STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035270	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silverwood Post Acute	15810 South 42nd Street Phoenix, AZ 85048

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Potential for minimal harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49499 Based on closed record review, staff interviews, review of facility documentation, policy and procedures, the facility failed to ensure that residents representatives were notified of significant changes in condition for one resident (#120). The deficient practice could result in resident representatives not being informed of the change and decisions regarding treatment. Findings include: Resident #120 was admitted on [DATE] with diagnoses of heart failure and atherosclerosis of coronary artery bypass graft. Review of the clinical record revealed the resident was admitted for a hospice respite stay for five days. The face sheet for the clinical record revealed a family member was listed at the emergency contact #1 as well as medical power of attorney (MPOA). A progress noted dated [DATE] at 6:25 p.m., revealed that hospice was notified in the morning that resident was not at baseline; and that, hospice was to come in the facility to evaluate the resident. Per the documentation, the resident was not responsive later during the shift; and that, staff called 911, started CPR (cardiopulmonary resuscitation) and the resident was taken to the hospital. The progress notes dated [DATE] revealed that gabapentin (anticonvulsant), baclofen (skeletal muscle relaxant) and Ativan (antianxiety) were held due to lethargy. A progress note dated [DATE] at 6:44 p.m., included that the supervisor notified hospice of a change in condition. However, the documentation did not indicate that the resident's MPOA was notified of the change in condition. Review of the clinical record revealed that the resident was discharged from the facility on [DATE]. An eINTERACT summary for physicians dated [DATE] revealed the resident had a change in condition for cardiac arrest. It also included that the resident had a full code status and the resident was sent to the hospital. (continued on next page)

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

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F 0580 Level of Harm - Potential for minimal harm Residents Affected - Some	Further review of the clinical record and facility documentation revealed no evidence that the resident's representative/MPOA was notified of the change in condition. During an interview with a licensed practical nurse (LPN/staff #5) conducted on February 9, 2024 at 11:00 a.m., the LPN stated when there is a change in condition in resident's status, a progress note and a change in condition form will be completed and the physician and family will be notified. The LPN said that hospice will also be notified if the resident was on hospice. The LPN stated that it was his responsibility as a nurse to notify hospice, family, and physician and enter any orders into the computer when there is a change in resident's condition. Further, he stated that he would notify hospice and the physician and the director of nursing (DON) if needed, of the resident's vital signs and what he saw. During an interview with the DON (staff #69) conducted on February 9, 2024 at 11:43 a.m., the DON stated that when there is a change of condition, it was expected that staff would document in the progress notes the last time the patient was seen, what time the resident was found and by whom, physician contact, family contact, details of what occurred, when, and by whom. Review of the facility policy titled Acute Condition Changes - Clinical Protocol revised on [DATE], included that the nurse was to notify the resident's physician regarding a change in condition. However, the policy did not include notification of the resident's representative.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49499 Based on clinical record review, observations, staff interviews, and review of policy and procedure, the facility failed to protect the residents' (#128, #161 #15 and #14) rights to be free from abuse by another resident (#15, #11, #17). The deficient practice could result in residents not protected from further abuse. Findings include: Regarding incident between resident #128 and resident #15 -Resident #128 (alleged victim) was admitted on [DATE] with diagnoses of cerebrovascular disease involving cognitive function following cerebral infarction, dementia with behavior disturbance and other personality and behavioral disorders. The care plan dated September 22, 2021, revealed the resident had an enteral feeding tube to meet nutritional needs related to cerebrovascular accident with dysphagia with interventions including aspiration precautions, dietary evaluation and monitoring, feedings at room temperature, feeding tube changes per order, feeding tube site care as ordered, and tube feeding formula administered per orders. Another care plan for resident #128 dated September 22, 2021 revealed the resident had impaired communication as evidenced by difficulty making self-understood and difficulty understanding others with interventions that included to use short phases that required yes/no answers; speaking in a normal tone voice clearly and slowly; gain the resident's attention and eye contact before speaking to the resident, and allowing sufficient time for the resident to process and respond. A physician order dated September 5, 2023 for feeding tube formula Jevity 1.5 at 60 ml (milliliters) per hour with water flushes at 20 ml per hour for 20 hours per day through the feeding tube; administer continuously through pump, begin at 12:00 p.m. and stop at 8:00 a.m. The progress notes dated October 16, 2023 at 8:41 a.m. revealed the facility attempted to contact the resident's family regarding the need for a new feeding tube. Per the documentation, at 9:00 a.m., the resident was moved to a new room for safety and the wound care doctor was notified to replace the feeding tube. The SBAR (Situation-Background-Assessment-Recommendation) dated October 16, 2023 included the resident had a verbal altercation with roommate; and that, when the roommate was re-directed away from resident, the resident's feeding tube was missing and later located near him. Per the documentation, the resident's tube site was assessed and was found with redness but no bleeding or other injury. At 5:30 p.m., the feeding tube was replaced and waiting for x-ray confirmation. Night shift was to wait for confirmation of x-ray results prior to resuming medication administration and feeding. A physician order dated October 16, 2023 included for a STAT x-ray to confirm feeding tube placement. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note dated October 17, 2023 revealed that the x-ray was completed; and, at 8:40 a.m., confirmation was received for the feeding tube placement was correct. -Resident #15 (alleged perpetrator) was admitted on [DATE] with diagnoses of traumatic subdural hemorrhage without loss of consciousness, unspecified injury of head, unsteadiness on feet, difficulty walking and need for assistance with personal care. The care plan dated August 22, 2023 revealed the resident exhibited or had the potential to exhibit physical behaviors related to history of harm to others, assaultive actions towards other residents, and resident-to-resident altercation. Interventions included to evaluate the nature and circumstances of the physical behavior with the resident or his representative; discuss the findings with the resident and family members and adjust care accordingly; evaluate the need for a psychiatric/behavioral health consult; encourage resident to seek staff support for distressed mood; remove the resident from the environment while speaking in a calm, reassuring voice; provide a calm, quiet well-lit environment; and, divert the resident by giving alternative objects or activities. A progress note dated October 16, 2023 at 8:45 a.m. revealed the facility attempted to contact the resident's family regarding the resident's behavior toward another resident (#128). Per the documentation, at 8:58 a.m. the facility notified state agencies regarding the altercation, the provider and psychiatry were notified with orders received; and resident #15 was placed on 15-minute checks. The SBAR dated October 16, 2023 included that resident #15 had a change in condition for behavior symptoms of agitation and psychosis of physical/verbal aggression. Per the documentation, the resident physical altercation resulted in the roommate's (resident #128) feeding tube being pulled out. Further, the documentation included that resident #15 shoved the CNA. A physician order dated October 16, 2023 included for laboratory test including blood and urine and psychiatric evaluation and treatment for increased behaviors. The care plan was revised on October 16, 2023 to include that the resident 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 well-being related to increased behaviors, verbal or physical altercation with other residents. Interventions included to assess clinical issues that may cause or contribute to mood pattern, encourage expression of feelings/concerns, maintain calm slow understandable approach, observe for signs and symptoms of depression/emotional distress, notify physician as needed, and refer to psychology/psychiatry as ordered. The facility investigation included that during their interview conducted with resident #15 on October 16, 2023 at 5:57 p.m., the resident stated that his roommate (resident #128) was talking and talking and he got mad, transferred himself into his wheelchair from the bed and went to the side of his roommate's bed. Per the documentation, resident #15 denied pulling out his roommate's feeding tube. The report also included that the facility was not able to interview resident #128 on October 16, 2023 at 6:13 p.m. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued review of the report included a written witness statement by licensed practical nurse (LPN/staff #12) dated October 16, 2023. The statement included that the LPN was passing morning medications when resident #15 was heard yelling. per the documentation, the LPN went to the resident's room and saw resident #15 leaning over and was pulling at resident #128; and that, the LPN told resident #15 to stop and yelled for help. The documentation included that two other CNAs and another nurse came into the room; and resident #15 continued to yell and shove one of the CNAs as the CNAs redirected him. It also included that resident #15 threw something and sat down; and, the LPN noticed resident #128 was missing his feeding tube and then located the feeding tube next to Resident #128. The report also included a written witness statement dated October 16, 2023 by Certified Nursing Assistant (CNA/staff #29) who stated that the CNA heard the nurse scream for help; and the CNA ran in and saw that the feeding tube of resident #128 was removed. The documentation also included that resident #15 continued to be uncooperative and tried to push the CNA when he was asked to sit down. An interview with an LPN (staff #12) was conducted on February 29, 2024 at 1:40 p.m. The LPN stated that the LPN was at the medication cart when resident #15 was heard yelling. Per the documentation, the LPN went to see and found resident #15 sitting in his chair and yelling at resident #128 who was lying in bed with the feeding tube laying in the bed next to him. The LPN said that resident #128 was non-verbal and could pull at tubes but was not ambulatory. Further, the LPN said that there was verbal yelling in the room; but the LPN was not in the room to know exactly what happened between resident #128 and resident #15. During an interview with CNA (staff #29) conducted on February 29, 2024 at 1:45 p.m., the CNA stated the CNA was in the hallway and heard resident #15 yelling at resident #128; and that, the CNA and the nurse (staff #12) ran into the room at the same time. The CNA said when they when they walked into the resident's room, the CNA saw resident #15 pull resident #128's feeding tube; and that, resident #15 threw the feeding tube in the air when staff entered the room. The CNA also stated that resident #15 continued to be angry and aggressive; was saying that resident #128 was cussing; and that, resident #15 was telling resident #128 to shut up. However, the CNA stated that resident #128 just mumbled and was not able to speak. Further, the CNA stated that resident #15 was moved to another room after the incident. Regarding incident between resident #15 and #11 -Resident #15 (alleged victim) was admitted on [DATE] with diagnoses of traumatic subdural hemorrhage without loss of consciousness, unspecified injury of head, unsteadiness on feet, difficulty walking and need for assistance with personal care. The care plan dated August 22, 2023 revealed the resident exhibited or had the potential to exhibit physical behaviors related to history of harm to others, assaultive actions towards other residents, and resident-to-resident altercation. Interventions included to evaluate the nature and circumstances of the physical behavior with the resident or his representative; discuss the findings with the resident and family members and adjust care accordingly; evaluate the need for a psychiatric/behavioral health consult; encourage resident to seek staff support for distressed mood; remove the resident from the environment while speaking in a calm, reassuring voice; provide a calm, quiet well-lit environment; and, divert the resident by giving alternative objects or activities. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note dated August 8, 2023 at 8:48 a.m. revealed that the resident continued to display agitative behavior when he does not have cigarettes or nicotine available to him and this anger could be displayed toward other residents and he wants to act out and needs to be intercepted before temper escalates. The progress note dated August 16, 2023 at 11:09 a.m. included that the resident displayed physical aggression. A late entry progress note dated August 17, 2023 at 8:55 a.m. revealed that there was a commotion heard in the dining room; and when the DON entered the dining room, the activities staff was standing between residents #11 and #15. Per the documentation, both residents were immediately separated and escorted to their rooms; and that, resident #11 had struck resident #15 in the face; and, resident #15 had a laceration to his bottom lip. Resident #11 had struck resident #15 in the face. The care plan was revised on August 22, 2023 to include the resident exhibited or had the potential to exhibit physical behaviors related to history of harm to others, assaultive actions towards other residents, and resident-to-resident altercation. Interventions included staff were to evaluate the nature and circumstances of the physical behavior with the resident or his representative; discuss the findings with the resident and family members and adjust care accordingly; evaluate the need for a psychiatric/behavioral health consult; encourage resident to seek staff support for distressed mood; remove the resident from the environment while speaking in a calm, reassuring voice; provide a calm, quiet well-lit environment; and divert the resident by giving alternative objects or activities. -Resident #11 (alleged perpetrator) was admitted on [DATE] with diagnoses of major depressive disorder, adjustment disorder with disturbance of conduct, unspecified mental disorder, unspecified signs and symptoms involving cognitive functions and awareness, and alcohol use with unspecified alcohol induced disorder. The BIMS score dated July 19, 2023 was 14 indicating the resident had intact cognition. The care plan dated February 4, 2021 revealed the resident had potential to demonstrate verbal behaviors related to history of verbal outbursts directed toward others, ineffective coping skills, and psychiatric disorders. Interventions included to monitor medications for side effects and response contributing to verbal behaviors; evaluate nature and circumstances of verbal behaviors; evaluate need for psychiatric/behavioral health consultation, and explain all care before initiating care. The SBAR dated on August 16, 2023 revealed that activities staff got supervisors to break up fist fight between two residents. Per the documentation, resident #11 punched another resident in the face. A late entry note dated August 17, 2023 included that a commotion was heard in the dining room; and when the DON entered the dining room, the activities staff was standing between residents #11 and #15. Per the documentation, both residents were immediately separated and escorted to their rooms; and that, resident #11 was seen striking resident #15 in the mouth with his fist. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note dated August 17, 2023 at 12:49 p.m., resident #11 was sent out to the emergency room for psychiatric evaluation; and that, the resident returned to the facility at 10:00 p.m. with no new orders. The care plan was revised on August 17, 2023 to include that the resident exhibited or had the potential to exhibit physical behaviors related to poor impulse control. Interventions included to evaluate the need for psychiatric/behavioral health consult. The facility report included that the facility was not able to interview resident #11 due to cognitive deficit. It also included a written witness statement by staff #33 who reported that resident #15 was on his way to use the restroom when he bumped resident #11's table. Per the statement, resident #11 got mad, yelled at and punched resident #15 in the mouth. The report also included a written statement dated August 16, 2023 from staff #4 who wrote that resident #15 accidentally bumped resident #11 due to limited space as he was trying to get through; and that, resident #11 hit/punched resident #15 in the face. 49319 Regarding resident #161 and #17 -Resident #161 (alleged victim) was admitted on [DATE] with diagnoses of end stage renal disease (ESRD), hemorrhage of anus and rectum, large intestine cancer and depression. -Resident #17 (alleged perpetrator) was admitted on [DATE], with diagnoses of chronic obstructive pulmonary disease (COPD), major depressive disorder, myocardial infarction and history of falls. A progress note dated May 1, 2023 included that staff #12 could hear resident #17 yelling out explicit language and threatened another resident. Per the documentation, she looked outside in the smoking area and could see resident #17 sitting across from resident #161; and that, resident #17 was telling resident #161 that he was going to f--k resident #161 up while kicking resident #161 who told resident #17 to stop. However, the documentation included that resident #17 continued to kick resident #161. A progress note dated May 2, 2023 included that a licensed nurse (staff #8) reported to an officer around 6:00 p.m. that resident #17 kicked another resident (#161). Review of the facility 5-day report revealed that resident #17 kicked resident #161 while they were sitting next to each other; and that, they were immediately separated and assessed for injury. Per the documentation, there were no injury found. Regarding resident #14 and #3 -Resident #14 was admitted to the facility on [DATE] with diagnoses of cerebral infarction, hemiplegia and hemiparesis affecting left non-dominant side and major depressive disorder. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note dated August 12, 2023 included that the resident was punched in face by roommate. Per the documentation, the resident was sitting in wheelchair facing the door and the roommate (resident #3) was facing the resident; and that, both residents were yelling and cussing at each other. It also included that the staff went in between both residents; and, blood was noted running down from both sides of nose and a cut over right eye was noted. Further, the note included that the both residents was kept resident apart with the certified nurse assistant (CNA) assistance. -Resident #3 was admitted to the facility on [DATE], with past medical history of cerebrovascular disease, hypertension, hepatic failure, unspecified sequelae of cerebral infarction and adjustment disorder with disturbance of conduct. The progress note dated on August 12, 2023 that the resident #3 punched roommate (resident #14) in face; and that, the resident was standing over the roommate's face and both residents were yelling and cussing at each other. Per the documentation, the staff saw the right hand of resident #3 dropping down away from roommate's (#14) face. In an interview with resident #14 conducted on February 14, 2024 at 10:11 a.m., the resident stated that he left his room to smoke a cigarette and came back, was upset that his call light was on. Resident #14 said that resident #14 hit him. Resident #14 said there was no witness to the incident. Resident #14 further stated that he had injuries on his forehead; however, he did not go to the hospital. He also stated that he called the cops; and, had reported to an LPN (staff #104) that resident #3 had threatened him. In an interview with resident #3 on February 29, 2024 at 2:15 p.m., resident #3 stated that he punched resident #14. In an interview conducted on February 21, 2024 at 11:10 a.m., the LPN (staff #97) stated he had been the facility two weeks, was taught the abuse policy via on-line module required before working with residents. He defined abuse to include - physical, mental, financial, seclusion, sexual, exploitation and neglect. The LPN stated that he must report allegations immediately but no longer than two hours after the incident; and that, he would report to supervisor and executive director. Further, he stated that he would also follow up to ensure that something was done. An interview was conducted on February 21, 2024 at 11:30 a.m. with a CNA (staff #57) who stated that abuse was mental/emotional, physical, ignoring person, not answering call light timely; and that, she would report abuse to DON, supervisor and administrator within two hours. During an interview with the DON conducted on February 22, 2024 at 3:00 p.m., the DON stated that for abuse and neglect, the expectation was allegations of abuse are reported to her or the administrator (staff #106) within two hours. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the administrator (staff #106) conducted on February 29, 2024 at 2:28 p.m., the administrator stated that he was the abuse coordinator and was responsible for investigating allegations of abuse; and, he monitors for potential or actual reported allegations of abuse in several ways such as in-service, daily discussion and grievances. He said that he and the DON track all the self-reports. The administrator also said that abuse was not tolerated; and, if the facility suspect abuse, they will address it directly, terminate or write up staff, conduct in-service training for all staff and always address if there are difficult residents. The administrator stated that if an incident involved resident-to-resident, staff separate the two involved residents from each other; and if abuse allegation involved staff, the staff will be suspended pending investigation. A review of the facility's policy titled Resident Rights dated December 2016, revealed that the policy stated that the resident had the right to be free from abuse, neglect, misappropriation of property, and exploitation.

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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** 49499 Based on clinical record reviews, staff interviews, State Agency (SA) intake database and review of facility documentation, policies and procedures, the facility failed to have evidence that an allegation of abuse for two residents (#174, #125) and misappropriation of narcotics for three residents (#134, #135, #136) were thoroughly investigated. The deficient practice could result in further abuse and misappropriation of narcotics not prevented and appropriate actions not taken. Findings include: Regarding resident #174 and #11 -Resident #174 was admitted on [DATE] with diagnoses of COVID-19, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, schizophrenia and bipolar disorder. The care plan dated February 1, 2021 revealed the resident had a tendency to exhibit sexually inappropriate behavior related to cognitive loss/dementia, psychiatric disorder-schizophrenia and bipolar. The BIMS (brief interview for mental status) score dated March 9, 2021 was 15 indicating the resident was cognitively intact. -Resident #11 (alleged perpetrator) was admitted on [DATE] with diagnoses of major depressive disorder, adjustment disorder with disturbance of conduct, unspecified mental disorder, unspecified signs and symptoms involving cognitive functions and awareness, and alcohol use with unspecified alcohol induced disorder. The care plan dated February 4, 2021 revealed the resident had potential to demonstrate verbal behaviors related to history of verbal outbursts directed toward others, ineffective coping skills, and psychiatric disorders. Interventions included to monitor medications for side effects and response contributing to verbal behaviors; evaluate nature and circumstances of verbal behaviors; evaluate need for psychiatric/behavioral health consultation, and explain all care before initiating care. Review of the SA intake database revealed that on May 7, 2022, a self-report was received. Per the documentation, resident #11 was verbally abusive to resident #174 on March 16, 2021 at 12:15 p.m.; and that, resident #11 was yelling at resident #174 and calling him foul names. Further, the self-report included that resident #174 reported the incident to staff who reported it to the facility administrator and director of nursing. The BIMS score dated July 19, 2023 was 14 indicating the resident had intact cognition. However, there was no evidence found that a 5-day investigative report was submitted to the SA. There was no evidence found that the incident between resident #174 and #11 was thoroughly investigated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regarding resident #125 and staff -Resident #125 was admitted on [DATE] with diagnoses of metabolic encephalopathy, sepsis, cellulitis of right lower limb, embolism and thrombosis of arteries of lower extremities, urinary tract infection, acquired absence of right leg above knee, legal blindness, acute kidney failure, diabetes type 2, and heart failure. The care plan dated April 21, 2022 revealed the resident exhibited or had the potential to exhibit psychosocial distress secondary to infection prevention practices related to restricted visitation, changes in room or roommate, isolation, and absence of communal activities. Interventions included that staff were to evaluate the need for a behavioral health consult, assist the resident with communicating with family and friends, provide emotional support as needed, and provide the resident with individualized diversional activities. The BIMS score on April 23, 2022 was 9 indicating the resident had moderate cognitive impairment. A progress note dated May 5, 2022 at 6:33 p.m. revealed that the resident had verbal behaviors toward others, experienced agitation, restlessness and delusions. Review of the SA database revealed a facility a self-report was received on May 7, 2022 at 9:48 a.m. Per the documentation, resident #125 reported that a staff member kissed her; and that, resident #125 asked for staff to kiss her but the staff refused. Further, the documentation included that the facility will begin their 5-day investigation. However, the SA database revealed no evidence that a 5-day investigative report was submitted by the facility. There was also no evidence that this incident was thoroughly investigated. Regarding misappropriation of narcotics for 3 residents (#134, #135, #136) -Resident #134 was admitted on [DATE] with diagnoses of metabolic encephalopathy, sepsis, major depressive disorder and anxiety disorder. The clinical record revealed the resident was prescribed with oxycodone (narcotic) -Resident #135 was admitted on [DATE] with diagnoses of paraplegia, chronic pain, anxiety disorder, major depressive disorder and insomnia. The clinical record revealed the resident was prescribed with oxycodone. -Resident #136 was admitted on [DATE] with diagnoses that included ileostomy status, ventral hernia, Guillain barre syndrome, anxiety disorder, and severe protein-calorie malnutrition. The clinical record revealed that resident was prescribed with oxycodone and Percocet (narcotic). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the SA database revealed that a self-report from the facility was received on April 26, 2022 at 9:23 a.m. Per the documentation, there narcotics were missing from at least three residents (#134, #135, and #136), the investigation was still in progress, and one staff member had been suspended pending the investigation. However, the SA database revealed no evidence that 5-day investigative report was submitted by the facility. There was no evidence found that misappropriation of narcotics for residents #134, #135 and #136 was thoroughly investigated. Further, the facility was not able to provide narcotic count sheets and documentation of their investigation regarding the allegation of misappropriation of narcotics. An interview with the administrator (staff #106) was conducted on February 21, 2024 at 1:00 p.m. The administrator stated they were having difficulty locating the documents for these incidents as there was a facility change in ownership on September 1, 2023. In another interview with the administrator conducted on February 29, 2024 at 2:00 p.m., the administrator stated that they did not have the 5-day investigation reports requested if they had not already provided them; and that, they were not able to find any other 5-day investigative reports or documentation from the previous owner. An interview with the Director of Nursing (DON/staff #69) was conducted on February 29, 2024 at 4:00 p.m. The DON stated they did not have the investigative reports that remained missing or the narcotic count sheets. Review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised September 2022, included that upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator was responsible for determining what actions if any were needed for the protection of residents. All allegations were to be thoroughly investigated and that the administrator was responsible for initiating the investigation. The investigation was to include: reviews of documentation and evidence; reviews of the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; observations of the alleged victim; interview of the person reporting the incident; interviews of any witnesses to incident; interviews of the resident or resident representative, the resident's attending physician, staff members on all shifts who have had contact with the resident during the period of the alleged incident, the resident's roommate, family members, and visitors; review of all events that lead up to the incident; and document the investigation completely and thoroughly. Within 5 business days of the incident, the administrator was to provide a follow-up investigation report. The follow-up investigation report was to provide sufficient information that described the results of the investigation, and indicate any corrective actions taken if the allegation was verified. Review of the facility's policy titled Protection of Residents During Abuse Investigations revised April 2017, included that within 5 working days of the alleged incident, the facility was to give the state survey and certification agencies a written report of the findings of the investigation and a summary of corrective action taken to prevent such incident from recurring.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49499 Based on closed clinical record review, staff interviews, review of facility documentation, policy and procedures, and through observation of current practice. the facility failed to adequately provide activity of daily living (ADL) care for two residents (#127 and #137). The deficiency could result in residents not maintaining good personal hygiene. Findings include: -Resident #127 was admitted on [DATE] with diagnoses of neurocognitive disorder with Lewy bodies, dementia and abnormal weight loss. discharge date was October 25, 2021. Review of the clinical record revealed the resident was admitted for a hospice respite stay; and that, the resident required assistance from staff for toileting and personal hygiene (washing face, combing hair, and brushing teeth). The Brief Interview for Mental Status (BIMS) score dated October 15, 2021 revealed a score of 4 indicating the resident had severe cognitive impairment. The care plan dated October 20, 2021 included the resident was at risk for oral health or dental problems. Interventions included to brush or clean dentures, brush teeth and gums twice daily and as needed, and for staff to provide verbal cues. The October 2021 hospice documentation of ADL (activities of daily living) care on October 21, 2021 revealed that bathing and dressing was documented as activity did not occur or left blank from October 22 through 25, 2021. There was no documentation found in the clinical record that the resident was bathed or dressed for four days nor received oral care for three days. Further, the clinical record revealed no documentation that the resident refused care. During an interview with the Director of Nursing (DON/staff #69) conducted on February 22, 2021 at 10:23 a.m., the DON stated that the facility was responsible for providing care and assistance to the resident when hospice was not in the facility. Further, the DON was not able to provide additional documentation to show that ADL care or shower was provided for resident #127. - Resident #137 was admitted on [DATE] with diagnoses that included cerebral palsy, bullous pemphigoid, local infection of skin and subcutaneous tissues and immunodeficiency. The care plan dated April 30, 2021 revealed that it was important to the resident that she chose between a shower and bed bath. A review of the progress note dated October 7, 2021 revealed the resident refused bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The certified nursing assistant (CNA) documentation for October and November 2021 revealed that bathing was scheduled on October 31 and November 3, 2021. However, bathing was not marked as administered on October 31 and November 3, 2021. The clinical record revealed no documentation that the resident refused bathing or showers from October 27 through November 3, 2021. The BIMS score dated November 1, 2021 was 15 which indicated that the resident was cognitively intact. During an interview with the Director of Nursing (DON/staff #69) on February 29, 2024 at 4:00 p.m., the DON stated the facility did not have shower sheets for the requested time frame of October and November 2021. A review of the facility's policy on Hospice Program dated July 2017 revealed that hospice was responsible for managing the resident's medical and spiritual care related to terminal illness and related conditions and was to provide necessary medical supplies, medications, and equipment necessary for the palliation of pain and symptoms. The policy also stated that the facility was responsible for meeting the resident's personal care and nursing needs in coordination with the hospice representative. The facility policy on Supporting Activities of daily living (ADLs) dated March 2018 revealed that residents who were unable to carry out their ADLs independently were to receive the appropriate care and services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Appropriate care and services were to include appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care) and toileting.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49499 Based on record review, staff interviews, resident interview, review of facility documentation and policy, and through observation of current practice the facility failed to ensure care and services related to pressure ulcer was provided for one resident (#171). The deficient practice could result in new or worsened pressure injuries. Findings include: Resident #171 was admitted on [DATE] with diagnoses of encephalopathy, traumatic hemorrhage of cerebrum, convulsions, traumatic subdural hemorrhage, and traumatic subarachnoid hemorrhage. The care plan dated April 30, 2022 revealed the resident was at risk for skin breakdown. Interventions included that staff were to provide preventive skin care; apply barrier cream with each cleansing; observe skin for sign and symptoms of skin breakdown such as redness, cracking, blistering, decreased sensation, and skin that does not blanch easily; off load/float heels while in bed; utilize a device to assist the resident with turning or positioning to reduce friction/sheer; and complete weekly wound assessments to include measurements and description of wound status. A physician order dated May 1, 2022 requested that a moisture barrier was applied every shift and as needed to peri-area and buttocks. The physician order dated May 15, 2022 included an order to float heels while in bed; and, to apply skin prep to bilateral heels every day shift. The Braden scale assessment dated [DATE] included a score of 12 indicating the resident was at high risk for skin breakdown. Weekly skin checks dated June 4, 11 and 18, 2022 revealed the resident had an abrasion to his left buttock. The weekly skin checks dated June 25 and July 2, 2022 included that the resident did not have any wounds The progress notes dated July 5, 2022 revealed the resident had a change of condition, was very lethargic with a low-grade fever, was not eating or drinking but would open his eyes. Per the documentation, resident was administered with medication, the physician was notified and orders for laboratory test and urine analysis were received. The weekly skin check dated July 6, 2022 revealed that the resident had a blister and non-blanchable redness. However, the documentation did not include the location or size of the skin issue. The progress note dated July 6, 2022 revealed that the resident was seen by the physician; and that, at 12:00 p.m., there was a change of condition regarding skin wound or ulcer. Per the documentation, the resident had redness and blisters to bilateral lower extremities. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order dated July 7, 2022 revealed the following orders for the following wounds: -Wound #1 Right inner ankle - Monitor blister and cover with Opti foam for protection every day shift; -Wound #2 Outer ankle - Clean with wound cleanser and cover with dry dressing every day shift. The documentation did not specify which outer ankle was the order for.; and, -Wound #3 Right outer ankle- Monitor redness and cover with Opti-foam The orders for wound #2 was transcribed onto the TAR (treatment administration record) for July 2022. However, review of the TAR revealed that the treatment for wound #1 (right inner ankle) and #3 (right outer ankle) were not transcribed and not documented as administered. The clinical record revealed no evidence treatment was provided to the wounds to the right inner and right outer ankle. There was also no evidence found why treatment was not administered as ordered; and that, the physician was notified. The clinical record revealed that resident was discharged to the hospital on July 10, 2022. An interview with the DON (staff #69) was conducted on February 29, 2024 at 2:45 p.m. The DON stated that the wound care orders for should have been entered in the TAR or MAR (medication administration record). During the interview, a review of the clinical record was conducted with the DON who stated that stated the physician treatment orders for the resident's (#171) wounds #1 and #3 should been entered as other orders in the MAR/TAR; however, the record revealed that treatment had not been completed due to them not appearing on the TAR or MAR. In an interview with the wound care nurse (staff #46) conducted on February 21, 2024 at 10:45 a.m., the wound nurse stated there was one wound care nurse that does all complex dressing changes; and that, the floor nurses were trained to do simple dressing changes. Further, the wound nurse stated that all wounds were examined by the physician on a weekly basis. The facility policy on Wound Care revised in October 2010 revealed that the nurse was to verify that there was a physician's order for the procedure prior to completing the procedure.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49499 Based on closed record review, staff interviews, resident interview, review of facility documentation and policy and the 2010 Clinical Practice Guidelines for Clostridium difficile (C-diff) Infection in Adults, the facility failed to ensure infection prevention and control practices related to C-diff precautions were implemented for one resident (#123). The deficient practice could result in transmission of infection to residents and staff. Findings include: The resident #123 was admitted on [DATE] with diagnoses of sepsis due to Serratia and enterocolitis due to C-diff. The progress notes dated June 18, 2022 at 5:09 p.m., revealed the resident was receiving oral antibiotics for a C-diff infection. The progress note dated June 23, 2022 at 9:16 p.m. included the resident was on contact isolation due to a C-diff infection and was taking an antibiotic. A physician order dated June 17, 2022 revealed an order for the following medications: -Meropenem (antibiotic) solution 500 mg (milligram) IV (intravenous) every 6 hours for blood infection for 5 days; and, -Vancomycin (antibiotic) suspension 125 mg by mouth every 6 hours for C-diff, completed on July 2, 2022. There was no evidence found in the clinical record of any physician order for isolation/contact precautions for the C-diff infection. There was also no evidence found in clinical record that the resident was on isolation/precautions for C-diff infection. Further review of the clinical record revealed that the resident was discharged on [DATE]. An interview was conducted on February 22, 2024 at 1:10 p.m. with the Director of Nursing (DON/staff #69) who stated that there was no physician order to place resident #123 on isolations precautions for the C-diff infection. The DON stated that the admissions nurse was responsible for setting up the room, placing signs and PPE, and for obtaining orders from the doctor. In another interview with the DON on February 22, 2024 at 3:00 p.m., the DON stated that for infection control related to urinary tract infection, the expectation was that staff do not need to don a gown or glove unless providing personal care to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy on Infection Control revised on October 2018 revealed that the objectives of infection control policies and practices included prevent, detect, investigate, and control infections in the facility and maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. The Clinical Practice Guidelines for Clostridium difficile Infection in Adults: 2010 Update by the Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America dated March 10, 2010 stated healthcare workers and visitors must use gloves and gowns on entering a room of a patient with a C-diff infection.