STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555164	A. BUILDING _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR REHABILITATION & NURSING CENTER	900 NORTH CHURCH STREET LODI, CA 95240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Federal Recertification survey. The facility census was 124. The sample size was 26.	F 000	POC Received 9/13/2024 POC Approved 9/23/2024 BIC = 8/30/2024 per DB	
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of 26 sampled residents (Resident 72's) dignity was protected when the urine drainage bag was exposed to public view. This failure resulted in Resident 72 feeling embarrassed. Findings: Review of Resident 72's "ADMISSION RECORD," indicated the resident was admitted to the facility recently with diagnoses that included prostate gland enlargement that could cause urination difficulty.	F 557	POC entered on behalf of Kristine Perry, Administrator. PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. tHE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. F557---Respect, Dignity/Right to have	9/12/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/13/2024

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

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F 557	Continued From page 1 In a concurrent observation and interview on 8/19/24 at 8:58 a.m. in the resident's room, Resident 72 was in bed with his urine drainage bag hanging at the side of the bed facing toward the hallway. The door of the resident's room was wide open. The urine drainage bag contained yellow urine, was exposed, and visible from the hallway. Infection Preventionist (IP) verified Resident 72's urine drainage bag was exposed and stated it should have been covered with the dignity bag to protect the resident's dignity. In an interview on 8/21/24 at 12:07 p.m. in the Director of Nursing (DON's) room, the DON acknowledged, in the presence of the Assistant DON, the urinary drainage bag should have been covered for Resident 72. In an interview on 8/22/24 at 9:10 a.m. in Resident 72's room, Resident 72 indicated that he wanted his urine bag to be covered with the "blue bag [dignity bag]." The resident stated, "It's embarrassing without the blue bag."	F 557	Prsnl Property CFR(s): 483.10(e)(2) Correction for resident(s) affected: (1) The urine drainage bag for Resident 72 was covered with a dignity bag by the Infe tion Prevention Nurse (IPN) on 8/19/24. How to identify residents with potential to be affected by similar practice: (1) The IPN observed the remaining residents with urine drainage bags on 8/19/24 to potentially identify other residents without dignity bags. None were identified. Measures taken and put in place to maintain systematic changes: (1) On 8/28, 8/29 and 8/30/24, facility staff were in-serviced by the Director of Staff Development (DSD) and Director of Nursing (DON) on facility policy "Dignity - Promoting/Maintaining Dignity." Monitoring to ensure solution is sustained: (1) Weekly, x 2 months, the IPN/Designee will complete Compliance Rounds using the "Indwelling Catheter" autit tool, which includes observations of urine drainage bags to see that they are covered with a dignity bag. (2) Findings will be followed up on immediately for correction and will be reported to the Administrator and Quality Assurance Performance Improvement (QAPI) committee by the IPN/Designee until substantial compliance is met and	

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F 557	Continued From page 2	F 557	maintained, or as determined b the QAPI committee. Person(s) responsible for correction: The IPN is responsible for this correction, alleging compliance on 9/12/24.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to accommodate resident needs when call lights were inaccessible for three of 26 sampled residents. A. Resident 479 B. Resident 65 C. Resident 1 This failure prevented the residents from getting help as quickly as possible when experiencing pain, discomfort or for any emergency needs. Findings: A. Resident 479 was admitted to the facility in the summer of 2024 with diagnoses which included multiple fractures, repeated falls and need for assistance with personal care.	F 558	F558---Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) Correction for resident(s) affected: (1) On 8/21/24, the DSD placed the call lights within reach of residents 1, 65 and 479. How to identify residents with potential to be affected by similar practice: (1) On 8/21/24, the DSD completed facility rounds on each resident room to potentially identify other resident's call lights that were out of reach. None were identified. Measures taken and put in place to maintain systematic changes: (1) On 8/28, 8/29 and 8/30/24, facility staff were in-serviced by the Director of	9/12/24

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F 558	Continued From page 3 During a review of Resident 479's "Progress Notes [PO]," dated 8/14/24, the PO indicated, "Admitted to [name of hospital] hospital for recurrent ground-level falls. It appears ...possibly precipitated by orthostatic hypotension and syncope [a sudden drop in blood pressure when standing up from a seated or lying position] ...now admitted to SNF for rehabilitation ...Plan ...Implement fall prevention strategies ..." During a review of Resident 479's Care Plan titled, "At risk for falls and injuries r/t [related to] ...Medications ...Hx [history of] repeated falls," dated 8/14/24, the CP indicated, "Keep call light within reach ..." During a review of Resident 479's Minimum Data Set (MDS, an assessment tool), dated 8/19/24, the MDS indicated he was alert and oriented, able to make his needs known. He required partial to moderate assistance with personal hygiene, showering and dressing. During an initial tour observation on 8/19/24 at 9:38 a.m., Resident 479 was observed lying on his back in bed with his call light hooked to the wall, not within reach. He did not answer coherently when spoken to. During a concurrent observation and interview on 8/19/24 at 9:40 a.m. with Licensed Nurse (LN) 9, LN 9 verified the observation and said, "It [call light] should be within reach ..." During an interview on 8/20/24 at 10 a.m. with the Director of Nurses (DON), the DON was asked about her expectations regarding the call light and said, "My expectation is that the resident call light should be in reach at all times."	F 558	Staff Development (DSD) and Director of Nursing (DON) on facility policy "Call Lights: Accessibility and Timely Response." Monitoring to ensure solution is sustained: (1) Weekly, x 2 months, the DSD/Designee will complete Compliance Rounds using the "Staff Development - Quality of Bedside Care" audit tool, which includes observations of call lights to see that they are within reach. (2) Findings will be followed up on immediately for correction and will be reported to the Administrator and Quality Assurance Performance Improvement (QAPI) committee by the DSD/Designee until substantial compliance is met and maintained, or as determined by the QAPI committee. Person(s) responsible for correction: The DSD is responsible for this correction, alleging compliance on 9/12/24.	

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F 558	Continued From page 4 B. During a review of Resident 65's Admission Record, he was admitted in the facility on 9/26/20 with diagnoses which included hemiplegia and hemiparesis (hemiplegia is paralysis of one side of the body; hemiparesis is one-sided muscle weakness) following cerebral infarction (brain obstruction) affecting left non-dominant side, acute respiratory failure with hypoxia (lack of oxygen in the body) and pain in right shoulder. During a concurrent observation and interview inside the room of Resident 65 on 8/19/24 at 9 a.m., Resident 65 was lying on his bed, awake, and his call light was found looped and hung by the wall away from his reach. When asked if he could find his call light, Resident 65 responded, "I don't know where it's at." Certified Nursing Assistant 1 (CNA 1) confirmed the call light was looped and hung by the wall away from Resident 65's reach. CNA 1 stated, "Yes, it should be within his reach so he can call for help anytime." During a review of Resident 65's Care Plan, dated 9/26/20, indicated, "Self-Care Deficit As Evidence by: Needs one person max assistance with ADLs [activities of daily living] Related Dementia, CVA [stroke], Weakness." During a review of Resident 65's Care Plan, dated 12/25/23, indicated, "The resident has impaired function/dementia or impaired thought processes r/t [related to] vascular Dementia [can cause problems with memory, speech or balance], Hx [history] of BIMS [Brief Interview for Mental Status, evaluates mental impairment] score <13 [indicates cognitive impairment]."	F 558		

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F 558	Continued From page 5 C. During a review of Resident 1's Admission Record, he was admitted in the facility on 12/15/17 with diagnoses which included hemiplegia affecting right dominant side and left non dominant side, generalized epilepsy [seizures] and pain in left wrist. During a review of Resident 1's MDS the BIMS indicated Resident 1 was moderately cognitively impaired and Section G indicated he was dependent on staff for assistance with activities of daily living. During a concurrent observation and interview inside the room of Resident 1 on 8/19/24 at 9 a.m., Resident 1 was lying on his bed, awake, partially covered with white linen, and yelled "I'm cold, I'm cold." His call light was found on the floor away from his reach. CNA 1 confirmed the call light was on the floor away from Resident 1's reach. CNA 1 stated, "Yes, his call light should be near him on his bedside so he can press the button." During an interview on 8/22/24 at 10:30 a.m., with the Assistant Director of Nursing, (ADON), the ADON stated, "The location of the call lights should be within reach for all residents and the staff must make sure that they are in place." During a review of Resident 1's Care plan, dated 4/27/20, indicated, "Acute Urinary Condition of painful urination. During a review of Resident 1's Care Plan, dated 4/17/19, indicated, "Resident at risk for choking/aspiration due to edentulous [lacking	F 558		

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F 558	Continued From page 6 teeth]." During a review of Resident 1's Care Plan, dated 12/15/17, indicated, "Self-Care Deficit As Evidence by: Needs 1-2 person max to total assistance with ADLs Related to left side hemiplegia." During a review of the facility policy and procedure (P&P) titled, "Call Lights: Accessibility and Timely Response," implemented 10/22, the P&P indicated, "The call system will be accessible to residents while in their bed ...within the resident's room."	F 558		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		9/12/24

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F 656	Continued From page 7 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement a care plan for one of 26 sampled residents (Resident 120) when the care plan for fall interventions was not carried out. This failure had the increased potential for injury should Resident 120 fall again. Findings: Review of Resident 120's "ADMISSION RECORD," indicated the resident was admitted	F 656	F656---Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) Correction for resident(s) affected: (1) On 8/21/24, the ADON immediately replaced the fall mats for Resident 120. How to identify residents with potential to be affected by similar practice: (1) On 8/24/24, ADON and DON compared fall interventions on resident care plans to the resident rooms to	

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F 656	Continued From page 8 to the facility recently with diagnoses that included right side paralysis, generalized muscle weakness and other abnormalities of gait and mobility. Review of Resident 120's medical records, a care plan, created on 7/11/24, indicated the resident was identified at risk for falls and injury related to medications, stroke, and a heart problem. The care plan set goals to minimize and manage risk for falls with interventions including "fall mats on sides of bed" implemented on 8/5/24. Review of Resident 120's medical records, "SBAR [Situation, Background, Assessment, Recommendation, a medical communication framework] fall Report of Incident 8hr - V3," created on 8/3/24, indicated the resident had an actual fall, documented, "Seen pt [patient] lying on the floor at bedside in left lateral position...Noted to have bleeding to his left side of the head...Pt was sent out to [Name of Hospital] ER [Emergency Room] for evaluation." In a concurrent observation and interview on 8/21/24 at 9:05 a.m., in Resident 120's room, with Licensed Nurse (LN 1), the resident was observed to be lying in his bed. There were no fall mats at the side of his bed or anywhere in his room. LN 1 verified there was no fall mat in the resident's room and stated, "I don't see the fall mat at this moment." LN 1 then checked Resident 120's medical records at the nursing station and verified the resident's care plan for fall risk included the intervention for fall mats at the resident's bedsides. LN 1 stated the fall mats should have been placed at the bedside as care	F 656	potentially identify other residents with fall interventions not in place. One was identified (resident was at acute hospital) and corrected on 8/21/24. Measures taken and put in place to maintain systematic changes: (1) On 8/28, 8/29 and 8/30/24, facility staff were in-serviced by the Director of Staff Development (DSD) and Director of Nursing on facility policy "Care Plan, Comprehensive", including promptly notifying IDT of any fall intervention measure that is not in place, and how to locate the fall interventions on the resident Kardex in the electronic health record. Monitoring to ensure solution is sustained: (1) Weekly, x 2 months, Resident's assigned facility Ambassadors will complete the "Ambassador Program - Person Centered Rounding" form, which includes validation of fall care plan interventions are in place per the resident Kardex. (2) Findings will be followed up on immediately for correction and will be reported to the Administrator and Quality Assurance Performance Improvement (QAPI) committee by the assigned Managed (Ambassador)/Designee until substantial compliance is met and maintained or as determined by the QAPI committee. Person(s) resonsible for correction: The	

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F 656	Continued From page 9 planned. Review of the facility's December 2017 policy and procedure, "Care Plan, Comprehensive," stipulated, "The care plan is directed toward achieving and maintaining optimal status of health, functional ability, and quality of life..."	F 656	DON is responsible for this correction, alleging compiance on 9/12/24.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to meet the professional standards of practice of nursing for one of 26 sampled residents (Resident 20) when a medication was not administered as ordered. This failure had the potential for ineffective medication therapy for Resident 20. Findings: Review of Resident 20's medical record, "ADMISSION RECORD," indicated the resident was admitted to the facility recently with the diagnoses that included chronic lymphocytic leukemia, a type of cancer of the blood and bone marrow. A medication administration observation was conducted on 8/20/24 at 9:20 a.m. for Resident 20 by Licensed Nurse (LN 2). The medication	F 658	F658---Services Provide Meet Profession Standards CFR(s): 483.21 (b)(3)(i) Corrections for resident(s) affected: (1) On 8/21/24, the Ferrous Sulfate was received from Omnicare Pharmacy's over the counter (OTC) stock via rush (STAT) order, immediately placed on the medication care and then administered to Resident 20 by the Licensed Nurse (LN). How to identify residents with potential to be affected by similar practice: (1) On 8/21/24, a Medication Not Administered report was run by the Administrator to potentially identify other residents who did not receive Ferrous Sulfate as ordered due to being unavailable. Four other residents were identified as not receiving Ferrous Sulfate due to being unavailable.	9/12/24

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F 658	Continued From page 10 administration by LN 2 was reconciled with Resident 20's medication orders and noted that the resident had a physician order, dated 4/5/24, for Ferrous Sulfate 325(65 Fe, a mineral) mg (milligram, a unit of measurement) 1 tablet daily that was not administered during the medication administration. In an interview on 8/20/24 at 2:17 p.m., LN 2 verified Resident 20 had the physician order for Ferrous Sulfate and stated it was not administered because the medication was not available. Review of the facility's policy and procedure, revised 4/1/22, stipulated, "Facility staff should comply with Facility policy, Applicable Law and the State Operations Manual when administering medications." Review of the Nursing Practice Act Rules and Regulations indicated, "...the practice of nursing...means...Direct and indirect patient care services, including, but not limited to, the administration of medications...ordered by...a physician, as defined by Section 1316.5 of the Health and Safety Code." In an interview on 8/21/24 starting at 12:07 p.m., the Director of Nursing (DON), with the Assistant DON present, acknowledged the ferrous sulfate should have been administered to Resident 20 as ordered during the medication administration.	F 658	(2) On 8/21/24, the Ferrous sulfate was received from Omnicare Pharmacy's over the counter (OTC) stock via rush (STAT) order, immediately placed on the medication carts and then administered to these four residents by the Licensed Nurse (LN). Measures taken and put in place to maintain systematic changes: (1) On 8/28, 8/29 and 8/30/24, LNs were in-serviced by the Director of Staff Development (DSD) and Director of Nursing (DON) on facility policies "6.0 General Dose Preparation and Medication Administration" and 4.3 Reordering, Changing, Receiving Products and Services from Omnicare Pharmacy". Monitoring to ensure solution is sustained: (1) The DON/Designee will run and review a Medication Not Administered report from the medical record platform Point Click Care (PCC) on weekdays x 1 month and then weekly x 2 months to potentially identify medications not administered to residents due to being unavailable. (2) Findings will be brought to the resident specific LN assigned for immediate follow-up to ensure meds are reordered from the pharmacy or retrieved from OTC House Stock for Central Supply and promptly administered. (3) Findings will be reported to the Administrator and Quality Assurance	

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ARBOR REHABILITATION & NURSING CENTER	900 NORTH CHURCH STREET LODI, CA 95240

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F 658	Continued From page 11	F 658	Performance Improvement (QAPI) committee by the DON/Designee until substantial compliance is met and maintained or as determined by the QAPI committee. Person(s) responsible for correction: The DON is responsible for this correction, alleging compliance on 9/12/24.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure nail care was provided for one of 26 sampled residents (Resident 96). This failure had the potential for Resident 96 to sustain injury, neglected personal grooming and infection. Findings: A review of Resident 96's Admission Record indicated Resident 96 was admitted in the facility on 9/22/23, with the diagnosis that included Type 2 Diabetes Mellitus (high blood sugar), gout (painful form of arthritis), sepsis (infection), and muscle weakness. A review of Resident 96's Minimum Data Set (MDS-tool used to direct care), Brief Interview for	F 677	F677---ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) Correction for resident(s) affected: (1) On 8/21/24, Resident 96's fingernails were trimmed by the DON. How to identify residents with potential to be affected by similar practice: (1) On 8/21/24, the DSD completed facility rounds on each resident room to potentially identify other residents with long fingernails. None were identified. Measures taken and put in place to maintain systematic changes: (1) On 8/28, 8/29 and 8/30/24, Licensed/Certified nursing staff were in-serviced by the DSD and DON on	9/12/24

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F 677	Continued From page 12 Mental Status (BIMS, evaluates mental impairment] Section C - Cognitive Patterns, dated 6/12/24, showed Resident 96's cognition is intact with a score of 15. Section E - Behavior, dated 6/12/24, indicated, Resident 96 did not have a history of rejecting care. During a concurrent observation and interview on 8/19/24 at 10:10 a.m., with Resident 96 inside his room, Resident 96 was observed with contracted right hand, the skin was dry and peeling, his index, middle and ring fingers were tucked like a closed fist. The nails were long, with brownish/blackish substance underneath the fingernails. The pinkie/fifth digit finger was tucked under the ring finger and Resident 96 was unable to stretch it out. Resident 96 stated, "I can't straighten up my fingers, it hurts if I try to." When asked about his pinkie fingernail, Resident 96 confirmed, "My fingernail is very long for a year now and it's digging into my skin. I know because I can feel it, and I told the nurses about it, but they just ignored me." Resident 96 further stated some nurses tried to trim his fingernails in the past but gave up and never tried again. During an interview on 8/21/24 at 2:15 p.m., with License Nurse 4 (LN 4), LN 4 confirmed Resident 96's right hand has been contracted for a long time and he's unable to unfold his fingers. LN 4 stated, "I tried to trim his nails, but I can't, because he's contracted and he can't open his fingers," During an interview on 8/22/24 at 1030 a.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 96, needed assistance from the staff for his daily care such as trimming	F 677	facility policy "Bath, Bed", which includes care of fingernails. Monitoring to ensure solution is sustained: (1) Weekly, x 2 months, the DSD/Designee will complete Compliance Rounds using the "Staff Development-Quality of Bedside Care" audit tool, which includes observations of fingernails being trimmed. (2) Findings will be followed up on immediately for correction and will be reported to the Administrator and QAPI committee by the DSD/Designee until substantial compliance is met and maintained, or as determined by the QAPI committee. Person(s) responsible for correction: The DSD is responsible for this correction, alleging compliance on 9/12/24.	

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F 677	Continued From page 13	F 677		

his fingernails, but his right hand is contracted, and he is unable to open his fingers. The ADON further stated the expectation from the nurses is to do a full head to toe assessment as part of their nursing assessment and to report/document of their findings such as long fingernails. The ADON further stated, Resident 96's fingernails may injure his right hand because his nails are continuously growing and are not being trimmed.

A review of Resident 96's "Order Summary Report," dated 6/13/24, indicated, "Carrot-hand contracture of R hand."

A review of Resident 96's "Care Plan, [CP]" dated 9/24/23, indicated, "Self-Care Deficit As Evidence by: Needs assistance with ADLs Related to weakness ... CONTRACTURES: The resident has contractures of the RIGHT hand ..."

A review of Resident 96's CP dated 9/23/23, indicated, "The resident has Diabetes Mellitus ..."

During a review of the facility's policy and procedure titled, "Bath, Bed," dated 2006, indicated, " ...To inspect the body ...Observe condition of skin. Range of motion limitation. ADL function ...Wash neck, arms ...Dry skin well ...Give special care to umbilicus, folds of skin, hands ...Care of fingernails and toenails is part of the bath. Be certain nails are clean ...Fingernails and toenails of diabetic residents are cut by the licensed nurse or podiatrist ..."

A review of Resident 96's medical record for 2024 had no documentation that the facility consulted with available resources, including a podiatrist to care for Resident 96's nails when

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F 677	Continued From page 14 they were unable to care for his nails within the facility.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide meaningful ongoing activities for one of 26 sampled residents (Resident 120). This failure caused the resident to feel trapped. Findings: Review of Resident 120's "ADMISSION RECORD," indicated the resident was admitted to the facility recently with diagnoses that included right sided paralysis, heart and lung problems. In an observation on 8/19/24 at 9:36 a.m. in Resident 120's room, the resident was lying in bed with the TV on. The resident stated his right side of the body was paralyzed and wanted to do something to get it stronger, but showers were	F 679	F679---Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) Correction for resident(s) affected: (1) On 9/12/24, the MDS Coordinator and Activity Assistant completed a new Activity Assessment, care plan/Kardex for resident 120 to better align with his preferences for meaningful activities. How to identify residents with potential to be affected by similar practice: (1) Between 9/3-9/6/24, the Resident's assigned facility Manager (Ambassador) interviewed and observed other residents residing in the facility to potentially identify other residents without meaningful activities. None were identified.	9/12/24

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F 679	Continued From page 15 pretty much the only time he got out of bed. The resident complained he spent his day watching TV because the facility did not get him up and put him in the wheelchair. Resident 120 stated he liked to attend group activities. There were no books, magazines, crossword puzzles or any other activity materials visible in the room. The resident stated, "they come out once in a while and went away" when asked if the activities provided room visits. The resident stated, "I feel trapped...I feel like I am insignificant to them." Review of the facility provided 2015 policy and procedure, "Residents' Rights to Refuse Activities," stipulated, "Continuously offer residents a wide range of activity program opportunities so that they may explore potential leisure interests...Continue to invite residents to group programs, offer one-to-one activity contacts and/or offer materials for independent leisure pursuits...Record activity participation or attendance." Review of Resident 120's medical record included a care plan initiated 7/11/24 indicated the resident to spend, "...the majority of his free time resting in the comfort of his room involved in independent leisure pursuits..." with interventions included, "ROOM VISIT CHECK-INS: Activity staff and/or volunteers will offer room visit check-ins for Added socialization Friendly conversation topics may include but are not limited to: Welcome pet visits, Offer materials for independent use, Offer snacks from snack cart." In an interview on 8/22/24 at 9:10 a.m. in the Activity Director's (AD) room, the AD verified Resident 120 did not attend group activities and	F 679	Measures taken and put in place to maintain systematic changes: (1) On 9/12/24, the activity staff members were in-serviced by the Administrator on facility policies and forms "Residents' Rights to Refuse Activities", "One-to-One log (Room Visits form)' and "Room Visit Schedule Form', which includes but not limited to offering a wide range of activities, inviting residents to group activities, offering one-on-one activity contacts and/or materials for individual leisure activities and recording of activity participation/attendance. Monitoring to ensure solution is sustained: (1) Weekly, x 2 months, Resident's assigned facility Ambassadors will complete the "Ambassador Program - Person Centered Rounding form, which includes interview/observations of residents for meaningful activities. Findings will be reported to the Administrator and activity department staff for immediate correction. (2) Weekly, x 2 months, the Administrator will audit "Room Visits Form" and Room Visit Schedule Form" for accuracy and completion. Findings will be reported to the activity department staff for immediate correction. (3) Findings will be reported to the QAPI committee by the Administrator/Designee until substantial compliance is met and maintained or as determined by the QAPI committee.	

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F 679	Continued From page 16 there was no 1:1 room visit log, or any list of activity materials provided for Resident 120 to pursue independent leisure in his room. The AD stated the activity department visited resident in the morning daily to greet each resident, however, acknowledge it was not considered an activity. The AD stated the facility should have provided meaningful ongoing activities to Resident 120 and indicated watching TV all day long in bed was not a meaningful ongoing activity. The AD stated, "We should have gotten him up."	F 679	Person(s) responsible for orrection: The Administrator is responsible for the correction, alleging compliance on 9/12/24.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		9/12/24

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F 755	Continued From page 17 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to supply medication for one of 26 sampled residents (Resident 20) when ferrous sulfate, an iron supplement, was not available for administration. This failure resulted in Resident 20 not receiving the mineral supplement for five days. Findings: Review of Resident 20's medical record, "ADMISSION RECORD," indicated the resident was admitted to the facility recently with the diagnoses that included chronic lymphocytic leukemia, a type of cancer of the blood and bone marrow. Review of Resident 20's medical record included a physician order, dated 4/5/24, for ferrous sulfate 325(65 Fe, a mineral) mg (milligram, a unit of measurement) 1 tablet every day. During the medication administration observation on 8/20/24 starting at 9:20 a.m., Licensed Nurse (LN 2) did not administer ferrous sulfate.	F 755	F755---Pharmacy Services/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) Correction for resident(s) affected: (1) On 8/21/24, the Ferrous Sulfate was received from Omnicare Pharmacy's Over the counter (OTC) stock via rush (STAT) order, immediately place on the medication cart and then administered to Resident 20 by the Licensed Nurse (LN). How to identify residents with potential to be affected by similar practice: (1) On 8/21/24 a Medication Not Administered report was run by the Administrator to potentially identify other residents who did not receive Ferrous Sulfate as ordered due to being unavailable. Four other residents were identified as not receiving Ferrous Sulfate due to being unavailable. (2) On 8/21/24, the Ferrous Sulfate was received from Omnicare Pharmacy's over the counter (OTC) stock via rush (STAT) order, immediately placed on the medication carts and then administered to	

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F 755	Continued From page 18 Review of Resident 20's laboratory reports dated 5/14/24 and 5/18/24, indicated the resident's red blood cell counts were low at 3.81 and 3.83 (normal reference range: 3.93-5.22 millions/microLiter, a unit of measurement) respectively and the MPV (Mean Platelet Volume, a blood test that measures the average size of platelets) were also low at 9.0 and 9.1 (normal reference range: 9.4-12.4 femtoLiter, a measue of volume) respectively. Review of Resident 20's August 2024 Medication Administration Record (MAR) indicated the resident did not receive the iron supplement from 8/16/24 to 8/20/24 for five days. In an interview on 8/21/24 at 11:28 a.m., LN 2 stated she did not administer the iron supplement because there was no medication available. LN 2 verified Resident 20 did not receive the medication for five days since 8/16/24, and stated it was the facility policy that LNs are to let the central supply know when the over-the-counter medications were down to two bottles. LN 2 indicated LNs should have informed the central supply before ferrous sulfate ran out. In an interview on 8/21/24 at 12:07 p.m. in the Director of Nursing (DON's) office, the DON, in the presence of Assistant DON (ADON), acknowledged the facility should have supplied the medications as ordered by the physician.	F 755	these four residents by the Licensed Nurse (LN). Measures taken and put in place to maintain systematic changes: (1) On 8/28, 8/29 and 8/30/24, the LNs were in-serviced by the DSD and DON on facility policies "6.0 General Dose Preparation and Medication Administration" and "4.3 Reordering, Changing, Receiving Products and Services from Omnicare Pharmacy". Monitoring to ensure solution is sustained: (1) The DON/Designee will run and review a Medication Not Administered report from the medical record platform Point Click Care (PCC) on weekdays x 1 month and then weekly x2 months to potentially identify medications not administered to residents due to being unavailable. (2) Findings will be brought to the resident specific LN assigned for immediate follow-up to ensure meds are reordered from the pharmacy or retrieved from OTC House Stock from Central Supply and promptly administered. (3) Findings will be reported to the Administrator and QAPI committee by the DON/Designee until substantial compliance is met and maintained or as determined by the QAPI committee. Person(s) responsible for correction: The DON is responsible for this correction, alleging compliance on 9/12/24.	

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F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to ensure: 1. Expired medical supplies were removed from the medication storage room, and 2. Medication carts were maintained clean and in an orderly manner. These failures had the potential for accidental	F 761	F761---Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) Correction for resident(s) affected: (1) No residents were affected. The ADON immediately removed expired supplies and all med carts were checked for loose pills. None were identified.	9/12/24

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F 761	Continued From page 20 use of expired supplies and for drug diversion for a census of 124. Findings: 1. During the medication storage room check on 8/19/24 starting at 2:35 p.m. in the North Station with the Licensed Nurse (LN 4), an expired Mic-Key continuous feed extension set (a feeding tube extension) was stored in the medication room available for use. The expiration date was 10/7/23. There were Covid-19/Flu test kits also stored in the bag with the expiration date of 12/31/23. LN 4 verified the expiration dates of the medical supplies and stated they should have been discarded. Review of the facility's 8/1/24 revised policy and procedure, " Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles," stipulated, "Facility should ensure that medications and biologicals for expired...stored separately, away from use, until destroyed or returned to the provider." 2. a. During the medication cart check on 8/19/24 at 3:12 p.m. in the East Nursing Station, with LN 5 and the Assistant Director of Nursing (ADON), two loose pills and a broken pill were observed in the cart. LN 5 verified the loose pills. b. During the first of two medication cart checks on 8/19/24 at 3:19 p.m. in the South Station, with LN 6 and the ADON, one loose pill, loose white powder and brownish residue were observed in the back of the drawer of the medication cart. LN 6 verified the findings.	F 761	Measures taken and put in place to maintain systematic changes: (1) On 8/28, 8/29 and 8/30/24, LNs were in-serviced by the DSD and DON on facility policy "5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles. Monitoring to ensure solution is sustained: (1) Weekly, x 2 months the night shift LNs will audit the med rooms and med carts using the "Medication Room Compliance" and "Medication Care Compliance" audit tools to ensure that there are no expired medications, supplies or loose pills identified. (2) Findings will be followed up on immediately for correction by the LNs and will be reported to the DON and QAPI committee until substantial compliance is met and maintained or as determined by the QAPI committee. Person(s) responsible for correction: The DON is responsible for this correction, alleging compliance on 9/12/24.	

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F 761	Continued From page 21 c. During the second of two medication cart checks on 8/19/24 at 3:27 p.m. in the South Station, with LN 7 and the ADON, ten loose pills were observed in the cart. LN 7 verified the loose pills. The ADON stated LNs on the cart were responsible for cleaning the cart and indicated the facility expectation was no loose pills to be found in the medication carts. Review of the facility's 8/1/24 revised policy and procedure, " Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles," stipulated, "Facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts..." In an interview on 8/21/24 at 12:07 p.m. in the Director of Nursing (DON's) office with the ADON, the DON stated the Covid-19 test kits with the expiration date 12/31/23 in the medication storage room were not expired because the facility found a manufacturer's memo on their website that the company extended the expiration date of the Covid-19 test kits. The DON however, acknowledged the expired biologicals in the medication storage room over 8 to 10 months should have been removed. In an interview on 8/21/24 at 2:45 p.m. in the DON's office, the ADON clarified that the facility found the manufacturer's memo for the Covid-19 test kits expiration date extension after the medication storage room inspection done on 8/19/24. The ADON stated the Covid-19 test kits should have been removed when the medication storage room was cleaned.	F 761		
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		9/12/24

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F 812 SS=E	Continued From page 22 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow professional standards for food service safety when Quat (Quaternary Ammonium, a sanitizer) strips (measure the concentration of sanitizer) currently being used were expired. This failure increased the risk for food borne illness for the residents that consumed facility prepared meals in a total facility census of 124. Findings: During an initial tour observation of the kitchen	F 812	F812--Food Procurement, Store/Prepare/Service-Sanitary CFR(s): 483.60(i)(1)(2) Correction for resident(s) affected: (1) No residents were affected. On 8/19/24, the Certified Dietary Manager (CDM) removed and replaced the expired Quaternary Ammonium Test (QUAT) strips and retested the sanitizing solution the the new QUAT strips. The results were the same, indicating that the concentration of the sanitizing solution was within normal range.	

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F 812	Continued From page 23 on 8/19/24 at 8:38 a.m. with the Dietary Manager (DM), DM was asked to check the sanitizer level of the Quat solution used to sanitize surfaces in the kitchen. The bucket was tested at 150 ppm (parts per million, a measurement) and then the DM was asked for the expiration date on the strips. The DM verified the Quat strips expired 5/15/24. During a concurrent interview, the DM was asked his expectations regarding the checking of expiratory dates of the sanitizer strips and said, "I expect the date should be checked frequently enough that they are not expired." During an interview on 8/20/24 at 10:43 a.m. with the Registered Dietician (RD), the RD was asked her expectations for checking expiratory dates of the "Quat strips" (Quaternary Ammonium, test strips used to test sanitizing solution chemical levels) and said, "Sanitizer strips [expiration date] should be checked before usage." During a review of the facility policy and procedure (P&P) titled, "CHEMICAL SANITIZING," dated 2/09, the P&P indicated, "Ensure equipment and work surfaces are sanitized...For equipment that cannot be put in water, use double strength sanitizer and water...Multi-Quat 150-400ppm [parts per million] ..." There was no instruction to check the date of expiration of the strips. During a review of the facility document titled, "Sanitizer Log (SL)," dated 8/24, the SL indicated, "Check sanitizer solution with the proper test strip..." There were no instructions to check the date of expiration of the test strips.	F 812	How to identify residents with potential to be affected by similar practice: (1) On 8/19/24, the CDM inspected other bottles of QUAT strips in inventory. None were expired. Measures taken and put in place to maintain systematic changes: (1) The kitchen staff were in-serviced by the CDM on facility policy "Chemical Sanitizing". (2) The monthly Kitchen Sanitation audit form was revised by the Registered Dietitian on 8/25/24 to include validation of QUAT strips are not expired. Monitoring to ensure solution is sustained: (1) Monthly, x2 months, the RD will complete a Kitchen Sanitation audit, which includes verifying that the QUAT strips are not expired. (2) Findings will be followed up on immediately for correction and will be reported to the admministrator and QAPI committee by the RD/Designee until substantial compliance is met and maintained or as determined by the QAPI committee. Person(s) responsible for correction: The CDM is responsible for this correction, alleging compliance on 9/12/24.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		9/12/24

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F 880	Continued From page 24 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		

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F 880	Continued From page 25 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for of census of 124 residents when:	F 880	F880---Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) Correction for resident(s) affected: (1) On 8/19/24, the IPN covered the oxygen cannula and tubing with a respiratory bag for resident 116. (2) No residents were identified and	

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F 880	Continued From page 26 1. Resident 1's nasal cannula (thin, flexible tube with two prongs that fit into the patient's nostrils and is attached to an oxygen source), and tubing were laying on top of the oxygen condenser (a medical device that takes air from the surroundings, extracts oxygen and filters it into purified oxygen); 2. Hand hygiene was not practiced during the meal service; 3. Resident 72's urinary bag touched the floor; 4. PPE (Personal Protective Equipment) was not donned for Resident 38; and 5. Linen cart was not covered, and Laundry Aide's (LA) uniform touched the clean personal clothes of the residents while hanging them. These deficient practices had the potential to spread infection and disease among residents, staff, and visitors. Findings: 1. Resident 116 was admitted to the facility in the summer of 2024 with diagnoses which included chronic obstructive pulmonary disease (COPD, a lung disease), respiratory failure and shortness of breath. During a review of Resident 116's Minimum Data Set (MDS, an assessment tool), dated 7/9/24, the MDS indicated Resident 116 had moderate memory loss. She required partial/moderate assistance to maintain personal hygiene. During a review of Resident 116's physician order (PO), dated 7/10/24, the PO indicated, "Oxygen at 2 LPM [liters per minute, a measurement of	F 880	documented by the survey team for individual corrective measures related to hand hygiene during meal pass. (3) On 8/19/24, the IPN secured Resident 72's urine bag to prevent it from touching the floor. (4) On 8/19/24, the IPN provided one-on-one education on Enhanced Barrier Precautions to Resident 38's LN. (5) On 8/20/24, the IPN ensured that the linen cart was appropriately covered. The laundry aide self-identified when her uniform contacted the clean personal clothes, and she put the item back in the soiled linen barrel to be re-washed. How to identify residents with potential to be affected by similar practice: (1) On 8/19/24, the IPN rounded on other residents with orders for Oxygen administration to potentially identify cannulas and tubing that were not covered with a respiratory bag. None were identified. (2) On 8/23/24, the IPN observed meal service during lunch time to potentially identify other staff with non-compliance related to hand hygiene. None were identified. (3) The IPN observed the remaining residents with uring drainage bags on 8/19/24 to potentially identify other uring bags touching the floor. None were identified. (4) On 8/23/24, the IPN observed finger sticks and insulin administration for diabetic residents who were also on Enhanced Barrier Precautions to	

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F 880	Continued From page 27 volume] via NC [nasal cannula] ..." During a review of Resident 116's care plan (CP) titled, "Acute Respiratory Condition (SOB [shortness of breath]), undated, the CP indicated "O2 [oxygen] as ordered..." During an initial tour observation on 8/19/24 at 10:14 a.m., Resident 116's nasal cannula was found on top of the oxygen concentrator uncovered. During a concurrent observation and interview on 8/19/24 at 10:19 a.m. with the Director of Nurses (DON), the DON verified the observation and said, "The oxygen cannula is not covered. It should be covered..." During an interview on 8/22/24 at 7:17 a.m. with the infection Preventionist (IP), the IP was asked what her expectations were for covering nasal cannula when not in use and said, "I expect the oxygen tubing to be in a respiratory bag, covered at all times, when not in use." During a review of the facility policy and procedure (P&P), titled "procedure-Oxygen Concentrator," undated, the P&P indicated "Store tubing/mask in a sanitary manner, such as in a clean plastic bag..." 2. a. During the dining observation on 8/19/24 starting at 12:15 p.m. in the main dining hall, Certified Nurse Assistant (CNA 2) was observed to be sitting next to a resident at the table and touching the resident on his back while talking to him. CNA 2 then pulled the resident's wheelchair by the wheel with her bare hand to the table in	F 880	potentially identify other LNs who did nnot don the proper Personal Protective Equipment (PPE). None were identified. (5) On 8/20/24, the IPN observed the other in-use linen carts and laundry observations to potentially identify other carts that were not fully covered and staff uniforms contacting clean personal clothing. None were identified. Measures taken and put in place to maintain systematic changes: (1) On 8/28, 8/29 and 8/30/24, facility staff were in-serviced by the DSD and DON on facility policies "Procedure-Oxygen Concentrator", "Hand Hygiene", Catheter Associated Urinary Tract Infection (CAUTI) Prevention", Enhanced Barrier Precautions" and "Clean Linen". Monitoring to ensure solution is sustained: (1) Weekly, x 2 months, the IPN/Designee will complete Compliance Rounds using the "Oxygen Concentrator", "Hand Hygiene and Glove Use Monitoring Form", "Indwelling Catheter", Enhanced Barrier Precautions", and "Laundry and Linen Handling" autit tools, which includes observations of all infection control items identified in findings one through five. (2) Findings will be followed up on immediately for corrrection and will be reported to the Administrator and QAPI committee by the IPN/Designee until substantial compliance is met and	

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F 880	Continued From page 28 order for the resident to sit close to and aligned with the table. CNA 2 then resumed serving drinks for other residents and pouring coke for another resident. CNA 2 did not wear gloves or perform hand washing during the process. In an interview on 8/19/24 at 1:14 p.m. in the dining hall, CNA 2 acknowledged she did not wash her hands after pulling the resident's wheelchair and before serving drinks for other residents. CNA 2 acknowledged she should have practiced hand hygiene for infection prevention control. b. During the dining observation on 8/19/24 starting at 12:15 p.m. in the main dining hall, Restorative Nursing Assistant (RNA 1) was observed pushing the drink cart and serving drinks for residents. RNA 1 stopped and stroked a resident's back with her hand who was dozing at the table as she said something to the resident. RNA 1 went back to her cart and continued serving drinks and crackers to other residents. RNA 1 then stopped at one table and poured a drink from the cup on the table to a resident's sippy cup (a training cup that is designed to prevent or reduces spills), closed the lid of the cup and gave the cup back to the resident. RNA 1 did not wash her hands or use hand sanitizer during these processes. In an interview on 8/19/24 at 1:29 p.m., RNA 1 acknowledged she did not wash her hands between the residents and stated she should have washed hands when she touched residents and/or objects or poured the juice in the cup into the resident's sippy cup.	F 880	maintained, or as determined by the QAPI committee. Person(s) responsible for correction: The IPN is responsible for this correction, alleging compliance on 9/12/24.	

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In an interview on 8/22/24 at 10:13 a.m. in the DON's office, with the Assistant DON present, the DON stated it was her expectation that staff touched residents then wash hands before taking another resident. The DON stated, "They should have washed their hands."

3. Review of Resident 72's "ADMISSION RECORD" indicated the resident was admitted to the facility recently with diagnoses that included enlarged prostate.

Review of Resident 72's medical record included a care plan for the resident being at high risk for urinary tract infection due to indwelling catheter which was initiated on 7/25/24. The care plan included an intervention, "Ensure catheter tubing and drainage bag are properly positioned to prevent back-flow or contamination."

In a concurrent observation and interview on 8/19/24 at 3:51 p.m. in Resident 72's room, Resident 72 was in bed with his urinary tubing fastened to the side of his bed. The resident's urine bag was laid on the floor with the collected urine in it. The lower half of the urine bag was touching the fall mat and the floor, and the rest of the bag was held upright position.

In a concurrent observation and interview on 8/19/24 at 3:51 p.m. in Resident 72's room, Licensed Nurse (LN) 8 verified the resident's urine bag was touching the fall mat and the floor. LN 8 stated the resident's urine bag should float above the floor, not touching the floor as it posed the risk to obtain a bacterial infection.

Review of the facility's 2012 policy and

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procedure, "CATHETER ASSOCIATED URINARY TRACT INFECTION (CAUTI) PREVENTION," stipulated, "Keep the collection bag and tubing off the floor."

In a concurrent observation and interview on 8/21/24 at 2:47 p.m., in Resident 72's room, the resident was in bed with his urine bag fastened to the bed. Again, the urinary bag was observed to be touching the floor. LN 1 verified the observation and stated the resident urine bag was touching the floor because the resident's bed was low. LN 1 acknowledged the urine bag should not touch the floor for infection control issues.

4. Review of Resident 38's medical record, "ADMISSION RECORD" indicated that the resident was admitted to the facility in the Spring of 2024 with diagnoses that included diabetes. Her medical record, "[Name (#)]" indicated she was on enhanced precaution that required gown and gloves when performing high contact tasks due to wound.

During the medication administration observation on 8/20/24 starting at 11:42 a.m., LN 3 checked Resident 38's finger stick blood sugar (FSBS) before the lunch tray was served in her shared room. The resident's FSBS results required 2 units of insulin injection according to the sliding scale insulin order by the physician. LN 3 prepared the insulin at the medication cart at the door of the resident's room, went into the room and injected the insulin to the resident's right upper arm. During the process, LN 3 did not wear a protective gown that was required for enhanced precautions. When asked about donning PPE

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F 880	Continued From page 31 (Personal Protective Equipment) for Resident 38, LN 3 acknowledged he should have worn the gown when he checked the FSBS and administered the insulin. LN 3 stated, "I completely forgot about it." 5. a. During a concurrent observation and interview on the South hallway on 8/20/24 at 1:30 p.m., LA 2 pushed a partially covered linen cart that contained clean linens. When asked, LA 2 acknowledged the linen cart was partially covered, and stated, clean linens must be fully covered and protected at all times to promote infection control prevention. b. During a concurrent observation and interview in the laundry room on 8/21/24 at 11:10 a.m., LA's uniform touched the clean personal clothes of the residents while hanging them on the hangers. LA acknowledged she's been in and out of the laundry room and her uniform may have been contaminated and shouldn't touch the clean clothes to prevent cross contamination. During an interview in the laundry room on 8/21/24 at 11:25 a.m., with the Environmental Services Manager (EVS Mgr.), the EVS Mgr. confirmed, LA's uniform should not touch the clean clothes, and all laundry should be handled and transported in a sanitary method to promote infection control. During an interview on 8/21/24 at 2:40 p.m., with the IP, the IP stated, the staff must practice hand hygiene during meal service, after touching a chair and before touching residents' utensils. Linen cart contained clean linens must be fully covered at all times to protect it from dust and soil during transport, to avoid cross	F 880		

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F 880	Continued From page 32 contamination, "They should cover it all up." The IP further stated, "The LA must prevent her uniform from touching the clean clothes because their uniforms are contaminated, infection control must be practiced all the time." During a review of the facility's policy and procedure titled, "LAUNDRY MANUAL POLICIES & PROCEDURES," effective 8/14, indicated, " ...1. Clean linen shall be stored, handled and transported in a manner that prevents cross-contamination ..."	F 880		