STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375568	A. Building B. Wing	02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Care Center	6202 East 61st Street Tulsa, OK 74136

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 35196 Based on record review and interview, the facility failed to ensure beneficiary protection notices were provided for two residents (#281 and #67) of three reviewed for beneficiary notices who had skilled days remaining. The Administrator reported 49 residents received skilled services in the past six months. Findings: 1. Resident (Res) #281 received skilled services 06/15/21 through 07/29/21. Res #281 had 55 skilled days remaining upon discharge to home. Res #281's beneficiary notices were reviewed and a NOMNC (notice of medicare noncoverage) was not documented as provided. 2. Res #67 received skilled services 07/30/21 through 09/05/21. Res #67 had 20 skilled days remaining upon discharge from skilled services and remained in the facility. Res #67's beneficiary notices were reviewed and a NOMNC was not documented as provided. On 02/22/22, the Administrator reported the NOMNC was not provided.

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41810 Based on record review and interview, the facility failed to ensure an incident report was reported to OSDH (Oklahoma State Department of Health) for one resident (#97) of two reviewed for fall with major injury. The DON reported no falls with major injuries in the past 90 days. Findings: 1. Resident (Res) #97 had diagnoses which included dementia, unsteadiness on feet, and contusion of left wrist. A quarterly MDS assessment, dated 01/10/22, documented the resident was impaired with cognition and required extensive assistance with ADLs. The assessment documented one fall without injury. A care plan, dated 10/18/21, documented in part .Falls/Safety- Resident is at increased risk of falls r/t diagnosis of Osteoporosis . A progress note, dated 10/03/21 at 4:28 a.m., documented in parts .Resident observed sitting on her buttocks just outside the door of her restroom, legs straight out. Resident complained of pain in left wrist, slight swelling observed, no discoloration observed at this time. Resident holding left arm away from her body, cries out in pain when nurse touches forearm. Resident refuses to move her wrist or fingers, states, I need a cast.New order to xray left wrist and call placed to JTK imaging to get stat xray of left wrist. This nurse called Emergency contact to inform of incident and xray order. Emergency contact agrees with plan of care . A post-fall progress note, dated 10/03/21 at 10:44 a.m., documented in parts . fracture to left distal radius and ulnar styloid. Diorsal displacement at the radial fracture site. Injuries Identified at Time of Initial Fall:: Suspected Fracture .Since the Fall, Resident Requires:: Additional Assistance with Transfers, Additional Assistance with Ambulation . On 02/17/22 at 10:21 a.m., the DON reported the incident report form, for 10/03/21 fall with major injury, should have been sent to OSDH with 24 hours. 35196

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38495 Based on record review, observation, and interview, the facility failed to complete a comprehensive admission assessment within 14 days of admission for one (#278) of 44 residents whose assessments were reviewed. The census and conditions form documented 121 residents resided in the facility. Findings: Resident (Res) # 278 was admitted on [DATE] with diagnoses which included diabetes mellitus, chronic kidney disease, and osteoarthritis. Review of the Res's clinical record revealed an admission assessment, dated 02/13/22, was in progress and incomplete. On 02/15/22 at 2:17 p.m., the DON stated MDS admission assessment for Res #278 was not completed. On 02/15/22 at 2:21 p.m., MDS coordinator #1 stated an admission assessment was not completed for the resident. She stated an admission assessment should be completed 14 days after admission.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35196 Based on record review and interview, the facility failed to ensure minimum data set assessments (MDS) were submitted within 14 days of completion for nine residents (#1, 3, 4, 5, 7, 15, 16, 23, and #126) of 44 sampled residents. The Administrator reported a census of 121 residents. Findings: 1. Resident (Res) #1 was admitted on [DATE]. A discharge MDS assessment, dated 12/13/21 was documented as in process and was not submitted within 14 days of completion. 2. Res #3 was admitted on [DATE]. A quarterly MDS assessment, dated 12/19/21, was documented as in process and was not submitted within 14 days of completion. 3. Res #4 was admitted on [DATE]. An annual MDS assessment, dated 12/18/21, was documented as in process and was not submitted within 14 days of completion. 4. Res #5 was admitted on [DATE]. An annual MDS assessment, dated 12/17/21, was documented as in process and was not submitted within 14 days of completion. 5. Res #7 was admitted on [DATE]. A quarterly MDS assessment, dated 12/17/21, was documented as in process and was not submitted within 14 days of completion. 6. Res #15 was admitted on [DATE]. A quarterly MDS assessment, dated 12/13/21, was documented as in process and was not submitted within 14 days of completion. 7. Res #16 was admitted on [DATE]. An annual MDS assessment, dated 12/16/21, was documented as in process and was not submitted within 14 days of completion. 8. Res #23 was admitted on [DATE]. A quarterly MDS assessment, dated 01/22/22, was documented as in process and was not submitted within 14 days of completion. 9. Res #126 was admitted on [DATE]. A significant change MDS assessment, dated 12/02/21, was documented as in process and was not submitted within 14 days of completion. On 02/22/22, the Administrator and the DON reported a turnover in MDS staff during December and January.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35196 Based on record review and interview, the facility failed to ensure a baseline care plan was conducted within 48 hours of admission for three residents (#123, 6, and # 278) of five new admissions reviewed. The DON reported 41 new admissions in the past 90 days. Findings: 1. Res #123 was admitted on [DATE] and had diagnoses which included end stage renal disease and diabetes mellitus. An admission MDS assessment, dated 02/09/22, documented the resident was severely impaired with cogntion and required extensive assistance with activities of daily living. The assessment documented the resident received dialysis. Res #123 EHR documented no base line care plan within 48 hours of admission. On 02/17/22, the DON reported the facility failed to document a baseline care plan within 48 hours of admission for Res # 123. 2. Res # 6 was admitted to the facility on [DATE] with diagnoses end stage renal disease requiring dialysis treatments, pressure ulcers, and diabetes mellitus. An admission MDS assessment, dated 02/08/22, documented the resident was cognitively intact, totally dependent on staff for activities of daily living, and required dialysis. Res #6 EHR documented no base line care plan within 48 hours of admission. A nursing assessment, dated 02/09/22, documented the resident's skin condition as stage 4 pressure ulcer sacrum. On 02/22/22 at 3:06 p.m., the DON reported a 48 care plan was not done and should have been. 3. Resident (Res) # 278 was admitted on [DATE] with diagnoses which included diabetes mellitus, chronic kidney disease, and osteoarthritis. Res #278 EHR documented no base line care plan within 48 hours of admission. On 02/15/22 at 2:17 p.m., the DON stated a base line care plan had not been completed. 37851 38495

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35196 Based on record review, observation, and interview, the facility failed to ensure bathing was provided timely for four residents (#70, 76, 83, and #108) of four residents reviewed for bathing and activities of daily living. The census and condition form documented a census of 121 residents. Findings: 1. Resident (Res) #76 had diagnoses which included hemiplegia and need for assistance with personal care. A comprehensive care plan, updated 11/04/21, documented in parts .requires moderate to maximum assistance with ADL's due to hemiparesis secondary to CVA . An annual MDS assessment, dated 12/07/21, documented the resident was cognitively intact and required extensive assistance with ADLs. On 02/15/22 at 10:18 a.m., the resident reported they had not received a bath for 34 days. The resident reported they wanted a bath at least once a week. Res #76 EHR bathing documentation was reviewed and documented the resident received a bath only on 12/07/21, 01/03/22, and 01/29/22. On 02/16/22 at 10:56 a.m., CNA #1 reported the resident required extensive assistance with bathing and was scheduled for bathing three times a week. On 02/22/22, the DON reported she was unaware the resident was not receiving bathing timely. 2. Res #83 had diagnoses which included muscular dystrophy, cognitive communication deficit, aphasia, and dysphasia. A care plan, dated 06/17/21, documented in parts .the resident was staff supported for bathing. A quarterly MDS assessment, dated 01/14/22, documented the resident was severely impaired with cognition, required extensive assistance with activities of daily living, was frequently incontinent of bowel, and had a urinary catheter. On 02/14/22 at 2:17 p.m., Res #83 was observed to have uncombed and matted hair, unknown particles in the bed, and their lips were crusted with secretions. On 02/17/22 at 12:43 p.m., the DON reviewed the TARS for the dates 02/11/22, 02/12/22, 02/14/22, and 02/17/22 and stated the resident was not bathed during those times and should have been. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Res #108 had diagnoses which included severe obesity, muscle wasting, and incontinence of bowel and bladder. A care plan, revised on 10/21/21, documented in parts .check for incontinence every two hours and as needed. A quarterly MDS assessment, dated 12/10/21, documented the resident was cognitively intact, required extensive assistance with activities of daily living, did not ambulate, and was incontinent of bowel and bladder. On 02/14/22 at 11:24 a.m., Res #108 reported to not have had incontinent care as needed. Res #108 reported on 02/12/22 they waited over four hours to receive assistance from staff and defecated while waiting. On 02/15/22 at 1:41 p.m., CMA #1 reported Res #108 should have been checked every two hours for incontinence. CMA #1 stated to have witnessed Res #108 and other residents sitting in feces and urine for over four hours. On 02/15/22 at 1:46 p.m., CNA #6 stated, upon starting a shift, residents were found sitting in feces and urine often. On 02/15/22 at 1:49 p.m., LPN #3 stated to have observed multiple residents lying in feces and urine for long periods of time. On 02/15/22 at 2:23 p.m., the DON stated staff were supposed to have made rounds every two hours and checked residents for incontinence. The DON reported residents should not sit in feces or urine over two hours. 4. Resident (Res) #70 had diagnoses which included respiratory failure, stage 3 chronic kidney disease, diabetes mellitus, and muscle weakness. A care plan, dated 11/22/21, documented bathing /hygiene with two person assist. An admission MDS assessment, dated 12/05/21, documented Res #70 had intact cognition, required extensive assistance with hygiene and bathing with physical help of one staff member. A care plan, last updated on 02/04/21, documented in parts .hospice provides shower/bath . The care plan documented in parts .Hospice was discharged [DATE] . A record review of bathing, documented in January 2022, the resident had no documented bathing entries in the EHR. On 02/14/22 at 11:09 a.m., Res #70 stated he could not remember the last time he had a bath. He stated he wished he could get a bath more often. On 02/16/22 at 2:02 p.m., the resident stated he finally got a bed bath last night. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/16/22 at 2:12 p.m., CNA #1 stated the resident was to receive a bath every Monday, Wednesday, and Friday. 37851 38495

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35196 Based on record review, observation, and interview, the facility failed to ensure pressure ulcers received necessary treatment and services per physician orders for three residents (#77, 6, and #70) of three residents reviewed for pressure ulcers. The census and condition form documented 16 residents with pressure ulcers. Findings: 1. Resident (Res) #77 was admitted on [DATE] with diagnoses which included pressure ulcer of sacral region. A re-admission MDS assessment, dated 12/13/21, documented the resident was cognitively impaired and was total dependent of two staff for all ADLs. The assessment documented the resident had two Stage IV pressure ulcers upon re-entry to the facility. A care plan, date unknown, documented in parts .admitted with 3 Pressure ulcers; coccyx, right upper buttock, left outside ankle. Potential for deterioration of wounds r/t overall poor health status and multiple co-morbidities . A physician order, dated 02/11/22, documented in parts .Wound Treatment Order: Location: Left ischium, Clean with Normal Saline/Wound Cleanser, Apply: Santyl, Cover with Primary Dressing: Soft Silicone bordered dressing and Secure Once A Day . and .Wound Treatment Order: Location: sacrum, Clean with Normal Saline/Wound Cleanser, Apply: santyl, Saline moistened gauze, Cover with Primary Dressing: Secure with foam border dressing (silicone-Sacrum) Once A Day . 02/14/22 2:19 p.m., the resident was observed lying on her right side with the HOB elevated. The resident was observed lying on an air flow mattress. 02/15/22 at 7:40 a.m., the resident was observed lying on their back with the HOB elevated. The resident was observed lying on an air flow mattress. On 02/17/22 at 9:27 a.m., LPN #1 was observed performing pressure ulcer care. LPN #1 removed the old dressing, dated 02/14/22. The resident had two pressure ulcer located on the left ischium and on the sacrum. LPN #1 reported the left ischium pressure ulcer was unstageable due to slough and the sacrum pressure ulcer was stage IV. LPN #1 reported if the wound care was ordered daily, it should have been done daily. LPN#1 reported it was the first time she had observed the residents wounds. LPN #1 stated the physician observed the pressure ulcers today and was in the process of changing her pressure ulcer orders. On 02/22/22, the DON reported the pressure ulcer care should have been performed as ordered. 2. Res #6 had diagnoses which included end stage renal disease, a stage 4 pressure ulcer, and diabetes mellitus. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order, dated 02/01/22, documented daily to clean the left buttock with normal saline and wound cleanser, pat dry, and apply Santyl (a medication to prevent worsening of pressure ulcers), and cover with primary dressing and cleanse the sacrum with normal saline and wound cleanser, pat dry, and apply Medihoney(a debridement medication for pressure ulcers), and cover with a border foam dressing and secure. An admission MDS assessment, dated 02/08/22, documented the resident was cognitively intact, totally dependent on staff for activities of daily living, required dialysis, and had a stage 4 pressure ulcer. An nursing admission assessment, dated 02/09/22, documented the resident's skin condition had a stage 4 pressure ulcer sacrum. On 02/15/22 at 3:31 p.m., Res #6 reported wound care was performed every three to four days. On 02/16/22 at 3:15 p.m., during wound care observation, LPN #1 removed the primary dressing from the buttocks of the resident. The border foam dressing was removed from the sacral area, LPN#1 displayed the date and the border foam dressing was dated 02/04/22. LPN #1 stated the residents wound care must not have been performed since 02/04/22 and should have been. On 02/17/22 at 10:15 a.m., the DON reviewed the MARS and reported pressure ulcer treatments had been missed on 02/07, 02/11, and 02/15/22 and should have been done. 3. Resident (Res) #70 had diagnoses which included pressure ulcer of sacral region, stage 4. A admissions MDS assessment, dated 12/05/21, documented the resident was intact with cognition, required extensive assistance with activities of daily living, and had 3 stage four pressure ulcers upon admission. A care plan, last revised 02/04/22, documented in parts .treatment for wounds as ordered including wound vac . On 02/14/22 at 1:10 a.m., Res #70 was observed lying in bed. A physicians order, dated 02/09/22, documented to start Pro-stat (a liquid protein that promotes tissue healing) 45 cc by mouth twice a day. A physicians order, dated 02/15/22, documented to hold Pro-stat until available. Review of the resident clinical record, the resident had not received Pro-stat for 7 days. On 02/22/22 at 2:36 p.m., the dietitian stated there was not any Pro-stat in the facility after the order. The resident had not been getting it. On 02/22/22 at 3:07 p.m. the DON stated the Pro-stat had been ordered and the resident did not receive Pro-stat for 7 days after the order. 37851 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	38495

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37851 Based on record review, observation, and interview, the facility failed to ensure residents were free from accident hazards for one (#31) of two reviewed for falls. The facility failed to prevent a fall resulting in a leg fracture. The census and condition form documented a census of 121 residents. Findings: Res #31 had diagnoses which included muscle weakness, muscle wasting, unsteadiness on feet, and a fracture of the left leg. A quarterly assessment, dated 08/12/21, documented the resident was cognitively intact. The assessment documented the resident required extensive assistance with activities of daily living. The assessment documented the resident did not ambulate, required a mechanical lift for transfers, was frequently incontinent of bowel and bladder, and had no falls. A care plan, edited 10/22/21, documented in parts .I will need to be transferred using the total lift. Please ensure this is a bariatric lift . A incident report, dated 11/03/21, documented in parts .resident was with staff and transferring to bed, completing a stand pivot transfer, when resident became dizzy upon sitting on edge of bed and fell to the ground and heard a pop in the lower left leg. Resident was sent to the emergency department and was noted to have a fractured tibia on the left leg. A progress note, dated 11/03/21, documented in parts .A CNA came to the nurse and informed the nurse the resident had fallen. The nurse assessed the resident and the resident could not move her left ankle . A progress note, dated 11/03/21, documented the resident was readmitted back to the facility with a diagnoses of a fracture to the left ankle. A significant change assessment, dated 11/12/21, documented the resident was cognitively intact. The assessment documented the resident required extensive assistance with activities of daily living. The assessment documented the resident did not ambulate, required a mechanical lift for transfers, was frequently incontinent of bowel and bladder, and had no falls. On 02/15/22 at 7:40 a.m., Res#31 was observed lying in bed. Res #31 reported to have had a history of falls. Res #31 reported on 11/03/21, a CNA was in the room, stood Res #31 up from a motorized wheelchair, and while the CNA was moving the motorized wheelchair back, Res. #31 became dizzy and fell resulting in a left leg fracture. Res. #31 reported there was supposed to be two staff members present while transferring. Res. #31 reported staff members were supposed to use a mechanical lift while transferring. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 02/16/22 at 7:53 a.m., TNA #1 stated to have been employed at the facility greater than five months. TNA #1 stated Res #31 was to be transferred by a mechanical lift and to always make sure two staff members were present in the room during a transfer. On 02/16/22 at 07:56 a.m., TNA #2 stated to have been employed at the facility greater than four months and Res #31 had always required a mechanical lift during a transfer. On 02/16/22 at 7:58 a.m., LPN #2 stated to have been employed at the facility greater than two months and Res #31 required a mechanical lift. On 02/16/22 at 8:30 a.m., the facility Administrator was notified of a potential harm with substandard quality of care and expanding the survey. On 02/16/22 at 9:18 a.m., Res#31 was observed lying in bed. Res #31 reported on the day of the fall, CNA #1 was in the room preparing to help Res.#31 get in the bed. Res#31 stated CNA #1 helped the resident stand up, and while the resident was standing, CNA #1 was moving the motorized wheelchair backwards. Res #31 stated the CNA left the resident standing when the resident became dizzy and fell . Res #31 stated to have been sent to the emergency department and was diagnoses with a left lower tibia fracture above the left ankle. Res #31 stated there was no other staff in the room when the fall occurred. On 02/16/22 at 9:29 a.m., CNA #4 stated on 11/03/21 to have been in Res#31's room. CNA #4 stated the resident was ready to go to bed. CNA #4 stated to have stood the resident up from a motorized wheelchair, and while moving the chair backwards, Res #31 fell . CNA#4 stated there was no other staff member in the room. On 02/16/22 at 10:15 a.m., the point of care system (POC) was reviewed and documented in parts . was to be transferred by a mechanical lift or a physical transfer of two or more staff members . On 02/16/22 at 10:22 a.m., CNA #2 stated they followed the care plan for transfer assistance. On 02/16/22 at 10:00 a.m.,CNA #3 stated the care plan was followed for resident transfers, toileting, and resident care. On 02/16/22 at 10:05 a.m., CNA #4 stated the care plan was followed for resident transfers. On 02/16/22 at 10:10 a.m., CNA #5 stated the care plan was followed for transfer requirements. On 02/17/22 at 10:23 a.m., the DON stated a mechanical lift should have been used to transfer Res #31.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Care Center	6202 East 61st Street Tulsa, OK 74136

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 35196 Based on record review, observation, and interview, the facility failed to ensure sufficient nursing staff was provided on a 24-hour basis to meet the needs of the residents. The census and condition report documented a census of 121 residents. Findings: Upon entrance and throughout the survey, multiple residents were interviewed and complained the facility was understaffed and their needs were not being met timely. Resident council meeting minutes documented multiple complaints of needs not being met timely and not enough staff. The minutes documented complaints of call lights being turned off and care not received timely, not getting bathing as scheduled, and food being unpalatable. Staffing reports were reviewed for October 2021. Inadequate direct care staff per 24 hours for 15 of 31 days. Staffing reports were reviewed for November 2021. Inadequate direct care staff per 24 hours for 12 of 30 days. Staffing reports were reviewed for December 2021. Inadequate direct care staff per 24 hours for 27 of 31 days. Staffing reports for January 2022 were not provided. On 02/22/22, the Administrator and the DON reported the facility was under new management and they were new to the facility. The Administrator and DON reported they were aware of staffing issues. The Administrator reported agency staff was employed temporarily.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38495 Based on record review, observation, and interview, the facility failed to prepare food which was palatable and at an appetizing temperature for the residents. The census and conditions form documented 108 residents in the facility who receive meals from the kitchen. Findings: Throughout the survey, multiple residents complained of cold and tasteless food, including residents #64, #114. #278, #105, #30, #76, #31, and #277. Resident council meeting minutes documented multiple concerns of cold, tasteless food. On 02/15/22 at 1:15 p.m., a sample tray was tested for temperature and palatability of the food. The fish temperature tested at 100.7 degrees Fahrenheit (F) and was cold and bland. The mashed potatoes tested at 140 F tasted warm and had a good flavor. The okra and tomatoes testes at 127 F cool and tasted bland. On 02/22/22 at 9:45 a.m., the DM was asked if she had received complaints of cold and bland food. The DM stated yes. The DM stated the food just does not get to the residents quick enough.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38495 Based on record review, observation, and interview, the facility failed to store, prepare, and serve food in a sanitary manner. The census and conditions form documented 108 residents in the facility who receive meals from the kitchen. Findings: 1. On 02/14/22 at 9:58 a.m., an Initial tour was conducted in the kitchen. At this time the walk in refrigerator contained a pan covered with plastic wrap which contained what looked like chilled fat. This was not labeled or dated. Fried chicken was observed dated 02/10/22. At 10:00 a.m., the DM stated that was ham in the pan it was not labeled or dated. She stated left overs can be kept three days before discarding. At 10:06 a.m., observed a large bag of noodles opened in the storage room. The lid covers to the dry good bins were cracked. At 10:28 a.m., the DM was observed wiping the inner lip of the ice drop of the ice machine with a white cloth. The white cloth was observed to have had a thick pinkish substance. At 10:40 a.m., observed the containers that hold the utensils with debris in the bottom of them. The rack that held the utensils was observed to have grease and grime on it and the shelving under the prep tables were also dirty. Cook #1 stated containers were not cleaned and should have been. At 9:49 a.m., the DM stated the Ice Machine Cleaning Sign Off sheet for December that was provided, documented the DM cleaned the ice machine 12/27/21. The DM stated she only cleaned the out side not the inside of the machine.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 38495 Based on record review, observation, and interview, the facility failed to implement CDC guidelines for infection control procedures to prevent the transmission of COVID-19 and /or other infections. The facility failed to : a) provide signage of the door of a COVID positive room. b) wear proper PPE into a COVID positive room. c) ensure catheter bags were properly contained off of the floor. d) ensure ice was distributed to the residents in a sanitary manner. e) report communicable disease to OSDH. The census and conditions form documented 121 residents resided in the facility. Findings: 1. Resident (Res) #280 had diagnoses which included chronic obstructive pulmonary disease, fracture of right femur, and COVID positive. On 02/14/22 at 3:53 p.m., observed the resident from the hall way laying on her bed in her room. Observed no sign on the isolation room door. Res #280 stated the staff used the proper PPE most of the time when coming into her room and assisting her. Res #280s catheter bag was observed laying on the floor by the resident's bed. On 02/14/22 at 4:00 p.m., a staff member was observed to enter the COVID positive room and assist the resident in the room. The staff member did not wear a gown or shield. On 02/14/22 at 4:03 p.m., LPN #3 stated full PPE should be worn, including gown, gloves, mask, and shield and the door should have been labeled as isolation. On 02/15/22 at 3:19 p.m., observed no signage on the isolation door and the catheter bag was touching the floor. On 02/15/22 at 3:44 p.m., LPN #4 stated the catheter bags should not be touching the ground. On 02/22/22 at 4:04 p.m., the DON stated there should be isolation signs upon the door and PPE should be used in an isolation room. 2. Resident (Res) #91 had diagnoses which included morbid obesity, spinal stenosis, chronic obstructive pulmonary disease, and repeated falls. A care plan, dated 12/15/21, documented in parts .requires an indwelling urinary catheter . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission MDS assessment, dated 12/21/21, documented the resident was cognitively intact, required extensive assistance with most activities of daily living and had an indwelling catheter. On 02/14/22 at 3:42 p.m., the resident catheter bag was observed laying on the floor and full of urine. On 02/14/22 at 3:44 p.m., CNA #2 stated the catheter bag should not be on the floor. 3. On 02/15/22 at 12:19 p.m., observed a resident, reaching in the ice chest, obtained the ice scoop from inside the ice chest, and placed ice in a personal cup. The resident was observed to place the ice scoop back into the ice chest. 02/15/22 at 12:58 p.m., observed the activities director serving ice. A resident ask for ice and had a Yeti cup. The activities director took the Yeti cup and scooped ice from the ice chest with the residents Yeti cup. On 02/15/22 at 1:04 p.m., the activities director stated she should not have used the resident's cup to scoop ice out of the ice chest. 4 Incident report forms were reviewed for Covid-19 communicable disease. Four residents and 5 staff who were positive with Covid-19 in January 2022 were not reported to OSDH within 24 hours. On 02/22/22, the Administrator and DON reported the incident report forms for Covid-19 were not sent to OSDH within 24 hours of positivity.

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure staff are vaccinated for COVID-19 35196 Based on record review and interview, the facility failed to ensure staff were fully Covid-19 vaccinated. The facility had a staff vaccination rate of 62.1%. The Covid-19 Staff Vaccination Status for Provider form documented 87 staff. Findings: Total number of staff was 87. Fully vaccinated staff was 54. Partially vaccinated staff was 4. Granted medical and non-medical exemptions 22. Not vaccinated without exemptions or delays were 7. The Administration reported they were aware the facility did not meet 80% vaccination within 30 days of the mandate.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 35196 Based on record review and interview, the facility failed to ensure the facility maintained an effective pest control program. The census and condition form documented a census of 121 residents. Findings: During entrance and throughout the survey, eight interviewable residents reported mice in their rooms over the past several months. On 02/14/22 at 1:50 p.m., observed multiple mouse dropping in the bottom drawer of a clothing dresser. On 02/14/22 at 2:03 p.m., observed mice traps in resident rooms on the central hall. The residents reported the facility put the sticky traps in their rooms and have not come back to check the traps. The residents report they see and hear them all the time. An invoice for pest control documented the last time pest control had been in the building was 12/09/21. The invoice documented in parts . general maintenance monthly to include treating .rodents . On 02/22/22, the maintenance supervisor reported the facility was aware of the mice problem.