STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035086	A. Building B. Wing	12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Sierra Vista, LLC	660 South Coronado Drive Sierra Vista, AZ 85635

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606 Based on clinical record review, facility documentation, staff interviews, and policies and procedures, the facility failed to ensure one resident (#166) was free from resident to resident abuse, which resulted in physical harm as evidenced by a 5 x 4 cm bruise on the resident's right wrist. The deficient practice could result in other residents being abused. Findings include: -Regarding Resident #166 Resident #166 (alleged victim) was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, anxiety disorder, major depressive disorder, and schizoaffective disorder. A neurological care plan initiated on July 13, 2019 indicated that the resident has an alteration in neurological status related to dementia. Goals included: resident will be able to communicate daily needs, and will maintain optimal status and quality of life within limitations imposed by neurological deficits. Interventions included give medications as ordered, monitor/document for side effects and effectiveness, evaluate and treat as ordered. Review of a care plan initiated on July 25, 2019 revealed that the resident demonstrated physical behaviors related to his impaired cognition. The goal was resident will not harm self or others. Interventions included to analyze key times, place, circumstances, triggers, and what deescalates behavior and document. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS assessment indicated that at the resident was negative for psychosis, behavioral symptoms, rejection of care, and wandering. A nursing note dated November 4, 2021 revealed that the resident presented to the nursing office and showed a nurse a bruise to his right wrist. The nursing note stated that the resident reported that his roommate punched him causing the bruise which measured 5 x4 cm. The note documented that resident #166 stated that he was going to his room when his roommate grabbed then punched him. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up nursing note dated November 4, 2021 indicated that resident #166 demonstrated exit seeking behavior after the incident. The note also noted that the resident wanted to talk to someone and kicked the exit door. The note documented that this occurred twice within a 30-minute period. A Health Status note dated November 4, 2021 indicated that during conversation with the resident regarding the incident, the resident stated that the man who hit him was standing next to him. Review of a progress note dated November 5, 2021 revealed that the incident which left a bruise on the resident's wrist was reported to Adult Protective Services (APS), non-emergency police, and the ombudsman. The note also stated that the residents were separated into different rooms. A weekly skin assessment dated [DATE] indicated that resident #166 had a new skin condition. It was described as right wrist bruise. Further review of the resident's clinical notes revealed a nursing note dated November 8, 2021 which indicated that resident had presented to the nurse's station multiple times stating he was being beat up in his sleep. The note indicated that the resident was reassured, redirected, and monitored. -Regarding resident #5 Resident #5 (alleged perpetrator) was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia without behavioral disturbance/psychotic disturbance/mood disturbance/anxiety, altered mental status, cerebrovascular disease, vascular dementia, anxiety disorder, and major depressive disorder. A cognition care plan initiated on April 30, 2018 revealed that the resident has impaired cognitive function/impaired thought process related to dementia. Interventions included to communicate with resident/family/caregivers regarding resident's capabilities and needs, review medications and record possible cause of cognitive deficit. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 5 indicating that the resident has severe cognitive impairment. Additionally, the MDS indicated that the resident has not exhibited psychosis or behavioral symptoms during the assessment period. A Health Status Note dated November 4, 2021 revealed that the resident # 5 was moved to another room in the secured unit. Review of a behavior note dated November 4, 2021 revealed that resident #5 stated that he did grab his roommate's arm and punched him with his fist. The note indicated that the incident occurred in the hallway and that the Director of Nursing (DON) was notified of the incident. A Social Services Progress note dated November 5, 2021 documented that per the DON, an Adult Protective Services (APS) report was submitted about a claim of a resident hitting roommate. The note indicated that residents have been separated into different rooms. It also noted that the incident was reported to the non-emergency police and that the ombudsman was notified. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation report dated November 9, 2021 revealed that according to Registered Nurse's statement, she was signing out medications in the nurse's office when resident #166 approached her and showed her his right wrist with a recent bruise. The report indicated that residents involved were unable to recall the event when interviewed. The investigation concluded that the allegation of abuse could not be substantiated due to lack of witnesses and inconsistency in resident statements. An interview with a Licensed Practical Nurse (LPN/staff #3) was conducted on December 7, 2023 at 1:52 p. m. Staff #3 stated that residents are supervised in order to mitigate resident to resident altercations. However, if it occurs, the staff will separate the residents immediately and report the incident. She indicated that she has not experienced such incidents in the facility. However, if it happens, it is reported to the Director of Nursing (DON), the social worker, physician, and family. Notification to the state and police is also done and the facility has to follow its protocol regarding abuse reporting and it is reported immediately. An interview with a Certified Nursing Assistant (CNA/staff #51) was conducted on December 7, 2023 at 2:08 pm. Staff #51 indicated that when they see a potential or actual resident to resident altercation, they try to redirect the residents. She noted that they get assistance to make sure the residents are separated and safe. Then they let the nurse know about the incident so it can be reported/documented. Staff #51 said that staff are provided abuse training. She said that it is provided as needed, when they do in-service training, and it is discussed during monthly meetings. An interview with the Director of Nursing (DON/staff #100) was conducted on December 7, 2023 at 3:07 p.m. Staff #100 stated that her expectation is for her staff to notify her immediately if an allegation of abuse occurs. She noted that she expects her staff to ensure that the resident(s) is safe. Notification regarding the allegation of abuse will then be accomplished by either the DON or the Executive Director (ED). The investigation is also usually done by the DON or the ED. Social Services assist with safety questions. The investigation involves interviewing anyone randomly where the incident occurred, interview the residents to see if they feel safe. With regards to the incident between residents #166 and #5, staff #100 noted that she remembers it. She noted that the incident was investigated and residents were assessed. Staff #100 noted that the residents were safe. She said to her recollection they were unable to unsubstantiated or substantiate due to the residents involved being in the dementia unit. The alleged victim was out in the hallway and it the timeframe could not be determined. Residents were not reliable historians. Regardless, she noted that the facility still must investigate, assess, separate the residents, and try to find out what happened. Review of facility policy titled Abuse Policy version dated 06/2022 indicated that the facility strive to prevent the abuse of all their residents. Furthermore, it noted that their objective is to provide a safe haven for our residents through preventive measures.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606 Based on clinical record reviews, staff interviews and facility policy and procedures, the facility failed to ensure that a Preadmission Screening and Resident Review (PASRR) level I was completed accurately and a level II was sent to the state for determination for one resident (#2). The deficient practice could result in specialized services not being identified and provided to residents. Findings include: Resident #2 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included acute stress reaction, and suicidal ideations. A cognition care plan revised on November 7, 2019 revealed that the resident has impaired cognitive function or impaired thought process. Interventions indicated to use residents name and identify yourself at each interaction. Review of a medication care plan revised on November 4, 2019 revealed that the resident is on psychotropic medications related to schizoaffective disorder. Interventions included administer medications as ordered, monitor/record occurrence of target behavior symptoms, monitor/record/report to physician side effects and adverse reaction to medication, and psychiatric/psychological consult as ordered. A medication care plan initiated on September 23, 2020 indicated that the resident is on antidepressant medication related to depression. Interventions included to monitor/document/report to physician as needed ongoing signs/symptoms of depression that is unaltered by medication, give antidepressant medications as ordered by physician, and refer for psychiatric/psychological consult as ordered. Review of the resident's face sheet revealed the following new diagnoses and date of onset: major depressive disorder dated July 11, 2021, anxiety disorder dated September 26, 2020, and schizoaffective disorder dated August 21, 2021. A medication care plan revised on September 28, 2020 revealed that the resident is on anti-anxiety medication related to anxiety disorder. Interventions included to give anti-anxiety medications as ordered, monitor/record occurrence of target behavior symptoms, and psychiatric/psychological consult as ordered. Review of the PASRR Level I Screening Tool dated March 9, 2021 revealed the form was not adequately filled out. Section B. Mental Illness was left blank. The symptoms portion under the area interpersonal with the question has the individual exhibited interpersonal symptoms or behaviors was left unanswered. Additionally, the concentration/task related symptoms portion was left answered. The portion pertaining to History of Psychiatric Treatment was also left blank. The area titled Psychotropic Medications was also left blank. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A communication care plan revised April 25, 2022 revealed that the resident has impaired hearing. Interventions included to be conscious of the resident's position when in groups, activities, and dining room to promote proper communication with others. It also recommended to use communication techniques which enhance interaction and to allow adequate time to respond. A care plan revised on April 25, 2022 indicated that the resident has a potential to demonstrate physical and verbal behaviors and refusal of care related to dementia. The goal was for resident not to injure self or others. Interventions included to administer and monitor the effectiveness of medications, assess and anticipate needs, evaluate for side effects of medication, intervene as needed to protect the rights and safe of others, remove from situation, when agitated-ensure safety and re-approach at a later time when less agitated. A medication care plan revised on February 17, 2023 revealed that the resident is on anti-psychotic medicates related to schizoaffective disorder. Interventions included to administer medications as ordered, and monitor for side effects. A behavioral care plan revised on July 26, 2023 revealed that the resident has behavior problems related to striking/swinging at staff during nursing care. Interventions included to administer medications as ordered, anticipate and meet needs, encourage to follow the care plan but respect choices, and explain all procedures to him before starting, allow time to adjust to changes. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 99, indicating that the resident was unable to complete the assessment. Section I. Active Diagnoses indicated the resident's diagnoses included dementia, anxiety disorder, depression, and schizophrenia. Further review of the clinical record did not reveal a PASRR Level I after the PASRR Level I dated March 9, 2021. An interview with the Resident Relations Manager who functions as Social Services (staff #107) was conducted on December 7, 2023. Staff #107 stated that when a resident first comes into the facility, they come in with a PASRR which she reviews/updates. After the resident is here after 40-day admission they review and will do a PASRR or hospital stay or change they do a level II PASRR. Staff #107 noted that if there is a mental illness and intellectual disability they will do a new PASRR and initiate a level II. PASRR audit is accomplished by corporate and they check PASRR. However, the audit does not include residents that have been in the facility over 40-days, so long term care residents are not part of the PASRR audit complete by corporate. Staff #107 stated that every single spot of the PASRR sheet should be completed and that included section B. She noted that if schizoaffective disorder is a new diagnosis after a PASRR is completed then a new PASRR will be triggered. Staff #107 noted that if a new PASRR is not accomplished following a new mental illness/disorder diagnoses then the facility will not be able to provide effective care for the resident. She stated that a new PASRR is a great identifier to provide care for what a resident need so if it is not completed then it can be a problem. Staff #107 verified that the most recent PASRR for resident #2 was dated March 9, 2021. She stated that with the diagnoses of schizoaffective disorder in August 21, 2021, it should have triggered a new PASRR I and should include the medications that is related to the pertaining diagnosis. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON/staff #100) was conducted on December 7, 2023 at 2:12 p.m. Staff #100 stated that her expectation is that PASRR is completed for each resident. She said that she also expects that when there is a new diagnosis related to mental illness/disorder a new PASRR is accomplished. Staff #100 stated that she has been made aware that a new PASRR should have been completed for resident #2 and that one will be done for him. Staff #100 stated that if a PASRR is not updated then the facility will not know how to properly care for the resident. Review of the facility's policy titled Pre-Admission Screening and Resident Review [PASRR]) version 0920 stated that the facility will strive to verify that a Level 1 PASRR screening has been conducted, in order to identify serious mental illness (MI) and/or an intellectual disability (ID) prior to initial admission of individual to the facility. Additionally, it stated that PASRR Level I screenings are used to determine whether the individual has a diagnosis or other presenting evidence that suggests the for MI or ID. If the resident is positive for potential MI or ID, a Level II PASRR referral must be submitted. The policy indicated that it is the responsibility of the facility to make referrals for a Level II PASRR, or that a referral is made by the ALTCs case manager, if a Level II is determined to be necessary. The policy also indicated that the facility will strive to submit an updated Level I Screening and Level II evaluation request within 14 days after the facility determines through the MDS assessment that there has been a significant change in the resident's physical or mental condition which may indicate the need for specialized MI or ID services, according to the Criteria for Level II Referrals. Furthermore, the policy stated that an updated Level I screening must be conducted for each resident of the facility who has serious mental illness or intellectual disability not less than annually.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on clinical record review, staff interviews, and the facility policy and procedures, the facility failed to ensure that adequate documentation for one resident's (#40) nutritional intake was completed. The deficient practice could result in nutritional deficiencies not being monitored. Findings include: Resident #40 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unspecified protein-calorie malnutrition, iron deficiency, chronic obstructive pulmonary disease, and acute kidney failure. Review of the care plan dated October 10, 2023 revealed that the resident is at risk for nutritional and hydration problems as evidenced by a low mini nutritional assessment (MNA) score of 6: malnourished. Interventions included fortified cereal, Med Pass nutritional shake two times daily, and to encourage intake. A mini nutritional assessment (MNA) dated October 11, 2023 revealed the resident's height was 68 inches and weight was 142 lbs and had a moderate decrease in food intake and lost more than 6.6 pounds over the last three months. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 14 indicating the resident was cognitively intact. The order summary revealed an order dated October 10, 2023 for a regular diet, regular texture, thin liquids consistency and fortified cereal. A progress note by the dietician dated November 12, 2023 revealed that the resident's weight was 133.5 lbs on November 3, 2023 and he had a 5.6% weight loss over the last 30 days. The resident is on a regular diet with 67% intake times one week, variable intake of fortified cereal, and an appetite stimulant is in place. The resident's weight is trending down despite interventions and will add Med Pass nutritional shake twice a day to maximize nutrition. Review of task for cereal intake revealed that there was no documentation on November 2, and 6, 2023 and documented as not applicable on November 10, 11, 12, 17, 18, 19, 23, 24, 25, 26, and December 1, 2, and 3, 2023. An interview was conducted on December 7, 2023 at 12:52 p.m. with a certified nursing assistant (CNA/staff #36), who stated that the percentage of food intake for every meal is documented for all the residents. She stated that if a resident refuses to eat, she documents the refusal on the task sheet and reports it to the nurse. She knows that the resident eats fortified cereal with a protein shake for breakfast and if it is a standing order, he should received the cereal every morning. She stated that if there is no documentation regarding the percentage of cereal eaten, it may mean that the cereal was not sent to the resident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on December 7, 2023 at 1:14 p.m. with a registered nurse (RN/staff #81), she referred to the cereal order and stated that it was part of the dietary order, but was not sure how often the resident was supposed to receive it. She went to check with the Director of Nursing (DON/staff #100) and stated the DON told her the order for the fortified cereal was for every day shift. Then, staff #81 reviewed the task sheet for the fortified cereal and stated that some of the documentation was missing, and there were multiple times that not applicable was documented. She was not able to state why the staff hadn't documented the amount of cereal eaten and did not know what was meant by not applicable. An interview was conducted on December 7, 2023 at 1:24 p.m. with the Director of Nursing (DON/staff #100), who stated that it was the same CNA who documented not applicable on the task sheet and needed to be reeducated on how to complete the task sheet accurately. Then, staff #100 reviewed the progress notes and stated that she couldn't find anything showing that the resident refused to eat cereal on the days that the data was marked not applicable. She stated that there is a risk to not documenting the percentage of meal intake or the refusal to eat because we are not able to see if the resident is benefiting from the cereal. The facility's policy Resident Nutrition Services dated November 2015 states that the multidisciplinary staff, including nursing staff, the attending physician and the dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits. They will develop a resident care plan based on this assessment. Nursing personnel will evaluate food and fluid intake in residents with, or at risk for, significant nutritional problems. Nursing staff will assess and document the amounts eaten as indicated for individuals with, or at risk for, impaired nutrition.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47911 Based on observations, clinical record review, interviews, and policy review, the facility failed to ensure one resident (#23) received the necessary services to maintain good bathing and grooming hygiene. This deficient practice could result in bathing and grooming needs not being met. Findings include: Resident #23 was admitted on [DATE] with diagnosis including Parkinson's Disease, unspecified dementia, psychotic disturbance, mood disturbance, anxiety, arthritis, major depressive disorder, muscle weakness and need for assistance with personal care. A review of the MDS (minimum data set) dated November 07, 2023 revealed a BIMS (brief interview of mental status) of 5 and further noting that for personal hygiene the resident requires one-person physical assistance. A review of the care plan for resident #23 revealed that the resident is at risk for functional selfcare deficits and that facility staff is to communicate the resident and or family regarding the resident's needs. A observation was conducted on December 07, 2023 at 1:54 P.M. Resident #23 was observed to be seated in the communal area of the unit watching television. The resident was not clean shaven and was observed to exhibit facial hair. A telephone interview with the representative, Individual #203, of resident #23. She stated that the resident likes to be shaved but had not been. Individual #203 stated that the resident's presonal razor had been brought to the facility and it was requested that staff shave the resident; however, based on the representatives statement and per observation, the resident had not been shaven. An interview was conducted on December 7, 2023 at 2:02 P.M. with resident #23. The resident stated that he did not like facial hair and would like to have a shave. The CNA (certified nursing assistant), staff #31, had walked into the room and stated that the resident had not been shaven for 3 to 4 days, because she can't find his personal razor. She stated that facility razors were available but they tend to cause 'nicks' and that is why she had not shaved the resident. When asked about an electric razor, staff #31stated that the facility does have one but she would have to track it down; however, neither a bladed or electric razor had been utilized to shave the resident. She stated that the last time the resident had received a shower was on December 06, 2023. She further stated that anytime a resident wants to be shaved that he should be shaved. An interview was conducted with 2 additional CNA's, staff #94 and staff #202, on December 07, 2023 at 2:06 P.M. CNA #202 stated that residents generally bring their own razors, but if not, a facility razor would be utilized and CNA #94 if a resident prefers to be shaven, staff would shave the resident on a daily basis. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on December 07, 2023 at 2:27 P.M. with LPN (licensed practical nurse) staff #3. Staff #3 stated that personal hygiene tasks such as shaving are generally completed twice a week during showers and as needed. Staff #3 reviewed the shower schedule for the resident and stated that it was noted that the last documented shower was on November 15, 2023. An interview was conducted on December 07, 2023 at 2:39 P.M. with the DON (director of nursing) staff #100. Staff #100 stated that shaving is contingent on whether a resident would like to be shaved or not and that it is most frequently offered during showers twice weekly. However, staff #100 stated that the last documented time the resident had received a shower was on November 15, 2023 and the facility expectation is 2 showers per week; however, per facility documentation, the last reported shower had been approximately 3 weeks ago which did not meet the facility's expectation. A review of the facility's Activities of Daily Living (ADL) policy, with a revision date of March 2018, revealed that appropriate care and services would be provided to residents who are unable to carry out ADL's independently to include bathing and grooming. The bath and shower policy dated 2022 revealed that staff are to document the date and time that the shower/ bath had been performed and further document skin related observations and or refusals; however, the last documented shower was noted to be on November 15, 2023.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff and resident interviews, and the facility policy and process, the facility failed to ensure one resident (#40) had access to activities. The deficient practice could impact the psychosocial well-being of residents. Findings include: Resident #40 was admitted to the facility on [DATE] with diagnoses that included a displaced intertrochanteric fracture of the left femur, chronic obstructive pulmonary disease, dependence on oxygen, major depressive disorder and an anxiety disorder. The activities care plan dated October 10, 2023 stated that the resident enjoys being in his room watching TV and looking outside his window getting sunlight and included one intervention to offer a variety of activity types and locations. Note: resident #40 shares a room and his roommate's bed is located on the side of the room where the window is located. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 14 indicating the resident was cognitively intact. Review of the clinical record did not reveal any documentation of activities that the resident attended or refused to attend. During the initial interview conducted on December 4, 2023 at 1:07 p.m. with resident #40, he stated that he is not invited to activities and doesn't know what activities are being offered. An activity calendar was observed hanging on wall directly across from the resident's bed and was dated November 2023. An interview was conducted on December 7, 2023 at 2:07 p.m. with the Activities Manager (#staff 61), who stated that the purpose of activities is to get the residents out of their rooms, to distract them. She makes an activities calendar each month for the residents, so they know what activities are being offered. She stated that she goes to the residents' rooms and invites them to activities and she memorizes which residents are not participating. She stated that resident #40 usually doesn't want to attend activities because he is not interested. She stated that the prior Activities Manager trained her, which included tracking and documenting resident participation, but she has not done this. An interview was conducted on December 7, 2023 at 2:27 p.m. with the Executive Director (ED/staff #11), who stated that he supervises the Activities Manager (staff #61) and he has never required her to track resident participation in activities. He stated that there is a large activities calendar posted in the hallway, so residents know what activities are scheduled. (continued on next page)

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	035086	A. Building B. Wing	12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Sierra Vista, LLC	660 South Coronado Drive Sierra Vista, AZ 85635

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a second interview conducted on December 7, 2023 at 2:47 p.m. with resident #40, he stated that he can't get out of bed by himself, so he would need assistance to attend an activity. He also stated that he can read, but he can't see the activities calendar hanging on the wall across the room. The facility's policy Activity Programs dated January 2011 states that the activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. Activities participation for each resident is approved by the Attending Physician based on information in the resident's comprehensive assessment. Scheduled activities are posted on the resident bulletin board. Activity schedules are also provided individually to residents who cannot access the bulletin board (e.g. bed bound or visually impaired residents).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on clinical documentation, staff interviews, and the facility policy and process, the facility failed to complete baseline vital assessments upon one resident's (#116) admission. The deficient practice result in a change of condition not being recognized. Findings include: Resident #116 was admitted to the facility on [DATE] with diagnoses that included displaced intertrochanteric fracture of the left femur, hypothyroidism, and depression. The admission evaluation dated May 26, 2023 at 3:25 p.m. did not include vitals. An admission summary progress note dated May 26, 2023 at 7:38 p.m. revealed that the resident arrived at the facility around 1:30 p.m. The resident was admitted for a displaced intertrochanteric fracture of the left femur, subsequent encounter for a closed fracture with routine healing. The resident's weight was 158 pounds. Review of the weights and vitals summary revealed that the resident's blood pressure was 129/68 and temperature was 97.6 F. at 4:00 p.m. A health status progress note dated May 26, 2023 at 5:37 p.m. revealed that the resident felt warm and her temperature was 99.5 F. The resident was offered Tylenol and declined stating that it gives her diarrhea. The resident was checked again at 8:58 p.m. and stated that she was having chest pain and that she had called her husband and told him to call 911. The ambulance arrived at 9:05 p.m. to transport the resident to the hospital as per the resident's request. Saturation of peripheral oxygen (SPO2) was 95%. Staff attempted other vitals, but the emergency staff arrived and took vitals. The discharge/transfer assessment dated [DATE] at 9:23 p.m. did not include vital signs. An interview was conducted on December 6, 2023 at 10:14 a.m. with the reporting source (#200), he stated that the resident had surgery and was treated for infection at the hospital. He stated that the resident called him and said that she was hot and sweaty, warm to the touch, and having heart palpitations. He was concerned because staff did not take the resident's vitals when she was admitted and her temperature baseline was below average. He called 911 and had the resident transported to the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on December 6, 2023 at 11:17 a.m. with the Director of Nursing (DON/staff #100), she stated that when a resident is admitted , the staff establish a baseline, which includes: mentation, vitals, skin check, heart and lung sounds, and pedal pulses and the results are documented in the initial evaluation or could be found in a progress note. It is her expectation that the vitals are done within the first hour of the resident being admitted . She referred to the admission evaluation and acknowledged that the vitals were not included. Then, she referred to the clinical record and stated that the resident was admitted at 1:30 p.m., blood pressure was taken at 4:00 p.m., and temperature was taken at 4:00 p.m. She stated that if the vitals were not taken when the resident was admitted , we wouldn't have a baseline and then we wouldn't know if there was a change of condition. She also stated that she thinks it is common for the elderly to have a lower temperature. An interview was conducted on December 6, 2023 at 2:12 p.m. with a licensed practical nurse (LPN/staff #18), who stated that when a resident is admitted , the nurse completes a head-to-toe assessment, which includes a full set of vitals and the documented in the clinical record. She stated that the facility doesn't have a policy regarding vitals.

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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. 46606 Based on observations, staff interviews, and policy reviews, the facility failed to ensure a sanitary kitchen with regards to peeling paint over the tray line counter. The deficient practice could increase the risk of foodborne illness. Findings include: An observation was conducted of the kitchen on December 6, 2023 at 12:13 p.m. During this observation, peeling ceiling paint was noticed above the tray line counter. A follow-up observation was conducted on December 6, 2023 at 3:00 p.m. It was observed that the cracked and peeling ceiling paint spanned the length of the 3 vents on top of the tray line counter. An interview with the Nutrition Services Manager (staff #55) was conducted on December 6, 2023 at 2:55 p. m. Staff #55 stated that there are plans for a kitchen renovation. He said that the facility knows about the cracked/peeling ceiling paint in the kitchen but no action has been taken. He stated that the facility has assessed but nothing has been done. Staff #55 stated that it does bother him and that the crack/peeling ceiling paint is around the 3 vents. He said that potentially particles can get in the food they are preparing. Staff #55 noted that over 6-months ago, he placed a work order about the ceiling but it still has not been fixed. An interview was conducted with the Executive Director (ED/staff #11) inside the kitchen on December 6, 2023 at 3:02 p.m. Staff #11 admitted that all the times he has been at the kitchen he has never looked up. Now looking at it, he admitted that it is a concern that there is cracked/peeling ceiling paint over the tray line. Staff #11 stated that it has probably been months that the ceiling has cracked/peeling paint. He indicated that renovations for the kitchen is supposed to start next week. Staff #11 agreed that having cracked/peeling ceiling paint over the tray line is an issue. Review of the TELS work order log with the timeframe of May 1, 2023 through December 5, 2023 did not reveal a work order request regarding the peeling ceiling paint in the kitchen. On December 7, 2023 at 9:16 a.m., the ED (staff #11) and the Nutrition Services Manager (staff #55) showed the surveyor that the kitchen ceiling was fixed. Review of the facility policy titled Sanitation revised October 2008 indicated that the food service area shall be maintained in a clean and sanitary manner. The facility policy titled Maintenance Service revised December 2009 indicated that the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Furthermore, the policy stated that the functions include maintaining the building in good repair and free from hazards. The policy noted that the Maintenance Director is responsible for maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47911 Based on staff interviews, and review of facility documentation and policies, the facility failed to ensure that the QAA (quality assessment and assurance) committee collected data and monitored it's performance regarding adverse events for performance improvement. Findings include: An interview was conducted on December 7, 2023 at 3:21 P.M. with the administrator, staff #11, and the director of nursing, staff #25. Staff #11 stated that the QAA comittee meets at least quarterly and that data for performance improvement is obtained from a variety of sources to include audits, staff and resident feedback. Some of the topics for PIP's (performance improvement plans) had included the facility census, pressure ulcers, weight loss, falls, psychotropic medications, call-light response and showers. Staff #11 stated that the data for each PIP is reviewed the following month during the QAPI (quality assurance and performance improvement program) meeting. Staff #11 stated that staff #25 utilizes audit forms and that data is kept in a specific binder. Status updates are then shared forward with staff and residents as applicable. She stated that two of the PIP's tracked included call-light response, which were stated to be ongoing and showers, which were stated as a completed PIP; however, when asked about the data tracking, the facility was unable to provide evidence of data tracking for either PIP. The administrator stated that both analysis of data and graphing of the data would be an expectation for any PIP. He stated that the risk of not tracking and appropriately documenting the data could include that the problem would not actually get fixed. A review of the Quality Assurance and Performance Improvement Meeting policy with a copyright date of 2016 revealed that the purpose of QAPI is to establish data-driven, facility-wide processes that improve the quality of care; however, for 2 of the performance measures, there was no evidence of data trend tracking for the identified PIP's.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 40581 Based on personnel file reviews, staff interviews, and the facility policy and procedures, the facility failed to provide evidence that 3 out of 10 staff (#98, #26, and #27) were provided resident rights training. The deficient practice could result in residents not being afforded their rights. Findings include: Review of the personnel file for staff #98, a physical therapist, revealed a hire date of June 1, 2023. Further review of the personnel file revealed no evidence that staff #98 had received training on resident rights. -Review of the personnel file for staff #26, a occupational therapist, revealed a hire date of June 1, 2023. Further review of the personnel file revealed no evidence that staff #26 had received training on resident rights. -Review of the personnel file for staff #27, a speech therapist, revealed a hire date of June 1, 2023. Further review of the personnel file revealed no evidence that staff #26 had received training on resident rights. An interview was conducted on December 6, 203 at 9:19 a.m. with the human resources (staff #201) all staff are required to complete training on resident rights. An interview was conducted on December 6, 2023 at 3:27 p.m. with a certified occupational therapy assistant (COTA)/Area Manager (staff #111. She stated that she doesn't have a sign-in sheet to show that staff (#98, #26, and #27) attended resident rights training. The facility policy Staff Development Program states all personnel must participate in initial orientation and regularly scheduled in-service training classes. DHS Mandatory topics include resident's rights.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 40581 Based on personnel file review, staff interviews, and the facility policy and procedures, the facility failed to provide evidence that 1 out of 10 staff (#98) was provided dementia training. The deficient practice could result in residents with dementia not receiving the care needed. Findings include: Review of the personnel file for staff #98, a physical therapist, revealed a hire date of June 1, 2023. Further review of the personnel file revealed no evidence that staff #98 had received dementia training. An interview was conducted on December 6, 203 at 9:19 a.m. with the human resources (staff #201) all staff are required to complete dementia training. An interview was conducted on December 6, 2023 at 3:27 p.m. with a certified occupational therapy assistant (COTA)/Area Manager (staff #111. She stated that she doesn't have a sign-in sheet to show that staff (#98) attended dementia training. The facility policy Staff Development Program states all personnel must participate in initial orientation and regularly scheduled in-service training classes. Topics did not include dementia training.