD of 2/16/23, showed section M, Skin Conditions, was 'In Progress. ' Review of resident #72's EMR Evaluations showed the following incomplete evaluations: -Braden Scale (to show risk of skin breakdown), due 2/16/23, -Weekly Skin Check, due 2/20/23, and -Weekly Pressure Ulcer BWAT Report, due 2/20/23. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of resident #72's TAR showed an order to, Remove knee immobilizer and check skin integrity. Notify provider with any skin breakdown, dated 2/20/23, 11 days after the resident's admission. Review of resident #72's care plan showed a lack of documentation of interventions to prevent pressure ulcers upon admission. Review of resident #72's shower documentation did not show showers occurred, and did not include information about skin conditions. Review of resident #72's Weekly Skin Checks, dated 2/11/23, 2/13/23, and 2/21/23, did not show documentation of pressure injuries. Review of the Weekly Pressure Ulcer BWAT Report, dated 2/25/23, showed: Site information: Left ankle (outer) Pressure: Width = , - Stage III. Date of initial observation: 02/25/2023. A review of the facility's policy, Pressure Injury Prevention and Management, dated 2022, showed: 2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment . 3. Assessment of Pressure Injury Risk a. Licensed nurses will conduct a pressure injury risk assessment .on all residents upon admission . 4. Interventions for Prevention and to Promote Healing a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45447 Based on interview and record review, the facility failed to protect a resident from an elopement for 1 (#26) of 1 sampled resident. This deficient practice resulted in a resident getting hypothermia. Findings include: Review of a Facility Reported Incident, reported to the State Survey Agency, dated 4/23/22, showed resident #26 had left the facility without signing himself out of the facility or notifying staff of his departure. The incident was found substantiated by the facility. Record review of a facility progress note, created 4/23/22 at 11:50 a.m., showed: res. was found to not be facility after breakfast, searched whole facility and outside, 2 staff members drove around for res., [Staff member name] was contacted and was told she was going to call [Staff member name], called police to report elopement gave description to dispatch, police found [Resident #26] @ 11:00 [a.m.] sitting outside a restaurant smoking, officer states he can't force [resident #26] to come back, [Officer name] stated they will keep an eye on him today, [Resident #26] also told police he would walk back to the facility. Record review of a facility progress note, dated 4/23/22 at 11:59 p.m., showed: resident has not returned to facility as of this time. Administrator and on call nurse [Nurses name] contacted. This nurse informed that resident can be gone for 24 hours before any action is to be taken. Record review of a facility progress note, created 4/24/22 at 8:35 a.m., showed: res. Did not come back to facility, received phone call from [Hospital name] ER, res. Is being treated @ hospital for hypothermia . Record review of a facility progress note, created 4/25/22 at 2:52 p.m., showed: The on-call nurse texted this writer at approximately 10:20 pm that resident had not returned to the facility and believed he was at the bars in downtown [City name]. .Prior to resident leaving facility. He was coherent and alert. The resident is responsible for himself and was not assessed to be a wander risk. Record review of resident #26's Unsafe Wandering Risk Evaluation, dated 4/27/22, showed: .A. Risk Factors A2. Is the patient cognitively impaired (e.g. Alzheimer's disease, Dementia)? Answer - Yes (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	. A.4 Does the patient have impaired decision-making skills that decrease his/her awareness of safety? Answer - Yes .Summary/Conclusions and rationale for careplan decision: Resident likes to leave the facility independently, lived on the street in the past and may in the future have desire to do the same as the weather warms up. Record review of a facility document, Elopement and Wandering Residents, revision date 11/14/22, showed: Policy: This facility ensures that residents who exhibit wandering behaviors and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. .3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Record review of resident #26's MDS, OBRA Quarterly Review, dated 12/20/22, showed resident #26 had a BIMS score of 7, meaning the resident was severely cognitively impaired. Record review of resident #26's Care Plan, with the resident's admitted [DATE], showed no focus, goals, or interventions for the risk of elopement. During an interview on 3/1/23 at 2:53 p.m., staff member B said the facility did a full investigation of the incident. Staff member B said an action plan was developed, and a new elopement policy was written. Staff member B said resident #26 was allowed to leave the building. The facility failed to adequately assess resident #26 for elopement risk, and thus, did not implement appropriate interventions to prevent the elopement.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 40068 Based on observation, interview, and record review, the facility failed to provide the necessary feeding assistance or cueing to a resident who was in need of assistance during meals, resulting in a severe weight loss, for 1 (#21) of 2 sampled residents. Findings include: During an observation on 2/28/23 at 8:32 a.m., resident #21 was in her room alone and in bed, with her breakfast tray in front of her, on the bedside table. Resident #21 was not eating her food. Resident #21 was speaking very slowly and slurring her words, her eyes were only half open. During an interview on 3/1/23 at 8:17 a.m., staff member F stated resident #21 did not need to be supervised while she was eating, and she did not need to be assisted at all. During an observation on 3/1/23 at 8:34 a.m., staff member I entered resident #21's room. The room was very dark. Staff member I placed the tray on resident #21's bed side table and did not remove anything from the food tray. Staff member I did not assist resident #21 with her food tray, or sit her up in bed. Resident #21 appeared lethargic, and asked what time it was. Staff member I did not turn on any lights in resident #21's room upon exit. During an interview on 3/1/23 at 9:27 a.m., staff member U stated she was aware resident #21 was losing weight, and the resident had interventions implemented to prevent further weight loss. Staff member U stated she did not believe the resident needed assistance, other than set up, for her meals. Staff member U stated the resident would benefit from cueing from staff to eat. Review of resident #21's MDS, with and ARD of 2/10/23, showed, H - Eating . Supervision . 2. One person physical assist. Review of resident #21's nutrition weight review, dated 2/23/23, showed, Noted 3.4# loss x 1 wk and significant loss of -6.6# (6.2%) x 3 wk since admit . Currently receiving health shakes daily, but will increase to all meals d/t decrease in intakes/appetite and noted weight loss. Continue to encourage resident to get up for meals and family brings in snacks as well . Review of resident #21's nutrition weight review, dated 3/1/23, showed, Noted weight loss of -3.6# in past week and significant loss of -10.2# (9.6%) in 1 month since admit. Resident receiving healthshakes w/meals and usually drinks well. Recommending change to [Heath shake name] to increase nutrient density of supplement available and encourage wt maintenance/gain vs continued loss .Resident also benefiting from being OOB for meals and staff providing cueing, encouragement and recommending meals in assisted dining as able. Staff to provide assistance in room if isolation precautions are necessary .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 44769 Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff were available for the provision of resident care and answering call lights for 12 (#s 2, 7, 23, 30, 21, 41, 50, 56, 74, 444, 445, 446, & 447) of 18 sampled residents. This deficient practice had the potential to affect all residents residing in the facility. Findings include: During a phone interview on 2/28/23 at 11:51 a.m., NF5 stated she heard from discharged residents, and family members of discharged residents, the facility was short staffed. Residents that had left did not want to return. Families were complaining about call lights not answered timely, and residents were not getting showers. During an interview on 2/28/23 at 1:53 p.m., staff member HH stated there should be four CNAs and two bath aides working, but there was only her and two other CNAs, for all the residents in the facility. During an observation and interview on 2/28/23 at 1:55 p.m., staff member P was observed, on her hands and knees, using her torso, smashing red plastic biohazard bags on the 100 hall floor. Staff member P stated, I was supposed to be the bath aide today, but they're making me gather and dump all these garbage bags. During an interview on 2/28/23 at 2:29 p.m., staff member GG stated she had worked at the facility for almost two years. She stated, I have 30 residents to take care of today, it is always that way. I feel like resident care is suffering. Some things I can't do, I can't do skin checks everyday like I used too. A while ago they took away my nurse and gave me a med tech, then they took her away. I used to have only 20 residents to take care of. Now I have 30 residents to take care of. I am taking care of 30 residents for med pass, treatments, and skin checks. During an interview on 2/28/23 at 2:38 p.m., Staff member Q stated, I have 16 acute residents to take care of today. I've worked here two months and it's a challenge. I feel I can get everything done if no one calls off. Resident bathing has been a problem. During an interview on 3/1/23 at 11:37 a.m., staff member D stated she had not been able to complete resident MDS's on time because she had been working as a nurse, with the facility's low staffing. During an interview on 3/1/23 at 11:50 a.m., staff member A stated she felt the staff got behind on their duties, and neglect happened, because the staff did not have a staff member as a resource or person to go to. Staff member A stated most of their issues with care not being given came down to staffing issues. During a meeting with the facility resident council, on 3/1/23 at 3:12 p.m., resident #7 and 32 stated, It sometimes takes a while for a call light to be answered, sometimes 45 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/1/23 at 3:54 p.m., staff member Q stated the facility was so short staffed, when the travel staff came they did not have an orientation checklist and only followed one or two staff, before going to work on the floor. A review of resident grievances, dated 10/2022 through 2/2023, showed: - On 10/4/22, resident #444, Resident stated that she was due medications at 1830 (6:30 p.m.) but didn't receive them until 11:30. - On 10/4/22, resident #23, Resident had no medications until about 2pm and had only two baths since admitted (according to the MDS entry tracking record, resident #23's admitted was 9/16/22). - On 11/15/22, resident #30, . reported to therapy that she had been in her recliner since the previous night and wanted to get into bed. - On 12/2/22, resident #23, Turned off call light and told him not to put it on again. - On 12/28/22, resident #56, Resident was left in dining room for 8 hours. - On 12/28/22, resident #2, Resident was left in dinning room for 8 hours. - On 12/30/22, resident #41, Foley catheter isn't being changed - On 2/1/23, resident #445, PT requested medication at 1:00 AM but didn't get them until 4 AM. - On 2/7/23, resident #41, Night nurse isn't changing foley catheter. - On 2/9/23, resident #446, Resident requested pain meds at 9 PM and didn't receive them until after midnight. - On 2/9/23, resident #447, Resident didn't get her medication for 3 hours and she didn't get any water for 9 hours. - On 2/19/23, resident #446, Resident recalls her call light being on for an hour without being answered. - On 2/21/23, resident #74, Resident used the BSC for a BM and turned the call light to have BSC emptied no one came for 2 hours. - On 2/23/23, resident #50, Resident hadn't been changed and was concerned about getting the CNA in trouble. - On 2/23/23, resident #50, Resident needed to be changed (brief) and sat in his wet brief for 12 hours, until he was changed. - On 2/24/23, resident #50, Resident turned his call light on, the CNA came in and said they would be right back, and didn't come back. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of a CNA staff posting for February 14 - 28, 2023, showed a need for more than one or two CNAs on every day shift, except 2/27/23 and 2/28/23. 45447

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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. 44769 Based on interview and record review, the facility failed to have the services of a registered nurse, for eight consecutive hours, on a weekend. This deficient practice had the potential to affect all residents residing in the facility. Findings include: A review of a facility document titled, Punch Detail-Report, showed: - On 7/2/22, 2.75 hours for RN (registered nurse) services. - On 7/16/22 and 7/17/22, there were no recorded hours for RN services. - On 11/5/22 and 11/6/22, there were no recorded hours for RN services. - On 12/4/22, there were no recorded hours for RN services. During an interview on 3/2/23 at 11:20 a.m., staff member A stated, the time logs that were originally submitted to the survey team were inaccurate. The revised time logs showed only one day without RN coverage for the fourth fiscal quarter. A review of the PBJ Validation Issues Report, received from staff member A on 3/2/23 at 11:20 a.m., showed, on 7/2/22, 2.75 hours of RN staffing.

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F 0741 Level of Harm - Actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45447 Based on observation, interview, and record review, the facility failed to educate staff on the identification of residents with behavioral health needs, and implementation of non-pharmacological behavioral interventions, for residents with anxiety, for 2 (#s 15 & 71) of 4 sampled residents. This deficient practice caused a resident to experience prolonged levels of anxiety and cause distress, impeding the resident's ability to avoid psychosocial harm. Findings include: 1. During an observation and interview on 2/28/23 at 8:12 a.m., resident #71 was calling and asking for help to a passing staff member, who did not go into the resident's room. Resident #71 spoke to the surveyor, appearing anxious and quick in speech, asking for help, and repeatedly stating she needed help. The surveyor went out of the room and asked a passing staff member about the resident. Staff member O stated, She (resident #71) is so neurotic, she doesn't understand her surroundings. During an interview on 3/1/23 at 11:29 a.m., staff member L stated there was no timeline for when the psychosocial evaluation was completed for residents upon admission. Staff member L stated resident #71 was admitted on [DATE], and she did not complete the psychosocial evaluation for the resident until 2/28/23, after surveyors requested the documentation. Staff member L stated resident #71 was very anxious, and had a phobia of healthcare settings and being away from her significant other. Staff member L stated resident #71 started to become very anxious after about one week of being in the facility. Staff member L stated she needed to update resident #71's care plan with non-pharmacological interventions for the resident's anxiety. During an interview on 3/1/23 at 11:22 a.m., staff member P stated she worked often with resident #71, and noticed the resident used her call light many times a day. Staff member P stated resident #71 would make many requests to use the bathroom, or get situated in bed, and the resident would forget why she put her call light on in the first place, because she was so worked up. Staff member P stated she felt resident #71 was bored and needed attention. Staff member P stated she had never had any special training on behavioral health needs at the facility. Staff member P stated there were a few residents she did not know how to respond to when they were having behaviors, and, Training on what to do would be good to have, in those instances. During an interview on 3/1/23 at 3:54 p.m., staff member Q stated she admitted resident #71 to the facility, and she thought she had a history of anxiety. Staff member Q stated resident #71 had a hard time making decisions upon admission. Staff member Q stated she had not completed any behavioral health training since she had been at the facility. Staff member Q stated there was no orientation checklist to go over behavioral or other nursing items. Staff member Q stated the facility was so short staffed the temporary staff they had went to work on the floor quickly. Staff member Q stated she thought it was strange there was no orientation for new employees. Review of resident #71's EMR showed the following behavioral notes: -2/16/23: Resident is extremely anxious throughout HS shift .Resident extremely anxious, tearful, 'overwhelmed', this morning. Resident cannot speak in complete sentences without hyperventilating .She continues to state 'I'm overwhelmed, I can't concentrate'. [sic] (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	-2/21/23: Resident extremely anxious throughout day .RN went into resident's room in response to call light. Resident shaking, visibly anxious, and states 'I don't know what to do I haven't slept and im so anxious'. This RN gave PRN Ativan, and resident continues anxious behavior throughout morning .later this shift, resident has continued putting call light on .she continues to state 'I'm sorry I'm just worried and I really don't want to be a bother to you' .This RN talked with husband and social services about anxious behavior. Will continue to monitor at this time. [sic] -2/24/23: Resident continues to show extremely anxious behavior. Resident calls out for help and uses call bell consistently throughout shift. Resident continues to state 'Am I okay' .'Can you come see if I'm okay' .Will continue to monitor. [sic] -2/25/23: Resident shakey, anxious, and asking this RN 'Am I okay' .Resident very warm, having anxious sweats so skin is moist .Will continue to monitor. [sic] -2/26/23: Resident continuously using call light and stating 'am I okay?'. CNA and RN has been in throughout day .resident calling out am I ok I'm so anxious'. This RN administered Ativan PRN, and resident continues to hit call light. Will continue to monitor. [sic] Review of resident #71's EMR showed the resident was admitted on [DATE], and the resident's Psychosocial Evaluation was not completed until 2/28/23, when it was requested from surveyors. Review of resident #71's MDS, with an ARD of 2/22/23, showed the Mood and Behavior sections were not completed. Review of resident #71's care plan showed a lack of interventions for the resident's anxiety and psychosocial adjustment to the facility. 40068 2. During an interview on 3/1/23 at 3:30 p.m., staff member EE stated resident #15 had behaviors occasionally. She stated he sometimes had outbursts if he did not get his way. Staff member EE stated she just tried to talk calmly to him and sometimes it worked. During an interview on 3/2/23 at 8:45 a.m., staff member DD stated she was a travel nurse and usually worked in ERs. She stated she had not received any behavioral health training for long-term care, or at the facility. Review of resident #15's nursing progress note, dated 2/10/23, showed, Resident was up in the hallways for most of the morning. He has been very agitated this morning. Yelling and cursing at most of the staff. Review of resident #15's NP progress notes, dated 2/14/23, showed, He is walking around the facility with his walker. He reports he is doing well. He does have a hx of encephalopathy with bouts of behavior changes. He is at his normal mh (mental health) baseline. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	Review of resident #15's nursing progress notes, dated 2/21/23, showed, Resident had two episodes of yelling at staff this shift. This afternoon resident asked staff sitting at nurse's station for a clipboard. Staff searched for an extra clipboard and were unsuccessful at finding one. Resident became angry and yelled. Again this evening, while nursing staff were doing report, resident interrupted and asked staff to make a phone call for him. Resident was told that after report, assistance would be given to him. He became angry and yelled and cursed at staff. During an interview on 3/1/23 at 2:50 p.m., staff member L stated staff member D and her were in charge of implementing and updating care plans. Staff member L stated if a resident was having behavioral health issues, nursing staff let her know, and she implemented a care plan for behavioral health. Staff member L also attended the residents' care plan meetings. Staff member L stated she was not aware of resident #15 having any behaviors. Review of resident #15's care plan did not show any information regarding his behavioral health needs. During the Quality Assurance interview on 3/2/23 at 9:48 a.m., staff membr A stated the facility did not do behavioral health training with the staff. Staff member A stated the facility would benefit from having behavioral health training. Staff member D stated she was aware some residents who had behavioral health needs, did not have it addressed in their care plans. She stated she was working to update those at that time. Review of the Facility Assessment, dated 2/14/23, showed: Resident support/care needs 2.1 Types of care/services we (or contracted services) provide to the residents: .Mental health and behavior .the IDT will develop and implement interventions in managing resident's behavior and to help support individuals with issues dealing with anxiety . A review of the facility's policy, Behavioral Health Services, revised 11/9/22, showed: 7. The facility utilizes the comprehensive assessment process for identifying and assessing a residents mental and psychosocial status .Staff will: c. Monitor the resident closely for expressions or indications of distress . e. Utilize MDS and care area assessments. f. Assess and develop a person-centered care plan . i. Ensure appropriate follow-up assessment, if needed . k. Evaluate resident and care plan routinely to ensure the approaches are meeting the needs of the resident. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	10.Behavioral health training .will include .the competencies and skills necessary to provide the following: b. Interpersonal communication that promotes mental and psychological well-being. e. Individualized, non-pharmacological approaches to care.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 44769 Based on interview and record review, an unlicensed staff member provided the wrong medication to a resident, and administering medication was not a part of the staff member's daily assigned duties, causing a medication error, for 1 (#49) of 1 sampled resident. Findings include: A review of a nursing progress note for resident #49, dated 12/7/22, written by staff member FF, showed: Writer had gotten these residents medications along with roommates, when setting medications down to empty bedpan CNA assumed roommates' meds were this said residents (resident #49) and administered them (to #49). Writer came back from bathroom and noticed that pills were missing and asked. CNA stated she thought she only saw one set of meds and assumed it was this said residents (resident #49). Writer reported to MD and did q2hr checks, Vitals WNL.[sic] A review of a facility document, dated 12/9/22, titled, [Resident #49] Interview, showed: [Resident #49] stated that the nurse had came into her room to give her and her roommate their medications; the nurse had set them down really quick to help assist in emptying my roommates bed pan, while my nurse was helping my roommate the CNA came in and asked if the medications were mine and I explained to her that I didn't know, and I said all I know is one of those cups are mine, the CNA then gave me a cup and I took the medications thinking they were mine.[sic] During an interview on 2/28/23 at 4:02 p.m., staff member L stated staff member FF was assisting resident #49's roommate, with the curtain closed, and staff member BB saw resident #49 was trying to reach for the medications on the bedside table closest to resident #49. Staff member BB thought the medications were for resident #49, and gave them to resident #49. The medications were for resident #49's roommate. During an interview on 2/28/23 at 4:23 p.m., staff member B stated staff member FF was verbally educated by staff member BB immediately after the incident occurred. Staff member B further stated staff member FF was verbally educated by the DON following the incident. A review of a facility policy, titled Medication Administration, with a copyright date of 2022, showed: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, .

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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** 45447 Based on observation, interview, and record review, the facility failed to provide adequate training and education to kitchen staff. This caused food to be served cold to the residents, inadequate disposal of expired food items, and unsafe thawing of food items. This deficient practice had the potential to affect all residents in the facility. Findings include: During an observation and interview on [DATE] at 3:14 p.m., surveyors found multiple undated and expired food items in the kitchen, dry goods, and refrigerated areas (see F812 for further information). Staff member Y stated she started working at the facility on [DATE], and she was not sure on the facility policy on how often she was supposed to go through the dry and refrigerated food to find expired items. Staff member Y stated she did not know of a process used to date produce in the refrigerator. Staff member Y stated she did not get that much training when she started working at the facility. During an interview on [DATE] at 9:35 a.m., staff member R stated she had not received training in the kitchen in a couple of years. Staff member R stated she had heard complaints from residents about cold food, specifically when the night shift, staff members V and W, were working. Staff member R stated the night kitchen staff refused to use the hot plates because it burnt their fingers, so the residents got cold food. Staff member R stated staff members V and W needed a lot more training, as they did not understand textures. During an interview on [DATE] at 9:45 a.m., staff members S and T stated they heard complaints from residents about staff members V and W regarding food temperatures. Staff members S and T stated staff members V and W needed a lot of training, and there had been no training since COVID started, except for a quick texture training. During an interview on [DATE] at 9:55 a.m., staff member Y stated no one was in the kitchen training her from [DATE] - [DATE], the first week of her employment. Staff member Y stated she inaccurately signed and dated her dietary manager training competencies documentation yesterday, on [DATE]. Staff member Y stated the [DATE] date on the competencies documentation, received by surveyors, was incorrect. Staff member Y stated there were many items on the competency documentation she had never heard of, and she stated the facility managers and administration still had her sign and write a false date of completion. During an observation on [DATE] at 4:30 p.m., two pork loin rolls were thawing on a cookie sheet on the countertop in ambient air, without running water over them. During an interview on [DATE] at 10:28 a.m., staff member R stated the pork loins, being thawed on the counter on [DATE], were in the cooler that morning. Staff member R stated staff member X thawed the pork loin the prior night, and staff member R was slow cooking it at that time. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 10:30 a.m., staff member X stated she got sidetracked the previous night, and she left the thawing pork loins out on the sink counter for a few hours. Staff member X stated she thought she put the pork loins in the cooler around 4:00 p.m. Staff member X stated she knew she was supposed to thaw the loins in the cooler, instead of the sink. During an interview on [DATE] at 10:35 a.m., staff member Y stated the pork loins were put in the cooler the previous night, just before dinner, around 5:00 p.m. Staff member Y stated she knew she should have thawed them under running water, and would go educate the staff then. A request for staff member Y's training and competencies was submitted to the facility by surveyors on [DATE]. Review of the documentation provided showed a document, titled, Competencies for Food and Nutrition Services Employees, with a completion date of [DATE], and signed by staff members Y and U. Review of the other facility document provided, titled, Dietary Manager Training Competencies, showed staff members Y and U signed the competencies as completed on [DATE]. This date was inconsistent with the statement from staff member Y. A request for kitchen staff training and orientation was submitted by surveyors on [DATE]. The requested documentation was not received by the end of the survey.

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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. 45447 Based on observation, interview, and record review, the facility failed to serve food at a palatable temperature for 5 (#s 29, 31, 45, 53, and 57) of 18 sampled residents. Findings include: During an interview on 2/28/23 at 8:31 a.m., resident #45 stated the food at the facility was cold most of the time, and late. Resident #45 stated the whole kitchen food process was a mess. During an interview on 2/28/23 at 9:12 a.m., resident #31 stated the food was cold most of the time. Resident #31 stated the food trays were, stone cold, by the time it reached the resident's room. Resident #31 stated he did not think the staff would eat what they serve here at home, and the food has gotten worse since the COVID lockdown. During an interview on 2/28/23 at 9:28 a.m., resident #29 stated the food was overall terrible, and had been cold when served. During an observation and interview on 2/28/23 at 11:08 a.m., resident #53's food tray from breakfast was still sitting on his bedside table, and the resident stated the food was terrible. Resident #53 stated he ordered takeout at times because the food was so terrible. During an interview on 2/28/23 at 11:17 a.m., resident #57 stated the food was horrible, always cold, and overcooked. During an interview on 3/1/23 at 9:35 a.m., staff member R stated the kitchen received complaints about cold food, mainly from the night shift, because the night shift staff refused to use the hot plates provided. During an interview on 3/1/23 at 9:45 a.m., staff members S and T stated they heard complaints from residents about cold food from the night staff all the time, and there were a lot of, complainers. During an observation and interview on 3/1/23 at 12:40 p.m., staff member F pulled a food cart down to the 300 hallway. The cart had a large hole in the front door panel, where a handle was missing, approximately 4in x 6in in size. Staff member F stated she had to serve food to both the 200 and 300 halls by herself, and had to go change a brief. Staff member Y arrived to start passing trays, and took temperatures of the first and last trays for the food tray pass. The starting temperature for the hot food was 129.9 degrees Fahrenheit, and the cold food was 45.6 degrees Fahrenheit. The lunch trays were passed out by 1:10 p.m. The final tray temperatures were 127.8 degrees Fahrenheit for the hot food, and 51.9 degrees Fahrenheit for the cold food. All temperatures were not within the recommended serving temperatures. During an interview on 3/1/23 at 1:12 p.m., staff member J stated she would reheat food for residents in a microwave by keeping a lid on the plate, and microwaving it for a few minutes. Staff member J stated she would then serve it, and would not check the temperature. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/1/23 at 2:34 p.m., staff member Y stated she received a lot of complaints about cold food from the residents. Staff member Y stated the food tray carts were, trash, and did not hold heat. Staff member Y stated the staff were supposed to use hot plates and insulated covers, but the carts did not help keep food warm. Staff member Y stated she wanted new carts and had not requested them yet. Staff member Y stated she thought the cold food issue was talked about briefly in QAPI, and she let the QAPI team know if they, Keep going how we are, we will keep serving food that is cold. During a resident council interview on 3/1/23 at 3:17 p.m., residents stated the food was only good before dinner, and the food quality was getting worse, and dry. The residents stated if they ate in their rooms, the food was cold, and the kitchen just started using the plate warmers when the surveyors showed up. During an interview on 3/2/23 at 9:26 a.m., staff member U stated she did not recall if food temperature issues were brought up at the last QAPI meeting on 2/14/23, and would expect staff member Y to bring issues up, and attend resident council, to get feedback from residents on food quality. Review of the facility's documents, Food Temperature Records, dated 12/8/22-2/14/22, showed the food temperatures were not recorded for all meals for 11 out of 14 days from 12/8/22-12/21/22. The temperature records also showed there were no records of food temperatures taken from 12/22/22-1/31/23. A review of the facility's policy, Food Preparation Guidelines, dated 10/8/22, showed: 3. Food and drinks shall be palatable, attractive, and at a safe and appetizing temperature. Strategies to ensure resident satisfaction include: .c. Serving hot foods/drinks hot and cold foods/drinks cold. d. Addressing resident complaints about food/drinks.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45447 Based on observation, interview, and record review, the facility failed to properly date and label open foods, dispose of expired food items, and store and thaw foods in a safe and sanitary manner. This deficient practice had the potential to affect all residents in the facility. Findings include: During an observation on [DATE] at 3:14 p.m., the following undated and expired items were found: In the dry goods storage area: -1 box of serving cups on the floor, and -3 tubs of fat free Italian dressing without a use by date. In the walk-in refrigerator: -2 16oz tubs of beef base with no use by date, -1 tub of beef base, opened, with no use by date, in a box with a brown substance caked on another tub, -3 lbs broccoli florets with no use by date, -1 box of peeled garlic with no use by date, -1 box of tomatoes with no use by date, -1 box of button mushrooms with no use by date, -1 box of bacon, opened and uncovered, -1 pack of bacon wrapped in foil, opened, undated, -3 bags of lettuce with best if used by dates of [DATE], -1 bag shredded cheddar cheese, opened and undated, -1 bag parmesan cheese, opened and dated [DATE], -1 gallon jug of Caesar dressing, opened and dated [DATE], -1 jug of fat free Italian dressing, opened and undated, -1 gallon jar of jalapenos, opened ,d+[DATE], (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-1 gallon jar of dill pickle chips, opened [DATE], -1 dressing dispenser filled with ranch dressing, undated, -1 8.44lb container of enchilada sauce, opened and undated, -2 bottles of caramel sauce, opened and exp [DATE], and -1 bottle of chocolate sauce, opened and exp [DATE]. In the walk-in freezer: -2 cups of ice cream on the floor. On a bread shelf: -2 loaves of white bread, no exp or received date, -2 packs of English muffins, opened, undated, -2 packs of hamburger buns, opened, undated, and -1 loaf of wheat bread, no exp date or received date. Kitchen prep area: -An employee's coffee mug was sitting on the food prep area, -the large stand mixer had a white, crusted substance on the area where the mixer attaches, -1 large plastic tub was not inverted on top of a rack, -multiple spices were not dated with use by dates, -the stove had a thick, black, greasy film on top of it with crumbs, and -a box of rolls was uncovered and placed on the upper right shelf by the stove. During an interview on [DATE] at 3:14 p.m., staff member Y stated she was not sure on the policy on how often she was supposed to go through the dried and refrigerated food to dispose of expired and undated items. Staff member Y stated she thought she was supposed to discard refrigerated items three days after the opened date, but she was not completely sure. Staff member Y stated the food should have been dated for when to discard it and did not know of the process, or who was responsible for discarding items, or what process was used to date produce in the refrigerator. Staff member Y stated there should be a received date for all produce. Staff member Y stated employee drinks should not be in the food prep area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on [DATE] at 11:30 a.m., the bread from the previous day's observation was still undated and opened, without twist ties to close the bags up, two boxes of cups and plastic silverware were sitting on the floor of the dry goods storage room, the stand mixer had more white, crusted particles on it, and the stove still had a black, greasy film on it. During an interview on [DATE] at 12:10 p.m., staff member A stated staff member U would be responsible for auditing the kitchen for cleanliness and food dates. During an interview on [DATE] at 9:26 a.m., staff member U stated she was the as needed resource for the kitchen staff. Staff member U stated she did a monthly audit of the kitchen's safety and sanitization practices. Staff member U stated she looked at dates of food and cleanliness of the kitchen facility. Staff member U stated the staff should go by the delivery date of food items and toss them out six months after the delivery date. Staff member U stated she did a date review and audit on the morning of [DATE], prior to surveyors arriving. Staff member U stated all kitchen staff were responsible for dating, restocking, and disposing of expired food. During an observation on [DATE] at 4:30 p.m., two full pork loin rolls, wrapped in clear plastic wrap, were thawing on a cookie sheet on the countertop in ambient air, without running water over them. During an interview on [DATE] at 10:28 a.m., staff member R stated the pork loins, being thawed from the prior evening, were in the cooler that morning. Staff member R stated staff member X thawed the pork loin last night, and staff member R was slow cooking it at that time. During an interview on [DATE] at 10:30 a.m., staff member X stated she got sidetracked the previous night, and left the thawing pork loins out on the sink counter for a few hours. Staff member X stated she thought put the pork loins in the cooler around 4:00 p.m. Staff member X stated she knew she was supposed to thaw the loins in the cooler, instead of the sink. During an interview on [DATE] at 10:35 a.m., staff member Y stated the pork loins were put in the cooler the previous night, just before dinner, around 5:00 p.m. Staff member Y stated she knew she should have thawed them under running water, and would go educate the staff then. Staff member Y stated she knew for sure the pork loin was out for 2 hours, and was still frozen solid, so she felt it was still safe to serve. A review of a facility document, titled, Food and Nutrition Services Use by Date Guidelines, undated, showed: -The Manufacturer's expiration date, when available, is the 'use by' date for unopened items . -Guidelines apply, regardless of storage location (kitchen, pantries, etc) -Shelf stable dry goods that do not have an expiration date will be dated using the ship date from the food vendor and must be used by 6 months of the ship date . - .Produce .'Use by' date as stated in expiration date or 7 days after opening or preparing . - .salad dressings .'Use by date' 30 days after opening . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Breads, rolls, buns, bagels- 'Use by' date or 7 days after opening .

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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** 45448 Based on observation, interview, and record review, the facility failed to follow CDC transmission based precautions guidelines for a COVID-19 outbreak for all 71 residents residing in the facility; failed to practice isolation precautions on contaminated laundry processed within the facility; failed to identify and follow the correct isolation precautions for residents with clostridium difficile infection for 2 (#s 21 and 76); and failed to clean resident bathrooms as needed, for 2 (#s 1 & 8) of 4 sampled residents. Findings include: 1. During an observation and interview on 2/27/23 at 1:38 p.m., staff member B informed the survey team the facility was currently in outbreak. All residents were currently in pre-emptive isolation. Staff member B said the facility had staff members that had tested positive for COVID-19, and one resident that had tested positive for COVID-19. The resident that had tested positive was not longer residing in the facility. Staff member B said an N-95 mask and eye protection were required for all staff while working around the residents. Upon entering the facility, no signage was noted on the external doors or the visitor check-in desk to alert visitors to the outbreak status of the facility. During an observation on 2/28/23 at 8:14 a.m., staff member F was serving meal trays to resident rooms in the 300 hallway. All resident room doors were noted to contain posted signs for droplet isolation and instruction for donning PPE. Staff member F exited room [ROOM NUMBER] wearing full PPE, blue cover gown, gloves, N-95 mask, and eye protection. Staff member F then entered room [ROOM NUMBER] wearing the same PPE from the previous room, no glove change or hand hygiene was performed. Staff member F then went to the meal tray cart, removed a meal tray, entered room [ROOM NUMBER] with the meal tray, served the resident the meal tray, exited the room with the dinner meal tray from the previous night, and placed it in the meal tray cart. Staff member F then removed a meal tray from the cart and delivered the meal to room [ROOM NUMBER], wearing the same PPE. No hand hygiene or PPE change was observed to occur. During an observation on 2/28/23 at 8:21 a.m., a staff member was observed walking down the 400 hallway, with a PPE blue plastic gown wadded in her hands, no gloves were worn. The staff member disposed of the PPE in a plastic receptacle, containing two clear garbage bags. The receptacle was positioned mid-way down the hallway, and one side was labeled for garbage, and the other side was labeled for linen. Neither side had a biohazard indicator. During an observation and interview on 2/28/23 at 8:24 a.m., staff member K was observed pushing an opened, two tier wheeled cart, containing resident meal trays, down the 400 hallway. Staff member K was observed delivering meal trays into four resident rooms that were designated to be on droplet isolation. Staff member K was observed to be wearing eye protection and N-95 mask below her nose. She had not donned the recommended PPE for droplet isolation identified on each resident doorway. Staff member F stated she had changed her gown between each resident. Staff member G was observed delivering meal trays to each resident room without changing her gown. Staff member G had her gown untied and was not wearing gloves. Staff member G asked the surveyor if she was required to change the gown between each resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 2/28/23 at 8:34 a.m., staff member G informed a visiting family member a blue gown and gloves were required, in addition to the N-96 mask and eye protection, while visiting in the facility during an outbreak. During an interview on 2/28/23 at 10:04 a.m., NF1 stated the community transmission levels were moderate at this time. NF1 said residents should not have been isolated in their rooms because there were no positive residents. NF1 said the concern was with staff members. NF1 said, I feel staff members should be wearing PPE because they are the ones that are transmitting (COVID-19) to the residents. NF1 said as long as the facility has no positive residents, residents should not be isolated in rooms and should be allowed to socialize. During an interview on 2/28/23 at 10:28 a.m., staff member A said the facility had a resident test positive for COVID-19 on 2/18/23. The positive resident was discharged to another facility on 2/22/23. The facility began testing all residents daily and all staff prior to their shift. All residents have been tested multiple times, and the facility has had no other residents testing positive. The facility began contact tracing with the first positive staff member and then went to broad-based isolation with the second positive staff member. Staff member A said the facility went into full outbreak status at that time and stopped all activities and dining in the dining room. Staff member A said they had been having difficulty with staffing the infection preventionist position, the infection preventionist quit mid shift when the state survey team entered the facility on 2/27/23. Staff member A said she had been educating staff on the proper handling of the outbreak and had been passing the information on to staff. Staff member A said she had been getting different directions on isolation practices and was confused, so her staff was confused. Staff member A said she had contacted NF1 for direction, and the information was confusing. She had then contacted the state on 2/23/23 for recommendations, and had not heard back. Staff member A said staff member D was certified, and was now assuming the infection preventionist position until another one could be hired. During an interview on 3/1/23 at 9:44 a.m., NF2 said when the facility notified the county of a COVID-19 outbreak, a letter was sent to the facility with a link to the current guidelines for the facility to reference. The facility had reached out to the county health department for direction. NF1 had been sending information for guidance. NF2 said she and NF1 tried to explain the difference between empirical and transmission-based precautions to the facility. NF2 said the facility was informed that residents that had not been identified with contact tracing, or tested positive, did not need to be in isolation. NF2 said the state office of infection prevention had offered to come in and educate the facility and staff while the facility was in outbreak. The facility had not accepted the offer at that time. Record review of a facility document, COVID-19 Infection Control Morning Meeting Addendum, dated the week of 2/19/23, showed the residents were tested for COVID-19 on 2/19/23 through 2/23/23. One resident tested positive on 2/19/23 through 2/22/23, when the resident was transferred to another facility. No other residents in the facility tested positive for COVID-19, and no residents showed symptoms of COVID-19. All residents were placed on precaution/isolation on 2/19/23. Record review of a facility document, Infection Control - COVID-19 Education, not dated, showed: . Masks: All staff and visitors are required to wear a mask for source control. The mask should be worn over the nose and mouth. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	.Gowns are for single use only and should not be multiple interactions with the same resident or for residents with the same diagnosis. Gowns should be disposed of when removed and placed in the biohazard container. Record review of a facility provided email from NF1, dated 2/28/23 at 10:54 a.m., showed: .Residents in Transmission Based Precautions: As we discussed earlier, I have recommended the staff currently interact with residents wearing droplet precaution PPE. This is not due to the residents being in Transmission Based Precautions themselves or requiring any isolation. This is instead being recommended due to the on-going transmission that is occurring between staff members. I have recommended they wear this PPE when having longer than 15-minute interactions with residents to stop any possible transmission to the resident from potentially exposed staff members. .As of right now, communal dining and activities have been cleared to continue by me, but I have also consulted the state on this matter to make sure that they agree with this decision. .As of this time I am recommending the following PPE be worn by staff: N-95 or NOISH approved respirator, Gloves, Eyewear. Record review of a facility provided email from NF1, dated 2/28/23 at 3:09 p.m., showed: .Asymptomatic Residents/Patients who were a close contact: -In general, asymptomatic residents do not require empiric use of Transmission-Based Precautions while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. 2. During an interview and observation on 3/1/23 at 9:19 a.m., staff member I said laundry was collected by CNA staff, taken to the dirty utility room, and placed in the laundry bin. The laundry bin was observed to be full and overflowing, with a clear white plastic bag lining the bin. Staff member I said when the laundry bag is from an isolation room, the laundry should be placed in a separate laundry bag. Staff member I said it was the aide's responsibility to place the isolation laundry into the correct bag. Staff member I was unable to answer why the laundry was overflowing, and not placed in the proper bag for safe laundering. Staff member I said the laundry was then taken to the laundry area, PPE was donned by laundry staff, and laundry was separated into bins as whites and colored items. The laundry was then placed into the washing machine, and the PPE gown was placed into the wash to be processed. Staff member I was unable to answer why laundry in separate bags were removed and sorted. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 3/1/23 at 9:28 a.m., staff member J was preparing to enter a resident room with a droplet isolation sign posted outside the door. Staff member J was wearing an N-95 mask and eye protection. She donned a blue cover gown and secured it with ties. Staff member J then reached into the glove box, removed a pair of gloves, and an extra glove came out of the box and fell to the floor. Staff member J picked up the glove from the floor and inserted it back into the glove box, donned the pair of gloves she had retrieved, and entered the room. She removed the blankets and bedding from the resident's bed, placed it in a small clear trash bag, obtained from the resident's garbage can, and placed the soiled bedding into the clear bag. The blankets and bedding were hanging out of the clear bag. Staff member J then obtained another bag from the resident's trash can and placed the disposable, absorbable pad, into the clear bag. She then placed both open bags on the floor, just inside of the resident room, removed her PPE, and disposed of the PPE in the biohazard receptacle in the resident room. Staff member J picked up the two bags containing biohazard items with her bare hands, and discarded the bags into a plastic receptacle containing two clear garbage bags, located in the middle of the 400 hallway. Neither bag in the receptacle were labeled as biohazard. Staff member J said she asked the nurse this morning if the resident laundry should be labeled as contaminated since all the residents were in isolation. Staff member J said the nurse was not sure. Staff member J said she did not know if she should be using the separate bags for the laundry. Review of a CDC document titled, Infection Control in Healthcare Settings, showed: . 7. Textiles (linen and laundry) Contact with textiles has not been implicated in the transmission of SARS-CoV. Therefore, no special handling procedures are recommended for linen and laundry that may be contaminated with SARS-CoV. -Store clean linen outside patient rooms, taking into the room only linen needed for use during the shift. -Place soiled linen directly into a laundry bag in the patient's room. Contain linen in a manner that prevents the linen bag from opening or bursting during transport and while in the soiled linen holding area -Wear gloves and gown when directly handling soiled linen and laundry (e.g., bedding, towels, personal clothing) as per Standard and Contact Precautions. Do not shake or otherwise handle soiled linen and laundry in a manner that might aerosolize infectious particles. -Wear gloves for transporting bagged linen and laundry. -Perform hand hygiene after removing gloves that have been in contact with soiled linen and laundry. -Wash and dry linen according to routine standards and procedures. https://www.cdc.gov/sars/guidance/i-infection/healthcare.html#:~:text=and%20Community%20Settings-,III.%20Infection%20Control%20in%20Healthcare%20Facilities,-Print (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/28/23 at 3:28 p.m., staff member D stated she was aware that resident #76 had C. diff. She stated resident #76 was diagnosed with C. diff on 1/14/23, before she was admitted to the facility. Staff member D stated she was put on contact precautions as soon as she entered the facility. Staff member D stated the facility would notify the nurse on the resident's unit, and the facility would expect that nurse would pass on the contact precaution information, and the specifics, to the rest of the floor staff. Staff member D stated she was not sure if the resident still had active C. diff. She stated the resident would be taken off contact precautions for C. diff after the resident had formed stool for 48 hours. Staff member D stated the facility did not retest if the resident had had C. diff in the past 6 weeks. Staff member D stated she was not aware of resident #21 having any signs or symptoms of C. diff and did not think she was on precautions for C. diff. Staff member D stated the nursing staff was supposed to report any signs and symptoms to her. Review of a nurse progress note for resident #21 dated 2/3/23 showed, Resident arrived in w/c via Van accompanied by facility transporter. Her son followed her over and was also present .Resident is incontinent of bladder. Also incontinent of bowels at the moment due to diarrhea r/t c-diff infection. Contact isolation precautions in place. Review of a MD communication note for resident #21, dated 2/13/23, showed, Completed ABX for C-diff. Remains lethargic family recommending labs get obtained. Review of a nursing progress note, Infection note, for resident #21, dated 2/25/23, showed, C-diff test ordered, awaiting collection. Resident having diarrhea and lethargic behavior. Will continue to monitor. Review of resident #76 Hospital Discharge paperwork, dated 1/30/23, showed: 1/11: readmitted to inpatient for right lobar PNA. Completed antibiotic course, weaned down to room air. Developed C-difficile colitis on 1/14, started PO vancomycin (completed 10 days), PO metronidazole added 1/18 (to complete 1/28). Review of nursing progress notes for resident #76, dated 2/11/23, showed, Resident having loose stools with strong odor. Droplet precautions continue. During an interview on 2/28/23 at 4:07 p.m., staff member D stated resident #s 21 and 76 now had the proper signage outside their rooms to show they were on contact precautions for C. diff. Staff member D stated resident #21 had orders for a C. diff test, and were waiting for the results. Resident #76 still had loose stool, and therefore should still have been on precautions for C. diff. During an observation on 3/1/23 at 7:58 a.m., resident #76 was eating breakfast in the dining room, sitting in her wheelchair, and sitting across from another resident. During an observation on 3/2/23 at 8:43 a.m. resident #76 was in the dining room eating breakfast at a table with another resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 3/1/23 at 8:34 a.m., staff member I donned a gown and entered resident #21's room with her breakfast tray. Staff member I rearranged items on her bed side table and set the breakfast tray down. Staff member I doffed the gown and exited resident #21's room. Staff member I used hand sanitizer and continued passing trays. She did not wash her hands with soap and water. Staff member I stated she did not know why the resident was on contact precautions other than for covid and was not told if the resident had any other illness. Review of the facility's Infection Log for 2/2023 did not show resident #76 had C. diff. Resident #21's C. diff was dated 2/5/23, and showed she was on isolation precautions. Review of a facility policy titled, Management of C. Difficile Infection, dated of 9/28/22 showed: .C. diff is a bacterium that causes diarrhea a colitis. It is shed in feces and is spread by direct contact with contaminated objects or the hands of persons who have touched a contaminated object . 5. General principles related to contact precautions for C. difficile: a. All staff to wear gloves and a gown upon entry into the resident's room and while providing care for the resident with C. difficile infection. b. Hand hygiene shall be preformed by handwashing with soap and water in accordance with facility policy for hand hygiene. c. Maintain on contact precautions for the duration of illness, but no less than 48 hours after diarrhea has resolved .7. Testing considerations: .c. Repeat testing (within 7 days) during the same episode of diarrhea is not recommended . e. After treatment, repeat testing is not recommended if the resident's symptoms have resolved. Do not test to detect cure, as residents may remain positive for equal to or greater then 6 weeks. f. A reoccurrence of symptoms following successful treatment and diarrhea cessation should be assessed by repeat testing .11. Surveillance: a. The Infection Preventionist shall conduct surveillance activities related to C. difficile based on the facility's infection control risk assessment and antibiotic stewardship program. 44769 During an observation on 2/28/23 at 8:26 a.m., feces and toilet paper bits were noted on the toilet seat of resident #1 and 8's shared bathroom. During an observation on 2/28/23 at 4:19 p.m., feces and toilet paper bits were noted on the toilet seat of resident #1 and 8's shared bathroom. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 3/1/23 at 9:05 a.m., feces and toilet paper bits were noted on the outer edge of one side of the toilet seat of resident #1 and 8's shared bathroom. During an interview on 3/1/23 at 8:56 a.m., staff member CC stated there were two people for the day to do housekeeping, and one was in laundry. We can't get to every room, housekeeping probably did not look at resident #1 and 8's shared bathroom all day. During an interview on 3/1/23 at 2:19 p.m., staff member A stated resident #1 and 8's room was a high touch room, and should have been checked by housekeeping more often, because those residents needed stuff picked up off the floor. A review of a facility policy, titled, Routine Cleaning and Disinfection, with an implemented date of 8/25/2022, showed: Policy: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Policy Explanation and Compliance Guidelines: . 4. Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include, but not limited to: .g. Toilet seats.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 45448 Based on interview and record review, the facility failed to offer, or ensure the resident's medical record contained documentation of a declination of refusal, including education regarding the benefits and potential risks associated, with the influenza vaccine, for 4 (#s 10, 35, 51, and 58) of 5 sampled residents. Findings include: During an interview on 2/28/23 at 10:28 a.m., staff member A said the facility was in outbreak for the flu from November 2022 through the middle of January 2023. The facility infection preventionist resigned in December, and a new infection preventionist was hired. The new infection preventionist resigned upon arrival of the state survey team. During an interview on 3/2/23 at 10:55 a.m., staff member C and staff member E said the facility had identified an issue with the influenza vaccinations. Staff member C said she had identified 14 residents who were positive for influenza, three of those residents had been vaccinated, five of those residents have been discharged unvaccinated, and six residents remained in the facility and were unvaccinated. Staff member E said the audit of influenza vaccinations of residents was performed and consents were obtained after the state agency requested the information. Record review of resident #10's electronic medical record showed resident #10 had not received an influenza vaccination as of 2/28/23. Review of a facility document, Influenza Vaccine Consent Form, showed resident #10 declined the influenza vaccination on 2/28/23. Record review of resident #35's electronic medical record showed resident #35 had not received an influenza vaccination as of 2/28/23. Review of a facility document, Influenza Vaccine Consent Form, showed resident #35's husband verbally declined an influenza vaccination on 2/28/23. Record review of resident #51's electronic medical record showed resident #51 had not received an influenza vaccination as of 2/28/23. Review of a facility document, Influenza Vaccine Consent Form, showed resident #51 declined the influenza vaccination on 3/1/23. Record review of resident #58's electronic medical record showed resident #58 had not received an influenza vaccination as of 2/28/23. Review of a facility document, Influenza Vaccine Consent Form, showed resident #58 gave consent for the influenza vaccination on 2/28/23. Review of a facility policy, Influenza Vaccination, revised 9/14/22, showed: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.9. The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and the resident received or did not receive the immunization due to medical contraindication or refusal.