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	07/25/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a Resident's Representative Party (RP) when the resident experienced a change in condition for two of seven residents (Resident (R) 3 and R4) reviewed for changes out of a total sample of 18 residents. The failure to notify an RP for family member of a change in condition and/or transfer could lead to an inability to support their family member during a time of illness. This failure had the potential to affect any of the fifty-current residents that might have a change in condition and/or a transfer to another facility for evaluation.Findings include:R3 1.During an interview on 07/21/25 at 12:44 PM, RP3 stated, About six months ago I was at the hospital and looked over and he [R3] was over in the ER [emergency room]. I asked staff what was wrong with him, he wasn't feeling well for a few days, so they decided to bring him in here [ER]. I was not called. I called [name] at the facility, she said it was constipation. He was there until after 9:00 PM, they gave him IV [intravenous] fluids and an antibiotic … I get called for injuries and infections, but if [R3] visits the emergency room they don't call me about that. Review of R3's electronic medical record (EMR) Progress Notes tab revealed: Effective Date: 12/06/2024 09:03 Type: Nursing Progress Note Text: (QUIET/LESS ACTIVE/EYES CLOSED)- Resident this morning with continued change in condition. Less active then [sic] usual, not attempting AROM [active range of motion], more quieter, not very vocal, eyes remain closed, not looking around. CNA [Certified Nurse Aide] on Night Shift reports No urine output all night. PO [oral] intake of food and fluids has been good. Reported Lg. [large] BM [bowel movement] x 1. Resident to be sent to [hospital identified] [NAME] [ER Department] for further evaluation d/t [due to] change in disposition. Transfer Sheet and Bed Hold Policy provided to resident prior to transfer. … Effective Date: 12/06/2024 14:37 Type: COMMUNICATION - with Family… Note Text: Family member [RP3 identified] had called this afternoon d/t notice [R3] at the Hospital, Writer updated her on his change in disposition, but eating/drinking well and VSS [Vital signs stable]. Sent to clinic for evaluation. Advised [RP3] that we will notify her following MD [Medical Doctor] evaluation. During an interview on 07/24/25 at 4:23 PM, the Interim Director of Nursing (IDON) read the notes and stated the Charge Nurse was responsible for calling the RP. The IDON stated the facility did not have a policy regarding notification of change. The IDON confirmed it was not done. R4 (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's record documented the facility admitted the resident on 2/7/23 with diagnoses including heart failure (heart disorder which causes the heart to not pump the blood efficiently), diabetes, and dementia. R4's Minimum Data Set (MDS-assessment tool), dated 4/20/25, documented R4's brief interview for mental status was 2. (BIMS, a scoring system used to determine the resident's cognitive status about attention, orientation, and ability to register and recall information. A BIMS score of 0 to 7 is an indication of severe cognitive impairment), and was dependent on staff for eating, toileting, dressing, personal hygiene, mobility and transfers and did not walk and used a wheelchair. Review of R4’s current care plan, printed on 7/21/25, documented a self-care deficit related to limited mobility, weakness and frailty, vision deficient, and wheelchair use with resident required total assistance from staff for personal hygiene and used a mechanical lifter by 2 persons during transfer. Review of R4’s Profile in electronic health record documented her FM1 was substitute decision, emergency contact #1 and financial representative and FM1’s mobile phone was shown. No other family members were shown. Review of R4’s progress notes documented: *7/3/25. FOOT 3 OR MORE VIEWS. Exam Date: JUN 27, 2025@13:37. Reason for study: Right plantar swelling/injury? COMPARISON: No prior studies available. Impression: Posterior calcaneal (heel) minimally displaced fracture.*7/5/25 by Registered Nurse (RN)2. P1 referred resident to Podiatry. 92F(emale) Nursing Home resident w localized right foot plantar tenderness/swelling-x-ray shows posterior calcaneal minimally displaced fracture. Patient presents to podiatry clinic for follow up diabetic foot check and toenail debridement. Patient has also been referred for complaint of tenderness and pain to RIGHT heel 2/2 minimally displaced calcaneal fracture… Recommended cushining (sic) padding to right heel with foam/sponge heel off loading pressure relief ankle and foot orthosis, foot care orders for [nursing home] staff, examine feet QAM and QPM (every morning and every evening), make sure there are not external pressures to patient's feet that may lead to pressure ulcerations, Between podiatry visits, trim patient's toenails, ted hose to bilateral lower legs if patient has no h/o CHF (history of congestive heart failure), patient should have heel protectors to feet at all times.*7/6/25 by Licensed Practical Nurse (LPN)7 “Writer email CMS regarding Closed Fracture to right foot and tried contacting [FM1 at phone number shown on resident profile] (phone not working).” During interview on 7/21/25 at 2:11 PM called FM1 at phone number shown on resident profile, FM1 stated that they were not informed of resident’s foot fracture. FM1 stated that no one at the facility called about it and it was not mentioned during visit to the facility last Friday. During an interview on 7/22/25 at 2:37 PM LPN7 stated that she returned from vacation and came across notes about resident right heel fracture and called it in on 7/6/25 because she saw that no one had called it in yet. LPN7 stated that R4 is total care and not sure how resident fractured her foot. LPN7 stated, “I called FM1 but there was no phone service, it’s the only number we have and we couldn’t leave a message.” During an interview on 7/24/25 at 1:07 PM with the Interim Director of Nursing (IDON) and Director of Nursing, IDON stated that when staff should notify resident representatives of changes in resident conditions such as fracture foot. If staff is unable to reach the family or representative, staff should hand it off to the next shift. During an interview on 7/24/25 at 2:34 PM LPN7 stated that she did not tell the next shift to call FM1 because FM1’s phone was not working. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of email communications with IDON, dated 7/24/25 at 3:09 PM, documented facility policy for notification for change in condition is made by the charge nurse on duty, which is charted in progress notes. Facility did not have a policy for Notification of Change in Condition.

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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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report allegations of abuse to the Centers for Medicare and Medicaid Services within the required time frame for 1 of 2 sampled residents (R)(4) reviewed for abuse. This failure placed residents at risk for abuse.Findings includeFacility policy, Abuse-Investigation and Reporting, revised date 4/18/24, documented .facility practices (b) to prohibit abuse, neglect.3. Residents shall not be subject to abuse by any individual.4. Identification: The facility will identify events such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse.7. Reporting/Response: Charge Nurse shall report incident immediately to Physician, family, and nursing administration. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the Nursing administration, Chief Executive Officer (CEO), and CMS. The protocol for alleged instances of abuse included: The On-duty Charge Nurse (CN) shall start and complete the Risk Incident (RI) report immediately and forward notification of incident to the Resident Family/Power of Attorney (POA), Social Services Coordinator (SSC), Nursing Administration, CEO and CMS. If reportable bodily injury, CN shall report the RI to the Resident Family/POA, SSC, Nursing Administration, CEO, NN [Navajo Nation] Case Manager, Arizona (AZ) Ombudsman, CMS, APS [Adult Protective Services] and/or law enforcement within 2 hrs [hours]. If NO Bodily injury: CN shall report the RI to the Resident Family/POA, SSC, Nursing Administration, CEO, NN Case Manager, AZ Ombudsman, CMS, APS and/or law enforcement within 24 hrs. Review of R4's record indicated the facility admitted the resident on 2/7/23 with diagnoses including heart failure (heart disorder which causes the heart to not pump the blood efficiently), diabetes, and dementia. R4's Minimum Data Set (MDS-assessment tool), dated 4/20/25, documented R4's brief interview for mental status was 2. (BIMS, a scoring system used to determine the resident's cognitive status about attention, orientation, and ability to register and recall information. A BIMS score of 0 to 7 is an indication of severe cognitive impairment), and was dependent on staff for eating, toileting, dressing, personal hygiene, mobility and transfers and did not walk and used a wheelchair. Review of R4's current care plan, printed on 7/21/25, documented a self-care deficit related to limited mobility, weakness and frailty, vision deficient, and wheelchair use with resident required total assistance from staff for personal hygiene and used a mechanical lifter by 2 persons during transfer.Review of R4's progress notes documented: *6/24/25 by Nursing: Resident started crying beginning of shift stopping intermittently for about one to two hours then, repeating episodes, through the night. Offered Tylenol 650 mg 2045 and 0400 however repeatedly, resident spitting out offer. *6/26/25 by Provider(P)1: Comfortably sleeping. Nursing staff: light bruising to rt (right) plantar (sole or bottom) foot and has left 5th toenail avulsion (tear). Assessment/Plan:Rt foot swelling lat(eral) (outside) plantar aspect-possibly injured during hoyer lift transfer?Pt does not ambulate or get up. Rt foot xray order placed 6/24/2025. *7/3/25. FOOT 3 OR MORE VIEWS. Exam Date: JUN 27, 2025@13:37. Reason for study: Right plantar swelling/injury? COMPARISON: No prior studies available. Impression: Posterior calcaneal (heel) minimally displaced fracture.*7/5/25 by Registered Nurse (RN)2. P1 referred resident to Podiatry. 92F(emale) Nursing Home resident w localized right foot plantar tenderness/swelling-x-ray shows posterior calcaneal minimally displaced fracture. Patient presents to podiatry clinic for follow up diabetic foot check and toenail debridement. Patient has also been referred for complaint of tenderness and pain to RIGHT heel 2/2 minimally displaced calcaneal fracture.decreased osseous mineralization. Fracture deformity about the posterior calcaneous of unknown chronicity. Mild polyarticular arthritic changes. Arteriosclerotic vasculary disease. No significant soft tissue swelling. Further explained that given patient's age and health profile, and since patient does not ambulate, the fracture is not indicated for surgical intervention. Recommended cushining (sic) padding to right heel with foam/sponge heel off loading pressure relief ankle and foot orthosis, foot care orders for [nursing home] staff, examine feet QAM and QPM (every morning and every evening), make sure there are not external pressures to patient's feet that may lead to pressure ulcerations, Between podiatry visits, trim patient's toenails, ted hose to bilateral lower legs if patient has no h/o CHF (history of congestive heart failure), patient should have heel protectors to feet at all times.*7/6/25 by Licensed Practical Nurse (LPN)7 Writer email CMS regarding Closed Fracture to right foot and tried contacting [family member, phone number] (phone not working).During an interview on 7/21/25 at 12:51 PM Interim Assistant Director of Nursing/Quality Assurance Quality Improvement/Infection Control Nurse (IADON/QA QI/CN) (who was on

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility failed to have documented evidence of thorough investigation, including preventing further potential abuse while the investigation of the alleged violation was in progress, of alleged abuse for 1 of 2 sampled residents (R) (R4) reviewed for abuse. Without thorough investigations, the facility could not prevent or prohibit further abuse. These failures placed residents at risk for abuse.Findings includeFacility policy, Abuse-Investigation and Reporting, revised date 4/18/24, documented .facility practices (b) to prohibit abuse, neglect.3. Residents shall not be subject to abuse by any individual.5. Investigation. The facility will investigate different types of incidents and identify the staff member responsible for.investigation of alleged violations, e.g. mistreatment, neglect, abuse, injuries of unknown source.6. Protection. How the facility will protect its residents from harm during the investigation: .b. The alleged violations will be thoroughly investigated.All alleged violators (employees) shall be placed on administrative leave by the immediate supervisor(s).Review of R4's record indicated the facility admitted the resident on 2/7/23 with diagnoses including heart failure (heart disorder which causes the heart to not pump the blood efficiently), diabetes, and dementia. R4's Minimum Data Set (MDS-assessment tool), dated 4/20/25, documented R4's brief interview for mental status was 2. (BIMS, a scoring system used to determine the resident's cognitive status about attention, orientation, and ability to register and recall information. A BIMS score of 0 to 7 is an indication of severe cognitive impairment), and was dependent on staff for eating, toileting, dressing, personal hygiene, mobility and transfers and did not walk and used a wheelchair. Review of R4's current care plan, printed on 7/21/25, documented a self-care deficit related to limited mobility, weakness and frailty, vision deficient, and wheelchair use with resident required total assistance from staff for personal hygiene and used a mechanical lifter by 2 persons during transfer.Review of R4's progress notes documented: *6/24/25 by Nursing: Resident started crying beginning of shift stopping intermittently for about one to two hours then, repeating episodes, through the night. Offered Tylenol 650 mg 2045 and 0400 however repeatedly, resident spitting out offer.*6/26/25 by Provider(P)1: Comfortably sleeping. Nursing staff: light bruising to rt (right) plantar (sole or bottom) foot and has left 5th toenail avulsion (tear). Assessment/Plan:Rt foot swelling lat(eral) (outside) plantar aspect-possibly injured during hoyer lift transfer?Pt does not ambulate or get up. Rt foot xray order placed 6/24/2025. *7/3/25. FOOT 3 OR MORE VIEWS. Exam Date: JUN 27, 2025@13:37. Reason for study: Right plantar swelling/injury? COMPARISON: No prior studies available. Impression: Posterior calcaneal (heel) minimally displaced fracture.*7/5/25 by Registered Nurse (RN)2. P1 referred resident to Podiatry. 92F(emale) Nursing Home resident w localized right foot plantar tenderness/swelling-x-ray shows posterior calcaneal minimally displaced fracture. Patient presents to podiatry clinic for follow up diabetic foot check and toenail debridement. Patient has also been referred for complaint of tenderness and pain to RIGHT heel 2/2 minimally displaced calcaneal fracture. decreased osseous mineralization. Fracture deformity about the posterior calcaneous of unknown chronicity. Mild polyarticular arthritic changes. Arteriosclerotic vasculary disease. No significant soft tissue swelling. Further explained that given patient's age and health profile, and since patient does not ambulate, the fracture is not indicated for surgical intervention. Recommended cushining (sic) padding to right heel with foam/sponge heel off loading pressure relief ankle and foot orthosis, foot care orders for [nursing home] staff, examine feet QAM and QPM (every morning and every evening), make sure there are not external pressures to patient's feet that may lead to pressure ulcerations, Between podiatry visits, trim patient's toenails, ted hose to bilateral lower legs if patient has no h/o CHF (history of congestive heart failure), patient should have heel protectors to feet at all times.Observation on 7/21/25 at 11:59 AM showed R4 sitting in high back wheelchair with eyes closed. Staff sat next to resident and offered several spoonsful and placed cups to resident's lips, but resident only opened her mouth a few times and did not consume much. Staff called the resident's name, patted the resident on her back or shook her shoulder but the resident did not respond or open her eyes.During an interview on 7/21/25 at 12:51 PM Interim Assistant Director of Nursing/Quality Assurance Quality Improvement/Infection Control Nurse (IADON/QA QI ICN) stated that R4 who was completely dependent on staff for care and did not have a fall had a closed ankle fracture based on xray results on 6/27/25. A facility investigation for an injury of unknown origin and possible abuse or neglect should have been completed for resident but it was not. Observation on 7/22/25 at 10:10AM showed Certified Nursing Assistant (CNA) 26 and 21 change resident's briefs and then used mechanical lift to

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure required documentation for discharge was present in the medical record for 1 of 2 sampled residents (Resident 51), when there was no physician documented reason for discharge.This placed the resident at risk of being discharged from the facility without a physician's assessment to ensure all treatment options were explored which may have allowed resident to remain in the facility.Findings includeFacility policy Transfer/Discharge, undated, documented It is the policy of the [name of facility] Nursing Home to transfer or discharge a resident once the resident has been admitted to the facility on ly within the Federal Rules and Regulations. To protect all residents form being removed from the facility without the necessary requirements having been met.The facility may not transfer or discharge the resident unless:1. The transfer or discharge is necessary to meet the resident's welfare and the resident's and the resident's welfare cannot be met in the facility;.3. The safety of individuals in the facility is endangered.4. The health of individuals in the facility would otherwise be endangered.8. To demonstrate situations 1 and 2 above, the residents; physician must provide the documentation.9. In the situation 4 above, the documentation must be provided by any physician.10. Reason for transfer/discharge; Review of Resident 51's records documented that resident was admitted to the facility on [DATE], readmitted on [DATE] and discharged on 6/13/25. R51's diagnoses included dementia, psychotic disturbance, mood disturbance, anxiety, acute kidney failure and diabetes. R51's Minimum Data Set (MDS-assessment tool), dated 6/13/25, documented R51's brief interview for mental status was 9. (BIMS, a scoring system used to determine the resident's cognitive status about attention, orientation, and ability to register and recall information. A BIMS score of 8 to 12 is an indication of moderate cognitive impairment). Review of R51's Transfer/Discharge Notification, dated 6/13/25, documented resident was being transferred/discharged to another nursing facility due to ongoing verbal and physical aggressive behavior towards caretakers with care. Nursing home can no longer able to tolerate her behavior and the effective date was per case manager request to discharge [name of resident] to [name of another nursing facility].Review of progress notes, dated 6/12/25, by Interim Director of Nursing (IDON) documented Upon arrival this morning writer was informed of incident 6/11/2025 by resident toward staff member. Physical and verbal aggression with actual contact to (sic) staff member. [Name of Case Manager] Case Manager was contacted, [Name of Social Services Coordinator, SSC] SSC was also informed to get the expedite the transfer process to get resident to the proper care she needs. Facility has depleted resources to attempt continuity of care, but with her continued manipulative behavior, now with physical aggression she needs to be transferred as soon as possible due to safety measures of all involved, including the resident, as she has been inflicting self-harm and accusing staff. Documents were gathered and forwarded to [Case Manager]. She called back at 1650 to inform writer that resident has been accepted to [Name of another nursing facility]. Review of provider orders showed order from Provider (P)2, dated 6/12/25, to Discharge and Transfer to [name of nursing facility] with medications and treatment plans.' The order did not document the reason for discharge or transfer.Review of progress notes did not show evidence that a physician documented the reason for discharge or transfer. During an interview on 7/24/25 at 10:59 AM IDON stated that R51 was discharged to another nursing home because the resident's needs could not be met in the facility and the safety of individuals, resident, other residents, visitors and staff, and the resident was endangered due to the behavior status of the resident. IDON stated that the last straw was R51 attacked nurse twice in one day, resident had physical aggression towards staff, this was not the best appropriate place for her, resident needed a place where her behavioral needs could be met. The resident was alert, oriented and knew what she was doing, she was manipulative and targeted the nurse. The resident was a danger to herself, she scratched both arms, made false accusations that we were hurting her, we could not manage that level of behavior. We tried several things such as 2 persons, redirection, encouraged her to take her medications, reminders and consequences of behaviors. IDON confirmed there was no documentation in the medical record by a physician that a transfer or discharge was necessary or documentation of the basis for the transfer or discharge.

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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** 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 6 sampled residents (R) (R53 and R57) reviewed for timeliness in transmitting discharge Minimum Data Set (MDS-an assessment tool). This 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 53 Review of Resident 53’s (R53) record documented the resident was admitted on [DATE] and discharged on 4/11/25. Review of the facility's electronic health record system Point Click Care showed that a discharge MDS with an ARD of 4/11/25 was not submitted and accepted until 5/8/27; therefore, the transmittal was not completed within the required 14 days. During a concurrent interview and record review on 7/24/25 at 3:12 PM 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 53's MDS look up assessment showed the discharge MDS dated [DATE] was submitted on 5/8/27; more than the required 14 days from the ARD date. MDS Nurse stated that it was submitted late because staff kept saying they weren't sure if the resident was coming back or not. MDS RN stated, “I told them we needed to complete the MDS or we will be late.” During an interview on 7/24/25 at 1:07 PM with the Interim Director of Nursing (IDON) and Director of Nursing, IDON stated that they expected the MDS to be completed and transmitted in a timely manner. Resident 57 Review of R57's admission Record, printed from the electronic medical record (EMR) Profile tab showed a facility admission date of 04/10/25, readmission on [DATE], with medical diagnoses that included type II diabetes, nutritional deficiency, and hypertension. (continued on next page)

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R57's EMR Progress Notes tab revealed: Effective Date: 05/05/2025 15:03 Type: COMMUNICATION - with Family/NOK [Next of Kin]/POA [Power of Attorney] Note Text : NOTIFICATION TO FAMILY MEMBER-Son [name] notified by Writer to inform him that his Father [name] will be Transported to an Out of Facility Hospital for further care (possible Pacemaker). Son advises He will call the [name] Hospital to follow-up on his Fathers' medical evaluation and transport Per facility Driver The Doctor was saying [R57's name] would probably be sent to Phoenix. Writer called [hospital name]-[NAME] [emergency room Department] and confirmed that [R57's name] will be sent to [name] Medical Center in Phoenix, AZ. Per [NAME] Receptionist, Family (NOK) which at the [facility name] lists [R57's] Daughter and Spouse have been notified. Review of R57's EMR MDS tab showed a DCRA with an Assessment Reference Date (discharge date) of 05/05/25, but the EMR History tab for the MDS showed it was not submitted until 05/29/25. During an interview on 07/23/25 at 4:02 PM regarding MDS submission policy, the Interim Director of Nursing (IDON) stated they follow the RAI (Resident Assessment Instrument) manual. During an interview on 07/24/2025 at 1:35 PM regarding the DCRA submission on 05/29/25, the MDS Coordinator (MDSC) stated, The MDS sections did not meet the times for each area completion. They were late so I submitted it (DCRA) late. Review of the October 2024 RAI Manual, page 2-39, revealed: 10. OBRA Discharge Assessment–Return Anticipated .-Must be completed when the resident is discharged from the facility and the resident is expected to return to the facility within 30 days…-Must be completed . within 14 days after the discharge date . (i.e., discharge date . + 14 calendar days).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview, record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate for one of three sampled residents (Resident (R) 37) for pressure ulcers. The failure to accurately code/assess the resident's condition had the potential to affect the care planning for the resident to receive all required services.Findings include: During the initial attempt for an interview on 07/21/25 at 3:33 PM, R37 was found non-interviewable, but had triggered for review of a facility acquired pressure ulcer. Review of R37's admission Record printed from the electronic medical record (EMR) Profile tab showed a facility admission date of 07/26/21 with medical diagnoses that included dementia, type II diabetes, protein calorie malnutrition, age related physical debility, and hemiplegia/hemiparesis following cerebrovascular disease with history of transient ischemic attacks and cerebral infarction (stroke). Review of R37's quarterly MDS with an Assessment Reference Date (ARD) of 06/14/25 showed a Brief Interview for Mental Status (BIMS) score of three out of a possible 15, indicative of severe cognitive impairment. Review of R37's MDS skin assessments for unhealed pressure ulcers showed on the following assessment reference dates:-03/13/24 Quarterly - none-06/13/24 Quarterly - none-09/13/24 Quarterly - one stage one-12/02/24 Annual - none-03/14/25 Quarterly - none-06/14/25 Quarterly - one stage two Review of R37's EMR Assessments tab, Progress Notes tab, and Miscellaneous tab did not show any documentation regarding pressure ulcers. During an interview on 07/23/25 at 3:00 PM, the Interim Director of Nursing (IDON) stated, I don't remember him [R37] ever having a pressure ulcer. During a follow-up interview on 07/23/25 at 4:02 PM regarding an MDS accuracy policy, the IDON stated they follow the RAI (Resident Assessment Instrument) manual. During an interview on 07/24/25 at 3:40 PM, the MDS Coordinator (MDSC) stated she coded the pressure ulcer on the 06/14/25 assessment from this EMR Progress Note because she couldn't find any notes that it was healed: Effective Date: 03/04/2025 19:38 Type: Skin/Wound Note Text: RT. BUTTOCK OPEN WOUND- Measuring 1.5 cm. x 1.9 cm. x 0. Superficial. Wound edges intact. No undermining. No surrounding redness. Scant amt. of bleeding with cleansing. LT. BUTTOCK OPEN WOUND- Measuring 1.0 cm. x 1.6 cm. x 0. Superficial. Wound edges intact. No undermining. No surrounding redness. Scant amt. of bleeding with cleansing.-At 4:06 PM, the MDSC showed a progress note, dated 04/25/25, stating the buttocks were healed, and stated, I coded it because I looked back to the March 14th through June 25th for the assessment. Review of the October 2024 Resident Assessment Instrument (RAI) manual with MDSC, page M-5, revealed: Coding Instructions Code based on the presence of any pressure ulcer/injury (regardless of stage) in the past 7 days. Code 0, no: if the resident did not have a pressure ulcer/injury in the 7-day look-back period. Then skip to M1030, Number of Venous and Arterial Ulcers. Code 1, yes: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. The MDSC stated the MDS was coded incorrectly for a pressure ulcer.

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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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure resident's plan of care were revised when diet texture was changed, glasses were no longer available, transfer needs changed, and foot fracture was sustained for 1 of 18 sampled residents (R) (R4) whose care plans were reviewed. This failure increased the risk for unmet care needs.Findings includeReview of R4's record indicated the facility admitted the resident on 2/7/23 with diagnoses including heart failure (heart disorder which causes the heart to not pump the blood efficiently), diabetes, and dementia. R4's Minimum Data Set (MDS-assessment tool), dated 4/20/25, documented R4's brief interview for mental status was 2. (BIMS, a scoring system used to determine the resident's cognitive status about attention, orientation, and ability to register and recall information. A BIMS score of 0 to 7 is an indication of severe cognitive impairment), and was dependent on staff for eating, toileting, dressing, personal hygiene, mobility and transfers and did not walk and used a wheelchair.Review of R4's July Medication Administration Record documented resident's diet was CCHO (consistency carbohydrate) diet pureed texture, nectar consistency.Review of R4's current care plan, printed on 7/21/25, documented a self-care deficit related to limited mobility, weakness and frailty, vision deficient, and wheelchair use with resident required total assistance from staff for personal hygiene and 1. Utilized a stand-up lifter and must be assisted by two staff members (Date initiated 4/20/21) 2. Assist [name of resident4] by two (2) person during transfer using mechanical lifter for safety (Date initiated 8/26/22)3. Remind/assist [name of resident4] to wear glasses when up. Ensure [name of resident4] is wearing glasses which are clean free from scratches and in good repair. Report any damage to nurse/family. (Date Initiated: 4/20/21)4. Please offer [name of resident4] all Liquids w/straw as [name of resident4] states she does better drinking through the straw. (Date Initiated: 4/20/21)5. Provide [name of resident4] Diet as ordered (CCHO diet, pureed texture, nectar consistency) (Date initiated 1/25/20)6. There was no care plan for resident's right heel fracture per x-ray exam on 6/27/25Progress notes documented on 7/5/25 by Registered Nurse (RN)2. Provider 1 referred resident to Podiatry. 92F(emale) Nursing Home resident w localized right foot plantar tenderness/swelling-x-ray shows posterior calcaneal minimally displaced fracture. Patient presents to podiatry clinic for follow up diabetic foot check and toenail debridement. Patient has also been referred for complaint of tenderness and pain to RIGHT heel 2/2 minimally displaced calcaneal fracture.decreased osseous mineralization. Fracture deformity about the posterior calcaneous of unknown chronicity. Mild polyarticular arthritic changes. Arteriosclerotic vasculary disease. No significant soft tissue swelling. Further explained that given patient's age and health profile, and since patient does not ambulate, the fracture is not indicated for surgical intervention. Recommended cushining (sic) padding to right heel with foam/sponge heel off loading pressure relief ankle and foot orthosis, foot care orders for [nursing home] staff, examine feet QAM and QPM (every morning and every evening), make sure there are not external pressures to patient's feet that may lead to pressure ulcerations, Between podiatry visits, trim patient's toenails, ted hose to bilateral lower legs if patient has no h/o CHF (history of congestive heart failure), patient should have heel protectors to feet at all times.Observation on 7/21/25 at 11:59 AM showed R4 sitting in high back wheelchair with eyes closed. Staff sat next to resident and offered cup to resident's lips, but resident only opened her mouth a few times and did not consume much. R4 diet was pureed texture and there was no straw on meal tray. Resident was not wearing glasses. During a phone interview on 7/21/25 at 2:11 PM Family Member (FM)1 stated that resident used to have glasses but hadn't been wearing them.Observation on 7/22/25 at 10:10AM showed Certified Nursing Assistant (CNA) 26 and 21 change resident's briefs and then transfer resident with mechanical lift to high back wheelchair. Resident was not wearing glasses. During multiple observations from 7/21/25 to 7/25/25 R4 was not observed wearing glasses.During an interview on 7/22/25 at about 10:13AM Certified Nursing Assistant (CNA) 26 stated that she knows R4 well, having taken care of her during the past 3 years. CNA26 stated that resident is transferred via mechanical lift and not the stand-up lifter or sit to stand as resident does not stand. CNA26 also stated that she has never seen R4 wear glasses and has not seen glasses in her room.During an interview on 7/23/25 at 8:57 AM CNA21 stated that resident is transferred using mechanical hoyer lift with two people. During an interview on 7/24/25 at 1:07 PM with the Interim Director of Nursing (IDON) and Director of Nursing, IDON stated that care plans should reflect care that is needed.Record review of email communications, dated 7/24/25 at 2:33 PM, Interim Director of Nursing (IDON) documented The interim care plans are done by the nurses. Any updates are usually done by RegisteredNurse Assessment Coordinator (RNAC) During a phone interview on 7/25/25 at 9:40 AM

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that residents were evaluated for the need and safety for the use of bed rails prior to the installation/use of rails, failed to document alternatives to bed rails were attempted prior to the use of bed rails, failed to document reasons for failure of alternatives, and failed to advise residents and/or Resident Representatives (RR) of the risks and/or benefits of rail use with informed consent signed prior to the installation of bed rails for three of three residents (Resident (R) 14, R33, and R57) reviewed for bed rail use of 50 census residents. In addition, the facility had failed to evaluate the need and safety of bed rail use for all residents in the facility. This failure had the potential for all residents, or the RRs to be uninformed of the risks associated with bed rail use and could put the residents at risk for injury or entrapment due to all residents having bed rails.Findings include: 1. During an observation and interview on 07/21/25 at 11:27 AM, R14 was noted to have bilateral bed rails on his bed. R14 stated he used them, but Nobody talked to me about the risks. The physical therapist [name] talked to me about how to use it and how not to use it. Further discussion revealed R14 had not been advised of the potential risks for injury or entrapment. R14 also had a trapeze and floor to ceiling transfer pole. Review of R14's admission Record printed from the electronic medical record (EMR) Profile tab showed a facility admission date of 04/17/24 with medical diagnoses that included type II diabetes, dementia, cerebral infarction with subsequent hemiparesis and hemiplegia. Review of R14's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/01/25 showed a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15, indicative of being cognitively intact. Review of R14's EMR Assessment tab showed no evaluations for bed rail use. Review of R14's EMR Miscellaneous tab showed no assessments, evaluations, or informed consents for bed rails. Review of R14's care plan from the EMR Care Plan tab did not reveal a bed mobility plan that included bed rails. 2. During an observation and interview on 07/22/25 at 9:55 AM, R33 was noted to have bilateral bed rails on his bed. R33 stated he used them. When asked if anyone had explained any risks (with examples), R33 stated, No. Review of R33's admission Record printed from the EMR Profile tab showed a facility admission date of 11/05/24 with medical diagnoses that included chronic obstructive pulmonary disease (COPD), visual loss, osteoarthritis, gastroesophageal reflux disease (GERD), and hypertensive heart disease. Review of R33's quarterly MDS with an ARD of 05/21/25 revealed a BIMS score of 14 out of a possible 15, indicative of being cognitively intact. Review of R33's EMR Assessment and Miscellaneous tabs revealed no assessments, evaluations, or informed consents for bed rails. Review of R33's care plan from the EMR Care Plan tab did not reveal a bed mobility plan that included bed rails. 3. During the first portion of the survey, R57's bed was observed to have bilateral bed rails. R57 was observed sleeping in bed with bilateral bed rails on 07/22/25 at 9:43 AM and 07/23/25 at 9:15 AM. Review of R57's admission MDS with an ARD of 04/23/25 showed a BIMS score of 11 out of a possible 15, indicative of moderate cognitive impairment. Review of R57's EMR Assessment and Miscellaneous tabs revealed no assessments, evaluations, or informed consents for bed rails. Review of R57's care plan from the EMR Care Plan tab did not reveal a bed mobility plan that included bed rails. During an interview on 07/23/25 at 11:52 AM regarding evaluations for bed rails, the Interim Director of Nursing (IDON) stated We don't have side rails. When explained they had assist bars and upper quarter rails which were considered side rails. The IDON responded The only place it will be indicated is in the care plan. At 3:00 PM, when requesting a policy for bed rails, the IDON stated We don't have it and confirmed all residents had hand bars. Upon request, IDON provided a list of residents with bed rails, all but one current resident was listed as having a right and left rail. Observation of that one bed on 07/21/25 at 9:40 AM, revealed the bed was noted to have bilateral bed rails with an air mattress. During a follow up observation on 07/25/25 at 2:29 PM, Licensed Practical Nurse (LPN) 6 confirmed that that bed did have bilateral bed rails.Observation of Household 1 on 7/24/25 at about 4 PM showed bedrails on all resident beds. During an interview on 07/25/25 at 10:35 AM, the Maintenance Director stated he did not remove bed rails between residents and that Every bed has some type of hand rail. During an interview on 07/25/25 at 2:39 PM regarding bed rail evaluations and informed consent, the Director of Nursing (DON) stated she had identified the issue and was working on a risk/benefit and consent form. The DON stated, All residents need to be updated with consent forms yearly or when there are changes. The families and residents need to be educated regarding the risk/benefits and alternatives, we need to get orders [physician], get consents, and then use should be care planned

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review it was determined the facility failed to ensure a registered nurse worked eight consecutive hours for 1 of 203 days reviewed for staffing. This placed residents at risk for lack of nursing assessments.Findings includeA review of the facility's Licensed Nurses Schedule for week of 5/19/25 showed there were no RN on duty on 5/18/25. Review of Interim Director of Nursing (IDON) Custom Time Card Report for 5/18/25 showed hours worked from 8:30 AM to 1:00 PM (4.5 hours) and then 6:30 PM to 9:15 PM (2.75 hours). The facility census was less than 60.During a concurrent review and interview on 7/24/25 at 10:59 AM IDON confirmed the facility did not have an RN for eight consecutive hours on 5/18/25.

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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** Based on interview and record review, the facility failed to ensure resident's drug regimen was free from unnecessary drugs for 1 of 5 sampled resident (R) (R7) reviewed for unnecessary medication use. R7 received anti-hypertensive medications that did not meet physician's ordered blood pressure parameters. This failure placed residents at risk for adverse side effects such as hypotension, dizziness, and falls. Findings includeReview of R7's records documented resident was admitted on [DATE] with diagnoses including congestive heart failure (heart disorder which causes the heart to not pump the blood efficiently), hypertension, dementia, diabetes, and cerebral infarction (stroke, blood supply to part of the brain is blocked, causing parts of the brain to be damaged or die, can cause weakness in one side of the body and swallowing difficulties).Review of R7's care plan documented [Name of R7] has hypertension and takes medicines with goal for resident's blood pressure to be within normal limits.Review of R7's physician orders and July 2025 Medication Administration Record documented *Hydralazine 25 mg, give 50 mg by mouth three times a day for hypertension. Hold for SBP (systolic blood pressure, top number of blood pressure) less than 130.During the month of July, resident's SBP was less than 100 but Hydralazine was documented as given five times on 7/5/25 (BP 124/49), 7/6/25 (BP 123/52), 7/7/25 (BP 128/69), 7/12/25 (BP 107/65), 7/20/25 (BP 125/67). During a concurrent interview and record review on 7/24/25 at 1:07 PM with Interim Director of Nursing (IDON) and Director of Nursing, IDON stated that R7's blood pressure medications should have been held if blood pressure was too low and nurses need to be following physician's orders.Facility policy Medication Administration, dated 1/2024, documented Medications are administered in accordance with written orders of the attending physician.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure records were complete and accurate for 1 of 5 sampled residents (R)(R7) reviewed for unnecessary medication use. This placed residents at risk for incomplete clinical records.Findings includeReview of R7's records documented resident was admitted on [DATE] with diagnoses including congestive heart failure (heart disorder which causes the heart to not pump the blood efficiently), hypertension, dementia, diabetes, and cerebral infarction (stroke, blood supply to part of the brain is blocked, causing parts of the brain to be damaged or die, can cause weakness in one side of the body and swallowing difficulties).Review of R7's care plan documented [Name of R7] has hypertension and takes medicines with goal for resident's blood pressure to be within normal limits.Review of R7's physician orders and July 2025 Medication Administration Record documented *Hydralazine 25 mg, give 50 mg by mouth three times a day for hypertension. Hold for SBP (systolic blood pressure, top number of blood pressure) less than 130.During the month of July, resident's SBP was less than 100 but Hydralazine was documented as given five times on 7/5/25 (BP 124/49), 7/6/25 (BP 123/52), 7/7/25 (BP 128/69), 7/12/25 (BP 107/65), 7/20/25 (BP 125/67).During a concurrent interview and record review on 7/23/25 at 1:36 PM Licensed Practical Nurse (LPN)2 stated that although R4's Medication Administration Record shows she gave Hydralazine on 7/20/25 when BP was 125/67 (SBP was less than 130), she knows that is a mistake because she recalls resident's SBP was low all day Sunday so she held the resident's BP medications. LPN6 stated that she might have clicked the wrong thing in the electronic health record Point Click Care. When asked about 7/7/25 BP reading of 128/69, LPN6 stated she also did not administer Hydralazine on this day since it shows resident's SBP was less than 130. LPN6 stated that she is aware the record shows she gave the Hydralazine, but it was a mistake. LPN6 stated that she understands that it is important that the medical record documentation is accurate and also that if resident is given Hydralazine when SBP is not greater than 130, then the resident's BP could drop too low.During a concurrent interview and record review on 7/24/25 at 1:07 PM with the Interim Director of Nursing (IDON) and Director of Nursing, IDON stated that R7's blood pressure medications should have been held if blood pressure was too low and nurses need to be following physician's orders, and it is important that the medical record reflect accurate and complete documentation. During an interview on 7/25/25 at about 2:10 PM IDON stated that the expectation is medical record documentation is accurate and reflect what was done. Upon request for medical record policy for documentation accuracy, facility provided Content of Medical Record. This policy did not outline the need for medical record documentation to be accurate.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to submit mandatory staffing information based on the payroll data journal and other verifiable and auditable data as required. This placed residents at risk for inaccurate staffing information.Findings includeReview of the Payroll Based Journal (PBJ) Staffing Data Report for Fiscal Year Quarter 2, 2025 ([DATE] to March 30) indicated the facility failed to submit required data for the quarter.During Entrance Conference on 7/21/25 at about 8:37 AM Administrator was informed that PBJ Report for Q2 2025 was not submitted. Administrator stated that a new Chief Operations Officer (COO) started in May and is responsible for submitting PBJ reports.During an interview on 7/22/25 at 10:33 AM Interim Director of Nursing (IDON) stated that Payroll specialist used to complete PBJ submissions and she left about four months ago with new COO starting on 5/5/25. IDONs stated that no one trained new COO regarding submitting PBJ reports.Review of Centers for Medicare and Medicaid Services Electronic Staffing Data Submission Payroll-Based Journal Long-Term Care Facility Policy Manual version 2.6, dated June 2022, documented Section 6106 of the Affordable Care Act requires facilities to electronically submit direct care staffing information based on payroll and other auditable data .(p) Mandatory submission of staffing information based on payroll data in a uniform format .(5) submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to maintain a Quality Assessment and Assurance (QAA) committee that included the required participants for 2 of 4 quarters reviewed for participation. This failed practice placed residents at risk for quality and infection control deficiencies, adverse events, and diminished quality of life.Findings includeFacility's 2025 Quality Assessment Performance Improvement (QAPI) Committee, undated, documented meetings were at a minimum once every quarter with members listed: Interim Assistant Director of Nursing/Quality Assurance Quality Improvement/Infection Control Nurse (IADON QA QI ICN), Interim Director of Nursing (IDON), Medical Director, Consult Pharmacist, Board of Directors, Supervisors for Housekeeping/dietary, Maintenance, Social Services, Lead Certified Nursing Assistant (CNA), MDS (Minimum Data Set) Coordinator, Activity Supervisor and Nurses, CNAs and all staff are welcome to attend. The facility's list of QAPI/QAA participants met the minimal regulatory requirements that the Medical Director/Designee, Director of Nursing Services (DON), Administrator/Owner/Board Member/Other Leader, Infection Prevention & Control Officer (IP), At least two additional members participated and QAA met at least quarterly. Review of facility's 2024 and 2025 QAPI binder showed that 3/26/25 meeting did not have the required meeting participants when the Medical Director and Administrator/Board member did not attend. In addition, the Medical Director did not attend the 10/2/24 meeting. During text communications on 7/25/25 at 9:05 AM IADON/QA QI ICN (who was on leave and available via text or phone) stated that if the Medical Director was not on the sign-in sheet, he most likely was not able to attend. During an interview on 7/25/25 at 10:25 AM IDON stated that the Medical Director stated that he has no proof that he attended the 3/26/25 meeting.

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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. 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 staff did not change gloves during 1 of 2 sampled resident (R) (4) personal care observation when going from dirty tasks to clean tasks. This placed residents at risk for the spread of infection and its associated discomfort and decline in physical condition.Findings includeReview of R4's record indicated the facility admitted the resident on 2/7/23 with diagnoses including heart failure (heart disorder which causes the heart to not pump the blood efficiently), diabetes, and dementia. R4's Minimum Data Set (MDS-assessment tool), dated 4/20/25, documented R4's brief interview for mental status was 2. (BIMS, a scoring system used to determine the resident's cognitive status about attention, orientation, and ability to register and recall information. A BIMS score of 0 to 7 is an indication of severe cognitive impairment), and was dependent on staff for eating, toileting, dressing, personal hygiene, mobility and transfers and did not walk and used a wheelchair. Review of R4's current care plan, printed on 7/21/25, documented a self-care deficit related to limited mobility, weakness and frailty, vision deficient, and wheelchair use with resident required total assistance from staff for personal hygiene. Observation on 7/22/25 at 10:10AM showed Certified Nursing Assistant (CNA) 26 and 21 change resident's briefs. CNA26 unfastened resident's briefs with gloved hands, then wiped resident private area several times. With same gloved hands, CNA26 picked up clean new brief and placed under resident and then repositioned resident on her side and fastened briefs.During an interview on 7/22/25 at about 10:13AM Certified Nursing Assistant (CNA) 26 stated that R4's briefs was wet. When asked about changing gloves during brief change, CNA26 stated that she used one pair of gloves. When asked how she kept new brief clean when she touched brief with same gloves she used to clean resident's soiled briefs. CNA26 stated that I guess the glove was dirty when she touched the clean brief with the gloves she had just used. CNA26 stated that it's not like she keeps briefs in her pocket and she needs to attend to the resident.During text communications on 7/25/25 at 9:07 AM Interim Assistant Director of Nursing/Quality Assurance Quality Improvement/Infection Control Nurse (IADON/QA QI ICN) (who was on leave and available via text or phone) documented the expectation is staff to know when to change gloves after a dirty procedure and before doing a clean procedure or act. Staff should not be using one pair of gloves when changing soiled briefs. During an interview on 7/24/25 at 1:07 PM with Interim Director of Nursing (IDON) and Director of Nursing, IDON stated that staff should be changing gloves between dirty and clean tasks.Facility policy Handwashing/ Hand Hygiene, dated 1/2024, documented change gloves and perform hand hygiene during patient care, if.c moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure two of five residents (Resident (R) 6 and R56) reviewed for immunizations had been provided with education and the opportunity to decline or receive an updated pneumococcal conjugate vaccine (PCV20 or PCV21). This failure had the potential to affect the residents' ability to decrease the possibility of serious pneumococcal infection and potential hospitalization.Findings include: Review of the facility's policy titled, Pneumococcal Vaccine, revised October 2023, revealed:Policy Statement. All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Policy Interpretation and Implementation.7. Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. 1. Review of R6's admission Record, printed from the electronic medical record (EMR) Profile tab revealed a facility admission date of 10/18/23, readmission on [DATE], with medical diagnoses that included dementia, trigeminal neuralgia, acute embolism and thrombosis, hypertension, and age-related physical debility. Review of R6's EMR Immunization tab showed an unidentified pneumococcal vaccine on 07/09/07 and a PCV13 vaccine on 08/12/15. Further review of R6's record did not show documentation that R6 or her Responsible Party (RP) had been educated regarding the Centers for Disease Control (CDC) recommendations for PCV20 or PCV21 to complete the pneumococcal vaccine. Review of the CDC PneumoRecs VaxAdvisor application located at https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/app.html, dated 01/15/25, showed a recommendation of Give one dose of PCV20 or PCV21 at least one year after PCV13. Regardless of which vaccine is used (PCV20 or PCV21), their pneumococcal vaccinations are complete. During an interview on 07/25/25 at 1:54 PM, the [NAME] Clerk stated there was no documentation regarding the PCV20 which was what the facility offered. 2. Review of R56's admission Record, printed from the EMR Profile tab, revealed a facility admission date of 09/17/24 with medical diagnoses that included dementia and adult failure to thrive. Review of R56's EMR Immunization tab showed she had received the PCV13 on 10/11/17 and that a pneumococcal vaccine and COVID vaccine had been refused by family on 09/19/24. However, a COVID vaccine had been administered on 10/11/24. A request was made for the declination with education. During an interview on 07/25/25 at 1:54 PM, the [NAME] Clerk stated she was unable to find anything more regarding the PCV20. When asked about the declination and administration of the COVID vaccine, at 2:05 PM the [NAME] Clerk provided a consent form for all vaccines signed by R56 and her RP, but she was unable to find any documentation that the PCV20 had been administered after the consent. Review of the CDC PneumoRecs VaxAdvisor application located at https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/app.html, dated 01/18/25, showed a recommendation of Give one dose of PCV20 or PCV21 at least one year after PCV13. Regardless of which vaccine is used (PCV20 or PCV21), their pneumococcal vaccinations are complete. During an interview on 07/25/25 at 2:40 PM, the Director of Nursing (DON) stated an expectation that anyone in the door, we would check their vaccine status, educate and offer the pneumonia vaccine. After reviewing the EMR, the DON stated R6, and her RP should have been educated and offered the pneumonia vaccine. After reviewing the EMR and consent, the DON stated R56 should have had the pneumonia vaccine administered.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on interview and record review the facility failed to offer training on its compliance and ethics program for 5 of 5 sampled staff (Certified Nursing Assistant) (CNA)(3, 21, 26, 6, and 19) reviewed for training. This placed residents at risk for non-compliant and unethical treatment.Findings includeReview of facility all staff list documented CNA3 was hired in March 2014.Review of facility training records for CNA3 lacked documented evidence of compliance and ethics training.Review of facility all staff list documented CNA21 was hired in May 2017.Review of facility training records for CNA21 lacked documented evidence of compliance and ethics training.Review of facility all staff list documented CNA26 was hired in April 2022. Review of facility training records for CNA26 lacked documented evidence of compliance and ethics training. Review of facility all staff list documented CNA6 was hired in January 2008. Review of facility training records for CNA6 lacked documented evidence of compliance and ethics training.Review of facility all staff list documented CNA19 was hired in January 2024. Review of facility training records for CNA19 lacked documented evidence of compliance and ethics training.During a phone interview on 7/25/25 at 11:42 AM Interim Assistant Director of Nursing/Quality Assurance Quality Improvement/Infection Control Nurse (IADON/QA QI ICN) (who was on leave and available via text or phone) stated that she oversaw the facility's staff training which was conducted and tracked through Relias system. When asked about compliance and ethics training, IADON/QA QI ICN stated that she did not assign any compliance and ethics training module in Relias for staff to complete. IADON/QA QI ICN stated that the previous compliance officer did not provide any staff training on the compliance and ethics program and the new compliance officer (start date May 2025) has not provided compliance and ethics training.During an interview on 7/25/25 at 1:18 PM CNA26 stated that they had not received any training on the facility's compliance and ethics program.During an interview on 7/25/25 at 1:26 PM Licensed Nurse Aide (LNA)7 stated that they worked at the facility for the past seven years and had not received training on the facility's compliance and ethics program.During an interview on 7/25/25 at 1:45 PM Interim Director of Nursing (IDON) stated that the facility's compliance and ethics program was discussed at the February 2025 staff meeting. Review of the agenda and notes of the meeting lack documentation that compliance and ethics was discussed. The meeting attendance sheet documented about 10-15 names. IDON stated that not all staff or CNAs attended the meeting/training.During an interview on 7/25/25 at about 2:10 PM IDON stated that the expectation is compliance officer provides training to all staff on the facility's compliance and ethics program.Review of Compliance and Ethics Program, dated as approved by Board of Directors on 7/25/24, documented any such Associates or Affiliates who ultimately work more than 160 hours during a year must complete Orientation Training. At a minimum, the related training materials will provide: A description of the Program, Education on each Associate and Affiliate's responsibilities and [name of facility] expectations regarding compliance with laws. On an annual basis, the following individuals.must complete Refresher Training on the Code (delivered by the Human Resource Coordinator) and the Program. All full-time, part-time, and per-diem Associates, All Affiliates who furnish patient care items or services.

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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. Based on interview and record review, the facility failed to ensure 4 of 5 currently employed sampled Certified Nursing Assistant (CNA)(3, 21, 26, and 6) reviewed for training completed the required 12 hours of annual in-service education based on their hire dates. The facility also failed to ensure CNA26 and CNA6 received annual abuse, dementia, and infection control training. This placed residents at risk for receiving care from unskilled staff and increased risk for abuse, neglect and diminished quality of care.Findings includeReview of facility all staff list documented CNA3 was hired in March 2014.Review of facility training records for CNA3 documented 7.82 hours of annual training was completed; less than the required 12 hours. Review of facility all staff list documented CNA21 was hired in May 2017.Review of facility training records for CNA3 documented 8.57 hours of annual training was completed; less than the required 12 hours.Review of facility all staff list documented CNA26 was hired in April 2022.Review of facility training records for CNA3 documented 0.17 hours of annual training was completed; less than the required 12 hours and did not include abuse, dementia care, and infection control training.Review of facility all staff list documented CNA6 was hired in January 2008. Review of facility training records for CNA3 documented 0 hours of annual training was completed; less than the required 12 hours and did not include abuse, dementia care, and infection control training. The last training module completed was on 5/11/23.During a phone interview on 7/25/25 at 11:42 AM Interim Assistant Director of Nursing/Quality Assurance Quality Improvement/Infection Control Nurse (IADON/QA QI ICN) (who was on leave and available via text or phone) stated that she oversaw the facility's staff training which was conducted and tracked through Relias system. During a concurrent record review and interview on 7/25/25 at 1:18 PM CNA26 stated that Relias is how staff completes training topics. CNA26 reviewed her Relias training record which showed 0.17 hours completed and confirmed the training record was accurate and did not include completing training on abuse, dementia or infection control. CNA26 stated that she is unable to complete Relias computer-based training at home because she does not have good internet service at home so she has to complete training while at work, often there is no time to complete these trainings at work so she focuses on doing the trainings that don't take a lot of time. CNA26 stated that otherwise, she would have to come to the facility on her days off, she does not live close by, it would waste gas, and it would be unpaid time.During an interview on 7/25/25 at about 2:10 PM IDON stated that the expectation was for CNAs to complete the required 12 hours of training annually and this has been an ongoing challenge to achieve. IDON stated that she is aware some staff do not have good internet service at home and staff can come into the facility on their days off, and complete four hours of training and the facility will pay them. IDON stated that staff will be reminded of this at the next staff meeting.Review of Facility Assessment, reviewed 3/26/25, documented Staff education and trainings are provided by the RELIAS online training program. Annual training modules are assigned based on Centers for Medicare and Medicaid Services (CMS) requirements for inservice trainings. The topics for CNAs included annual abuse, infection, and dementia care.