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F 000	INITIAL COMMENTS	F 000		
✓ ok/CP	Correction date: January 23, 2025 The following deficiencies resulted from the facility's Annual Recertification Survey conducted on December 2, 2024 to December 19, 2024. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.			
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.	F 607		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 1/16/25

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 607	Continued From page 1 §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on employee file review, staff interview, and policy review, the facility failed to complete a criminal record check and dependent adult/child abuse registry check prior to an employee's rehire date for 1 of 5 employee files reviewed. The facility reported a census of 61. Findings include: Employee record review of Staff E, Registered Nurse, showed a rehire date of 9/9/24. Staff E's updated Single Contact License and Background Check was initiated on 9/4/24 at 3:57 PM. The Criminal History Background Check indicated further research required and to await Division of Criminal Investigation's (DCI) final response. Staff E's employee record did not show that any further follow-up completed prior to working with residents. The facility initiated another Single Contact License and Background Check on 11/11/24 at 3:57 PM. The background check process was completed on this date. However Staff E had been working with residents from 9/9/24-11/11/24. During an interview on 12/5/24 at 10:45 AM, the Provisional Administrator acknowledged that the criminal and dependent adult/child abuse registry check was not completed prior to Staff E's re-hire date of 9/9/24. This oversight was identified during the facility's employee record audit the Administrator completed on 11/11/24.	F 607		

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F 607	Continued From page 2 The facility policy titled "Background Investigations" revised 11/2024 stated "The Human Resource department will conduct all applicable background investigation(s) on each individual making application for employment with this company and on any current employee if such background investigation is appropriate for position for which the individual has applied."	F 607		
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 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	F 656		

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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 clinical record review, policy review, and staff interview, the facility failed to ensure the Care Plan addressed high risk medications such as insulin and antidepressants for 1 of 5 residents reviewed for medications(Resident #29). The facility also failed to follow the Care Plan with regard to smoking materials for 1 of 4 residents reviewed for smoking (Resident #57). The facility reported a census of 61 residents.

Findings include:

1. The Admission Minimum Data Set(MDS) assessment tool, dated 10/19/24, listed diagnoses for Resident #29 which included diabetes, anxiety, and depression. The MDS stated the resident received insulin (a medication used to lower blood sugar), antianxiety medications, and antidepressant medications and listed her Brief Interview for Mental Status(BIMS)

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score as 15 out of 15, which indicated intact cognition.

The December 2024 Medication Administration Record(MAR) listed the following:
a. an 11/29/24 order for Lispro insulin(a type of fast-acting insulin) per sliding scale
b. an 11/30/24 order for Duloxetine(an antidepressant) 30 milligrams(mg) daily

The resident's Care Plan, as of 12/4/24, did not address the resident's antidepressant or insulin and lacked information for staff regarding side effects to monitor for.

On 12/5/24 at 11:21 a.m., the Director of Nursing(DON) stated care plans should address high risk medications such as insulin and antidepressants.

2. On 12/02/24 at 11:21 AM, Resident #57 stated he smoked and was observed with his cigarettes and lighter in his shirt pocket. He stated he keeps his cigarettes with him because the facility would not replace lost cigarettes.

The Quarterly Minimum Data Set (MDS) dated 10/29/24 for Resident #57 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated completely intact cognition. It included diagnoses of depression, hypertension (HTN), Parkinsons (brain conditions

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that cause slowed movements, stiffness, and tremors), right upper limb cellulitis, hypothyroidism, and malignant neoplasm (cancerous tumor) of the thyroid gland. It indicated he was independent with eating and applying/removing footwear, required setup assistance with oral hygiene and upper body dressing, and required maximum assistance with all other Activities of Daily Living (ADLs). It also revealed he did not ambulate, required setup and supervision with toilet transfer and shower transfer; respectively, and was independent with all other aspects of mobility.

The Electronic Health Record (EHR) included a Safe Smoking Assessment Form that indicated the resident was safe to smoke without supervision but his cigarettes and lighter would be kept at the nurses' station.

The Care Plan included potential for injury because the resident liked to smoke. It directed staff to ensure that there was no lighter/cigarettes at bedside and staff would provide such during smoking time in the smoking room.

On 12/05/24 at 12:36 PM, the Director of Nursing (DON) stated staff should follow the Care Plan or document noncompliance.

A policy titled "Comprehensive Care Plan" revised 11/2024 indicated the Care Plan would include resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. It also indicated the facility would develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable

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F 656	Continued From page 6 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interviews, and facility policy review the	F 657		

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facility failed to fully review and revise the comprehensive Care Plans when a resident had a change in advance directives and smoking status for 6 of 24 residents reviewed (Residents #10, #21, #26, #34, #45, and #61). The facility reported a census of 61 residents.

Findings include:

1. Review of Resident #10's Iowa Physician Orders for Scope of Treatment (IPOST), dated 7/23/24, revealed Resident #10 indicated in the event she had no pulse and was not breathing, Do Not Attempt Resuscitation (DNR).

Review of Resident #10's Care Plan dated 11/5/24, indicated Resident #10 requested Full Code status, indicating providing emergency measures as appropriate, including CPR (Cardiopulmonary Resuscitation).

2. Review of Resident #34's IPOST, dated 5/23/24, indicated DNR code status.

Review of Resident #34's Care plan dated 11/19/24, revealed Full Code status.

3. Review of Resident #45's IPOST, dated 12/5/22, indicated Full Code/CPR to attempt resuscitation.

Review of Resident #45's Care Plan dated 12/2/24, failed to indicate Resident's code status.

During an interview on 12/5/24 at 11:56 AM, Staff H, Social Worker stated, on admission residents fill out an IPOST indicating their wishes for code

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status. The IPOST is then signed by the facility Physician on admission or the next day. IPOST and code status is also reviewed or updated with the resident and their representative during the resident's Quarterly Care Conferences. Staff H stated, once the IPOST is completed (on admission or Care Conference) she scans these to the resident's EHR (Electronic Health Record) and updates the resident's Care Plan. If IPOST changes are completed by nursing staff, Staff H, is notified of change during morning meetings or by the nursing staff and updates the resident's Care Plan.

During an interview on 12/5/24 at 1:00 PM, the Director of Nursing (DON) stated, nurses complete a resident's IPOST on admission and obtain the Physician's signature, then Staff H, Social Worker, will scan the IPOST to the resident's EHR and update their Care Plan. IPOST and code status are reviewed by Staff H during resident's Care Conferences and updated in the resident's Care Plan if any changes.

Review of facility provided, Residents' Rights Regarding Treatment and Advance Directives Policy, revision date 11/24, revealed the following:
1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive.
2. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff.
3. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives.

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4. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions.
5. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care.

4. Review of Resident #21's Smoking Assessment, dated 3/16/24, indicated for safety Resident #21's smoking materials (cigarettes and lighter) will be kept at the nurses' station and Resident #21 is to wear a smoking apron.

Review of Resident #21's Care Plan, dated 11/15/24, identified Resident as a smoker and not at risk for smoker related injury. Resident #21 may smoke independently per facility assessment. Interventions included, instructing Resident about the facility policy on smoking: locations, times and safety concerns. Resident #21's Care Plan failed to indicate resident is to wear a smoking apron while smoking.

5. Review of Resident #26's Smoking Assessment, dated 9/13/24, revealed Resident #26 had past accidents/incidents with smoking materials, visible burn marks on Resident's clothing/coat and need for a smoking apron. IDCT (Interdisciplinary Care Team) decision of Smoking Assessment indicated, Resident #26 refused to wear the smoking apron and is not safe smoking cigarettes. Resident had been approved to use a Vape, but not approved to

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smoke cigarettes.

Review of Resident #26's Care Plan, dated 8/8/24, revealed Resident #26 needing supervision and to wear an apron while smoking. Resident #26's Care Plan failed to indicate Resident's approval for Vape and no approval to smoke cigarettes due to safety concerns.

6. On 12/2/24 at 2:59 PM, Resident #61, was observed smoking a cigarette, supervised by staff, and not wearing a smoking apron.

On 12/4/24 at 3:04 PM, Resident #61, was observed smoking a cigarette, supervised by staff, and wearing a smoking apron.

Review of Resident #61's EHR, failed to indicate a completed Smoking Assessment.

Review of Resident #61's Care Plan, dated 8/29/24, failed to indicate Resident #61 is a smoker and identify any interventions.

During an interview on 12/5/24 at 12:20 PM, Facility Administrator stated, Smoking Assessments are completed on admission, if resident voices interest in smoking, and/or any changes in condition. On completion of the Smoking Assessment, the nurse administering the assessment will then update the resident's Care Plan.

During an interview on 12/5/24 at 1:00 PM, DON stated, nurses complete the Smoking Assessment for residents that want to smoke, the Smoking Assessment is then reviewed by IDCT to determine safety interventions for the resident while smoking. Once IDCT determination is

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made, the resident's Care Plan is updated.

During an interview on 12/5/24 11:07 AM, Staff M, MDS Coordinator stated, she receives notification during morning meeting of any changes that need to be made to a resident's Care Plan. If it is a drastic change, like Hospice care, the Care Plan will be updated right away. All changes in resident's conditions/status should be relayed to the MDS Coordinator to be added/updated in the resident's Care Plan. Staff M stated, she tries to have the update completed within 24 hours.

Review of facility provided, Resident Smoking Policy revision date 6/24 stated the following:
1. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan
2. If resident who smokes experiences any decline in condition or cognition, he/she will be reassessed for ability to smoke independently and/or to evaluate whether any additional safety measures are indicated
3. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan

Review of facility provided, Care Plan Revisions Upon Status Change Policy, revised 11/24 stated the following:
The Comprehensive Care Plan will be reviewed and revised as necessary, when a resident experiences a status change.

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F 657	Continued From page 12 Procedure for reviewing and revising the Care Plan when a resident experiences a status change: a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. b. The MDS Coordinator and the Interdisciplinary Team will discuss the residents condition and collaborate on intervention options. c. The team meeting discussion will be documented in the nursing progress notes. d. The care plan will be updated with the new or modified interventions. e. Staff involved in the care of the resident will report resident's response to new or modified interventions. f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. g. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the resident ' s care. h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs.	F 657		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.	F 678		

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This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews, and facility policy review the facility failed to provide physician orders related to code status and accurately document in clinical records so that staff know immediately what action to take or not take when an emergency arises for 2 of 24 residents reviewed (Residents #10 and #34). The facility reported a census of 61 residents.

Findings include:

1. Review of Resident #10's Iowa Physician Orders for Scope of Treatment (IPOST), dated 7/23/24, revealed Resident #10 indicated in the event she had no pulse and was not breathing, Do Not Attempt Resuscitation (DNR).

Review of Resident #10's Care Plan dated 11/5/24, indicated Resident #10 requested Full code status, indicating providing emergency measures as appropriate, including CPR (Cardiopulmonary Resuscitation).

Review of Resident #10's Electronic Health Record (EHR) indicated on the page header, Resident's code status as Full code/CPR

Review of Resident #10's Physicians order dated 9/10/24 indicated Resident #10's code status of CPR.

Review of a Care Conference Attendance Record for Resident #10, dated 9/9/24, indicated Resident #10's code status as DNR.

2. Review of Resident #45's IPOST, dated

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12/5/22, indicated Full Code/CPR to attempt resuscitation.

Review of Resident #45's Care Plan dated 12/2/24, failed to indicate Resident's code status.

Review of Resident #34's EHR, indicated on the page header, Resident's code status as Full Code/CPR

Review of Resident #34's Physicians order dated 10/2/24 indicated Resident #10's code status of CPR.

During an interview on 12/4/24 at 12:20 PM, Staff I, CMA, said she would look at the resident's EHR page header to identify a resident's code status.

During an interview on 12/4/24 at 12:24 PM, Staff J, LPN, stated she looks at the header in resident's EHR to find their code status.

During an interview on 12/5/24 at 11:56 AM, Staff H, Social Worker stated, on admission residents fill out an IPOST indicating their wishes for code status. The IPOST is then signed by the Physician on admission or the next day. IPOST and code status is also reviewed or updated with the resident and their representative during the resident's Quarterly Care Conferences. Staff H stated, once the IPOST is completed (on admission or Care Conference) she scans them to the resident's EHR and updates the resident's Care Plan. If IPOST changes are completed by nursing staff, Staff H, is notified of change during morning meetings or by the nursing staff and updates resident's Care Plan.

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During an interview on 12/5/24 at 1:00 PM, the Director of Nursing (DON) stated, nurses complete a resident's IPOST on admission and obtain the Physician's signature. Then Staff H, Social Worker, will scan the IPOST to the resident's EHR and update their Care Plan. IPOST and code status are reviewed by Staff H during resident's Care Conferences and updates resident's Care Plan with any changes. The nurse will initiate a new order indicating the resident's code status preference and send it to the Physician. Once the order is signed by the Physician, the nurse will process the order in the resident's EHR and this will trigger the code status header.

Review of facility provided, Communication of Code Status Policy, revised 11/24 stated the following:
1. The facility will follow facility policy regarding a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an Advance Directive.
2. When an order is written pertaining to a resident's presence or absence of an Advance Directive, the directions will be clearly documented in designated sections of the medical record. Examples of directions to be documented include, but are not limited to:
a. Full Code
b. Do Not Resuscitate
c. Do Not Intubate
d. Do not Hospitalize
3. The nurse who notates the physician order is responsible for documenting the directions in all relevant sections of the medical record.
4. The designated sections of the medical record PCC; Profile; code status.
5. Additional means of communication of code

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F 678	Continued From page 16 status include: IPOST,MOST, POLST forms depending on the state. 6. In the absence of an Advance Directive or further direction from the physician, the default direction will be Full Code. 7. The presence of an Advance Directive or any physician directives related to the absence or presence of an Advance Directive shall be communicated to Social Services. 8. The Social Services Director shall maintain a list of residents who have an Advance Directive on file. 9. The resident's code status will be reviewed at least quarterly and documented in the medical record.	F 678		
F 687 SS=J	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review, and resident and staff interviews, the facility failed to ensure Resident#32 received diabetic shoes as ordered by the physician on 7/10/24 to maintain good foot health and to prevent complications for a resident with a known history	F 687		

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of bilateral foot diabetic ulcers. The failure continued throughout July and an encounter note on 7/26/24 recorded the resident required diabetic shoes due to a history of type 2 diabetes mellitus with foot ulcer and neuropathy (nerve damage). the facility failed to follow up with a shoe vendor to ensure the shoes ordered. On 8/26/24 the resident expressed a desire for the diabetic shoes and on 8/30/24, the facility identified the resident had developed a foot ulcer. The survey team found concerns with 1 of 1 residents reviewed with a history of diabetic wounds(Resident #32). The facility reported a census of 61 residents.

The IJ was determined on 12/16/24 at 3:00 PM. The IJ began on 7/26/24. The IJ immediacy was removed on 12/18/24 at 11:55 AM. The facility staff removed the Immediate Jeopardy on 12/19/24 through the following actions:

· The DON and designee(s) conducted a full-house audit on diabetic residents to determine at-risk diabetics and ensure proper preventative foot care.
· An audit was conducted to ensure all treatments, supplies, and equipment were readily available for order by the physician and were being followed to ensure residents received the proper preventative foot care.
· DON or designee(s) reviewed the medical records of diabetic residents to ensure that weekly skin assessments were completed and treatment recommendations/orders were in place.
· The DON or designee conducted a care plan audit to ensure that treatment recommendations/orders were included in the care plan and that they were being followed
· All facility policies and procedures related to

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F 687	Continued From page 18 podiatry services, skin integrity foot care, and physician orders reviewed and revised as needed. · Education provided to regional Clinical Manager at Curana to ensure that all practitioners that come to Pine Acres will be collaborating with the IDT team to ensure referrals are made timely and appropriately · An audit of orders, interventions, and devices regarding foot care and foot services was conducted by the Nursing Supervisor(s) to ensure proper use. · The DON/Corporate Nurse/Consultant educated all licensed nurses on facility policies and procedures related to diabetes, foot care, and appropriate wound treatment measures. This included ensuring residents had necessary support surfaces and pressure-relieving devices and that staff followed the manufacturer ' s recommended use. · The DON/Corporate Nurse/Consultant educated all licensed nurses on appropriate documentation, which included transcription and entering treatment orders on the physician ' s order sheet in the EHR and the resident ' s TAR. · DON/Corporate Nurse/Consultant educated all nurse aides on preventative diabetic foot care. · DON/Corporate Nurse/Consultant conducted daily treatment record and nursing documentation audits to ensure accurate and complete documentation of diabetic foot care and preventative measures. · For residents returning from the hospital, treatment recommendations/orders and wound care appointments will be transcribed and overseen by the DON and Corporate Nurse · DON/Corporate Nurse/Consultant Monitoring will continue to monitor/audit the following:	F 687		

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o Observation of treatments for diabetic foot care prevention and orders
o Weekly physician orders
o Weekly diabetic skin treatment orders related to diabetics.
o Treatment recommendations and orders are being added and processed into the EHR and TAR
· A QAPI PIP has been initiated to report on the above monitoring and auditing procedures. All findings from the PIP will be presented at the monthly QAA meeting. Monitoring/auditing and reporting will continue for a minimum of three months.

The scope lowered from "J" to "G" at the time of the survey after ensuring the facility implemented education and their policy and procedure.

Findings include:

The Quarterly Minimum Data Set(MDS) assessment tool, dated 8/11/24, listed diagnoses for Resident #32 which included diabetes, muscle weakness, and repeated falls. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition.

Care Plan entries, dated 5/24/23, stated the resident was at risk for diabetic ulcers of the left and right feet and would have no complications related to the ulcer through the review date. The entries directed staff as follows;
- ensure the application of appropriate protective devices to the affected areas.
-inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness.

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-monitor, document, and report as needed signs and symptoms of infection to any open areas to include; redness, pain, heat swelling or pus formation

A 7/10/24 shoe vendor Diabetic Footwear Prescription Form listed the diagnoses of polyneuropathy (a disease that affected multiple nerves throughout the body, causing weakness, numbness, and pain) and a history of callus (a thickened area of skin that formed on the body as a result of repeated friction, pressure, or irritation) and listed the covered procedures as depth shoes and diabetic inserts. The top of the form stated the prescription must be accompanied by a signed statement of certifying physician.

A 7/26/24 00:00 provider Encounter Note stated the resident had a history of Type 2 diabetes with foot ulcers and required diabetic shoes.

Encounter Note dated 8/16/24 00:00 listed medication Sulfamethoxazole/Trimethoprim (antibiotic) DS (double strength) take twice daily for ten days, indicated use: left foot and heel infection.

An 8/21/24 00:00 provider Encounter Note stated the resident requested diabetic shoes and (facility staff) placed the order.

An 8/30/24 4:27 PM Nursing Note stated the resident had a wound to his left heel which measured 5 inches x 3 inches across the entire heel. The facility obtained a treatment order and an order for boots, including no shoe to left foot until healed.

The facility lacked further documentation

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regarding the provision of the resident's diabetic shoes. The facility lacked documentation of communication or follow-up with the shoe vendor between 7/10/24 and 8/30/24 when the resident developed the heel wound.

A 9/3/24 provider Encounter Note stated the resident had wounds to his left foot and the resident was not aware of how he sustained the wounds. A diabetic shoe order was completed on 7/26/24 and staff waited to hear back from the shoe vendor regarding the shoes.

A 9/11/24 Skin/Wound note stated the wounds deteriorated and the resident had an order for an antibiotic, labs, and an x-ray.

A 9/17/24 provider Encounter Note stated the left heel was not improving. The resident would likely need debridement(a procedure which involved removing dead or infected tissue from a wound).

A 9/25/24 Nursing Note stated the resident underwent debridement.

A 10/1/24 provider Encounter Note stated the resident's heel was not improving.

A 10/7/24 Order Note stated facility staff informed the shoe vendor his diabetic shoe order was on hold due to his foot ulcer. The facility documentation lacked action of the facility to reach out, and follow up with getting the resident diabetic shoes, to help protect the residents other foot.

A 10/14/24 Nursing Note stated the resident's wound would not heal.

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10/15/24 Nursing Notes stated the resident's heel had redness around the wound with an odor. The notes documented a new treatment order and the resident received an order for vascular testing(a test to determine blood flow).

A 10/24/24 Nursing Note stated the facility received a call from the foot clinic and the resident's wound worsened. The clinic wished to send the resident to a surgeon for evaluation.

A 10/25/24 Nursing Note stated the resident admitted to the hospital.

A hospital Progress Note, dated 10/31/24, stated the resident had an X-ray of the left foot on 10/24/24 which showed acute osteomyelitis(inflammation of the bone) and a wound culture which showed pseudomonas(a bacteria). The resident underwent a left foot amputation on 10/26/24.

An 11/2/24 Nursing Note stated the resident had an above the ankle amputation on 10/31/24.

An 11/13/24 provider Encounter Note stated the resident had a left foot amputation on 10/26/24 and a left below the knee amputation on 10/31/24.

The facility policy "Wound Treatment Management", revised 11/2024, stated in order to promote wound healing the facility would provide evidence-based treatments in accordance with current standards of practice and physician orders.

On 12/2/24 at 11:59 a.m., Resident #32 stated he had to have his leg amputated and he was upset

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F 687	Continued From page 23 about it. He stated he did not know how this happened. On 12/5/24 at 8:37 a.m., via phone Staff G shoe vendor Office Manager stated they requested additional paperwork from the facility in order to carry out the shoe order but they did not receive it. She stated she called the facility and informed them of this but they continued to send the same paperwork. On 12/5/24 at 8:55 a.m., via phone, Staff F Medical Doctor(MD) stated he could not say for certain if the shoes would have prevented the resident's ulcers but stated the shoes would help reduce ulcers. He stated if there was an order for diabetic shoes, he would want this carried out as soon as possible. He stated the facility would follow-up with the paperwork to make sure they obtained them. On 12/5/24 at 9:58 a.m., the Director of Nursing(DON) stated if they faxed an order for shoes, they would follow up within 24-48 hours and "absolutely" would follow up within 2 weeks. She stated staff should keep checking on this until it was resolved. On 12/5/24 at 2:59 p.m., the Administrator stated she had no additional documentation related to communication between the facility and the shoe vendor.	F 687		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		

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as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident and staff interview, record and policy review, the facility failed to provide services to protect the resident from accidents or hazards by transferring a resident in a wheelchair without foot pedals (#20), not providing supervision or apron during resident smoking breaks for 3 of 3 residents (#21, #26, and #61), and not retrieving smoking materials from 3 of 3 residents (#21, #26, and #57). The facility reported a census of 61.

Findings include:

1) On 12/02/24 at 11:21 AM, Resident #57 stated he smoked and was observed with his cigarettes and lighter in his shirt pocket. He stated he keeps his cigarettes with him because the facility would not replace lost cigarettes.

The Minimum Data Set (MDS) dated 10/29/24 for Resident #57 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated completely intact cognition. It included diagnoses of depression, hypertension (HTN), Parkinsons (brain conditions that cause slowed movements, stiffness, and tremors), right upper limb cellulitis, hypothyroidism, and malignant neoplasm (cancerous tumor) of the thyroid gland. It indicated he was independent with eating and applying/removing footwear, required setup assistance with oral hygiene and upper body dressing, and required maximum assistance with

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all other Activities of Daily Living (ADLs). It also revealed he did not ambulate, required setup and supervision with toilet transfer and shower transfer; respectively, and was independent with all other aspects of mobility.

The Electronic Health Record (EHR) included a Safe Smoking Assessment Form that indicated the resident was safe to smoke without supervision but his cigarettes and lighter would be kept at the nurses' station.

The Care Plan included potential for injury because the resident liked to smoke. It directed staff to ensure that there was no lighter/cigarettes at bedside and staff would provide such during smoking time in the smoking room.

A policy titled "Resident Smoking" revised 6/2024 indicated if a resident or family does not abide by the smoking policy or care plan (e.g. smoking materials are provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional safety measures. It also indicated any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan.

On 12/05/24 at 12:36 PM, the Director of Nursing (DON) stated staff should collect the cigarettes and lighter from the resident and secure them in the lockbox otherwise document resident refusals.

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2. Review of Resident #21's MDS, dated 11/5/24, identified the resident had a Brief Interview for Mental Status (BIMS) of 13, which indicated intact cognition. The MDS documented Resident #21's current tobacco use, having no impairment of upper or lower extremities, and independent with use of walker or wheelchair for mobility.

Review of Resident #21's Care Plan, dated 11/15/24, identified Resident as a smoker and not at risk for smoker related injury. Resident #21 may smoke independently per facility assessment. Interventions included instructing Resident about the facility policy on smoking: locations, times and safety concerns.

Review of Resident #21's Smoking Assessment, dated 3/16/24, documented Resident #21's need for adaptive equipment including use of a smoking apron, all smoking materials (cigarettes and lighter) will be kept at the nurses' station, and safe to smoke without supervision.

Progress Note dated 8/26/24, Facility Administrator, documented speaking to Resident #21 about smoking policy, made Resident aware of smoking aprons, and Resident gave Facility Administrator a lighter and smoking material to lock at nurses' station.

Progress Note dated 10/2/24, Staff H, Social Services, documented finding a lighter in Resident #21's room. Staff H, documented removing the lighter from Resident's room and placed with smoking items at the nurses' station.

Observation on 12/2/24 at 2:59 PM, revealed Staff K, CMA, supervising smokers outside in the smoking area. Resident #21 was observed sitting

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in his wheelchair with a lit cigarette in his hand and not wearing a smoking apron.

Observation on 12/3/24 at 10:56 AM, revealed three unsupervised residents outside in the smoking area, Resident #21 observed in his wheelchair with a lit cigarette in hand and not wearing a smoking apron. At 11:00 AM, Staff D, CNA, was observed exiting the building to the smoking area, saying to the three residents "What are you doing? It's not smoke time. Where did you get the cigarettes and lighter?" Stuff D, CNA, supervised the three residents until completing their cigarettes and did not provide smoking aprons.

3. Review of Resident #26's MDS, dated 10/8/24, identified the resident had a BIMS of 15, indicating intact cognition. The MDS documented Resident #26 having no current tobacco use, having no impairment of upper or lower extremities, needing moderate to maximal assistance with transfers and cares, and use of wheelchair for mobility. Resident #26's MDS indicated diagnoses of hemiplegia affecting the right side and major depressive disorder.

Review of Resident #26's Care Plan, dated 8/8/24, identified Resident #26 is a supervised smoker and cannot safely get in and out of the smoking doors, to the outside. Care plan indicated to assess Resident #26's ability to smoke independently and safely, Resident #26 utilizes a smoking apron for safety and requires close monitoring while smoking in the smoking area. Staff are to ensure there is no lighter and cigarettes at bedside: staff will provide items during smoking time in the smoking room and

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observe clothing and skin for signs of cigarette burns.

Review of Resident #26's Smoking Assessment, dated 9/13/24, revealed Resident #26 had past accidents/incidents with smoking materials, visible burn marks on Resident's clothing/coat, all smoking materials (cigarettes, lighter and electronic smoking device) will be kept at the nurses' station and resident needs to wear a smoking apron. IDCT (Interdisciplinary Care Team) decision of Smoking Assessment indicated Resident #26 refused to wear the smoking apron and is not safe smoking cigarettes. Resident #26 requires supervision and had been approved to use a Vape, but not approved to smoke cigarettes.

Progress note dated 9/17/24, Former Director of Nursing (DON), documented Resident #26 is upset that he was told he can no longer smoke. He is not following the smoking policy and has been instructed several times regarding the smoking policy. Resident refuses to wear smoking apron and does not have his own smoking materials. The DON and Administrator compromised with Resident #26 and will allow resident to vape. Smoking assessment 9/13/24 and revised 9/17/24, Resident #26 is not safe to smoke, he had several burn holes in his clothes.

Progress note dated 9/24/24, Staff L, RN, documented confiscating a pack of cigarettes from Resident #26 ' s room as Resident was outside smoking without supervision, Resident had failed smoking assessment prior to this.

Progress note dated 10/9/24, Staff H, Social Worker, documented Resident #26 has agreed to

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follow smoking policy and has not been abiding to the agreement. Resident has been keeping smoking materials at the nurses' station and also storing additional materials in his room. Resident has been smoking outside of designated smoking times, according to smoking assessment Resident #26 must comply with wearing a smoking apron.

Progress note dated 11/20/24, Staff H, Social Worker, documented Resident #26 agreed to follow the smoking policy, Resident does have to be reminded to wear a smoking apron and will wear one upon reminder.

Observation on 12/2/24 at 2:59 PM, revealed Staff K, CMA, supervising smokers outside in the smoking area. Resident #26 was observed sitting in his wheelchair with a lit cigarette in his hand and not wearing a smoking apron.

Observation on 12/3/24 at 10:56 AM, revealed three unsupervised residents outside in the smoking area, Resident #26 observed in his wheelchair with a lit cigarette in hand and not wearing a smoking apron. At 11:00 AM, Staff D, CNA, was observed exiting the building to the smoking area, saying to the three residents "What are you doing? It's not smoke time. Where did you get the cigarettes and lighter?" Stuff D, CNA, supervised the three residents until completing their cigarettes and did not provide smoking aprons.

Observation on 12/4/24 at 2:54 PM, revealed Resident #26 attempting to exit the door to go to the designated smoking area, setting off the door alarm. Staff C, CNA, quickly responded to the door alarm and stopped Resident #26 from

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exiting the building. Staff C, CNA reminded Resident #26 smoking is at 3:00 PM and Resident cannot go outside without someone to supervise. Staff C asked Resident #26 to give her a few more minutes to finish what she was working on, then she would take Resident outside to smoke. Resident observed in his wheelchair with a blanket draped over his lap holding a cigarette in one hand and lighter in the other.

Interview on 12/4/24 at 2:54 PM, Staff C, CNA stated the protective aprons are available by the door to go outside and acknowledged Resident #26 is to wear one when smoking. Staff C also revealed, she was not aware of any residents using a vape or an electronic cigarette.

Observation on 12/4/25 at 3:04 PM, revealed Staff C, CNA supervising the four residents smoking, all were wearing smoking aprons and Resident #26 was smoking a cigarette and had a lighter in his other hand.

4. Review of Resident #61's MDS, dated 10/29/24, identified the resident had a BIMS of 13, indicating intact cognition. The MDS documented Resident #61 having no impairment of upper or lower extremities, and independent with cares and mobility. Resident #61's MDS indicated a diagnosis of Schizophrenia and history of nicotine dependence.

Review of Resident #61's Admission MDS, dated 8/23/24, documented Resident #61 having no current tobacco use.

Review of Resident #61's Care Plan, dated 8/29/24, failed to indicate Resident #61 as a

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smoker and identify any interventions.

Review of Resident #61's EHR, failed to indicate a completed Smoking Assessment.

On 12/2/24 at 2:56 PM, observation of Staff K, CMA, taking residents outside to smoke. Staff K was getting smoking materials at the nurses' station and stated "there's no lighter" Resident #61 approached the nurses' station, Staff K asked Resident #61 if he had a lighter. Resident #61 acknowledged Staff K, saying he had one and pulled it out of his jacket pocket.

Observation on 12/2/24 at 2:59 PM, revealed Staff K, CMA, supervising smokers outside in the smoking area. Resident #61 was observed standing, smoking a cigarette and not wearing a smoking apron.

During an interview on 12/5/24 at 12:20 PM, Facility Administrator stated Smoking Assessments are completed on admission, if resident voices interest in smoking, and/or any changes in condition. On completion of the Smoking Assessment, the nurse administering the assessment will then update the resident's Care Plan. The Administrator stated all Resident's smoking materials are locked at the nurses station and the staff members supervising smokers are notified by the resident's nurse of any changes.

During an interview on 12/5/24 at 1:00 PM, DON stated, nurses complete the Smoking Assessment for residents that want to smoke, the Smoking Assessment is then reviewed by IDCT to determine safety interventions for the resident while smoking. Once IDCT determination is

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made, the resident's Care Plan is updated. DON revealed, there's a Smoking Book at the nurses' station that includes the facility's Smoking Policy, a list of residents that smoke with their listed restrictions and provisions. DON also indicated the storage of resident's smoking materials is dependent on the level of independence of each resident. There is a lock box at the nurses' station to hold the smoking materials.

Review of facility provided Resident Smoking Policy revision date 6/24 stated the following:
1. Smoking is prohibited in all areas except the designated smoking area.
2. All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process.
3. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all.
4. Electronic cigarettes (e-cigarettes/vapes/vapor pen) can catch on fire and/or explode if not handled and stored safely. Safety measure for the us of electronic cigarettes by residents will include, but are not limited to:
a. A safe smoking assessment will be completed on all residents using e-cigarettes.
b. Staff supervision of resident use if indicated.
c. Encourage residents to use e-cigarette devices with safety features such as firing button locks, vent holes, and protection again overcharging.

Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan.

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If resident who smokes experiences any decline in condition or cognition, he/she will be reassessed for ability to smoke independently and/or to evaluate whether any additional safety measures are indicated.
All safe smoking measures will be documented on each resident ' s care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident ' s care plan.
If resident or family does not abide by this policy or the resident ' s plan of care will not be permitted to supervise resident ' s smoking
Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff.
The interdisciplinary team, with guidance from the physician, will help to support the resident ' s right to make an informed decision regarding smoking by:
a. Including the resident, family, and/or resident representative in discussion regarding the risks associated with smoking.
b. Developing a safe smoking plan, or an individualized plan to quit smoking.
Documentation to support decision making will be included in the medical record, including but not limited to:
a. Resident ' s wishes, or those of the resident ' s representative.
b. Assessment of relevant functional and cognitive factors affecting ability to smoke safely.
c. Response to smoking cessation interventions.
d. Compliance with smoking policy.

5. The Minimum Data Set(MDS) assessment tool, dated 11/5/24, listed diagnoses for Resident

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F 689	Continued From page 34 #20 which included difficulty walking, heart failure, and diabetes and stated the resident was independent with propelling wheelchair. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 14 out of 15, indicating intact cognition. A 6/29/22 Care Plan entry stated the resident had altered cardiovascular status and was at risk for pain, numbness, and weakness in the extremities. On 12/2/24, Staff C Certified Nursing Assistant(CNA) pushed Resident #20 in his wheelchair from the 200 Hall to the scale located near the nursing station. The resident held his feet up but they dangled very close to the floor during the transport. The facility policy "Safe Resident Handling/Transfers", reviewed 11/2024, stated staff members should maintain compliance with safe transfer practices. The policy did not specifically address foot pedals. On 12/5/24 at 11:21 a.m., the Director of Nursing(DON) stated resident's feet should sit on foot pedals while staff pushed them in a wheelchair.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 698		

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This REQUIREMENT is not met as evidenced by:
Based on observation, resident and staff interviews, record review, and policy review, the facility failed to consistently perform required pre-dialysis and post-dialysis assessments for 1 of 1 resident (#35). The facility reported a census of 61.

Findings include:

On 12/02/24 at 2:34 PM, Resident #35 stated staff had not routinely performed assessments before or after her hemodialysis treatments.

The Minimum Data Set (MDS) dated 9/19/24 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated completely intact cognition. It included diagnoses of anemia, hypertension, End-Stage Renal Disease (ESRD), Diabetes Mellitus (DM), epilepsy, psychotic disorder, and Non-Alzheimer's dementia. It also revealed the resident required maximum assistance with eating and oral hygiene, and was dependent with all other Activities of Daily Living (ADLs). It indicated the resident received dialysis within previous 14 days.

The Care Plan dated 7/10/22 included a dialysis focus and directed staff to perform pre/post dialysis assessments.

The Electronic Health Record (EHR) included a physician's order to complete a pre and post dialysis assessment on dialysis days every Monday, Wednesday, and Friday for dialysis chair time of 7:45 AM.

The EHR Progress Notes lacked pre-dialysis

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F 698	Continued From page 36 assessment documentation for 11/11/24 and included post-dialysis assessment documentation only for 11/08/24, 11/13/24, 11/25/24, and 11/29/24. There were no documented post-dialysis assessments located for the other eight (8) dialysis treatments Resident #35 received during November 2024. On 12/05/24 at 7:41 AM, Staff A, Registered Nurse (RN), stated a pre-dialysis and post-dialysis assessment should be completed for dialysis residents and documented in the EHR. On 12/05/24 at 8:10 AM, the Director of Nursing (DON) stated nurses should complete the specific user-defined assessments (UDA) in the EHR. A policy titled "Hemodialysis" revised 11/2024 indicated the nurse will ensure that the dialysis access site (e.g. AV shunt or graft) is checked before and after dialysis treatments and every shift for patency by auscultating for a bruit and palpating for a thrill. If absent, the nurse will immediately notify the attending physician, dialysis facility and/or nephrologist.	F 698		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F 725		

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diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, policy review, and staff interviews, the facility failed to provide resident care needs for 1 of 1 residents reviewed for staffing(Resident #51). The facility reported a census of 61 residents.

Findings include:

The Minimum Data Set(MDS) assessment tool, dated 11/5/24, listed diagnoses for Resident #51 which included hemiplegia(one-sided weakness), anxiety, and diabetes, and stated the resident was dependent on staff for toilet transfers and toileting hygiene. The MDS stated the resident was occasionally incontinent of urine and listed his Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition.

The facility policy "Call Lights: Accessibility and

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Timely Response", reviewed 11/2024, stated all staff members who saw or heard an activated call light was responsible for responding and stated if the staff member could not provide what the resident desired, the appropriate personnel should be notified.

Care Plan entries, dated 12/12/22, stated the resident had the potential for impaired skin integrity related to frequent episodes of incontinence of bowel and bladder.

A Care Plan entry, dated 3/23/23, stated the resident required the assistance of 1 staff member for personal hygiene.

Observations on 12/3/24 revealed the following:
At 8:35 a.m., Resident #51 sat in the hall and wore black shorts. The resident stated his shorts were wet and he needed changed.
At 8:39 p.m., the resident entered his room and alerted his call light.
At 8:41 am. a staff member walked by, but did not enter the room. The resident yelled "help".
At 9:00 a.m., the resident's call light remained on and a staff member walked by his room but did not enter.
The resident's call light remained on until 9:06 a.m. and the resident intermittently yelled "help"
At 9:07 a.m., Staff D Certified Nursing Assistant(CNA) entered the resident's room. While she was in the room, the resident's call light went off. Staff D exited the resident's room at 9:08 a.m.
At 9:09 a.m., the resident remained in his room and wore black shorts. He stated they had to hurry and "come on".
No staff entered the resident's room from 9:07 a.m. until 9:17 a.m. and the resident continued to

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F 725	Continued From page 39 intermittently yell "come on". At 9:18 a.m., the State Agency informed the Administrator the resident needed assistance. At 9:19 a.m., Staff D entered the resident's room. On 12/5/24 at 11:21 a.m., the Director of Nursing(DON) stated ideally staff should respond to the call light within 5 minutes. Staff should leave the light on and find the appropriate staff(to care for the resident).	F 725		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview, and policy review, the facility failed to ensure food prepared and maintained at the appropriate temperature as well as dishes and utensils cleaned in a sanitary manner related to incomplete food and dishwasher logs. The facility reported a census of 61. Findings include: 1. The Food Temperate Record logs reviewed for the months of September, October, and November. From 9/1/25 thru 10/5/24, 24 meals were incomplete or did not have any food temperatures recorded out of 105 meals. From 10/6/24 thru 11/2/24, 24 meals were incomplete or did not have any food temperatures recorded	F 800		

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PINE ACRES REHABILITATION AND CARE CENTER	1501 OFFICE PARK ROAD WEST DES MOINES, IA 50265

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F 800	Continued From page 40	F 800		

out of 84 meals. From 11/3/24 thru 11/30/24, 13 meals were incomplete or did not have any food temperatures recorded out of 84 meals. A food thermometer and alcohol wipes were observed in the food prep area for staff use.

2. The Dishmachine Quality Assurance Forms reviewed for the months of October and November. From 10/7/24 thru 11/3/24, 8 out of 84 meals did not have verification that the dischmachine chemical sanitizer reached 50 ppm or greater. From 11/4/24 thru 12/1/24, 16 out of 84 meals did not have verification that the dishmachine chemical sanitizer reached 50 parts per million (ppm) or greater.

During an interview on 12/2/24 at 11:00 AM, the Certified Dietary Manager (CDM) acknowledged the gaps in both the food temperature and dishmachine logs. Cooks are expected to record food temperatures (hot and cold items) just prior to meal service. This is done for each meal, 3 meals per day. The washer is expected to check the chemical sanitizer level of the dishmachine 3 times per day, correlating with meals. Test strips were observed in a plastic folder along with the Dishmachine Quality Assurance Form.

The policy "Food Safety Requirements" reviewed/revised on 11/2024 states "food shall be prepared as directed until recommended temperature for the specific foods are reached." The policy further stated "all equipment used in handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination. The policy "Sanitation Inspection" reviewed/revised 11/2024, states "food service staff shall inspect ...dishwasher temperatures daily."

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary 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 observations, policy review, and staff interview, the facility failed to ensure food is stored in a sanitary manner to prevent contamination and foodborne illness. The facility reported a census of 61. Findings include: Initial kitchen tour completed on 12/2/24 at 10:00 AM revealed the following: a. Walk-in freezer floor with excess debris (food crumbs, several small food items, packing tape from delivery boxes) b. Fryer, which was not in use, full of oil with no cover c. Plastic cereal containers with no label or	F 812		

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F 812	Continued From page 42 dates During an interview on 12/2/24 at 11:00 AM, the Certified Dietary Manger (CDM) reported there are no required daily or weekly cleaning checklists which staff completed. A general checklist of cleaning needs is located on the whiteboard as staff enters the kitchen. Walk-in cooler and freezer floors are swept out as needed. When not in use, the fryer should have a sheet pan over the oil to protect from contamination. The CDM acknowledged the lack of labels for the cereal containers since the cereals are not stored in their original packaging. The policy "Food Safety Requirements" reviewed/revised on 11/2024 states "Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms." The policy also notes "equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination." The policy "Sanitation Inspection" reviewed/revised 11/2024 states "food service staff shall inspect refrigerators/coolers, freezers ..." daily. The policy also directs the dietary manager to complete weekly inspections of the food service area weekly to ensure areas are clean and comply with sanitation and food service regulations. This includes the food preparation area, main production area, and the refrigerator/freezer.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

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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;
(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

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(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, resident and staff interview, record review, and policy review, the facility failed to implement infection control practices to prevent urinary tract infection (UTI) for 1 of 1 resident (#28). The facility reported a census of 61.

Findings include:

On 12/02/24 at 2:07 PM, the urine in the resident's indwelling catheter was noted to be opaque and cloudy.

The Minimum Data Set (MDS) revealed a Brief

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Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of obstructive uropathy (urine unable to drain normally), acute renal failure, and anemia. It indicated the resident required moderate assistance with personal hygiene and was dependent with toileting hygiene. It also revealed the resident had developed a urinary tract infection (UTI) while a resident.

The Care Plan dated 7/05/24 included an indwelling catheter focus and directed staff to position the catheter bag and tubing below the level of the bladder and away from entrance room door.

The Electronic Health Record (EHR) Progress Notes indicated the resident was hospitalized for a UTI on 6/22/24. It also indicated the resident received Cefepime for a UTI per a progress note dated 10/09/24.

The Treatment Administration Record (TAR) dated October 2024 revealed the resident received Cefepime antibiotic from 10/01/24 to 10/08/24.

On 12/05/24 at 10:15 AM, a continuous indwelling catheter care observation revealed Staff B, Certified Nurse Aide (CNA) grabbed the resident's wheelchair and moved it with gloved hands. She turned to the bedside table, opened an alcohol pad package and placed it on paper towel on the bedside table. She lifted the resident's urine catheter bag above the resident while the resident lied in bed. Urine was observed flowing back into the resident. She positioned the urine drainage bag over the measuring cylinder,

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F 880	Continued From page 46 opened the drain bag spigot, and emptied the urine into the cylinder. She grabbed the alcohol swab with the same left gloved hand, wiped the drain spigot, clamped it, and placed it back in the holder. On 12/05/24 at 10:30 AM, Staff B stated she should've performed hand hygiene and changed gloves before wiping the drain spigot. She also stated her training was to not lift the urine bag above the resident's bladder. On 12/05/24 at 12:50 PM, the Director of Nursing (DON) stated staff should follow the policy, appropriately perform hand hygiene, and not lift the bag above the bladder. A policy titled "Catheter Care" revised 11/2024 directed staff to ensure drainage bag is located below the level of the bladder to discourage backflow of urine.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative	F 883		

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has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

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This REQUIREMENT is not met as evidenced by:
Based on electronic health record (EHR) review, staff interview, and policy review, the facility failed to ensure 1 of 5 residents reviewed for immunizations was provided up to date pneumococcal vaccinations (Resident #45). The facility reported a census of 61 residents.

Findings include:

Resident #45's Face Sheet listed her age as 81 years old. The original admission date listed as 12/6/22.

The Immunization Record for Resident #45 lacked documentation on the resident's pneumococcal vaccination status. On 7/25/23, Resident #45 signed the Pneumococcal Vaccine Consent Form and Wavier, which indicated an interest in receiving the vaccine. The EHR lacked documentation if the vaccine had been administered as requested.

During an interview on 12/5/24 at 2:00 PM , the Provisional Administrator acknowledged the lack of documentation for Resident #45's pneumococcal vaccination status and if the vaccine was administered in 2023.

The "Infection Prevention and Control Program" document reviewed/revised on 7/2024 states residents will be offered the pneumococcal vaccines recommended by the Centers for Disease Control upon admission, unless contraindicated or received the vaccines elsewhere. The "General Immunization/Vaccination" policy reviewed/revised on 11/2024 states "The resident

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F 883	Continued From page 49 ' s medical record or staff/volunteer's medical file will include documentation ...that the resident received or did not receive the immunization(s) due to medical contraindication or refusal."	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes	F 887		

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documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).
This REQUIREMENT is not met as evidenced by:
Based on electronic health record (EHR) review, staff interview, and policy review, the facility failed to ensure 2 of 5 residents reviewed for immunizations were provided up to date Covid vaccinations (Resident #2 and Resident #45).
The facility reported a census of 61 residents.

Findings include:

1. Resident #2's Face Sheet listed her age as 91 years old. The original admission date listed as 9/27/14.

The Immunization Record for Resident #2

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documented the last Covid vaccination was administered on 11/29/22. The EHR lacked documentation if an updated Covid vaccine was offered or administered in 2023.

2. Resident #45's Face Sheet listed her age as 81 years old. The original admission date listed as 12/6/22.

The Immunization Record for Resident #45 documented the last Covid vaccination was administered on 12/21/2021. The EHR lacked documentation if an updated Covid vaccine was offered or administered in 2022 or 2023

During an interview on 12/5/24 at 2:00 PM , the the Provisional Administrator acknowledged the lack of documentation for Resident #2 and Resident #45's Covid vaccination status.

The "Infection Prevention and Control Program" document reviewed/revised on 7/2024 states residents will be offered "the COVID-19 vaccine when vaccine supplies are available to the facility." The "General Immunization/Vaccination" policy reviewed/revised on 11/2024 states "The resident's medical record or staff/volunteer's medical file will include documentation ...that the resident received or did not receive the immunization(s) due to medical contraindication or refusal."

PINE ACRES
REHABILITATION AND CARE CENTER

This serves as a credible allegation of compliance for Pine Acres Nursing and Rehabilitation. We assert that all correctives described in this plan of correction have been implemented. In regard to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of actions. The staff of Pine Acres Nursing and Rehabilitation is committed to delivering high quality healthcare to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit that Pine Acres Nursing and Rehabilitation is in substantial compliance as set forth below. We are confident that we will be found in substantial compliance upon resurvey. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. Pine Acres Nursing and Rehabilitation has completed the following interventions due to the survey's findings exiting 12/19/2024. The facility will be in substantial compliance by 01/23/2025.

Action Plan

F607 – Develop/Implement Abuse/Neglect Policies

Corrective Action

Staff Member E Background check was completed prior to the survey entrance date on 11/11/24

Identification of Others

On 11/11/24, the facility conducted a whole-house audit to ensure all staff background checks were completed. On or before 1/23/25, a secondary audit was completed to ensure every staff member had a background check completed.

Systemic Changes to Prevent Future Occurrence

The BOM was educated regarding the new hire process on or before 1/23/25. New hires will have a background check completed, and offers of employment are contingent upon the successful completion of a background screening.

Monitoring

The administrator, HR director, or designee will audit newly hired staff twice weekly for 12 weeks. Audit results and additional corrected actions will be reported and discussed in QAPI, and further corrections will be discussed in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 01/23/25

F656 – Develop/Implement Comprehensive Care Plans

Corrective Action

1. On or before 1/23/2025, the MDS coordinator updated the care plan for resident #29 to include insulin and antidepressants.
2. On or before 1/23/25, the MDS coordinator updated resident #57's care plan in concurrence with the resident's updated smoking assessment. Resident #57's most recent assessment determined that he is independent with smoking and, therefore, may maintain all smoking materials on his person.

Identification of Others

1. On or before 1/23/25, the MDS Coordinator updated residents' care plans for those prescribed antidepressants or insulin to ensure a comprehensive care plan.
2. On or before 1/23/25, the MDS coordinator updated residents' care plans for smokers to reflect their most recent smoking assessment.

Systemic Changes to Prevent Future Occurrence

On or before 1/23/25, the IDT team, including the MDS Coordinator, Director of Nursing (DON), and Social Services Director, was educated regarding comprehensive care plans, including medications and smoking. On or before 1/23/25, nursing staff were educated regarding following the comprehensive care plan.

Monitoring

The MDS Coordinator, director of nursing (DON), or designee will review 2 residents' Care plans per week for 12 weeks to ensure that the care plan Is Comprehensive and is followed. Audits will consist of residents who take insulins, antidepressants, and those that smoke. Audit results and additional corrected action will be reported and discussed in QAPI, and further corrections will be in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 01/23/25

F657 – Care Plan Timing and Revision

Corrective Action

1. On or before 1/23/25, the MDS Coordinator reviewed and revised the care plans for residents # 10, 21, 26, 34, 45, and 61 to ensure they were by their smoking status or elected Advanced Directive status.
2. On or Before 1/23/25 The DON or MDS ensured Resident # 10's IPOST was updated to reflect DNR status
3. On or before 1/23/25 the DON or SSD updated resident 34's care plan to indicate DNR status per Resident/Responsible party wishes.
4. On or before 1/23/25, the DON or SSD updated resident 45's Care plan to indicate their code status.
5. On or before 1/23/25, The DON or Designee updated the smoking assessment for resident 21 to ensure the care plan had appropriate interventions in place in the care plan.
6. On or before 1/23/25 the DON or designee updated the smoking assessment for resident 26 to ensure the resident had appropriate interventions in place in the care plan
7. On or before 1/23/25, the Don or designee evaluated the resident's smoking status and ensured an appropriate assessment was in place, and the care plan was updated appropriately.

Identification of Others

The deficient practice could potentially affect residents. On or before 1/23/25, the Social Services Director completed a whole-house audit to review residents' codes and smoking status. The care plan was updated to reflect these changes, and discrepancies were corrected immediately.

Systemic Changes to Prevent Future Occurrence

The IDT Team, including the social services director and MDS coordinator, was educated on or before 01/23/25 regarding care plan timing and revision.

Monitoring

The MDS Coordinator, Social Services Director, or designee will audit 2 residents' care plans weekly for 12 weeks to ensure the Code status is accurate, the order is in place, IPOST is in place, and the care plan is updated. The MDS Coordinator, Social Services Director, or Designee will audit 2 residents smoking status to ensure the care plan is in place, updated, and followed. Audit results and additional corrected action will be reported and discussed in QAPI, and further corrections in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 01/23/25

F678 – Cardio-Pulmonary Resuscitation (CPR)

Corrective Action

1. On or before 1/23/25 the DON or designee updated resident 10's orders to reflect current code status.
2. On or before 1/23/25 the DON or designee updated resident 34's orders to reflect current code status.

Identification of Others

Residents had the potential to be affected. On or before 1/23/25, the Social Services Director, DON, or Designee completed a whole-house audit for all residents to ensure that the Code status order, IPOST, and the care plan were consistent with the residents' wishes for code status. All discrepancies were corrected immediately.

Systemic Changes to Prevent Future Occurrence

1. On or before 1/23/25 the IDT team, including the DON and Social Services Director, was educated to ensure the code status is reviewed and revised as appropriate per the residents' wishes at admission, with each change in condition, hospital stay, and quarterly.
2. The resident and/or responsible party will review and revise the resident's code status as appropriate at admission and readmission, with a change in condition, and quarterly to ensure the resident's wishes are maintained.

Monitoring

The DON, Social Services Director, or designee will audit 5 residents' Code status weekly to ensure that the order, the Care Plan, and the IPOST are updated and reviewed appropriately. Audit results and additional corrected actions will be reported and discussed in QAPI, and further corrections will be discussed in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 01/23/25

F687 – Foot Care

Corrective Action

1. Resident #32 was fitted for diabetic shoes on 12/03/2024, resident diabetic shoes are in the process of being made Fusion foot and ankle will alert the facility as soon as they're ready to be picked up.

Identification of Others

The facility conducted a whole-house audit on or before 12/16/24 and ensured that all residents diagnosed with Diabetes received proper preventative foot care. If discrepancies were identified, they were corrected immediately.

Systemic Changes to Prevent Future Occurrence

On or before 12/19/24, licensed staff and the IDT team were educated on Diabetic foot care and preventative measures. On or before 12/19/24, the Regional Clinical Manager for Curana was educated to ensure all practitioners who provide services at the facility are educated to consult with the IDT team to ensure timely correspondence for any referrals for outside services.

Monitoring

The Director of Nursing (DON), Regional Clinical Director, or designee will audit all new admissions weekly to ensure preventative foot care is in place for residents with diabetes Weekly for 12 weeks. The DON or designee will audit and observe treatments for residents with diabetic foot ulcers, diabetic skin treatment orders, physician orders, and treatments/ recommendations, which are transcribed to the EHR for 5 residents per week for 12 weeks. Audit results and additional corrected action will be reported and discussed in QAPI, and further corrections will be in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 12/19/24

F689 – Free of Accident/Hazards/Supervision/Devices

Corrective Action

1. On or before 1/23/25, the don or designee provided education to all staff regarding using foot pedals appropriately while assisting resident #20 in the wheelchair
2. On or before 1/23/25, the DON evaluated residents #21, 26, and 61 for appropriate use of a smoking apron.
3. On or before 1/23/25, the DON, SSD, or Administrator educated residents #21, 26, and 57 about maintaining their smoking materials. An evaluation was completed, and the residents 21 and 57 were determined to be independent with smoking. Resident 26 was determined to be su[ervised and need assistance with smoking. The policy was revised.

Identification of Other

Residents who smoke have the potential to be affected. On or before 1/23/25, the facility completed a whole-house audit of smoking residents. The policy was revised, residents who smoke were reevaluated, and their care plans were updated.

Systemic Changes to Prevent Future Occurrence

On or before 1/23/25, staff were educated on the revised smoking policy, and residents were re-evaluated and determined to be independent or require supervised smoking at designated times. Newly admitted residents will be evaluated if they smoke and provided with the policy and education. Current residents who smoke will be reviewed with a change in condition or quarterly for safety with smoking. The care plan will reflect the residents' status.

Monitoring

The administrator, Social Services Director, or DON will conduct a random audit three times weekly for 12 weeks to ensure that all residents appropriately abide by the smoking policy. Audit results and additional corrected actions will be reported and discussed in QAPI, and further corrections will be discussed in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 01/23/25

F698 Dialysis

Corrective Action

On or before 1/23/25, the Director of Nursing (DON) or Designee ensured that all licensed staff were educated regarding dialysis pre- and post-assessments for resident #35.

Identification of Others

Residents who receive Dialysis services have the potential to be affected

Systemic Changes to Prevent Future Occurrence

On or before , the Director of Nursing (DON), or designee educated Licensed nurses on completing the pre- and post-dialysis assessments.

Monitoring

The Director of Nursing (DON) or Designee will audit three times weekly for 12 weeks to ensure the pre- and post-dialysis assessments are completed. Irregularities will be corrected immediately. Audit results and additional corrected actions will be reported and discussed in QAPI, and further corrections will be discussed in the monthly meeting for six months or until sustained compliance is achieved.

Compliance Date: 1/23/25

F725 – Sufficient Nursing Staff

Corrective Action

1. On or before 12/3/24, the DON or designee ensured that resident 51's needs were immediately addressed and assistance with dressing was provided, the resident stated that he spilled water on his black shorts.

Identification of Others

Residents had the potential to be affected.

Systemic Changes to Prevent Future Occurrence

On or before 1/23/25, the DON or designee educated all nursing staff on answering call lights in a timely manner and prompt attention to needs.

Monitoring

The administrator, Social Services Director, or DON will conduct a random audit three times weekly for 12 weeks for call light times to ensure resident needs are met promptly. Audit results and additional corrected actions will be reported and discussed in QAPI, and further corrections will be discussed in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 01/23/25

F800 – Provided diet meets the needs of each resident

Corrective Action

On or before 12/2/24, the CDM educated all kitchen staff on conducting food temperatures before meal service and completing the Dish machine chemical sanitizer to reach 50ppm.

Identification of Others

Residents had the potential to be affected.

Systemic Changes to Prevent Future Occurrence

On or before 12/2/24, the CDM, Administrator, or designee educated all dietary staff to ensure that meal temperatures are taken before meal service and that the dish machine chemical sanitizer is checked before use to ensure that it is 50 ppm. The cook ensures these logs are completed before leaving each shift.

Monitoring

The CDM, Registered Dietician, or designee will randomly audit 2 times per week for 12 weeks to ensure logs are completed accurately. Audit results and additional corrected actions will be reported and discussed in QAPI, and further corrections will be discussed in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 01/23/25

F812 – Food Procurement, Store, Prepare/Serve-Sanitary

Corrective Action

1. On or before 12/2/24 The CDM ensured the Walk-in freezer was cleaned from debris
2. On of before 12/2/24 The CDM ensured the Fryer had a cover placed on it.
3. On or before 12/2/24 The CDM ensured the cereal containers were labeled and dated.

Identification of Others

Residents had the potential to be affected.

Systemic Changes to Prevent Future Occurrence

On or about 12/2/24- The CDM, Registered Dietician, or designee educated all dietary staff regarding ensuring storing, preparing, and sanitary conditions.

Monitoring

The CDM, Registered Dietician, or designee will complete a weekly walkthrough to ensure the fryer is stored appropriately, items are labeled and dated appropriately, and the kitchen is sanitary. Findings will be immediately corrected. Audits will continue weekly for 12 weeks. Audit results and additional corrected action will be reported and discussed in QAPI, and further corrections will be made in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 01/23/25

F880 – Infection Prevention and Control

Corrective Action

On or about 12/05/24, the DON immediately educated staff B regarding gloving, emptying the catheter bag, and UTI prevention by keeping the catheter bag lower than the bladder for resident #28.

Identification of Others

Residents that have an indwelling Catheter have the potential to be affected.

Systemic Changes to Prevent Future Occurrence

1. On or before 1/23/25 the Director of Nursing (DON) or designee conducted education for all nursing staff regarding gloving, emptying the catheter bag, and UTI prevention by keeping the catheter bag lower level than the bladder.
2. On or before 1/23/25, the Director of Nursing (DON) or designee conducted a competency for catheter care for all Certified Nursing Assistants.

Monitoring

The director of nursing (DON) or designee will randomly audit a 2-resident sample weekly for 12 weeks to ensure that catheter care is completed appropriately. Audit results and additional corrected actions will be reported and discussed in QAPI, and further corrections will be discussed in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 01/23/25

F883 Influenza and Pneumococcal immunizations

Corrective Action

On or before 1/23/25, the DON ensured that resident #45's pneumococcal immunizations were current. The resident had previously received the series this was documented in the EHR.

Identification of Others

On or about 1/23/25, the DON or Designee completed a whole-house audit to ensure that all residents who requested the Pneumococcal vaccination had the vaccination administered. Residents that were eligible for the vaccine, orders were obtained and the vaccine was ordered fromm the pharmacy to be administered upon arrival.

Systemic Changes to Prevent Future Occurrence

On or before 1/23/25- the director of nursing (DON) or designee educated staff on immunizations and the admission/re-admission process regarding requesting and consenting vaccinations.

Monitoring

The director of nursing (DON) or designee will randomly audit two resident EHRs to ensure that their vaccination status is up to date weekly for 12 weeks, and the DON will audit all new admissions weekly to ensure that requested and consented vaccinations are provided. Audit results and additional corrected action will be reported and discussed in QAPI, and further corrections will be in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 1/23/25

F887 COVID-19 Immunization

Corrective Action

On or before 12/31/25, the DON or Designee should ensure that Resident #2 and Resident #45 had the most recent COVID-19 Vaccination as consented.

Identification of Others

The facility determined that residents have the potential to be affected.

Systemic Changes to Prevent Future Occurrence

1. On or before 1/23/25, the DON, or Designee, conducted a whole house audit of records to ensure that the COVID-19 Vaccination was offered and administered to residents who had not received the vaccination.
2. The Director of Nursing (DON) conducted an in-service education program for nursing staff to ensure vaccinations are documented in the EHR. Education was also provided regarding the admission re-admission process to ensure vaccinations are administered as the resident consents, and refusals will be reported in the EHR.

Monitoring

The Director of Nursing Services, or designee, will conduct a random audit of two (2) residents' Vaccination status weekly for 12 weeks. The DON, or Designee, will review all new admissions' vaccination status to ensure the vaccination status is current, consent is completed, and documentation is in the EHR for 12 weeks. Audit results and additional corrected action will be reported and discussed in QAPI, and further corrections will be made in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 1/23/25