STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035117	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Payson Care Center	107 East Lone Pine Drive Payson, AZ 85541

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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 - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that one resident (#35) was issued a written Notice of Medicare Non-Coverage (NOMNC) and the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) within the required timeframe and one resident (#26) was not given the SNF ABN notification as required. Findings include: Resident (#35) was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, abnormalities of gait and mobility, and generalized muscle weakness. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 11 indicating the resident had a moderate cognitive impairment. Review of the Occupational Therapy Discharge Summary revealed dates of service December 20, 2024 through January 31, 2025. It also revealed that the resident had reached maximum potential with skilled services. The resident was discharged as per physician or case manager. Review of the Physical Therapy Discharge Summary revealed dates of service December 22, 2024 through January 17, 2025. The resident achieved the highest practical level. Review of the NOMNC form revealed that Medicare services would end on February 3, 2025. Continued review of the notice revealed documentation that the resident's power of attorney (POA) was verbally contacted on February 3, 2025 at 11:05 a.m. to discuss the NOMNC. The POA was notified and explained the NOMNC and verbal consent was given over the phone. The SNF ABN form revealed that beginning on February 3, 2025 the resident may have to pay out of pocket for physical therapy, occupational therapy, and daily skilled nursing care if the resident doesn't have other insurance that may cover costs. Continued review of the notice revealed documentation that the resident's power of attorney (POA) was verbally contacted on February 3, 2025 at 11:05 a.m. to discuss the NOMNC. The POA was notified and explained the NOMNC and verbal consent was given over the phone. (continued on next page)

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Notice of Resident Transfer Or Discharge form revealed that the resident was transferred from skilled nursing to long-term care at the facility. The documented reason for the transfer was that the resident was switched to private pay. The POA was notified verbally on February 3, 2025. -Resident #26 was admitted to the facility on [DATE] with diagnoses the included encounter for orthopedic aftercare following surgical amputation, chronic kidney disease, and generalized weakness. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact. Review of the Occupational Therapy Discharge Summary revealed dates of service October 10, 2024 through December 20, 2024. It also revealed that the resident has made consistent progress with skilled interventions. The resident has met long term/short term goals. The resident was discharged as per physician or case manager. Review of the Physical Therapy Discharge Summary revealed dates of service October 9, 2024 through December 20, 2024. The resident achieved the highest practical level. Review of the NOMNC form revealed that Medicare services would end on December 20, 2024. Review of the clinical record did not reveal the SNF ABN form and continued to reside at the facility. An interview was conducted on March 7, 2025 at 9:12 a.m. with the Social Services Director (SSD/staff #20) and the Business Office Manager (BOM/staff #24). Staff #20 stated that the purpose of the NOMNC is to notify the resident when skilled services are about to end and to let the resident know he/she have the right to appeal. She stated that the NOMNC is to be issued at least three days prior to the last covered date, so the resident has time to appeal. She stated that if the NOMNC is given to the resident late, the resident doesn't have enough time to do the appeal, prepare for discharge, and talk to physician to prepare for the appeal or the discharge. She stated that the SNF ABN form must be given to the resident at least three days prior to the discharge from skill nursing and the purpose of the SNF ABN form is to notify the resident that he/she would be private pay if skilled services are continued and should include the estimated cost. Risk to not giving the ABN is that the resident doesn't know how much to pay or money to pay for skilled services and she was not required to give resident #24 an SNF ABN form because the resident transferred to long-term care in the facility. (BOM/staff #24) stated that there is no way to know the last covered date of Medicare Part A because Medicare doesn't issue an authorization letter for skilled services. Neither staff was able to explain how the last covered day of service for the above residents was determined. Staff #24 also stated that the facility didn't have a SNF ABN form for resident #26. The facility policy, Denial or End of Benefits states that the Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123, is given to all Medicare beneficiaries at least two days before the end of a Medicare Part A stay or when all of Part B therapies are ending. The facility policy, Notice of Charges states that the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) is only issued if the beneficiary intends to continue services and the SNF believes the services may not be covered under Medicare. It is the facility ' s responsibility to inform the beneficiary about potential non-coverage and the option to continue services with the (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	beneficiary accepting financial liability for those services.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50887 Based on documentation, staff interviews, and facility policy and procedures, the facility failed to ensure one resident (#18) was provided with adequate supervision to prevent falls. The deficient practice could result in residents being harmed physically. Findings include: Resident #18 was admitted to the facility on [DATE] with diagnoses that included, pain in thoracic spine, pain in left and right leg, age related osteoporosis, and other abnormalities of gait and mobility. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 11, indicating moderate cognitive impairment. The assessment also revealed that the facility was unable to determine falls in the last month prior to admission or last 2-6 months of admission, but indicated the resident did not have any falls since admission. Review of the resident's care plan revealed no evidence of a focus or interventions related to falls prior to or after each documented fall. Review of the resident's clinical record revealed that the resident had falls in the facility on the following dates: -2 falls on January 28, 2025 -1 fall on February 2, 2025 -1 fall on February 8, 2025 -1 fall on February 9, 2025 An event note dated January 28, 2025 at 10:45 PM revealed that the nurse was called to the resident's room by a certified nursing assistant (CNA) to find the resident sitting upright on the floor next to her bed on a crash pad, her legs were out in front of her. The note indicates that the resident did not use the call bell for assistance, and that the resident was very confused with altered mental status. The resident was assisted back into low bed with crash pads on floor at bedside. No injuries to the resident were noted for this fall. An event note dated February 2, 2025 at 2:33 PM revealed that the resident was found lying on her left side on the floor near her restroom. The resident had self-ambulated to her restroom with a walker and had non-slip socks on. The resident did not use her call light. Resident's eyes were open but did not respond when asked questions. No visible injuries were noted during that time. 911 was contacted and the resident was sent to the hospital. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A health status note dated February 2, 2025 at 5:23 PM indicated that the resident went to the hospital and that the resident had sustained a rib fracture to 4 and 5. The resident was transported back to the facility and was alert and responsive. Per the Director of Nursing (DON) the resident would be on 15-minute checks. Review of the order summary revealed an active physician's order dated February 2, 2025 to check the resident every 15 minutes. No evidence of any other orders related to fall interventions were identified. A physician/physician's assistant/nurse practitioner note dated February 3, 2025 at 1:58 PM revealed that the resident was sent to the hospital for evaluation and had sustained left 4th and 5th rib fractures laterally, non-displaced, after resident fell in facility on February 2, 2025. An event note dated February 8, 2025 at 11:50 PM revealed that a crash was heard at the nurse's station and the resident was found lying on her left side. Blood was noticed to be on the floor, and the resident had a large laceration to the left elbow and a small hairline cut to the left orbital region. The note revealed that the resident was trying to hold onto the sink but just couldn't make it. Resident appeared to have altered mental status and was sent to the hospital for evaluation. A health status note dated February 9, 2025 at 2:25 AM indicated that the facility had spoken with the hospital and indicated that the resident sustained a new T1 compression fracture. An event note dated February 9, 2025 at 5:01 PM revealed that the resident was observed to be sitting on the floor in front of the nurse's station wearing a gown, brief, and non-skid socks. The resident's wheelchair was behind the nurse's station with the brakes engaged. The note indicated that the resident wanted to go back to bed but the wheels were locked so she tried scooting herself back to her room. The note also indicated that the resident stated she hit the back of her head and was then sent to the hospital for evaluation. An event note dated February 9, 2025 at 5:32 PM indicated that resident had returned to the facility and per the hospital, the resident sustained another rib fracture. An observation was conducted on March 5, 2025 at 11:55 AM of resident #18. The resident was laying in bed, with the bed low, and nonskid socks on both feet. During this observation, the surveyor attempted to interview the resident about the falls, the resident said she slipped but could not provide any other details about any of the fall incidents. The resident also stated that she does use her call light. An interview was conducted on March 5, 2025 at 11:38 AM with Certified Nursing Assistant (CNA/Staff #49) who stated that they are informed of resident's needs by either the nurses or other CNAs. She stated that she would be notified of fall interventions for residents by either the nurses or CNAs informing her, or on the fall packet that is done after a resident has a fall. The CNA stated that the fall interventions in place for resident #18 included having a fall matt on both sides of the bed and performing hourly checks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on March 5, 2025 at 11:42 AM with Licensed Practical Nurse (LPN/Staff #61) who stated that residents are assessed for falls upon admission, every three months, and as needed. The LPN stated that he is informed of what interventions are in place for residents by either the care plan, progress notes, or by report from other nurses. During the interview, the LPN reviewed resident's #18 clinical record and stated that the fall interventions for this resident included an active order for 15-minute checks and the resident being on the restorative program. An interview was conducted on March 5, 2025 at 1:40 PM with Certified Nursing Assistant (CNA/ Staff #47) who stated that he was not aware of any 15-minute checks that had been done for resident #18. The CNA also stated that it would be documented on the 15-minute check form and there was not one for this resident. In another interview with the LPN (staff #61) on March 5, 2025 at 1:58 PM, he stated that anyone could complete the 15-minute checks for the resident. He also stated that the risk of not completing the 15-minute checks could put the resident in danger for additional falls and injuries. An interview was conducted on March 5, 2025 at 1:24 PM with the health information management director (staff #11) who stated the CNAs or nurses fill out the 15-minute check forms when they complete the checks. She stated that the forms are collected from the nurse's station daily, but she did not have a 15- minute check form for resident #18. She further stated that it must be at the nurse's station #2 in her health information management box to be picked up. On March 5, 2025 at 1:35 PM staff #11 went to the nurse's station with the surveyor and observed that the health information management box was empty. Staff #11 stated that she could not find a 15-minute check form for resident #18. An interview was conducted on March 5, 2025 at 1:08 PM with the Director of Nursing (DON/Staff #39) who stated the process after a resident falls includes to meet with the DON, document the incident on the risk management form, and talk about what interventions are in place and what new interventions are needed. The DON also stated that the care plan should be updated at the same time the risk management form is completed. Once it is discussed then it would go into the nursing orders. Another interview was conducted on March 5, 2025 at 2:09 PM with the Director of Nursing (DON/Staff #39) who stated that the purpose of the 15-minute checks for the resident would be to help prevent further falls. The DON also stated that the risk of not completing the 15-minute checks of the resident could be further falls and injury. Review of the facility policy, Fall Management, reviewed September 25, 2024, indicated that the facility will assess the resident upon admission, quarterly, with change in condition, and with any fall event or fall risks and will identify appropriate interventions to minimize the risk of injury related to falls. The policy also indicated that each resident will receive adequate supervision and assistance devices to prevent accidents. The policy revealed that the interdisciplinary team will review and revise the care plan upon a fall event and as needed thereafter.

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F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care/assistance for a resident with a prosthesis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51103 The facility failed to ensure resident # 26 was provided care and assistance, to aid in the preparation of the left prosthetic device readiness. This deficient practice can result in resident deconditioning, adversely impacting prosthetic device use. Findings include: Resident #26 was readmitted to the facility on [DATE], following amputation of the left lower extremity on October 2, 2024. Additional clinical diagnoses include Type 2 Diabetes Mellitus, bilateral amputation of the lower extremities, muscle weakness, and limitation of activities due to disability. A physical therapy consultation report dated October 9, 2024 revealed the resident will need a fitting for the right lower prosthetic. A progress note dated October 11, 2024 revealed the resident was a little sad, but willing to try the prosthetic device. An order dated October 15, 2024 revealed an order for the resident be referred for resizing of the right below the knee amputation. A progress note dated October 21, 2024 revealed the resident was in possession of a right leg prosthesis, and voiced enthusiasm about receiving the left leg prosthetic. A progress note dated November 18, 2024 provided revelation that the staples were removed from the surgical incision and had prosthetic measurements done. A progress note dated November 28, 2024 revealed an abdominal pad needed to be applied to the right lateral knee over small reddened area prior to wearing the sleeve prosthetic. A progress note dated December 4, 2024 revealed the abdominal pad dressing for the right lateral knee was no longer applicable. An order dated December 9, 2025 revealed the resident was allowed to have full weight bearing with the prosthetic/mobility device. A physical therapy discharge summary note dated December 21, 2024 revealed the resident was not able to ambulate due to waiting for prosthesis. A progress note dated February 26, 2025 revealed pain and weakness in the musculoskeletal review of systems. (continued on next page)

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F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Occupational Therapy Discharge Summary for the certification period of December 5, 2024 through January 1, 2025 was signed by OT on December 5, 2025, and by the provider on December 16, 2024. The OT discharge summary supported the design and implementation of a restorative nursing program. The discharge summary advised that the resident is a fall risk, decrease in level of mobility, decreased participation with functional tasks, decreased ability to return to prior level of assistance and decreased ability to return to prior level of supervision. The Physical Therapy Discharge Summary dated December 21, 2024 recommended the restorative program, and to resume physical therapy once the prosthetic arrived. It was revealed the resident was not able to ambulate due to waiting for the prosthesis. A letter of medical necessity was undated and unsigned by the provider was received March 7, 2025, revealing the resident was medically stable and possessed previous experience with prosthetic devices. The clinical record failed to reflect care planning for the left lower extremity amputation that occurred on October 2, 2o24. The clinical failed to reflect an order for prosthetic follow up for the left below the knee amputation or the prosthetic device. An interview conducted with the resident on March 5, 2025 at approximately 9:15 a.m., the resident revealed measurements were performed for the leg prosthetic. The resident voiced having no clue it will arrive. The resident further revealed questioning the staff and provider about it, but receiving no concrete answer. The resident admitted to eagerness to obtain the new prosthetic, not only to walk, but expressed fear for waiting so long the muscles will be to weak. The resident stated I do not know what is taking so long, my leg has been healed for a while! An interview was conducted with the Rehabilitation Services Director (Staff # 73), on March 6, 2025 at approximately 9:28 a.m. The director revealed the delay was related to the need of additional documentation from the provider. In order to continue the process, the director reported that the Letter of Medical Necessity for the resident was drafted today (March 6, 2025) and sent to the provider for review and further instruction. An interview was conducted with the Restorative Nurse Assistant (RNA) on March 6, 2025 at approximately 9:40 a.m. The RNA revealed the resident was not on the restorative therapy caseload. The RNA revealed the restorative program does have a special treatment plan which is tailored toward residents with prosthetic needs. An interview was conducted with the Certified Medication Aide (Staff #46), who revealed the resident attended prosthetic fitting appointments on November 11, 2024 and January 6, 2025. (continued on next page)

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F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was attempted with the prosthetics provider on March 6, 2025 at approximately noon. The office was closed for the day, and the voicemail referred callers to the company website. The provider website revealed the facility is open by appointment only. The corporate office was then contacted, and was advised to refer to the website for pre-prosthetic training information. As part of pre-prosthetic training, it advises patients to gain strength and avoid contractures (muscle tightening). In addition, website advised that referred patients will need to obtain a prescription from their provider in order to obtain the prosthetic device. An interview was conducted with the Director of Nursing (Staff # 39) and the Director of Clinical Services (Staff # 62) on March 7, 2025 at approximately 10:00 a.m. Both parties agreed, the facility expectation has yet to be met, but progress has been made. Both parties agree that the resident is under care of a prosthetics provider, and are actively investigating restorative therapy and specialized rehabilitation services options to assist the resident. The parties revealed the care plan for the left below the knee amputation will also be initiated. The Prosthesis Care and Management policy revealed the facility must ensure the resident who has a prosthetic device is provided care and assistance, in order to wear and be able to use the prosthesis.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50887 Based on clinical record review, staff interviews, and policy and procedures review, the facility failed to ensure that consent was obtained by the resident before psychotropic medications were administered for one of five sampled residents (#23). The deficient practice could result in residents receiving an unnecessary psychotropic medication. Findings include: Resident #23 was admitted to the facility on [DATE] with diagnoses that included pneumonitis due to inhalation of food and vomit, acute and chronic respiratory failure with hypoxia, and chronic obstructive pulmonary disease. Review of the order summary revealed a physician's order dated April 24, 2024 for Duloxetine hydrochloric acid (HCL) capsule delayed release particles 30 milligrams (MG); give two capsules by mouth at bedtime for depression dated. Review of resident's #23 clinical record revealed a medication informed consent form dated April 24, 2024 that listed the medication Duloxetine. However, the consent form was not signed by the resident or a resident representative. The form also did not include the non-drug approaches proven to be ineffective, the reason why the medication was prescribed, or the expected benefits to the resident. Review of the resident's care plan initiated April 25, 2024 revealed a focus for the resident using the antidepressant medications, Duloxetine and Trazodone, related to depression. The care plan indicated interventions that included: to administer antidepressant medications as ordered by physician, observe for side effects and effectiveness every shift, and to observe for and report as needed any adverse reactions to antidepressant therapy. A quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The assessment also included that the resident had depression and that the resident was taking antidepressants. Review of the Medication Administration Records (MAR) dated January, February, and March of 2025 revealed that the resident was administered Trazodone and Duloxetine. Further review of the order summary revealed a physician's order dated March 5, 2025 for Trazodone HCL oral tablet 100 MG (Trazodone HCL); give one tablet by mouth at bedtime for diagnosis of depression, inability to sleep related to depression unspecified. The order summary also revealed a physician's order dated April 24, 2024 for Trazodone HCL oral tablet 150 MG (Trazodone HCL); give one tablet by mouth at bedtime for diagnosis of depression, inability to go to sleep, that had been discontinued. Further review of the resident's medical record revealed a psychoactive medication informed consent form dated March 5, 2025 that listed Duloxetine and Trazodone and was signed by the resident. However, there was no evidence of a medication informed consent prior to this date for Trazodone. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on March 6, 2025 at 11:47 AM with Licensed Practical Nurse (LPN/Staff #60) who stated the process for a resident taking an antidepressant medication included to verify the physicians order, monitor for any adverse effects, document any assessments on the Treatment Administration Record (TAR) and address any adverse effects if needed. The LPN stated that the consent is completed by the nurse before the resident is administered antidepressant medications for the first time. The LPN further stated that Duloxetine and Trazodone would require a consent to be completed. During the interview the LPN reviewed resident's #23 clinical record and stated that there was not a consent completed for Trazodone, and the consent for Duloxetine was not complete due to the resident not signing the consent form. The LPN stated the risk of not having the resident consent to these medications could be that the resident would not be well informed to make the proper decisions and would not be aware of any side effects or adverse reactions. The LPN also stated that it did not meet facility expectations to not have completed consents prior to the resident being administered the Trazodone and Duloxetine. An interview was conducted on March 6, 2025 at 12:04 PM with the interim Director of Nursing (DON/Staff #39) who stated that the process when a resident is taking an antidepressant medication included to have a consent be signed by the resident or family member when it is ordered. The DON stated that the consent would be completed by the nurse before the medication is administered. The DON also stated that Duloxetine and Trazodone would require a consent form to be completed. During the interview, the DON reviewed the resident's #23 clinical record and stated that there was not a consent for trazodone and the consent for Duloxetine was not complete because the resident did not sign the form. The DON stated that a risk to the resident by not having a completed consent for these medications would be that they have the right to choose if they want to take the medication or not. The DON further stated that it did not meet facility expectations to not have completed consents prior to the resident being administered these medications. During the interview conducted on March 6, 2025 at 12:19 the DON (staff #39) and the surveyor went to medical records and was provided a psychoactive medication informed consent for Duloxetine and Trazodone signed by the resident on March 5, 2025. The DON stated that there should have been a consent completed and signed by the resident prior to the consent done on March 5, 2025 and prior to the resident being administered the medications. The facility policy titled, Psychotropic Medication Informed Consent Policy, reviewed September 16, 2024, indicated that the facility will obtain consent or refusal to the use pf psychotropic medications. The policy revealed that the documentation will reflect that the intended or actual benefit is understood by the resident and, if appropriate his/her family and/or representative and is sufficient to justify the potential risks or adverse consequences associated with the selected medication, dose, and duration. The policy also indicated that the medication should not be started until after approved by the resident and, if appropriate, his/her family and/or representative.

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51103 Based on clinical record review, interviews, and facility policy, the facility failed to ensure one sampled resident (#26) received the restorative nursing services necessary to attain the resident's highest level of health and well-being. This deficient practice can result in the impairment of residents' ability to carry out activities of daily living (ADLs). Findings include: Resident # 26 was admitted to the facility on [DATE] for orthopedic aftercare following an amputation of the lower extremity. Further clinical diagnoses include a previous amputation of the lower extremity, muscle weakness, protein-calorie malnutrition, Type 2 Diabetes Mellitus (DM), and Chronic Kidney Disease (CKD). The Occupational Therapy Discharge Summary for the certification period of December 5, 2024 through January 1, 2025 was signed by OT on December 5, 2025, and by the provider on December 16, 2024. The OT discharge summary supported the design and implementation of a restorative nursing program. The discharge summary advised that the resident is a fall risk, decrease in level of mobility, decreased participation with functional tasks, decreased ability to return to prior level of assistance and decreased ability to return to prior level of supervision. The Physical Therapy Discharge Summary dated December 21, 2024, revealed Restorative Nursing Assistance was recommended, and to return to Physical Therapy once the prosthetic arrived. The recommendation further included the restorative program was to include standing in par bars exercise. The quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The assessment revealed the resident was independent in all areas of self-care. During the assessment period of October 9, 2024 through December 15, 2024, the resident did not receive restorative nursing services, which included training and skill practice in amputation/prostheses care. A progress note dated February 26, 2025 revealed pain and weakness in the musculoskeletal review of systems. The clinical record failed to support initiation or completion of the resident's Restorative Care Referral form. An interview was conducted with the resident on March 5, 2025 at approximately 9:15 a.m. The resident revealed not participating or recalled being offered to participate in the restorative nursing program. A resident council meeting was held on March 6, 2025 beginning at 1:00 p.m. One participant with upper extremity contractures would love to have someone to start doing therapy with her. (continued on next page)

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Rehabilitations Director (Staff # 73) on March 6, 2025 at approximately 9:28 a.m. The director explained that a goal of restorative therapy is to provide the residents with assistance to maintain and improve their ability to perform ADLs. The director explained how the restorative therapy program utilizes both nursing and skilled rehabilitation services to help assist the resident in achieving their desired level of functional independence. The director is aware that the resident is eager to receive and begin using both his prosthetic legs to be able to walk again, so the goal is to ensure the resident is ready once the they (the prosthetics) arrive. In cases where the Restorative Nursing Assistant (RNA) and care team determine the resident has additional needs from specialized rehabilitation services, the lines of communication are always open between departments, and the resident can be referred back. Upon further review of the clinical record review, the director was unable to support the resident receipt of restorative therapy nor recalls any refusals for restorative services, and revealed this does not meet facility expectation. An interview was conducted with the RNA (Staff # 40) on March 6, 2025 at 9:40 a.m. The RNA revealed that the resident was not on the facility's restorative therapy program case load. The RNA stated that referrals are completed on a Restorative Care Referral Form. The RNA further elaborated that the form contains items such as the type of program the resident needs, special instructions, and therapy goals. The RNA conducts sessions in the therapy room or the resident's, room depending upon resident's preference. In the RNA's experience at the facility, the RNA revealed a majority of the resident's enjoy doing the group sessions in the therapy room the most. If a resident is losing strength, or exhibits any other concerning change, restorative therapy department works closely with both the nursing and rehabilitative service departments to address any concerns. Although not on the restorative therapy caseload, the RNA voiced familiarity with the resident, and would love to assist in any way possible. A joint interview was conducted on March 7, 2025 at approximately 10 a.m. with the Director of Nursing (DON/ Staff #39) and the Director of Clinical Operations (Staff # 62) both parties agreed that there was no evidence to support the resident participation in the restorative therapy program. The facility's Activity of Daily Living policy revealed that any change in the resident's ability to perform ADLs will be reported to the nurse. The facility's Restorative Nursing policy identified the restorative nursing program is to promote the resident's optimum function. The policy advises that a resident may be started on a restorative nursing program upon admission with restorative needs, but is not a candidate for formalized rehabilitation therapy. In addition, the policy identified amputation/prosthesis care and walking as a category of restorative nursing functions.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51006 Based on personnel file review, staff interviews, and facility policy review, the facility failed to maintain an effective training program for five of nine sampled staff (#28, #34, #48, #53, and #56). The deficient practice could lead to a deficit in staff or volunteers' knowledge and/or skills which could affect resident care, leading to harm. Findings include: - Regarding the certified nursing assistant (CNA/Staff #28) Review of personnel file for the CNA (staff #28) revealed a hire date of March 1, 2010. Physical sign-in sheets and certification of online completion provided by the facility revealed that Staff #28 did not complete required annual training for dementia for the year of 2024 and 2025. - Regarding the occupational therapist (OT/Staff #34) Review of personnel file for the OT (staff #34) revealed a hire date of April 3, 2024. Physical sign-in sheets and certification of online completion provided by the facility revealed that Staff #34 did not complete required training for dementia for the year of 2024 and 2025. - Regarding the licensed practical nurse (LPN/Staff #48) Review of personnel file for the LPN (staff #48) revealed a hire date of August 17, 2020. Physical sign-in sheets and certification of online completion provided by the facility revealed that Staff #48 did not complete required training for dementia, infection prevention and control, and resident rights for the year of 2024 and 2025. - Regarding the CNA (CNA/Staff #53) Review of personnel file for the CNA (staff #53) revealed a hire date of August 25, 2021. Physical sign-in sheets and certification of online completion provided by the facility revealed that Staff #53 did not complete required training for dementia, infection prevention and control, resident rights, and abuse for the year of 2024 and 2025. - Regarding the registered nurse (RN/Staff #56) Review of personnel file for the RN (staff #56) revealed a hire date of October 30, 2023. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physical sign-in sheets and certification of online completion provided by the facility revealed that Staff #56 did not complete required training for infection prevention and control, and, abuse for the year of 2024 and 2025. On March 5, 2025 at 8:14AM, employee personnel records for 10 random employees were requested for review. The requested documents included proof of Tuberculosis screening, proof of cardiopulmonary resuscitation and first aid training completion, proof of a signed job description, proof of current license if applicable, proof of current fingerprint clearance cards, and, proof of 2024 and 2025 annual and in-service trainings for abuse/neglect, resident rights, dementia, and infection prevention and control. An interview was conducted on March 5, 2025 at 10:00AM with a Business Office Manager (Staff #26), and Staff #26 provided documentation supporting nine staff members, and advised that one out of the ten staff members was a corporate employee and will require additional requests from their corporate office. Following this interview, a secondary document request was submitted to the facility on [DATE] at 10:20AM for copies of training completion for all nine staff members, proof of fingerprint clearance for one staff member out of nine, proof of cardiopulmonary resuscitation and first aid training completion for one staff member out of nine, proof of a signed job description for one staff member out of nine, and, proof of licensure for three staff members out of nine. After a review of the supplemental information provided by Staff #26, a third document request was submitted on March 6, 2025 at 10:01AM to provide proof of abuse training completion for five staff members out of nine, proof of resident rights training for three staff members out of nine, proof of infection control and prevention training for four staff members out of nine, and, for proof of dementia training for six staff members out of nine. In an interview with Staff #26 conducted on March 6, 2025 at 11:32AM revealed that they were not able to provide proof of abuse training completion for two staff members out of nine, proof of resident rights training for two staff members out of nine, proof of infection control and prevention training for three staff members out of nine, and, for proof of dementia training for four staff members out of nine. In an interview on March 7, 2025 at 9:27AM with interim director of nursing (Staff # 39) and regional director of clinical services (Staff #62) revealed that the facilities expectations regarding training completion and maintaining documentation of the completion of training. Staff #62 also revealed that the risk of not maintaining training completion of abuse training, dementia training, infection control training and resident rights training can result with incompetent care and services being provided, alongside a lack of understanding of the polices current practices and policies. In an interview on March 7, 2025 at 9:38AM with the executive director (Staff #65) revealed Staff #65's their expectations regarding staff training completion and maintaining documentation of the completion of training. Staff #65 also stated that the risk of not maintaining training completion of abuse training, dementia training, infection control training and resident rights training can result with incompetent care and services being provided, alongside a lack of understanding of the polices current practices and policies. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a policy titled Education and Training Requirements revealed that trainings pertaining to topics such as abuse, dementia management, infection control and resident rights should be met prior to independently providing services, annually, and as necessary based on the facilities assessment. Review of the facility's assessment revealed that resident right's and the facility's responsibility training is required by all staff at least quarterly and as needed; abuse training, including dementia care/management training, is required by all staff at least quarterly and as needed; and, infection prevention and control is required at least annually and as needed.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51006 Based on personnel file review, staff interviews, and facility policy review, the facility failed to ensure that five of nine sampled staff sampled staff (#28, #34, #48, #53 and #56) received ongoing education on abuse, neglect, exploitation, and providing care to those with Alzheimer's or other dementia. The deficient practice could lead to a deficit in staff or volunteers' knowledge and/or skills which could affect resident care, leading to harm. Findings include: - Regarding the certified nursing assistant (CNA/Staff #28) Review of personnel file for the CNA (staff #28) revealed a hire date of March 1, 2010. Physical sign-in sheets and certification of online completion provided by the facility revealed that Staff #28 did not complete required annual training for dementia for the year of 2024 and 2025. - Regarding the occupational therapist (OT/Staff #34) Review of personnel file for the OT (staff #34) revealed a hire date of April 3, 2024. Physical sign-in sheets and certification of online completion provided by the facility revealed that Staff #34 did not complete required training for dementia for the year of 2024 and 2025. - Regarding the licensed practical nurse (LPN/Staff #48) Review of personnel file for the LPN (staff #48) revealed a hire date of August 17, 2020. Physical sign-in sheets and certification of online completion provided by the facility revealed that Staff #48 did not complete required training for dementia for the year of 2024 and 2025. - Regarding the CNA (CNA/Staff #53) Review of personnel file for the CNA (staff #53) revealed a hire date of August 25, 2021. Physical sign-in sheets and certification of online completion provided by the facility revealed that Staff #53 did not complete required training for dementia and abuse for the year of 2024 and 2025. - Regarding the registered nurse (RN/Staff #56) Review of personnel file for the RN (staff #56) revealed a hire date of October 30, 2023. Physical sign-in sheets and certification of online completion provided by the facility revealed that Staff #56 did not complete required training for abuse for the year of 2024 and 2025. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 5, 2025 at 8:14AM, employee personnel records for 10 random employees were requested for review. The requested documents included proof of Tuberculosis screening, proof of cardiopulmonary resuscitation and first aid training completion, proof of a signed job description, proof of current license if applicable, proof of current fingerprint clearance cards, and, proof of 2024 and 2025 annual and in-service trainings for abuse/neglect, resident rights, dementia, and infection prevention and control. An interview was conducted on March 5, 2025 at 10:00AM with a Business Office Manager (Staff #26), and Staff #26 provided documentation supporting nine staff members, and advised that one out of the ten staff members was a corporate employee and will require additional requests from their corporate office. Following this interview, a secondary document request was submitted to the facility on [DATE] at 10:20AM for copies of training completion for all nine staff members, proof of fingerprint clearance for one staff member out of nine, proof of cardiopulmonary resuscitation and first aid training completion for one staff member out of nine, proof of a signed job description for one staff member out of nine, and, proof of licensure for three staff members out of nine. After a review of the supplemental information provided by Staff #26, a third document request was submitted on March 6, 2025 at 10:01AM to provide proof of abuse training completion for five staff members out of nine, proof of resident rights training for three staff members out of nine, proof of infection control and prevention training for four staff members out of nine, and, for proof of dementia training for six staff members out of nine. In an interview with Staff #26 conducted on March 6, 2025 at 11:32AM revealed that they were not able to provide proof of abuse training completion for two staff members out of nine, proof of resident rights training for two staff members out of nine, proof of infection control and prevention training for three staff members out of nine, and, for proof of dementia training for four staff members out of nine. In an interview on March 7, 2025 at 9:27AM with interim director of nursing (Staff # 39) and regional director of clinical services (Staff #62) revealed that the facilities expectations regarding training completion and maintaining documentation of the completion of training. Staff #62 also revealed that the risk of not maintaining training completion of abuse and dementia training, and services being provided, alongside a lack of understanding of the polices current practices and policies. In an interview on March 7, 2025 at 9:38AM with the executive director (Staff #65) revealed Staff #65's their expectations regarding staff training completion and maintaining documentation of the completion of training. Staff #65 also stated that the risk of not maintaining training completion of abuse and dementia training can result with incompetent care and services being provided, alongside a lack of understanding of the polices current practices and policies. Review of a policy titled Education and Training Requirements revealed that trainings pertaining to topics such as abuse and dementia management should be met prior to independently providing services, annually, and as necessary based on the facilities assessment. Review of the facility's assessment revealed that abuse training, including dementia care/management training, is required by all staff at least quarterly and as needed.