STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035255	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Valley Post Acute	13575 West McDowell Road Goodyear, AZ 85395

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49325 Based on clinical record review, staff and family interviews, and review of facility policy and documentation, the facility failed to ensure personal privacy and confidentiality of medical records were maintained for one resident (#604). The deficient practice could result in unauthorized disclosure of resident information. Findings include: Resident # 604 was admitted on [DATE] with diagnoses of unspecified psychosis, anxiety disorder, type 2 diabetes mellitus, and depression. A health status note dated October 28, 2022 included that the resident was alert, verbally responsive and oriented to self, place and situation with forgetfulness; and was admitted with diagnoses of anxiety disorder, late effect stroke and diabetes mellitus (DM) type II. The eINTERACT summary dated October 29, 2022 revealed that the resident had a change in condition; and that the resident reported burning when urinating. Per the documentation, UA (urinalysis) and CS (Culture sensitivity) tests were ordered for a diagnosis of dysuria. The eINTERACT summary dated October 30, 2022 included that the resident complained of pain with urination, swollen penis with purulent exudate. The recommendation was to send the resident to the hospital. The health status note dated October 30, 2022 included that the resident came back at the facility with new orders for Keflex (antibiotic) 500 mg (milligrams) twice daily for 14 days for UTI (urinary tract infection) and Nystatin (antifungal) topical daily for 14 days for urogenital candidiasis. The facility initial self-report dated October 31, 2022 revealed that an agency nurse sent a photo of the resident's genital area to the resident's family instead of sending it to the provider for evaluation. The facility's 5-day report dated November 4, 2022 included that on October 31, 2022 a staff member received a text message with a photo of the resident's genital area. The documentation included that the resident's nurse accidentally texted the resident's photo to the family member instead of the physician using the facility secured nurse cellphone. The facility concluded that the incident did occur. (continued on next page)

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

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted February 28, 2024 at 09:16 a.m. with Licensed Practical Nurse (LPN/Staff # 229) who stated that upon hire she recalls a power point education regarding HIPAA (health insurance portability and accountability act) which applies to any medical information. Staff # 229 stated she the education was related to using verbiage to describe skin conditions i.e. laceration to the head; and, was never taught to send photographs. An interview was conducted with Registered Nurse (RN/Staff # 100) on February 28, 2024 at 09:28 a.m. The RN stated that staff were not supposed to talk about the resident's information unless when discussing the treatment of the resident with the team. In an interview conducted with Director of Nursing (DON/Staff # 118) on February 28, 2024 at 09:51 a.m., the DON said HIPAA education is provided on orientation and also annually; and that, the expectation was that HIPAA and privacy is maintained. The DON further stated that a resident's information should not to be shared with anyone not privileged or authorized; and that, information is shared only within the group providing treatment to the resident. A review of the facility policy titled, Confidentiality of Information and Personal Privacy (Revised October 2017) revealed that the facility will strive to protect the resident's privacy regarding his or her: medical treatment; personal care. Access to resident personal and medical records will be limited to authorized staff and business associates. A review of a facility Admission Agreement titled, Arizona Admission Agreement dated May 2022 revealed that Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50116 Based on observation and and interviews, the facility failed to provide a homelike dining environment. Findings include: During and observation of lunch conducted on February 25, 2024 at 1:40 p.m., Meal trays for lunch being delivered at 1340 on 02/25/24. Resident #69 trays have been late. Tray was brought into resident's room and dome lid was left covering the plate. Other residents eating in rooms or at the dining area in the 200 wing. Trays placed in front of residents with dome covers still on plates. TV on in corner of dining area with staff passing out coffee. 2/28/29 Lunch trays being delivered at 1245 to the floor. Trays being passed out to residents eating in the dining area first. Trays to the tables with the domes still on the food. Residents removing the domes then eating. Trays then delivered to those in their rooms. Two residents in reclining type of chairs next to tables. One resident in motorized wheel chair and next to table. Unable to fit under table. 2/29/24 1226, no trays delivered to 200 wing. 1228, the 400 wing received their trays. Trays were already delivered to 100's and 300's. Trays being picked up from dining tables. Noted for trays with domes on scattered tables. Trays to 200 wing at 1234. Lemonade being served in disposable cups. Residents eating off of trays.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47341 Based on clinical record review, staff interviews, facility documentation and policy and procedure review, the facility failed to protect the rights of one residents (#79) to be free from sexual abuse by another resident (#252); and, failed to protect the rights of one resident (#33) from physical abuse by another residents (#354 and #356). The deficient practice could result in further abuse of residents to occur. Findings include: Regarding resident #79 and #252 -Resident #79 (alleged victim) was admitted to the facility on [DATE] with diagnoses of unspecified dementia without behavioral disturbance, history of TBI (traumatic brain injury) and epilepsy. The comprehensive care plan included the resident had anxiety and delusions, was at risk for falls related to dementia with poor cognition. Interventions included to administer psychotropic medications as ordered. Goals included that resident will show decreased episodes of signs/symptoms of anxiety, depression and fewer indications of decreased well-being. The admission Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 3 indicating the resident had severe cognitive impairment. The MDS also included that the resident did not have any behavioral symptoms coded. -Resident #252 (alleged perpetrator) was admitted on [DATE] with diagnoses of dementia with behavioral disturbance and major depressive disorder. The discharge date was September 23, 2022. The care plan dated November 10, 2019 revealed that resident #252 had history of inappropriately touching of staff/peers and public masturbation. Interventions included 1:1 sitter while awake; psych consult; monitored closely around other residents and every attempt should be made to keep other residents safe including actively attempting to separate resident #252 from other residents; and, staff should be aware of their position of their body maintaining a safe distance to avoid being pinched, grabbed or fondled. A health status note dated November 11, 2019 included that the resident was noted to be exhibiting sexual tendencies; and to prevent any type of potential inappropriate behaviors with peers, a 1:1 sitter had been implemented as well as a psych evaluation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A psychiatric consult note dated November 12, 2019 included that the resident had recent sexually inappropriate behavior; and that, the resident had a history of inappropriately touching other female residents. The documentation included that staff reported that resident was recently seen reaching at female resident's skirt and attempting to make inappropriate sexual contact; and that, staff were able to intervene and redirected and warned the resident. Per the documentation, the resident said that it was the first time he ever did something like this and he was not sure why he did it; and that, he does not remember inappropriately touching other residents. It also included that the resident had sexually inappropriate impulses before; and that, the resident had intermittent sexual preoccupation and impulsive sexual actions toward others. An alert note dated January 19, 2022 revealed that resident #252 had his hand on resident #79's breast; and that, this incident was witnessed by a CNA. (certified nurse assistant). The facility report dated January 29, 2022 included that resident #252 was witnessed to have his hand over the breasts outside of the blouse of resident #79. The report included that the CNA was at the nurses' station with the nurse and both residents #79 and #252 were in the hallway when the CNA witnessed the hand of resident #252 on the breast outside of the blouse of resident #79. Further, the report included that the allegation was substantiated. Review of the clinical record revealed no new interventions were implemented to address the resident's continued sexually inappropriate behaviors. A physician progress note dated July 24, 2022 revealed the resident was alert and oriented x1, had impaired cognition and poor insight and judgment. The intake received from the facility on July 25, 2022 included that resident #252 wheeled himself to and placed his hand on the leg of resident #79. The facility 5-day report dated August 1, 2022 revealed that on July 25, 2022, resident #252 wheeled himself to resident #79 in the dining room and rested his hand on the leg of resident #79. Per the documentation, a CNA quickly intervened and separated the two residents. The report also included that the allegation was not substantiated. In an interview with a CNA (staff #108) conducted on February 26, 2024 at 9:46 a.m., she stated that if two residents have an altercation, staff would separate them and let their nurse and the unit manager know about the incident. The CNA said that in order to keep the residents safe, staff will keep them separate, update the care plan, and place the aggressor on frequent checks. Regarding the incident between resident #79 and #252, the CNA stated that she did not work at the facility at the time that it occurred. The CNA stated that resident #79 does not have any behaviors, trauma indicators or triggers from the incident in July 2022. In an interview with the Director of Nursing (DON) on February 26, 2024 at 11:27 a.m., the facility does not have any incident reports on file for residents #252 and #79 due to the acquisition of the facility from a previous owner. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In another interview with the DON conducted on February 29, 2024 at 1:38 p.m. she stated that regarding the incident between resident #79 and #252, the DON was not able to speak to the specific incident due to not having documentation of the incident and not working at the facility when it originally occurred. 47669 Regarding incident between resident #33 and #354 -Resident #33 was admitted on [DATE] with diagnoses of schizophrenia and unspecified intracranial injury with loss of consciousness of unspecified duration. The care plan dated November 26, 2019 included that the resident had an impaired cognitive function/impaired thought process related to injury The care plan dated April 23, 2020 include the resident had a behavior of inappropriately touching and making sexual advances to staff, sexual and racial comments, verbally abusive, yelling out and was aggressive. Interventions included to document behaviors as they occur to monitor trends, intervene as necessary to protect the rights and safety of others. A health status note dated August 3, 2022 included that the CNA (certified nurse assistant) reported that the resident was rolling around in w/c, yelled out, 'I am Gay'. Per the documentation, another resident (#354) swung a towel and hit resident #33 in the face. It also included that there were no injury and resident #33 denied pain at this time. The health status dated August 4, 2022 revealed that Adult Protective Services (APS) was at the facility to follow-up on peer to peer altercation between resident #33 and #354. -Resident #354 (alleged perpetrator) was admitted on [DATE] with diagnoses of schizoaffective disorder and major depressive disorder. The clinical record review revealed the resident had a Brief Interview of Mental Status (BIMS) score of 12 indicating the resident had moderate cognitive impairment. The care plan with revision and resolved date of March 31, 2021 included that the resident was on an antipsychotic medication related to diagnosis of schizoaffective disorder bipolar type manifested by behaviors of paranoid delusions with poor medication compliance. Intervention included to monitor specific behaviors per physician orders and psych follow-up as needed. The care plan dated March 2, 2022 revealed that the resident was involved in a physical aggression incident toward peer. Interventions included redirection when resident shows increased behaviors and to encourage resident to report abuse to staff right away. The health status note dated August 03, 2022 revealed that the CNA reported that resident #354 swung a towel and hit another resident (#33) in the face; and that, resident #354 said that he just wanted resident #33 to stay away from him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An alert note dated August 03, 2022 included that the resident swatted another resident (#33) with a towel so he could be left alone; and that, the resident was aggressive towards peers. Per the documentation, there were no injuries noted and abuse reporting protocol was initiated. The health status note dated August 04, 2022 revealed that APS was at the facility to follow up on peer to peer altercation. Another health status note dated August 4, 2022 documented peer to peer post altercation; and that the resident was separated from the other peer. A health status note dated August 5, 2022 revealed that the resident was closely monitored due to incident of altercation; and that, the resident remained separated from other resident involved in the altercation. A review of the undated facility 5-day report revealed that a certified nurse assistant (CNA/staff #215) witnessed while resident #354 was holding the patio door open, resident #354) swatted resident #33 in the face with a towel. Resident (33) was just sitting in his chair in front of the patio door and said I'm gay to resident (354). Per the documentation, after the incident resident #3 laughed and rolled away; and, both residents were separated from each other. The report included an interview with resident #354 conducted by the Director of Nursing (DON/staff #300) included that resident #354 reported that he was standing at the patio exit when another resident (#33) wheeled himself up and said I am gay to resident #354. Per the documentation, resident #354 reported that he did not want to be bothered; and that, he wanted the other resident (#33) to leave him alone so he decided to [NAME] his towel at resident #33. The documentation also included that resident #354 reported that he did not want to hurt resident #33; and that, his intention was not to have the towel touch resident #33 and he just simply wanted resident #33 to go away. Regarding incident between resident #33 and #356 -Resident #33 was admitted on [DATE] with diagnoses of schizophrenia and unspecified intracranial injury with loss of consciousness of unspecified duration. The care plan dated November 26, 2019 included that the resident had an impaired cognitive function/impaired thought process related to injury -Resident #356 was admitted on [DATE] with diagnoses of schizophrenia and diffuse traumatic brain injury. The behavior dated May 16, 2023 included that the resident was new admit, pulled on g tube, kept turning feeding machine off and pulling g tube off. Per the documentation, the resident stayed awake most of the night, yelling, moaning, entered resident rooms and begin yelling/screaming at them and became aggressive when staff did not understand him. It also included that the resident required 1 on 1 care. The behavior note dated August 22, 2023 included the resident wandered around unit thru out the day, had physical and verbal aggression with redirection and voided and defecated on floor in room even with frequent checks. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing noted dated August 22, 2023 revealed the resident continued to wander throughout the unit for most of the shift, was redirected, was tolerating psych med changes with no adverse reactions noted. The behavior note dated August 23, 2023 included the resident wandered around the unit, yelling, cursing, verbally and physically aggressive to staff; and, agitated other residents due to his yelling. Per the documentation, the resident was monitored closely and safety maintained. A behavior note dated August 27, 2023 included that resident was coming out of his room, was walking around in the hallway and was redirected from crossing the red line. Per the documentation, the resident was easily redirected a couple of times and then he started yelling and was resistive; and that, the resident was reminded that it was nighttime and all the other residents were sleeping and he needed to stop yelling so that he does not wake up other residents. It also included that the resident said that staff were awake and the only people awake were meth addicts and cocaine users; and that, staff must be cocaine users. The documentation included that resident was informed that staff were working; the resident then started yelling out again, would not go back into his room, put up his fists and started swinging at the staff. Per the documentation, the resident was escorted back to his room. The 72-hour charting dated September 1, 2023 included that the resident continued to wander the halls in and out his room, tried to wander into peers' rooms and was verbally and physically aggressive at times; and that, staff were able to redirect the resident. A behavior note dated September 1, 2023 included that resident wandered around the unit, urinated by the door at the end of the hallway, was yelling, had verbal and physical aggression; and, when a staff was changing the resident's dressing on the GT (gastrostomy tube) site, the resident kept on showing his genitalia. The behavior notes dated September 2, 2023 that the resident had multiple episodes of behaviors this shift, including wandering the whole unit for 3 hours; displayed episodes of verbal and attempted physical aggression; shouted out profanities to himself, or during a delusion to someone who was not there; and, becomes irritated when re-direction from staff was attempted, puffed out his chest, and threatens harm. Per the documentation, staff were not able to calm resident, left alone watching from a distance while wandering the unit. The behavior note dated October 23, 2023 included that the resident wandered around the unit, with exit seeking behavior, hit the door, was frustrated that he cannot open it and was verbally aggressive to staff. The documentation included that the resident was difficult to redirect; and that, the resident was monitored closely. A behavior note dated November 25, 2023 included that when the resident returned to the dining area he became combative, attempted to get physical with staff and began yelling at other residents with his fist in the air. Per the documentation, the resident paced around unit exit seeking throughout the shift and staff redirected resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavior note dated November 26, 2023 included that the resident was in and out of the room pacing around the unit during shift, began yelling obscenities and was pacing in a circle around the tables in the dining area between shifts. Per the documentation, staff redirected the resident who then began yelling at staff calling them stupid bitches and need to burn in hell. A nurse practitioner note dated November 28, 2023 included chief complaint of schizoaffective disorder and major neurocognitive disorder related to TBI (traumatic brain injury) with behaviors which include psychosis and delusions. The documentation included that the resident was alert x1, had disorganized though process, had severe cognitive impairment and had an impaired insight and judgement; and that, the resident had no documented history of mental illness priori to TBI. Plan included medication changes, laboratory to be drawn and for nursing staff to continue PRN (as needed) psychotropic medications for increased behaviors. The behavior note dated December 2, 2023 revealed that the resident paced around unit prior to breakfast and became aggressive toward another resident. Per the documentation, the resident reported that other residents were laughing at him and he began lunging towards others. It also included that the resident paced throughout shift in and out of his room; and, continued to exit seek, ask to go as the world was ending. The behavior note dated December 4, 2023 revealed that the resident was verbally aggressive, wandered, exit seeker, yelled out and had an unstable mood. Per the documentation, staff tried to redirect the resident and it was effective for short periods. A behavior note dated December 10, 2023 included that resident remained calm most of the shift and only getting upset when other residents came too close to him. The behavior note dated December 11, 2023 revealed resident was easy to redirect and had verbal outbursts when redirected away from other resident's rooms and exit doors. A behavior note dated December 12, 2023 included that resident wandered around the unit with exit seeking behavior, with verbal aggression and was redirected as needed. The nursing note dated December 14, 2023 revealed that the CNA (staff #196) reported that resident was sitting in dayroom, became agitated and started yelling out; walked toward another resident (#33), punched him three times in the face. Per the documentation residents were separated and staff remained with him. Review of the facility follow up investigation report dated December 14, 2023 included that at 9:23 a.m. in the dayroom of the behavioral unit during juice and coffee time, a CNA (staff #196) saw resident #356 stood up, walked over to and hit resident #33 three times on the head. Per the documentation, the CNA quickly got between the two patients and called for help; and that, resident #33 was taken to his room while another staff member escorted resident #356 to the couch to sit down. The documentation also included that a staff member was assigned to stay with resident #356 until he was able to be sent out for additional psych evaluations; resident #33 was sent out for CT scan; and there were no injuries were noted. Further, the report included that the allegation was verified by evidence collected during the investigation; and that, a staff member witnessed the incident and intervened as quickly as possible. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON conducted on February 29, 2024 at 1:38 p.m. she stated that a thorough investigation for a facility reported abuse incident depended on the allegation or incident. The DON stated that for an allegation of a resident to resident altercation, investigation would include interview with the current staff present at the time of the altercation and other for witnesses. The DON also said that if she did not have an exact timeframe for the alleged incident, she will conduct interviews with majority of staff and residents that have the potential to be affected. She also said that if there were two residents having an altercation, the expectations were for staff to maintain the safety immediately following the incident and is dependent on the severity of the incident. The DON said that she would assign a 1:1 (one on one staff) after immediately separating the residents; would involve the psychiatric provider and a primary care physician to see how to manage the victim and perpetrator; would conduct post incident follow up that would involve psychosocial monitoring. Further, the DON stated that the IDT (interdisciplinary team) would meet to monitor and determine if the perpetrator had gotten to a safe place where they can decrease interventions. The facility policy on Abuse, Neglect, Exploitation and Misappropriation Prevention Program with last revision date of April 2021 stated that residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse and physical or chemical restraint not required to treat the resident's symptoms. It also included that all reports of resident abuse will be reported to local, state, and federal agencies and thoroughly investigated by facility management. The resident abuse, neglect and exploitation prevention program consists of a facility commitment and resource allocation to support the objective to protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, and/or any other individual. Findings of all investigations are documented and reported. At a minimum the individual conducting must review the documentation and evidence; review the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; observe the alleged victim, including his or her interactions with staff and other residents; interview the person(s) reporting the incident; interview any witnesses to the incident; interview the resident (as medically appropriate) or the resident's representative; interview the resident's attending physician as needed to determine the resident's condition; interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; interview the resident's roommate, family members, and visitors; interview other residents; review all events leading up to the alleged incident; and document the investigation completely and thoroughly.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47341 Based on clinical record review, staff interviews, facility documentation and policy and procedure review, the facility failed to ensure an allegation of sexual abuse was thoroughly investigated for one resident (#79). The deficient practice could result in further abuse of residents not prevented and appropriate corrective actions not taken. Findings include: -Resident #79 (alleged victim) was admitted to the facility on [DATE] with diagnoses of unspecified dementia without behavioral disturbance, history of TBI (traumatic brain injury) and epilepsy. -Resident #252 (alleged perpetrator) was admitted on [DATE] with diagnoses of dementia with behavioral disturbance and major depressive disorder. The discharge date was September 23, 2022. A physician progress note dated July 24, 2022 revealed the resident was alert and oriented x1, had impaired cognition and poor insight and judgment. The intake received from the facility on July 25, 2022 included that resident #252 wheeled himself to and placed his hand on the leg of resident #79. The facility 5-day report dated August 1, 2022 revealed that on July 25, 2022, resident #252 wheeled himself to resident #79 in the dining room and rested his hand on the leg of resident #79. Per the documentation, a CNA (certified nurse assistant) quickly intervened and separated the two residents. The report also included that the allegation was not substantiated. Further review of the facility report included a written summary of interviews conducted during facility investigation with a CNA who witnessed the incident between resident #79 and #252; and, with the Director of Nursing (DON) who received the report from the CNA. However, the report did not include interviews conducted with other residents and there was no corrective action taken to prevent further abuse after the incident was substantiated. In an interview with a CNA (staff #108) conducted on February 26, 2024 at 9:46 a.m., she stated that if two residents have an altercation, staff would separate them and let their nurse and the unit manager know about the incident. The CNA said that in order to keep the residents safe, staff will keep them separate, update the care plan, and place the aggressor on frequent checks. Regarding the incident between resident #79 and #252, the CNA stated that she did not work at the facility at the time that it occurred. The CNA stated that resident #79 does not have any behaviors, trauma indicators or triggers from the incident in July 2022. In an interview with the Director of Nursing (DON) on February 26, 2024 at 11:27 a.m., the facility does not have any incident reports on file for residents #252 and #79 due to the acquisition of the facility from a previous owner. (continued on next page)

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

In another interview with the DON conducted on February 29, 2024 at 1:38 p.m. she stated that a thorough investigation for a facility reported abuse incident depended on the allegation or incident. The DON stated that for an allegation of a resident to resident altercation, investigation would include interview with the current staff present at the time of the altercation and other for witnesses. The DON also said that if she did not have an exact timeframe for the alleged incident, she will conduct interviews with majority of staff and residents that have the potential to be affected. She also said that if there were two residents having an altercation, the expectations were for staff to maintain the safety immediately following the incident and is dependent on the severity of the incident. The DON said that she would assign a 1:1 (one on one staff) after immediately separating the residents; would involve the psychiatric provider and a primary care physician to see how to manage the victim and perpetrator; would conduct post incident follow up that would involve psychosocial monitoring. Further, the DON stated that the IDT (interdisciplinary team) would meet to monitor and determine if the perpetrator had gotten to a safe place where they can decrease interventions. Regarding the incident between resident #79 and #252, the DON was not able to speak to the specific incident due to not having documentation of the incident and not working at the facility when it originally occurred.

The facility policy on Abuse, Neglect, Exploitation and Misappropriation with last revision date of April 2021 stated all reports of resident abuse will be reported to local, state, and federal agencies and thoroughly investigated by facility management. The resident abuse, neglect and exploitation prevention program consists of a facility commitment and resource allocation to support the objective to identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property; and to investigate and to protect residents from any further harm during the investigation. Findings of all investigations are documented and reported. At a minimum the individual conducting the investigation:

-Review the documentation and evidence;

-Review the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident;

-Observe the alleged victim, including his or her interactions with staff and other residents; interview the person(s) reporting the incident;

-Interview any witnesses to the incident;

-Interview the resident (as medically appropriate) or the resident's representative;

-Interview the resident's attending physician as needed to determine the resident's condition;

-Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident;

-Interview the resident's roommate, family members, and visitors; interview other residents;

-Review all events leading up to the alleged incident; and,

-Document the investigation completely and thoroughly.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932 Based on clinical record reviews, staff interviews, and facility policy review, the facility failed to ensure a written notice of the transfer or discharge was provided to resident representative for one resident (#81); and failed to provide a copy of the notice of discharge/transfer to the hospital was provided to the ombudsman for one resident (#65). The deficient practice could result in residents protected from being inappropriately transferred or discharged and not having access to an advocate who can inform them of their rights. Findings include: -Resident #81 was admitted on [DATE] with diagnoses of Huntington's Disease, epilepsy and a history of falling. The care plan dated February 26, 2021 included that the resident had an alteration in neurological status related to Huntington's Disease. Intervention included to assess for effects of psychotropic medications, dystonia, akithesia (inability to remain still), akinesia (inability to perform a clinically perceivable movement), rigidity, tremors, etc.; and, if seizure activity occurs, place on side, maintain open airway and remove obstacles to ensure safe environment. The ADL (activities of daily living) care plan dated March 11, 2021 revealed the resident had an ADL Self Care Performance deficit related to advanced Huntington's disease and primarily required extensive assistance. Regarding transfer to Hospital on September 9, 2023 The eINTERACT summary dated September 9, 2023 revealed that the resident was febrile, tachycardic, weak and kept on sliding down the wheelchair. per the documentation, the primary care provider was notified and laboratory orders were received, An alert note dated September 9, 2023 included that resident was noted with a fever of 102, had jerky movement, both hands clenched, was responding with yes or no only and had uncontrolled movement increased from baseline. Per the documentation the physician was notified and an order was received to send the resident to the ER (emergency room). The documentation also included that the resident family/representative was notified. An alert note dated September 10, 2023 included that the resident family reported that the resident was admitted to the hospital with UTI (urinary tract infection), uncontrolled fever and seizures. The admission/readmission summary note dated September 14, 2023 included that the resident arrived via stretcher and was alert and oriented x3. Despite documentation of the resident's transfer to the hospital, there was no evidence that the resident family/representative was notified in writing of the resident's transfer to the ER. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regarding transfer to Hospital on February 2024 The eINTERACT summary note dated February 16, 2024 included that the resident had a change in condition; and that, the resident had an episode of wet cough from thin liquid while participating in activity. Per the documentation, the resident was coughing. A nursing note dated February 16, 2024 revealed the resident was continued to be monitored for coughing. The nurse practitioner (NP) note dated February 17, 2024 included that the resident was seen and examined to follow up on the cough. Per the documentation, there was no cough noted on exam, the lungs were clear to auscultation and no distress noted. The eINTERACT summary note dated February 20, 2024 revealed the resident was noted as being pale in color, diaphoretic, and not acting like herself). Per the documentation, the NP was notified and orders were received to send the resident to the ER. The SBAR (Situation-Background-Appearance-Review) communication form signed and dated February 20, 2024 included that the resident family/representative was notified. However, the documentation did not indicate whether the resident family/representative was notified in writing. The 72-hour charting dated February 21, 2024 included that the resident was admitted to the hospital for a diagnosis of tremor. The admission/readmission summary note dated February 27, 2024 revealed that at around 7:00 p.m., resident arrived via stretcher accompanied by one person. Per the documentation, the resident was alert and oriented x 2-3, was able to verbalize her needs with some difficulty with verbalization. However, review of the clinical record and facility documentation revealed no evidence that the resident family/representative was notified in writing of the resident's transfer to the hospital. An interview was conducted with the Director of Nursing (DON/staff #118) on March 1, 2024 at 10:19 AM. The DON provided a copy of the change of condition form which had documented that the notification was made to the resident family/representative regarding the resident's transfers. However, the documentation did not indicate how the notification was made; and, the DON stated that the notification of transfer made to the resident representative was made probably via phone. In another interview conducted with the DON (staff #118) on March 1, 2024 at 10:35 a.m., the DON stated that the timing of the notification of transfer/discharge made to the resident's family/representative was dependent on the situation. The DON stated that a staff would not stop life saving measures to do a notification as patient care was the priority. Further, the DON stated that notification was done either verbally if it was an emergency transfer to a hospital; however, if it was a notice of Medicare non-coverage (NOMNC) then it would be written. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on Change in a Resident's Condition or Status revised on May 2017, revealed that the facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status. A nurse will notify the resident's representative when a decision has been made to discharge the resident from the facility and/or it is necessary to transfer the resident to a hospital or treatment center. However, the policy did not include whether this notification to the resident representative was verbal or written. 50116 -Resident (#65) was admitted on [DATE] with diagnoses of rhabdomyolysis, ESRD (end-stage renal disease and chronic peripheral venous insufficiency. The eINTERACT summary dated December 24, 2023 included the resident had a change in condition: abnormal vital signs, altered mental status and shortness of breath. Review of the clinical record revealed the resident was transferred to the hospital on December 24, 2024 for diagnoses of influenza and pneumonia. Further review of the clinical record revealed that the resident was readmitted back to the facility on [DATE] into a private room for isolation due to Influenza A diagnosis. However, continued review of the clinical record revealed no evidence that the resident/ representative was notified in writing of the reason of the transfer. There was no documentation that the Ombudsman was notified of the resident's transfer/discharge. Review of the copies of notification of discharges and transfers for November through December 2023 and January 2024 revealed that the November and December transfers to the hospital were not sent to the Ombudsman. In an interview with Social Worker (#143) conducted on February 29, 2024 at 11:58 a.m., The social worker stated that the hospital transfers/discharges for November and December 2023 were not sent to the Ombudsman. In another interview conducted with the DON (staff #118) on March 1, 2024 at 10:35 a.m., the DON stated that the timing of the notification of transfer/discharge made to the resident's family/representative was dependent on the situation. The DON stated that a staff would not stop life saving measures to do a notification as patient care was the priority. Further, the DON stated that notification was done either verbally if it was an emergency transfer to a hospital; however, if it was a notice of Medicare non-coverage (NOMNC) then it would be written and was typically documented in the progress notes.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47669 Based on clinical record reviews, resident and staff interviews, review of policy and procedures, the facility failed to submit a Level II Pre-Admission Screening and Resident Review (PASARR) for one resident (#356). The deficient practice could result in specialized services not being identified and provided to residents. The findings included: Resident #356 was initially admitted to the facility on [DATE] and readmitted back to the facility on [DATE] with diagnoses that included schizophrenia (primary), unspecified, diffuse traumatic brain injury (TBI) with loss of consciousness of unspecified duration. A quarterly MDS (minimum data set) assessment dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) was not conducted because resident was rarely/never understood. The MDS noted that resident #356 was assessed as exhibited physical and verbal behavior symptoms directed towards others occurring daily, and other behavioral symptoms not directed toward others; behaviors of rejecting evaluations and care, and wandering daily. The MDS noted that resident had active diagnoses of TBI, anxiety disorder, depression, and schizophrenia. The MDS also revealed that resident was taking antipsychotic, antianxiety, and antidepressant medications during the last 7 days or since admission. Review of a behavior note dated December 9, 2023 revealed resident urinated on the floor in his room by the bed and the mattress on his bed was flipped over on the bed and resident was found on the other bed in his room, under the covers. Review of a behavioral note dated December 10, 2023 revealed resident became upset when other residents came too close to him. A behavior noted dated December 11, 2023 revealed resident had verbal outbursts and had had to be redirected aware from other residents' rooms and exit doors. A behavioral note dated December 12, 2023 revealed resident wandered around the unit with exit seeking behavior and had verbal aggression. A nurse's note dated December 14, 2023 revealed resident was sitting in dayroom when he became agitated and began yelling out; walked toward another resident and punched the other resident three times in the face. A Nurse Practitioner was notified and ordered to have resident evaluated at a hospital. Review of the facility Level I PASARR dated April 25, 2023 revealed that the resident was noted to have a mental disorder of schizophrenia and had a history of psychiatric treatment including received mental health services and in patient psychiatric hospitalization and has had significant life disruption because of mental illness including housing change because of mental illness. The Level 1 PASARR also included psychotropic medications including clonazepam, lithium and haldol; and have a diagnosis of intellectual disability. The no referral necessary for Level II box is checked for this evaluation. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders revealed an order for trileptal oral tablet 300 milligrams (mg) (Oxcarbazepine) give 1 tablet by mouth two times a day for mood stabilizer as evidenced by agitation; lithium carbonate oral tablet 300 MG (Lithium Carbonate) give 3 tablet by mouth in the morning for schizophrenia total 900 mg and give 2 tablet by mouth at bedtime for schizophrenia total 600 mg; trazodone hydrochloride oral tablet 100 mg (Trazodone HCl) give 1 tablet by mouth at bedtime for depression as evidenced by sleeplessness; olanzapine oral tablet 5 MG (Olanzapine) Give 1 tablet by mouth in the morning for TBI as evidenced by delusion oral tablet 10 mg (Olanzapine) Give 1 tablet by mouth at bedtime for TBI as evidenced by delusion; psychological evaluation and treatment as needed; psychiatric evaluation and treatment if indicated. Review of the physician orders revealed an order to send resident to the emergency room due to harm to self and others. A review of the resident care plan initiated on May 26, 2023 and revised on October 25, 2023 revealed resident had the potential to demonstrate physical behaviors, physical aggression related to schizophrenia, anger, and poor impulse control. The goal was not to harm self or others through the review date. Interventions included, to assess and anticipate resident's needs; cognitive assessment; provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated; evaluate for side effects of medications; monitor/document/report to physician of danger to self and others; and psychiatric/psychogeriatric to continue to follow as needed. An interview was conducted on February 27, 2024 at 2:45 P.M. with Social Services Director (SSD, staff #143) regarding the Preadmission Screening and Resident Review (PASARR). The SSD was asked what the process was for PASRR and newly admitted residents. The SSD stated that admissions will review the PASRR and if it is incomplete the PASRR is flagged, the SSD is notified and a new PASRR will be completed. The SSD stated she was familiar with resident #356. The SSD stated that had the resident still been in the facility he would have been submitted for a Level II PASRR. The SSD stated resident #356 was not appropriate for the facility. Review of facility policy, Admission Criteria PASSAR with a revision date of March 2019, revealed, Our facility admits only residents whose medical and nursing care needs can be met. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medical Pre-Admission Screening and Resident Review (PASSARR) process. The facility conducts a Level I PASSAR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for MD, ID or RD. b. If the Level I screen indicates that the individual may meet the criteria for a MD, ID or RD, he or she is referred to the state PASSARR representative for the Level II (evaluation and determination) screening process. (1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority.

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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** 47669 Based on clinical record reviews, interviews, and review of policy and procedures, the facility failed to develop and implement a comprehensive person-centered care plan for one resident (#28) related to left-hand contracture; and, non-pharmacological approaches related to use of psychotropic medications for one resident (#115). The deficient practice could result in residents not receiving necessary care and services and result in suboptimal care for residents, hindering their access to holistic treatment approaches and potentially exacerbating their conditions. Findings included: Resident #28 was initially admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, brain stem stroke syndrome; contracture of muscle, left hand; neurofibromatosis, type 1, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and anxiety disorder. Review of a MDS (minimum data set) assessment dated review of the resident's Brief Interview of Mental Status (BIMS) reveals that the resident had a BIMS of 13 indicating that the resident is cognitively intact. Review of the records revealed no comprehensive care plan or physician orders addressing resident #28's left hand contracture. A review of the resident physical therapy revealed resident was accessed on December 6, 2023. The resident was instructed on bed mobility, sit and manual assistance to control lower extremities and coordinate upper body to sit edge of bed. Resident instructed on sit-to-stand training with max assist x 2 and knee block for safety and control with wheelchair for sequencing. The therapy did not address left-hand contracture. An observation of resident #28 was conducted on February 25, 2024, at 3:05 P.M.; February 28, 2024 at 2:25 P.M. and on February 29, 2024 at 11:00 A.M. and resident #28 did not have any splint or towel on left hand contracture. An interview was conducted with a Licensed Practical Nurse (LPN #164) on February 29, 2024, at 11:05 A. M. the LPN stated that the resident came to the facility with a contracture of the left hand and that there were no orders to address this issue. An interview was conducted with Director of Rehabilitative Services (#167) on February 29, 2024 at 12:15 P. M. and staff #167 stated that the resident has not received an Occupational Therapy Evaluation to address the left-hand contracture. 48812 -Regarding resident #115: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #115 was admitted on [DATE], with diagnoses that included atherosclerotic heart disease, dementia, and bipolar disorder. A review of the physician's current orders revealed an order of Quetiapine Fumarate (antipsychotic) 100 milligrams (MG) by mouth two times per day for bipolar disorder, with a targeted behavior of physical aggression; haloperidol oral tablet (antipsychotic) 1 mg every four hours for bipolar disorder, with a targeted behavior of physical aggression; depakote oral tablet delayed release (antiepileptic) 250 mg, one tablet by mouth two times a day for schizoaffective disorder, with a targeted behavior of physical aggression. These orders were transcribed onto the Medication Administration Record (MAR) and were administered as ordered. The admission MDS assessment dated [DATE], revealed resident being administered an antipsychotic medication. A care plan dated March 10, 2023, identified that the resident used psychotropic medication, quetiapine fumarate, and haloperidol related to bipolar disorder. The goal was for the resident to remain free of drug-related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction, or cognitive/behavioral impairment. Interventions included monitoring the resident's condition based on clinical practice guidelines or clinical standards of practice related to using quetiapine fumarate and haloperidol. Additionally, the care plan stated that each antipsychotic medication should be administered as ordered, monitored/documented for side effects and effectiveness, and monitored/recorded the occurrence of target behavior symptoms. The care plan made no mention of attempting non-pharmacological interventions for the resident before giving the resident a psychotropic medication. Additionally, the MAR is void of any attempt to perform a non-pharmacological intervention before giving the resident the antipsychotic medication from November 01, 2023 through February 28, 2024. During an interview conducted on February 27, 2024, with the unit nurse manager (Staff #52), she stated that every time a medication is given, a non-pharmacological intervention is to be attempted, such as repositioning, providing a snack, etc.When asked if there had been any non-pharmacological interventions before giving the resident any medications, she stated that, per the resident's medical record, none were performed from November 2023 to February 2024. During an interview conducted on February 28, 2024, with the director of nursing (DON, Staff #118), she stated that she expected the staff to attempt some form of non-pharmacological intervention before giving a resident their psychotropic medication. She further stated that she did not expect the staff to mark its effectiveness, as the care plan stated, and that she expected the psychiatric provider to do that. Additionally, the physician ordered non-pharmacological interventions, but per the resident's medical record, they were not performed. (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 facility policy, Care Plans, Comprehensive Person-Centered, with a revision date of December 2016, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care planning process will include an assessment of the resident's strengths and needs; the comprehensive person-centered care plan will incorporate identified problems or concerns; aid in preventing or reducing decline in the resident's functional status and/or functional levels; and enhance the optimal functioning of the resident by focusing on rehabilitative programs.

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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** 47341 Based on clinical record review, interviews, and review of policy, the facility failed to ensure one residents (#96) participated in their care plan development; and failed to ensure care plan was revised timely for one resident (#111). The deficient practice could result in resident not receiving appropriate treatment to meet their needs. Findings include: -Resident #96 admitted to the facility on [DATE] with diagnoses that included hyperlipidemia, type 2 diabetes mellitus, and essential hypertension. Review of a quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 13, indicating cognitively intact. An interview was conducted with resident #96 on February 25, 2024 at 12:20 P.M. and resident stated that she had never been invited to a care plan meeting and was not aware of the services and care she was supposed to receive at the facility. Review of a care plan invitation for August 22, 2023 and November 21, 2023, revealed care conference invitation was addressed, To the family or POA of [resident #96]. There was no indication that this invitation was extended to the resident. Review of records revealed no documentation of the resident being informed of, declining or attending, nor participating in a care conference meeting. An interview was conducted on February 29, 2024 at 11:58 A.M. with the social services director (staff #143) and she stated that care conferences are completed at admission, then quarterly or upon request. Residents and family members are invited each time and the communication was to be documented in the electronic health record. Staff #143 stated the process had recently changed for how care plans were to be documented in the chart, but previously the MDS nurse would have a paper copy of care conferences. Review of documentation revealed care conferences regarding resident #96 were held on May 23, 2023, August 22, 2023, November 7, 2023 and February 6, 2024. The care conference did not indicate that resident #96 was invited or that she was in attendance. Review of facility policy titled, Care Conference revised on February 2021, revealed, The resident's right to participate in the development and implementation of his or her plan of care includes the right to be informed, in advance, of changes to the plan of care and have access to and review the care plan. The social services director or designee is responsible for notifying the resident and for maintaining records of such notices. Notices include the date, time and location of the conference, the name of each person contacted and the date he or she was contacted, the method of contact, input from the resident if they are not able to attend, refusal of participation, if applicable, and the date and signature of the individual making the contact. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47576 -Regarding resident #111 Resident #111 was admitted to a secured memory care unit of the facility on February 6, 2023 with a diagnosis of unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, and Parkinsons. Review of an MDS assessment dated [DATE] revealed a BIMS score of 9 indicating moderate cognitive impairment. During an observation of the secured memory care unit on February 26, 2024 at 8:48 A.M., it was noted that a battery powered keypad lock was on the door of resident #111's room. An interview was conducted with resident #111 on February 26, 2024 at 8:52 A.M. and the resident stated he requested for the lock to be placed on the door. When asked if he had missing items from his room, he stated no. A review of the quarterly care plan initiated on February 6, 2023 and revised on February 22, 2024 and progress notes from admission through Febraury 26, 2024 revealed no notes regarding a care plan conference with the resident or resident representative related to the door lock placed. The care plan did note that resident #111 was at risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual wellbeing related to diagnosis of dementia. There were no measurable objectives or timeframes regarding competency of the resident being able to utilize the lock. There were no risk factors associated with the newly identified need of the lock that could be reflected in the treatment goals, timetables and objectives in measurable outcomes. An interview was conducted on February 27, 2024 at 2:57 P.M. with Social Service Director (staff #143), and the staff stated that care plan meetings for long term care residents are done quarterly on Tuesdays and for skilled residents, 14 days after admission then monthly on Thursdays. Staff #143 stated that the MDS coordinator provided Social Services with a list of residents that are due for care plan meetings and then the resident representative are notified via mail. Staff #143 stated that for facility-initiated care plan meetings, the expectation was that a progress note will be entered. An interview was conducted on February 27, 2024 at 10:40 A.M. with a unit manager, licensed practical nurse (LPN, staff #52). Staff #52 stated, that her expectation was that a door lock would be on the resident's care plan and that her expectation was that there would be an order and an evaluation of the resident to have a lock on the door in a memory care unit. Staff #52 verified resident #111's records that there was no order for the lock; there were no progress notes related to the lock; a safety or competency assessment was not conducted; and, the lock was not noted on the resident's care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the policy titled, Care Plans, Comprehensive Person-Centered revised December 2016 revealed that the each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to participate in determining the type, amount, frequency and duration of care as well as receive the services and/or items included in the plan of care; and see the care plan and sign it after significant changes are made. Further review of the policy revealed that an explanation will be included in a resident's medical record and the person-centered care plan will include measurable objectives and timeframes.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on review of clinical records and policy, observations, and staff interviews, the facility failed to ensure that non-pharmacological approaches to pain management were offered and documented in the medical record for one resident (#46). The sample size was 29. The deficient practice could result in an increased prevalence of pain medication administration and a potential addiction for this residents. Findings included: Resident #46 was admitted on [DATE] with diagnoses that included chronic pain syndrome, anxiety disorder, recurrent depressive disorder, chronic migraine, internal derangements of left/ right knee and abnormalities of gait/ mobility. A review of the quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 15 indicating the resident was cognitively intact. The MDS further revealed that the resident was receiving regularly scheduled pain medications, as needed pain medications, and non-pharmacological interventions. A review of the MAR (medication administration record) for February 2024 revealed an order which stated that alternate measures must be tried before giving pain medication and that alternate measures must be tried before giving an as needed psychotropic medication. The MAR review further revealed non-pharmaceutical interventions were not provided for the entire month of February 2024. A review of the care plan for resident #46 noted that medications are to be administered as ordered; however, the 'as needed' order for pain medication stated that alternate measures must first be tried prior to giving pain medications. A review of the progress notes for resident #46 revealed no evidence that non-pharmaceutical or alternate interventions had been attempted prior to administering, as needed, pain medications. An interview was conducted on February 28, 2024 at 9:57 A.M. with staff #196 a certified nursing assistant (CNA, staff #196). The CNA stated that non-pharmaceutical interventions are implemented with all residents prior to giving as needed pain medications. She further stated that CNA's do not document this. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on February 28, 2024 at 10:00 A.M with a licensed practical nurse (LPN, staff #164). The LPN stated that all non-pharmaceutical interventions are documented in the MAR. She stated if non-pharmaceutical interventions are conducted by a CNA, the CNA would let the nurse know, who would then document the information in the MAR. She stated that it would always be documented in the MAR, regardless of who provided the intervention. The LPN reviewed the MAR for resident #46 and stated that she did not know what 'x' stood for but stated that she did not see any evidence of non-pharmaceutical interventions. She stated that the expectation is that non-pharmaceutical interventions were always documented and that the risk for not following orders, to first attempt non-pharmaceutical interventions, could include the resident receiving too much medication and becoming addicted. She further stated that resident #46 had a tendency to refuse non-pharmaceutical interventions and it would be important to show that the resident had refused these, but stated that this was not documented in the record. An interview was conducted on February 28, 2024 at 1:41 P.M. with a LPN (staff #229). The LPN stated that an 'x' in the MAR indicated that either a medication was not administered or a task was not done. An interview was conducted on February 29, 2024 at 7:45 A.M. with the director of nursing (DON, staff #118). The DON stated that the expectation was to conduct and document non-pharmaceutical interventions, as ordered by the physician. She stated that there was no risk unless the medication was administered outside of the ordered frequency. She further stated, that in this case, perhaps the risk might be failure to document. A review of the facility's policy titled, Administering Medications revised in 2019, noted that medications were to be administered in accordance with prescriber order.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932 Based on clinical review, staff interviews, and review of facility policies, the facility failed to ensure a discharge summary for one resident (#552) contained a recapitulation of the resident's stay. The deficient practice could result in an unsafe discharge for residents. Findings include: Resident #552 was admitted to the facility on [DATE] with diagnoses that included acute kidney failure, spinal stenosis, and acidosis. A discharge Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. Review of the clinical record indicates that resident #552 was discharged on [DATE]. Review of the social service progress notes indicates resident #552 requested a transfer to another facility on June 1, 2024. The clinical record revealed a transfer/discharge form was signed by resident #552 on June 4, 2022 at 18:00 (6:00 PM). The transfer/discharge form included a list of medications resident #552 was taking, their current diagnoses, insurance information, advance directive, allergies, primary physician contact information, most recent vitals, and dietary needs. A review of the clinical record found there was no discharge summary that includes the resident's physical and mental status, impairments, activities of daily living (ADL), special treatments/procedures, psychosocial status, discharge potential, dental status, activities and rehabilitation potential. An interview was conducted with the Social Services Director (staff #143) on February 27, 2024 at 2:00 PM. Staff #143 indicated that when a resident is discharged , the facility will send the clinical information and medication orders with a resident. They also indicated the discharge summary is a document that goes over everything the resident will need to know including the transportation company information, any durable medical equipment they will need, their medication information, dietary needs, diagnosis, and information on where they are going. Staff #143 indicated they are responsible for completing the social services portion of the discharge summary while floor nurses will do the nursing portion. When asked if resident #552's discharge summary was in their electronic health record (EHR), staff #143 indicated they could not find the discharge summary on file and was not sure why it was not there. On February 28, 2024 at 8:09 AM a copy of the June 3, 2022 care plan meeting for resident #552. Surveyor was notified, by staff #143, that the care conference meeting scheduled for June 3rd was not held due to resident #552 being discharged the next day. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the policy titled, Discharge Summary and Plan, revised on October 2022, indicates that a discharge summary will be developed when a resident's discharge is anticipated. The policy continues to indicate that the discharge summary includes, physical and mental functional status, information on ADLs any sensory and physical impairments, nutritional status, special treatments/procedures, mental and psychosocial status, discharge potential, dental condition, activities potential, and rehabilitation potential.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47341 Based on clinical record review, resident and staff interviews, facility documentation and policy, the facility failed to ensure that one resident (#253) had side rails installed for mobility independence as ordered by the physician. The deficient practice could result in a decrease in independence for the resident. Findings include: Resident #253 admitted to the facility on [DATE] with diagnoses that included fracture of left femur, osteoarthritis, and major depresive disorder. Resident was discharged on [DATE]. The Admission Minimum Data Set (MDS) Assessment completed on October 3, 2022 she scored a 15 on a Brief Interview for Mental Status (BIMS) which indicated she was cognitively intact; and that, she required extensive assistance from 2 staff for activities of daily living (ADL), bed mobility and transferring. A physician order dated September 27, 2022 for a two, non-restraining, quarter side rails for her bed as enabler to assist with bed mobility. A bedrail assessment completed on September 27, 2022 indicated the resident requested bed rails for bed mobility. The recommendation was for two 1/4 rails with a referral to therapy for other interventions to promote bed safety. A progress note timestamped 9/27/2022 8:29 pm documented the interdisciplinary team met and reviewed the bed safety assessment; and that, the bed was appropriate for height and weight with no risk of entrapment. A physician order dated September 28 and 29, 2022 respectively for an evaluation and treatment by Physical Therapy (PT) and Occupational Therapy (OT). The care plan initiated on September 29, 2022 included the resident was at risk of falls with a goal to not sustain serious injury through the review date . Interventions included side rails as ordered. The care plan goal initiated on 10/07/2022 reflected her ADL Self Care performance deficit related to her left femoral fracture, with interventions that included continuing with PT/OT to reach highest level of function through next review date. Physical therapy progress notes dated October 11, 2022 revealed that the resident and her family talked with therapy regarding her bedrails not being installed. In an interview on February 27, 2024 at 10:55 am with Physical Therapist, Staff #167, he stated that Physical Therapy is responsible for completing the assessment and order for bed rails. Maintenance will install the rails. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on the Maintenance Director, Staff #134, on February 27, 2024 at 10:02 am he stated that nursing is in charge of assessing and approving bed rails. Specifically the nurse will place a work order in their system which will go to maintenance and he will complete the work order on his end. Staff #134 started working on March 13, 2023, but is able to pull up the time period of September and October 2022 in the work order management system. He stated that there are 6 orders for bed/side rail installation in that time period and none attached to the bed in 416-1, which is the room that Resident #253 was in. He has no work orders for room [ROOM NUMBER] at all. In an interview on February 27, 2024 at 12:35 PM with the Director of Nursing (DON), Staff #118, she stated that the side rails installation process starts with the IDT doing an assessment for bed rails. If ordered, nursing will then tell maintenance who will install them. Nursing staff does not document when the work is completed. She stated the work order system did not show they were installed, but since there is an order for them, she cannot say definitively that the resident did not receive them. She stated she would need to look into the physical therapy documentation of family discussing with them on two occasions during her stay to have side rails installed. In a facility policy entitled Bed Safety and Bed Rails last revised August 2022, it states maintenance staff inspect all beds and related equipment such as bed rails . and the maintenance department provides a copy of inspections to the administrator and report results to the QAPI committee for appropriate action as needed. Another facility policy entitled Physician Orders, Accepting, Transcribing, and Implementing (Noting) last revised on April 2020, stated Licensed nursing personnel will ensure that written (noting), telephone, and verbal orders will be recorded and implemented.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on observations, staff interviews, and the facility policy and process, the facility failed to ensure one resident (#80) received the assistance needed for transfers; and failed to ensure one resident (#406) received the necessary services to maintain good grooming hygiene, to include nail care. The deficient practice could result in residents needs and services not being provided. Findings include: Resident #80 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included anoxic brain damage, hydrocephalus unspecified, anxiety and depression. The minimum data set (MDS) dated [DATE] revealed a brief interview for mental status (BIMS) score of 99 indicating that the resident was not able to complete the interview and was severely impaired. It also included that the resident is dependent on staff assistance when rolling from left to right and returning on lying on back on the bed and does not have a wheelchair. Review of the care plan dated February 23, 2021 revealed that resident #80 is at risk for falls related to a traumatic brain injury, cognition, debility/weakness, gait/balance problems, is a quadriplegic but has spastic movements, moving more in bed, dependence on staff for all transfers, history of placing feet on the wall and pushing self out of bed onto the floor mat, muscle spasms. Interventions included to assist the resident with all transfers using the Hoyer lift, ensure helmet is worn while out of bed, and to be out of bed for increased activities in the geriatric chair as tolerated. The acitivities care plan dated March 18, 2021 revealed that the resident is dependent on staff for activities and is unable to physically participate due to poor mobility. The resident requires one-to-one activities for cognitive stimulation, social interaction related to cognitive deficits, immobility, and physical limitations. Interventions included to keep the television on during the day as per the family's request and to propel the resident to and from group activities when he is out of bed. Review of the group activities task sheets revealed: -December 2023, the resident attended group activities one day out of thirty-one days. -January 2024, the resident attended group activities two days out of thirty-one days. On February 25, 2024 at 11:42 a.m., the resident was observed lying in bed with the TV on. On February 26, 2024 at 9:00 a.m., the resident was observed lying in bed with the TV on. On February 26, 2024 at 11:39 a.m., the resident was observed lying in bed with the TV on. On February 27, 2024 at 10:16 a.m., the resident was observed lying in bed with the TV on. On February 28, 2024 at 11:25 a.m., the resident observed lying in bed with the TV on. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on February 27, 2024 at 10:55 a.m. with the Director of Activities (staff #180), who stated that he completes an assessment for each resident to determine what type of activities are appropriate. Once the assessment is completed, he develops the activities care plan, which is reviewed annually by him to ensure it is still appropriate. He stated that activities are important for the intellect, social, and well-being of the resident. He stated that the facility does provide services for residents with multiple challenges and they usually implement one-to-one activities and want the resident to get up and listen to music. He stated that resident #80 is non-verbal, can't self-propel, and needs assistance to transfer out of bed and it is important for the resident to get up and participate in activities, such as listen to music and watch movies with the other residents every Wednesday. He stated that he would need to find documentation showing that the resident was attending group activities, such as music and the group movie on Wednesdays. During a second interview conducted on February 27, 2024 at 12:02 p.m. with the Director of Activities (staff #180), he reviewed the resident's activity attendance and stated that the resident had not attended the group movie on Wednesdays since January 3, 2024, and had not attended group activities from January 4, 2024 through January 31, 2024. During a third interview conducted on February 28, 2024 at 8:02 a.m. with the Director of Activities (staff #180), he reviewed the activity care plan for resident #80 and stated that the interventions included that the resident will attend group activities when the resident is up in his chair. Then he stated that the CNAs should be getting the resident up daily, so he can participate in group activities. He stated that the group movie, music, parties, prayer, and the petting zoo are all group activities that are appropriate for the resident. He stated that his staff have asked the CNAs to get the resident up and he has reported it to (LPN/staff #230), who stated that she would talk to the CNAs. An interview was conducted on February 29, 2024 at 9:35 a.m. with a certified nursing assistant (CNA/staff #121), who stated that she has provided care for resident #80. She stated that she didn't get the resident out of bed because an nurse told her he can't get out of bed because he doesn't have a wheelchair and that it was not safe to get him out of bed because he is not stable and wobbles. An interview was conducted on February 29, 2024 at 9:41 a.m. with a licensed practical nurse (LPN/staff #48), who stated that she was in charge of the section of rooms that included the resident's room. She stated that she has provided care for the resident before and he is not stable enough to get out of bed. (LPN/staff #230) joined the interview and stated that the resident has always had a chair and is able to get out of bed. She stated that he was up yesterday and residents who are able to get up, should get up daily. An interview was conducted on February 29, 2024 at 9:47 a.m. with the Director of Nursing (DON/staff #118), who stated that it is her expectation that the CNAs get the residents up to participate in things that they are able to do, including activities. She stated that resident #80 has access to a facility geratric chair and needs a one-to-one staff when he is in the chair, but the chair is being used by multiple residents and they need to share. She stated that she has spoken to the Activities Director and asked if the resident could be gotten up to attend more often. 47911 -Regarding resident #406: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #406 was admitted on [DATE] with diagnosis including unspecified epilepsy, encephalopathy, pain, restlessness and agitation, and schizoaffective disorder. A review of the quarterly MDS (minimum data set) revealed that the resident's BIMS (brief interview of mental status) score was noted to be a 99, suggesting that the resident's cognition interview was not successful. The MDS further revealed both upper and lower extremity impairment and that the resident requires extensive assistance with activities of daily living. A review of the physician orders revealed that weekly skin assessments were ordered and followed. The records revealed no evidence of skin related injuries pertaining to the residents hands. A review of the progress notes revealed one documented instance of nail care, which transpired on February 27, 2024. An observation on February 25, 2024 at 12:19 P.M. revealed the resident seated in a geri-chair located in the day room. The resident was observed to have a severe right-handed contracture; however, no splint, washcloth or other device was observed to aide the resident with the contracture. The resident's nails on the right and left hand were observed to be long and jagged. An observation on February 25, 2024 at 3:08 P.M. revealed the resident in the day room. The resident's fingernails were observed to be long and jagged. A further observation on February 26, 2024 at 8:54 A.M revealed the resident's fingernails to be long and jagged nails still present; however there was no evidence observed that the nails were causing immediate skin damage. A subsequent observation on February 27, 2024 at 9:38 A.M. revealed that staff #196, CNA (certified nursing assistant), was cleaning and moisturizing the resident's face and hands; however, the nails on the contracted hand were still observed to be long and jagged in appearance. An interview conducted on February 27, 2024 at 10:12 A.M was conducted with staff #196, CNA. When asked about the condition of the resident's nails, she looked at the nails and said that the nails should not be that long or jagged. She stated that the risk to the resident could include injury to his palm, as his right hand is contracted. She stated that staff attempt to place a wash cloth in the resident's palm to assist with the contracture; however, the resident is generally resistive to having anything placed in his palm. The CNA proceeded to move the resident to his room and trimmed the resident's nails. An interview was conducted on February 27, 2024 at 10:25 A.M. with staff #56, LPN (licensed practical nurse). The LPN stated that nail care is done on Sundays, separately from shower days, but may also be done as needed for residents. The LPN stated that the CNA's will file the nails unless the resident is diabetic, in which case the nurse would perform the nail care. The LPN stated that that nails would be filed but on occasion clippers would be used to remove the sharp edges. She stated that if she conducted the nail care she would document it in the resident's electronic health record. She stated that the expectation would be the same with a resident who had contractures. She stated that the risk for jagged or long nails on a resident with contractures could include the nails growing into the skin, pain and possibly infection. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on February 29. 2024 at 7:44 A.M with staff #118, DON (Director of Nursing). The DON stated that nail care is typically done on Sundays; however, when the DON reviewed the resident's record, she stated that there was no evidence of nail care being done or having been refused by the resident. She stated that she would make sure that it would be scheduled and documented for this resident. She stated that the risk could include the resident scratching or injuring himself. A review of the Activities of Daily Living (ADLs), Supporting policy revised 2018, revealed that the appropriate care and services will be provided for residents who are unable to carry out ADL's independently, to include hygiene care such as bathing, dressing, grooming and oral care. The policy further stated that a resident's ability to perform ADLs will be measured using clinical tools, to include the MDS; however this residents MDS revealed impairment of both upper and lower extremities and that the resident requires extensive assistance.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on observations, staff interviews, and the facility policy and process, the facility failed to ensure that three residents (#80, #58, and #108) were provided with an ongoing program of activities that met the needs of the residents. The deficient practice could impact the residents' mental and social well-being. Findings include: Resident #80 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included anoxic brain damage, hydrocephalus unspecified, anxiety and depression. The minimum data set (MDS) dated [DATE] revealed a brief interview for mental status (BIMS) score of 99 indicating that the resident was not able to complete the interview and was severely impaired. It also included that the resident is dependent on staff assistance when rolling from left to right and returning on lying on back on the bed and does not have a wheelchair. Review of the care plan dated February 23, 2021 revealed that resident #80 is at risk for falls related to a traumatic brain injury, cognition, debility/weakness, gait/balance problems, is a quadriplegic but has spastic movements, moving more in bed, dependence on staff for all transfers, history of placing feet on the wall and pushing self out of bed onto the floor mat, muscle spasms. Interventions included to assist the resident with all transfers using the Hoyer lift, ensure helmet is worn while out of bed, and to be out of bed for increased activities in the geriatric chair as tolerated. The activities care plan dated March 18, 2021 revealed that the resident is dependent on staff for activities and is unable to physically participate due to poor mobility. The resident requires one-to-one activities for cognitive stimulation, social interaction related to cognitive deficits, immobility, and physical limitations. Interventions included to keep the television on during the day as per the family's request and to propel the resident to and from group activities when he is out of bed. Review of the group activities task sheets revealed: -December 2023, the resident attended group activities one day out of thirty-one days. -January 2024, the resident attended group activities two days out of thirty-one days. On February 25, 2024 at 11:42 a.m., the resident was observed lying in bed with the TV on. On February 26, 2024 at 9:00 a.m., the resident was observed lying in bed with the TV on. On February 26, 2024 at 11:39 a.m., the resident was observed lying in bed with the TV on. On February 27, 2024 at 10:16 a.m., the resident was observed lying in bed with the TV on. On February 28, 2024 at 11:25 a.m., the resident observed lying in bed with the TV on. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on February 27, 2024 at 10:55 a.m. with the Director of Activities (staff #180), who stated that he completes an assessment for each resident to determine what type of activities are appropriate. Once the assessment is completed, he develops the activities care plan, which is reviewed annually by him to ensure it is still appropriate. He stated that activities are important for the intellect, social, and well-being of the resident. He stated that the facility does provide services for residents with multiple challenges and they usually implement one-to-one activities and want the resident to get up and listen to music. He stated that resident #80 is non-verbal, can't self-propel, and needs assistance to transfer out of bed and it is important for the resident to get up and participate in activities, such as listen to music and watch movies with the other residents every Wednesday. He stated that he would need to find documentation showing that the resident was attending group activities, such as music and the group movie on Wednesdays. During a second interview conducted on February 27, 2024 at 12:02 p.m. with the Director of Activities (staff #180), he reviewed the resident's activity attendance and stated that the resident had not attended the group movie on Wednesday since January 3, 2024, and had not attended group activities from January 4, 2024 through January 31, 2024. During a third interview conducted on February 28, 2024 at 8:02 a.m. with the Director of Activities (staff #180), he reviewed the activity care plan for resident #80 and stated that the interventions included that the resident will attend group activities when the resident is up in his chair. Then he stated that the CNAs should be getting the resident up daily, so he can participate in group activities. He stated that the group movie, music, parties, prayer, and the petting zoo are all group activities that are appropriate for the resident. He stated that his staff have asked the CNAs to get the resident up and he has reported it to (LPN/staff #230), who stated that she would talk to the CNAs. An interview was conducted on February 29, 2024 at 9:35 a.m. with a certified nursing assistant (CNA/staff #121), who stated that she has provided care for resident #80. She stated that she didn't get the resident out of bed because a nurse told her he can't get out of bed because he doesn't have a wheelchair and that it was not safe to get him out of bed because he is not stable and wobbles. An interview was conducted on February 29, 2024 at 9:41 a.m. with a licensed practical nurse (LPN/staff #48), who stated that she was in charge of the section of rooms that included the resident's room. She stated that she has provided care for the resident before and he is not stable enough to get out of bed. (LPN/staff #230) joined the interview and stated that the resident has always had a chair and is able to get out of bed. She stated that he was up yesterday and residents who are able to get up, should get up daily. An interview was conducted on February 29, 2024 at 9:47 a.m. with the Director of Nursing (DON/staff #118), who stated that it is her expectation that the CNAs get the residents up to participate in things that they are able to do, including activities. She stated that resident #80 has access to a facility geriatric chair and needs a one-to-one staff when he is in the chair, but the chair is being used by multiple residents and they need to share. She stated that she has spoken to the Activities Director and asked if the resident could be gotten up to attend more often. 47669 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #58 was admitted on [DATE] with diagnoses of acute respiratory failure with hypoxia, dependence on respirator (ventilator), morbid (severe) obesity, tracheostomy status, and legal blindness. The clinical record review revealed a Brief Interview of Mental Status (BIMS) score of 14 indicating the resident had intact cognition. The fall care plan dated July 12, 2023 included that the resident was at risk for all with or without injury due to generalized weakness and visual impairment. The ADL (activities of daily living) care plan dated July 24, 2023 included that resident had an ADL self-care performance deficit related to visual impairment. Intervention included to encourage resident to participate to the fullest extent possible with each interaction. The care plan dated July 25, 2023 included the resident was able to initiate her own leisure activities of her interest and socialize daily. Interventions included to encourage resident to participate in group activities of her choice, provide a copy of monthly calendar, notify resident of changes and to provide material for leisure activities of her interest. Review of the activities documentation from January 31 through February 26, 2024 revealed that resident #58 had refused activities multiple times and was not available for the activities 4x during this period. Despite documentation that resident was legally blind, continued review of the activities' documentation, revealed that the resident attended the following activities on these dates: -Arts and crafts on [DATE] and 20; -Bible study on January 31; -Bingo on February 2, 10 and 12; -Beading jewelry on February 9; and, -Bowling on February 3 and 5. During an interview with resident #58 was conducted on February 26, 2024 at 12:31 p.m., the resident stated that she has not engaged with and attended activities. An interview with the activities director (staff #180) was conducted on February 28, 2024 at 2:18 p.m. The activities director stated that he did not think that activities were actually being completed and provided to residents. The activities director further stated that his staff might just be documenting and marking that activities were provided. During an interview with activities assistant (staff #124) conducted on February 28 at 2:50 p.m., the activities assistant stated that activities staff were documenting in the clinical record that resident attended group activities even when the residents actually did not attend the activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In another interview with resident #58 conducted on February 29, 2024 at 1:15 p.m., the resident stated she does not get involved in the facility's activities because the resident stated she was blind and cannot walk. The resident stated that she did not know her interest anymore as she was blind and cannot walk; and that, everything she enjoyed was tied to her eyes. Further, the resident stated that the staff do not get her up. Another interview with the Activities Director (staff #180) was conducted on February 29, 2024 at 3:50 p.m.; and, a review of the activities documentation for resident #58 was conducted with the activities director during the interview. The activities director stated resident #58 had been involved in activities such as arts and crafts, card games, bowling, bingo, bible study, exercise, table games, etc.; and that, the documentation of activities attended by the resident is completed daily. When asked how could resident #58 who was blind could be involved in some of these activities, the activities director stated that maybe someone was helping the resident. 48087 -Resident #108 was admitted to the facility on [DATE] with diagnoses of chronic respiratory failure with hypoxia, urinary tract infection, quadriplegia, post-traumatic stress disorder, anxiety disorder, and depression. The admission minimum data set (MDS) dated [DATE] revealed a brief interview for mental status (BIMS) score of 12, which indicated the resident is mildly impaired. The MDS assessment also included that the resident is feeling down, depressed, or hopeless. Additionally, the MDS assessment revealed that resident #108 states it ' s very important for the resident to go outside to get fresh air when the weather is good, participate in religious services or practice, and listen to music the resident likes. Review of resident #108 care plan dated 12/14/2023 did not show that the resident activities were care planned. Review of the psychosocial well-being care plan dated 2/9/2024 states resident #108 is at risk for psychosocial well-being concerns related to inability to verbally express concerns and or emotions, bed bound related to (r/t) vent/trach status/enteral tube, post traumatic stress disorder (PTSD), anxiety, depression, and CVA. Review of the communication care plan dated 2/10/2024 states resident #108 has impaired communication related to aphasia, difficulty making self-understand, difficulty understanding others, neurological disorder, impaired cognition, shakes head yes and no to the same questions, does not answer questions appropriately or consistently. Review of the group activities task sheets revealed: -January 2024, the resident attended group activities two days out of thirty-one days. -February 2024, the resident attended group activities thirteen days out of thirty-one days. Multiple observation conducted and resident #108 was seen lying in bed in the resident room with the TV on with the vent/trach for the following dates and time: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On February 25, 2024 at 12:42 p.m. -On February 26, 2024 at 10:22 a.m. -On February 27, 2024 at 9:40 a.m. and 3:42 p.m. -On February 28, 2024 at 11:52 a.m. An interview was conducted on 2/27/2024 at 10:55 a.m. with the Director of Activities (staff #180), who stated that he completes an assessment for each resident to determine what type of activities are appropriate. Once the assessment is completed, he develops the activities care plan, which is reviewed annually by him to ensure it is still appropriate. He stated that activities are important for the intellect, social, and well-being of the resident. He stated that the facility does provide services for residents with multiple challenges and they usually implement one-to-one activities and want the resident to get up and listen to music. He stated that resident #80 is non-verbal, can't self-propel, and needs assistance to transfer out of bed and it is important for the resident to get up and participate in activities, such as listening to music and watching movies with the other residents every Wednesday. He stated that he would need to find documentation showing that the resident was attending group activities, such as music and the group movie on Wednesdays. A second interview was conducted on 02/28/2024 at 2:19 p.m. with staff #180, to verify the group activities task sheet for resident #108 where it was marked that resident #108 attended group activities for: bowling, watching movies, bingo, chair zumba, Dear [NAME], jeopardy, and card games. Staff #180 states I'm not sure, my staff might just be marking completion that the activities are being provided. When asked are the activities are actually being completed and provided to the resident, staff #108 stated I don ' t think so. An interview completed with Activities Assistant (staff #124) on 02/28/2024 at 2:50 p.m., who stated that every morning she passes out the daily chronicles news to the residents and would tell the residents about the activities of the day. She will invite them and will inform the CNA to have the patient ready when the activity does happen. Staff #124 states Dear [NAME] is a group activity where residents would come to the common area outside of the activity office and the staff would read the Dear [NAME] newspaper or story to the resident daily. Staff #124 states this happens every morning as a group activity. During the interview, staff #124 states she is familiar with the resident and stated this resident does not come to group activities. When asked why the resident does not come to group activities, staff #124 states that the resident is bed bound, non-verbal and dependent on his vent/trach which makes it very hard for him to leave his room. Staff #124 states we do activities one on one with other residents but stated I have personally never seen him in group activities or provided one on one services for him. When asked why group activities like games, chair Zumba, bowling, jeopardy, bingo, arts and crafts, card games, cooking class, Dear [NAME], exercise, hang-man, horse racing, and movie & popcorn are documented that the resident attends these group activities? Staff #124 states I don't know why his chart says he comes to the activities. The resident has never attended group activities. Additionally, staff #124 stated Yes, I would agree that my colleagues and I are documenting that he attends group activities when the residents actually don't. The resident would be able to comprehend games like jeopardy as he is non-verbal. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview conducted with Licensed Practical Nurse (staff #229) on 02/28/2024 at 3:02 p.m., who stated that she has never seen any one on one activities being provided to this resident and the resident has never left his room for activities as he is dependent on the vent/trach. An interview was conducted on February 29, 2024 at 9:47 a.m. with the Director of Nursing (DON/staff #118), who stated that it is her expectation that the CNAs get the residents up to participate in things that they are able to do, including activities. She stated that resident #80 has access to a facility geriatric chair and needs a one-to-one staff when he is in the chair, but the chair is being used by multiple residents and they need to share. She stated that she has spoken to the Activities Director and asked if the resident could be gotten up to attend more often. A review of the Activities of Daily Living (ADLs), Supporting policy revised 2018, revealed that the appropriate care and services will be provided for residents who are unable to carry out ADL's independently, to include hygiene care such as bathing, dressing, grooming and oral care. The policy further stated that a resident's ability to perform ADLs will be measured using clinical tools, to include the Minimum Data Set (MDS).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47669 Based on clinical record reviews, resident and staff interviews, facility documentation, policy, and procedures, the facility failed to ensure care and services related to left hand contracture was provided for one resident (#28). The deficient practice could result in resident's decline in range in motion and mobility. Findings include: Resident #28 was admitted on [DATE] with diagnoses of contracture of muscle, left hand and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. A review of the clinical record revealed a Brief Interview of Mental Status (BIMS) score of 13 indicating the resident was cognitively intact. Review of the care plan dated July 22, 2021 included that the resident had an ADL (activities of daily living) self-care performance deficit related to hemiplegia with left arm and leg contractures. Interventions included extensive staff participation to reposition and turn in bed, skin inspection, totally dependent on staff to provide bath twice weekly, total asssistance with personal hygiene, and dressing, and required mechanical aid-hoyer lift for transfers to geri-chair. The care plan did not include intervention/s to address the resident's left arm and leg contractures. The diagnosis sheet dated April 9, 2023 revealed resident had contracture of the muscle, left hand. The care plan dated October 26, 2023 revealed the resident had complaints of chronic multiple joint pain and required daily pain management. The care plan with revision date of December 6, 2023 included the resident was at risk for falls related to cognition, debility/weakness, gait/balance problems and CVA (cardiovascular accident). Interventions included bed bolsters for proper body alignment and positioning and anticipate and meet resident needs. A review of the physical therapy (PT) discharge saummary revealed the resident was evaluated by PT on December 06, 2023, and was discharged from PT on December 10, 2023. Interventions provided were therapeutic activities and exercises, gross motor training, bed transfer training ad education for safe mobility. Further review of the clinical record revaled no evidence that the resident's left hand contracture was assessed and interventions were put in place to prevent furtther decline of the resident's left hand contracture. During observations of resident #28 conducted on February 25, 2024, at 3:05 p.m., February 28, 2024 at 2:25 p.m. and February 29, 2024 at 11:00 a.m., there was no splint or towel on the resident's left hand contracture. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with a Licensed Nurse Practitioner (LPN/staff #164) on February 29, 2024, at 11:05 a.m. The LPN stated that resident #28 came to the facility with a contracture of the left hand and that there were no orders to address this issue. In an interview with Director of Rehabilitative Services (staff #167) conducted on February 29, 2024, at 12:15 p.m., staff #167 stated that resident #28 has not received an occupational therapy (OT) evaluation to address the left-hand contracture. A review of facility policy, Resident Mobility and Range of Motion, with a revision date of July 2017 OBRA Regulatory Reference number 483.25(c) Version 1.0 (H5MAPP1451) provided the following information: Policy Statement- 1. Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. Policy Interpretation and Implementation: 1. As part of the resident's comprehensive assessment the nurse will identify the resident's: a. Current range of motion of his or her joints; c. Limitations in movement or mobility; d. opportunities for improvement. 2. As part of the comprehensive assessment, the nurse will also identify conditions that place the resident at risk or complications related to ROM and mobility, including: a. pain; c. muscle wasting and atrophy; e. contractures. 5. The care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and or improve mobility and range of motion.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47341 Based on clinical record review, resident and staff interviews, facility documentation and policy review, the facility failed to ensure that medications were not left unattended at the bedside for one resident (#96). The deficient practice could result in the resident sustaining accidental medication related injuries. Findings include: Resident #96 was admitted to the facility on [DATE]. According to a Quarterly Minimum Data Set (MDS) Assessment completed on January 30, 2024, she scored a 13 on a Brief Interview for Mental Status (BIMS) which indicated she was cognitively intact. A physician order dated May 5, 2023 included for moisture barrier to be applied to the buttock/sacrum area every shift and as needed for episodes of incontinence. A review of the physician orders and assessments revealed no evidence of an order nor assessment of competency for the self-administration of any medications. During an observation conducted on February 25, 2024 at 12:26 PM, a 4 ounce tube of Chamosyn with Manuka Honey, a medicated moisture barrier and skin protectant referred to as MedHoney, was observed on Resident #96's bedside table. The resident stated that it is for her buttocks. During an interview conducted on February 25, 2024 at 2:32 PM, with a Certified Nursing Assistant, Staff #108. She looked at the Chamosyn with Manuka Honey and stated that it was not the brand that the facility uses. She did not know where it came from, but stated that all treatment creams should be put away and staff keep the creams/ointments in the side drawer by the resident's bed. She stated that there is a risk of a resident eating the product if confused and this is why it is supposed to be in the drawer. A follow up observation was conducted on February 28, 2024 at 3:00 PM which revealed that the MedHoney was still in her room. During an interview conducted with a Licensed Practical Nurse, (Staff #233), on February 28, 2024 at 3:06 PM, she stated MedHoney belongs on the wound cart. She stated if a resident had MedHoney in her room, then staff would need to take it from the resident and put it on the medication or wound cart. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing, (Staff #118), on February 29, 2024 at 1:38 PM she stated that her expectation is that there should not be medications at residents bedside because it is more difficult to manage what medications a resident is receiving. She stated that she will do weekly Angel Rounds to look in resident rooms to see if they have any unauthorized medications or ointments in the drawer or at bedside. She further stated that MedHoney is considered a medicated barrier ointment which is not permitted. She reviewed the residents electronic health record and concluded that Resident #96 had not had an assessment for self-administration of medications completed. In a facility policy entitled Administering Medications last revised April 2019, it states that residents may self-administer their own medication only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined they have the decision-making capacity to do so safely. Additionally there is a facility policy entitled Self-Administration of Medications last revised February 2021, which states that if it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on observations, clinical record reviews, staff and resident interviews and review of policies and procedures, the facility failed to ensure physician orders, for hydration, were followed for resident #83. The deficient practice could result in fluid overload, electrolyte imbalance and a detrimental impact on kidney function. Findings include: Resident #83 was admitted on [DATE] with diagnosis including end stage renal disease, acute kidney failure, hypocalcemia, hypo-osmolarity, hyponatremia, encephalopathy and schizophreniform disorder. A review of the quarterly MDS (minimum data set) dated December 26, 2023 revealed that the resident has a BIMS (brief interview of mental status) score of 13, indicating that the resident's cognition was intact. The MDS further revealed that the resident is on dialysis. A review of the physician orders revealed that resident #83 was on fluid restrictions. The order noted a maximum of 1200 ml per day. A review of the resident's care plan with an initiation date of March 29, 2021, revealed that the resident requires hemodialysis due to end stage renal disease and that fluid intake and output are to be monitored. The care plan further notes that supplements and nourishments are to be followed as ordered. A review of the CNA's (certified nursing assistant) task documentation in the electronic health record revealed that the fluid intake, for resident #83, exceeded the fluid intake specified in the physician's order. On February 16, 2024, the resident's total fluid intake was noted as 1490 ml for the day. On February 17, 2024 the total fluid intake was 1510 ml. On February 20, 2024 the total fluid intake was noted as 1380 ml. On February 21, 2024, the total fluid intake was 1480 ml. On February 22, 2024 the total fluid intake was noted to be 1480 ml and on February 23, 2024 the total fluid intake was 1640 ml. In all, the electronic health record, revealed 6 days out of compliance with the physician prescribed fluid restriction. On February 27, 2024 at 9:44 AM a full water pitcher was observed on the resident's bedside table. On February 28, 2024 at 1:05 PM a water pitcher observed to be approximately half-full was observed on the resident's bedside table. An interview was conducted on February 28, 2024 at 1:13 PM with a Licensed Practical Nurse (staff #164). Staff #164 stated that it is important for fluid restrictions to be implemented as ordered for a dialysis patient. She stated that if fluid restrictions are not followed and monitored the resident could go into fluid overload or become dehydrated. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on February 29, 2024 at 10:45 AM with a CNA (staff #196). Staff #196 stated that information on fluid restriction for a resident is either noted in the care plan or on Kardex. She stated that if she could not find the information in the electronic health record she would ask the nurse. Staff #196 further stated that it was important to follow the fluid restrictions as ordered, because the risk to the resident could include swelling and more fluid build-up in the body. A subsequent interview was conducted on February 29, 2024 at 10:50 AM with staff #164, LPN. Staff #164 reviewed the orders for resident #83 and confirmed that the resident was on a maximum fluid intake restriction of 1200 ml per day. She reviewed the CNA's task section and confirmed that there were days outside of the ordered parameters for fluid intake and that these had exceeded the 1200 ml per day maximum. She stated that the expectation is that doctor's orders are followed for fluid restrictions, but stated that they had not been for this resident. She stated that the risk could be fluid overload and that dialysis may need to pull more fluids from the resident when that happens. She further stated that this could impact his kidneys. Staff #164 stated that in the past fluid restrictions for specific residents were posted on the wall, but after the facility painted the walls, these were removed and not put back up. An interview was conducted on February 29, 2024 at 1:02 PM with the Director of Nursing (staff #118). Staff #118 reviewed the electronic health record and confirmed the order of 1200 ml per day for resident # 83 and stated that per the CNA hydration task sheet, the entries were outside of the physician ordered parameters. She stated that the expectation is that fluid restrictions are followed as noted in the doctor's orders. Staff #118 stated that the risk could be volume overload. A review of the facility policy entitled Resident Hydration, with a revised date of October 2017, revealed that a physician order to limit fluids will take priority over calculated fluid needs and that nursing will monitor and document fluid intake.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40581 Based on observation, resident and staff interviews, and the facility policy and process, the facility failed to ensure staff was available to provide assistance with activities of daily living (ADLs) for one resident (#126). The deficient practice could result in resident care/needs not being met. Findings include: Resident #126 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included acquired absence of the left leg below the knee, polyneuropathy, and hypertension. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 12 indicating the resident had a moderate cognitive impairment. The ADL care plan dated August 13, 2023 states that the resident has an ADL self care performance deficit related to left knee prosthetic joint infection secondary to Methicillin-resistant Staphylococcus Aureus (MRSA); chronic left knee wound status post multiple total knee arthroplasty (TKA) revisions; syndrome of inappropriate antidiuretic hormone (SIADH); chronic pressure wounds, sacrum and left gluteal; pneumonia; urinary tract infection; severe protein calorie malnutrition; history of chronic obstructive pulmonary disease (COPD) and Clostridium difficile (C-Diff); chronic post traumatic disorder; neoplasm of the kidney; benign prostatic hyperplasia; emphysema; degeneration of the lumbosacral intervertebral disc; carcinoma of the parotid gland; neuropathy and weakness. Interventions included to encourage the resident to participate to the fullest extent possible with each interaction and encourage to use bell to call for assistance. On February 26, 2024 at 9:25 AM, the call-light for room [ROOM NUMBER] was observed to be on. During this time an interview was conducted with resident #126, who stated that staff don't like to come into his room because he is sick. He also stated that when the Certified Nursing Assistant (CNA/staff #173) brought his breakfast this morning, he told her that he needed assistance with getting dressed and brushing his teeth before the notary arrived at 10:00 AM. The resident's breakfast tray was observed sitting on his table. He stated that he had an appointment with the notary because he needed to sign some paperwork. Then, he pointed to his electric toothbrush that was plugged into the wall and sitting on the floor by the opposite wall from where his bed was located and stated that he was not able to get out of bed and get it himself. At 9:45 AM, the notary arrived and went to talk to the nurse about the PPE requirements. At 9:58 AM (CNA/staff #173) came to the room and then left to locate goggles before entering the room. At 10:09 AM, (CNA/staff #173) came back to the room to assist the resident with dressing and hygiene. (CNA/staff #173) stated that residents usually get dressed after breakfast and she was not able to come sooner because she was assisting other residents. The resident waited forty-four minutes for assistance and did not have his teeth brushed or was dressed when the notary arrived. The notary was observed entering the resident's room while the CNA was still in his room assisting with ADLs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on February 29, 2024 at 10:22 AM with the Director of Nursing (DON/staff #300), who stated that she would like for call-lights response time to be 15 minutes. She stated that it if a resident needs to get up and get dressed by a certain time to meet a visitor and has a meeting, the CNA should ask staff for help, so the resident receives the assistance needed to ready on time. The facility's policy, Activities of Daily Living (ADLs), Supporting revised March 2018 states that appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 40581 Based on observation, staff interview, and the facility policy and process, the facility failed to ensure that the daily staff posting was posted daily. Findings include: On February 25, 2024 at 9:55 a.m., the daily staff posting was observed on the table directly across from the reception counter. Further observation revealed that the posting was dated February 22, 2024. An interview was conducted on February 29, 2024 at 10:22 a.m. with the Director of Nursing (DON/staff #118), who stated that the daily staff posting was supposed to be posted daily, but she does not know who was responsible for posting it on the weekends. She stated that the posting should include : the number of nursing staff, number of hours worked by staff, the census, and the date. The facility's policy, Staffing Sufficient and Competent Staffing revised August 2022 states that direct care daily staffing numbers (the number of nursing personnel responsible for providing direct care to residents) are posted in the facility for every shift.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47576 Based on a clinical record review, staff interviews, and policy, the facility failed to ensure that non-pharmacological approaches to care were implemented for two residents (#61 and #151). This deficient practice could result in suboptimal care for residents, hindering their access to holistic treatment approaches and potentially exacerbating their conditions. Findings include: -Regarding #61 Resident #61 admitted on [DATE] with a diagnosis of Alzheimer's Disease, Unspecified dementia, depression and unspecified psychosis not due to a substance of known physiological condition and a BIMS (Brief Interview for Mental Status) of 00 suggesting severe cognitive impairment. A review of the resident's record revealed the following psychotropic medication orders for the resident #61: 1. Fluoxetine (Prozac) daily for depression AEB (As Evidenced By) tearfulness with a start date of 5/19/22. 2. Lorazepam at bedtime for anxiety AEB restlessness with a start date of 11/30/22 3. Seroquel two times a day for psychosis AEB delusions with a start date 6/20/23 then discontinued on 2/20/24. The Seroquel medication was renewed on 2/20/24 and to be administered two times a day for psychosis related to major neurocognitive disorder AEB delusions. 4. Morphine Sulfate by mouth three times a day for pain A review of the resident's February 2024 MAR (Medication Administration Record) did not reveal any non-pharmacological interventions. A review of the active orders did not reveal orders for non-pharmacological interventions. 48812 -Regarding Resident #115 Resident #115 was admitted on [DATE], with diagnoses that included atherosclerotic heart disease, dementia, and bipolar disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan dated March 10, 2023, identified that the resident uses psychotropic medication, Quetiapine Fumarate, and Haloperidol related to Bipolar Disorder. The goal was for the resident to remain free of drug-related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction, or cognitive/behavioral impairment. Interventions included monitoring the resident's condition based on clinical practice guidelines or clinical standards of practice related to using Quetiapine Fumarate and Haloperidol. Additionally, the care plan states that each antipsychotic medication should be administered as ordered, monitored/documented for side effects and effectiveness, and monitored/recorded the occurrence of target behavior symptoms. The admission minimum data set assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13/15, which indicated that the resident's cognition is intact. The MDS assessment also included the resident being administered an antipsychotic medication. A mood/behavior note dated May 31, 2023, revealed the resident had attempted to elope from the facility by going to the back hall and trying to go out the doors. She was able to be redirected by facility staff but again attempted to leave and told the nurse that she wanted to call the police because they were keeping her at the facility. On May 31, 2023, there was an order for Haloperidol Oral Tablet (antipsychotic) 1 MG every four hours for bipolar disorder, with a targeted behavior of physical aggression. Depakote oral tablet delayed release (antiepileptic) 250 MG, one tablet by mouth two times a day for Schizoaffective Disorder, with a targeted behavior of physical aggression. This order was transcribed onto the MAR, and the first dose was administered on May 31, 2023. Another mood/behavior note dated June 01, 2023 revealed the resident is in bed with her eyes closed resting. A review of the clinical record from November 01, 2023, through February 28, 2024, revealed zero days with documentation that the resident had physical aggression. A review of the physician's orders revealed an order of Quetiapine Fumarate (antipsychotic) 100 milligrams (MG) by mouth two times per day for bipolar disorder, with a targeted behavior of physical aggression. Haloperidol Oral Tablet (antipsychotic) 1 MG every four hours for bipolar disorder, with a targeted behavior of physical aggression. Depakote oral tablet delayed release (antiepileptic) 250 MG, one tablet by mouth two times a day for Schizoaffective Disorder, with a targeted behavior of physical aggression. These orders were transcribed onto the Medication Administration Record (MAR) and administered as ordered. Per the residents' MAR, it is ordered to monitor for physical aggression every shift; no behaviors by the residents were indicated via the MAR from November 01, 2023, through February 28, 2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additionally, the MAR is void of any attempt to perform a non-pharmacological intervention before giving the resident the antipsychotic medication from November 01, 2023, through February 28, 2024. A physician progress note dated January 23, 2024, revealed no acute overnight events since the resident's last visit and that the resident was doing well with no new complaints from residents or staff. The note also included that the resident was on Quetiapine Fumarate, Haloperidol, and Depakote and to resume the following medication with no rationale A physician progress note dated February 21, 2024, revealed no acute overnight events since the resident's last visit and that the resident was doing well with no new complaints from residents or staff. The note also included that the resident was on Quetiapine Fumarate, Haloperidol, and Depakote and to resume the following medication with no rationale. Resident #115 was observed on February 26, 2024, from 10:23 a.m. through 11:19 a.m. She was observed in her room in bed with a blanket covering her. She was wearing clean clothes with neatly combed hair. Resident #115 was awake, calm, and pleasant but did not appear alert when staff talked to her. Multiple staff approached her during this time, and she was not observed to be anxious, upset, combative, or angry with staff. During an interview conducted on February 27, 2024, with the Unit Nurse Manager (Staff #52), she stated that every time a medication is given, a non-pharmacological intervention is to be attempted, such as attempting to reposition, providing a snack, etc. She stated that every antipsychotic medication that is given to a resident must have a separate and specific targeted behavior; if they are all the same, there is no way for the staff to know that they are effective and would additionally consider this a duplicate therapy. When asked if there had been any non-pharmacological interventions before giving the resident any medications, she stated that, per the resident's medical record, none were performed from November 2023 to February 2024. During an interview conducted on February 28, 2024, with the Director of Nursing (DON, Staff #118), she stated that she expects the staff to attempt some form of non-pharmacological intervention before giving a resident their psychotropic medication. She further noted that if the resident is getting multiple medications for the same targeted behavior, there is no way for the staff to know if the medication is effective. She would consider this to be a duplicate therapy. She further stated that she does not expect the staff to mark its effectiveness, as the care plan states and her expectation is for the psychiatric provider to do that. Additionally, the physician ordered non-pharmacological interventions, but per the resident's medical record, they were not performed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facilities policy titled Tapering Medications and Gradual Drug Dose Reduction (revised April 2007) reads that staff and practitioner will consider tapering under certain circumstances, including when non-pharmacological interventions, including behavioral interventions, have been effective in reducing symptoms however the facility never implemented non-pharmacological interventions. A review of the facilities policy titled Administering Medications (revised April 2019) does not cover non-pharmacological interventions as part of the administering medications practice. The facility policy titled Psychotropic Medication Use, last revised in June 2022, stated Residents will not receive medication that is not clinically indicated to treat a specific condition. Psychotropic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. Residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on an observation, staff interviews, and the facility policy and procedures, the facility failed to ensure one medication cart was secured when left unattended. The deficient practice could result in residents having access to medications resulting in harm. Findings include: On February 25, 2024 at 10:36 a.m., a licensed practical nurse (LPN/staff #150) was observed removing multiple medications from a medication cart, which was located to the right of the nursing station on hall #200. She was observed taking the medications down the hall to a second medication cart that was located next to room [ROOM NUMBER], and taking the medications into the medication room. During this time, the medication room door was closed and the medication cart located to the right of the nursing station was left unlocked. When staff #150 came out of the medication room, she stated that she was transferring treatment medications from the medication cart located to the right of the nurse's station to the medication cart down the hall and had taken one treatment medication to the medication room. She acknowledged that the medication cart next to the nurse's station was left unlocked and that it is supposed to be locked to prevent anyone from having access to the medications. An interview was conducted on February 29, 2024 at 4:59 p.m. with the Director of Nursing (DON/staff #118), who stated that medication carts are supposed to be locked when nursing staff are not within eyesight of the cart to prevent residents and staff from having access to the medications. The facility policy, Administering Medications revised April 2019, stated that during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50116 Based on observations, staff interviews, and policy review, the facility failed to ensure food items were dated when opened; failed to ensure there were no expired food items readily available for resident use; and, failed to ensure the kitchen staff practices safe food storage and sanitary conditions. The deficient practice could result in outbreak of foodborne illnesses. Findings include: During the initial kitchen observation conducted on February 25, 2024 at 10:16 a.m. revealed that the kitchen staff (#82) was wearing a cap on his head but had no cover over his beard/mustache. The vents over the food tray line had a brown string-like substance hanging from vents. The logs for the walk-in refrigerator and freezer were posted but had missing dates on February 19 and 24, 2024. The following food items were opened and not dated: -Cheese slices; -Lemonade had a date written as February 18; however, the documentation did not indicate whether the date was an open or used/expiration date; -Reduced fat gallon of milk; -Cucumbers in a box; -One fruit cup covered in cellophane wrap; -Covered dessert cups with cheese cake; -3 brown dessert cups with pudding; and, -14 small white cylinders with lids. The following food items were expired and were found readily available for resident use: -Flour had a used by dates if [DATE] and February 4, 2024; -Cornstarch with an open date of February 20, 2024 and had expiration date of February 20, 2024 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Valley Post Acute	13575 West McDowell Road Goodyear, AZ 85395

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted with the kitchen manager (staff #135) conducted immediately following the observation, the kitchen manager stated that they use the expiration date preprinted on the milk jug for expiration; and that, the cucumbers in a box had a date of February 24, 2024 and the cucumber and the fruit cups expires in 5 days. The kitchen manager said that the expiration date on the cornstarch should be longer. During another kitchen observation conducted on February 28, 2024 at 10:42 a.m., the kitchen staff (#82) had a beard net pulled under mouth with mustache exposed. Another kitchen staff present in the kitchen had a face mask on but was placed under the chin with the facial hair exposed. At this point of the observation, the dietary consultant (Staff #301) told the kitchen staff to cover his facial hair. In an interview with the maintenance staff (#134) conducted on February 28, 2024 at approximately 2:38 p.m. , staff #134 stated that the kitchen was important and the facility want to keep A+ rating. The facility policy on Infection Control revealed that the facility's infection control policies and procedures are intended to facilitate maintaining safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The facility policy on Cleaning and Disinfecting Environmental Surfaces included that environmental surfaces will be disinfected or cleaned on a regular basis (e.g., daily, 3x per week) and when surfaces are visibly soiled. Review of the facility policy on Food Receiving and Storage included that foods shall be received and stored in a manner that complies with safe food handling practices. Food services, or other designated staff will maintain clean food storage areas at all times. Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). Such foods will be rotated using a first in-first out system. All foods in the refrigerator or freezer will be covered, labeled and dated (use by date). Beverages must be dated when opened and discarded after 24 hours. Other opened containers must be dated and sealed or covered during storage. The facility policy on Food Preparation and Service included that food and nutrition services staff wear hair restraints (hair net, beard restraints, etc) so that hair does not contact food.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47669 Based on observations, clinical record review, resident representative and staff interviews, and policies and procedures, the facility failed to ensure that activities were accurately documented in the clinical record for two residents (#108 and #58). The deficient practice could result in resident not receiving the appropriate care and services needed based on their comprehensive assessment. Findings include: -Resident #58 was admitted on [DATE] with diagnoses of acute respiratory failure with hypoxia, dependence on respirator (ventilator), morbid (severe) obesity, tracheostomy status, and legal blindness. The clinical record review revealed a Brief Interview of Mental Status (BIMS) score of 14 indicating the resident had intact cognition. The fall care plan dated July 12, 2023 included that the resident was at risk for all with or without injury due to generalized weakness and visual impairment. The ADL (activities of daily living) care plan dated July 24, 2023 included that resident had an ADL self-care performance deficit related to visual impairment. Intervention included to encourage resident to participate to the fullest extent possible with each interaction. The care plan dated July 25, 2023 included the resident was able to initiate her own leisure activities of her interest and socialize daily. Interventions included to encourage resident to participate in group activities of her choice, provide a copy of monthly calendar, notify resident of changes and to provide material for leisure activities of her interest. Review of the activities documentation from January 31 through February 26, 2024 revealed that resident #58 had refused activities multiple times and was not available for the activities 4x during this period. Despite documentation that resident was legally blind, continued review of the activities' documentation, revealed that the resident attended the following activities on these dates: -Arts and crafts on [DATE] and 20; -Bible study on January 31; -Bingo on February 2, 10 and 12; -Beading jewelry on February 9; and, -Bowling on February 3 and 5. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with resident #58 was conducted on February 26, 2024 at 12:31 p.m., the resident stated that she has not engaged with and attended activities. An interview with the activities director (staff #180) was conducted on February 28, 2024 at 2:18 p.m. The activities director stated that he did not think that activities were actually being completed and provided to residents. The activities director further stated that his staff might just be documenting and marking that activities were provided. During an interview with activities assistant (staff #124) conducted on February 28 at 2:50 p.m., the activities assistant stated that activities staff were documenting in the clinical record that resident attended group activities even when the residents actually did not attend the activities. In another interview with resident #58 conducted on February 29, 2024 at 1:15 p.m., the resident stated she does not get involved in the facility's activities because the resident stated she was blind and cannot walk. The resident stated that she did not know her interest anymore as she was blind and cannot walk; and that, everything she enjoyed was tied to her eyes. Further, the resident stated that the staff do not get her up. Another interview with the Activities Director (staff #180) was conducted on February 29, 2024 at 3:50 p.m.; and, a review of the activities documentation for resident #58 was conducted with the activities director during the interview. The activities director stated resident #58 had been involved in activities such as arts and crafts, card games, bowling, bingo, bible study, exercise, table games, etc.; and that, the documentation of activities attended by the resident is completed daily. When asked how could resident #58 who was blind could be involved in some of these activities, the activities director stated that maybe someone was helping the resident. 48087 -Resident #108 was admitted on [DATE] with diagnoses of chronic respiratory failure with hypoxia, urinary tract infection, quadriplegia, post-traumatic stress disorder, anxiety disorder, and depression. The admission minimum data set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 12, which indicated the resident had mild cognitive impairement. Review of the psychosocial well-being care plan dated February 9, 2024 included that the resident was at risk for psychosocial well-being concerns related to inability to verbally express concerns and or emotions, bed bound related to (r/t) vent/trach status/enteral tube, post traumatic stress disorder (PTSD), anxiety, depression, and CVA (cardiovascular accident). The communication care plan dated February 10, 2024 revealed the resident had impaired communication related to aphasia, difficulty making self-understand, difficulty understanding others, neurological disorder, impaired cognition, shakes head yes and no to the same questions, does not answer questions appropriately or consistently. Review of the group activities task sheets for January and February 2024 revealed that on January 2024, the resident attended group activities 2 days out of 31 days; and, on February 2024, the resident attended group activities 13 days out of 31 days. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review activities documentation for February 2024 included that resident #108 attended the following activities on these dates: -Arts and crafts on February 2 and 12; -Beading jewelry on February 9; -Bingo on February 2, 10 and 12; -Bowling on February 3 and 5; -Card games on February 3, 9, 16 and 25; and, -Zumba on February 3. Observations were conducted for the following dates and time: -February 25, 2024 at 12:42 p.m.; -February 26, 2024 at 10:22 a.m.; -February 27, 2024 at 9:40 a.m. and 3:42 p.m.; and, -February 28, 2024 at 11:52 a.m. During these observations, resident #108 was lying in bed in the resident room with the television on. An interview was conducted on February 28, 2024 at 2:19 p.m. withactivities director (staff #180) who stated that he was not sure why and how resident #108 was marked attending group activities such as bowling, watching movies, bingo, chair zumba, Dear [NAME], jeopardy, and card games; and that, his staff might just be marking completion that the activities are being provided. The activities director further stated that he did not think that these activities were actually completed and provided to the resident#108. During an the interview with activities assistant (staff #124) conducted on February 28, 2024 at 2:50 p.m., she stated that she was familiar with resident #108; and that resident #108 does not come to group activities. The activities assistant said that resident was bed bound, non-verbal and dependent on his vent/trach which makes it very hard for him to leave his room. The activities assitant also stated that activity staff do activities one on one with other residents; however, she personally have never seen resident #108 in group activities and have not provided one on one services for resident #108. The activities assistant stated that she does not know why it was documented that resident #108 attended the group activities such as games, chair Zumba, bowling, jeopardy, bingo, arts and crafts, card games, cooking class, Dear [NAME], exercise, hang-man, horse racing, and movie & popcorn. Further, the activities assistant stated resident #108 had never attended group activities; and that, she agreed that activities staff were documenting that residents attended group activities when the residents actually did not. The activities assistant also said that resident #108 would be able to comprehend games like jeopardy as the resident was non-verbal.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on observations, staff interviews, facility policy and procedures, the facility failed to ensure staff follow infection control practices when performing services and providing care to residents. The deficient practice could result in the spread of infection. Findings include: On February 27, 2024 at 11:51 a.m., one bowl with white liquid, dried food remnants and a spoon along with a clear colored glass with pink colored liquid approximately three quarters full were observed on the counter in the dining room on hall #200. There were also five residents observed in the dining area at this time. An interview was conducted on February 27, 2024 at 11:54 a.m. with a certified nursing assistant (CNA/staff #302), who stated that the bowl, spoon, and glass probably came out of one of the resident's room. She didn't know what was in the bowl, but stated that it looked dirty, as if it had been used, and the liquid in the glass was cranberry juice or fruit punch. She stated that dirty dishes are supposed to be taken directly to the kitchen because they are contaminated and shouldn't be left in an open space where residents have access because there is a risk of residents being infected or getting sick. On February 28, 2024 at approximately 10:30 a.m., a certified nursing assistant (CNA/staff #108) was observed in a room assisting a resident on hall #200. Staff #108 doffed her gloves and was observed picking up two bags from the floor with her right hand, pulling the curtain between the residents closed with her left hand, and then pushing one resident's tray closer to the resident with both hands, while holding the bags. Also, just outside the door, two plastic burgundy colored coffee cups with fluid were observed on the handrail. When staff came out of the room, she stated that she that she had trash and dirty linens in the two plastic clear bags. She also stated that she is supposed to take dirty dishes directly to kitchen because there is a risk of spreading infection. An interview was conducted on February 28, 2024 at 11:19 a.m. with a registered nurse (RN/staff #100), who stated that staff should not leave dirty dishes in public areas because there is a risk of infection and it is unsanitary. During a second interview on February 28, 2024 at 11:30 a.m. with (CNA/staff #108), she stated that there is a possibility of transferring infection if holding potentially contaminated bags while touching a resident's tray. An interview was conducted on February 29, 2024 at 10:33 a.m. with the Director of Nursing (DON/staff #118), who stated that dirty dishes should be taken directly to the kitchen, because there a risk of spreading infection if left in common areas. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, Food Preparation and Service revised November 2022 states that cross-contamination can occur when harmful substances, i.e., chemical or disease-causing microorganisms are transferred to food by hands (including gloved hands), food contact surfaces, sponges, cloth towels, or utensils that are not adequately cleaned. Cross-contamination can also occur when raw food touches or drips onto cooked or ready-to-eat foods. -Resident #126 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included acquired absence of the left leg below the knee, polyneuropathy, and hypertension. Review of the clinical record revealed that the resident was diagnosed with entercolitis due to Clostridium Difficile (C-Diff), recurrent on September 9, 2023. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 12 indicating the resident had a moderate cognitive impairment. The care plan dated February 5, 2024 states that the resident has C-Diff related to an ongoing history. Start Vancomycin titration. The interventions included contact isolation: wear gowns and mask when changing contaminated linens. Place in private room with contact precautions. Review of lab results dated February 6, 2023 revealed a positive result for C-Diff. Review of the bowel movement task sheets revealed the resident had loose stool on February 22, 23, 24, 25, and 26. Review of a progress note completed by the Control Preventionist/Director of Staff Development (ICP/staff #87) on February 29, 2024 stated the resident was readmitted on [DATE] and is on Vanco related to C-Diff. Since February 18, 2024, the resident is not meeting criteria for C-Diff because the resident is having formed stools, per M.D. Isolation has not been needed since February 18, 2024. On February 25, 2024 at 10:26 a.m., (LPN/staff #150) stated that the resident in room [ROOM NUMBER] was on contact precautions. During this time, signage was observed posted on the right side of the wall next the room [ROOM NUMBER]: -Proper PPE: gowns, gloves, face shield, and wash hands -See nurse prior to entering On February 26, 2024 at 10:10 a.m. the infection Control Preventionist/Director of Staff Development (ICP/staff #87) was observed hanging signage next to room [ROOM NUMBER] for PPE requirements, which included a gown, gloves, goggles/face shield and N95 or mask. She stated that the staff didn't need to wear a face shield, but did need to wear a surgical mask when entering the room. She also stated that she needed to post donning and doffing instructions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On February 28, 2024 at 9:44 a.m., (CNA/staff #121) was observed exiting room [ROOM NUMBER] wearing a surgical mask below her nose and goggles on the top of her head. She stated that the resident was on contact precautions, but she only handed him cream cheese and then left the room. She stated that she is supposed to doff the gown, gloves, surgical mask, and goggles and throw them away, and wash her hands with soap and water before exiting the room. She stated that she did not remove the surgical mask, goggles, or wash her hands with soap and water because she did not provide direct care, but did sanitize her hands. Staff threw away the surgical mask, but continued to wear the goggles on her head. During the interview, she was observed touching the goggles with her right hand. Then, she preceded to put ice in the residents' cups for rooms #218 and #217. When she was done, she took the ice cart back to the dining room across from room [ROOM NUMBER]. An interview was conducted on February 28, 2024 at 11:19 a.m. with (RN/staff #100), who stated that the resident in room [ROOM NUMBER] is on contact precautions and only gloves and a gown are required, but if staff are wearing a surgical mask and goggles, the PPE should be removed prior to the staff exiting the resident's room because it is already contaminated. An interview was conducted on February 29, 2024 at 10:33 a.m. with the Director of Nursing (DON/staff #118), who stated that the resident in room [ROOM NUMBER] is on contact precautions. She also stated that if goggles were worn in the room, the goggles should have been thrown away or cleaned prior to staff leaving the room, and the surgical mask should have been removed and thrown away prior to the staff leaving the room. The staff should have washed his/her hands with soap and water. She stated that there is a risk of spreading C-Diff when staff wear PPE outside of the room. The facility policy, Isolation - Categories of Transmission Based Precautions states that when a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The facility policy, Clostridium Difficile revised October 2018 states that a residents who are colonized with C. Diff (diarrhea free) for 48 hours can be removed from precautions. 47911 An observation was conducted on February 28, 2024 at 8:17 AM in the central dining area located on the 300 unit. Resident #10 was observed accessing the open standing meal cart containing dirty meal trays. Resident #10 was observed to have both hands up to his elbows inside the meal cart. Staff #213, CNA (certified nursing assistant), observed the resident, came over to the resident and redirected him. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

An interview was conducted on February 28, 2024 at 8:20 AM with staff #213 , CNA. The CNA stated that the meal cart remains in the day room until all dining trays have been removed from the resident rooms and central dining area. He stated that it had never been a concern in the past; however, unit 300 is a secured unit and the meal cart was open and accessible to all residents. Staff #213 stated that resident #10 is known to wander throughout the unit. Staff #213 stated that the risk for the resident accessing the meal cart containing dirty dishes and trays could include injury and infection.

An interview was conducted on February 29, 2024 with staff #240 LVN (Licensed Practical Nurse). Staff #240 stated that residents should not have access to the meal carts. She stated that she had not observed residents accessing the carts in the past, but stated that the risk could include infection.

An interview was conducted on February 29, 2024 at 1:02 P.M. with staff #118 DON (director of nursing). Staff #118 stated that the expectation is that dirty trays be collected, placed in the cart and put out of reach of residents. Staff #118 stated that there probably would not be a risk for having the meal carts in a central area but in this case the risk to the resident could include injury.

A review of the facility policy entitled Infection Control, revised 2018, revealed that a safe, sanitary and comfortable environment is to be maintained for personnel, residents and visitors; however, open meal carts containing dirty dishes, in a locked unit with residents diagnosed with behavioral health concerns, could potentially cause a risk for bodily injury and the spread of disease.

49325

-An observation was conducted on February 26, 2024 at 1:04 p.m. There was a Centers for Disease Control (CDC) Prevention recommended sequence of wearing personal protective equipment (PPE) signage was posted beside the doorway entrance into the room of resident #125. Beside the entrance there was a printed signage with 2 visual illustrations as well as an isolation cart containing gloves, masks, gowns, and face goggles.

In an observation conducted on February 27, 2024 at 1:07 p.m., a certified nurse assistant (CNA/Staff #63) exiting the room of resident #126 holding a clear trash bag containing disposed PPE pulled out of the trash can. The CNA walked into a room across the hallway when another CNA (staff #108) redirected and instructed staff #63 that the bag she held should be placed outside the facility. Staff # 63 took the bag outside the facility, returned into the facility, entered the room of resident #50 without washing her hands. Staff #63 then walked out of the resident room holding a meal tray. At this time, the other CNA (Staff #108) asked Staff #63 if she had placed the bag into the designated biohazard area. Staff #63 she replied that this was the first time she was hearing that a bag should go into the biohazard area. At 1:15 p.m., staff # 63 then washed her hands in the dining area; however, staff #63 continued to wear the goggles over her head.

-Resident #50 was admitted on [DATE] with diagnoses of post-traumatic stress disorder, malignant neoplasm of unspecified kidney, depression, and unspecified open wound (left knee).

The laboratory testing result for collection date of January 3, 2024 revealed positive results for clostridium difficile toxin.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan initiated on January 04, 2024 revealed that Resident #126 had diagnosis of clostridium difficile infection. The most recent Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident was cognitively moderately impaired. The assessment also included an active diagnosis of enterocolitis due to clostridium (recurrent). The laboratory testing result for collection date of February 4, 2024 revealed positive results for clostridium difficile toxin. Review of the documentation for bowel continence for February 2024 revealed that resident #126 had at least 1 episode of loose/diarrhea bowel movement on February 18, 19, 22, 23, 24, 25, and 26. -Resident #126 was and placed under contact-based precautions due to his active clostridium difficile diagnosis. During an interview conducted on February 27, 2024 at 1:21 p.m. the CNA (staff #63) stated that she did not wash her hands after she exited the room of resident #126 and before entering the room of resident #50. In an interview with another CNA (staff #108) conducted on February 27, 2024 at 1:28 p.m., staff #108 stated that goggles should be left in the room because of the risk of be cross-contamination. During a second interview with the CNA (staff #63) conducted on February 27, 2024 at 1:33 p.m., staff #63 stated that she had her goggles were still resting on top of her head; and that, staff can keep their goggles on them. An interview was conducted with a licensed practical nurse (LPN/Staff # 230) on February 27, 2024 at 1:36 p. m. The LPN stated that resident #126 had clostridium difficile; and that, staff were to wash their hands with soap and water. The LPN also stated that if the goggles were reusable, staff should place them in their designated area otherwise the risks are contamination or spread of infection. In an interview with a Licensed Practical Nurse/Infection Preventionist (LPN/IP/Staff # 87) conducted on February 29, 2024 at 9:08 a.m., the IP stated appropriate hand hygiene for clostridium difficile was soap and water; and never use a sanitizer gel. The IP stated that as long as staff were inside a resident's room with clostridium difficile, staff have to wash their hands whether staff were providing care or not. The IP also said that if staff do not follow contact-based precautions for a resident with clostridium difficile, you do not know what staff was touching and this can hurt the other residents. Further, the IP said that it would not meet facility expectations that reusable goggles would be worn or kept outside. An interview was conducted with a Director of Nursing (DON/Staff # 118) on February 29, 2024 at 9:41 a.m. The DON stated that the expectation was that staff follow transmission-based precautions because there is a potential to spread infection. The DON said that if a staff member was caring for a resident with clostridium difficile the expectation was for staff to wash their hands with soap and water. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy and practices document titled, Infection Control (revised October 2018), revealed that the infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. It apply equally to all personnel, consultants, contractors, residents, visitors, volunteer workers, and the general public. The objectives of our infection control policies and practices are to: Prevent, detect, investigate, and control infections in the facility; Maintain a safe, sanitary, and comfortable environment for perso1mel, residents, visitors, and the general public; Establish guidelines for implementing Isolation Precautions, including Standard and Transmission-Based Precautions; Establish guidelines for the availability and accessibility of supplies and equipment necessary for Standard and Transmission-Based Precautions; Provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The facility's policy and practices document titled, Clostridium Difficile (revised October 2018), revealed that measures are taken to prevent the occurrence of Clostridium difficile infections (CDI) among residents. Precautions are taken while caring for residents with C. difficile to prevent transmission to others residents. Residents considered at high risk of developing symptoms associated with C. difficile include those with: Advancing age. Steps toward prevention and early intervention include: Ongoing surveillance of CDI; Increasing awareness of symptoms and risk factors among staff, residents and visitors. Residents with diarrhea associated with C. difficile (i.e., residents who are colonized and symptomatic) are placed on Contact Precautions. Residents who are asymptomatic (diarrhea free) for 48 hours can be removed from precautions. When caring for residents with CDI, staff is to maintain vigilant hand hygiene. Hand washing with soap and water is superior to ABHR for the mechanical removal of C. difficile spores from hands. When caring for residents with CDI, staff is to maintain vigilant hand hygiene. Hand washing with soap and water is superior to ABHR for the mechanical removal of C. difficile spores from hands. The facility's policy and practices document titled, Infection Prevention and Control Program (revised October 2018), revealed an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The program is based on accepted national infection prevention and control standards; and, is coordinated and overseen by an infection prevention specialist (infection preventionist). Policies and procedures are utilized as the standards of the infection prevention and control program; and, reflect the current infection prevention and control standards of practice. Outbreak management is a process that consists of: managing the affected residents; preventing the spread to other residents; educating the staff and the public. Important facets of infection prevention include: identifying possible infections or potential complications of existing infections; instituting measures to avoid complications or dissemination; educating staff and ensuring that they adhere to proper techniques and procedures; communicating the importance of standard precautions and cough etiquette to visitors and family members; implementing appropriate isolation precautions when necessary; and following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). Those with potential direct exposure to blood or body fluids are trained in and required to use appropriate precautions and personal protective equipment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035255	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Valley Post Acute	13575 West McDowell Road Goodyear, AZ 85395

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy and practices document titled, Isolation - Categories of Transmission-Based Precautions (revised September 2022), revealed transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk. of transmitting the infection to other residents. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Contact precautions are also used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, even before a specific organism has been identified. Staff and visitors wear gloves (clean, non-sterile) when entering the room. While caring for a resident, staff will change gloves after having contact with infective material (for example, fecal material and wound drainage). Gloves are removed and hand hygiene performed before leaving the room. Staff avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. The facility's policy and practices document titled, Personal Protective Equipment (revised October 2018), revealed training on the proper donning, use and disposal of PPB is provided upon orientation-and at regular intervals. Employees who fail to use personal protective equipment when indicated may be disciplined in accordance with personnel policies. The facility's CDC document titled, How to Safely Remove Personal Protective Equipment (PPE), revealed that if the goggles or face shield is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container.

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NAME OF PROVIDER OR SUPPLIER Palm Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 13575 West McDowell Road Goodyear, AZ 85395	

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 47576 Based on closed clinical record review, interviews, and policies, the facility failed to provide a safe, functional environment for residents and staff. The deficient practice could lead to resident's not having a safe living environment. Findings include: Resident #111 admitted to the secured memory care unit, on 2/6/23 with a diagnoses of Unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, Parkinson's and a BIMS (Brief Interview for Mental Status) score of 09. During an observation of the unit on 2/26/24 at 8:48 a.m., a battery powered keypad lock was on the door of resident #111's room. An interview was conducted with resident #111 on 2/26/24 at 8:52 a.m. The resident he requested for the lock to be placed on the door. On 02/27/24 at 10:40 a.m., an interview was conducted with a licensed practical nurse (LPN/saff #52) who stated that the Veranda unit was a secured memory care unit; and, a code was needed to enter and exit the unit. The LPN said that staff had a code to enter the secured unit; and, visitors had to come to the window at the nurse's station and request to enter. However, the LPN said that for residents who had been at the facility for a while, their family has a code for the unit. Regarding resident #111, the LPN said that she did not know that the resident's room had a keypad lock and does not know the code to enter the resident's room. Staff #52 stated that her expectation was that a door lock would be on the resident's care plan; and that, there would be a physician order and an evaluation of the resident to have a lock on the door in a memory care unit. During the interview, a review of the clinical record was conducted with the LPN who stated that there was no physician order, progress note, safety or competency assessment or care plan for the resident's keypad lock on the door found. An observation was conducted on 2/27/2024 at 10:50 a.m. with the LPN who stated that the lock probably did not work. The LPN then knocked on the door, tried to enter but was unable to; and, was surprised that the lock was engaged and she could not open the door. The LPN then used a code and was able to open the resident room door. Resident #111 came to the door and the LPN asked the resident if he knew that there was a lock on his door. Resident #111 replied by saying no. The LPN then asked for the code from resident #111 who refused to give the code to the LPN. In another observation conducted on 2/27/2024 at 10:54 a.m. a certified nursing assistant (CNA/staff #219) was able to gain access to the resident's room utilizing a code on the keypad. The CNA stated that the CNAs know the code to get in the resident room; and that, the CNAs do not have a key to the resident's room but that the nurses do. The LPN (staff #120) who was present during this observation stated that there was no key for the lock for the resident's room; and that, the maintenance staff should have a key. (continued on next page)

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the director of nursing (DON/staff #118) conducted on 2/27/24 at 11:04 a.m., the DON was surprised to know that resident #111 had a keypad lock to his room. The DON stated that there was no care plan focus or an evaluation for the lock to be on the resident's door; and that she was not able to find a progress note, order or care plan for the lock on the resident's room. On 2/27/24 at 1:09 p.m., an interview was conducted with the plant and operations manager (staff #134) who stated that work orders get submitted by the nursing staff who have a portal to reach maintenance staff in the electronic record. Staff #134 stated that there was only one lock on a resident's door and that lock was on the Veranda unit; and that's for resident #111. Staff #134 stated all CNAs and nurses have the code to enter the room including management; and that, all three disciplines have a separate code. Staff #134 stated that there was a key that was attached to nurses' keys on the unit, the maintenance department had a key as well as management. Staff #134 was not able to identify each manager that has a key. Staff #134 also stated that there was not a log that keeps track of who enters the room via keypad code. Staff #134 stated that there was not a current schedule for lock maintenance such as changing the batteries. Staff #134 stated that staff were notified of the lock but a training was not conducted; and that, the code for resident #111's room wass the same code to enter the unit. Staff #134 said that families have a code that was separate from the code for the resident's room. Staff #134 stated that a work order was created on 5/25/23, completed on 5/26/23 and the administrator (staff 142) had approved the lock on the door. An interview was conducted with Activities Assistant (staff #71) for the Veranda unit on 2/29/24 at 11:51 a.m. The activities assistant stated that she was aware of the lock but she does not know the code; and that, she thinks the nurses have a key. The activities assistant stated that if the battery failed on the keypad lock, the resident can get stuck in there or what if he was on the floor from a fall. Further, the activities assistant stated that she did not have any training or in-services related to the lock on resident #111's door. In an interview with another LPN (staff #120) conducted on 2/29/24 at 11:57 a.m., the LPN she was aware of the lock, she does know the code and she thinks the other nurse had a key to the room. The LPn said that there was only one key for the resident's room and it was assigned to the nurse providing care to that resident. The LPN also stated that the resident was not on any safety checks but if resident #111 was her resident, she would have him on one-hour checks. Staff #220 was not able to provide potential negative outcomes related to the lock failing and limited access with a key. An interview was conducted on 2/29/24 at 12:05 p.m. with another CNA (staff #219) who stated that she was aware of the lock, knew the code and the nurses had a key. The CNA also stated that a potential negative outcome of the lock failing would maybe a resident fall in the bathroom and staff cannot get into the room. The CNA stated that if the lock failed and if the nurse was not available, she would call maintenance; and that, if the maintenance staff were not available, the CNA do not know what to do after that. The facility was not able to provide a policy for resident door locks.