STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035242	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dr Guy Gorman Sr Care Home	Highway 191 & Hospital Road Chinle, AZ 86503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35588 Based on observation, interview and record review, the facility failed to ensure 1 of 16 sampled residents (R) (R27) was treated with respect and dignity and received care in an environment that promoted maintenance or enhancement of his or her quality of life. R27 was fed by staff standing over him. This failed practice had the potential to negatively affect the resident's self-esteem. Findings include Review of Resident 27's (R27) record documented resident was admitted on [DATE] with diagnoses including cerebral infarction with hemiplegia (blocks blood supply to part of the brain or when a blood vessel in the brain bursts and part of brain becomes damaged or dies resulting in weakness or loss of strength on one side of the body), diabetes, benign prostatic hyperplasia (enlarged prostate that can block flow of urine out of the bladder) with lower urinary tract symptoms. During an observation on 9/24/24 at about 3:55 PM Certified Nursing Assistant (CNA)13 stood while placed several spoonfuls of apple sauce into R27's mouth as resident sat. This continued until the container of apple sauce was empty. During an interview on 9/24/24 at about 4:00 PM CNA13 confirmed she stood while feeding resident his afternoon snack of apple sauce and said that she should had sat down and acknowledged a chair was readily available next to the resident. During an interview on 9/27/24 at 9:21 AM when informed of observation, Director of Nursing stated that staff should be seated while assisting residents with their snacks or meals. Review of facility policy Quality of Life-Dignity, dated 1/2024, documented, 1. Residents shall be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.

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

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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 - 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** 35588 Based on interview and record review, the facility failed to protect the resident's right to be free from neglect (R106) and failed to protect residents' right to be free from physical abuse by another resident for (R)(R2 and R27) for 7 sampled residents reviewed for abuse as evidenced by: 1. Failed to ensure resident-centered care and treatment was provided in accordance with professional standards of practice to 1 of 6 sampled residents (R) (R106) reviewed for accidents. Licensed Practical Nurse (LPN) 6 failed to conducted neuro checks to assess for neurological changes and ensure timely interventions after R106's unwitnessed fall, 2. Failed to provide adequate supervision for 1 of 6 sampled residents (R106) reviewed for accidents to prevent recurrent falls when one to one staffing was recommended but not provided, 3. Failed to provide sufficient certified nursing aides (CNA)s on R106's unit for 7 of 16 days when R106 fell . 4. Failed to ensure 1 of 6 sampled staff (LPN6) reviewed completed required annual training including Fall prevention and management during the past two years. The cumulative effect of these failures contributed to environment of neglect. The failure to implement 1:1 monitoring as assessed and identified to ensure resident's safety given repeated falls, failure to ensure staff completed training on fall prevention and management, failure to conduct neuro checks after unwitnessed fall and failure to ensure sufficient nurse staffing to ensure resident safety resulted in harm to R106 who required hospitalization , ventilator care, surgery and subsequently died after final fall in the facility. In addition, the facility failed to: 5. Ensure R27 was free from physical abuse when R106 hit him in the face and pulled his arm. 6. Ensure R2 was free from physical abuse when R21 hit her in the face. These failures placed R27 and R2 at risk for pain and a diminished quality of life. Findings include Review of facility policy Abuse-Investigation and Reporting, revised [DATE], documented Neglect/Mistreatment was defined as failure to give appropriate care, ignore or disregard Residents shall not be subject to abuse by any individual which includes .other residents. The policy outlined that abuse included physical abuse such as hitting/slapping grabbing . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 106's (R106) record documented the resident was admitted on [DATE] with diagnosis including dementia, diabetes, frequent falls, orthostatic hypotension (sudden drop in blood pressure when you stand up from a sitting or lying position) and stroke. R106's Minimum Data Set (MDS-assessment tool), dated [DATE], documented resident's brief interview for mental status was 12 of 15, indicating moderate cognitive impairment and required supervision or touch assistance when transferring from chair to bed or walking 50 feet while using a walker. Resident was transferred to the hospital on [DATE]. Review of R106's care plan documented resident was at risk for falls related to history of recurrent falls, wandering, confusion and gait (walking) imbalance with goal that resident would not sustain serious injury related to fall. Actions to achieve goal included follow facility fall protocol to prevent fall and monitoring protocol with start date [DATE] and had unwitnessed fall on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE] and witnessed fall on [DATE] and [DATE]. Please monitor his vital signs, neuro checks, pain, skin condition, ROM (range of motion) and delayed injuries. Follow the facility protocol for monitoring s/p (status post, after) fall condition with start date [DATE]. Review of facility's fall incident reports documented resident had 16 falls during four-month stay. Falls on [DATE] (unwitnessed), [DATE] (unwitnessed), [DATE], [DATE], [DATE] (unwitnessed), [DATE] (unwitnessed), [DATE], [DATE] (unwitnessed), [DATE] (unwitnessed), [DATE] (unwitnessed), [DATE] (unwitnessed), [DATE] (unwitnessed), [DATE](unwitnessed), [DATE] (unwitnessed), [DATE], [DATE] (unwitnessed). Twelve of the 16 falls were unwitnessed. 1. Neuro checks (Please also refer to F689) Review of facility's Falls and Fall Risk Managing policy, dated ,d+[DATE], documented under section Steps (Post Fall) 30 minutes 3. neurological checks: Required for all falls with head injury or unwitnessed falls. a. Neurological checks include assessing: i. Glasgow Coma Scale [a tool used to measure a person's level of consciousness and how responsive they are], ii. LOC (level of consciousness), iii. Orientation, iv. Movement in Extremities, v. Pupil size and reaction and vi. Speech and Responses. b. For 72 hours at a frequency of: i. q (every) 15 min(utes)x1 hour, ii. q30 min(utes) x 1 hour, iii. q1 hourx4 hours, iv. q4 hoursx24 hours, then v. qshift x72 hours, 4. Monitor vital signs, 5. Monitor for signs/symptoms of delayed injury (i.e., bruising, bleeding, fracture). 1 hour: 2. Complete the following documentation: a. Post Fall Screening Sheet .e. Neurological Checklist with a head injury and unwitnessed fall (UDA)(user defined assessment) PROGRESS NOTES Review of R106's progress notes, dated [DATE] at 8:46 PM, Licensed Practical Nurse (LPN)6 documented Informed by another resident (R), R106 was sitting on floor in the Great Room. No wheelchair in area and attempting to get up but not calling out. Resident's wheelchair was found in room [ROOM NUMBER] by bathroom door and bed linen in room was ruffled up. Resident was attempting to get up during assessment. No injury noted, no bump on head, no bleeding. Resident questioned if he was hurting or if he bumped his head. Denied both and wanted to get up. Resident asked if he needed to go to the hospital - denied. Resident was then assisted to w/c. Continuing on VS [vital signs] from recent fall earlier. Phone cont(inue) busy. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of R106's progress notes, dated [DATE] at 10:57 PM LPN6 documented During shift report, CNA (Certified Nursing Aide) reported Resident (R106) having multiple episodes of emesis (vomiting). Near beginning of shift CNA reported Resident vomited; VS [vital signs] taken, BSL @ (blood sugar level at) 223. Elevated BP, confused and aggressive. Review of R106's progress notes, dated [DATE] at 2:58 AM LPN6 documented Resident reported with bout of emesis this shift approx(imately) 2000 (8PM). VS taken and CNA reported elevated BP (blood pressure). Resident monitored by CNA, attempting to get up OOB (out of bed), bed alarm sounding d/t (due to) continued restlessness. During bed checks, Resident sleeping w/ (with) legs hanging off the side of the bed, , d+[DATE] dressed and partly exposed. Assisted CNA with getting Resident back into bed and changed. Encouraged Resident to rest and he calmed down.Called to room when emesis reported. VS cont(inue) w/ elevated BP, skin cool to the touch, staff reported Resident did not look right/normal. Called ER (emergency room) and spoke w/ Nurse [Name of nurse], we would send Resident in via facility van. Returned to Resident and was informed Resident was now unable to stand, more lethargic, VS unchanged and cont(inue) cool to touch. Called ER, then EMS for transport. Resident left facility at 2340 (11:40 PM) FALL INVESTIGATION Review of facility incident witness report form, dated [DATE] at 8:30 PM, documented by LPN6 showed checkmark in box for Other and a checkmark was not shown in box for Fall for type of incident. The details section documented Alerted to (R106) was sitting on floor in Great Rm (room) but another resident. No calling out observed. When notified by staff, Resident wanted assist to get off of floor. During the assessment of Resident, CNAs attempted to get Resident up but were told to wait since Resident had to be assessed. Resident told staff I slipped when asked. But no w/c (wheelchair) nearby. WC found in Rm 1213 with alarm sounded and muted. Resident assisted off of floor to w/c x3 staff. While being assess Resident denied hitting head, denied pain, denied wanting to go to the hospital. Just wanted to get up. Resident on AC (alert charting) for recent fall, no new protocol continued. Resident cont(inued) with ongoing behavior prior to fall. Had resident sit in w/c-later assisted to room. Review of facility incident witness report form, dated [DATE] at 8:15 PM, documented by LPN2 showed checkmark in box for Fall as type of incident with details At approx(imately) 2015 (8:15 PM) I was completing treatments in (nursing unit). I had gathered my supplies and was entering Rm 1207 when I heard [name being called], I leaned back out of the room and resident [room number of resident] was pointing into the living room area. As I looked in that direction, I observed [R106] lying on the floor near the [unit] kitchenette. [Name of LPN6] was nearby and I asked her Did you guys put [R106] on the floor? He's on the floor. [LPN6] walked over and observed resident then called to the night CNAs The following documents were not provided by facility for [DATE] fall, which were required per facility policy after an unwitnessed fall, including: 1. Post Fall Screening form which is a checklist to determine why resident fell such as what type of footwear resident was wearing, if environment was clear or cluttered, was resident confused or dizzy, was resident wearing glasses or hearing aide, if there were skin tears, lacerations or any injuries, immediate blood pressure, oxygen saturation level, heart rate, temperature, pain level, level of consciousness. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2. Interdisciplinary Post-Fall Assessment form which describes fall, outlines the number of falls in the last 30, 90 and 180 days, if there were recent medication changes, pattern of current falls such as time of day, six month review of falls and if there were any patterns or trends related to falls, probable cause of falls, root cause analysis of falls, recommendations from the review by IDT (Interdisciplinary Team), and care plan revisions. 3. Neurological check form that documented initial assessment of resident's pupil size and reaction to light, movement of extremities, vital signs, and level of consciousness. 4. Post Fall-Nurse Neurological Check Guidelines that documented assessment of resident's pupil's reaction to light, able to follow finger, verbal responses, pain level and level of consciousness every 15 minutes for 1 hour, every 30 minutes x4, every hour x4, every four hours x4 and every shift x3. 5. 72-hour intentional rounding after fall that assessed and documented pain, positioning, peri-needs and possessions such as call light within reach, glasses, water and environmental conditions every hour. INTERVIEWS During an interview on [DATE] at 7:36 AM LPN2 stated that when residents have an unwitnessed fall she completes neuro checks and completes fall packet which includes neuro checks every 15 minutes x4, then every 30 minutes x4 and so forth as outlined on form. LPN2 stated that she checks on the resident's level of consciousness, if the resident is alert, lethargic, nonresponsive, the resident's pupils reaction to light, size, extremity strength, weakness, and take their vitals. LPN6 stated when R106 fell on [DATE] she had worked the day shift and her shift ended at 7:30 PM but was doing a last minute treatment on R106's unit when she heard a resident calling her name who directed her that R106 was on the floor. LPN2 stated that she asked LPN6 if she put R106 on the floor and LPN6 said no and then LPN6 called the CNAs over to help. LPN2 stated that R106's fall was unwitnessed because R106 was found on the floor and staff did not put R106 on the floor. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 2:48 PM Assistant Director of Nursing (ADON) who was also the facility's Quality Assurance and Performance Improvement and Infection Preventionist (ADON/QAPI/IP) stated that R106 had multiple falls in the facility and confirmed during resident's four month stay in the facility, resident had 16 falls, which were both witnessed and unwitnessed. ADON/QAPI/IP confirmed that when resident have an unwitnessed fall, nursing is directed to complete fall packet which includes post fall screening form, neurological check form, post fall nurse neurological check guidelines and 72 hour intentional rounding form. ADON/QAPI/IP further stated that licensed nurses should complete neuro check form for the specific time period as outlined on the form such as every 15 minutes x4, then every 30 minutes x4 to check for concussion or effects of head injuries. ADON/QAPI/IP stated that R106 had a witnessed fall on [DATE] and an unwitnessed fall on [DATE] and she should have received a fall packet including fall sheet and neuro checks for the [DATE] fall but didn't. ADON/QAPI/IP stated that when she did not receive the fall packet at the end of the day on [DATE], she asked LPN6 for the fall packet and LPN6 responded that she didn't complete the fall packet including neuro checks. ADON/QAPI/IP stated that she reviewed the video footage for R106's [DATE] fall and saw that R106 tripped and fell near the kitchenette, and LPN6 was not observed to complete a neuro assessment or vital signs after the fall but should have. The next day in the evening, R106 vomited and wasn't himself so he was sent to the emergency room . ADON/QAPI/IP stated that LPN6 no longer works at the facility. ADON/QAPI/IP stated that it was important to do neuro checks for the frequency and duration because of latent effects, residents can have a change in level of consciousness later and R106 didn't have nausea/vomiting for almost 24 hours after his fall. During an interview on [DATE] at 9:34 AM Medical Doctor (MD)1 confirmed he was R106's physician, resident had multiple falls and it was important to do neuro checks for ,d+[DATE] hours after falls because of latent injuries and possible concussion. MD1 further stated that it was important to watch for neuro changes that so actions can be taken as soon as possible. MD1 confirmed that resident's vomiting and change in mental status the day after a fall could be contributed to a head injury from the fall. MD1 also confirmed that after resident was transferred to the emergency room , he was air lifted to nearby hospital as family wanted everything done, resident was full code, and resident was found to have a subdural hematoma that required ventilator support, surgery, intensive care services and subsequently died . During an interview on [DATE] at 9:21 AM Director of Nursing (DON) stated that staff are expected to complete neuro checks and continue assessments for 72 hours after an unwitnessed fall because there could be delayed effects, and this was not done for R106 during his last fall in the facility. 2. 1:1 supervision (Please also refer to F689) Review of R106's care plan documented resident was at risk for falls related to history of recurrent falls, wandering, confusion and gait (walking) imbalance with goal that resident would not sustain serious injury related to fall. Actions to achieve goal included follow facility fall protocol to prevent fall and monitoring protocol with start date [DATE] and monitor (R106)'s location frequently and assess his needs. Assist with toileting, transferring and walking as need. (R106) requires every 15 minutes safety check with start date [DATE]. Review of fall incident reports documented: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	*Fall on [DATE] at 7:31 AM was unwitnessed. Wheelchair rolled while resident was attempting to transfer, breaks were unlocked, resident confused, impulsive, no safety awareness and sustained bruises from fall. The interdisciplinary team recommendations included 1:1 supervision (1 staff member dedicated to supervising R106, ratio of 1 staff to 1 resident). 1:1 supervision was not added to resident's care plan. *Fall on [DATE] at 5:10 AM was unwitnessed. Resident was found in the living room and sustained abrasions to his head and both knees. Resident stated, I hit my head. The wheelchair alarm was delayed. Resident transported to the emergency room . The interdisciplinary team recommendations included 1:1 monitoring. 1:1 monitoring was not added to resident's care plan. *Fall on [DATE] at 9:00 PM was unwitnessed in hallway, in great room. Resident stated, I was trying to go to the bathroom, got up from wheelchair while in great room to go to the bathroom and fell in the hallway. The interdisciplinary team recommendations included 1:1 monitoring (not available at facility at this time) and constant redirection. 1:1 monitoring was not added to resident's care plan. During interview on [DATE] at 2:48 PM ADON/QAPI/IP stated that she conducted fall investigations which included reviewing documents in fall packet such as incident witness report forms, post fall screening form, neurological check form, post fall nurse neurological check guidelines and video footage and she completed the Interdisciplinary Post-Fall Assessment form with the input from the interdisciplinary team which included unit charge nurses, Director of Nursing, social workers, MDS nurse, Housekeeping, Maintenance, and sometimes activities and the lead CNA. When asked what were some of the root cause analysis of the falls and interventions to prevent recurrent falls ADON/QAPI/IP mentioned several actions and stated that resident was a high fall risk, would sundown in the evenings, and resident was sometimes confused, reorientation didn't always work, he had orthostatic hypotension, impulsive behaviors of getting up all the time, and he sometimes turned off the wheelchair and bed alarms so we couldn't rely on them. When asked about the level of supervision, ADON/QAPI/IP stated that they had every 15-minute safety checks, but we didn't have 1:1 even though it was something that we recommended but we don't have that level of funding for staff to sit with him. When staff had free time, they sat and kept an eye on him, but we were short on staff and didn't have the adequate staff he needed, on nights we sometimes had only two CNAs and the nurse was passing medications. ADON/QAPI/IP stated that the only intervention that would keep R106 safe would be 1:1 supervision but the facility could not provide that level of supervision because the facility did not have the staff. ADON/QAPI/IP acknowledged the facility was responsible for keeping R106 safe and the facility did not provide adequate supervision to R106. During an interview on [DATE] at 9:21 AM DON stated that facility was short staffed and unit aides used to provide 1:1 monitoring but unit aides were lost when the covid waivers went away. DON confirmed R106 was inadequately supervised because he really needed 1:1 monitoring which the facility could not provide. DON further stated that they were trying to get R106 to a memory care facility, but it was not covered under resident's insurance. 2. Staffing (Please also refer to F725) (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Facility Assessment (document describing resident population and needs to determine staff and other resources necessary to competently care for residents) received from facility on [DATE], dated [DATE], documented eight CNAs were needed on the weekdays and six CNAs were needed on the weekends/holidays. Under another section of Facility Assessment titled Staff Type/Plan, the following was documented for Direct care staff: 1:,d+[DATE] resident ratio Days and 1:,d+[DATE] resident ratio Nights. Facility Assessment also documented there were 27 residents on B wing (where R106 resided) in January to [DATE]. During a concurrent interview and joint review of Facility Assessment on [DATE] at 2:32 PM ADON/QAPI/IP stated that the facility assessment was based on resident acuity. When asked to explain the Facility Assessment and how many CNAs were needed during the weekdays and weekends for each shift, ADON/QAPI/IP stated that it is three CNAs per each unit (male household and female household) on day shift and the same on night every day. ADON/QAPI/IP also stated that the facility was so short staffed with licensed nurses and CNAs that they could not account for someone like R106 who needed 1:1 supervision. Review of C.N.A Weekly Group Schedule for [DATE] to [DATE], documented less than required 3 CNAs worked on R106's unit seven times during the specific date and times when R106 fell . During a concurrent interview and joint review of CNA schedule and CNA punch timecards, Payroll Specialist (PS) confirmed two CNAs worked on the specific dates and shifts below. *On [DATE] at 5:50 PM R106 fell and two CNAs worked, less than required 3 CNA worked. *On [DATE] at 6:00 PM R106 fell and two CNAs worked, less than required 3 CNA worked. *On [DATE] at 7:31 AM R106 fell and two CNAs worked, less than required 3 CNA worked. *On [DATE] at 6:05 PM R106 fell and two CNAs worked, less than required 3 CNA worked. *On [DATE] at 5:10 AM R106 fell and two CNAs worked, less than required 3 CNA worked. *On [DATE] at 6:00 PM R106 fell and two CNAs worked, less than required 3 CNA worked. *On [DATE] at 9:00 PM R106 fell and two CNAs worked, less than required 3 CNA worked. During an interview on [DATE] at 9:21 AM DON stated that facility was short staffed and unit aides used to provide 1:1 monitoring but unit aides were lost when the covid waivers went away. DON confirmed R106 was inadequately supervised because he really needed 1:1 monitoring which the facility could not provide. DON further stated that they were trying to get R106 to a memory care facility, but it was not covered under resident's insurance. 4. Annual trainings (Please also refer to F726) (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 10:35 AM ADON/QAPI/IP stated that she oversaw nursing staff training which was completed and documented through Relias system. ADON/QAPI/IP further stated that the facility did not have a policy for staff competency but stated all nursing staff including licensed nurses were required to minimally complete 22 modules each year which included module Preventing Falls: An Interdisciplinary Approach. ADON/QAPI/IP provided copy of LPN6's official transcript which showed during 2022, a half hour training titled About Falls was completed. Preventing Falls training or any training regarding Falls was not completed in 2023 and 2024. In addition, 10 of the 22 required training was not completed in 2022, 21 of the 22 required training was not completed in 2023 and 22 of the 22 required training was not completed in 2024. ADON/QAPI/IP confirmed LPN6 did not complete required annual training during 2022, 2023 and 2024 which was expected for all nursing staff. ADON/QAPI/IP stated that LPN6 was notorious for not completing training and LPN6 was informed verbally and in writing to complete training, but trainings were not completed. During an interview on [DATE] at 9:21 AM DON stated that the expectation is staff complete required training annually and when it is overdue it should be completed as soon as possible but it was so difficult because facility was so crunched and short with staffing. RESIDENT to RESIDENT ABUSE Review of R27's progress notes dated [DATE] at 10:35 PM documented R27 was hit in the face by [R106]. R27 was noted to have minimal amount of redness to the right side of his face. Review of facility's alleged abuse investigation, dated [DATE] documented that Licensed Nurse Aide (LNA)2 observed on [DATE] at 7:20 PM that R106 hit R27 on the right side of R27's head/face. R27 was parked in front of R106, R27 turned around to see what was happening and R106 grabbed R27's right arm and was aggressive towards him/shaking R27. R27 was trying to pull his arm back as he was sitting away from R106. LNA2 stated that she yelled stop, don't do that, let him go and ran over to have R106 let go. The two residents were separated. Protective measures to ensure that further abuse, neglect does not occur included .(R106) to be monitored frequently, not able to provide 1:1 monitoring at this time IDT (interdisciplinary team) recommended the following changes in facility procedures of a plan of care frequent monitoring of (R106)---as staffing allows. During a concurrent interview and record review on [DATE] at 3:45 PM ADON/QAPI/IP reviewed facility's investigation that included video footage and ADON/QAPI/IP confirmed that R27 was abused when R106 hit R27's face and grabbed R27's arm. 41020 -R21 was readmitted to the facility on [DATE] with diagnoses which included unspecified dementia (a clinical syndrome that occurs when a person has dementia but it can't be diagnosed as a specific type), unspecified severity, with other behavioral disturbance (a pattern of disruptive behaviors that can cause problems in social, home, and school settings) and delirium (a mental state that causes a person to be confused, disoriented, and have reduced awareness of their surroundings) due to known physiological condition. Review of the annual Minimum Data Set (MDS) (Comprehensive) assessment dated [DATE] revealed the resident scored 12 on the Brief Interview for Mental Status (BIMS) assessment, indicating moderately impaired cognition. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An Incident Note dated [DATE] at 3:12 PM revealed the resident was the recipient of physical aggression from another resident (R206). -R206 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and delirium due to known physiological condition. The admission MDS assessment dated [DATE] revealed the resident scored 9 on the BIMS assessment, indicating moderately impaired cognition. An Incident Note dated [DATE] at 3:59 PM revealed R206 initiated physical aggression with another resident (R21). Review of the facility's investigation report dated [DATE], revealed the charge nurse heard some verbal commotion as she was at the Household 1 nursing station. The commotion was coming from down the hallway. Just as the nurse looked that direction, she witnessed both residents parked parallel to one another and verbally exchanging words. Then, R206 swung her arm out and hit R21 on the right arm. From the opposite direction, another staff witnessed R206 also hit R21's right cheek. The two staff members who observed the altercation immediately intervened and ran over to separate the two residents. An interview was conducted on [DATE] at 2:15 PM with a Certified Nursing Assistant (CNA14). She stated that R206 would go into R21's bathroom and sometimes they would have altercations about it. She stated that they moved R206 to another room, but R206 would tend to stay around R21's room. She stated that staff would separate the residents and that R206 was on 15-minute checks for the longest time because of her behavior. During an interview conducted on [DATE] at 2:41 PM with a Licensed Practical Nurse (LPN2). She stated that R21 was always doing things to the other residents, and that R206 went into everybody's room. She stated that at that time, they just kept them separated. She stated they would take R206 back to her room, but she just couldn't comprehend that. R21 was educated to come to staff, but they couldn't always keep an eye on them. She stated that she saw R206 raise her fist and hit R21 on the right arm. Another staff (CNA15) saw R206 hit R21 in the right cheek. She stated that she thought R21 might have had a little bit of redness, she couldn't really remember. She stated that R206 was not hit. On ,d+[DATE] at 1:13 PM an interview was conducted with the Director of Nursing. She stated that supervision was one of the hardest challenges, and day shift was really, really busy. She stated that she was trying to emphasize that the charge nurse goes rounding with the CNA's so they that things are getting done. She stated that she tries to educate the charge nurses because it was hard to say that supervision was being done. She stated that it was unfortunate that the blanket waiver for unit aides was lifted, so they don't have them anymore. She stated that they were really helpful and prevented a lot of incidents. She stated that the intervention was to keep the residents apart as much as possible, and to have the social worker to educate them on not behaving like that. She stated that they still slipped through, and that staffing-related issues were one of the biggest challenges right now. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A request was made for the Resident Supervision and Dementia Care policies. The Assistant Director of Nursing indicated that they did not currently have policies on resident supervision and dementia care.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35588 Based on interview and record review the facility failed to ensure background check for criminal history was completed prior to caring for vulnerable adults for 1 of 9 sampled staff (Licensed Practical Nurse (LPN)6) reviewed for background check. This failure placed residents at risk for receiving care from unqualified staff and at risk of abuse and neglect. Findings include Review of staffing schedule from [DATE] to [DATE] showed Licensed Practical Nurse (LPN)6 worked on [DATE], [DATE]. Review of facility policy Abuse-Investigation and Reporting, revised [DATE], documented .[name of facility] shall not employ individuals with criminal background. Background check shall be completed with and/or State of Arizona Public Safety Fingerprinting Department of fingerprinting clearance before employment . Review of LPN6's personnel file documented hire date of [DATE] with employment end date of [DATE] and Arizona fingerprinting expiration date was [DATE]. Further review of LPN6's personnel file showed memos dated [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] that Arizona Public Safety Fingerprinting Clearance Class I/II expired on [DATE]. The memo further documented Please review and provide updated documents (credentials), as soon as possible to the Human Resources Department. These required credentials to be placed in your Personnel File. Your cooperation is appreciated. Your credentials have EXPIRED. Please update with Human Resources Immediately, or you will be removed from the schedule without pay, including disciplinary actions The memo showed it was distributed to the Director of Nursing. During concurrent record review and interview on [DATE] at 9:12 AM a joint review of LPN6's personnel record was conducted with Human Resources Manager (HRM). HRM confirmed LPN6 did not complete fingerprinting which facility used to conduct criminal background checks. HRM further stated that finger printing was completed every five years, but it was never completed for LPN6. HRM stated that LPN6 was an emergency hire and multiple finger printing reminders were sent but it was never completed despite LPN6 continuing to provide care. HRM stated that LPN6 had worked full-time at the facility prior to her last day worked. During an interview on [DATE] at 9:21 AM DON stated that LPN6 was previously a regular full-time employee and staff are expected to be current on credentialing and not have lapses or expired credentials. When asked if they can still work and be on the schedule if credentials such as background checks are not completed, DON stated yes, only because we are so crunch with staffing. Staff travel to another location to get finger printing completed and they can't be taken off the work schedule because they need staff to work and all they can do is push for staff to complete credentialing requirements. (continued on next page)

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Personnel Policy Manual, revised [DATE], documented that Arizona Department of Public Safety State fingerprinting card was required before any interview was scheduled. Under the section Background Check, a. Due to the sensitive nature of working with the elderly, it is mandatory that all positions have a complete five (5) years criminal background check completed with the Arizona Department of Public Safety (DPS), b. Fingerprinting of all applicants shall be conducted. The background checks shall be completed within the 90-day probationary period

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35588 Based on interview and record review, the facility failed to ensure allegations of abuse was reported to the Centers for Medicare and Medicaid Services (CMS) within the required timeframe for 1 of 7 sampled residents (R) (R27) reviewed for abuse allegations. This failure placed the resident at risk for potential unidentified abuse and lack of protection from abuse. Findings include Review of facility policy Abuse-Investigation and Reporting, revised 4/18/24, outlined that abuse included physical abuse such as hitting/slapping grabbing . Under the Reporting/Response section the protocol for alleged instances of abuse documented if reportable bodily injury, CN (Charge Nurse) shall report RI (risk incident) to CMS within 2 hours and if no bodily injury, CN shall report to CMS within 24 hours. Review of R27's progress notes dated 3/18/24 at 10:35 PM documented R27 was hit in the face by [R106]. R27 was noted to have minimal amount of redness to the right side of his face. Review of facility's alleged abuse investigation, dated 3/18/24 documented that Licensed Nurse Aide (LNA)2 observed on 3/18/24 at 7:20 PM that R106 hit R27 on the right side of R27's head/face. R27 was parked in front of R106, R27 turned around to see what was happening and R106 grabbed R27's right arm and was aggressive towards/shaking R27. R27 was trying to pull his arm back as he was sitting away from R106. LNA2 stated that she yelled stop, don't do that, let him go and ran over to have R106 let go. The two residents were separated. Reporting/Time frame section for reporting section documented no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Report to: administrator or [of] the facility and to other officials (CMS, APS (Adult Protective Services), Local Law Enforcement) Review of email communications from facility to CMS representative dated 3/19/24 at 3:10 PM documented reporting of the incident above. The email further documented I was not aware of the incident until recently, so I am not sure why the incident was not reported. The IDON (Interim Director of Nursing) was notified by the charge nurse via text but I am not sure why she did not direct the charge nurse to notify CMS within the 2-hour time frame. During a concurrent interview and record review on 9/25/24 at 3:45 PM Quality Assurance and Performance Improvement and Infection Preventionist (ADON/QAPI/IP) reviewed facility's investigation that included video footage and ADON/QAPI/IP confirmed that R27 was abused when R106 hit R27's face and grabbed R27's arm. During an interview on 9/27/24 at 12:18 PM ADON/QAPI/IP stated that abuse needs to be reported within 2 hours of being informed or made aware of incident. CN should have reported to CMS directly. This should have happened but didn't.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35588 Based on interview and record review, the facility failed to transmit required Minimum Data Set (MDS-assessment tool) resident assessment data to the Centers for Medicare & Medicaid Services (federal agency that provides health coverage) within the required timeframe for 2 of 2 sampled residents (R) (R10 and R30) reviewed for timeliness in transmitting discharge Minimum Data Set (MDS-an assessment tool). This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings include Review of Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Version 1.19.1, dated October 2024, documented discharge (non-comprehensive) MDS must be completed no later than 14 days after the Assessment Reference Date (ARD) (A2300), and it must be submitted/transmitted within 14 days of the MDS completion date (Z0500+14 days) to the database as required. Resident 10 Review of Resident 10's (R10) record documented the resident was admitted on [DATE] and discharged on [DATE]. Review of the facility's electronic health record system Point Click Care showed that a discharge MDS with an ARD of 5/17/24 was not submitted and was over 120 days late. During a concurrent interview and record review on 9/25/24 at 11:24 AM MDS Nurse stated that the RAI manual for MDS completion was used as the facility policy and reference source. MDS Nurse stated that they would complete the discharge MDS within 14 days from the ARD. Joint record review of Resident 10's MDS look up assessment showed the discharge MDS dated [DATE] was not completed. MDS Nurse stated that the Discharge return not anticipated is showing as completed but not yet accepted and it should show export ready, but it is not showing that way and it should. MDS Nurse stated that something was wrong. During an interview on 9/27/24 at 9:21 AM Director of Nursing stated that they expected the MDS to be completed and transmitted in a timely manner. 40844 Resident 30 Review of R30's electronic health record revealed the facility admitted R30 on 11/23/23 and had a planned discharge on 05/07/24. Review of the MDS tab in Point Click Care on 09/25/24 showed that a discharge MDS with an ARD of 05/07/24 was not submitted and was over 120 days late. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 09/27/24 at 08:52 AM MDS Nurse stated she was aware R30's discharge MDS was not transmitted timely after the earlier interview about R10's MDS. Since then, MDS Nurse stated she had figured out how to complete the assessment and export it. She showed the surveyor the MDS tab now showed the assessment was accepted, and confirmed it was transmitted late.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35588 Based on interview and record review, the facility failed to ensure the required Minimum Data Set (MDS-assessment tool) resident assessment data for 6 of 16 sampled residents (R) were accurate as of the Assessment Reference Date (ARD) as evidenced by: 1. R33, R41, R17, R15 medications were inaccurate, 2. R38's wound was inaccurate. 3. R31's restorative care was inaccurate These failure increased the residents' risk for having unmet health care needs. Findings 1. inaccurate medication coding: Review of Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Version 1.19.1, dated October 2024, documented under section N0415 enter yes if an antipsychotic medication (class of medications that treat psychotic symptoms such as hallucinations and delusions) was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Resident 33 Review of Resident 33's (R33) record documented the resident was admitted on [DATE]. R33's Minimum Data Set (MDS-assessment tool), dated 7/14/24, documented resident was taking an antipsychotic medication. Review of R33's July Medication Administration Record (MAR) did not show resident received antipsychotic medications. During a concurrent interview and record review on 9/25/24 at 11:24 AM MDS Nurse stated that the RAI manual for MDS completion was used as the facility policy and reference source. Joint record review of Resident 33's 7/14/24 MDS Assessment documented resident received antipsychotic medications. When asked to name the psychotic medication R33 was taking, MDS Nurse stated it was Memantine. MDS Nurse searched webMD, https://www.webmd.com/drugs/2/drug-77932-377/memantine-oral/memantine-oral/details, which showed Memantine was not an antipsychotic but was a cognition-enhancing medication to treat dementia associated with Alzheimer's disease. Memantine belonged to a class of medicines called N-methyl-D-aspartate (NMDA) antagonists. MDS Nurse stated that she thought Memantine was an antipsychotic medication and got confused between antipsychotics (medications used to treat hallucinations/delusions) and psychotropic (medications that affected brain activity). During an interview on 9/27/24 at 9:21 AM Director of Nursing stated that they expected the MDS to accurately reflect resident's medications. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 41 Review of Resident 41's (R41) record documented the resident was admitted on [DATE]. R41's Minimum Data Set (MDS-assessment tool), dated 9/7/24, documented resident was taking an antipsychotic medication. Review of R41's September MAR and current physician orders did not show resident received antipsychotic medications. During a concurrent interview and record review on 9/25/24 at 11:24 AM MDS Nurse stated that the RAI manual for MDS completion was used as the facility policy and reference source. Joint record review of Resident 41's 9/7/24 MDS Assessment documented resident received antipsychotic medications. When asked to name the psychotic medication R41 was taking, MDS Nurse stated it was Donepezil. MDS Nurse searched webMD, https://www.webmd.com/drugs/2/drug-14334-9218/donepezil-oral/donepezil-oral/details, which showed Donepezil was not an antipsychotic but was a cognition-enhancing medication. During an interview on 9/27/24 at 9:21 AM Director of Nursing stated that they expected the MDS to accurately reflect resident's medications. 41020 For R17: Review of R17's record revealed he was admitted to the facility on [DATE]. R17's MDS assessment dated [DATE] revealed the resident was taking antipsychotic medication. Review of R17's September MAR and current physician's orders did not show the resident was receiving antipsychotic medication. For R15: R15's record indicated that she was admitted to the facility on [DATE]. The MDS assessment dated [DATE] revealed the resident was taking antipsychotic medication. However, review of R15's September MAR and current physician's orders did not show the resident was receiving antipsychotic medication. On 09/26/24 at 4:19 PM an interview and concurrent record review was conducted with the MDS nurse. She stated that it was brought to her attention that some of the medications used for dementia were listed psychotropic medications. She stated that it was an error on her part. 2. R38's wound was inaccurate. R38 was admitted to the facility on [DATE]. The MDS assessment dated [DATE] indicated the resident had a wound infection. Review of R38's September Treatment Administration Record (TAR) and the current physician's orders did not show the resident was receiving care for an infected wound. On 09/26/24 at 2:58 PM an interview was conducted with a Licensed Practical Nurse (LPN2). She reviewed the resident's progress notes and stated that all she could see was a skin tear, but nothing major. No major wounds. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review conducted on 09/26/24 at 4:19 PM with the MDS nurse she stated that she saw the resident had a local skin infection June 22, 2024, through June 30, 2024. She stated she was going by that diagnosis that had been put into the resident's record. She stated that she had looked back for the whole previous quarter. She stated that the resident was not receiving antibiotics and/or did not have any skin/wound infections currently. During an interview with the DON on 09/27/24 at 1:13 PM she stated that she expected the MDS assessments to be accurate. 40844 3. R31's restorative care was inaccurate Review of Admission Minimum Data Set (MDS) assessment dated [DATE] revealed the facility admitted R31 on 04/17/24 with diagnoses which included hemiparesis/hemiplegia (weakness/paralysis on one side of the body) following cerebral infection affecting non-dominant side, history of falling, and need for assistance with personal care. R31 was cognitively intact scoring 13 out 15 on a Brief Interview for Mental Status (BIMS). R31 was dependent on staff for transfers and activities of daily living with moderate to maximal assistance except for eating. Quarterly MDS assessment dated [DATE] revealed during the look back period R31 had received one day restorative services for walking only. During an interview and concurrent record on 09/27/24 at 08:52 AM MDS Nurse confirmed R31 was receiving restorative services. A review of Restorative Notes between the look back period of 07/24/24 to 07/31/24 revealed 2 notes. 07/27/24 Restorative Note indicated Physical Therapist (PT) worked with R31 on lower extremity strengthening for transfer and walking, and upper extremity exercises. 07/28/24 Restorative Note indicated PT worked with R31 on transfer skills using sit to stand exercises. Concurrent review of the RAI Manual revealed under section O500: Restorative Nursing Programs, Steps for Assessment 1. Review the restorative nursing program notes and/or flow sheets in the medical record. 2. For the 7-day look-back period, enter the number of days on which the technique, training or skill practice was performed for a total of at least 15 minutes during the 24-hour period. MDS Nurse confirmed R31 had two days of restorative treatments for transfers and one day for walking.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35588 Based on observation, interview and record review the facility failed to update or correct the Preadmission Screening and Resident Review (PASARR) and notify the state mental health authority for 1 of 1 sampled resident (R) (R29) reviewed for Pre-Admission Screening and Resident Review (PASRR) that had a mental health condition or an inaccuracy with current level I form. This failure placed the resident at risk for unmet mental health services necessary to obtain the resident's highest level of functioning and psychosocial well-being. Findings include Review of R29's PASRR Level I, dated 6/30/21, showed No was circled for both Mental Retardation (MR) evaluation criteria and Mental Illness (MI) evaluation criteria. Under MI evaluation criteria, No was circled that resident did not have a primary diagnosis of serious mental illness (SMI) defined in DSM IV at: major depression, psychotic disorder, mood disorder, schizophrenia, delusional disorder (i.e., paranoid) and level of impairment limiting life activities within the past 3 to 6 months and recent treatment within the past two years. Section E. Referral Action showed No was circled for Referral Necessary for any Level II. Review of Resident 29's (R29) record documented resident was admitted on [DATE] with diagnoses including dementia, major depressive disorder recurrent severe with psychotic features and post-traumatic stress disorder (PTSD). R26's Minimum Data Set (MDS-assessment tool) dated 8/10/24 documented resident had a BIMS (Brief Interview for Mental Status) score of 5, which indicated severe cognitive impairment, resident had physical behavioral symptoms directed towards others (e.gl, hitting, kicking, pushing, scratching, grabbing) 1 to 3 days during the look-back period, and verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) 4 to 6 days, but less than daily during the look-back period. Review of resident's current care plan documented problems for resident having inappropriate, aggressive verbal language using foul language related to major depressive disorder, recurrent, severe with psychotic symptoms, PTSD. Another problem that resident was resistant to care related to major depression disorder, PTSD and dementia. During concurrent observation and interview on 9/24/24 at 12:56 PM with Social Services (SS)1 and resident made eye contact, provided appropriate although short response to questions asked and mood was calm. SS1 stated that resident used to work at police station and went to the morgue. Resident has images and recollections of dead people and events involved in the past which has been traumatic for the resident. With SS1 interpreting, resident was asked if the facility was addressing past trauma, resident did not respond. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 9/25/24 at 1:43 PM SS1 stated that resident receives mental health visits, has PTSD and psychotic symptoms. SS1 further stated that PASARR level I form was completed by the group care home that resident was transferred from prior to admission. When asked if the PASARR form was reviewed to assess its accuracy, SS1 stated that the PASARR form is in the packet and is filed when received. SS1 stated that facility does not complete PASARR as that is done prior to admission. When asked if given resident's mental health diagnosis and receipt of mental health services after admission, is the PASARR level I form accurate and should resident be referred for level II, SS1 stated that she does not do anything with the PASARR as it is completed prior to admission and when the form is received it is filed. When asked if she re-evaluates and refers residents for PASARR level II, SS1 shook her head no. During an interview on 9/26/24 at 8:55 AM Licensed Practical Nurse (LPN)2 stated that R29 used to work at the police substation and transported bodies to the morgue and when resident first came to the facility resident said that he bodies and people in his room so he would close his eyes and resident is still seeing a psychiatrist because he is on sertraline (anti-depressant). LPN2 stated that resident's hallucinations have lessened, he uses the four letter word and curses, some psychosis but not much and he is much better than when he first came here. During an interview on 9/27/24 at 9:21 AM Director of Nursing (DON) stated that R29 sees a psychiatrist, has PTSD, psychotic features and is on anti-depressant and didn't know much about PASARR process. Upon request for PASARR policy, facility provided Arizona Health Care Cost Containment System Medical Policy Manual Policy 680-C-Attachment A-Arizona Pre-Admission Screening and Resident Review (PASRR) Level I Screening Tool, dated 5/15/23, under Mental Illness (Section B) question Does the individual have any of the following Serious Mental Illness (SMI)? with checkboxes for major depression, psychotic/delusional disorder. The form also included Currently, or within the past 2 years, has the individual received any of the following mental health services? Review of Arizona Health Care Cost Containment System website for Pre-Admission Screening and Resident Review (PASRR), accessed on 10/1/24, located at https://www.azahcccs.gov/PlansProviders/CurrentProviders/PASRR.html#PASRRFQA13, showed Nursing facilities are required to notify the state mental health authority (AHCCCS) or state intellectual disability authority (DES), as applicable, of the need for a Resident Review promptly after a significant change in the mental or physical condition of a resident who has, or is suspected of having, a mental illness, intellectual disability or related condition. All PASRR screening information shall accompany the readmitted or transferred individual.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40844 Based on observation, interview, and record review the facility failed to develop and or implement a comprehensive care plan for two of 16 sampled residents (R31 and R16). * R31: The Physical Therapist (PT) was not included in the care planning process, and their input and recommendations for knee brace related to knee buckling, and trapeze for mobility were not incorporated into the care plan. Staff were unaware of PT recommendations for transfer and mobility care, and did not implement transfer care as care planned and recommended by PT. The care plan did not include if R31 had refused to use any of the PT's recommendations. Additionally, the Kardex used by the Certified Nursing Assistants (CNA) for awareness of the care plan did not include the use of a sit to stand lift and was outdated. The Treatment Record, used by the nurses for awareness of the care plan, did not include the transfer interventions as planned on the care plan. * R16: The facility identified significant weight loss on 12/29/23 and was currently on-going and did not develop a care plan to address the weight loss. Failing to comprehensive plan resident centered care has the potential for residents to not receive care and services needed to reach their highest potential. Findings: * R31: Review of Admission Minimum Data Set (MDS) assessment dated [DATE] revealed the facility admitted R31 on 04/17/24 with diagnoses which included hemiparesis/hemiplegia (weakness/paralysis on one side of the body) following cerebral infection affecting non-dominant side, history of falling, and need for assistance with personal care. R31 was cognitively intact scoring 13 out 15 on a Brief Interview for Mental Status (BIMS). R31 was dependent on staff for for transfers and activities of daily living with moderate to maximal assistance except for eating. The assessment triggered care areas including falls, and ADLs for care planning. R31 has impairment of the upper and lower body on one side. During an observation and interview with R31 on 09/24/24 at 10:12 AM, R31 was sitting in wheelchair in his room. Observed R31 did not move his left side independently and describe his left side Did not work. R31 stated the facility's Physical Therapist (PT) gave him a leg brace due to his knee buckling. The knee brace did not fit properly, and thought they ordered another one a few months ago, however, had not heard anything about it since. Review of PT progress notes revealed R31 worked with the therapist frequently, 2-3 times each week since admission. Note dated 04/22/24 revealed R31 was fitted with a left knee brace for knee buckling. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Initial Assessment noted dated 04/21/24 revealed R31 complained of left knee buckling with sit to stand pivot transfers. R31 was high risk for falls during pivot transfer due to the left lower extremity weakness. Note dated 05/18/24 read, Patient came to PT clinic reporting of right distal biceps pain since the AM when he grabbed bed rail to roll onto left side Spoke with RN [name] regarding injury. Recommend over-bed trapeze bar to facility bed mobility and transfers. Note dated 06/10/24 read, Reassessed patient ability with w/c [wheelchair] to/from bed and to/from toilet transfers. Based on left leg being unstable and buckling with standing pivot transfers, increasing the risk of injury to either knee, would strongly recommend consistency in using sit to stand lifter to perform all future transfers . Some caregivers may not feel comfortable using sit to stand lifter, thus would recommend additional staff training. Note dated 06/30/24 revealed R31 was fitted with a left knee brace, however it was too long for his leg and uncomfortable to wear. Note dated 08/04/24 indicated PT recommended right lower extremity strengthening, however R31 refused stating he would do that later. During an interview on 09/27/24 at 08:43 AM, Certified Nursing Assistant (CNA) 10 confirmed she was familiar with R31's care. CNA10 stated they provided assistance for transfers with a gait belt and R31 bears weight on one leg. I just help him up and lower him down. When asked if they used a lift, she stated I don't think so, I never did. When asked if R31 had a knee brace she stated, not that I know of. She denied R31 used a trapeze bar over the bed for mobility. She stated she was aware of the care plan by a Kardex kept at the CAN charting station. A concurrent review of the Kardex for R31 revealed it was current As of 6/13/24. Under the category of Safety it read R31 needed a safe environment with even floors free of spills/clutter, adequate light, and call bell within reach. Staff were to educate R31 about safety reminders, ensure he was wearing appropriate footwear, had an unobstructed path to the restroom, follow facility fall protocol, and Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Under Resident Care it indicated R31 was working with PT for Restorative Program twice weekly and read, Activity: As Tolerated. Should work with PT @ NH [nursing home] to optimize maintaining mobility and function . Determine [R31's] transferring and gait/balance status and what assistance he needs. The Kardex did not provide specifics about the type of assistance R31 needed for mobility and transfers, or PT's recommendations for sit to stand lifter, trapeze bar, or knee brace. Interviewed the MDS Nurse on 09/27/24 at 08:52 AM. MDS Nurse confirmed she attended care planning meetings and was involved in the care planning process. When asked if PT was involved with care plan development she stated no, as PT worked on the weekends. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/27/24 at 10:34 AM Licensed Practical Nurse (LPN) 2 was asked about the PT's recommendations. LPN2 stated she was not aware of any trapeze being used. She was aware of the injury reported in May and stated, that the grab bar was on the wrong side, and they moved him to a different room to adjust for that. She explained that care planned recommendations should be entered into the Treatment Record so we are aware and pass it on to the CNAs. A concurrent review of the Treatment Record revealed no entries regarding the use of sit to stand lifter, trapeze bar, or knee brace. During a phone interview with PT on 09/27/24 at 11:43 AM, PT confirmed he was familiar with R31. When asked about the knee brace PT explained they had tried a new one however it did not fit. R31 need an order to go to the hospital PT department. I talked with the nurse and told her he needs a referral to go to the hospital PT department for the knee brace, I have exhausted resources available to me. When asked about his recommendations, such as the sit to stand lifter, and care planning he stated, That is problem and described he had talked to a nursing supervisor however his recommendations do not get incorporated. CNA/Ward clerk confirmed on 09/27/24 at 12:15 PM that R31 did not have a referral to go to the hospital PT department for a knee brace. Review of R31's care plan revealed a problem of limited physical mobility and self-care deficit initiated on 04/17/24. Goals included R31 'requires staff assistance with ADLs and R35 will use safety measures to minimize potential for injury. Transfer intervention initiated 07/25/24 read, [R31] needs two-person assistance with transferring using a sit-to-stand lifter. Please apply a gait belt during the transfer. He [complins of] leg weakness early in the morning; please consider the resident's complaint and assist him carefully. The facility initiated a problem of limited physical mobility [related to] left sided weakness on 04/18/24. An intervention was added on 06/11/24 which read, The Physical therapist recommended consistency in using sit to stand lifter to perform all future transfers. The care plan in its entirety did not include any current or resolved interventions related to a knee brace, a trapeze bar, or bed mobility. The care plan did not include if R31 had declined or refused to use a sit to stand lifter. During an interview on 09/27/24 at 02:24 PM the concerns with the care plan, outdated Kardex, the lack of Treatment Record entries related to PT recommendations, and the lack of collaboration between PT and care planning were discussed with the Director of Nursing. The DON confirmed their system did not incorporate the PT's perspective and they needed to work on that. Facility policy titled Comprehensive Assessment and Care Planning with review date 01/2024, revealed The Interdisciplinary Team (IDT) . will consist of: MDS Coordinator, Nursing: DON and Staff Nurse . Professional Therapies as indicated, and Restorative nursing services . Our facility will develop a Comprehensive Care Plan for each resident * R16: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of electronic medical record showed the original admitted was 02/07/23. The diagnoses tab included age-related physical debility, hypertensive heart disease with heart failure, personal history of other diseases of the digestive system, diverticulosis of small intestine without perforation or abscess without bleeding, type 2 diabetes mellitus, gastro-esophageal reflux disease with esophagitis, without bleeding, altered mental status, unspecified, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, essential (primary) hypertension, and major depressive disorder. The Annual MDS assessment dated [DATE] revealed the facility readmitted R15 on 01/31/24 following a hospital stay. The MDS indicated staff assessed R16 to moderately cognitively impaired and was dependent on staff for eating. R16's most recent weight was 116 pounds, and the assessment indicated it no or unknown if R16 had a significant weight loss. The assessment triggered the nutritional care area for care planning. During a meal observation on 09/24/24 at 12:16 PM, R16 was seated at table being assisted by staff, feeding pureed food into R16's mouth. Staff interacted with and encouraged R16 to eat at her own pace. Though R16 appeared to be dozing at times, she responded to the cueing and ate over 75% of her meal. LPN2 described R16 as being dependent for her food intake and required thickened liquids. She confirmed R16 has lost weight over time, and they were providing supplements she sips at. On 09/26/24 at 04:27 PM during an interview and concurrent review of the meal intake log, CNA14 confirmed R16 required total assistance with her meals. She described her intake as variable with usual intake of about 75%. Review of Nutrition/Dietary Progress notes revealed a note dated 02/24/24 which read, Resident referred to RD [Registered Dietitian] due to weight change review. -11.5% loss in 5 months. Document titled Dietitian Recommendations dated 02/26/24 revealed the RD notified the physician and recommended adding House Supplement of choice (No added sugar) 120 [ml] BID [twice a day]. The physician responded he agreed. The progress notes revealed the RD continued to follow R16 monthly, a 07/29/24 note read. Agree with current dietary interventions. Continue to offer diet as ordered, honor food preferences, encourage intakes, offer snacks prn, offer alternates as needed, offer supplement as ordered. Monitor weights per facility protocol. Will continue to monitor for significant changes in labs, meds, weights and [oral] intakes. R16's weight was 105.4 pounds, an -8.7% weight loss. Review of Quarterly MDS dated [DATE] revealed R16's weight was 111 pounds which was a significant weight loss, not prescribed by the physician. Review of Quarterly MDS dated [DATE] revealed R16's weight was 105 pounds which was a significant weight loss, not prescribed by the physician. Review of the care plan revealed a problem focus of risk for nutritional imbalance related to therapeutic mechanically altered diet, impaired dentition and Type II diabetes initiated on 11/03/23. The care plan did not address actual weight loss identified in February, or as identified on the April and July Quarterly MDSs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/27/24 at 01:44 PM the Dietary Manager (DM) stated R16 started losing weight in December 2023. She is offered the med pass [a supplement] no added sugar, nectar thick [liquids] and puree [consistency]. She described R16's intake as typically 100%, and staff offered snacks. She described the RD was following R16 for wounds. When asked about the weight loss, DM stated, Let me check. We don't have R16 on here. During a concurrent review of the care plan DM stated there was one for aspiration related to dysphagia (impaired swallowing) and imbalance related to diabetes. When asked about the care plan for actual weight loss DM confirmed there was not one and stated, We should have one. During an interview with the MDS Nurse on 09/27/24 at 02:03 PM she confirmed that care plan meetings were held on the schedule of when MDS assessments were done. When asked about care plan for R16's weight loss, MDS Nurse stated, It got missed. Review of facility policy titled Comprehensive Assessment and Care Planning with review date 01/2024, read under the policy statement, Initially and periodically, [the facility] will conduct a comprehensive, accurate, standardized reproductive assessment of each resident's functional capacity. This assessment will provide the facility with the information necessary to develop a care plan and to provide the appropriate care and services for each resident. Under the Policy Interpretation and Implementation in pertinent part it read, The assessment must include at least . Nutritional status . Under the Care Plan Policy it read in pertinent part, The Care Plan will be reviewed as often as changes occur in the resident's condition and will be revised to maintain accuracy. During an interview with the DON on 09/27/24 at 02:29 PM, confirmed she was familiar with R16 and her expectation is that a care plan is developed when a resident has a significant weight loss.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41020 Based on interview, record review, and policy the facility failed to update/revise the comprehensive care plan for one of two residents (R)17 reviewed for pressure ulcers (PU). The deficient practice had the potential to negatively impact the provision of care and services for R17. Findings include: R17 was admitted to the facility on [DATE] with diagnoses which included unspecified dementia (dementia without a specific diagnosis; a condition which causes a person to lose the ability to think, remember, and reason to the point that it interferes with their daily life, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.) Review of the Weekly Wound Measurements dated 06/02/24 at 7:44 AM revealed for a wound to the resident's right lower leg (front) described as, 1 centimeter (cm) by 1.5 cm, with 0.5 cm by 0.5 cm of yellow eschar tissue, surrounded by 4 cm of yellowish eschar. 2 smaller yellow eschars above this area 1.5 cm and 0.5 cm by 0.8 cm. Areas not draining. Another wound was described as 0.5 cm by 1 cm open area to middle of buttock fold, 0.5 cm by 0.5 cm open area to right buttocks. Area cleaned with wound cleaner and Duoderm (hydrocolloid dressing) applied. However, review of the resident's care plan did not include an update/revision to include the wounds. A PU care plan initiated on 06/13/24 related to a stage I PU of the coccyx had a goal for signs and symptoms of wound healing. Interventions included to assess/record/monitor R17's coccyx wound, including measuring length, width, and depth per facility protocol. Document wound perimeter, wound bed, and healing progress with each wound treatment. However, the care plan provided no evidence of the wounds to the resident's right lower leg. A Skin/Wound Note dated 06/18/24 at 8:10 PM included the coccyx area was dry and intact, with no open area. Healed. According to the note, the treatment had been discontinued as per order, Until healed/resolved. The Weekly Wound Measurements dated 06/30/24 at 10:06 AM included 3 wounds to the resident's right lower leg: 1) a wound measuring 0.1 cm by 0.5 cm supra fiscal (sic) open area without signs or symptoms of drainage, no signs or symptoms of infection. 2) a wound measuring 0.8 cm by 0.5 cm open area with 0.4 cm by 0.4 cm of yellow eschar in middle of open area. Slight bleeding. 3) 2 cm scratch, well approximated without signs or symptoms of infection. Another wound on the document included the right great toe measuring 0.8 cm by 0.7 cm discoloration with 0.5 cm by 0.4 cm open area, red wound bed with 0.1 cm white center. Review of the resident's care plan did not include the additional wounds. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Weekly Wound Measurements dated 07/14/24 at 8:50 PM included a wound to the resident's right lower leg (front) which measured 0.6 cm by 0.5 cm with an open area of 0.4 cm by 0.4 cm of yellow eschar in the middle of open area. No bleeding or signs/symptoms of infection. The resident's care plan did not demonstrate a revision or update to include the wound. On 09/27/24 at 11:34 AM a phone interview was conducted with a Registered Nurse (RN4). She stated that she works with the nursing/care plan team and Minimum Data Set (MDS) coordinator. She stated she also updates and revises care plans. She stated she would add a new skin condition/wound to the care plan. She stated that it would be important to include for continuity of care, prevention, dietary interventions, care and monitoring. She stated that the wounds to the resident's lower legs and great toe should have been in the care plan. She stated that she thought they missed it. During an interview with the Director of Nursing conducted on 09/27/24 at 1:13 PM, she stated that wounds should be assessed as ordered. She stated that assessment included measurements - weekly or as needed if the wound changes. She stated that wounds should be included in the resident's care plan. Review of the facility policy titled, Comprehensive Assessment and Care Planning, reviewed 1/2024, included, the facility will develop a comprehensive care plan for each resident, including measurable objectives and timetables to meet a resident's medical, nursing, mental and psychological needs as identified in the comprehensive assessment. The care plan will be reviewed as often as changes occur in the resident's condition and will be revised to maintain accuracy. The discipline recording the change in condition shall be responsible for making the appropriate changes to the care plan. Review of the facility policy titled, Skin Wound System of Documentation, revised 3/18/24, included each resident who has any open skin condition will have a care plan providing staff with a treatment plan that includes treatment of the current wound along with preventative inteventions.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41020 Based on interview, record review, and policy, the facility failed to ensure that wound care was provided in accordance with the comprehensive care plan and professional standards of practice for one of two residents reviewed (Resident (R) 17). The deficient practice increased the risk for pain, infection and rehospitalization . Findings include: R17 was admitted to the facility on [DATE] with diagnoses which included unspecified dementia (dementia without a specific diagnosis; a condition which causes a person to lose the ability to think, remember, and reason to the point that it interferes with their daily life, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety) and type 2 diabetes mellitus without complications (a chronic disease that causes a person's blood glucose levels to rise too high). The admission MDS assessment dated [DATE] revealed the resident scored 10 on the BIMS assessment, indicating moderately impaired cognition. Review of Section M of the assessment (Skin Conditions) indicated the resident did not have pressure ulcers, venous or arterial ulcers, or other wounds or skin problems. A physician's order dated 12/06/23 included for weekly skin checks by night nurse on Wednesday, every night shift, every Wednesday for monitoring skin/wounds. The Weekly Wound Measurements dated 06/02/24 at 7:44 AM revealed a wound to the resident's right lower leg (front) (Site 41) described as, 1 centimeter (cm) by 1.5 cm, with 0.5 cm by 0.5 cm of yellow eschar tissue, surrounded by 4 cm of yellowish eschar. 2 smaller yellow eschars above this area 1.5 cm and 0.5 cm by 0.8 cm. Areas not draining. Another wound (specified at Other site) was described as 0.5 cm by 1 cm open area to middle of buttock fold, 0.5 cm by 0.5 cm open area to right buttocks. Area cleaned with wound cleaner and Duoderm (hydrocolloid dressing) applied. On 06/09/24 at 7:39 AM the Weekly Wound Assessments included a wound to the resident's right lower leg (front) (Site 41) measuring 1 cm by 1 cm and 2.5 cm by 2 cm shearing without signs or symptoms of infection. However, there was no specific information provided to indicate whether the wound to the front of the resident's lower leg was one of the same wounds that had been described at Site 41 on the wound assessment dated [DATE]. In addition, the wound on the resident's coccyx was not measured or assessed. Review of the significant change MDS assessment dated [DATE] revealed the resident was at risk of developing pressure ulcers, that he had 1 stage 1 pressure ulcer and 2 unstageable pressure ulcers. A pressure ulcer care plan initiated on 06/13/24 related to a stage I pressure ulcer of the coccyx had a goal for signs and symptoms of wound healing. Interventions included to assess/record/monitor R17's coccyx wound, including measuring length, width, and depth per facility protocol. Document wound perimeter, wound bed, and healing progress with each wound treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Skin/Wound progress note dated 06/18/24 included the resident's coccyx area was clean, dry, and intact with no open area. No further assessment of the resident's wounds was identified in the resident's record until 06/30/24 at 10:06 AM. At which time, the Weekly Wound Assessment included 3 wounds to the resident's right lower leg: 1) (Site 41) a wound measuring 0.1 cm by 0.5 cm supra fiscal (sic) open area without signs or symptoms of drainage, no signs or symptoms of infection. 2) (Site 41) a wound measuring 0.8 cm by 0.5 cm open area with 0.4 cm by 0.4 cm of yellow eschar in middle of open area. Slight bleeding. 3) (Site 41) 2 cm scratch, well approximated without signs or symptoms of infection. Another wound on the document (specified at Other site) included the right great toe measuring 0.8 cm by 0.7cm discoloration with 0.5 cm by 0.4 cm open area, red wound bed with 0.1 cm white center. No evidence of update or revision to the resident's care plan was identified. A subsequent Weekly Wound assessment dated [DATE] at 8:50 PM included a wound to the resident's right lower leg (front) (Site 41) which measured 0.6 cm by 0.5 cm with an open area of 0.4 cm by 0.4 cm of yellow eschar in the middle of open area. No bleeding or signs/symptoms of infection. An additional wound documented at the same location on the resident's right lower leg (front) (Site 41) was described as Resolved. A Skin/Wound progress note dated 07/31/24 at 1:12 AM included, No signs of infection to right great toe. Wound cleaned and dressed per protocol. Tolerated with moderate discomfort. Continue to monitor. At 7:34 AM on 07/31/24 a Skin/Wound progress note indicated the resident was reported to have a fissure to gluteal fold with no drainage or redness noted. Skin barrier cream applied. No further assessments of the right lower leg wounds were identified in the resident's record. A Skin/Wound progress note dated 08/01/24 revealed the wound to the resident's right great toe had healed. On 08/18/24 at 12:39 AM Weekly Wound Measurements included an abrasion to the resident's left lower leg (front) (Site 42) which measured 0.4 by 0.3. The wound was described as an abrasion with slight redness noted. On 08/19/24 at 4:00 PM a Skin/Wound progress note revealed the wound to the resident's right lower extremity had healed. On 09/27/24 at 1:13 PM an interview was conducted with the Director of Nursing. She stated that wounds should be assessed as ordered. She stated that assessment included measurements - weekly or as needed if the wound changes. She stated that wounds should be included in the resident's care plan. She stated that it did not meet her expectation for wounds to be assessed only monthly. She stated that the risks to the resident would include infection, sepsis, and death. She stated that they do not have a wound nurse. She stated that they do not have anyone in the building that is wound certified. She stated that LPN2 took the classes but did not get certified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Skin Wound System of Documentation, revised 3/18/24 included that on admission, the head-to-toe exam of the resident's skin will be done within the first 24 hours and documented in the Nursing Admission Screening/History under Assessment. Each resident with a wound will have weekly wound assessment/measurement completed by the designated licensed nurse. Management of the skin/wound will be implemented as prescribed by the physician treatment orders. Wound measurements and assessments will be done weekly that includes a description of the wound to monitor the healing/worsening process. Each resident who has any open skin condition will have a care plan providing staff with a treatment plan that includes treatment of the current wound along with preventative interventions.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40844 Based on observation, interview, and record review the facility failed to ensure that one of two residents review for pressure ulcers received care consistent with professional standards when Resident 35's (R35) wound care assessments were not completed weekly, and care planned intervention of a multi-podus boot (an orthopedic device) was not implemented. This had the potential for R35's pressure ulcers to worsen. Findings: Observed R35 on 09/24/24 at 09:18 AM sitting in a wheelchair in the common area of Household 1. R35 was propelling herself slowly by using her feet over to the surveyor. R35 responded to the surveyor's questions indicating she could not remember what she had for breakfast that day. R35 was well groomed and wore slippers. R35's wheelchair did not have footrests attached. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed the facility admitted R35 on 10/18/23 without any pressure ulcers. The facility assessed R35 to be at risk for pressure ulcers and utilized pressure reducing device for a chair. R35 had severe cognitive impairment, scoring a 6 out 15 on a Brief Interview for Mental Status (BIMS). Diagnoses included acute embolism and thrombosis of unspecified vein, hypertension, osteoporosis, dementia, trigeminal neuralgia, constipation, weakness, physical debility, and history of urinary tract infection. The assessment triggered the pressure ulcer care area for care plan development. Review of the Quarterly MDS assessment dated [DATE] revealed R35 did not have any pressure ulcers. Review of the Quarterly MDS assessment dated [DATE] revealed R35 developed a stage 2 pressure ulcer, and an unstageable pressure ulcer On 09/26/24 at 08:48 AM Licensed Practical Nurse (LPN) 4 stated R35 had dressing changes to the ankles every five days, last completed on 09/25/24. When asked about the wounds, LPN4 stated they have been monitoring weekly and they are slowly improving. She was uncertain of when they developed and unaware they were pressure ulcers. Upon a concurrent record review, LPN4 confirmed R35 was seeing a podiatrist since April of 2024. [R35] started with rashes in April, and it was going everywhere and started going down to legs. They [Podiatry clinic] trying to find out what was going on. When asked if the ankle wounds were pressure ulcers, LPN4 stated, No. During an interview 09/26/24 at 09:34 AM Certified Nursing Assistant (CNA) 14 stated she was assigned to and worked with R35 frequently. CNA14 stated R35 had a dressing on each ankle the nurses changed and was not aware of the type of wound under the dressings. CNA14 described R35 required extensive assistance with activities of daily living and had edema (swelling caused by too much fluid trapped in the body's tissues) in the lower legs, though could not wear compression stocking due to the friction it causes to the wounds. Concurrently observed R35 lying in bed with her feet elevated off the mattress. CNA14 stated I put a blanket under her feet, she wanted it way high. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 09/26/24 at 10:41 AM, CNA14 assisted R35 to get up out of bed. Observed R35 had some swelling of the lower extremities, and intact dressings on the outer aspect of each ankle, over the bony prominence dated 9/25. CNA14 stated R35 had special shoes showing the surveyor a pair of slippers with a Velcro closure. CNA14 assisted R35 putting on the pair of slippers. A specialized splint or device was not observed in the room. Review of podiatry progress note dated 05/06/24 revealed podiatry was seeing R35 for ischemic (a restriction in blood supply) lesions, petechiae (small flat round spots that appear on the skin when small blood vessels break), excoriations and itchiness to the lower legs. The note indicated the petechiae and excoriations were resolved, and read, Noted remaining ischemic lesion, explained to the patient and granddaughter the lesions are ischemic in nature as they are punched out, and they arose where the microvasculature bursted (sic) intradermally causing skin necrosis and now they are eschar lesions &/ scabs . Podiatry progress note dated 05/29/24 read, . Also, noted new stable eschar lesions to lateral malleoli [the bone on the outside of the ankle joint, called the fibula] of bilateral ankle, which are very likely to repetitive & shearing forces causing pressure injury. Podiatry progress note dated 06/05/24 revealed two new diagnoses added to R35's medical history: Pressure injury of left ankle stage II and Pressure injury of right ankle stage III. A weekly wound assessment dated [DATE] documented the wound on the right lower extremity was 1cm x 0. 5cm scab with dark center, 2.5 cm by 2cm of discoloration and 1cm by 1.5cm dark eschar area (a collection of dry, dead tissue within a wound). The left lower extremity wound was described as 5cm x 4cm of discoloration, with scab areas 1cm x 0.5, 0.5 x 0.5 cm 0.5 x 0.2cm that were healing well without signs or symptoms of infection. Weekly wound assessments dated 09/04/24 revealed the wound to left outer ankle, measured 0.5 cm x 0.4 cm x 0.3 cm. The wound to right outer ankle measured 0.7 cm x 0.7 cm x 0.4 cm. Review of the nursing assessments revealed weekly wound measurements were completed on 06/09/24, 07/14/24, 07/21/24, and 09/04/24. Assessments for 06/16/24 through 07/07/24, and 07/28/24 through 08/28/24 were not found. During an interview with the Director of Nursing (DON) on 09/27/24 at 02:24 PM, the DON confirmed R35 developed pressure ulcers to her ankles during her stay at the facility. They did identify she was [resting her ankles] on her wheelchair footrest. She stated after addressing this, the wounds began to heal. Review of R35's care plan problem of risk for pressure ulcer development initiated on 10/28/24 revealed goals of minimizing the risk and that R35 will have intact skin. Interventions included: To apply moisturizer daily, and not to massage over bony prominences; Follow protocols for the prevention/treatment of skin breakdown; and reposition in wheelchair every 2 hours. R35's ADL care plan initiated on 10/28/23 revealed R35 required extensive assistance including being dependent on staff for dressing, making sure shoes are comfortable and not slippery. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care plan problem of actual impairment to skin integrity initiated on 04/15/24 revealed goals of no infection to the lower legs, R35's lower extremities will not progress and R35 will comply with wound care. The ankle treatment was revised and updated on 07/29/24 with the current treatment orders. Two new intervention was added after 05/29/24: On 07/29/24 an intervention to elevate feet as much as possible [related to] ulcers to bilateral ankles was initiated; and on 08/31/24, Please offload ankles [with] Multi-Podus Boot. Keeping pressure off lateral ankle. A multi-podus boot is an orthopedic device that suspends the heel and holds the ankle in a neutral position. The care plan in its entirety did not address (current or resolved) if R35's wheelchair should have footrests or not, if R35 should or should not wear compression stockings, or the impact a multi-podus boot would have on R35's mobility. Facility policy titled Skin Wound System of Documentation revised 03/18/24 read, Each resident with a wound will have a weekly wound assessment/measurement completed by the designated licensed nurse Each resident who has any open skin condition will have a care plan providing staff with a treatment plan that includes treatment of the current wound along with preventative interventions.

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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** 35588 Based on observations, interviews, review of records, and policy, the facility failed to ensure that 3 of 6 residents reviewed for accidents (Residents (R) 207, R106, and R156) did not sustain preventable falls with major injuries. Specifically, 1) The facility failed to conduct neuro checks after an unwitnessed fall, ensure neuro checks conducted were consistent with their policy, implement fall interventions, and provide adequate supervision for R106. R106 had 16 falls during his four-month stay, including three falls where the facility recommended 1:1 monitoring which was not implemented. After the series of falls where 1:1 monitoring was recommended but not implemented, R106 had four additional unwitnessed falls. After the last unwitnessed fall, the assigned LPN failed to conduct neuro checks as required by facility policy and professional standards of practice. The facility's failure caused harm to R106 who had repeated falls in the facility with the last fall resulting in transfer to the Emergency Department, where R106 was diagnosed with a subdural hematoma (serious condition usually caused from a head injury when blood collects between the brain and its outermost covering), requiring hospitalization , ventilator support, and ultimately died . 2) The facility failed to implement an intervention of an anti-rollback device which the IDT recommended for the prevention of falls for R156. R156 had 15 falls during their stay in the facility, half of which involved R156 not locking her wheelchair breaks, and all of which involved R156's non-compliance with following facility education to request assistance with transfers and ambulation. The facility's failure caused harm to R156 who had repeated falls in the facility and resulted in transfer to the Emergency Department where R156 was diagnosed with a subdural hematoma, requiring hospitalization . 3) The facility failed to ensure one resident (R207), with assessed ADL dependence and severe cognitive impairment received mobility services/assistance to propel her wheelchair to ensure she did not sustain a preventable fall with major injury, hospitalization , and death. Cross reference to F600 Findings include * For Resident 106: Review of Resident 106's (R106) record documented the resident was admitted on [DATE] with diagnosis including dementia, diabetes, frequent falls, orthostatic hypotension (sudden drop in blood pressure when you stand up from a sitting or lying position) and stroke. R106's Minimum Data Set (MDS-assessment tool), dated [DATE], documented resident's brief interview for mental status was 12 of 15, indicating moderate cognitive impairment and required supervision or touch assistance when transferring from chair to bed or walking 50 feet while using a walker. Resident was transferred to the hospital on [DATE]. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	1. Neuro checks Review of facility's Falls and Fall Risk Managing policy, dated ,d+[DATE], documented under section Steps (Post Fall) 30 minutes 3. neurological checks: Required for all falls with head injury or unwitnessed falls. a. Neurological checks include assessing: i. Glasgow Coma Scale [a tool used to measure a person's level of consciousness and how responsive they are], ii. LOC (level of consciousness), iii. Orientation, iv. Movement in Extremities, v. Pupil size and reaction and vi. Speech and Responses. b. For 72 hours at a frequency of: i. q (every) 15 min(utes)x1 hour, ii. q30 min(utes) x 1 hour, iii. q1 hourx4 hours, iv. q4 hoursx24 hours, then v. qshift x72 hours, 4. Monitor vital signs, 5. Monitor for signs/symptoms of delayed injury (i.e., bruising, bleeding, fracture). 1 hour: 2. Complete the following documentation: a. Post Fall Screening Sheet .e. Neurological Checklist with a head injury and unwitnessed fall (UDA)(user defined assessment) Review of R106's care plan documented resident was at risk for falls related to history of recurrent falls, wandering, confusion and gait (walking) imbalance with goal that resident would not sustain serious injury related to fall. Actions to achieve goal included follow facility fall protocol to prevent fall and monitoring protocol with start date [DATE] and had unwitnessed fall on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE] and witnessed fall on [DATE] and [DATE]. Please monitor his vital signs, neuro checks, pain, skin condition, ROM (range of motion) and delayed injuries. Follow the facility protocol for monitoring s/p (status post, after) fall condition with start date [DATE]. PROGRESS NOTES Review of R106's progress notes, dated [DATE] at 8:46 PM, Licensed Practical Nurse (LPN)6 documented Informed by another resident (R), R106 was sitting on floor in the Great Room. No wheelchair in area and attempting to get up but not calling out. Resident's wheelchair was found in room [resident's room] by bathroom door and bed linen in room was ruffled up. Resident was attempting to get up during assessment. No injury noted, no bump on head, no bleeding. Resident questioned if he was hurting or if he bumped his head. Denied both and wanted to get up. Resident asked if he needed to go to the hospital - denied. Resident was then assisted to w/c. Continuing on VS [vital signs] from recent fall earlier. Phone cont(inue) busy. Review of R106's progress notes, dated [DATE] at 10:57 PM LPN6 documented During shift report, CNA (Certified Nursing Aide) reported Resident (R106) having multiple episodes of emesis (vomiting). Near beginning of shift CNA reported Resident vomited; VS [vital signs] taken, BSL @ (blood sugar level at) 223. Elevated BP, confused and aggressive. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of R106's progress notes, dated [DATE] at 2:58 AM LPN6 documented Resident reported with bout of emesis this shift approx(imately) 2000 (8PM). VS taken and CNA reported elevated BP (blood pressure). Resident monitored by CNA, attempting to get up OOB (out of bed), bed alarm sounding d/t (due to) continued restlessness. During bed checks, Resident sleeping w/ (with) legs hanging off the side of the bed, , d+[DATE] dressed and partly exposed. Assisted CNA with getting Resident back into bed and changed. Encouraged Resident to rest and he calmed down. Called to room when emesis reported. VS cont(inue) w/ elevated BP, skin cool to the touch, staff reported Resident did not look right/normal. Called ER (emergency room) and spoke w/ Nurse [Name of nurse], we would send Resident in via facility van. Returned to Resident and was informed Resident was now unable to stand, more lethargic, VS unchanged and cont(inue) cool to touch. Called ER, then EMS for transport. Resident left facility at 2340 (11:40 PM) FALL INVESTIGATION Review of facility incident witness report form, dated [DATE] at 8:30 PM, documented by LPN6 showed checkmark in box for Other and a checkmark was not shown in box for Fall for type of incident. The details section documented Alerted to (R106) was sitting on floor in Great Rm (room) but another resident. No calling out observed. When notified by staff, Resident wanted assist to get off of floor. During the assessment of Resident, CNAs attempted to get Resident up but were told to wait since Resident had to be assessed. Resident told staff I slipped when asked. But no w/c (wheelchair) nearby. WC found in [another resident room] with alarm sounded and muted. Resident assisted off of floor to w/c x3 staff. While being assess Resident denied hitting head, denied pain, denied wanting to go to the hospital. Just wanted to get up. Resident on AC (alert charting) for recent fall, no new protocol continued. Resident cont(inued) with ongoing behavior prior to fall. Had resident sit in w/c-later assisted to room. Review of facility incident witness report form, dated [DATE] at 8:15 PM, documented by LPN2 showed checkmark in box for Fall as type of incident with details At approx(imately) 2015 (8:15 PM) I was completing treatments in (nursing unit). I had gathered my supplies and was entering [another resident's room] when I heard [name being called], I leaned back out of the room and resident [room number of resident] was pointing into the living room area. As I looked in that direction, I observed [R106] lying on the floor near the [unit] kitchenette. [Name of LPN6] was nearby and I asked her Did you guys put [R106] on the floor? He's on the floor. [LPN6] walked over and observed resident then called to the night CNAs The following documents were not provided by facility for [DATE] fall, which were required per facility policy after an unwitnessed fall, including: 1. Post Fall Screening form which is a checklist to determine why resident fell such as what type of footwear resident was wearing, if environment was clear or cluttered, was resident confused or dizzy, was resident wearing glasses or hearing aide, if there were skin tears, lacerations or any injuries, immediate blood pressure, oxygen saturation level, heart rate, temperature, pain level, level of consciousness. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	2. Interdisciplinary Post-Fall Assessment form which describes fall, outlines the number of falls in the last 30, 90 and 180 days, if there were recent medication changes, pattern of current falls such as time of day, six month review of falls and if there were any patterns or trends related to falls, probable cause of falls, root cause analysis of falls, recommendations from the review by IDT (Interdisciplinary Team), and care plan revisions. 3. Neurological check form that documented initial assessment of resident's pupil size and reaction to light, movement of extremities, vital signs, and level of consciousness. 4. Post Fall-Nurse Neurological Check Guidelines that documented assessment of resident's pupil's reaction to light, able to follow finger, verbal responses, pain level and level of consciousness every 15 minutes for 1 hour, every 30 minutes x4, every hour x4, every four hours x4 and every shift x3. 5. 72-hour intentional rounding after fall that assessed and documented pain, positioning, peri-needs and possessions such as call light within reach, glasses, water and environmental conditions every hour. INTERVIEWS During an interview on [DATE] at 7:36 AM LPN2 stated that when residents have an unwitnessed fall she completes neuro checks and completes fall packet which includes neuro checks every 15 minutes x4, then every 30 minutes x4 and so forth as outlined on form. LPN2 stated that she checks on the resident's level of consciousness, if the resident is alert, lethargic, nonresponsive, the resident's pupils reaction to light, size, extremity strength, weakness, and take their vitals. LPN6 stated when R106 fell on [DATE] she had worked the day shift and her shift ended at 7:30 PM but was doing a last minute treatment on R106's unit when she heard a resident calling her name who directed her that R106 was on the floor. LPN2 stated that she asked LPN6 if she put R106 on the floor and LPN6 said no and then LPN6 called the CNAs over to help. LPN2 stated that R106's fall was unwitnessed because R106 was found on the floor and staff did not put R106 on the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During an interview on [DATE] at 2:48 PM Assistant Director of Nursing (ADON) who was also the facility's Quality Assurance and Performance Improvement and Infection Preventionist (ADON/QAPI/IP) stated that R106 had multiple falls in the facility and confirmed during resident's four month stay in the facility, resident had 16 falls, which were both witnessed and unwitnessed. ADON/QAPI/IP confirmed that when resident have an unwitnessed fall, nursing is directed to complete fall packet which includes post fall screening form, neurological check form, post fall nurse neurological check guidelines and 72 hour intentional rounding form. ADON/QAPI/IP further stated that licensed nurses should complete neuro check form for the specific time period as outlined on the form such as every 15 minutes x4, then every 30 minutes x4 to check for concussion or effects of head injuries. ADON/QAPI/IP stated that R106 had a witnessed fall on [DATE] and an unwitnessed fall on [DATE] and she should have received a fall packet including fall sheet and neuro checks for the [DATE] fall but didn't. ADON/QAPI/IP stated that when she did not receive the fall packet at the end of the day on [DATE], she asked LPN6 for the fall packet and LPN6 responded that she didn't complete the fall packet including neuro checks. ADON/QAPI/IP stated that she reviewed the video footage for R106's [DATE] fall and saw that R106 tripped and fell near the kitchenette, and LPN6 was not observed to complete a neuro assessment or vital signs after the fall but should have. The next day in the evening, R106 vomited and wasn't himself so he was sent to the emergency room . ADON/QAPI/IP stated that LPN6 no longer works at the facility. When asked about if the frequency and duration for neuro checks on the post fall nurse neurological check guidelines form should match the facility's fall policy, ADON/QAPI/IP stated yes. Joint review of two documents comparing frequency, duration, and content was conducted and ADON/QAPI/IP confirmed that the form did not direct nurses to assess for movement of extremities, pupil size, and instead of monitoring for neuro checks every 4 hours for 24 hours, the form only directed staff to monitor for every 4 hours four times (shortened duration of monitoring by 8 hours). ADON/QAPI/IP stated that due to the format of the form, staff were not monitoring neuro checks per facility policy which was based on policy reference source of Glascow coma scale and medpass and that shouldn't have happened. ADON/QAPI/IP also stated that it was important to do neuro checks for the frequency and duration because of latent effects, residents can have a change in level of consciousness later and R106 didn't have nausea/vomiting for almost 24 hours after his fall. During an interview on [DATE] at 9:34 AM Medical Doctor (MD)1 confirmed he was R106's physician, resident had multiple falls, and it was important to do neuro checks for ,d+[DATE] hours after falls because of latent injuries and possible concussion. MD1 further stated that it was important to watch for neuro changes so action can be taken as soon as possible. MD1 confirmed that resident's vomiting and change in mental status the day after a fall could be contributed to a head injury from the fall. MD1 also confirmed that resident was transferred to the emergency room , was air lifted to nearby hospital as family wanted everything done, resident was full code, and resident was found to have a subdural hematoma that required ventilator support, surgery, intensive care services and subsequently died . During an interview on [DATE] at 9:21 AM Director of Nursing (DON) stated that staff are expected to complete neuro checks and continue assessments for 72 hours after an unwitnessed fall because there could be delayed effects, and this was not done for R106 during his last fall in the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of Emergency Department (ED) note, dated [DATE], showed R106 was well known to the ED and had a history of frequent falls. His last visit to this ED was due to a fall on [DATE] with an atraumatic head CT (noninvasive imaging involving x-rays and computer showing no trauma). He was seen in ED for lethargy and vomiting 3 times tonight at the nursing home. The nursing home think the resident had a fall the night before ([DATE]), nothing was witnessed. The ED records showed resident was lethargic, closed his eyes quickly after opening, left eye lid droops, good gag, moved all four extremities equally and purposefully, doesn't stay awake long enough to test anything else such as finger-nose, and usually resident known to joke around but today resident is so lethargic it is hard to evaluate his mental state. A CT of the head was completed due to resident's altered mental status and was compared to [DATE] previous exam. The CT of the head showed there was a left subdural hematoma with maximal diameter of 1.7 cm with a shift to the midline from left to the right. Resident had a history of frequent falls who presented today some 30 hours after a presumed fall at the nursing home with progressive lethargy and vomiting. Resident's diagnosis and prognosis was communicated to family members who understood resident's condition was poor and outcome is uncertain and confirmed resident was full code and that they want everything done. The plan was to intubate (flexible tube placed through the mouth and down into the windpipe to help keep the airway open), do all critical care necessary to keep resident alive and family understood resident would be on life support. Subsequently, resident was intubated, placed on a ventilator (a machine that helps a person breathe when they are unable to do so on their own by pushing air into the lungs through a tube), a cervical collar was applied, multiple intravenous lines and monitoring devices were initiated and resident was transferred to another hospital for intensive care services via air transport on [DATE] at 9:37 AM. Review of R106's progress notes, dated [DATE], documented resident died and family members picked up resident's personal belongings at the facility. 2. Inadequate fall management Review of R106's care plan documented resident was at risk for falls related to history of recurrent falls, wandering, confusion and gait (walking) imbalance with goal that resident would not sustain serious injury related to fall. Actions to achieve goal included follow facility fall protocol to prevent fall and monitoring protocol with start date [DATE] and monitor (R106)'s location frequently and assess his needs. Assist with toileting, transferring and walking as need. (R106) requires every 15 minutes safety check with start date [DATE]. Review of facility's fall incident reports documented resident had 16 falls during four-month stay. Falls on [DATE] (unwitnessed), [DATE] (unwitnessed), [DATE], [DATE], [DATE] (unwitnessed), [DATE] (unwitnessed), [DATE], [DATE] (unwitnessed), [DATE] (unwitnessed), [DATE] (unwitnessed), [DATE], [DATE] (unwitnessed), [DATE] (unwitnessed), [DATE](unwitnessed), [DATE] (unwitnessed), [DATE], [DATE] (unwitnessed). Twelve of the 16 falls were unwitnessed. Review of facility's fall incident reports documented: *[DATE] (unwitnessed fall) *[DATE] (unwitnessed fall) *[DATE] (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	*[DATE] *[DATE] (unwitnessed fall) *[DATE] at 7:31 AM with unwitnessed fall. Wheelchair rolled while resident was attempting to transfer, breaks were unlocked, resident confused, impulsive, no safety awareness and sustained bruises from fall, bumped his head slightly. The interdisciplinary team recommendations included 1:1 supervision (1 staff member dedicated to supervising R106, ratio of 1 staff to 1 resident). 1:1 supervision recommended and not implemented. 1:1 supervision was not added to resident's care plan. Wheelchair rolled while resident attempting to transfer, wheelchair breaks were unlocked. *[DATE] *[DATE] at 5:10 AM with unwitnessed fall. Resident was found in the living room and sustained abrasions to his head and both knees. Resident stated, I hit my head. The wheelchair alarm was delayed. Resident transported to the emergency room . The interdisciplinary team recommendations included 1:1 monitoring. 1:1 monitoring recommended and not implemented. 1:1 monitoring was not added to resident's care plan. *[DATE] (unwitnessed fall) *[DATE] at 3:55 PM with unwitnessed fall. Resident wandered into another room. Anti-roll back wheelchair was recommended (device attached to wheelchair that locks wheels automatically when resident begins to stand). Anti-roll back wheelchair was not added to resident's care plan. *[DATE] (unwitnessed fall) *[DATE] at 9:00 PM with unwitnessed fall in hallway, in great room. Resident stated, I was trying to go to the bathroom, got up from wheelchair while in great room to go to the bathroom and fell in the hallway. The interdisciplinary team recommendations included 1:1 monitoring (not available at facility at this time) and constant redirection. 1:1 monitoring was recommended and not implemented. 1:1 monitoring was not added to resident's care plan. Anti-roll back wheelchair was recommended. Anti-roll back wheelchair was not added to resident's care plan. *[DATE] (unwitnessed fall): wheelchair breaks unlocked. Resident getting up from wheelchair without assistance. Attempting to transfer to bed and fell . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	*[DATE](unwitnessed fall): resident hit his head, sent to ED. *[DATE] (unwitnessed fall) *[DATE] *[DATE] at 8:30 PM with unwitnessed fall. Neuro checks should have been initiated but was not. During interview on [DATE] at 2:48 PM ADON/QAPI/IP stated that she conducted fall investigations which included reviewing documents in fall packet such as incident witness report forms, post fall screening form, neurological check form, post fall nurse neurological check guidelines and video footage and she completed the Interdisciplinary Post-Fall Assessment form with the input from the interdisciplinary team which included unit charge nurses, Director of Nursing, social workers, MDS nurse, Housekeeping, Maintenance, and sometimes activities and the lead CNA. When asked what were some of the root cause analysis of the falls and interventions to prevent recurrent falls ADON/QAPI/IP mentioned several actions and stated that resident was a high fall risk, would sundown in the evenings, and resident was sometimes confused, reorientation didn't always work, he had orthostatic hypotension, impulsive behaviors of getting up all the time, and he sometimes turned off the wheelchair and bed alarms so we couldn't rely on them. When asked about the level of supervision, ADON/QAPI/IP stated that they had every 15-minute safety checks, but we didn't have 1:1 even though it was something that we recommended but we don't have that level of funding for staff to sit with him. When staff had free time, they sat and kept an eye on him, but we were short on staff and didn't have the adequate staff he needed, on nights we sometimes had only two CNAs and the nurse was passing medications. ADON/QAPI/IP stated that the only intervention that would keep R106 safe would be 1:1 supervision but the facility could not provide that level of supervision because the facility did not have the staff. ADON/QAPI/IP acknowledged the facility was responsible for keeping R106 safe and the facility did not provide adequate supervision to R106. During an interview on [DATE] at 8:10 AM Restorative Nursing Assistant (RNA) stated that she did not recall providing or seeing R106 with an anti-roll back wheelchair. RNA stated that R106 received therapy services. During an interview on [DATE] at 2:05 PM Physical Therapist (PT) stated that he did not recall what type of wheelchair R106 had and if R106's wheelchair included an anti-roll back device. PT stated that it should be documented in therapy/restorative notes as part of services provided but sometimes wheelchairs are switched even without a referral. Review of therapy notes provided by facility upon request for all of R106's physical therapy and restorative notes, including assessment on [DATE] and [DATE], did not show documented evidence that R106 received or used a wheelchair with anti-roll back devices. During an interview on [DATE] at 8:14 AM Certified Nursing Assistant (CNA)10 and CNA11 were interviewed. CNA11 stated that she recalled R106 whose room was right near charting station and resident was constantly trying to stand up and move, resident would propel wheelchair and would lift feet and place over wheelchair leg rest and was very challenging. CNA11 stated that she did not recall R106 having anti-roll back devices on his wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During an interview on [DATE] at 9:21 AM DON stated that facility was short staffed and unit aides used to provide 1:1 monitoring but unit aides were lost when the covid waivers went away. DON confirmed R106 was inadequately supervised because he really needed 1:1 monitoring which the facility could not provide. DON further stated that they were trying to get R106 to a memory care facility, but it was not covered under resident's insurance. During an interview on [DATE] at 4:16 PM MDS nurse stated that she and Registered Nurse (RN)4 who help develop care plans attended IDT meetings to discuss R106's falls and actions to reduce falls and any recommendations made at meeting should be reflected in R106's care plan. MDS nurse further stated that if an action is not in the care plan, it is a break in the intended process. Please refer to F600. 40844 * For Resident 156: Review of Admission MDS assessment dated [DATE] revealed the facility admitted R156 on [DATE] with diagnoses of non-Hodgkin lymphoma, adult failure to thrive, pain in right knee, unsteadiness on feet, repeated falls, mechanical ptosis (a condition in which the upper eyelid droops, sags or falls over the eye) of bilateral eyelids, paralytic ptosis of right eyelid, and need for assistance with personal care. R156's cognitive function was assessed to be intact scoring 13 out 15 on a Brief Interview for Mental Status. The assessment indicated R156 exhibited rejections of care 1 to 3 days during the 7 previous days. The initial nursing assessment dated [DATE] indicated R156 required staff assistance with transfers and a ADLs. The note read, Resident is very unsteady gait/poor balance and needs assistance x 1. Very High Risks for fall. Under observations it read, needs full assistance with transfers and ambulation - not safe to ambulate by self. The facility developed a care plan focus upon admission for R158's risk for falls with a goal of being free from injury. Interventions included to provide assistance with transfers and ambulation, anticipating R158's needs, keeping the call bell within reach, providing a safe environment, the use of chair and bed sensors, follow facility fall protocol, ensure appropriate footwear, and keeping the environment free of clutter. Review of the April fall log provided by the facility revealed R158 had three falls in April on, [DATE], [DATE], and [DATE]. All three were unwitnessed falls. Review the facility's investigation into the falls provided by the facility revealed the root cause of the falls included R156 self-transferring, not asking for assistance, and failing to lock the brakes of the wheelchair. The IDT documented two recommendations on the Post-Fall assessment dated [DATE]: Encourage using call light for assistance - refuses @ times. And Antiroll back wheelchair. An anti-roll back device is a braking mechanism that automatically locks rear wheelchair wheels when a patient stands. Additional review of the facility fall logs for May, June, July, August revealed R158 had 5 additional falls in May ([DATE], [DATE], [DATE], [DATE], and [DATE]); 3 falls in June ([DATE], [DATE], and [DATE]); 2 falls in July ([DATE], and [DATE]); and 2 falls in August ([DATE] and [DATE]). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Additional review of the facility fall investigations revealed 6 of the 12 falls between May and August ([DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]) identified not locking wheelchair breaks as a root cause. The IDT identified a component of non-compliance to their efforts to educate R158 to ask for assistance before getting up, and/or to lock her wheelchair breaks for all 15 falls. Additional review of the care plan for falls revealed frequent updates related to educational interventions for safety, fall events, and monitoring, however the care plan lacked the recommended intervention of using anti-rollback device on the wheelchair. The facility reported the [DATE] fall to CMS as a fall with major injury. The report indicated neuro checks were initiated with findings that right eye was not reactive to light, though R156 has problems with that eye. R156 was sent to the local hospital for evaluation after R156 complained of left arm pain. Hospital records included a CT of the head completed on [DATE] which read, Acute subdural hematoma over the right anterior frontal lobe. During an interview with the Assistant Director of Nursing (ADON) who was also the facility's Quality Assurance and Performance Improvement and Infection Preventionist (ADON/QAPI/IP) on [DATE] at 09:57 AM, R156's falls and fall investigations were reviewed. ADON/QAPI/IP described R156 as aware of where she is, who she is. She was identified as a fall risk. We had no issues the first couple of days. Then we would get notifications she having difficulty going to bed, impulsive getting up on her own. We oriented to her environment and the call light . we would find her getting up and rummaging through her drawers, and staff heard the shower on, [she was showering independently]. At first, with those reorientations or reminders she was receptive and after a while she would become aggressive and lash out. ADON/QAPI/IP confirmed the IDT identified R156 as being resistant to requesting assistance, and frequently did not lock her wheelchair breaks before self-transferring. When asked the IDT recommendation on [DATE] for an anti-roll back device, ADON/QAPI/IP confirmed it was a recommendation. She stated, We talked about it, we had some available, we just didn't go back to revisit it. When asked why a recommendation by the IDT would not be implemented ADON/QAPI/IP replied, I don't know, probably busy. She described the IDT as including all department heads, and confirmed when a recommendation was made, it was not assigned to anyone specific to follow through on it. She stated if a device was issued it would be on the care plan. She stated she would review and provide additional documentation if a device was issued. Additional documentation was not provided prior to the survey exit. During an interview on [DATE] at 04:35 PM, Restorative Nurse's Aide (RNA) confirmed the facility had several anti-rollback devices for wheelchairs. She described they had a nurse who ordered them. It is for a resident that gets up and . she demonstrated on a wheelchair in the rehab gym how the device engaged the wheels and prevented the wheelchair from rolling back. RNA was not aware of a system for knowing who has one on their chair or not. She stated, nobody is charting it. When asked if she recalled R156, she confirmed she was familiar with the resident. She stated R156 did not have an anti-rollback device on her chair and showed the surveyor R156's chair. Observed the wheelchair shown, stored in the rehab gym, had R156's name on it. It did not have an anti-rollback device on it. Review of progress note type: Discharge Summary dated [DATE] revealed R156 was still in the hospital, and the family reported R156 would be starting rehab. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of facility policy titled Falls and Fall Risk Managing dated - read under the policy statement, Based on previous evaluations and current data, the staff shall identify interventions related to the resident's specific risks and causes to try to reduce falls, reduce injuries, and minimize complications related to falls and identify residents at risk for falls. 41020 * For Resident 207: R207 was admitted to the facility on [DATE] with diagnoses which included unspecified dementia (a condition that causes a person to lose the ability to think, remember, and reason to the point that it interferes with their daily life, with no specific diagnosis) and wedge compression fracture (a type of vertebral fracture that occurs when the front of the vertebra collapses, giving the bone a wedge shape) of unspecified lumbar vertebra (lower back), initial encounter for closed fracture. A limited physical mobility and self-care deficit care plan initiated on [DATE] had a goal which indicated the resident required assistance with ADLs (Activities of Daily Living). Interventions included PT/OT (Physical Therapy/Occupational Therapy) evaluation and treatment as ordered. According to the ADL (Activities of Daily Living) Index Report (meaures a person's ability to perfor[TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35588 Based on observation, interview and record review, the facility failed to ensure 1 of 1 sampled resident (R) (R24) reviewed for urinary catheter received treatment and services to prevent urinary tract infections when staff failed to ensure urinary drainage bag spigot/spout did not touch the inside of the urinal to prevent contamination and failed to develop individualized and specific clinical indications for changing the urinary and bag instead of changing at routine fixed intervals. These failures placed the resident at increased risk for urinary tract infections and its associated complications. Findings include Review of facility policy Indwelling Catheter Care, reviewed 1/2024, documented The urinary tract is the most common site of Healthcare-Associated Infections (HAI), accounting for approximately 40% of hospital infections. The intent of this policy .will assist in the prevention of Catheter-Associated Urinary Tract Infections (CAUTI) .6. Urine in drainage bags should be emptied at lease (least, sp) once each shift Care must be taken to keep the valve from becoming contaminated . Under the Catheter Change section, 1. Catheter change: The interval between catheter changes should be determined by the individual patient's needs and physician orders. Indications for change may include mechanical dysfunction or blockage of the urinary catheter system and contamination of the closed system. 2. Indwelling catheters should not be changed at arbitrary fixed intervals. Review of the Centers for Disease Control (CDC) guidelines for the Prevention of Catheter-Urinary Tract Infection, 2009 documented Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. Review of Resident 27's (R27) record documented resident was admitted on [DATE] with diagnoses including cerebral infarction with hemiplegia (blocks blood supply to part of the brain or when a blood vessel in the brain bursts and part of brain becomes damaged or dies resulting in weakness or loss of strength on one side of the body), diabetes, benign prostatic hyperplasia (enlarged prostate that can block flow of urine out of the bladder) with lower urinary tract symptoms. R27's Minimum Data Set (MDS-assessment tool) dated 9/13/24 documented resident had an indwelling catheter (tube placed in the bladder to drain urine). During an observation on 9/24/24 at 3:45 PM Certified Nursing Assistant (CNA)13 emptied R27's urinary catheter bag. CNA wore gown, gloves, booties, face shield and placed urinal on the floor near toilet and then removed tubing attached to bag of urine and placed end of tubing into the urinal to empty the bag. While draining into urinal, the end cap or spigot of the urinary bag was observed touching the inside of the urinal. The bag drained about 425 cc clear yellow urine. During an interview on 9/24/24 at about 4:00 PM CNA13 was asked about preventing urinary tract infections and stated several actions such as wearing gloves and emptying the bag before it gets too full. When asked about urinary catheter spigot touching the inside of the urinal, CNA13 shook her head and stated that the spigot is not supposed to touch the urinal but acknowledged that it did. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R27's current physician orders documented Indwelling Foley Catheter #16 Fr(ench, size)/30cc (cubic centimeter) (per manfuc(turer) (Change every 30 days and PRN (pro [NAME], as needed) dislodgement). The start date was 1/29/23. Another order was Change Foley Drainage Bag Every Sunday with start date 10/18/21. Review of R27's August and September Treatment Administration Record (TAR) and progress notes from 7/31/24 to 9/27/24 documented order to change foley drainage bag every Sunday which was done on 8/4/24, 8/11/24, 8/18/24, 8/25/24, 9/1/24, 9/8/24, 9/15/24, 9/22/24 and catheter change every 30 days and PRN dislodgement which was done on 8/21/24 and 9/6/24, 9/9/24, and 9/12/24. No notes were entered by staff for catheter change on the above dates due to obstruction, blockage, leakage, infection, or catheter falling out on its own or during cares or any other clinical indication for changing the catheter. The catheter was leaking on 8/15/24 and was subsequently changed, this change was not documented in TAR. Review of R27's current care plan included the above physician's orders for changing the foley catheter every 30 days and PRN dislodgement and changing foley drainage bag every Sunday. The care plan did not include medical rationale for routine or scheduled catheter and bag changes. A review of physician history and physical, physician progress notes and nursing assessments found no clinical justification for routine catheter changes. During an interview on 9/26/24 at 9:31 AM Medical Doctor (MD)1 confirmed he was R27's physician and wrote the orders for changing the urinary catheter and urinary bag routinely at fixed intervals. When asked about the rationale and clinical indications, MD1 stated that he was not sure if the nursing staff would recognize when the catheter or bag needed to be changed so he preferred to have it done routinely. When informed of current CDC recommendations for not changing urinary catheters or bags at routine fixed intervals but only when there is obstruction, infection or other clinical basis, MD1 stated that he had heard something about that but would prefer if the facility had a policy supporting this practice. When shown facility's policy in alignment with CDC recommendations for not changing catheters or bags at routine fixed intervals, MD1 stated that he was not aware that this was the facility policy. MD1 further stated that the facility's infection preventionist or medical director have not mentioned or brought to his attention that his orders were not in accordance with current CDC recommendations or facility policy, otherwise, he would have changed his orders. During an interview on 9/26/24 at 9:42 AM Quality Assurance and Performance Improvement and Infection Preventionist (ADON/QAPI/IP) acknowledged awareness that R27's orders were not consistent with current CDC recommendations and facility policy, but stated this was not discussed with MD1. ADON/QAPI/IP also stated that urinary spigot should not be touching the urinal because of the risk of contamination. During an interview on 9/27/24 at 9:21 AM when informed of observation, Director of Nursing stated that staff should be following infection control practices when emptying urinary catheter bags and agreed that facility policy and CDC recommendations should be followed to reduce risk of urinary tract infections.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41020 Based on interview, record review, and policy, the facility failed to ensure that 1 out of 6 residents (R) reviewed for timeliness of physician's visits (R207), was seen by a physician at least once every 30 days for the first 30 days after admission. This deficient practice had the potential to affect resident care and services. Findings include: Review of the facility policy titled, Physician Services and Visits, revised 01/2024, included it was the policy of the facility, as stated in Federal regulations that govern this certified nursing facility that the resident will be seen at least every thirty (30) days for the first ninety (90) days and at least every sixty (60) days thereafter. A physician's visit is considered timely if it occurs no later than ten (10) days after the visit is required. At the option of the Physician, the required visits in Nursing facilities, after the initial visit, may alternate between personal visit by the Physician and visits by the Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS). R207's admission record revealed the resident admitted to the facility on [DATE]. An admission evaluation (Admission P.E.) was completed 07/29/24. R206 was 7 days overdue for a physician visit. On 10/11/24 at 7:51 AM an interview was conducted with the Medical Director. He stated that he was not an attending physician. He stated that he participates in QAPI (Quality Assurance and Performance Improvement) via Zoom. He stated that he did not monitor physician's visits and that he did not provide feedback to providers regarding their performance and/or practices. He stated his expectations were for physicians to complete their visits as appropriate, upon admission, every 30 days for the first 90 days, and every 60 days thereafter. He stated that the nurses monitor the physicians on the timeliness of their rounds. He stated that he expects the providers to make note during the visits so that if staff have to contact him, they can read back on the previous notes to know what has been going on with the patient [resident]. He stated that adverse consequences of the physician not providing timely visits would include deterioration of the resident's condition, their medication may not be helping them. He stated that after a resident admits, they should be seen within the week. He stated that they would not want to delay a month or so, there are pretty strict orders regarding visits. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 10/11/24 at 12:08 PM with a Medical Doctor (MD2). MD2 stated that they receive a call from the facility when a new resident was admitted and that usually they would know ahead of time when the resident was coming. MD2 stated that providers are scheduled to visit the facility within the first 30 days after a new admission, then monthly. After the first 90 days, they are able to visit the residents every 60 days. MD2 stated the ward clerk provides a list of residents that need to be seen that day. MD2 stated they were unsure of whether there was a facility policy regarding the timeline for physician visits but according to the Memorandum of Understanding (agreement between the providers and the facility), they would provide primary care every 30 days. MD2 stated that after every physician's visit there will be a physician's note in the resident's record. MD2 reviewed their schedule for June and July 2024 and stated that they did not have R207 written down. MD2 stated they could not remember why the resident would not have been seen. MD2 stated if they had seen the resident, they would have written an admission note. MD2 stated that it was important to see a new resident within the first 30 days because they might not be aware of all the resident's potential problems, fall risks, or anything that was not on their problem list. An interview was conducted on 10/11/24 at 12:42 PM with a Member of the Board of Directors (MBD). He stated that his responsibility was to review and update the facility's policies. He stated that QAPI reviews all the audit findings, and reviews updates on corrective actions. He stated that he was fully engaged in improvement of the operations in the facility and that his approach was more involved with the corrective actions. He stated that the ultimate responsibility of the board was to ensure that everything was running effectively. He stated that the Administrator reports to the board and that the board had a direct obligation to ensure that everything was above board. He stated that the board oversees the monthly reports from the facility, for monitoring. He stated that the board has been aware of the number of resident falls with injury. He stated that staffing was one of the main concerns of the facility, which goes back to lack of funding. During an interview conducted on 10/11/24 at 2:04 PM with the Director of Nursing (DON), she stated that the physicians visit new admissions within the first 30 days, then every 30 days for the first 90 days and every 60 days thereafter. She stated that the ward clerk usually schedules the appointments or the nurses will say when a resident needs to be seen. She stated that residents with significant changes are seen as needed. She stated that follow-up visits will usually be scheduled within a week for residents who have been hospitalized . She stated that for the population they have, anything can make them take a turn, depending on their condition. She stated that physician's visits were important because the residents could take a turn for the worst without anyone really realizing it - and they could lose them. During a discussion regarding R207's lack of a timely physician's visit, the DON stated that it sounded like the resident got missed and that she would get on top of it.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35588 Based on interview and record review the facility failed to ensure sufficient staffing to meet resident care needs on 7 of 16 days when resident (R) R106 fell and there were less than three required Certified Nursing Assistant on duty, as outlined in the Facility Assessment. This placed resident at risk for delayed or unmet care needs and lack of supervision to prevent falls and resident to resident altercations. Findings include Review of Resident 106's (R106) record documented the resident was admitted on [DATE] with diagnosis including dementia, diabetes, frequent falls, orthostatic hypotension (sudden drop in blood pressure when you stand up from a sitting or lying position) and stroke. R106's Minimum Data Set (MDS-assessment tool), dated 1/30/24, documented resident's brief interview for mental status was 12 of 15, indicating moderate cognitive impairment and required supervision or touch assistance when transferring from chair to bed or walking 50 feet while using a walker. Resident was transferred to the hospital on 5/1/24. Review of Facility Assessment (document describing resident population and needs to determine staff and other resources necessary to competently care for residents) received from facility on 9/23/24, dated 9/19/24, documented eight CNAs were needed on the weekdays and six CNAs were needed on the weekends/holidays. Under another section of Facility Assessment titled Staff Type/Plan, the following was documented for Direct care staff: 1:10-15 resident ratio Days and 1:10-15 resident ratio Nights. During a concurrent interview and joint review of Facility Assessment on 9/26/24 at 2:32 PM ADON/QAPI/IP stated that the facility assessment was based on resident acuity. When asked to explain the Facility Assessment and how many CNAs were needed during the weekdays and weekends for each shift, ADON/QAPI/IP stated that it is three CNAs per each unit (male household and female household) on day shift and the same on night every day. ADON/QAPI/IP also stated that the facility was so short staffed with licensed nurses and CNAs that they could not account for someone like R106 who needed 1:1 supervision. Review of C.N.A Weekly Group Schedule for January 2024 to May 1, 2024, documented less than required 3 CNAs worked on R106's unit seven times during the specific dates and times when R106 fell . During a concurrent interview and joint review of CNA schedule and CNA punch timecards, Payroll Specialist (PS) confirmed two CNAs worked on the specific dates and shifts below. *On 1/23/24 at 5:50 PM R106 fell and two CNAs worked, less than required 3 CNA worked. *On 2/3/24 at 6:00 PM R106 fell and two CNAs worked, less than required 3 CNA worked. *On 3/22/24 at 7:31 AM R106 fell and two CNAs worked, less than required 3 CNA worked. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*On 3/23/24 at 6:05 PM R106 fell and two CNAs worked, less than required 3 CNA worked. *On 3/28/24 at 5:10 AM R106 fell and two CNAs worked, less than required 3 CNA worked. *On 3/30/24 at 6:00 PM R106 fell and two CNAs worked, less than required 3 CNA worked. *On 4/11/24 at 9:00 PM R106 fell and two CNAs worked, less than required 3 CNA worked. During an interview on 9/27/24 at 9:21 AM DON stated that facility was short staffed and unit aides used to provide 1:1 monitoring but unit aides were lost when the covid waivers went away. DON confirmed R106 was inadequately supervised because he really needed 1:1 monitoring which the facility could not provide. DON further stated that they were trying to get R106 to a memory care facility, but it was not covered under resident's insurance. Please also refer to F600 and F689.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35588 Based on interview and record review the facility failed to ensure 2 of 6 sampled staff reviewed for competencies had documented competencies as evidenced by charge nurse did not complete any trainings in past two years, including fall prevention and Certified Nursing Assistant (CNA) working the floor had an expired CPR certificate. These failures placed residents at risk for unmet and unsafe care needs. Findings include Review of Facility Assessment (document describing resident population and needs to determine staff and other resources necessary to competently care for residents) received from facility on [DATE], dated [DATE], documented the following was required for CNAs, RNs (Registered Nurses), and LPNs (Licensed Practical Nurses), Cardiopulmonary Resuscitation (CPR) Basic Life Support (BLS) upon hire and every two years when CPR expired and training on resident fall prevention protocols and fall management policy upon hire, annually, and as needed. Charge nurse Review of staffing schedule from [DATE] to [DATE] showed Licensed Practical Nurse (LPN)6 worked on [DATE], [DATE]. During a concurrent interview and record review on [DATE] at 10:35 AM ADON/QAPI/IP stated that she oversaw nursing staff training which was completed and documented through Relias system. ADON/QAPI/IP further stated that the facility did not have a policy for staff competency but stated all nursing staff including licensed nurses were required to minimally complete 22 modules each year which included module Preventing Falls: An Interdisciplinary Approach. ADON/QAPI/IP provided copy of LPN6's official transcript which showed during 2022, a half hour training titled About Falls was completed. Preventing Falls training or any training regarding Falls was not completed in 2023 and 2024. In addition, 10 of the 22 required training was not completed in 2022, 21 of the 22 required training was not completed in 2023 and 22 of the 22 required training was not completed in 2024. ADON/QAPI/IP confirmed LPN6 did not complete required annual training during 2022, 2023 and 2024 which was expected for all nursing staff. ADON/QAPI/IP stated that LPN6 was notorious for not completing training and LPN6 was informed verbally and in writing to complete training, but trainings were not completed. During an interview on [DATE] at 9:21 AM DON stated that the expectation is staff complete required training annually and when it is overdue it should be completed as soon as possible but it was so difficult because facility was so crunched and short with staffing. CNA Review of Certified Nursing Aide (CNA) 16's personnel file reviewed documented hire date of [DATE] and CPR BLS certificate expired on [DATE]. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of staffing schedule for [DATE] to [DATE] showed CNA16 worked on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. During concurrent record review and interview on [DATE] at 9:09 AM a joint review of CNA16's personnel record was conducted with Human Resources Manager (HRM). HRM confirmed CNA16's CPR expired in [DATE] however, CNA16 continued to work in the facility. HRM stated that she was working with DON to get caught up with ensuring staff have the required competencies and they were not always able to get someone to do CPR class here. HRM further stated that staff are supposed to get credentials including CPR current certification to continue working. During an interview on [DATE] at 9:21 AM DON stated that the expectation is staff should be up to date with CPR. Review of R106's care plan showed resident was a full code, dated [DATE], and staff were to initiate cardio pulmonary resuscitation if [R106] was found unresponsive. Please refer to F600 and F689.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40844 Based on interview and record review the facility failed to ensure Resident 158 (R158) did not receive duplicate anticoagulant therapy unnecessarily when they failed to ensure the physician intended R158 to be treated with two different anticoagulants. This placed R158 at higher risk of bleeding side effects. Findings: Review of R158's most recent Quarterly MDS assessment dated [DATE] revealed the facility admitted R158 on 05/24/24, diagnoses included hypertension, cerebral infarction (stroke), COVID-19, atrial fibrillation, and gastroesophageal reflux disease. Section M (Medications) indicated R158 took anticoagulant therapy. Review of active physician order dated 5/28/2024 read, Apixaban Oral Tablet 2.5 MG (Apixaban) Give 2.5 mg by mouth two times a day for reducing the risk for stroke and blood clots. related to unspecified atrial fibrillation (an abnormal heart rhythm that predisposes a person to blood clots). Apixaban is an oral anticoagulant. Progress note dated 09/12/24 08:51 revealed R158 was not feeling well and was being prepared to be sent to the local hospital for evaluation. Progress note dated 09/14/24 15:30 revealed R158 returned to the facility. Additional review of active physician's orders revealed order dated 09/14/24 read, Enoxaparin Sodium Injection Solution Prefilled Syringe 40 MG/0.4ML [MG/ML - milligrams per milliliter] Inject 40 mg subcutaneously two times a day related to embolism and thrombosis of renal vein. Enoxaparin is an injectable coagulant. Review of hospital discharge instruction located on the Misc tab of the electronic health record revealed R158 was diagnosed with a blood clot in the renal vein and was to start the enoxaparin injections. The instructions indicated that the home heart medications, amiodarone, and metoprolol, should continue. The instructions did not indicate if the apixaban should continue or not. Review of the medical record lacked a notation if both anticoagulants should be administered following the 09/14/24 hospital discharge. During an interview with Licensed Practical Nurse 4 (LPN4) on 09/27/24 at 12:33 PM confirmed the enoxaparin was added to following the recent hospitalization for a clot to a renal vein. LPN2 was able to describe appropriate monitoring for anticoagulants. When asked if Residents were normally on two different anticoagulants, LPN4 did not answer. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 9/27/24 at 02:25 PM, DON stated that any changes are reviewed, and orders updated when residents return from the hospital. When asked if the discharge notes indicated R158 should be on enoxaparin and the apixaban, which was not addressed in the discharge instructions, she stated she would have to review the process notes and would let the surveyor know. Additional information was not received prior to the survey exit. Review of facility policy titled Medication Administration with review dated 1/2024 read, Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive . the physician is contacted for clarification prior to the administration of the medication.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41020 Based on interviews, review of records, and policy, the facility failed to ensure one of two residents reviewed for dental concerns (Resident (R) 38) received routine dental care. The deficient practice resulted in delayed dental services. Findings include: R38 was admitted to the facility on [DATE] with diagnoses that included Parkinson's Disease (a progressive brain disorder that causes nerve cells in the brain to die or become damaged, leading to movement problems, stiffness and other symptoms) with dyskinesia (involuntary movement disorder that involves involuntary movements, such as tics, tremors, or shakes) with fluctuations (may range from mild to severe) and low back pain, unspecified. Review of the Nursing Admission Screening/History dated 11/20/24 at 12:45 PM included an assessment of the resident's mouth. Per the documentation, the resident had dental caries (decay/cavities) and broken teeth. The notes indicated the resident had, Several remaining natural teeth to upper and lower gums. Poor condition. The Admission Summary note dated 11/20/24 at 2:16 PM included that the resident had several remaining teeth to top and bottom (poor condition, broken tips, missing teeth.) An impaired dentition care plan initiated on 11/27/23 related to natural teeth in poor condition, upper and lower gumline had a goal for R38 to be free of infection, pain or bleeding in the oral cavity. Interventions included to coordinate arrangements for dental care, transportation as needed/as ordered. The admission Minimum Data Set assessment (Comprehensive assessment) dated 12/03/23 included that the resident scored 14 on the Brief Interview for Mental Status, indicating intact cognition. Review of Section V (Care Area Assessment Summary) revealed the care area for dental care had triggered, which indicated the need for additional assessment based on problem identification, and that it had been addressed in the resident's care plan. However, review of the resident's clinical record provided no evidence that the resident had received dental services to meet her needs. A Care Plan Meeting note dated 06/07/24 included that the resident attended the meeting with no family present. The resident's care plan was conducted with team members. According to the note, the resident had no dental visits for the quarter. On 09/24/24 at 8:43 AM an interview with the resident was conducted. She stated that she wanted to go to the dentist. She stated that her teeth were broken, and the roots hurt when she eats. She stated that she has asked to go to the dentist previously, but nothing ever came of it. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/26/24 at 10:37 AM an interview was conducted with a representative from Social Services (SS2). She stated that they make recommendations for the resident to be seen by the dentist during the care plan meeting. She stated that they talk about the last time the resident went and which appointments they need to go to quarterly. She stated that residents go to the dentist at least twice a year, recommended by the physician. She stated that she thought they had made a recommendation recently for R38 to see a dentist. She stated that the resident does not complain. She stated that if she gets a report of pain, or the need to be seen, an appointment will be made. Otherwise, she stated she would get a report at the care plan conference or when the physician visits every 60 days. She stated that the resident had not told her that her teeth hurt, but that the provider should have made the appointment. Otherwise, she said that the ward clerk would make the appointment. She stated that the residents go next door for the dentist and they have to have an appointment. During an interview conducted on 09/26/24 at 10:55 AM, the Director of Nursing (DON) stated that she expects residents to be seen by the dentist annually, or as needed. She stated that the provider comes every 60 days to see the residents. Usually, when the provider comes over, if there are complaints, the provider will write an order for the resident to be seen. She stated that there are no standing orders for dental services, they are seen as needed. She stated that there was no policy on dental visits. An interview on 09/26/24 at 2:20 PM was conducted with a Certified Nursing Assistant (CNA14). She stated that R38 had told her that her teeth hurt. She stated that she did not remember whether she had mentioned it to the nurse. She stated that she was not sure whether the resident had an appointment for her teeth. On 09/26/24 at 2:48 PM during an interview with a Licensed Practical Nurse (LPN2), she stated that for a while the dental clinic was closed for a month or two because they were renovating. At that time, only residents with severe tooth aches were seen. She stated that usually, they would be sent right away. She stated that she thought it just got missed. She stated, Maybe they need to put that in the standing orders. An interview was conducted on 09/26/24 at 4:19 PM with the MDS nurse. She stated that when the provider comes in to do the admission assessment, they will refer to dental. She stated that whenever they do care plans, they will request a dental evaluation. She stated that she guessed they had missed R38. She stated that the resident did have complaints of pain, but it was not related to oral pain. She stated that the resident should not have had to complain about it in order to get an appointment. She stated that she did not understand how it was missed when it was brought up on the admission assessment and the admission MDS assessment. She stated that it should have been addressed, it should have been addressed on the 30-day evaluation. She stated that usually, those issues are addressed there. She stated, I have no excuse.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41020 Based on observations, interviews, and review of policy, the facility failed to ensure food was stored in accordance with appropriate guidelines. Specifically, 1. A box of frozen blueberries was not left in the freezer open and undated, 2. A scoop was not left in the powdered sugar bin, 3. Expired baking soda was not left on the pantry shelf available for resident use, 4. Refrigerator temperatures/temperature logs were maintained for facility refrigerators, and 5. Staff did not keep personal food items in the resident's refrigerator. The facility census was 53. The deficient practice could increase the risk for foodborne illness. Findings include: On [DATE] at 8:05 AM an observation of the kitchen was conducted with the Dietary Manager (DM). During a review of the walk-in freezer, a box of frozen blueberries with a received date of [DATE] was noted. The box had been ripped open and the interior plastic bag had been opened but not resealed. The DM stated that dietary staff were supposed to tie the bag up after opening. She instructed a Dietary Assistant to throw the blueberries away. At approximately 8:15 AM on [DATE] during a walk-through of the food storage pantry, a scoop was identified in the powdered sugar bin. The DM stated, They know better. Additional review of the pantry revealed that 8 boxes of baking soda with an expiration date of [DATE] were noted on a pantry shelf. The DM stated that they should be throw away. During an observation of the nourishment refrigerator in Household 1 on [DATE] at 12:05 PM the Refrigerator Temp & Maintenance Log was reviewed for ,d+[DATE] through [DATE]. At the top of the form the documentation included, Department: HH #1 Nourishment Room. Temp Range: not greater than 40. The next line stated, Report to Supervisor/Maintenance when recorded temperatures are not adequate. There was a column on the left side of the form which had the days of the month, the next column was titled Temp, the third column was titled Initial, the fourth column was titled Comments/Actions taken. It was noted that on ,d+[DATE], ,d+[DATE] and ,d+[DATE] no temperatures, initials, or actions taken had been documented. Further review revealed that the temperature of the refrigerator on ,d+[DATE] was 44 and on ,d+[DATE] the temperature was 42. Initials were identified in the third column but in the fourth column, Comments/Actions taken was written N/A (Not Applicable). On [DATE] at 12:08 PM an observation of nourishment refrigerator log in Household 2 was conducted. On , d+[DATE], in the space provided for a temperature, a number 3 was written and crossed out. No initials or Comments/Actions taken were documented. On ,d+[DATE] no temperature, initials, or Comments/Actions taken were documented. Further review revealed that on ,d+[DATE] the temperature of the refrigerator was 49. In the Comments/Actions taken section N/A was written. In addition, when the freezer was opened, an open package of dark chocolate Raspberry Cheesecake Bites was observed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on [DATE] at 2:22 PM with a Certified Nursing Assistant (CNA14), she stated that they just turn the temperature down when it is above 40 degrees. She stated that night shift is the ones that check the temperatures most. She stated that she had not noticed a problem on day shift. At 2:25 PM on [DATE] Licensed Practical Nurse (LPN4) stated that when the refrigerator was running too warm, they were supposed to report it to maintenance then report it to the supervisors. On [DATE] at 3:48 PM an interview was conducted with the DM. She stated that the nursing staff have been told over and over, they have their own employee refrigerators. On the refrigerator temp logs, they are supposed to write what they did, (i.e., put in a work order). She stated that the logs are supposed to have all the temps and actions taken. She stated, See it's even written at the top - report to maintenance. On [DATE] at 1:13 PM an interview was conducted with the Director of Nursing. She stated that nursing night shift will do the recording. She stated that if they don't, then day shift should do it. If the temperature goes over 40 degrees, it gets reported to maintenance to come back and adjust as needed. She stated that they never get feedback from maintenance on whether something has been reported. Nursing is supposed to write that the temperature has been checked and that they notified maintenance. She stated that personal snacks are not supposed to be in the residents' refrigerator. Review of the undated facility policy titled, Record of Refrigeration Temperatures, included a daily temperature record is to be kept of refrigerated items. The Dietary Manager is to assign an employee to record daily all refrigerator and freezer temperatures on Record of Refrigeration Temperatures (Form 403). Nursing unit refrigerators should also be recorded. The freezer temperature must be 0* F or below. The refrigerator temperatures must be 41 * F or below. Temperatures above these areas must be reported to the Dietary Manager immediately. Note on the temperature forms the plan of action taken when temperatures are not in acceptable range. Have work orders in writing as proof of requested work. Nursing unit refrigerators must be clean, have dated food products (not outdated), and have temperatures recorded. Employee food and resident food should not be stored together. Review of the Dry, Refrigerated and Freezer Storage Chart included: -Baking soda may be kept for 2 years or expiration date on package. Keep dry and covered. -Frozen fruit may be kept for 12 months.

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	035242	A. Building B. Wing	09/27/2024

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 35588 Based on interview and record review the facility's assessment (document describing resident population and needs to determine staff and other resources necessary to competently care for residents) was not conducted with input from the required individuals stated in the regulation. This failure placed residents at risk for unmet care needs if their assessed population's needs and resources were not comprehensively identified and addressed. Findings include Review of Facility Assessment (FA) received from facility on 9/23/24, dated 9/19/24, documented several individuals were involved in completing assessment. The following required individuals were not listed: representative from governing body, medical director, resident, representatives, direct care staff and representatives of the direct care staff. The FA showed date assessment reviewed with QAA/QAPI (Quality Assessment and Assurance/ Quality Assurance and Performance Improvement) committee was blank and no date was entered. During an interview on 9/26/24 at 2:32 PM Quality Assurance and Performance Improvement and Infection Preventionist (ADON/QAPI/IP) stated that she edited and revised the Facility Assessment, and it had not been gone to QAA/QAPI committee yet because it was scheduled for yesterday but was cancelled because of the survey. When asked about the persons involved in conducting and developing the FA, ADON/QAPI/IP stated that governing body and medical director is part of QAA/QAPI committee. Direct care staff are not represented by a union or advocacy group. ADON/QAPI/IP acknowledged that input was also not obtained from residents, representatives or direct care staff and a process to obtain their input was not in place. During an interview on 9/26/24 at 2:47 PM ADON/QAPI/IP stated that the facility did not have a policy for the Facility Assessment. During an interview on 9/27/24 at 9:21 AM Director of Nursing stated that ADON/QAPI/IP was responsible for developing and coordinating FA and the FA should include all requirements such as appropriate persons involved in developing it.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 40844 Based on interview and record review the facility failed to demonstrate they had implemented any performance improvement activities for any of their identified concerns. Failure to evaluate problem areas systemically and identify, and test solutions has the potential for resident quality of life to negatively impact all residents. Findings: Review of the facility's 2024 Quality Assurance & Performance Improvement (QAPI) Plan revealed under the heading Scope, The QAPI team will determine which problems will become the focus for a performance improvement project (PIP). Depending on the PIP to be started, the QAPI team will charter a PIP Team who is entrusted with a mission to investigate a problem area and come up with plans for correction and/or improvement to be implemented During an interview on 09/27/24 at 03:30 PM the facility's Quality Assurance and Performance Improvement and Infection Preventionist (ADON/QAPI/IP) and the Director of Nursing (DON) described the QAPI program. ADON/QAPI/IP stated the committee meets quarterly and all departments, the Medical Director, the CEO, and the Governing Body attend. Each department presents a report for their respective areas. A supervisor's report is presented which uses data, they track and trend on quality concerns such as falls, incidents, infections, and complaints. They confirmed that quality measures they followed included concerns the surveyors identified during the survey. ADON/QAPI/IP presented graphs of infection rates and stated, we will talk about it, if we need to implement any interventions. When asked if they looked at the falls, and Abuse allegations systemically they stated they do track these and discuss them. When asked to demonstrate a process improvement they have completed, or were working on, ADON/QAPI/IP stated they did not have one. We have one [Social Services] is starting, addressing Resident complaints. They confirmed they did not have one for over a year.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35588 Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases when gloves were not changed between residents during 1 of 3 staff (Licensed Practical Nurse 2) medication pass observations. This failure increased the resident risk for infections and its associated discomfort and decline in physical condition. Findings include During an observation on 9/26/24 at 7:22 AM Licensed Practical Nurse (LPN)2 was observed passing medications to residents in the dining room. LPN2 wore gloves and passed four medications to Resident (R)34. Wearing the same gloves, LPN2 prepared, poured and passed seven medications to R27. LPN2 returned to medication cart and wearing the same gloves, prepared and poured three medications for R39. LPN2 approached R39 who was eating his breakfast and touched resident's hand and then repositioned knife that was previously held by resident. LPN2 then placed spoonful of medications mixed in applesauce into R39's mouth and held cup of water to resident's mouth while resident drank the water. There was no glove change between passing medications to different residents. LPN2 then returned to medication cart and prepared and poured medications for R27. When asked when glove change occurs, LPN2 stated I change gloves after every four residents. I remove gloves and do hand hygiene. During an interview with 9/26/24 at 9:38 AM Quality Assurance and Performance Improvement and Infection Preventionist (ADON/QAPI/IP) stated that hand hygiene should be done between each resident during medication pass. When asked about the use of gloves, ADON/QAPI/IP confirmed gloves are not a substitution for hand hygiene and are not required for medication pass but if gloves are worn, they should also be changed with hand hygiene done between each resident when passing medications. During an interview on 9/27/24 at 9:21 AM Director of Nursing stated that the expectation is hand hygiene is done between each resident during medication pass. Review of facility policy Medication Administration, reviewed 1/2024 , documented The person administering medications adheres to Universal Precautions, using proper hand hygiene, gloves when appropriate, before beginning a medication pass, prior to handling, and after coming into direct contact with a resident.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 41020 Based on interview and record review, the facility failed to ensure that staff completed mandatory QAPI (Quality Assurance and Performance Improvement) training as part of its QAPI program. The deficient practice placed residents at risk for receiving care from staff who did not understand the goals and various elements of the program, including their role in communicating concerns, problems, or opportunities for the facility's improvement to the facility's QAA (Quality Assessment and Assurance) Committee. Findings include: During an extended survey, conducted 10/09/24 through 10/11/24 a review of staff education records was conducted. Review of the evidence provided via electronic training records revealed approximately 48 out of 54 direct care staff had not completed QAPI training for 2024. On 10/09/24 at 2:45 PM an email was received from the Assistant Director of Nursing (ADON). She stated that the QAPI training module had a due date until 12/31/24 and the module was open as well, meaning that staff could complete before the due date. At 3:16 PM on 10/09/24 another email from the ADON stated, I attached the {electronic training] module content and the course completions for staff who already completed the module in advance. All other staff have not yet completed the modules, since the due date is not until 12/31/24. On 10/10/24 at 3:57 PM an email was received from the Director of Nursing (DON). She stated that the policy for Staff Education Requirements had not been developed, but that they would develop one and get it processed. During an interview conducted on 10/11/24 at 11:34 AM with the ADON, she stated that she was responsible for assigning and following up on the [electronic training] modules. She stated that she announces training at general staff and direct-care staff meetings. She stated that she provides printouts for staff that are overdue for training, when she identifies one specific staff that is overdue in 3 or 4 modules. She stated that she was able to look through the electronic training plan itself and identify which staff were on time, and which had overdue modules. She stated that she talks about training in QAPI, not an official report, but it is something that they just talk about. She stated that she had come up with a plan where staff have 5 modules to complete within 3 months. She stated that it was working better, they had more time and flexibility to complete their training, and the staff seemed to like it more. She stated that she thought that the DON had implemented a program into staff's performance evaluations. She stated that she had a PIP (Performance Improvement Plan started for last year and then there was a change in DON. She stated that she thought it might have gotten lost in the change. However, the ADON did not indicate/provide evidence of how staff would be trained on an ongoing basis and/or in the event a performance improvement plan was identified and implemented, including for falls. (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/24 at 2:04 PM an interview was conducted with the DON. She stated in regard to the electronic training, her expectation was for staff to complete their training on time. She stated that she was implementing this into the employee's performance reviews, but they still ignore them. She stated that QAPI training was about compliance and updated information. She stated that it was important because it identifies weak area so they can improve them. She stated that nurses and Certified Nursing Assistants were involved in QAPI and that it helped a lot. She stated that the ADON did report to QAPI regarding training. She stated that they were aware, she stated that all they could do was to keep reminding staff that they need to complete training. Looking forward, she stated that they could provide more frequent reminders to staff to make them aware they were in the red. She stated that she thinks she may need to let them know that they will be taken off the schedule if they are not accountable and responsible to complete their training.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 35588 Based on interview and record review, the facility failed to ensure five of five currently employed sampled Certified Nursing Assistants (CNAs) or Licensed Nursing Assistants (LNA) (CNA16, LNA2, CNA13, CNA9, CNA8) completed the required 12 hours of annual in-service education based on their hire dates. The facility also failed to ensure CNA16 received annual abuse and dementia training and LNA2 received annual infection control training. These failed practices had the potential to negatively affect the competency of the NAs, placed residents at risk for receiving care from unskilled staff and increased risk for abuse, neglect, unmet care needs and diminished quality of life. Findings include Review of CNA16's personnel file and training records documented hire date of 6/22/21 and 0.5 hours of annual training was completed and did not include abuse and dementia. Review of LNA2's personnel file and training records documented hire date of 6/2/23 and 8.47 hours of annual training was completed and did not include infection control. Review of CNA13's personnel file and training records documented hire date of 5/3/17 and 9.02 hours of annual training was completed. Review of CNA9's personnel file and training records documented hire date of 10/4/22 and 10.94 hours of annual training was completed. Review of CNA8's personnel file and training records documented hire date of 10/9/20 and 4.17 hours of annual training was completed. Review of Facility Assessment (document describing resident population and needs to determine staff and other resources necessary to competently care for residents) received from facility on 9/23/24, dated 9/19/24, documented CNAs, RNs (Registered Nurses), and LPNs (Licensed Practical Nurses) were required to receive training on abuse and neglect, dementia and infection control upon hire, annually, and as needed. During a concurrent interview and record review on 9/27/24 at 10:35 AM Quality Assurance and Performance Improvement and Infection Preventionist (ADON/QAPI/IP) stated that she oversaw nursing staff training which was completed and documented through Relias system. ADON/QAPI/IP further stated that the facility did not have a policy for staff competency but stated all nursing staff including nurse aides were required to minimally complete 22 modules each year which included modules on dementia, abuse and infection control. ADON/QAPI/IP reviewed CNA16, LNA2, CNA13, CNA9, CNA8's training records and confirmed the required annual topics and required hours were not completed. Review of email received from ADON/QAPI/IP dated 9/27/24 at 2:12 PM documented the facility stated it did not have a policy for CNA annual training.