STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055189	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fairfield	1260 Travis Blvd Fairfield, CA 94533

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on interview and records review, the facility failed to ensure the prescribing physician obtained Informed Consent for one of 23 sampled residents (Resident 26) prior to the administration of a psychotropic medication (medications which affects mood or behavior). This failure did not provide Resident 26's Responsible Party the right to be fully informed regarding care and treatment in order to make health care decisions for Resident 26. A review of the Face sheet (a one-page summary of important information about a resident) indicated Resident 26 was admitted on [DATE], with diagnoses, including but not limited to, Hemiplegia and Hemiparesis (paralysis of one side of the body); Contracture (a loss of full active and passive range of motion [ROM - the extent or limit to which a part of the body can be moved around a joint or a fixed point] in a limb, which can result from limitations imposed by the joint, muscle, or soft tissue) of right hand; and Dementia (impaired ability to remember, think, or make decisions which interferes with doing everyday activities). A review of the Minimum Data Set (MDS -health status screening and assessment tool used for all residents), dated 11/15/23, indicated Resident 26 had a BIMS score of 3 out of 15 (Brief Interview for Mental Status - a 15-point cognitive (relating to the mental process involved in knowing, learning, and understanding things) screening measure that evaluates memory and orientation. A score of 13 to 15 is cognitively intact, 08 to 12 is moderately impaired, and 00 to 07 is severe impairment). A review of the facility document titled, Order Summary Report, for March 2024, indicated Resident 26 was not capable of giving Informed Consent and/or able to participate in a treatment plan. The order was written on 1/22/15. A review of the facility document titled, Informed Consent for Physical Restraint (means of purposely limiting or obstructing the freedom of a person's bodily movement)/ Psychotherapeutic Drugs (drugs that are used to treat problems in thought processes of individuals with both perceptual and behavioral disorders)/Prolonged Use of a Device, dated 1/20/17, indicated a new order for Quetapine (Also known as Seroquel - an antipsychotic drug to manage psychosis) 25 mg (milligram-a unit of mass) to be given twice a day. The document indicated consent was obtained from Resident 26. A review of the facility document titled, Order Summary Report, for March 2024, indicated a doctor's order written on 1/27/24 for Seroquel Oral Tablet 25 mg to be given at bedtime for the diagnosis of Dementia. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing on 3/25/24 at 3:18 p.m., when the DON was asked who was responsible for obtaining Informed Consent for psychotropic medications, the DON stated either the nurses or the resident's physician were responsible for obtaining Informed Consent from the resident if she/he had the capacity to make medical decisions or from the resident's Responsible Party. She stated the nurse or the physician was responsible to discuss indication and adverse effects of medication. When the DON was asked if there was an updated Informed Consent for Psychotherapeutic Drug use for Resident 26, the DON stated Resident 26 had already been on Seroquel 25 mg twice a day. She stated there was no need to obtain another consent since the order was reduced to 25 mg at bedtime. However, after review of the Informed Consent, dated 1/20/17, with the DON, she verified the consent was obtained from Resident 26 and concurred consent should be obtained from Resident 26's Responsible Party. A review of the Facility policy and procedure titled, Antipsychotic Drugs and Monitoring System, revised on 01/2024, indicated, The physician or through a designee shall make reasonable attempts to notify the resident's interested family member, as designated in the resident's health record, within 48 hours of the prescription, order, or an increase of an antipsychotic medication.

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 39792 Based on observation and interview, the facility failed to: 1) employ staff who treat the residents (Resident 12, 31 and 18) with respect and dignity; and, 2) the facility did not follow its policy with regards to the laundry services, resulting in one of one sampled Residents (Resident 7) refusing to wear anything other than a patient gown (a type of gown usually worn in hospitals which does not close in the back, it only has ties to attempt to close the back part). This left Resident 7 not trusting the laundry services to return her personal clothes and left her not feeling like an individual. Findings: 1. During an interview on 3/18/24 at 11:12 a.m., with Resident 18's Family Member (FM), the FM indicated there was an unlicensed staff member who was informed that Resident 18 needed to be changed and left the room. The unlicensed staff member did not return until the call light was turned on, the same unlicensed staff member returned and did not change Resident 18. The call light was pressed again and for a third time the same unlicensed staff member came to the room and did not change Resident 18 out of his soiled briefs. The FM indicated, every time there had been a visit to the facility and unlicensed staff member was taking care of Resident 18, he was always soiled and needed to have his brief changed. During an interview on 3/18/24 at 12:14 p.m., Resident 31 indicated there was an unlicensed staff member who was combative and had a bad attitude, and when Resident 31 complained to leadership nothing was done because, they liked her. Resident 31 indicated the unlicensed staff member would not clean her properly (from being soiled with urine or feces). Resident 31 indicated she had reported the name of the unlicensed staff person to leadership, but nothing was done, the staff member still worked in the facility and there was no follow-up with Resident 31. During a concurrent observation and interview on 3/18/24 at 3:53 p.m., with Resident 12, Resident 12 indicated the bed next to her was alarming and Resident 12 put her call light on. There was no one lying in the bed while the bed was making noise and then Unlicensed Staff Q entered the room, turned off the bed alarm and did not acknowledge Resident 12 or the Surveyor. Resident 12 was attempting to engage in conversation about the bed, but Unlicensed Staff Q did not respond and left the room. The bed alarm came back on and Unlicensed Staff Q entered the room to turn off the bed alarm. The Surveyor asked Unlicensed Staff Q what was going on with the bed, and Unlicensed Staff Q indicated the bed did not have a person lying in it, so there was an alarm and Unlicensed Staff Q also indicated that the alarm would be reset and continue to alarm. Unlicensed Staff Q turned around and left the room, in the middle of the conversation. Resident 12 indicated she usually would not put her call light on because of that type of interaction. Resident 12 indicated most of the staff were pleasant, but Unlicensed Staff Q was particularly bad. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an interview on 3/21/24 at 9:35 a.m., Resident 7 was observed to be wearing a patient gown, and Resident 7 indicated she only wore patient gowns because her personal clothes did not get returned from the laundry. Resident 7 indicated she had labeled her clothes in the past repeatedly and would find other residents wearing her clothes or would not ever have her personal clothes returned. Resident 7 indicated it was easier to just wear a patient gown than having nothing to wear and was tired of not getting her clothes back from the laundry. During an interview on 3/21/24 at 3:37 p.m., the Laundry Aide indicated when a resident was admitted to the facility, unlicensed staff and licensed staff were required to label each resident's clothes with black marker so when the clothes were laundered, the laundry aides would be able to return the clothes appropriately. The Laundry Aide indicated all clothes were supposed to be labeled. An area of the laundry was designated for clothes which had been donated, and the Laundry Aide indicated those clothes would have been labeled. The rack was observed and there were a few shirts and a pair of sweats which were not labeled. The Laundry Aide indicated that should not have happened and indicated the unlicensed and licensed staff were not labeling clothes, making it difficult, if not impossible, to locate the appropriate resident. During a review of the facility's policy and procedure, Personal Property, dated 1/2024, A representative of the Nursing will inventory the resident's personal possessions upon admission .Label resident name in each of the personal possession presented on admission .Any additional personal possession that would be brought to the facility after admission will be presented to the nursing staff to make sure that they are labeled and accounted for in the resident's medical record.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on observations, interviews and records review, the facility failed to accommodate the individual needs and preferences for one of 23 sampled residents (Resident 21), when Resident 21's bed did not have enough room for him to turn and reposition. This failure resulted in Resident 21 feeling scared and not willing to move in bed due to fear of the bed falling apart. Findings: A review of the Face sheet (A one-page summary of important information about a resident) indicated Resident 21 was admitted on [DATE], with diagnoses including but not limited to: Diabetes Mellitus; Morbid obesity (resident weighs 100 pounds over his recommended weight); and Hemiplegia and Hemiparesis (paralysis of one side of the body). A review of the Minimum Data Set (MDS -health status screening and assessment tool used for all residents), dated 12/10/23, indicated Resident 21 had a BIMS score of 15 out of 15 points (Brief Interview for Mental Status - a 15-point cognitive [relating to the mental process involved in knowing, learning, and understanding things] screening measure that evaluates memory and orientation. A score of 13 to 15 is cognitively intact, 08 to 12 is moderately impaired, and 00 to 07 is severe impairment). During an observation and concurrent interview with Resident 21 on 3/18/24 at 3:34 p.m., Resident 21 was on his bed, lying on his back. When Resident 21 was asked if he had any concerns to share with this writer, Resident 21 stated he felt unsafe on his bed. He stated the bed was too small and felt something would fall every time he's being moved. Resident 21 stated he already requested another bed, but nothing had happened. A review of the electronic record for Resident 21, under The Weights and Vitals Summary tab, indicated Resident 21 was 75 inches tall and weighed 215.8 pounds on 3/05/24. During an observation and concurrent interview with Resident 21 on 3/19/24 at 9:24 a.m., Resident 21 was on his bed, lying on his back. His left foot was touching the foot of the bed. When Resident 21 was asked how he felt when his left foot was touching the bed frame, Resident 21 stated he felt uncomfortable and thought his bed was small for him and wondered if he could have a bigger bed. During an observation in Resident 21's room and concurrent interview with the Director of Nursing (DON) on 3/20/24 at 4:26 p.m., Resident 21 was on his bed, lying on his back, asleep. The head of bed was slightly elevated. Resident 21's left foot was touching the bed frame. When the DON was asked if Resident 21 reported that his bed was broken and that his bed was small for him, the DON stated she did not hear from Resident 21 requesting for another bed or that his bed was broken. When the DON was asked if Resident 21's bed was appropriate for his height, the DON stated she would ask the Maintenance Director to switch Resident 21's bed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation in Resident 21's room and concurrent interview with Resident 21 on 3/22/24 at 3:13 p. m., when Resident 21 was asked if his bed had been replaced, he stated, No. This writer observed a mattress gap filler (closes the gap between the mattress and bed frame) at the foot part of Resident 21's bed; however, Resident 21's left leg was almost touching the bed frame. When Resident 21 was asked how he felt with the mattress gap filler placed on his bed, he stated it did not make any difference. He stated he would prefer the facility to change his bed because he still felt the bed was too small for him. A review of the Facility policy and procedure titled, Accommodation of Needs, revised on 1/2024 indicated, The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observations, interviews, and record reviews: 1. The facility did not post the contact information for State Survey and Certification agency (Office of Health Care Quality which has the primary responsibility to determine whether or not health care providers meet the federal (a system of government in which the same territory is controlled by two levels of government) certification standards to participate in the Medicaid (a joint federal and state program that helps cover medical costs for some people with limited income and resources) and/or Medicare (federal health insurance for anyone age 65 and older) programs; 2. The facility failed to provide six out of six residents (Resident 14, Resident 34, Anonymous Residents 1, 2, 3, and 4) with the contact information for the State survey and certification agency and how to formally complain to the State about the care they were receiving at the facility; and, 3. The facility did not ensure six out of six residents (Resident 14, Resident 34, Anonymous Residents 1, 2, 3, and 4) were informed of their right to file a complaint with the State survey and certification agency. These failures resulted in residents not being informed of their right to formally complain and how to formally file a complaint to the State about the care they were receiving at the facility, leaving Resident 14 feeling angry, and residents not knowing where State information postings were located, and residents not knowing the State contact information if they needed to formally complain about the care they were receiving at the facility. These failures could also lead to residents feeling frustrated. Findings: Resident 14 was initially admitted to the facility on [DATE], with the diagnoses of Diabetes Mellitus (a disease in which the body does not control the amount of glucose (a type of sugar) in the blood and the kidneys make a large amount of urine). His Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 2/21/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 14, indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses. His MDS assessment also indicated he needed moderate to maximal assistance from staff when performing his activities of daily living (ADL, activities related to personal care). Resident 34 was initially admitted to the facility on [DATE]. His diagnoses included Atrial Fibrillation (Afib, an irregular heartbeat that occurs when the electrical signals in the atria (the two upper chambers of the heart) fire rapidly at the same time), Hypertension (HTN, high blood pressure) and DM. His MDS, dated [DATE], indicated he needed substantial assistance from staff when performing his ADLs. (continued on next page)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/19/24 at 3:30 p.m., Anonymous Residents 1, 2, 3 and 4 stated they did not know where the state information postings were, and they were not informed of their right to formally complain to the State about the care they were receiving. Anonymous Residents 1, 2, 3, and 4 stated they did not know how to directly complain to the State about the care they were receiving at the facility, and they had no information on how to contact the State to complain. Anonymous Residents 1, 2, 3, and 4 stated they did not know where to find the information to call the State to complain about their care if needed. Anonymous Residents 1, 2, 3, and 4 would like to know the process and contact information on how to report care issues to the State, if needed. Anonymous Resident 1 stated it was their right to know this information. Anonymous Resident 2 stated this information about State reporting was not discussed in the Resident Council meetings. During an observation on 3/21/24 at 10:04 a.m., the facility did not have the state information posted anywhere in the building. During an interview on 3/21/24 at 10:10 a.m., Unlicensed Staff R stated he could not find the information on how residents could complain about the care they were receiving at the facility, to the State, if needed. Unlicensed Staff R stated this information should be readily available in case residents wanted to file a complaint about the care they were receiving at the facility. Unlicensed Staff R stated it was a resident's right. Unlicensed Staff R stated, if this information was not readily available or posted in a place where it was accessible, it could lead to residents feeling like their issues could not be resolved and the issues could continue. Unlicensed Staff R stated residents would feel frustrated. During an interview on 3/21/24 at 10:15 a.m., the Activity Director (AD) stated the facility did not have any posting of State information in case a resident needed this information to file a complaint to the State about the care they were receiving at the facility. When asked if the State contact information and information on how residents could file a formal complaint to the State about the care they were receiving at the facility was discussed during the monthly Resident Council meetings, she stated she could not recall if these were discussed. When asked if this information was important for the residents to know, she stated, Yes. During an interview on 3/21/24 at 11.Metformin.m., Resident 14 stated he did not know how to contact State if he needed to complain about his care. Resident 14 stated it made him feel angry nobody told him this was his right. Resident 14 stated he wished the facility would let the residents know about the State contact information and how to contact the State directly to file a complaint, if needed. During an interview on 3/21/24 at 10:25 a.m., Resident 34 stated he did not know it was his right to directly file a complaint about the care he was receiving at the facility, and nobody from the staff told him about the State contact information if he wanted to directly file a complaint about the care he was receiving at the facility. Resident 34 stated this saddened him and wished staff would share this information to all the residents. During an interview on 3/21/24 at 10:30 a.m., Licensed Staff S stated she did not know where to find the contact information for the State if a resident would like to formally complain to the State about the care they were receiving at the facility. Licensed Staff S stated residents should know this information because it was their right, and it was the facility's responsibility to share this information to the residents and staff. (continued on next page)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/21/24 at 10:38 a.m., the Infection Preventionist (IP) stated it was important residents were aware of the State contact information and how to call them if they would like to formally complaint about the care they were receiving at the facility. The IP stated, knowing the State contact information was important so that residents could make a complaint to the State, if needed. The IP stated this was a resident's right. The IP stated, if the residents did not know the State contact information and did not know they could make the complaint to the State, it meant residents' right was not upheld and could result in residents feeling like their needs were not met. During an interview on 3/21/24 at 10:47 a.m., the Administrator confirmed the State contact information was not posted anywhere in the building. The Administrator stated residents should know where to look for the State contact information and should be made aware it was their right to formally complain to the State about the care they were receiving at the facility. The Administrator stated she knew there was no State information posted anywhere in the building but forgot to get to it. The Administrator stated it was a resident right to know the State contact information. During an interview on 3/21/24 at 11:00 a.m., the DON confirmed the facility did not have a policy and procedure on required notices.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record reviews, the facility failed to: 1. Report the verbal altercation between Residents 30 and 49 to the California Department of Health (CDPH, the State department responsible for public health in California) timely. 2. Ensure staff were aware of the correct reporting time fame for reporting abuse allegations to the CDPH, the Ombudsman (an official who investigates complaints, usually lodged by private citizens against businesses, public entities, or officials) and the local Police Department (PD). 3. Include in the Abuse Prohibition policy the correct time frame on when to report abuse allegations to the CDPH, the Ombudsman, and the local (PD). These failures led to the late reporting of abuse allegations to the CDPH, the Ombudsman and the local PD. These failures could also lead to ongoing abuse and residents feeling anxious and depressed. Findings: A review of Resident 49's face sheet (demographics) indicated he was initially admitted to the facility on [DATE], with diagnoses of Hypertension (HTN, high blood pressure) and Dysarthria (a speech disorder in which the muscles you use to produce speech are damaged, paralyzed or weakened). His Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 2/5/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 15, indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). A review of Resident 30's face sheet indicated he was initially admitted to the facility on [DATE]. His diagnoses included HTN and Hyperlipidemia (HLP, abnormally high levels of fats (lipids) in the blood, which include cholesterol and triglycerides). His MDS assessment, dated 11/18/23, BIMS score was 15, indicating intact cognition. A review of Residents 49 and 30's SOC 341 (a form used to report suspected dependent adult/elder abuse), dated 11/5/23, indicated there was resident-to-resident verbal altercation on 11/4/23 at 5:30 p.m., in the dining room. The SOC 341, under section J, indicated this form was faxed to the CDPH and the Ombudsman on 11/5/23. During an interview on 3/19/24 at 5:17 p.m., Unlicensed Staff W stated allegations should be reported to the nurse supervisor or within two days to the Ombudsman, State, and local PD if there's physical injury. Unlicensed Staff W stated staff would need to gather information first before reporting days to the Ombudsman, State, and local PD. Unlicensed Staff W stated, if abuse was not reported timely, the abuse could worsen and could happen again. Unlicensed Staff W stated, residents would be anxious and would be emotionally distressed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/24 at 5:24 p.m., Licensed Staff S stated abuse allegations were reported to the DON as soon as possible. Licensed Staff S stated abuse allegation should be reported to the Ombudsman only, within 24 hours. When asked what could happen if the abuse allegation was not reported timely, Licensed Staff S stated the abuse could happen again, and it became a safety issue. During an interview on 3/19/24 at 5:32 p.m., the Activity Assistant (AA) stated the abuse allegations should be reported to the State, the Ombudsman, and the local PD immediately within 24 hours. The AA stated it was against the law if the abuse was not reported timely. The AA stated, not reporting abuse allegations timely put the safety of the residents at risk. During an interview on 3/19/24 at 5:39 p.m., Unlicensed Staff X stated all types of abuse should be reported to Ombudsman, Police and the State at least within 24 hours. When asked what could happen if the abuse was not reported timely, Unlicensed Staff X stated residents could be depressed. Unlicensed Staff X stated the safety of residents becomes at risk. During an interview on 3/19/24 at 5:46 p.m., the Administrator stated abuse allegations should be reported to the State and the Ombudsman only, immediately within 24 hours if no injury, however if there was an injury then it should be reported within two hours. When asked what could happen if an abuse was not reported timely, the Administrator stated the abuse could continue and could escalate. The Administrator stated it became a safety issue for the resident. During an interview on 3/22/24 at 3:15 p.m., the Director of Staff Development (DSD) stated abuse should be reported to the Ombudsman and the State only, within 24 hours, however if there was an injury, they would report it to the State, the Ombudsman and the local PD within two hours. The DSD stated, if an abuse was reported late, it could result in continued abuse. During an interview on 3/22/24 at 3:27 p.m., the Director of Nursing (DON) stated abuse should be reported to the Ombudsman and the State within 24 hours however, if there was an injury, they would report it to the State, the Ombudsman, and the local PD within two hours. The DON stated, if an abuse was reported late, the abuse could continue. A review of the facility's policy and procedure (P&P) titled, Abuse and Neglect Prevention Management, revised 12/2014, the P&P indicated the result of investigation must be reported to the DPH within 24 hours of incident.

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	055189	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fairfield	1260 Travis Blvd Fairfield, CA 94533

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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** 46132 Based on interviews and record reviews, the facility failed to ensure injuries of unknown source (the source of injury was not observed by any person or the source of injury could not be explained by the resident and the injury is suspicious because the extent of the injury or the location of the injury is located in an area not generally vulnerable to trauma) was thoroughly investigated and reported to the appropriate agency, for one out of one resident (Resident 38). This failure could lead to not knowing the extent of injury, worsening of an injury or the incident to recur. Findings: A review of Resident 38's face sheet (demographics) indicated she was [AGE] years-old, initially admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease (AD, a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities) and Vitamin D deficiency (loss of bone density, which can contribute to osteoporosis and fractures (broken bones). Her Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 10/31/23, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 3, indicating severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During an interview on 1/30/24 at 10:14 a.m., Licensed Staff A stated she was not aware of the facility's policy for injury of unknown source. Licensed Staff A stated she had not received any in-service about injury of unknown source. Licensed Staff A stated she was not sure what injury of unknown source meant, nor the reporting time frame. When asked if injury of unknown source should be investigated and reported, Licensed Staff A stated injury of unknown source should always be investigated and reported because if it was not reported or investigated, incidents surrounding injury of unknown source would continue, the incident could happen again, and injury could worsen. Licensed Staff A stated resident safety was important. Licensed Staff A stated residents' safety should not be neglected. Licensed Staff A stated resident's safety would be placed at risk and that should never happen. Licensed Staff A stated there was no investigation and care plan regarding Resident 1's discolorations/bruising on her knuckles and the back of her neck that she could recall. Licensed Staff A stated, having bruise or discoloration on the knuckles and back of neck were unusual places to have a discoloration or bruise. Licensed Staff A stated discolorations/bruising of this nature should be investigated and reported. Licensed Staff A stated discoloration/bruising on knuckles could mean resident was punching other resident, might mean a resident was defending herself, or it could mean it was an ongoing abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/24 at 10:53 a.m., Unlicensed Staff B stated she had not received an in-service about injuries of unknown source, and she was not sure what injuries of unknown source meant. Unlicensed Staff B stated, bruising on knuckles and back of the hand was an unusual spot and should be investigated and reported. Unlicensed Staff B stated she was not aware of the reporting time frame for injuries of unknown source. When asked what the risk was if an unknown source of injury was not reported or investigated, Unlicensed Staff B stated it could result in worsening of the injury, and the incident could happen again. Unlicensed Staff B stated, not reporting or investigating an unknown source of injury could jeopardize resident's safety. Unlicensed Staff B stated Resident 38's bruising on her knuckles and back of the neck were an unusual spot and should have been reported and investigated. During an interview on 1/30/24 at 11:23 a.m., the Director of Staff Development (DSD) stated he was not sure of the facility's policy and procedure (P & P) for injuries of unknown source. The DSD stated he did not recall giving an in-service to staff regarding injuries of unknown source. When asked what injuries of unknown source meant, the DSD stated it was an injury that could not be explained by staff. The DSD stated injuries of unknown source should be reported and investigated. The DSD stated, bruising on knuckles and back of neck were unusual spots and should have been reported and investigated. The DSD stated, injury of unknown source should be reported to the physician, the Director of Nursing (DON) and the Administrator. The DSD stated the Administrator then would decide if it needed to be reported to the State. The DSD stated he was not sure if the Ombudsman and Police needed to be involved. The DSD stated he was also not sure of the reporting time frame when making the report to the State. When asked what could happen to the resident if an unknown source of injury was not reported or investigated, the DSD stated if an injury of unknown source was not reported or investigated, injuries could worsen, and the incident could happen again. The DSD stated, ultimately resident's safety would be at risk if an injury of unknown source was not investigated or reported. When asked if he knew how Resident 38 could have gotten the bruise on her knuckles and the back of her neck, the DSD responded, No. The DSD stated he was not sure if the bruising/discoloration on Resident 38's knuckles and back of her neck was investigated at all. During an observation on 1/30/24 at 11:45 a.m., Resident 38 had a purplish-brown discoloration on the left side back of the neck. When asked if it hurt when she touched it, Resident 38 nodded her head. Resident 38 would not answer when asked how she might have gotten the bruising or discoloration on the back of her neck. During an interview on 1/30/24 at 12:04 p.m., Unlicensed Staff C stated she did not know the facility's P & P for injuries of Unknown origin, did not know what injury of unknown source meant, it's reporting time frame and to whom to report injuries of unknown source. Unlicensed Staff C stated she could not recall receiving an in-service about injuries of unknown source. Unlicensed Staff C stated, if an unknown source of injury was not reported or investigated, the injury could worsen, the incident would continue, residents would suffer, and the incident could happen again. Unlicensed Staff C stated she did not know how Resident 38 could have gotten the bruising on her knuckles and the back of her neck. Unlicensed Staff C stated bruising on knuckles and the back of her neck were unusual spots and should have been investigated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/24 at 12:30 p.m., the interim Director of Nursing (DON) stated she was not sure about the facility's P & P on injuries of unknown source. The interim DON stated injuries of unknown source meant the facility was not aware of how the injury came about. The interim DON stated, injury of unknown source would be reported to the nurse and the nurse would report to the DON and the Administrator. The interim DON stated the Administrator will report to state and the Ombudsman (a person who investigates, reports on, and helps settle complaints) only, if needed. When asked what could happen to a resident if an unknown source of injury was not reported or investigated, the interim DON stated the extent of the injury would be unknown, the injury could worsen, and resident safety would be at risk. The interim DON stated she was not sure how Resident 38 had might gotten the discolorations/bruising on the back of her neck and knuckles. The interim DON stated these bruising's were not reported to her. The interim DON stated these bruising's should have been investigated and reported to her. The interim DON verified this injury of unknown source (the discoloration/bruising on her neck and knuckles) was not investigated nor reported to the State, the Ombudsman, and the local Police. The interim DON stated the discoloration/bruising on Resident 38's neck and knuckles should have been investigated and should be reported to the State and the Ombudsman within 24 hours. A review of the facility's policy and procedure (P & P) titled, Abuse and Neglect Prevention Management P & P, revised 2/2018, it indicated it was the facility's policy to ensure that staff are doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown source .all staff will be observant for any resident that might be indicative or predictive of potential abuse and or neglect such as suspicious bruising .Injury of Unknown source definition: the source of injury was not observed by any person or the source of injury could not be explained by the resident and the injury is suspicious because the extent of the injury or the location of the injury is located in an area not generally vulnerable to trauma .All injuries of unknown origin that meet the reporting criteria will be investigated in an effort to determine cause and rule out potential abuse/neglect .the facility ensures that all alleged violations involving mistreatment, neglect, abuse including injury of unknown source immediately reported to the Administrator and DON, with subsequent mandatory reporting to law enforcement, state, ombudsman, and other agencies as required .report allegations involving neglect, exploitation or mistreatment incl injury of unknown source within 24 hours.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on interviews and records review, the facility failed to complete a comprehensive assessment for one of 23 sampled residents (Resident 21), when a Minimum Data Set (MDS - an assessment tool completed by clinical staff to identify potential resident problems, strengths, and preferences) was not completed within 14 days for Resident 21, after returning from the hospital with a new above-the-knee amputation (AKA - removing the leg from the body by cutting through both the thigh tissue and femoral (thigh) bone) of the right leg. This failure resulted in an inaccurate representation of Resident 21's current clinical status and had the potential to cause inadequate care based on a delinquent comprehensive assessment and care planning. (Reference F684) Findings: A review of the Face sheet (A one-page summary of important information about a resident) indicated Resident 21 was admitted on [DATE], with diagnoses including but not limited to: Diabetes Mellitus (disease that result in too much sugar in the blood); Morbid obesity (resident weighs 100 pounds over his recommended weight); and Hemiplegia and Hemiparesis (paralysis of one side of the body). A review of the Progress Note, dated 1/25/24 at 10:14 a.m., indicated Resident 21 was sent to the hospital for wound debridement (the removal of damaged tissue or foreign objects from a wound). A review of the hospital document titled, Wound Documents, dated 1/25/24, indicated Resident 21 had right fibula (the outer and usually smaller of the two bones between the knee and ankle in the hind or lower limbs) osteomyelitis (inflammation or swelling that occurs in the bone), bilateral (both) foot cellulitis (a common, potentially serious bacterial skin infection) and gangrene of toes. A review of the hospital document titled, Discharge Documents, dated 1/31/24, indicated Resident 1 had right above-the-knee amputation on 1/28/24. During an interview and concurrent record review with the MDS Coordinator (MDSC - a nursing professional who helps manage a nursing team in a medical facility) on 3/21/24 at 4:53 p.m., the MDSC stated Resident 21 had right leg amputation on 1/28/24. When the MDSC was asked if a Significant Change in Status Assessment was completed to reflect Resident 21's current condition, he stated, No. However, he stated a 5-day assessment was completed on 2/07/24, where Resident 21's leg amputation was captured. After review of the MDS, dated [DATE], the MDSC stated the amputation was not captured on the MDS assessment. When the MDSC was asked if leg amputation met the requirement for a Significant Change in Status Assessment, he stated, Yes. When the MDSC was asked about the purpose of an MDS assessment, he stated MDS provided an accurate and relevant assessment to guide the health care staff in the development of a comprehensive care plan for the resident. A review of the Facility policy and procedure titled, Resident Assessments, revised on 1/2024, indicated, The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: Significant Change in Status Assessment. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Review of the Resident Assessment Instrument (RAI - a comprehensive, standardized tool. It is the basis for the accurate assessment of each resident) Manual, effective 10/01/23, indicated a Significant Change in Status Assessment must be completed by the end of the 14th calendar day following determination that a significant change has occurred. The RAI Manual indicated a, significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered, self-limiting; 2. Impacts more than one area of the resident's health status; and, 3. Requires interdisciplinary review and/or revision of the care plan.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on interviews and records review, the facility failed to ensure the Minimum Data Set (MDS - health status screening and assessment tool) was accurately completed for two of 23 sampled residents (Residents 21 and Resident 40), when: 1. The MDS, dated [DATE], for Resident 21 did not address his right above-the-knee amputation (AKA - removing the leg from the body by cutting through both the thigh tissue and femoral (thigh) bone); 2. The MDS, dated [DATE], for Resident 40 indicated he had an unhealed pressure ulcer (also known as bedsore - damage to an area of the skin caused by constant pressure on the area for a long time); however, the MDS did not indicate the stage of the pressure ulcer. These failures resulted in unidentified health concerns and areas of risk for Resident 21 and Resident 40 and prevented the development of the most appropriate resident-centered care plans. Findings: Resident 21 A review of the Face sheet (A one-page summary of important information about a resident) indicated Resident 21 was admitted on [DATE], with diagnoses including but not limited to: Diabetes Mellitus (disease that result in too much sugar in the blood); Morbid obesity (resident weighs 100 pounds over his recommended weight); and Hemiplegia and Hemiparesis (paralysis of one side of the body). A review of the Progress Note, dated 1/25/24 at 10:14 a.m., indicated Resident 21 was sent to the hospital for wound debridement (the removal of damaged tissue or foreign objects from a wound). A review of the hospital document titled, Discharge Documents, dated 1/31/24, indicated Resident 1 had right above-the-knee amputation on 1/28/24. During an interview and concurrent record review with the MDS Coordinator (MDSC - a nursing professional who helps manage a nursing team in a medical facility) on 3/21/24 at 4:53 p.m., the MDSC stated Resident 21 had right leg amputation on 1/28/24. When the MDSC was asked if a Significant Change in Status Assessment was completed to reflect Resident 21's current condition, he stated, No. However, he stated a 5-day assessment was completed on 2/07/24, where Resident 21's leg amputation was captured. After review of the MDS, dated [DATE], the MDSC stated the amputation was not captured on the MDS assessment. Resident 40 A review of the Face sheet indicated Resident 40 was admitted on [DATE], with diagnoses including but not limited to: Hemiplegia and Hemiparesis (paralysis of one side of the body) and Congestive Heart Failure (CHF - blood often backs up and fluid can build up in the lungs, causing shortness of breath). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the MDS, dated [DATE], and concurrent interview with the MDSC on 3/19/24 at 12:13 p.m., the MDS indicated Resident 40 had an unhealed pressure ulcer. When the MDSC was asked about the location and stage of the pressure ulcer, the MDSC stated the pressure ulcer was on Resident 40's right ankle which healed on 12/03/23. The MDSC stated the assessment was inaccurate and would immediately be corrected. When The MDSC was asked about the importance of an accurate assessment, he stated an accurate assessment would guide staff to develop a care plan for the residents. A review of the Job Description and Performance Standards for the Minimum Data Set (MDS) Assessment Nurse indicated, The purpose of this position is to assess residents' physical and mental function and document data on minimum data set forms completely and accurately; document all additional assessments required completely and accurately; and determine appropriate referrals to other health care professionals; and to use the resident assessment protocols to determine whether to proceed or not proceed.

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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** 46132 Based on observation, interviews and record reviews, the facility failed to develop and implement a person-centered care plan for two of 23 sampled residents (Resident 38 and 21), when: 1. The facility did not ensure it addressed the causal factors of fall incidents in developing and implementing relevant, consistent, and individualized interventions to prevent future fall incidents and failed to follow the fall care plan (a form where you can summarize a person's health conditions, specific care needs, and current treatment) for Resident 38. These failures resulted in Resident 38 to incur six incidents of falls at the facility between 6/2023 and 1/2024. 2. The facility did not address on Resident 21's care plan how Resident 21 would be kept free from pain and discomfort after a right leg amputation. This failure had the potential for Resident 21 to experience pain and discomfort due to lack of pain management program. Findings: Resident 38 A review of Resident 38's face sheet (demographics) indicated she was [AGE] years-old, initially admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease (AD, a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities) and Vitamin D deficiency (loss of bone density, which can contribute to osteoporosis and fractures (broken bones). Her Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 10/31/23, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 3, indicating severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During an interview on 1/30/24 at 10:14 a.m., Licensed Staff A stated it was important to address fall risk and causal factors when formulating a fall care plan and the care plan should be followed. When asked what the risks were if the fall care plan was not followed, Licensed Staff A stated residents would fall. Licensed Staff A stated, not following the care plan and not addressing the root cause of a fall could result in further fall incidents which could result in pain, fracture, internal bleeding, bruising and bumps on the head. During an interview on 1/30/24 at 10:53 a.m., when asked what the risks were if a fall care plan was not followed, Unlicensed Staff B stated residents would fall, and their safety would be at risk. Unlicensed Staff B stated, not following a fall care plan could result in further incidents of falls and injuries. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/24 at 11:23 a.m., the Director of Staff Development (DSD) stated, if a care plan was not followed, residents could fall and get injured. The DSD stated a fall care plan was in place and should be followed for residents' safety. When asked if Resident 38's fall could have been avoided, the DSD stated Resident 1's fall could have been prevented if staff were monitoring and supervising her. During an interview on 1/30/24 at 12:04 p.m., Unlicensed Staff C stated, if a fall care plan was not followed, residents would suffer, could fall which could result in injury, fracture, bruising and pain. Unlicensed Staff C stated Resident 38's fall could have been prevented if staff were supervising and monitoring her for falls and for safety. During an interview on 1/30/24 at 12:30 p.m., the Interim Director of Nursing (DON) stated the Interdisciplinary Team (IDT, a complex process in which different types of staff work together to share expertise, knowledge, and skills to impact patient care) meeting post-fall and care planning, was important to ensure there was a preventive measure geared towards ensuring residents' safety. The interim DON stated, while the IDT determined the root cause of the fall, the fall care plan needed to address risk factors and root cause of the fall. The interim DON stated the fall care plan ensured resident risks for falls were decreased. The interim DON stated fall care plans should be updated after every fall, as needed, and should have interventions specific to address the cause of the fall and how the fall could be prevented. When asked what the risks were if the fall care plan was not followed and was not updated to address fall risks, the interim DON stated, not addressing the risk factor, the root cause of the fall and not following the fall care plan increased a resident's risk for falls with injuries. During a concurrent interview and fall incidents record review on 1/30/24 at 1:15 p.m., the interim DON verified Resident 38 fell a total of six times between 6/26/23 and 1/21/24, and a total of eight times between 6/18/22 and 1/21/24. During an observation on 1/30/24 at 1:35 p.m., Resident 38 was walking in the hallway unsupervised. Resident 38 was noted with uncoordinated and unsteady gait. During a concurrent telephone interview and fall care plan record review on 1/31/24 at 3 p.m., the interim DON verified Resident 38's Actual Fall Care Plan did not address the cause of Resident 1's on 1/21/24. The interim DON verified the At Risk For Fall Care Plan indicated Resident 38 should be supervised when out of bed was still in effect but was not followed when Resident 1 fell on [DATE]. The interim DON stated Resident 38's Fall Care Plans were generic and were not individualized. When asked if Resident 38's fall on 1/21/24, could have been prevented if staff supervised Resident 38 while she was up ambulating, the Interim DON stated yes, and she understood. During a telephone interview on 2/2/24 at 3:26 p.m., the interim DON confirmed, despite Resident 38's multiple falls, the facility was not able to determine the causative factor on why Resident 38 continued to fall. The interim DON stated Resident 38's fall care plan was generic and did not really provide interventions based on Resident 1's risk and cause of fall. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 38's At Risk For Fall Care Plan, dated 12/29/22, indicated to observe Resident 38 frequently and place in supervised area when out of bed, to assess and analyze resident's falls to determine pattern/trend. Resident 38's Actual Fall CP, dated 1/21/24, indicated Resident 38 had poor balance, poor communication/comprehension. The care plan had no interventions to address root cause of the fall, poor balance and poor communication/comprehension. During an interview on 2/23/24 at 1:52 p.m., Licensed Staff E stated it was important a Fall Care Plan was individualized and should address fall risk factors. Licensed Staff E stated care plans should be followed for staff to provide safe care to residents. When asked if Resident 38's fall care plan was followed when she was allowed to ambulate by herself without staff monitoring or supervision, Licensed Staff E stated, No. Licensed Staff E stated Resident 38's falls could have been prevented if the Fall Care Plan was followed and she was supervised and monitored by staff closely during ambulation. A review of the facility's policy and procedure (P & P) titled, Fall Risk Intervention and Monitoring, revised 12/2014, the P & P indicated it was the facility's policy to identify interventions related to residents' specific risks and causes to try and prevent a resident from falling and try to minimize complications from falling .the multi-disciplinary team including the physician will identify appropriate interventions to reduce the risk of falls . if falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current intervention remains relevant .the multi-disciplinary team will identify and implement relevant interventions to try and minimize serious consequences of falling .if resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. 31424 44968 Resident 21 A review of the Face sheet indicated Resident 21 was readmitted on [DATE], with diagnoses including, but not limited to: Diabetes Mellitus (disease that result in too much sugar in the blood); Morbid obesity (resident weighs 100 pounds over his recommended weight); and Hemiplegia and Hemiparesis (paralysis of one side of the body). During an interview and concurrent care plan review with the MDS (Minimum Data Set -health status screening and assessment tool used for all residents) Coordinator (MDSC - a nursing professional who helps manage a nursing team in a medical facility) on 3/21/24 at 4:53 p.m., the MDSC stated Resident 21 had a right leg amputation on 1/28/24. A review of the Amputation Care Plan with the MDSC did not indicate how staff will assess, monitor, and address pain for Resident 21. When the MDSC was asked about the purpose of care planning, he stated care plan provides guidance to health care staff when delivering resident care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent record review with the DON on 3/22/24 at 11:27 a.m., the DON stated Resident 21 was sent to the hospital and returned to the facility with right leg amputation. When the DON was asked about her expectations from the nurses to ensure Resident 21 was made comfortable after his right leg amputation, the DON stated she expected the nurses to administer pain medication according to the doctor's order. After review of the Physician's order, dated 1/31/24, with the DON, the DON concurred there was no scheduled pain medication ordered for Resident 21. The DON stated Resident 21 could have experienced pain after the amputation and should have a routine order of pain medication for pain management. A review of the Amputation Care Plan for Resident 21, initiated on 1/31/24, with the DON, indicated Care Plan interventions to include, but not limited to: Assessment of resident's skin; treatment as ordered; Remove dressing daily. Every other day, wash the wound with saline or soap and water. Provide shower as scheduled and as needed; monitor / observe for any signs and symptoms of skin infection such as redness, swelling, discharges; and notify the doctor and resident representative for progress and change of condition. The DON concurred the care plan did not indicate how staff would ensure Resident 21 would be free from pain and discomfort. The DON stated pain assessment/management should have been included in the care plan. A review of the Facility policy and procedure titled, Policy and Procedure - Care Plan, revised on 1/2024, indicated, A care plan is the summation of the resident concerns, goals, approaches and interventions in order to meet the goals and help minimize if not totally eradicate residents' problems.each resident has CP which is objective, measurable and time framed .is accomplished through the IDT, based on the assessment done by the group.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on observations, interviews and records review, the facility failed to meet professional nursing standards for 5 of 23 sampled residents (Resident 35, 33, 21, 12 and Resident 47), when: 1. Resident 35 and Resident 33, who had pressure ulcers (also known as bedsore - damage to an area of the skin caused by constant pressure on the area for a long time) were provided with Low Air Low (LAL) Mattress (mattress designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown); however, the air mattress was not inflated according to the resident's weight, and the facility staff did not follow its policy and procedure for, Pressure-Reducing Mattresses, Pressure Relieving Mattresses and Support Surfaces. This failure had the potential for Resident 35 and Resident 33 to develop new pressure ulcers and a potential worsening of an existing pressure ulcer; 2. Licensed Nurses did not administer pain medication for Resident 35 according to the doctor's order. This failure had the potential for Resident 35 to experience pain and discomfort due to ineffective pain management; 3. Licensed nurses did not appropriately assess a neurological condition related to Intracranial Hemorrhage in one out of one sampled Resident (12). The failures of assessment and professional standards put residents at risk for needless suffering, resulting in further pain and suffering, surgical removal for constipation, mismanagement of a resident with suicidal ideation, increased susceptibility to infection and malnutrition, and failure to asses for neurological changes, which had the potential to result in death; and, 4. Licensed Nurses did not follow physician orders for frequent monitoring (every 15 minutes) of Resident 47, who verbalized suicidal ideation's, nor did nurses follow facility policy to emergently transfer Resident 47 after she expressed potential self-harm. This failure placed Resident 47 at risk of death when staff did not monitor and transfer her while she was suicidal. Findings: 1. a. Resident 35 During a review of the Face Sheet indicated Resident 35 was admitted on [DATE], with diagnoses including but not limited to, Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities); Chronic Obstructive Pulmonary Disease (COPD - diseases that cause airflow blockage and breathing-related problems) and Pressure Ulcer of Sacral (the triangular bone just below backbone) Region. During a review of the facility document titled, Order Summary Report, for [DATE], indicated a doctor's order written on [DATE], for Low Air Low Mattress for wound management. The doctor's order indicated to monitor function every shift. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Pressure Ulcer Care Plan, revised on [DATE], for Resident 35, indicated Resident 35 had a pressure ulcer related to bed immobility (inability to move or be moved). Care Plan interventions included, but not limited to, Pressure relieving mattress. During a review of the facility document titled, Preliminary Wound Report, dated [DATE], indicated Resident 35 had as Stage IV pressure ulcer (Full thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle, bone, or supporting structure [such as tendon, or joint capsule]) to her sacrococcyx (pertaining to both the sacrum [the triangular bone just below backbone] and coccyx [the tailbone]). During an observation in Resident 35's room and concurrent interview with Licensed Staff O on [DATE] at 10:16 a.m., Resident 35 was lying on a LAL mattress covered with one fitted sheet. Resident 35 was also lying on top of a purple blanket that was folded twice creating four layers of linen, one white bath towel folded once creating two layers of linen, and three blue bed pads. When Licensed Staff O was asked if it was okay to have all the linens under Resident 35 when using a low air loss mattress, she stated, No. Licensed Staff O concurred having all the linens under Resident 35 defeated the purpose of the mattress which was to keep Resident 35 from pressure. When Licensed Staff O was asked how the low air loss mattress for Resident 35 was programmed, she stated the machine pump was programmed according to the weight of the resident. Licensed Staff O stated Resident 35's mattress was programmed at 180 lbs. (pounds - a unit of weight); however, after review of Resident 35's weight record, Licensed Staff O stated Resident 35 weighed 73 lbs. on [DATE]. Licensed Staff O concurred the current mattress setting of 180 lbs. was not appropriate and was too hard for Resident 35, putting her at risk for the development of new pressure ulcers. When Licensed Staff O was asked how the nurses were making sure the LAL mattress was programmed according to Resident 35's weight, Licensed Staff O stated the nurses were checking for proper functioning of the mattress; however, they were not checking if the bed was programmed according to Resident 35's weight. 1. b. Resident 21 During a review of the Face Sheet indicated Resident 21 was admitted on [DATE], with diagnoses including but not limited to: Diabetes Mellitus (disease that result in too much sugar in the blood); Morbid obesity (resident weighs 100 lbs. over his recommended weight); and Hemiplegia and Hemiparesis (paralysis of one side of the body) of the left side. During a review of the facility document titled, Order Summary Report, for [DATE], for Resident 21, indicated a doctor's order written on [DATE], for Low Air Loss Mattress for skin management. The doctor's order indicated licensed nurses were to monitor mattress functioning every shift. During an interview with the wound specialist Physician Assistant (PA) on [DATE] at 2:36 p.m., the PA stated Resident 21 had a Stage 4 pressure ulcer on his coccyx. During an observation and concurrent interview with the Director of Nursing (DON) on [DATE] at 4:29 p.m., Resident 21 was lying on a LAL mattress. The machine pump indicated the bed was programmed at 350 lbs. , and the lock key was turned on. When the DON was asked how the air loss mattress was programmed for Resident 21, she stated the bed had its, auto weight control feature, however she stated she was not sure how it was programmed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 21's electronic health record, under the, Weight and Vitals Summary, tab indicated Resident 21's weight on [DATE], was 215.8 lbs. During a concurrent observation and interview with the Director of Staff Development (DSD) on [DATE] at 4:35 p.m., the DSD concurred Resident 21's air mattress was programmed at 350 lbs. When the DSD was asked if the bed was programmed according to Resident 21's weight, the DSD stated he was not familiar on how to program the mattress and was not sure if the mattress was programmed correctly. He stated he would have to find out how to program the mattress and would have to provide training to the nurses. A Review of the Facility policy and procedure titled, Pressure Reducing Mattresses Pressure Relieving Mattresses And Support Surfaces, revised on ,d+[DATE], indicated, it was the facility's policy, to reduce pressure or relieve pressure, reduce skin irritation and prevent break in skin integrity. The policy indicated, Foam overlays and foam replacement mattresses have special covers for incontinent residents and should only have minimal necessary pads, sheets as additional linen will negate the benefit of the mattresses. Specialized mattresses/beds (i.e., Low Air Loss) are to be utilized according to the supplier's direction for use. 2. Resident 35 During a review of the facility document titled, Order Summary Report, for [DATE], for Resident 35, indicated a doctor's order written on [DATE], for Morphine Sulfate 0.25 ml (milliliter -a unit of volume) by mouth every two (2) hours as needed for mild pain and 0.5 ml by mouth every two hours as needed for moderate pain. During an interview and concurrent record review with Licensed Staff M on [DATE] at 3:22 p.m., when Licensed Staff M was asked about the facility's numeric pain rating scale (measures the subjective intensity of pain) when assessing a resident's pain, Licensed Staff M stated a numeric pain scale of ,d+[DATE] was mild pain; ,d+[DATE] was moderate pain and ,d+[DATE] was severe pain. When Licensed Staff M was asked how residents were medicated for complaints of pain, she stated residents were medicated according to the doctor's order. After review of the Medication Administration Record for Resident 35, with Licensed Staff M, Licensed Staff M verified Resident 35 received 0.25 ml of Morphine Sulfate on the following days: [DATE] at 9:23 a.m. for a numeric pain scale of six (6); [DATE] at 1:01 p.m., for a numeric pain scale of seven (7) and at 10:54 p.m., for a numeric pain scale of five (5); [DATE] at 5:35 p.m., for a numeric pain scale of 5; and [DATE] at 4:52 p.m., for a numeric pain scale of 6. When Licensed Staff M was asked if Resident 35's pain was addressed when she was given less than the ordered dose, Licensed Staff M stated she would reassess Resident 35 after two hours and would give another dose as needed. Review of the Facility policy and procedure titled, Policy and Procedure in Medication Administration, revised on ,d+[DATE], indicated, Medications shall be administered in accordance with our established policies and procedures. The policy indicated, Drugs must be administered in accordance with the written orders of the attending physician. Review of the Facility policy and procedure titled, Pain Management, revised on ,d+[DATE], indicated, To provide guidelines for consistent evaluation, management and documentation of pain, in order to provide the maximum level of comfort and enhanced quality of life for residents having pain or at risk of having pain. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	39792 3. Resident 12 During a review of Resident 12's, Admission Record, dated [DATE], indicated Resident 12 was admitted to the facility on [DATE], with a history of surgical amputation of left foot, major depression, heart disease and high blood pressure. During a review of Resident 12's, quarterly MDS (Minimum Data Set, a clinical assessment process provides comprehensive assessment of the resident's functional capabilities and helps staff identify problems), dated [DATE], indicated: Resident 12 had a BIMS (Brief Interview of Mental Status) score of 13, which showed mild cognitive impairment. During a concurrent interview on [DATE] at 3:43 p.m., with Resident 12 and her Care Giver, both indicated Resident 12 had not been acting herself, not being able to converse on the telephone and being more forgetful than usual. Resident 12's Care Giver indicated she had come to the facility in person because there was such a concern regarding Resident 12's change in condition. Resident 12's Care Giver indicated Resident 12 could not speak like she had normally been able to do because she was so sleepy, which was not her usual mental state, and when the Care Giver arrived at the facility, staff were not concerned regarding the changes to Resident 12's mental condition. The Care Giver indicated she demanded the facility send Resident 12 to a higher level of care for treatment. During a review of Resident 12's, Nursing Progress Note dated [DATE] at 4 p.m., indicated Resident 12's Care Giver had presented to the facility complaining of changes to Resident 12's speech and not acting the same as she had been before. The nursing note indicated Resident 12 had been assessed by licensed nurses and found to be stable, without confusion and no change in speech pattern. A Nursing Note indicated Resident 12 was asked if she wanted to go to a higher level of care and Resident 12 indicated, Yes. Resident 12's doctor was notified, and Resident 12 was then transferred out of the facility to a higher level of care, at approximately 2:45 p.m on [DATE]. During a review of Resident 12's, History and Physical, dated [DATE], indicated Resident 12 was hospitalized from [DATE] to [DATE], due to intercranial hemorrhage (bleeding within the brain) for which she had surgical repair, indicated to be a craniotomy (a surgical procedure in which part of the skull is temporarily removed to expose the brain to stop the bleeding or remove blood clots). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 11:23 a.m., with the DON, Resident 12's, Nursing Progress Notes, dated [DATE], was reviewed, and the DON indicated she had not been at the facility during that time period and only returned to work in March of 2024. A review of Resident 12's, History and Physical, dated [DATE], indicated Resident 12 had an intercranial hemorrhage and required surgery for repair. The DON indicated she was aware of what an intercranial hemorrhage was and what the surgical repair of a craniotomy was, but could not explain how the Care Giver noticed the mental status changes in Resident 12, but the licensed nurses did not. The DON indicated the nurse taking are of Resident 12 that day might have been new and not aware of Resident's 12's baseline mental status. The DON could not explain why the Progress Note, dated [DATE], indicated Resident 12's speech and mentation was not normal, and with the Care Giver highlighting this fact to the licensed nurse, the documentation in the Progress Note indicated the licensed nurse did not assess any changes with mentation or speech during the assessment prior to Resident 12 being transferred out of the facility. The DON acknowledged, History and Physical, indicated Resident 12 had an issue with her brain which would have resulted in changes to mentation and speech, but the licensed nurses did assess the changes to Resident 12's speech and mentation. The DON again, indicated she was not there and could not speak to the situation directly. During a concurrent interview and record review on [DATE] at 9:27 a.m., with the DSD, Resident 12's Nursing Progress Note, dated [DATE], and Resident 12's, History and Physical, dated [DATE], was reviewed. The DSD read the, Nursing Progress Note, dated [DATE], and stated the nursing assessment indicated there were no changes to Resident 12's baseline speech and mentation. The DSD acknowledged Resident 12's Care Giver was at the facility during the time of the nursing assessment, and the Progress Note further indicated it was Resident 12's choice to be transferred to a higher level of care. The DSD reviewed Resident 12's, History and Physical, dated [DATE], which indicted Resident 12 had returned from the hospital after undergoing a craniotomy. The DSD indicated he was not aware of why Resident 12 had been transferred to a higher level of care or what the diagnosis and treatment had been at the higher level of care. The DSD indicated he did not know Resident 12 had a craniotomy until the Surveyor presented the documentation for review. The DSD indicated, if the Care Giver had not been at the facility to advocate for Resident 12's change in mentation and speech, Resident 12 could have potentially died from not being neurologically assessed regarding Resident 12's baseline and status at the time of transfer. The DSD indicated he wanted to follow-up on Resident 12 after she had come back from the higher level of care, to see what the diagnosis and treatment was but had not had the chance. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 9:27 a.m., with Director of Nursing (DSD), the facility's, [Facility's Name] Licensed Nurse Competency Check List, was reviewed, which indicated, under, Change in Condition, Neurological Assessment, level of consciousness and speech, were to be a part of a total of six components for a further detailed neurological assessment. The DSD indicated the Nursing Progress Note, dated [DATE], did not indicate a full nursing neurological assessment had been conducted, and there was a disconnect between the Nursing Progress Note and the diagnosis of an intercranial hemorrhage, where it would be reasonable for Resident 12 to demonstrate changes to her mentation and speech. The DSD acknowledged there appeared to be a problem with neurologic assessments. The DSD indicated the neurological assessment outlined in the Licensed Nurse Competency Check list did not incorporate how to conduct a neurological assessment on a resident with dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement with symptoms that included but not limited to, forgetfulness, thinking abilities, which would interfere with daily functioning). The DSD acknowledged that conducting a neurological assessment on a resident with dementia would be important to add into the assessment to better document changes in condition and to relay that information to the doctor for diagnosis and treatment. During a review of the facility's, Performance Competency Evaluations, dated ,d+[DATE], indicated, A Competency evaluation will be completed upon hiring and at the conclusion of his/her 90-day probationary period and at least annually thereafter . 31424 4. Resident 47 During an observation on [DATE] at 10:38 a.m., Resident 47 was dressed and ambulated out of her room and down the hall independently, using a front-wheel walker (walker with wheels). During an interview on [DATE] at 10:49 a.m., Resident 47 stated she had been living at the facility off and on over the years due to multiple surgeries. She stated she was staying at the facility for awhile and she had no complaints. Review of Resident 47 electronic medical record (EMR) on [DATE] at 9:19 a.m., indicated she had diagnoses including depression, Bipolar disease (serious mental illness characterized by extreme mood swings; can include extreme excitement episodes or extreme depressive feelings), and anxiety. Her medical record revealed she was taking medication for her Bipolar Disease and taking two medications for her depression. Resident 47's medical record contained a psychiatric consultant note, dated ,d+[DATE], that indicated she was not suicidal (taking ones own life) at the time of the assessment. Review of Resident 47 EMR contained an active physician order, dated [DATE], that indicated, Monitor Q15 mins (every 15 minutes) for suicidal thoughts. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review Resident 47's EMR nurse Progress Note, dated [DATE], at 4 p.m., indicated Resident 47 had refused one of her morning medications and reported having a, terrible nightmare. The nurse documented, . (Resident 47) can hear voices . CNA assigned . reported that (Resident 47) called 911 (phone number to contact emergency services), police came at 0830 (8:30 a.m.) . this author (the nurse) called NP (the resident's Nurse Practitioner) . order to do 5150 (Involuntary 72-hour hold of someone who is a danger to themselves or others or is gravely disabled) . two police officer(s) were informed about it (the 5150) said they cannot sent [sic] resident (police cannot take resident to the hospital) .monitored every 15 minutes, emotional support provided . she was encouraged to attend group activities . she have [sic] no further episode of suicidal thought. I asked her if she is still feeling of [sic] suicidal and she express No . on call (provider) for MD (medical doctor) aware of incident and ordered Psychiatrist eval (evaluation) . The nurse progress note did not indicate Resident 47 was never left alone and did not indicate she was transported to an emergency room . Review of facility policy titled, Suicide Precautions, subtitled, Procedures (revised ,d+[DATE]) indicated, 2. If a resident verbalizes an intent to attempt suicide or takes any action that could be interpreted as a suicidal attempt, the following must happen: a. Do not leave resident alone . 3. Request orders for emergency transportation of resident to an emergency room or psychiatric evaluations facility as soon as possible . Review Resident 47's EMR nurse Progress Note, dated [DATE] at 11:29 p.m., indicated, . Resident in bed sleeping quietly and comfortable . Resident continues on monitoring for suicidal thoughts and actions. No episodes during the shift, continues on monitoring every 15 minutes . All sharp objects removed and replaced with plastic silverware. Will continue to monitor resident . Review Resident 47's EMR contained a nurse Progress Note the following day, [DATE]; the nurse did not document that monitoring for suicidal thoughts was performed every fifteen minutes. Nursing Progress Notes, dated [DATE] through [DATE] (timeframe in which the physician order for suicidal monitoring every fifteen minutes was active), did not contain documentation that nurses were monitoring for suicidal ideation. Review of Resident 47's medical record indicated her Medication Administration Reports (MAR; record on which nurse's document medication administration and various nursing interventions, including monitoring interventions), dated [DATE] and February 2024, did not contain documentation that nurses monitored Resident 47 for suicidal thoughts during that time. Review of Resident 47's medical record contained a psychiatric evaluation titled, Neurobehavioral and Consultation Executive Summary for (Resident 47), dated [DATE], indicated, Recommendations: .6. Given the patient's reported history of suicidal ideation, safety procedures should be implemented and include the following: Safety checks which include staff members checking in on patient as often as SNF (facility) policy states. Remove potentially dangerous items from room (e.g., remove cords and knives and forks for meals or use plastic knives). Closely monitor things, objects, pills, medications being brought into the SNF (facility) by third party .Ensure the patient does not have other medications/pills/substances in room (ensure nursing staff observe patient taking medications). The patient (Resident 47) should be supervised and monitored, at all times, if leaving the SNF . Should (Resident 47's) ideation and/or psychiatric symptoms escalate, transfer to a specialized psychiatric facility may be indicated . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] from 11:30 a.m. through 12 p.m., no nurse entered Resident 47's room (to monitor her). During an interview, Resident 47 stated she was feeling good. When asked if she had any feeling of self-harm (taking action to harm yourself), Resident 47 stated No. Resident 47 stated she had verbalized feelings of self-harm in the past and had tried to take her life when she was younger. When queried if the nurses asked her if she has feeling she might harm herself, Resident 47 stated the nurses did not ask her that. She stated the nurses asked her if she's, ok and asked how she was feeling in general, but they did not ask about feelings of self-harm. Resident 47 stated staff had given her plastic utensils, and at one point, she was only was provided a plastic spoon (for meals). She stated she had recently gotten her regular silverware back, including knives, forks and spoons. During an interview [DATE] at 12:29 p.m., Licensed Staff F (LS F) stated she was Resident 47's nurse that day and knew her (from caring for her in the past). LS F stated Resident 47 was alert and oriented (cognitively intact, not confused), was able to make her needs known, and was nice. When asked if there was anything she was monitoring Resident 47 for, LS F stated she was taking an antidepressant medication and staff were monitoring her for sadness. When asked how she did this, LS F stated every shift (not every 15 minutes), she assessed her for behaviors that would indicate if she was depressed. LS F was asked to look at Resident 47's physician orders (in the electronic medical record) that indicated Resident 47 needed to be monitored every fifteen minutes for suicide ideations (thoughts, ideas); LS F looked at the order and stated she was not doing that (monitoring for suicidal thoughts every fifteen minutes). LS F stated she was not at the facility in January (2024) when the order was written but she stated Resident 47 had been using plastic spoons when she (LS F) returned from vacation; LS F stated she was now getting regular utensils. When asked who made the decision to give Resident 47 back her regular knife, fork, and spoon, LS F stated she thought it was the social worker or the dietary supervisor (not a physician). Review of Resident 47's active nursing care plans (document that contains essential information about a patient's condition, diagnosis, goals, interventions, and outcomes), dated [DATE] (the day before Resident 47 called 911 for help), indicated, (Resident 47) verbalized depression or thinking of hurting herself during her conversation with Social Service Director . Care plan interventions indicated, .administer medications . obtain a psych (psychiatric) consult/psychosocial therapy . praise (Resident 47) when her behavior is appropriate . monitor (Resident 47) for signs of physical complications related to ingestion of foreign objects . support appropriate moods/behavior . provide 1:1 sessions . place (Resident 47) in a room near the nurse's station . A second, active nursing care plan, dated [DATE], indicated, (Resident 47) has depression manifested by verbalization of sadness. Nursing interventions indicated, .monitor resident for suicidal ideation or intention of hurting herself . strictly use plastic utensils only . assess if depression endangers the resident, intervene if necessary . An active nursing care plan, dated [DATE], indicated, Ineffective Coping related to depression as evidenced by disordered thoughts (suicidal ideation), called 911 stated she is having a suicidal thought . Nursing intervention indicated, keep sharp object(s) away from resident so resident cannot inflict self harm . monitoring q 15 minutes .provide resident with a safe environment . Psychiatrist consult as ordered . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent medical record review on [DATE] at 10:52 a.m., the Director of Staff Development (DSD) reviewed Resident 47's EMR. The DSD stated monitoring for suicidal thoughts every 15 minutes was not typical (in a skilled nursing facility). When asked how staff provided this type of monitoring, he stated, if a resident verbalized it (suicidal thoughts), staff would call the doctor and the family. The DSD confirmed Resident 47 was not being monitored by nursing every fifteen minutes and stated it could not be done in this type of facility. The DSD stated this was a safety issue, and he stated the facility would need to use a sitter (designated staff to stay with a resident; one staff for one resident, at all times) to provide that level of monitoring. The DSD stated he was not sure who advanced Resident 47 from using plastic spoons to using regular utensils (including knives). Review of facility policy titled, Suicide Precautions, subtitled, Policy (revised ,d+[DATE]), indicated, It is the policy of this facility to provide for the safety of all residents and to prevent injury from suicide .

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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** 44968 Based on observation, interviews and records review, the facility failed to ensure showers for one of 23 sampled residents (Resident 21) were given during his scheduled shower days. This failure to maintain Resident 21's personal grooming and hygiene needs had the potential to raise the risk of unidentified skin issues, bacterial and fungal infections. Findings: During a review of the Face Sheet (A one-page summary of important information about a resident) indicated Resident 21 was admitted on [DATE], with diagnoses including but not limited to: Diabetes Mellitus (disease that result in too much sugar in the blood); Morbid obesity (resident weighs 100 pounds over his recommended weight); and Hemiplegia and Hemiparesis (paralysis of one side of the body). During a review of the Minimum Data Set (MDS -health status screening and assessment tool used for all residents), dated 3/10/24, indicated Resident 21 had a BIMS score of 15 out of 15 points (Brief Interview for Mental Status - a 15-point cognitive ([relating to the mental process involved in knowing, learning, and understanding things] screening measure that evaluates memory and orientation. A score of 13 to 15 is cognitively intact, 08 to 12 is moderately impaired, and 00 to 07 is severe impairment). The MDS indicated Resident 21 was dependent on staff with shower/bathing and partial/moderate assistance (Helper lifts, holds or supports trunk or limbs, but provides less than half the effort) with personal hygiene. During an observation and concurrent interview with Resident 21 in his room on 3/19/24 at 10:46 a.m., Resident 21 was on his bed, lying on his back. His face had white flakes around his mouth. When Resident 21 was asked what days, he usually got his showers, Resident 21 stated he was told he could have a shower once a week. However, Resident 21 stated he never got a shower. He stated he would love to have a shower even if it was once a week. When Resident 21 was asked how he felt not getting his shower, he stated, I felt grimy and dirty. A review of the Facility PM shower schedule indicated Resident 21 was scheduled for showers on Tuesdays and Fridays. During an interview with Resident 21 in his room on 3/20/24 at 11:01 a.m., when asked if he received his shower on the evening of 3/19/24 (Tuesday), he stated, No. During an interview with Resident 21 in his room on 3/22/24 (Friday) at 3:10 p.m., when Resident 21 was asked if he had his shower today, he stated, Not yet but I hope they come and ask me. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Unlicensed Staff C on 3/25/24 at 11:16 a.m., when asked about Resident 21's shower days, Unlicensed Staff C stated Resident 21 was scheduled for showers every evening shift on Tuesdays and Fridays. When Unlicensed Staff C was asked if she had given Resident 21 a shower, she stated, No. When asked what she would do if a resident requested a shower outside his shower schedule, Unlicensed Staff C stated she would try to give it when she had the chance. She stated she would give the resident a complete bed bath and ask the incoming shift to give the shower if she did not have the time. When Unlicensed C staff was asked how a resident would feel if he got no shower, she stated she would not feel comfortable, not feel good and would be upset. During an interview and concurrent record review with the DSD on 3/25/24 at 11:42 a.m., when asked if he received a complaint from Resident 21 about not getting his shower on his shower days, the DSD stated Resident 21 was scheduled to get his showers twice a week, and he had not heard of any complaint from Resident 21 not getting his shower. The DSD stated the CNAs would have reported to Resident 21's nurse if he was refusing to get his shower. Review of the facility document titled, Documentation Survey Report v2, from 3/01/24 to 3/24/24, with the DSD indicated Resident 21 received four days of complete bed baths, one day of a partial bath and zero showers. A review of the Facility policy and procedure titled, Shower, revised on 01/24, indicated it was the facility's policy to promote cleanliness, stimulate circulation and to aid relaxation.

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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** 39792 Based on observations, interviews and records review, the facility failed to provide activities to meet the needs and preferences for four of 23 sampled residents (Residents 12, 21, 33, and 40). This failure resulted in Resident 12 feeling lonely, isolated, and depressed. Residents not receiving activities, according to their preference and needs, could potentially impact their physical, mental, and psychosocial well-being. Findings: Resident 12 During a review of Resident 12's, Admission Record, dated 7/25/22, indicated Resident 12 was admitted to the facility on [DATE], with a history of surgical amputation of left foot, major depression and heart disease. During a review of Resident 12's, quarterly MDS (Minimum Data Set, a clinical assessment process provides comprehensive assessment of the resident's functional capabilities and helps staff identify problems), dated 2/14/24, indicated: Resident 12 had a BIMS (Brief Interview of Mental Status) score of 13, which showed mild cognitive impairment. During a concurrent interview on 3/18/24 at 3:43 p.m., with Resident 12 and a Care Giver, both stated Resident 12 had requested a television in her room because she was bed-bound and felt isolated without any interaction. The Care Giver indicated the facility did not provide televisions, and her old room had a television, but this current room did not. Resident 12 indicated she did not get out of bed, and her roommates left the room and she had nothing to do and would enjoy watching television. During an interview on 3/19/24 at 4:22 p.m., with Activity Assistant H (ASH), ASH indicated Resident 12 was very conversational and liked to talk, and if Resident 12 wanted a television in her room that would be arranged by the Activity Director. ASH did not indicate there would be a problem for Resident 12 to have a television since many of the residents had televisions and some brought in their own, if they wanted a larger screen or something like that. During an interview on 3/20/24 at 4:35 p.m., with Activity Director (AD), AD indicated the facility did not provide televisions for each resident. If a television had already been installed in the resident's room then they would be able to use that television, but if there was not one in their room then they would have to purchase their own. During an interview on 3/21/24 at 11:23 a.m. with Director of Nursing, (DON), the DON indicated not every room had a television and if her room did not have one then the family or the care giver would have to bring one in for Resident 12. During a review of the facility's policy and procedure, Accommodations of Needs, dated 1/2024, Resident's individual needs are accommodated to the extent possible. 44968 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 21 During a review of the Face Sheet (A one-page summary of important information about a resident) indicated Resident 21 was admitted on [DATE], with diagnoses including but not limited to: Diabetes Mellitus; Morbid obesity (resident weighs 100 pounds over his recommended weight); and Hemiplegia and Hemiparesis (paralysis of one side of the body). During a review of the Minimum Data Set, dated dated [DATE], indicated Resident 21 had a BIMS score of 15 out of 15 points (A score of 13 to 15 is cognitively intact). During an observation in Resident 21's room on 3/19/24 at 9:24 a.m., Resident 21 was lying in bed, awake. His television, in front of him, was off. When asked about his activity preferences, he stated he had not been up since his leg was amputated. During an observation in Resident 21's room on 3/19/24 at 12:54 p.m., Resident 21 was lying on his back, his eyes were closed. The TV was off, and there was no music playing. During an interview and concurrent record review with the AD on 3/21/24 at 11:41 a.m., when the AD was asked what activities were provided to Resident 21, she stated Resident 21 liked to sleep and preferred to stay in bed all the time. The AD stated Resident 21 received one-on-one staff visits, and he liked to talk on the phone. A review of Resident 21's activity care plan with the AD indicated, [Resident 21] continues to respond to 1:1 (one-on-one) in-room visits with staff for socialization. He enjoys self-directed activities like watching TV and listening to the 70's, Soul and Country Music. Care plan interventions include: Converse with him about his other interests; Encourage [Resident 21] to participate on activities outside his room [ROOM NUMBER]-3 x a week; Offer and provide resident activity materials for independent use that might interest him like magazines and other materials; and Provide resident a monthly activity calendar. During an observation in Resident 21's room on 3/22/24 at 3:13 p.m., Resident 21 was in bed lying flat. His TV was programmed on a sports channel. When Resident 21 was asked if activity staff brought him books, newspapers, or magazines to read, he stated, No. Resident 33 During a review of the Face Sheet indicated Resident 33 was admitted on [DATE], with diagnoses including but not limited to Hemiplegia and Contractures (a loss of full active and passive range of motion [ROM - the extent or limit to which a part of the body can be moved around a joint or a fixed point] in a limb, which can result from limitations imposed by the joint, muscle, or soft tissue) of left hand and left knee. During a review of the MDS, dated [DATE], indicated Resident 33 had a BIMS score of 03 out of 15 points (a score of 00 to 07 is severe impairment). During an observation in Resident 33's room on 3/18/24 at 11:20 a.m., Resident 33 was asleep on his back. His TV was turned off. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation in Resident 33's room on 3/19/24 at 3:54 p.m., Resident 33 was lying in bed with his eyes closed. His TV was turned off, and there was no music playing. During an observation in Resident 33's room on 3/20/24 at 9:39 a.m., Resident 33 was lying in bed with his eyes closed. His TV was turned off, and there was no music playing. During an interview in Resident 33's room with Unlicensed Staff C on 3/20/24 at 10:16 a.m., when Unlicensed Staff C was asked about Resident 33's preferred activities, Unlicensed Staff C stated Resident 33 loved listening to radio and watching TV. However, neither Resident 33's TV nor his radio was on at time of the interview. Unlicensed Staff C stated activity staff kept Resident 33's radio. During an observation in Resident 33's room on 3/21/24 at 10:11 a.m., Resident 33 was lying in bed with his eyes closed. His TV was turned off, and there was no music playing. During an interview and concurrent record review with the AD on 3/21/24 at 11:37 a.m., when the AD was asked about Resident 33's preferred activities, she stated Resident 33 liked having conversation with staff. She stated ASH provided in room one-on-one visits three times a week between 5:30 p.m. to 8 p.m. The AD stated Resident 33 got up once a week to participate with activities and mostly stayed in bed due to Resident 33's history of pressure ulcer (also known as bedsore - damage to an area of the skin caused by constant pressure on the area for a long time). Review of the Activity Care Plan for Resident 33, with the AD, indicated, [Resident 33] is at risk for potential for social isolation related to spending most of his time in bed and having impaired mobility and communication. Care plan interventions included, but not limited to: Engage [Resident 33] in a conversation, listening to music via TV and radio; and room visits offered by activity staff. Resident 40 During a review of the Face Sheet indicated Resident 40 was admitted on [DATE], with diagnoses, including but not limited to: Hemiplegia and Congestive Heart Failure (CHF - blood often backs up and fluid can build up in the lungs, causing shortness of breath). During a review of the MDS, dated [DATE], indicated Resident 40 had a BIMS score of 5 out of 15. During an observation in Resident 40's room on 3/18/24 at 11:27 a.m., Resident 40 was lying on his bed, staring at the ceiling. The TV in front of Resident 40 was unplugged from the power outlet. During an observation in Resident 40's room on 3/19/24 at 9:26 a.m., Resident 40 was lying on his bed with his eyes closed. The TV in front of Resident 40 was unplugged from the power outlet. There was no music playing. During an observation in Resident 40's room on 3/19/24 at 4:09 p.m., Resident 40 was lying on his bed, staring at the ceiling. The TV in front of Resident 40 was unplugged from the power outlet. There was no music playing. During an observation in Resident 40's room on 3/19/24 at 11:01 a.m., Resident 40 was lying on his bed, staring at the ceiling. The TV in front of Resident 40 was unplugged from the power outlet. There was no music playing. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent observation in Resident 40's room with Unlicensed Staff C on 3/20/24 at 10:23 a.m., when Unlicensed Staff C was asked what activities were provided to Resident 40, Unlicensed Staff C stated Resident 40 liked to watch TV. However, the TV was off during the interview, Unlicensed Staff C stated there was no available power outlet for the TV because Resident 40's bed and feeding machine were in use. During an observation in Resident 40's room on 3/21/24 at 9:46 a.m., Resident 40 was lying on his bed, awake. Resident 40's TV was off, and there was music playing. During an interview and concurrent record review with the AD on 3/21/24 at 11:47 a.m., when the AD was asked what activities were provided to Resident 40, the AD stated Resident 40 loved to listen to hip hop music thru his TV. Review of the Activity Care Plan with the AD indicated, Resident 40 liked to watch movies on TV, spend time outside, and listen to music.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on interviews and records review, the facility failed to assess, monitor and provide necessary care and services, in accordance with professional standards of practice, for two of 23 sampled residents (Resident 21 and Resident 61), when: 1. Resident 21, who was at high risk for wounds due to Diabetes Mellitus (disease that result in too much sugar in the blood), developed a facility-acquired deep tissue injury (DTI - purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure) on his right heel on 12/20/23, and developed an open wound on his right lateral lower leg on 12/24/23, from the facility's use of a PRAFO boot (Pressure Relief Ankle Foot Orthosis - a device worn on the calf and foot, designed to, float the heel and hold the ankle in a neutral, 90 degree, position). However, nursing staff did not assess and monitor Resident 21's right foot and right leg for the development of new wounds and worsening of an existing wound after the identification of the wounds. This deficient practice resulted in the worsening of the wound, causing Resident 21 to be transferred to the hospital approximately one month after his right lateral lower leg wound was discovered. Resident 21 was found to have Osteomyelitis (inflammation or swelling that occurs in the bone) and gangrene (death of body tissue due to a lack of blood flow or a serious bacterial infection) of his toes. Resident 21 subsequently received above-the-knee amputation (AKA - removing the leg from the body by cutting through both the thigh tissue and femoral (thigh) bone); and, 2. Resident 61 was nonverbal and had a history of stroke, hemiplegia (total or nearly complete paralysis on one side of the body) and hemiparesis (weakness or paralysis on one side of the body) on the right side, and was dependent on staff for bowel management (the process which a person with a bowel disability uses to manage fecal incontinence or constipation); however, nursing staff did not monitor for signs of constipation (a condition of the bowels in which the feces [stool - waste matter discharged from the bowels after food has been digested] are dry and hardened, and evacuation is difficult and infrequent), did not administer medication to treat the constipation per physician orders and nursing standards of practice, and did not notify Resident 61's physician or family that he was experiencing constipation. These deficient practices caused Resident 61 to: 1. Experience projectile vomiting (when your body expels vomit with more force than usual) and abdominal distention (abdomen measurably swollen beyond its normal size); and, 2. Be transferred to the hospital emergently, where he was diagnosed with a small bowel obstruction (partial or complete blockage of the small intestine; a medical emergency requiring immediate care), severe constipation, acute kidney injury (AKI; also known as acute renal failure, a sudden episode of kidney failure or kidney damage that occurs within a few hours or a few days), and hypernatremia (high blood sodium levels, an electrolyte imbalance). Findings: 1. Resident 21 (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 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of the Face sheet (A one-page summary of important information about a resident) indicated Resident 21 was admitted on [DATE], with diagnosis including but not limited to: Diabetes Mellitus; Morbid obesity (resident weighed 100 pounds over his recommended weight); and Hemiparesis of the left side of the body. During a review of the Minimum Data Set (MDS -health status screening and assessment tool used for all residents), dated 12/10/23, indicated Resident 21 had a BIMS score of 15 out of 15 points (Brief Interview for Mental Status - a 15-point cognitive ([relating to the mental process involved in knowing, learning, and understanding things] screening measure that evaluates memory and orientation. A score of 13 to 15 is cognitively intact, 08 to 12 is moderately impaired, and 00 to 07 is severe impairment). The MDS indicated Resident 21 required Substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) from staff to roll from lying on his back to left and right side. During a review of the Progress Note, dated 12/20/23 at 3:26 p.m., the Progress Note indicated Resident 21 was found with deep tissue injury to the back of his right heel. The Progress Note indicated Resident 21 had a PRAFO boot on. During a review of Resident 21's January 2024, Physician's Order indicated an order written on 12/20/23, to monitor the popped blister (a small pocket of body fluid within the upper layers of the skin) on Resident 21's right heel every shift and to report to the physician if the condition worsened. During a review of the facility document titled, Weekly Skin Integrity Assessment for Non-Pressure Sore, dated 12/24/23, indicated an old scar on Resident 21's right lateral lower leg reopened due to, medical equipment damage. During a review of the facility document titled, Weekly Skin Integrity Assessment for Non-Pressure Sore, dated 1/10/24, indicated Resident 21's right lateral lower leg wound measured 14 cm. (centimeter - a unit of length) in length and 3 cm. in width. The document indicated, wound has drainage. During a review of the facility document titled, Weekly Skin Integrity Assessment for Non-Pressure Sore, dated 1/17/24, indicated Resident 21's right lateral lower leg wound measured 16 cm. in length, 3.5 cm in width and 2.5 in depth (deepness). The document indicated the wound had irregular edges, slough (thick, stringy, yellow dead tissue) on the wound bed (the base or open area of a wound) and had wound drainage. During a review of the facility document titled, Weekly Skin Integrity Assessment for Non-Pressure Sore, dated 1/24/24, indicated Resident 21's right lateral lower leg wound measured 16 cm. in length, 4 cm in width and 2.5 in depth. The document indicated the wound had irregular edges, slough on the wound bed and wound had drainage and odor. During a review of the Progress Note, dated 1/24/24 at 1:16 p.m., indicated the Wound Consultant saw Resident 21 on 1/24/24, and recommended to send Resident 21 to the hospital for debridement (the removal of damaged tissue or foreign objects from a wound). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of the hospital document titled, Wound Documents, dated 1/25/24, indicated Resident 21 had right fibula (the outer and usually smaller of the two bones between the knee and ankle in the hind or lower limbs) Osteomyelitis, bilateral (both) foot cellulitis (a common, potentially serious bacterial skin infection) and gangrene of his toes. During a review of the hospital document titled, Discharge Documents, dated 1/31/24, indicated Resident 1 had right above-the-knee amputation on 1/28/24. During an interview and concurrent record review with the Director of Nursing (DON) on 3/22/24 at 9:56 a.m., when the DON was asked about her expectation from the nurses on what to look for when a resident had a PRAFO boot, the DON stated she expected the treatment nurse and charge nurses to check the boot to make sure it was padded and applied properly, and to assess the skin underneath every shift for any skin breakdown. The DON stated, when a new wound was identified, she expected the nurses to assess and monitor the wound every shift and document the site and measurement of the wound, describe the appearance of the periwound (the area around the wound) whether redness, swelling, or maceration (a condition that occurs when a wound experiences excessive moisture, leading to the softening and breaking down of the surrounding skin) was observed, warm skin may indicate infection, document for presence of wound discharge or odor, undermining (occurs when significant erosion occurs underneath the outwardly visible wound margins resulting in more extensive damage beneath the skin surface), tunneling (wound that has progressed to form an opening underneath the surface of the skin), assess for presence of pain, and document stage of the wound if a pressure sore. She stated nurses were to notify the resident's physician for new or worsening wounds and expected the physician to assess the wound within 48 hours. After review of the Licensed Nurses Progress Notes with the DON related to Resident 21's wound assessment, from 12/20/23 to 1/24/24, the DON stated there was no documentation from the nurses, every shift, of their wound assessment for Resident 21 to indicate whether the wound had improved or had worsened. During an interview with Licensed Nurse L on 3/25/24 at 10:48 a.m., when Licensed Nurse L was asked about the facility's process for wound assessment, she stated an initial skin assessment would be completed upon identification of new skin breakdown(s) and would be assessed and measured separately, every week. She stated, for new wounds and worsened wounds, both treatment and charge nurses were responsible to notify the doctor and obtain wound treatment orders. She stated wound assessment and documentation should be done every shift. Review of the Facility policy and procedure titled, Prevention of Pressure Ulcers, revised on 1/2024, indicated, The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed .Pressure can also come from splints, casts, bandages, and wrinkles in the bed linen. If pressure ulcers are not treated when discovered, they quickly get larger, become very painful for the resident, and often times become infected. Review of the Facility policy and procedure titled, Change of Condition, revised on 1/2024, indicated, The licensed nurse responsible for the resident will continue assessment and documentation every shift for seventy-two (72) hours or until condition has stable. 31424 2. Resident 61 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/22/24 at 11:30 p.m., Confidential Family Member (CFM) stated Resident 61 had a hospital stay due to constipation. The CFM stated the facility nurses told her Resident 61 had no bowel movement for ten days and staff had to, clean him out at the hospital. When asked if facility nursing staff had informed her of Resident 61's ten-day constipation, CFM stated, No. When asked if nursing staff had informed Resident 61's physician of the constipation, the CFM stated she did not know. Review of Resident 61's facility medical record indicated a Nurse's Progress Note, dated 12/29/23 at 10:05 p. m., that indicated, . Resident had 3 episodes of projectile vomiting at around 8 p.m. Emesis (vomit) yellowish in color with moderate amount. HOB (head of bed) elevated to prevent aspiration (vomit getting into the lungs) . Assessed resident and noted with distended abdomen (swollen abdomen) . Resident is on G tube (gastrostomy tube; a surgically placed device used to give direct access to the stomach for supplemental feeding, hydration or medicine), cont. (continuous) feeding . No s/s (signs or symptoms) of pain. (Hospital) MD and RP (family) notified . Non-emergency ambulance to transfer resident to hospital for further evaluation and treatment. While waiting for the ambulance resident vomited again x 2 (twice) with moderate amount and yellowish in color . Resident left the facility via gurney . Review of Resident 61's hospital medical record (reflecting Resident 61's seven-day hospital stay from 12/29/23 through 1/5/24), Physician Discharge Summary (dated 1/5/24), indicated Resident 61 had a, . history of stroke, (was) non-verbal, G-Tube dependent . Brought by ambulance from (the facility) for multiple episodes of vomiting and abdomen distension. In the ED (Emergency Department) . CT (Computed Tomography; a computerized x-ray imaging procedure) of abdomen and pelvis showing [sic] SBO (small bowel obstruction) . Documentation of Resident 61's hospital course indicated Resident 61 was, .found to have severe constipation. Surgery (provider) evaluated patient, recommended aggressive bowel regimen (set of medications to help people avoid or relieve constipation; may involve medications, laxatives, and lifestyle changes). Patient was started on aggressive bowel regimen, which resolved his constipation. Once constipation resolved, patient tolerated his tube feeds (liquid nutrition via G-tube) well sodium elevated to 153 (normal sodium is 135-145) . likely secondary to dehydration. Hypernatremia and acute kidney injury resolved after IV (intravenous) fluids and increased free water flushes (into his feeding tube) . Review of Resident 61's nursing care plan, (dated 1/6/24), indicated, (Resident 61) is at risk for constipation r/t (related to) decreased mobility d/t (due to) complex medical conditions . Care plan interventions indicated, . Follow facility bowel protocol for bowel management . Review of Resident 61's medical record revealed a nursing summary assessment, dated 12/25/23 (four days prior to hospital transfer), that indicted Resident 61's last bowel movement was 12/22/23 (three days earlier). Review of Resident 61's December 2023 MAR (Medication Administration Report; record where nurses document interventions and medications) indicated nurses administered Dulcolax suppository (fast-acting stimulant laxative) and Milk of Magnesia (laxative) on 12/28/23 (three days after documenting his constipation). Fleets Oil enema (lubricant laxative that lubricates and softens the stool) and Senna tablet (laxative used to relieve constipation) were ordered to be given as needed; nursing staff did not document these medications were given. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 61's physician orders (with order range dates from 12/12/23 through 12/29/23), indicated the following active (prior to Resident 61's transfer to the hospital) medication orders: Dulcolax Suppository (ordered 12/12/23) . Insert 1 suppository rectally every 24 hours as needed for Bowel Regularity if MOM ineffective (daily/PRN) . Fleet Oil Enema (ordered 12/12/23) . Insert 1 application rectally as needed for Bowel Regularity if Dulcolax is ineffective, GIVE FLEET ENEMA ON THE NEXT SHIFT . Mild of Magnesia Suspension . (ordered 12/12/23) Give . needed for Bowel Regularity if no BM in 2 days . Senna Oral Tablet (ordered 12/13/23) . as needed for bowel Regularity Give 2 tablet(s) via G-Tube as needed at bedtime . A physician order, dated 12/12/23, indicated, Bowel Care Management. Call MD for further intervention/instruction if Fleet Enema is not effective. During an interview on 3/26/24 at 9:59 a.m., the Nurse Practitioner (NP) was asked about her expectation for nursing staff regarding bowel care for Resident 61. The NP stated all residents were started on a bowel regimen and it was standard (nursing) practice to implement bowel care (such as medication administration) if a resident did not have a bowel movement for three days. During an interview and concurrent medical record review on 3/26/24 at 10:52 a.m., the Director of Staff Development (DSD) reviewed Resident 61's bowel care, December 2023 MAR, and nursing summaries. The DSD stated Resident 61's routine bowel care (prior to his hospitalization) did not include scheduled medication (given routinely). The DSD confirmed the nursing summary, dated 12/25/23, indicated Resident 61's last bowel movement was on 12/22/24, but nursing did not administer medication to treat the constipation for an additional three days (on 12/28/23). The DSD confirmed nursing staff did not administer medication (already ordered by the physician) to treat Resident 61 for three days after his constipation was discovered by nursing on 12/25/23; he confirmed on 12/28/23, nursing staff medicated Resident 61 with Milk of Magnesia and Dulcolax. During the same interview on 3/26/24 at 10:52 a.m., the DSD confirmed nursing staff did not document they called anyone (including Resident 61's physician and family) regarding his constipation. When asked what his thoughts were regarding Resident 61's care, the DSD stated, We didn't do good bowel care, and he ended up in the hospital. When asked what nursing staff should have done on 12/25/23, the DSD stated the nurse should have given the ordered medication (to treat constipation) and asked (the doctor) for an order to perform a digital check for constipation (also called a digital exam; technique used to assess the presence of constipated stool in the rectum). The DSD confirmed the nursing care provided to Resident 61 did not reflect his high risk for constipation. When asked if he was aware Resident 61 had been impacted (inability to evacuate large, hard stool in the lower gastrointestinal tract) with stool, the DSD stated he heard about it after Resident 61 returned from his hospital stay. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of facility policy titled, Bowel (Lower Gastrointestinal Tract) Disorders - Clinical Protocol (revised 1/2024), indicated, . 2. Examples of lower gastrointestinal tract conditions and symptoms include: . i. Constipation . 3 . the nurse shall assess . d. Presence of fecal impaction; e. Signs of dehydration . f. Abdominal assessment; g. Digital rectal exam . i. All current medications . Under subtitle, Treatment/Management, the policy indicated, 1. The physician will identify and order pertinent cause-specific interventions, for example, modify tube feedings . institute a regimen to prevent constipation . 3. The staff and physician will address significant complications due to bowel dysfunction . 5. The physician will help identify the possible need for hospitalization to manage a gastrointestinal disorder . Under subtitle, Monitoring and Follow-Up, the policy indicated, The staff and physician will monitor the individual's response to interventions and overall progress, for example . frequency and consistency of bowel movements . 2. The physician will adjust interventions based on . resident responses to treatment .

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observations, interviews and record reviews, the facility failed to accurately assess, monitor, and provide wound care treatment to prevent development of facility acquired pressure ulcer (PU, a damage to an area of the skin caused by constant pressure on the area for a long time) and to prevent the worsening of an existing pressure ulcer for three of 23 sampled residents (Resident 21, Resident 33, and Resident 122), when: 1. a. The facility did not monitor Resident 21's right heel when he was wearing a Pressure Relief Ankle Foot Orthosis (PRAFO, an orthosis with an aluminum heel connecting bar that helps to hold the ankle in a neutral (90 degree) position. b. The facility was not able to provide documentation Resident 21 was being turned from side-to-side at least every two hours, per facility policy and per care plan (CP, a road map for the care of a patient). c. The facility did not identify Resident 21's pressure ulcer on his coccyx (tail bone) until 2/2/24, although Resident 21 had a PU on his coccyx from 12/2023, as stated by the Director of Nursing (DON). d. The facility did not request a physician order to treat Resident 21's PU on his coccyx, from 12/2023 up to 1/2024. e. The facility did not accurately identify the location of Resident 21's PU on his back, when staff documented on the weekly Skin Integrity Assessment for Pressure Sore/Post-Op [NAME] V2, Resident 21 had a PU on his sacrum (a large, triangle-shaped bone in the lower spine that forms part of the pelvis), instead of the coccyx, on these dates: 2/2/24, 2/10/24, 2/17/24, 2/24/24, 3/2/24 and 3/9/24. The Weekly Skin Integrity Assessment for Pressure Sore/Post-Op [NAME] V2 indicated Resident 21 had a PU on his sacrococcyx (fused sacrum and coccyx). f. The facility did not have a valid treatment order from the physician and did not provide consistent treatment to Resident 21's PU on his coccyx, from 12/2023 up to 1/2024. g. The facility did not complete a Weekly Skin Integrity Assessment for PU on Resident 21's coccyx from, 12/2023 up to 1/2024. h. The facility did not inspect Resident 21's skin daily, when they were providing care. i. The facility did not ensure Resident 21's low air loss mattress (LAL, a mattress designed to prevent and treat pressure wounds) setting was accurate and based on the manufacturer's recommendation, to prevent the development or worsening of pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	These failures resulted in Resident 1 developing a Deep Tissue Injury (DTI, a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) to his right heel and a Stage 2 pressure ulcer (a shallow open ulcer with a red or pink wound bed, caused when an area of skin is placed under pressure) on his coccyx, which had now progressed to Stage 4 pressure ulcer (a full thickness tissue loss with exposed bone, tendon, or muscle with slough- the yellow/white material in the wound bed; or eschar- a dead tissue that sheds or falls off from the skin). 2. The facility did not identify Resident 33's left heel pressure ulcer and did not have a doctor's order to treat the wound. This failure cause Resident 33 to experience pain / discomfort and had the potential for the wound worsening due to lack of monitoring and treatment; and, 3. The facility nurses did not implement treatment orders for Resident 122, per facility physician orders and nursing standards of practice, when his wound dressing changes were not performed per orders, his heels were not floated (position heel to remove all contact between the heel and the bed), and an appropriate pressure-reducing surface was not placed on his bed. This failure contributed to Resident 122's wound infection and potentially prevented wound healing, when staff did not ensure his heel was pressure-free. Findings: Resident 21 A review of Resident 21's face sheet (demographics) indicated he was readmitted on [DATE], with diagnoses of Hyperlipidemia (HLP, an elevated level of lipids like cholesterol and triglycerides in your blood), Type 2 Diabetes Mellitus (DM, a disease that occurs when your blood glucose, also called blood sugar, is too high), Depression (a constant feeling of sadness and loss of interest,) and Muscle Weakness. A review of Resident 21's hospital discharge note, dated 1/31/24, indicated he had a right Above-Knee Amputation (AKA, removal of the leg from the body by cutting through both the thigh tissue and femur- thigh bone) on his right lower extremity due to severe ischemia (lack of blood supply to a part of the body) and non-healing wound on his right lower extremity. His Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 3/10/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) condition of residents, score was 15, indicating Resident 21 had an intact cognition. His MDS assessment also indicated he had an impairment on his upper and lower extremities and needed staff assistance when performing his Activities of Daily Living (ADL, activities related to personal care such as bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet). During an observation on 3/19/24 at 10:51 a.m., Resident 21 was in bed, lying on his back. During an observation on 3/19/24 at 2:40 p.m., Resident 21 was still in bed, lying on his back. During an observation on 3/19/24 at 4:42 p.m., Resident 21 was still in bed lying on his back. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During an observation on 3/20/24 at 9:55 p.m., Resident 21 was in bed, lying on his back. During an observation on 3/20/24 at 11:55 p.m., Resident 21 was still in bed, awake, still lying on his back. During an observation on 3/20/24 at 2:55 p.m., Resident 21 was still in bed, asleep, lying on his back. During a concurrent observation and interview on 3/20/24 at 4:29 p.m., Resident 21 was lying on his back on a, Dynarex air mattress. The machine pump indicated the bed was programmed at 350 pounds (lbs, a unit of weight) and the lock key was turned on. When the DON was asked how the air loss mattress was programmed, she stated the bed had its, auto weight control feature, however she stated she was not sure how it was programmed. A review of the electronic health record for Resident 21 under the, Weight and Vitals Summary tab, indicated Resident 21's weight on 3/05/24, was 215.8 lbs. During a concurrent observation and interview with the DSD on 3/20/24 at 4:35 p.m., Resident 21 was on a low air loss mattress programmed at 320 lbs. When the DSD was asked if the bed was programmed according to Resident 21's weight, he stated he was not familiar on how to program the mattress and was not sure if the mattress was programmed correctly. He stated he would have to find out how to program the mattress and would have to provide training to the nurses. During an observation on 3/20/24 at 4:56 p.m., Resident 21 was still in bed, lying on his back. During an interview on 3/20/24 at 4:57 p.m., Unlicensed Staff I stated residents should be checked, changed, turned and repositioned every two hours for PU care. During an interview on 3/20/24 at 4:58 p.m., Licensed Staff F stated residents should be checked and changed every two hours and turned and repositioned every two hours for PU care. Licensed Staff F stated residents still needed to be turned and repositioned every two hours even though they were on a LAL mattress. During record review of the turning and repositioning (T&R, to reduce or eliminate pressure, thereby maintaining circulation to areas of the body at risk for pressure ulcers) documentation, dated 12/2023, and interview on 3/20/24 at 5:27 p.m., the Director of Staff Development (DSD) stated Resident 21 was a high risk for developing pressure ulcers. The DSD stated, per facility policy, residents should be turned and repositioned (T&R, turning people to change their body position to relieve or redistribute pressure) every two hours and incontinence care provided every two hours and as needed. The DSD confirmed the turning and repositioning documentation did not indicate which position Resident 21 was on when he was repositioned. The DSD stated the documentation was incomplete and was not acceptable. The DSD stated, to ensure resident 21 was being turned and repositioned, the documentation should include Resident 21's position prior to and after being repositioned. The DSD stated the documentation did not prove Resident 21 was turned and repositioned from side-to-side every two hours. The DSD also verified there was no T&R documentation for 12/2023, 1/2024, 2/2024, to indicate Resident 21 was being turned and repositioned every two hours. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During a concurrent observation and interview on 3/21/24 at 11 a.m., Resident 21 was lying on his back. Resident 21 stated he was feeling pain on his back due to the PU on his buttocks. Resident 21 also stated the pain was due to him being on his back all the time and sitting on his urine for long periods of time. Resident 21 stated staff told him he developed the pressure ulcer on his buttocks because he did not like to get up from bed. Resident 21 stated the facility did not provide him with interventions or alternative when he would not get up from bed. Resident 21 stated he was not being turned and repositioned by staff every two hours, and staff were not providing him incontinent care every two hours. Resident 21 stated he developed his PU on his buttocks and right heel at the facility. Resident 21 stated he had the PU on his buttocks even before he went to the hospital last January. Resident 21 stated he did not receive regular treatment on the pressure sore on his buttocks. Resident 21 stated he received different treatments for the pressure sore on his buttocks. Resident 21 stated it depended on who was scheduled as a treatment nurse. Resident 21 stated until today, his LAL mattress was so hard, it was uncomfortable. During an interview on 3/21/24 at 11:50 a.m., the DON verified it was the facility's policy to ensure an Interdisciplinary Team (IDT, a team of healthcare professionals from different professional disciplines who work together to manage the physical, psychological and spiritual needs of the patient) meeting was done within 72 hours after a new PU was identified or if a PU had worsened, on top of the weekly skin assessment that needed to be completed. The DON also stated a new Braden Scale (an assessment tool used to identify patients at-risk for pressure ulcers) skin assessment would need to be completed when a new PU was identified or if a PU had worsened. The DON also verified there would be a new Weekly Skin Integrity skin assessment triggered once a new wound/PU was identified. The DON stated the Weekly Skin Integrity Assessment was done weekly to track residents' PU's, to determine if the PU was getting better or worse or if the treatment was effective or ineffective. During an interview on 3/21/24 at 12:15 p.m., the DON stated Resident 21 was a high risk for developing pressure ulcers. The DON stated it was the facility's policy to ensure residents were turned, repositioned, offered toileting or incontinence care provided every two hours. The DON stated, if these were not done, these could be a contributing factor in residents acquiring a PU. When asked if Resident 21's PU on his right heel and coccyx was acquired at the facility, the DON stated, Yes. When asked if Resident 21 being left soaked in urine for a long period of time and not being repositioned every two hours could have contributed to Resident 21 developing PU's on his right heel and coccyx, the DON stated, Yes. The DON stated Resident 21's right heel PU was caused by a medical device. During a concurrent interview and T&R documentation for 3/2024, record review on 3/21/24 at 2:09 p.m., the DON verified the T&R documentation did not indicate what position Resident 21 was on before and after being repositioned. The DON stated the document did not include information on a residents' position before and after being repositioned. The DON stated this was important to track and ensure residents were being repositioned by the staff. When asked if these documents proved Resident 21 was being turned and repositioned by staff every two hours, the DON did not answer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During a concurrent observation and interview with the wound specialist Physician Assistant (PA) and Family Nurse Practitioner (FNP) on 3/21/24 at 2:36 p.m., the PA stated she only started seeing Resident 21 last week. The PA stated Resident 21 had a Stage 4 PU on his coccyx and was currently being treated with Santyl, Calcium Alginate then covered with dry dressing. The PA stated the current measurement of Resident 21's PU on his coccyx was 4.2 centimeter (cm, a unit of length) by 2.5 cm by 1.5 cm. The PA stated the PU was macerated (occurs when skin has been exposed to moisture for too long. A telltale sign of maceration is skin that looks soggy, feels soft, or appears whiter than usual) and had 30% slough. During a concurrent interview and electronic Treatment Administration Record for 12/2023 and 1/2024 (ETAR, a part of a patient's electronic health record that keeps track of when treatments are rendered to the patient), review on 3/21/24 at 4:45 p.m., Licensed Staff K verified these ETARs did not indicate a treatment was rendered on Resident 21's PU on his coccyx. Licensed K stated, if a treatment was not rendered, it could result in further skin issues, development or worsening of PU's and infection. During a concurrent interview and ETAR record review for 12/2023 and 1/2024, on 3/21/24 at 4:47 p.m., the Infection Preventionist (IP) verified the ETARs did not indicate a treatment was rendered to Resident 21's coccyx. The IP stated, if treatment was not rendered, it could lead to development or worsening of PU's. During a concurrent interview and ETAR record review, dated 12/2023 and 1/2024, on 3/21/24 at 5:01 p.m., the DON verified the ETARs did not indicate a treatment was rendered on Resident 21's PU on his coccyx. The DON stated Resident 21's PU on his coccyx was acquired at the facility. The DON stated, not providing treatment on Resident 21's PU on his coccyx could result in further skin issues, worsening of pressure sores and decline in wound status. When asked to provide the IDT notes for Resident 21's PU on his heel and coccyx, the DON stated she could not find any. The DON stated the IDT would meet to ensure root cause analysis was identified and appropriate interventions were kept in place to address risk factors and prevent acquiring further PU's and to prevent existing PU's from worsening. The DON stated, if an IDT was not completed, risk factors would not be identified, new PU's could develop and residents' PU's could worsen or get infected. During a concurrent interview and ETAR record review from 9/2023 up to 12/2023, on 3/22/24 at 9:15 a.m., the Minimum Data Set coordinator (MDS) stated the PRAFO was ordered on 1/11/22, to be worn on the bilateral lower extremity four to six hours daily, five times a week to prevent foot drop and pressure sores. The MDS coordinator stated the PRAFO boots was discontinued (DC'd) on 12/24/23, due to Resident 21 acquiring a DTI on his right heel. The MDS coordinator stated the DTI on Resident 21's right heel was facility acquired and was due to the PRAFO boots that was why it was DC'd on 12/24/23. The MDS coordinator stated the TARs for the months of 9/2023 up to 12/2023, indicated there were no order for staff to monitor Resident 21's skin while using the PRAFO boots on the bilateral foot. When asked if staff should be monitoring Resident 21's skin while using the PRAFO boots, the MDS coordinator did not answer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During an interview on 3/22/24 at 9:25 a.m., Licensed Staff F stated, residents who used PRAFO boots should have an order for skin monitoring to ensure residents did not develop pressure ulcers due to medical devices. Licensed Staff F stated it was important to monitor the skin for early identification of potential of skin issues. Licensed Staff F stated, if there was no skin monitoring, especially of the of heels when a resident was on PRAFO boots, this could result in the development of PU. During a concurrent interview, ETAR's for 11/2023 and 12/2023, PRAFO order for 11/2023 and 12/2023, record review on 3/22/24 at 10:34 a.m., the IP verified the ETAR's did not indicate whether staff were monitoring Resident 21's skin while he was on PRAFO boots. The IP stated the order for the PRAFO boots was vague and did not state clearly how long Resident 21 should wear the PRAFO boots. The IP stated it would have been beneficial for Resident 21 if there was documentation to indicate what time Resident 21 was on PRAFO boots and when staff removed the PRAFO boots. The IP also stated residents on medical devices such as PRAFO should have a skin assessment every shift to ensure early identification of potential skin issues and for prevention of pressure sore development. The IP stated Resident 21's DTI on his right heel could have been prevented if staff were monitoring his skin while he was on PRAFO boots. During a concurrent interview and Weekly Skin Integrity Assessment for Pressure Sore/Post Op forms, dated 2/2/24, with the MDS Coordinator, the assessment indicated Resident 21 had a pressure sore on his sacrum, unstageable, measuring 5 cm x 6 cm x 0 cm, with 40% of the wound bed covered with brown dead tissue. When asked if the nurse assessing Resident 21's PU on his sacrum staged his pressure sore appropriately since only 40% of the wound bed was covered with slough, the MDS Coordinator stated he would not comment but that he stood by the nurse's documentation. During a concurrent interview, review of Weekly Skin Integrity Assessment for Pressure Sore/Post Op [NAME] V2 record review, dated 2/2/24, 2/10/24, 2/17/24, 2/24/24, 3/2/24 and 3/9/24, on 3/22/24 at 12:55 p.m., the DON stated a PU that was partially covered with 40% slough should be staged. The DON stated the Weekly Skin Integrity Assessment for Pressure Sore/Post Op [NAME] V2, completed on 2/2/24, was inaccurate since it indicated Resident 21's PU was located at the sacrum; it was unstageable and was acquired at the hospital. The DON stated Resident 21 had a pressure ulcer on his coccyx and not on his sacrum, and it was acquired at the facility. The DON stated the Weekly Skin Integrity Assessment for Pressure Sore/Post Op [NAME] V2, dated 2/2/2024, 2/10/24, 2/17/24, 2/24/24, 3/2/24 and 3/9/24, were inaccurate since the nurse was documenting Resident 21 had a PU on his sacrum and not on his coccyx. The DON verified the PA's documentation on Resident 21's PU location on 3/21/24, was accurate since it indicated Resident 21 had a stage 4 PU on his coccyx. The DON stated accurate documentation was required for the physician to prescribe an appropriate treatment. The DON stated inaccurate documentations could lead to mis-identification, mis-staging of PU's and inaccurate treatments which could lead to worsening of PU's, infection, or non-healing wounds. During an observation on 3/25/24 at 8:40 a.m., Resident 21 was on his bed, lying on his back. During an interview on 3/25/24 at 8:45 a.m., the Administrator verified she could not locate the Wound Specialist wound care notes, from 12/2023 up to 3/9/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During an interview on 3/25/24 at 8:52 a.m., Licensed Staff L stated it was important to ensure location of the pressure sore was documented accurately to ensure accurate documentation and to ensure the physician gave an accurate treatment. Licensed Staff L stated inaccurate reports of PU location would not help the resident and could cause the PU to worsen and get infected. When asked what the facility policy was in preventing a PU from developing or from getting worse, she stated, turning, and repositioning every two hours, incontinent care every two hours or more often, as needed, and provision of appropriate treatment. Licensed Staff L verified Resident 21's pressure ulcer on his coccyx and his right heel DTI were facility acquired. When asked if the pressure ulcer on Resident 21's coccyx and right heel DTI could have been prevented, she stated, Yes. When asked if Resident 21's skin should have been monitored while on PRAFO boots, she stated, Yes. When asked if Resident 21 not being turned and repositioned every two hours or residents being left soaked in urine for extended periods of time could lead to pressure ulcer to develop or worsening, Licensed Staff L stated, Yes. Licensed Staff L stated, prior to Resident 21 being sent out to the hospital January of this year, she was already treating Resident 21's Stage 2 PU on his coccyx with Calcium Alginate (absorb wound fluid resulting in gels that maintain a physiologically moist environment and minimize bacterial infections at the wound site) and medihoney (a special honey that is derived from the nectar of the Leptospermum plant used to treat wounds and ulcers). During an observation on 3/25/24 at 10:41 AM, Resident 21 was still on his back, lying on his bed. During an observation on 3/25/24 at 3 p.m., Resident 21 was on his bed, lying on his back. During an interview on 3/25/24 at 4:56 p.m., the DON stated Resident 21 was a high risk for pressure ulcer development, and the DTI on his right heel and the PU on his coccyx was facility acquired. The DON stated residents on LAL mattresses still need to be T&R every two hours. The DON stated, if residents were not T&R every two hours and incontinence care was not provided every two hours or more often, as needed, then the facility policy was not followed. The DON stated residents not being T&R every two hours and incontinence care not provided every two hours or more often, as needed, could result in development of pressure ulcers, worsening of pressure ulcers and infection. The DON stated pressure ulcers also involved pain and could result in decreased quality of life. During an observation on 3/25/24 on 5:32 p.m., Resident 21 was still in bed lying on his back. During an interview on 3/26/24 at 10:22 a.m., the Nurse Practitioner (NP) stated she was not aware Resident 21 was refusing to be T&R. The NP stated Resident 21 was a high risk for developing pressure sores. The NP stated she expected staff to notify her or the physician if Resident 21 was refusing to be T&R because that would prompt an assessment, which could lead to interventions to be put in place to decrease risk of Resident 21 in developing PU's and to prevent his existing PU from worsening. The NP stated, if a resident was wearing a medical device, such as PRAFO, the expectation would be that staff monitor the resident's skin every shift for redness or potential skin issues. During an interview on 3/26/24 at 12:50 p.m., the Medical Record (MR) confirmed there was no order to treat Resident 21's PU on his coccyx, from 12/2023 and 1/2024. During an interview on 3/26/24 at 1:55 p.m., the DSD and the IP stated one would need a valid treatment order from the physician in order to treat a PU. The DSD and the IP stated, ensuring there was a valid treatment order ensured the nurses were providing the accurate treatment and the PU would not worsen or get infected. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During an interview on 3/26/24 at 2 p.m., the DON stated, acquiring an appropriate treatment from the physician or NP ensured a resident's PU was receiving an appropriate treatment. The DON stated, nurses providing treatment without a physician's order could lead to a PU getting worse or infected. During an interview on 3/26/24 2:48 p.m., the DON verified Resident 21 did not have a treatment order for the PU on his coccyx, from 12/2023 up to 1/2024. A review of hospital referral wound docs indicated Resident 21 was admitted to the hospital on 1/25/24, with a PU on his coccyx. A review of Resident 21's Physician's Order Summary, dated 12/2023 and 1/2024, indicated there was no treatment order for Resident 21's PU on his coccyx. There were no Weekly Skin Integrity Assessment for Pressure Sore/Post OP sheets for 12/2023 and 1/2024, identifying Resident 21's PU on his coccyx. There were no documentation to indicate the nurses were tracking Resident 21's PU on his coccyx, from 12/2023 and 1/2024. A review of Resident 21's Braden Scale for Prediction of Pressure Sore Risk, dated 12/7/23, indicated he scored 14, meaning he had a moderate risk for developing PU's due to his skin being occasionally moist, he was confined in bed, his mobility was very limited, and he required moderate to maximum assist when moving. A review of Resident 21's MDS Assessment, dated 9/12/23, indicated he was at risk for developing PU's but did not have any PU's at that time. 44968 Resident 33 During a review of the Face Sheet indicated Resident 33 was admitted on [DATE], with diagnoses, including but not limited, to Hemiplegia and Hemiparesis (paralysis of one side of the body); Contractures (a loss of full active and passive range of motion [ROM - the extent or limit to which a part of the body can be moved around a joint or a fixed point] in a limb, which can result from limitations imposed by the joint, muscle, or soft tissue) of left hand and left knee; and Peripheral Vascular Disease (PVD - a blood circulation disorder). During a review of the facility document titled, Joint Mobility Assessment, dated 9/16/23, indicated Resident 33 had severe limitation to his left hip and left knee; and moderate to severe limitation to his left ankle. During a review of the Pressure Ulcer (also known as bedsore - damage to an area of the skin caused by constant pressure on the area for a long time) Care Plan, initiated on 10/09/23, indicated Resident 33 was at risk for pressure ulcers related to impaired mobility. Care Plan interventions include, but were not limited to: Float heels while in bed, monitor for placement; Avoid shearing resident's skin during positioning, transferring, and turning; Keep bony prominences from direct contact with one another with pillows; Report any signs of skin breakdown (sore, tender, red, or broken areas); and turn and reposition every two hours. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During a review of the MDS, dated [DATE], indicated Resident 33 had a BIMS score of 03 out of 15 points (Brief Interview for Mental Status - a 15-point cognitive (relating to the mental process involved in knowing, learning, and understanding things) screening measure that evaluates memory and orientation. A score of 13 to 15 is cognitively intact, 08 to 12 is moderately impaired, and 00 to 07 is severe impairment). The MDS indicated Resident 33 had functional limitation in range of motion to both upper and lower extremities; Resident 33 was dependent on staff to roll from lying on back to left and right side. During a review of the facility document titled, Wound Management Review, dated 3/15/24, indicated Resident 33 had a Stage 3 (full thickness skin loss, where the subcutaneous fat [a type of fat that's stored just beneath your skin] may be visible to the naked eye) on his left lateral foot (the little toe side of the foot) measuring 1.5 cm (centimeter - a unit of length) x (by) 1.6 cm x 0.6 cm. During an Observation in Resident 33's room on 3/18/24 at 11:20 a.m., Resident 33 was asleep, lying on his back. His left knee was bent away from his body. Resident 21 had a knee brace (a medical device that stabilizes your knee joint and holds it in place) and heel protector (helps with pressure ulcers and is made with pressure-relieving polyfoam) in place; however, his left foot was resting on the bed surface. During an Observation in Resident 33's room on 3/19/24 at 11:58 a.m., Resident 33 was awake, lying on his back with his left and right knee bent away from his body in a frog leg position. Resident 33's foot of bed was elevated. Both heels had heel protectors; however, both feet were resting on the bed surface. During an Observation in Resident 33's room on 3/19/24 at 3:54 p.m., Resident 33 was lying on his back with his left knee bent away from his body, his left foot had heel protector and was touching the bed surface. During an Observation in Resident 33's room on 3/20/24 at 9:39 a.m., Resident 33 was lying on his backwith his left knee bent away from his body, his left foot had heel protector and was touching the bed surface. During an interview with Unlicensed Staff C on 3/20/24 at 10:16 a.m., when Unlicensed Staff C was asked about the reason for not getting Resident 33 out of bed, Unlicensed Staff C stated, to prevent [Resident 33] from having pressure ulcer. When Unlicensed Staff C was asked how is a pressure ulcer prevented when Resident 33 was not getting out of bed, Unlicensed Staff C stated, by turning [Resident 33] every two hours. Unlicensed Staff C stated it is the facility's practice to turn the residents in bed every two hours. During an Observation and concurrent interview with Unlicensed Staff C on 3/20/24 at 10:28 a.m., in Resident 33's room, Resident 33 was awake, lying on his back. When Unlicensed Staff C was asked how much assistance Resident 33 required to turn and reposition in bed, Unlicensed Staff C stated Resident 33 was dependent on staff with turning and repositioning in bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During an Observation in Resident 33's room and concurrent interview with Unlicensed Staff C on 3/21/24 at 10:14 a.m., Resident 33 was lying on his back with his left and right knee bent away from his body. When Unlicensed Staff C repositioned Resident 33's left leg, Unlicensed Staff C could barely stretch Resident 33's left leg. Unlicensed Staff C stated Resident 33 could not stretch both his left and right leg. During a wound treatment observation, record review and interview with Licensed Staff L on 3/25/24 at 10:48 a.m., Resident 33 was lying on his back with his left and right knee bent away from his body. Resident 33's right foot was resting on top of his left foot. Both feet had heel protectors. Two wound sites were seen on Resident 33's left lateral foot: The wound closest to his left little toe was noted with blackish matter approximately 0.5 cm in length and 0.5 cm in width; and an open wound farthest from his left little toe measuring approximately 1.5 cm. in length, 1.5 cm in width and 0.3 cm. deep. There was also an open wound to Resident 33's left outer aspect of his heel measuring approximately 2 cm. in length, 1.2 cm in width and 0.3 cm. deep. When Licensed Staff L was asked if Resident 33's left heel wound was new, Licensed Staff L stated, No, and stated she had treated the wound a few times. After review of the Treatment Administration Record with Licensed Staff L, Licensed Staff L stated the was a treatment order for Resident 21's left lateral foot. However, Licensed Staff L stated there was no treatment order written for the left heel. When Licensed Staff L was asked if there was a skin assessment for Resident 33's left heel, Licensed Staff L stated there was no skin assessment in Resident 33's medical record. When Licensed Staff L was asked what would happen if there was no record of baseline (an imaginary starting point or basis of comparison for something) wound measurement of Resident 33's left heel, Licensed Staff L stated there would be no comparison to determine whether the wound was bigger or had worsened. When Licensed Staff L was asked how she would classify Resident 33's left heel wound, she stated, Stage 2 pressure ulcer. When Licensed Staff L was asked about the facility's process for wound assessment, she stated an initial skin assessment would be completed upon identification of new skin breakdown(s) and would be assessed and measured separately every week. She stated for new wounds and worsened wounds, both treatment and charge nurses were responsible to notify the doctor and obtain wound treatment orders. She stated wound assessment and documentation should be done every shift. During an interview with the (NP - registered nurse who has advanced education and clinical train[TRUNCATED]

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44968 Based on observations, interviews, and records review, the facility failed to ensure two (Resident 33 and Resident 5) of 23 sampled residents received appropriate treatment and services to maintain joint mobility and prevent further decrease in Range of Motion (ROM - the capacity for movement at a given joint in a specific direction). These failures resulted in Resident 33 and Resident 5 experiencing pain during care and potentially further contractures. Findings: Resident 33 During a review of the Face Sheet (A one-page summary of important information about a resident) indicated Resident 33 was admitted on [DATE], with diagnosis including but not limited to Hemiplegia and Contractures (a loss of full active and passive range of motion [ROM - the extent or limit to which a part of the body can be moved around a joint or a fixed point] in a limb, which can result from limitations imposed by the joint, muscle, or soft tissue) of left hand and left knee. During a review of the facility document titled, Joint Mobility Assessment, dated 9/16/23, indicated Resident 33 had severe limitation to left hand, left hip and left knee; and moderate to severe limitation to his left ankle. During a review of the March 2024, Physician's Order for Resident 33, indicated a doctor's order for RNA (Restorative Nursing Assistant - assists patients with long-term treatment and recovery after an accident, surgery, or illness) to perform passive range of motion to both upper and lower extremities, written on 10/05/23; and RNA to apply hand roll to Resident 33's left hand, written on 11/03/23. During an observation in Resident 33's room on 3/18/24 at 11:20 a.m., Resident 33 was lying on his bed sleeping. Resident 33's left hand was contracted. There was no hand roll to his left hand. During an observation in Resident 33's room on 3/19/24 at 11:58 a.m., Resident 33 was awake, lying on his bed. There was no hand roll to his left hand. During an observation in Resident 33's room and concurrent interview with Unlicensed Staff C on 3/20/24 at 10:28 a.m., There was no hand roll to Resident 33's left hand. When Unlicensed Staff C was asked why Resident 33 did not have a hand roll to his left hand, Unlicensed Staff C stated the RNA should apply the hand roll every day. During an observation in Resident 33's room on 03/20/24 at 10:33 a.m., and concurrent interview with RNA V, when RNA V was asked why Resident 33 did not have the hand roll to his left hand, RNA V stated she applied a hand towel earlier in the morning and could have removed it. When RNA V was stretching Resident 33's fingers on his left hand, Resident 33 was grimacing. When RNA V was asked if Resident 33 showed signs of pain when applying the hand roll or when providing ROM, RNA V stated Resident 33 grimaced and got physically aggressive when touched. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation in Resident 33's room and concurrent interview with Unlicensed Staff C on 03/21/24 at 10:14 a.m., Resident 33 was grimacing with reddened face and teary eyed when Unlicensed Staff C was repositioning Resident 33's left leg. When Unlicensed Staff C asked Resident 33 if he was in pain, Resident 33 nodded his head. Unlicensed Staff C barely stretched Resident 33's left leg. She stated Resident 33 could not stretch his left and right legs. During an interview with the Director of Rehabilitation (DOR) on 3/25/24 at 10:41 a.m., when asked if he was aware Resident 33 was showing signs of pain when receiving range of motion, he stated Resident 33 had severe contractures to his left hand and left lower extremity. The DOR stated RNA S and CNAs (Certified Nursing Assistant) were instructed to stop the ROM if Resident 33 showed signs of pain. When the DOR was asked about the importance of providing ROM to the residents, the DOR stated, to maintain their functional levels; maintain strength; prevent the development of contracture and prevent the worsening of existing contractures. 39792 Resident 5 During a review of Resident 5's, Admission Record, dated 6/8/2008, indicated Resident 5 had been originally admitted to the facility on [DATE], and then most recently on 2/9/2022. During a review of Resident 5's doctor's progress note, Spherical Medical Group Progress Note, dated 11/1/2023, indicated Resident 5 had a history of paraplegia (loss of muscle function in the lower half of the body, including both legs) related to status post near drowning, dysphagia (difficulty swallowing), muscle spasms, contracture of the right/left hand, right/left shoulder, right/left elbow and high blood pressure. During a review of Resident 5's, Physician Order, dated 10/13/23, indicated, Resident 5's occupational therapy to be discontinued, and Resident 5 would be referred to the Restorative Nursing Assistant Therapy program for restorative therapy services for passive range of motion exercises along with mild stretching and positioning of left shoulder with rolled bed sheet between armpit to prevent further contractures, three times a week. During a concurrent interview and record review on 3/21/24 at 8:28 a.m., with Director of Rehabilitation (DOR), Resident 5's, Quarterly Rehabilitation Screen, dated 2/29/24, indicated Resident 5 had no significant changes from last review and suggested to continue with RNA (Restorative Nursing Assistant) program. RNA Weekly Assessments, dated 3/2/24 and 3/21/24, both indicated Resident 5 had not been on the RNA program. The DOR indicated he had written the Quarterly Rehabilitation Screen, dated 2/29/24, and Resident 5 should be on RNA services since he had contractures and would not want them to get worse or further contracted. The DOR could not explain why the documentation indicated Resident 5 was not on the RNA program. The DOR indicated he was not in charge of the staff carrying out the RNA program, but the nursing department would oversee those staff members. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record on 3/21/24 at 10:05 a.m., with the Director of Nursing (DON) reviewed the following, Quarterly Rehabilitation Screen, dated 2/29/24, indicating Resident 5 had been evaluated and continued to remain on the RNA program. RNA weekly Summary Notes, dated and reviewed in the following order: 3/2/24, 3/21/24, 1/27/24, 1/13/24, 12/23/23, 11/4/23, 10/22/23, all weekly progress indicated in one form or another that Resident 5 was no longer on the RNA program, had been discontinued from the program or not applicable, meaning Resident 5 was not on the RNA program. An, RNA Referral Document, dated 10/13/23, was reviewed with the DON which indicated Resident 5 had been referred to the RNA program, and Resident 5's order for occupational therapy had been discontinued. The DON indicated, after reviewing Resident 5's electronic medical record, that she could not locate documentation where Resident 5's RNA services had been discontinued. The DON indicated the only staff who could discontinue RNA services would be the therapy department or the doctor, and the quarterly screen, dated 2/29/24, indicated Resident 5 should remain on the RNA program. The DON confirmed, based upon Resident 5's history, he should remain on RNA services so his contractures did not get worse which could cause pain and skin breakdown and infections, if the limbs contracted at the shoulders, elbows, and wrist, and there was no air or movement to the effected area. During a concurrent interview and record review on 3/21/23 at 10:39 a.m., with RNA V, the, RNA Weekly Worksheet, dated 3/18/24, indicated Resident 5 was not on RNA services. RNA V indicated she did not document that note, that another RNA staff member did that documentation. A review of Resident 5's, Treatment Authorization Requests (TAR), March 2024, indicated RNA V had conducted RNA services, as ordered, three times a week. RNA V could not explain why the documentation on the Weekly RNA Summary Notes and the monthly TAR notes contradicted one another. RNA V indicated maybe, because the person documented the weekly summary was not aware that Resident 5 was receiving RNA services. RNA V indicated she had just come back from an extended leave, and the TAR for February 2024, was reviewed. For the month of February 2024, Resident 5 received one documented day (2/29/24) of RNA services. RNA V indicated she came back from the extended leave in the middle of the month, so Resident 5 should have received more RNA services than one day. During a concurrent interview and record review on 3/21/24 at 11:02 a.m., with the DON and RNA V, the TAR notes for February 2024, October 2023, November 2023 and December 2023, indicated Resident 5 did not have any documented RNA services for any of the months reviewed in the electronic medical record. Both RNA V and the DON indicated they were both gone from November 2023, until February 2024, but there was someone to cover those services, and neither could explain why there was no documentation to support Resident 5 had received RNA services for approximately five months. RNA V indicated Resident 5's shoulder had been very stiff but could not remember if it had gotten worse, but currently his should was stiff. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/22/24 at 9:27 a.m., with Director of Staff Development (DSD), reviewed order, RNA Referral Document, dated 10/13/23, which indicated Resident 5 had been referred to the RNA program. Reviewed, RNA Weekly Assessment, dated 10/22/23, which indicated Resident 5 was not on the RNA program. The DSD confirmed the documentation through the Electronic Medical Record and indicated the order had been missed and was not taken off or processed appropriately. The DSD indicated he did not know why the nursing and therapy departments both missed the order. A review of Resident 5's, Quarterly Rehabilitation Screen, dated 2/29/24, indicating Resident 5 had been evaluated and continued to remain on the RNA program and, RNA weekly Summary Notes, dated and reviewed in the following order: 3/2/24, 3/21/24, 1/27/24, 1/13/24, 12/23/23, 11/4/23, 10/22/23, all weekly progress indicated in one form or another that Resident 5 was no longer on the RNA program. The DSD indicated again that Resident 5 should have been receiving RNA services but, per the documentation, Resident 5 had not been getting RNA services. The DSD indicated there was a disconnect in communication between the two departments (Nursing and Therapy) and the documentation was inconsistent, indicating Resident 5 had been discontinued from the program but was evaluated to meet the criteria to stay on the RNA program. The DSD could not explain how this happened since there was a person identified to carry out the duties of the RNA program while RNA V was on leave. A review of the Facility policy and procedure titled, RNA Referral, revised on 1/2024, indicated, it is the facility's policy to provide rehabilitative services and a restorative nursing program for residents to prevent deterioration and to achieve and maintain optimal levels of functioning and independence. A review of the facility's policy and procedure titled, Joint Mobility Assessment (JMA), form, dated 1/2024, indicated, A joint mobility assessment form (JMA) is a tool used to assist in determining and or monitoring range of motion (ROM) for each resident in the facility .similarly if a deficit in ROM is identified during quarterly assessments (QA), Annual Assessments (AA), or change in condition (COC), and a PT/OT evaluation is not warranted, a JMA will be completed for monitoring purposes .

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observations, interviews and record reviews, the facility failed to develop and implement an effective fall management program for three out of 23 sampled residents(Residents 38, 13 and Resident 26) with Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), when: A. 1. The facility did not follow its fall care plan (CP, a form where you can summarize a person's health conditions, specific care needs, and current treatment) when Resident 38 was not observed frequently and was not placed in a supervised area when out of bed such as when she was ambulating. 2. The facility did not address the causal factors such as poor balance, poor/comprehension leading to Resident 38's fall incident in developing and implementing relevant, consistent, and individualized interventions to prevent future fall incidents. 3. The facility did not revise nor address Resident 38's risks for falls in the plan of care, as needed, to reduce the likelihood of another fall. These failures led to Resident 38's six incidents of falls at the facility between 6/2023 and 1/2024. The fall incident on 1/21/24, resulted in Resident 38's complaints of pain on both legs and lump on the left side of her forehead. This fall incident on 1/21/24, also resulted in Resident 38 being sent out to the Emergency Department (ED) for further evaluation and treatment where she was diagnosed with head contusion (a bruise to the brain itself. A contusion causes bleeding and swelling inside of the brain around the area where the head was struck). B. 1. Follow the Fall Management policy and procedure (P&P), when the facility did not collaborate with the physician to identify pertinent interventions to try and reduce the risks associated with Resident 13's falls on 4/12/23 and 12/2/23. 2. Follow the Fall Management P&P when the facility did not have the pharmacist complete a Medication Regimen Review (MRR, a review of all medications the patient is currently using to identify any potential adverse effects and drug reactions) after Resident 13 fell on [DATE] and 12/2/23. 3. There was no indication the facility reviewed and re evaluated the fall care plan for effectiveness. These failures resulted in Resident 13 sustaining a fall on 12/2/23, that resulted in a hospitalization on [DATE], with a diagnosis of laceration (a cut to the skin) above her right eyebrow, ecchymosis (bruise) and femur fracture (broken thigh bone). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	C. The facility did not provide one-on-one supervision (intervention aimed to keep patients safe through observation by staff) as part of Resident 26's Fall Care Plan. This failure resulted in Resident 26's repeated falls. Findings: Resident 38 A review of Resident 38's face sheet (demographics) indicated she was initially admitted to the facility on [DATE]. Her diagnoses included Alzheimers disease (AD, a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities) and Vitamin D deficiency (loss of bone density, which can contribute to osteoporosis and fractures (broken bones). A review of her Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 10/31/23, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 3, indicating severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). A review of Resident 38's At Risk for Fall care plan, revised 11/4/23, indicated to observe Resident 38 frequently and place in supervised area when out of bed, to assess and analyze resident's falls to determine pattern/trend. Resident 38's actual Fall CP, dated 1/21/24, indicated Resident 38 had poor balance and poor communication/comprehension. The care plan had no interventions to address root causes of the fall, poor balance and poor communication/comprehension. A review of Resident 1's nursing note, dated 1/21/24 4:48 p.m., indicated that at 3 p.m., Resident 38 was seen ambulating on B wing and at 3:10 p.m., Resident 38 was seen by the door in room [ROOM NUMBER], where she was lying on her left side on the floor. The nursing note further stated Resident 38 was unable to state what happened, due to her dementia . The nursing note indicated 911 (an emergency number for any police, fire or medic) was called at 3:10 p.m., paramedics arrived at 3:15 p.m., and Resident 38 was sent out to the ED at 15:24. The Emergency Discharge instruction indicated Resident 38 had a computerized tomography (CT) scan (a series of X-ray, a type of radiation used to create a picture of the inside of the body, images taken from different angles around your body) of her cervical spine without contrast, done on 1/21/24, due to neck pain and headache, which indicated Resident 38 had a left frontal scalp tissue (area in front of the head) swelling as indicated in the CT scan note. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/30/24 at 10:14 a.m., Licensed Staff A stated the facility's fall protocol included assessing for residents' fall risk, encouraging resident to use call light, supervising ambulatory residents with high fall risks, impaired safety awareness and impaired cognition. Licensed Staff A stated, if a resident was a high fall risk, these residents could benefit from rehabilitation treatments, close monitoring and supervision by staff when ambulating. Licensed Staff A stated it was important to address fall risks and causal factors when formulating a fall care plan, and the care plan should be followed. When asked what the risks were if the fall care plan was not followed, Licensed Staff A stated the resident could fall. Licensed Staff A stated a lot of the facility residents were confused and had impaired safety awareness, just like Resident 38. Licensed Staff A stated staff could not just ignore them. Licensed Staff A stated these residents should be supervised and monitored closely for safety. Licensed Staff A stated, not following the care plan and not addressing the root cause of a fall could result in further fall incidents which could result in pain, fracture, internal bleeding, bruising and bumps on the head. Licensed Staff A stated Resident 38 was confused, had an unsteady gait (a manner of walking or moving on foot) but loved to walk. Licensed Staff A stated Resident 38 fell mostly because she would walk unassisted, would get tired and will sit down, because she got tired and weak. Licensed Staff A stated Resident 38's falls were mostly due to walking unsupervised. Licensed Staff A stated Resident 38's fall could have been prevented if there were staff supervising and monitoring her since Resident 38 was confused and had an unsteady gait. During an interview on 1/30/24 at 10:42 a.m., Resident 49 stated the facility staff were lazy and did not want to do the work. Resident 49 stated staff did not pay attention to residents and that is why, people here fall all the time. Resident 49 stated, Do you see anyone supervising me or other patients? Resident 49 stated staff at the facility were not always attentive to the residents' needs. During an interview on 1/30/24 at 10:53 a.m., Unlicensed Staff B stated residents with impaired cognition and unsteady gait should be supervised and assisted during transfers and ambulation. When asked what the risks were if a fall care plan was not followed, Unlicensed Staff B stated residents would fall, and their safety would be at risk. Unlicensed Staff B stated, not following a fall care plan could result in further incidents of falls and injuries. Unlicensed Staff B stated Resident 38 was a high fall risk due to unsteady gait, weakness, multiple falls, and confusion. When asked if it was safe for Resident 38 to ambulate unsupervised or unassisted by staff, Unlicensed Staff B stated, No. When asked if Resident 38's fall could have been prevented, Unlicensed Staff B stated Resident 38's fall could have been prevented if staff were supervising or monitoring her during ambulation. Unlicensed Staff B stated Resident 38 was unsafe when ambulating unsupervised or unassisted. Unlicensed Staff B stated, having staff to assist, monitor and supervise her during ambulation would definitely keep Resident 38 from falling. During an interview on 1/30/24 at 11:23 a.m., the Director of Staff Development (DSD) stated residents who were confused should be monitored and supervised as often as possible to prevent falls. The DSD stated care plans were important and should be followed. The DSD stated, if a care plan was not followed, a resident could fall and get injured. The DSD stated fall a care plan was in place and should be followed for residents' safety. When asked if Resident 38's fall could have been avoided, the DSD stated Resident 38's fall could have been prevented if staff were monitoring and supervising her. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During a concurrent observation and interview on 1/30/24 at 11:45 a.m., in the dining room, Resident 38 was noted with purplish-brown discoloration on the left side back of the neck, Resident 38 winced and grimaced when asked to touch the area. When asked if it hurt, Resident 38 nodded her head. Resident 38 was also noted with a purplish maroon discoloration on her left eye and a small bump on the left side of her forehead. Resident 38 grimaced and winced when she touched the area. Resident 38 had difficulty answering yes or no to simple questions. Resident 38 would not answer when asked if she remembered falling and the incident surrounding her fall on 1/21/24. During an interview on 1/30/24 at 12:04 p.m., Unlicensed Staff C stated, residents who were confused with unsteady gait should be supervised when ambulating, for safety. Unlicensed Staff C stated a fall care plan was important and should be followed. Unlicensed Staff C stated, if a fall care plan was not followed, residents would suffer, could fall and could result in injury, fracture, bruising and pain. Unlicensed Staff C stated Resident 38 had an unsteady gait, was confused and was a high fall risk. Unlicensed Staff C stated Resident 38 had fallen multiple times at the facility. Unlicensed Staff C stated, even with her confusion and unsteady gait, Resident 38 was allowed to walk unsupervised and unassisted at the facility. When asked if Resident 38 was safe to walk around the facility unsupervised and unassisted, even if she was confused and had unsteady gait, Unlicensed Staff C laughed nervously but did not respond. When asked if Resident 38's fall could have been avoided, Unlicensed Staff C stated Resident 38's fall could have been prevented if staff were supervising and monitoring her for fall and for safety. During an interview on 1/30/24 at 12:30 p.m., the Interim Director of Nursing (DON) stated the Interdisciplinary Team (IDT, a complex process in which different types of staff work together to share expertise, knowledge, and skills to impact on patient care) meeting post-fall and care planning was important to ensure there was a preventive measure geared towards ensuring residents' safety. The interim DON stated, while the IDT determined the root cause of the fall, the fall care plan needed to address risk factors and root causes of the fall. The interim DON stated the fall care plan ensured resident risk for falls were decreased. The interim DON stated fall care plan should be updated after every fall as needed, and should have interventions specific to address the cause of the fall and how the fall could be prevented. When asked what the risks were if the fall care plan was not followed and was not updated to address fall risks, the interim DON stated, not addressing the risk factor, the root cause of the fall and not following the fall care plan increased a resident's risk for falls with injuries. When asked if Resident 1 was safe to ambulate unassisted or unsupervised by staff knowing Resident 38 was a high fall risk, had in fact fell in the facility five times since 6/2023, and one time in 1/2024, had poor safety awareness, had unsteady gait and was confused, the interim DON did not respond. The interim DON stated, moving forward, it would be safer if Resident 38 was supervised closely, when ambulating, for safety and as a fall precautionary measure. During a telephone interview on 1/30/24 at 12:46 p.m., the Rehabilitation Director (RD) stated, for safety purposes and as a fall prevention, he recommended staff supervision for Resident 38 when ambulating, for safety. During an observation on 1/30/24 at 12:55 p.m., Resident 38 was walking around the hallway, unsupervised, with an unsteady and uncoordinated gait. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/30/24 at 1:10 p.m., the MDS Coordinator stated Resident 38 had multiple falls at the facility and the majority of them were during ambulation. The MDS Coordinator stated Resident 38 was unsupervised when ambulating. When asked why, the MDS Coordinator did not respond. When asked if Resident 38's fall could have been prevented, the MDS Coordinator did not respond. When asked if it was safer for Resident 38 to be supervised by staff when ambulating, the MDS Coordinator stated, Yes. During a concurrent interview and fall incidents record review on 1/30/24 at 1:15 p.m., the interim DON verified Resident 38 had fallen a total of six times between 6/26/23 and 1/21/24, on these dates: 6/26/23, 7/3/23, 8/1/23, 11/16/23, 11/21/23, and 1/21/24. Resident 38 fell eight times between 6/18/22 and 1/21/24, on these dates: 6/18/22, 12/29/22, 6/26/23, 7/3/23, 8/1/23, 11/16/23, 11/21/23, and 1/21/24. During an observation on 1/30/24 at 1:35 p.m., Resident 38 was walking in the hallway unsupervised. Resident 38 was noted with an uncoordinated and unsteady gait. During a concurrent telephone interview and fall care plan record review on 1/31/24 at 3 p.m., the interim DON verified Resident 38's Actual Fall care plan, dated 1/21/24, did not address Resident 38's cause of fall on 1/21/24. The interim DON verified the At Risk for Fall care plan, revised 11/4/23, indicated Resident 38 should be supervised when out of bed and was still in effect but was not followed when Resident 38 fell on [DATE]. The interim DON stated Resident 38's fall care plan was generic and not individualized. When asked if Resident 38's fall on 1/21/24, could have been prevented if staff supervised Resident 38 while she was up ambulating, the Interim DON stated, Yes and she understood. During a telephone interview on 2/2/24 at 3:26 p.m., when asked if Resident 38 could have benefited from an in-depth rehabilitation evaluation on why Resident 38 was falling, the interim DON stated she would have the Director of Rehabilitation (DOR) services discuss this with the surveyor. The interim DON confirmed, despite Resident 38's multiple falls, the facility was not able to determine the causative factor on why Resident 38 continued to fall. The interim DON stated Resident 38's fall care plan was generic and did not really provide interventions based on Resident 38's risk and cause of fall. When asked if Resident 38 could have benefited from a rehabilitation evaluation which was focused on gait, balance, strength, fall risk and safe ambulation assessment due to multiple falls, the interim DON stated Resident 38 might benefit from a rehabilitation evaluation instead of rehabilitation screening only. During a telephone interview on 2/2/24 at 3:56 p.m., when asked what the difference between a rehabilitation screening and rehabilitation evaluation was, the DOR stated rehabilitation screening meant they only interview staff and residents, and it was not an in-depth assessment of residents' functional status, while a rehabilitation evaluation meant a rehabilitation therapist would assess residents' balance, gait, muscle strength and safe ambulation. When asked why Resident 38 only had a rehabilitation screening versus a rehabilitation evaluation, wherein the therapist could have assessed Resident 38's gait, fall risk, muscle strength and safe ambulation, the DOR did not answer. A review of the IDT post-fall documentation indicated Resident 38 fell on [DATE], 7/3/23, 8/1/23, 11/16/23, 11/21/23 and 1/21/24. The IDT post-fall review, dated 11/17/23, indicated Resident 38's fall risk assessment, done on 11/16/23 and 11/21/23, score was 13, indicating she was a high risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During an interview on 2/23/24 at 1:48 p.m., Unlicensed Staff D stated Resident 38 had an unsteady gait sometimes. Unlicensed Staff D stated Resident 38 was also noted with confusion and could be forgetful. Unlicensed Staff D stated Resident 38 needed supervision and assistance when ambulating, for safety. Unlicensed Staff D stated Resident 38 needed staff to monitor her closely during ambulation. During an interview on 2/23/24 at 1:52 p.m., Licensed Staff E stated Resident 38 was a high risk for falls. Licensed Staff E stated Resident 38 was confused and had poor safety awareness. Licensed Staff E stated that although Resident 38 was noted with weakness, the facility allowed her to ambulate by herself. Licensed Staff E stated Resident 38's falls could have been prevented if she was supervised and monitored by staff closely, during ambulation. During a Fall Risk Assessment (an assessment that checks to see how likely it is that you will fall) and Fall forms record review (a study that is based solely on existing data), Resident 38's Fall risk assessment, dated 1/21/24, score was 14, indicating she was a high risk for falls. Among her risks listed were disorientation, falls within the last 180 days, decreased muscle coordination and balance problem while walking. Resident 38's Fall risk assessment, dated 11/16/23 and 11/21/23, score was 13, indicating high risk for fall. Among her risks listed were disorientation, falls within the last 180 days and ambulatory/incontinence (inability to control the flow of urine from the bladder). The fall form # 1472, dated 11/21/23, indicated Resident 38 was oriented to person, confused, had impaired memory, lack of coordination and weakness. The fall form #1436, dated 11/16/23, indicated Resident 38 was confused and had gait imbalance. A review of the facility's policy and procedure (P & P) titled, Fall Risk Intervention and Monitoring, revised 12/2014, the P & P indicated it was the facility's policy to identify interventions related to resident's specific risks and causes to try and prevent resident from falling and try to minimize complications from falling .the multi-disciplinary team including the physician will identify appropriate interventions to reduce the risk of falls . if falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current intervention remains relevant .the multi-disciplinary team will identify and implement relevant interventions to try and minimize serious consequences of falling .if resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. A review of the facility's policy and procedure (P & P) titled, Fall Management, revised 12/2014, stated it was the facility's policy to provide consistent process for evaluating, managing, and reducing falls to minimize risks and improve quality of life, for residents who were at risk for falls .residents gait, balance and current medications associated with dizziness or increased fall risk should be evaluated following a fall . A review of the facility's policy and procedure (P & P) titled, Investigating Resident Related Incidents /Accidents, revised 7/2012, the P & P indicated it was the facility's policy to ensure provision of adequate supervision and assistance devices to residents, based on their specific care needs, to prevent incidents/accidents .incidents/accidents of unknown cause may be related to lack of supervision and or assistive device shall be investigated to ascertain surrounding circumstances that led to such incident/accident .examples of accidents/incidents to be reported included falls that were not witnessed, falls during ambulation, skin tears, abrasions, lacerations (a cut in the skin) bruises = of known or unknown cause . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Resident 13 A review of Resident 13's face sheet (demographics) indicated she was admitted to the facility on [DATE]. Her diagnoses included Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), History of Falls, Muscle Weakness and Restless Leg Syndrome (RLS, a condition that causes a very strong urge to move the legs). A review of her Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 11/1/23, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) score was 0, indicating severe cognitive impairment. Her MDS also indicated she needed moderate assistance (where staff lift, holds and support residents') from staff during ambulation. During an observation on 2/21/24 at 9:40 a.m., Resident 13 was in the activity room, but she had no activity in place. Only the Activity Director (AD) was in the activity room. There were no staff paying attention to Resident 13. An attempt made to interview, but Resident 13 could not be interviewed, as Resident 13 only provided nonsensical answers to simple questions. During an interview on 2/21/24 at 11:10 a.m., Licensed Staff N stated it was the facility's fall prevention policy to place residents on one-on-one monitoring (1:1) by staff if needed, to monitor residents every two hours or every 30 minutes as needed, for residents who were a high risk for falls, provide incontinence (an involuntary loss of urine) care every two hours and as needed. Licensed Staff N stated residents at risk for falls with history of falls and dementia had to be monitored and supervised closely. Licensed Staff M stated, if these were not done, it could result in accidents and falls. When asked if Resident 13 was a high risk for falls, she stated, Yes. When asked if care planning (CP, a form [where you can summarize a person's health conditions, specific care needs, and current treatments) was important, Licensed Staff M stated, Yes. Licensed Staff M stated, if a resident were risk for falls or had actual falls and CPs were not created or followed, it became a safety issue, and staff would not be able to care for residents adequately and safely. Licensed Staff M stated residents could fall and injure themselves. During an interview on 2/21/24 at 11:38 a.m., Unlicensed Staff C stated it was the facility's fall policy to provide incontinence care every two hours and to monitor residents every two hours or more frequently especially if they were a fall risk. When asked if Resident 13 was a fall risk, she stated, Yes. Unlicensed Staff C stated Resident 13 should be supervised because she was confused and was at risk for falls. Unlicensed Staff C stated residents who were confused or had dementia should be assisted to the bathroom and should not be left alone in their room. When asked if a fall CP was important, Unlicensed Staff C stated, yes, as it provided a map on how to care for residents safely. When asked what could happen if the fall CP was not followed, Unlicensed Staff C stated residents could receive unsafe care and residents would not receive the care that they needed. During an interview on 2/21/24 at 12:06 p.m., the Minimum Data Set (MDS) coordinator (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	stated Resident 13 had a femur fracture because she fell at the facility. The MDS coordinator stated Resident 13 attempted to get out of bed to use the bathroom and lost her balance. The MDS coordinator stated Resident 13 was a high risk for falls. The MDS coordinator stated Resident 13 fell twice last year, and the fall incident last December resulted to a femur fracture. When asked what was the facility's policy in preventing falls, the MDS coordinator stated the facility should develop a fall care plan to address risks and a fall risk assessments should be completed, to frequently check on residents every two hours or more often as needed and to provide incontinence care every two hours or less as needed. The MDS coordinator stated, if these were not followed, it could result in increased incidences of falls. The MDS coordinator stated Resident 13 was occasionally incontinent of bowel (inability to control bowel movements) and incontinent of bladder function (loss of bladder control). The MDS coordinator stated staff should be providing Resident 13 incontinence care every two hours and as needed or offering to bring her to the bathroom every two hours. When asked if care planning was important, the MDS coordinator stated, Yes, because it was the basis to execute care for residents and it was focused on identification of risks and goals and interventions. The MDS coordinator stated the CP provided structure on how to provide safe care to the residents. When asked what could happen if there was no fall CP or if a fall CP was not followed, the MDS coordinator stated, not following the fall CP or the fall policy put residents' safety at risk and could result in accidents, pain and fractures. The MDS coordinator stated, not following the care plan could also lead to residents not receiving the care they needed. During an interview on 2/21/24 at 12:42 p.m., Licensed Staff O stated Resident 13's fracture was due to a fall at the facility. Licensed Staff O stated Resident 13 was a high risk for falls. When asked what the facility's policy was for fall prevention, Licensed Staff O stated to provide incontinence care and turning and repositioning every two hours or more often as needed and to frequently monitor residents every two hours or more often if a resident was at risk for falls. When asked if fall care planning was important, Licensed Staff O stated, Yes, and the fall CP should be followed. Licensed Staff O stated, if the fall CP or the fall policy was not followed, it could be a safety risk for the resident. Licensed Staff O stated residents could fall and result in injury. During an interview on 2/23/24 at 1:26 p.m., Licensed Staff F stated Resident 13's fracture was due to a fall at the facility. When asked what the facility's policy for falls was, Licensed Staff F stated the policy indicated to monitor residents closely, not to leave a resident unattended especially if the resident was a high fall risk or had poor cognition. Licensed Staff F stated the fall policy also indicated to provide incontinence care every two hours and to monitor residents every two hours. Licensed Staff F stated residents should be assisted in the bathroom if they were confused, weak and had poor safety awareness. When asked if a fall care planning was important, Licensed Staff F stated, yes, as risks were addressed in CPs and appropriate intervention could be put in place. When asked what could happen if the fall CP or the fall policy was not implemented or followed, Licensed Staff F stated it put residents' safety at risk, residents could fall again and residents could be at risk for injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During an interview on 2/23/24 at 1:45 p.m., the interim Director of Nursing (DON) stated Resident 13 went to use the bathroom, unassisted, and fell . The DON stated this fall resulted in a fracture of the femur. The interim DON stated Resident 13 was a high risk for falls and had poor safety awareness. When asked what the facility's policy was to prevent falls, the interim DON stated the policy indicated to complete a Fall Risk Assessment (an assessment that checks to see how likely it is you would fall), medication review from the pharmacist, to monitor residents frequently every two hours and as needed and to provide incontinence care or offer toileting every two hours and as needed. When asked if fall care planning was important, the interim DON stated, Yes. The interim DON stated the CP provided a baseline on what to do as far as patient care went. When asked what could happen if the fall CP or the fall policy was not followed, the interim DON stated it could be a safety risk. The interim DON stated residents could end up falling, skin issues may arise, and residents may not receive safe and adequate care. During a concurrent interview and fall CP, dated 12/7/23, record review on 3/20/24 at 10:35 a.m., the MDS coordinator verified Resident 13 fell twice last year, on 4/12/23 and 12/2/23. The MDS coordinator verified the fall incident on 12/2/23, resulted in a fracture of Resident 13's femur. The MDS coordinator stated the At Risk For Fall CP, which included interventions such as providing frequent staff monitoring, providing toileting assistance two times per shift and at bedtime, observing resident frequently and placing Resident 13 in a supervised area when she was out of bed, dated 12/7/23, was in effect prior to Resident 13's fall incident on 12/2/23. During a concurrent interview and fall CP, dated 12/7/23, record review on 3/20/24 at 12:18 p.m., the MDS coordinator stated MDS coordinator 2 updated the At Risk For Fall CP and merged it with the actual fall CP on 12/2/23, as indicated on the CP, dated 12/7/23. When asked if he could identify which CP was for At Risk or which of the interventions were new, MDS coordinator did not respond. The MDS coordinator stated the CP was important because it provided a blueprint on how to care for the residents' safely. The MDS coordinator stated the CP should be followed to lessen incidences of falls and injury post fall to the resident. The MDS coordinator stated care plans were updated to ensure they still applied to the resident and to identify interventions which were not appropriate, so a different approach could be implemented. When asked if there were documentation's to indicate whether the care plan was reevaluated for effectiveness, the MDS coordinator stated, No. When asked how a staff could identify if a current care plan was effective, the MDS did not answer. When asked whether there was a collaboration with the physician to identify pertinent interventions to try and reduce the risks associated with subsequent falls, the MDS stated, No. The MDS coordinator was not able to identify which CP was for the At Risk For Fall, the actual fall on 4/12/23, and the fall on 12/2/23. The MDS coordinator was not able to identify whether new interventions were created after Resident 13 fell on [DATE]. The MDS coordinator was not able to provide documentation Resident 13 was offered toileting or provided incontinence care before she fell on [DATE]. During a concurrent interview and IDT post-fall follow-up record review, dated 12/4/23, on 3/20/24 at 3:37 p. m., the Administrator stated Resident 13 was in her room when she fell on [DATE]. The Administrator stated Resident 13 was incontinent and would need assistance in toileting as needed. The Administrator was unable to identify when was the last time Resident 13 was offered or provided toileting by staff before her fall on 12/2/23. The Administrator stated Resident 13 fell while trying to go to the bathroom by herself and probably lost her balance. The Administrator verified, per IDT, post-fall follow-up V3 form, dated 12/4/23, Resident 13's score was 13. The Administrator stated this indicated Resident 13 was a high fall risk. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During an interview on 3/20/24 at 3:50 p.m., the DON verified there was no MRR completed by the pharmacist, although there should be one completed as per the facility's fall policy and procedure, after Resident 13 fell on [DATE], and 12/2/23. During an interview on 3/21/24 3:28 p.m., Unlicensed Staff P stated she was working with Resident 13 on the night she fell . Unlicensed Staff P stated, on the night of Resident 13's fall incident last 12/2/23, she found Resident 13 on[TRUNCATED]

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on observations, interviews and records review, the facility failed to ensure staff provided appropriate respiratory care for two of 23 sampled residents (Resident 35 and Resident 33) when: a. The facility did not ensure Resident 33 received oxygen therapy, according to the doctor's order, and did not assess for signs of respiratory distress, when Resident 33 was not on oxygen therapy. This failure had the potential for Resident 33 to experience unidentified respiratory distress for not receiving oxygen therapy and lack of respiratory assessment from nursing staff. b. The facility did not attach a pre-filled humidifier (a refillable plastic bottle that infuses the normal flow of oxygen with water droplets to moisten the air and to prevent a resident's nasal membranes from becoming sore and scabby) to the oxygen (O2 - life-supporting component of the air) concentrator [a device used to provide oxygen to a resident in a steady even flow by means of a nasal cannula (a small, soft plastic tube that is divided into two prongs, which are placed in the nostrils)], when Resident 35 received more than two (2) liters per minute (LPM) of oxygen. This failure had the potential to result in Resident 35's discomfort associated to dry nose from continuous oxygen use. Findings: Resident 33 During a review of the Face Sheet indicated Resident 33 was admitted on [DATE], with diagnoses including but not limited to, Hemiplegia and Hemiparesis (paralysis of one side of the body); Congestive Heart Failure (CHF - blood often backs up and fluid can build up in the lungs, causing shortness of breath [SOB]) and Anxiety Disorder (intense, excessive, and persistent worry and fear about everyday situations). During a review of the Minimum Data Set (MDS -health status screening and assessment tool used for all residents), dated 3/11/24, indicated Resident 33 had a BIMS score of 03 out of 15 points (Brief Interview for Mental Status - a 15-point cognitive [relating to the mental process involved in knowing, learning, and understanding things] screening measure that evaluates memory and orientation. A score of 13 to 15 is cognitively intact, 08 to 12 is moderately impaired, and 00 to 07 is severe impairment). During a review of the Physician's order for March 2024, indicated a doctor's order written on 10/09/23, for oxygen at two liters per minute for SOB, wheezing (a sign that a person may be having breathing problems) and chest pain. During an observation in Resident 33's room on 3/18/24 at 11:20 a.m., Resident 33 was lying in bed, asleep. There was an oxygen concentrator (a medical device that gives you extra oxygen) at the bedside with a nasal cannula (tube which on one end splits into two prongs and are placed in the nostrils) attached. Resident 33 was not receiving oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation in Resident 33's room on 3/19/24 at 3:54 p.m., Resident 33 was lying in bed with his eyes closed. Resident 33 was not receiving oxygen therapy. During an observation in Resident 33's room on 3/20/24 at 9:39 a.m., Resident 33 was lying on his bed. Resident 33 was awake; he was not receiving oxygen therapy. During an observation in Resident 33's room and concurrent interview with Unlicensed Staff C on 3/21/24 at 10:11 a.m., Resident 33 was lying on his bed, awake. He was not receiving oxygen therapy. When Unlicensed staff C was asked when Resident 33 received oxygen therapy, Unlicensed Staff C stated, Only when it's needed. During an interview and concurrent observation in Resident 33's room with Licensed Staff U on 3/21/24 at 10:30 a.m., when Licensed Staff U was asked about the oxygen order for Resident 33, Licensed Staff U stated Resident 33 had an order for continuous oxygen at two LPM (Liters per minute) for SOB (Shortness of breath), and wheezing. Licensed Staff U verified Resident 33 was not receiving oxygen therapy. When asked about the reason for not putting Resident 33 on oxygen, Licensed Staff U stated Resident 33 often took off his oxygen. When Licensed Staff U was asked for records of respiratory assessment for Resident 33, Licensed Staff U stated there was no record of respiratory assessment for Resident 33. During a record review and concurrent interview with the Director of Nursing (DON) on 3/22/24 at 9:56 a.m., the physician's order indicated an order, written on 10/09/23, for continuous oxygen for Resident 33. When the DON was asked about her expectations from the nurses when Resident 33 continuously removed his oxygen, the DON stated she expected the nurses to make sure they followed the doctor's order, and if Resident 33 continuously removed his oxygen, she stated she expected the nurses to monitor Resident 33 for signs of respiratory distress and document. The DON stated if Resident 33 did not show signs of respiratory distress, she expected the nurses to call Resident 33's doctor to change the oxygen order to read, as needed. A review of the Respirator Care Plan, initiated on 10/09/23, indicated, Assess signs of ineffective airway clearance (abnormal breath sounds; ineffective/absent cough; abnormal respiratory rate, depth, rhythm; cyanosis [a bluish discoloration of your skin]; anxiety, restlessness). However, after review of the Medication Administration Record and Licensed Nurses Progress Notes with the DON, the DON stated there was no documentation from the nurses that Resident 33 was assessed for signs of respiratory distress, when Resident 33 was not receiving oxygen therapy. Resident 35 During a review of the Face Sheet indicated Resident 35 was admitted on [DATE], with diagnoses including but not limited to, Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities); and Chronic Obstructive Pulmonary Disease (COPD - diseases that cause airflow blockage and breathing-related problems). During a review of the facility document titled, Order Summary Report, for March 2024, indicated a doctor's order, written on 12/30/23, to change pre-filled humidifier every Saturday and an additional doctor's order, written on 1/08/24, for oxygen at two liters per minute (LPM) via nasal cannula for SOB, wheezing and chest pain. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation in Resident 35's room on 3/18/24 at 10:32 a.m., Resident 35 was sitting on her bed receiving oxygen therapy via nasal cannula at three LPM, via the oxygen concentrator. There was no pre-filled humidifier attached to the concentrator. During an observation in Resident 35's room on 3/19/ 24 at 12:58 p.m., Resident 35 was on her bed, awake, with oxygen therapy at three LPM via nasal cannula, thru an oxygen concentrator. There was no pre-filled humidifier attached to the concentrator. During an observation in Resident 35's room and concurrent interview with the Infection Preventionist (IP) on 3/20/24 at 9:03 a.m., Resident 35 was on her bed with oxygen therapy via nasal cannula. When the IP was asked how much oxygen the concentrator was set to, the IP stated the concentrator read two and one-half LPM. The IP also concurred there was no pre-filled humidifier attached to the concentrator. When the IP was asked about the risk for Resident 35 when receiving oxygen therapy above two LPM, without a pre-filled humidifier, the IP stated it could dry Resident 35's nose and could cause nasal bleeding and discomfort. A review of the Facility policy and procedure titled, Oxygen Therapy, revised on 1/2024, indicated, It is the facility's policy that oxygen therapy is administered, as ordered by the physician or as-an emergency measure until the order can be obtained. The policy indicated, Monitor for restlessness, cyanosis, and abnormal breathing pattern Humidifiers are not required if flow of oxygen is two (2) liters or less per minute

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F 0697 Level of Harm - Actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on observations, interviews and records review, the facility failed to ensure a pain management program was provided to relieve pain and discomfort for four of 23 sampled residents (Resident 33, 35, 21 and 122), when: 1. Resident 33 who had severe contractures (a loss of full active and passive range of motion [ROM - the extent or limit to which a part of the body can be moved around a joint or a fixed point] in a limb, which can result from limitations imposed by the joint, muscle, or soft tissue) on his left lower extremity and had pressure ulcers (also known as bedsores - damage to an area of the skin caused by constant pressure on the area for a long time) on his left foot, was not given pain medication before providing care and treatment. This failure caused Resident 33 to repeatedly experience pain and discomfort when receiving care from facility staff. (Cross-reference F656 and F686). 2. Resident 21 who had above-the-knee amputation (AKA - removing the leg from the body by cutting through both the thigh tissue and femoral (thigh) bone) was not offered pain medication after returning to the facility, after the procedure. This failure had the potential for Resident 21 to experience pain and discomfort. (Cross-reference F684). 3. Resident 35 and Resident 122 were not given pain medication before wound treatment, as ordered by a physician. This failure resulted in Resident 35 and Resident 122 experiencing pain and discomfort during wound treatment. (Cross-reference F686). Findings: RESIDENT 33 During a review of the Face sheet (a one-page summary of important information about a resident) indicated Resident 33 was admitted on [DATE], with diagnoses, including but not limited to Hemiplegia and Hemiparesis (paralysis of one side of the body); Contractures of left hand and left knee; and Peripheral Vascular Disease (PVD - a blood circulation disorder). During a review of the facility document titled, Joint Mobility Assessment, dated 9/16/23, indicated Resident 33 had severe limitation to left hand, left hip and left knee; and moderate to severe limitation to his left ankle. During a review of the Minimum Data Set (MDS -health status screening and assessment tool used for all residents), dated 3/11/24, indicated Resident 33 had a BIMS score of 03 out of 15 points (Brief Interview for Mental Status - a 15-point cognitive (relating to the mental process involved in knowing, learning, and understanding things) screening measure that evaluates memory and orientation. A score of 13 to 15 is cognitively intact, 08 to 12 is moderately impaired, and 00 to 07 is severe impairment). The MDS indicated Resident 33 had functional limitation in range of motion to both upper and lower extremities. The MDS indicated Resident 33 was dependent on staff to roll from lying on back to left and right side. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	During a review of the March 2024 Physician's Order for Resident 33, a doctor's order was written on 10/05/23, for RNA (Restorative Nursing Assistant - assists patients with long-term treatment and recovery after an accident, surgery, or illness) to perform Range of Motion (ROM) exercises to both upper and lower extremities. During an observation in Resident 33's room on 3/20/24 at 10:33 a.m., and concurrent interview with RNA V, Resident 33 was grimacing when RNA V was stretching Resident 33's finger on his left hand. When RNA V was asked about Resident 33 showing signs of pain when applying the hand roll or when providing PROM (Passive Range of Motion [the ROM that is achieved when an outside force (such as a therapist) exclusively causes movement of a joint and is usually the maximum range of motion that a joint can move]), RNA V stated Resident 33 grimaced and got physically aggressive when touched. RNA V stated she had reported to the nurse that Resident 33 was in pain. During an observation in Resident 33's room on 3/21/24 at 9:05 a.m., Resident 33 was grimacing when the Infection Preventionist (IP) was repositioning Resident 33's left leg after wound treatment. During an observation in Resident 33's room and concurrent interview with Unlicensed Staff C on 03/21/24 at 10:14 a.m., Resident 33 was grimacing with reddened face and teary eyed when Unlicensed Staff C was repositioning his left leg. When Unlicensed Staff C asked Resident 33 if he was in pain, Resident 33 nodded his head. Unlicensed Staff C barely stretched Resident 33's left leg. She stated Resident 33 could not stretch both his left and right legs. When Unlicensed Staff C was asked what she would do if she observed Resident 33 showing signs of pain, Unlicensed Staff C stated she would report it to the nurse. During an interview and concurrent record review with Licensed Staff U on 3/21/24 at 10:23 a.m., when Licensed Staff U was asked if she received a report from Unlicensed Staff C regarding Resident 33 showing signs of pain, Licensed Staff U stated No. Licensed Staff U stated Resident 33 was not on routine pain medications. However, she stated Resident 33 had an order for Tylenol, as needed. After review of the Medication Administration Record (MAR) with Licensed Staff U for Resident 21, Licensed Staff U stated Resident 33 did not have a doctor's order to monitor pain. She stated Resident 33 could not verbally express when he was in pain. She stated she would know if Resident 33 was in pain when grimacing, holding tightly on the bed rail or when combative. When Licensed Staff U was asked how would pain affect Resident 33's quality of life when his pain was not addressed, Licensed Staff U stated it was very important to assess Resident 33 for pain and address it. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	During an interview and concurrent record review with the Director of Nursing (DON) on 3/22/24 at 10:15 a.m. , when the DON was asked about her expectation from Resident 33's direct care staff (CNAs, RNAs, Nurses) when a sign of pain was observed while providing care, the DON stated CNAs and RNAs were expected to report to the nurse any signs of pain observed and expected the nurses to address the pain right away. The DON stated Resident 33 could not verbally express his need for pain medication due to verbal impairment. She stated she expected the staff to monitor for nonverbal indications of pain like facial grimacing, crying, moaning, etc. and to administer pain medications according to the doctor's order. The DON stated Resident 33 had contractures to both upper and lower extremities which could put Resident 33 at risk for pain while receiving care from staff. A Review of the Physician's Order for Resident 33 with the DON, indicated an order written on 10/04/23, to give two tablets of Tylenol (pain reliever and fever reducer) every six hours, as needed for mild pain. The Physician Order did not show a routine order for pain management. The DON stated Resident 33 should have a routine order for pain medication. When the DON was asked how pain would affect Resident 33's quality of life when his pain was not managed, the DON stated unmanaged pain could have physical and psychological impact to Resident 33. She stated Resident 33 could refuse to move or participate with care and could be physically aggressive to staff when in pain. During a review of the facility document titled, Wound Management Review, dated 3/15/24, indicated Resident 33 had a Stage 3 Pressure Ulcer (full thickness skin loss, where the subcutaneous fat [a type of fat that's stored just beneath your skin] may be visible to the naked eye) on his left lateral foot (the little toe side of the foot). During a wound treatment observation in Resident 33's room with Licensed Nurse L on 3/25/24 at 10:48 a.m. , Resident 33 had three wounds on his left foot: The wound closest to the left little toe was covered with blackish matter, the wound farthest from the left little toe and left outer aspect of the heel was open. Resident 33 was grimacing, his face was reddened and loudly verbalized, ahhh ., twice and, aray (Filipino word for ouch) during wound treatment. Resident 33 also hit Licensed Nurse L with his right hand, twice. During an interview with Licensed Staff F on 3/25/24 at 3:37 p.m., when Licensed Staff F was asked if Resident 33 received pain medication earlier during her morning shift, Licensed Staff F stated, No. Licensed Staff F stated Resident 33 did not have a scheduled order for pain medication. When Licensed Staff F was asked how she would know if Resident 33 was in pain, she stated she would know if Resident 33 was in pain because she could sometimes hear him scream in his room. Licensed Staff F concurred that Resident 33 could experience pain when receiving care from staff due to contractures and pressure ulcers, and stated Resident 33 could benefit from having a routine pain medication. During an interview with the (NP - registered nurse who has advanced education and clinical training in a health care specialty area) on 3/26/24 at 10:37 a.m., when the NP was asked if she was aware of Resident 33 showing signs of pain/discomfort during care and wound treatment, the NP stated she was made aware of the issue on 3/25/24, and it was addressed. RESIDENT 21 During a review of the Face sheet indicated Resident 21 was admitted on [DATE], with diagnoses, including but not limited to: Diabetes Mellitus (disease that result in too much sugar in the blood); Morbid obesity (resident weighs 100 pounds over his recommended weight); and Hemiplegia and Hemiparesis (paralysis of one side of the body). (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	During a review of the Progress Note, dated 1/25/24 at 10:14 a.m., indicated Resident 21 was sent to the hospital for wound debridement (the removal of damaged tissue or foreign objects from a wound). During a review of the hospital document titled, Wound Document,s dated 1/25/24, indicated Resident 21 had right fibula (the outer and usually smaller of the two bones between the knee and ankle in the hind or lower limbs) osteomyelitis (inflammation or swelling that occurs in the bone), bilateral (both) foot cellulitis (a common, potentially serious bacterial skin infection) and gangrene (a serious condition where a loss of blood supply causes body tissue to die) of toes. During a review of the hospital document titled, Discharge Documents, dated 1/31/24, indicated Resident 1 had right above-the-knee amputation on 1/28/24. During an interview and concurrent record review with the DON on 3/22/24 at 11:27 a.m., the DON stated Resident 21 was sent to the hospital and returned to the facility with right leg amputation. When the DON was asked about her expectations from the nurses to ensure Resident 21 was made comfortable after his right leg amputation, the DON stated she expected the nurses to administer pain medication, according to the doctor's order. After review of the Physician's order, dated 1/31/24, with the DON, the DON concurred there was no schedule pain medication ordered for Resident 21. The Physician's order indicated the following doctors order written on 1/31/24, to give one tablet of Acetaminophen (also known as Tylenol) Extra Strength 500 mg (milligram-a unit of mass), as needed for Pain; and to give one tablet of Norco (used to relieve moderate to severe pain) every four (4) hours, as needed for moderate pain. However, a review of the MAR with the DON, indicated Resident 21 did not receive a dose of Acetaminophen and received one dose of Norco for the whole month of February 2024. The DON stated Resident 21 could have experienced pain after the amputation and should have a routine order of pain medication for pain management. During an interview with Resident 21 on 3/22/24 at 3:13 p.m., when Resident 21 was asked if he was offered pain medication after his right leg was amputated, he stated he did not receive any pain medicine after coming back from the hospital. Resident 21 stated he did not think his right leg was amputated because he could feel his leg was, aching. Resident 21 stated he was scared to ask for pain medicine because he had history of drug use. During an interview with the NP on 3/26/24 at 10:17 a.m., when the NP was asked why Resident 21 did not have a scheduled order for pain medication after his right leg was amputated, the NP stated Resident 21 never complained of pain when he was assessed. However, when this writer shared an interview with Resident 21 stating he did not think his right leg was amputated because he could still feel his leg, the NP stated Resident 21 could be experiencing, phantom limb (an often painful sensation of the presence of a limb that has been amputated). RESIDENT 35 During a review of the Face sheet indicated Resident 35 was admitted on [DATE], with diagnoses, including but not limited to Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities); Chronic Obstructive Pulmonary Disease (COPD - diseases that cause airflow blockage and breathing-related problems) and Pressure Ulcer of Sacral (the triangular bone just below backbone) Region. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	During a wound treatment observation, record review and concurrent interview with Licensed Staff O on 3/20/24 at 10:16 a.m., Resident 35 was pulling her butt away when Licensed Staff O was applying the dressing to Resident 35's sacral wound and stated, Ouch. When this writer asked Resident 35 if she had pain, she stated, Yes. After wound treatment, when Licensed Staff O was asked if Resident 35 received any pain medication prior to the wound treatment, Licensed Staff O stated Resident 35 received a dose of Methadone (a powerful drug used for pain relief) at 6 a.m. Licensed Staff O concurred the effectiveness of the medication had worn off after four hours. She stated Resident 35 also had an order for Morphine (treats severe pain when other pain medications have not worked), as needed. However, after review of the MAR, Licensed Staff O stated Resident 35 received 0.25 ml (milliliter -a unit of volume) of Morphine on 3/19/24, and no dose of Morphine was given prior to wound treatment. During an interview with the NP on 3/26/24 at 10:11 a.m., when the NP was asked about her expectation from the nurses regarding pain management during wound care, the NP stated pressure ulcers could be painful during wound treatment, and stated residents with pressure ulcers should have a standing order for pain medication. She stated there should be coordination between the wound care nurse and the charge nurse to make sure the resident was pre-medicated prior to wound treatment. 31424 RESIDENT 122 During an observation and concurrent interview 3/18/24 at 4:15 p.m., Resident 122's heel was wrapped (with a dressing). Resident 122 stated he had been admitted to the facility about one and a half weeks earlier. He stated he was in a hospital prior to his facility admission and had a Stage 4 pressure ulcer (Bedsores; injuries to the skin and tissue due to pressure on the skin; Stage 4 extend deeper, exposing underlying muscle, tendon, cartilage or bone) on his right heel that went to the bone; he stated the wound had been debrided (removal of unhealthy tissue from the wound bed to promote wound healing). Resident 122 stated he took Vicodin (narcotic pain medication) for his heel pain but it did not help much. When asked if nursing staff pre-medicated (give pain medication before a potentially painful activity) him prior to his dressing changes, Resident 122 became tearful and stated the nurses did not pre-medicate him. He stated, if it had been three hours since he last took his Vicodin, and it was time for a dressing change, the nurse would just do the dressing change (without giving additional pain medication). (Online review of the Mayo Clinic website revealed a pain scale provides a standardized means of measuring pain intensity and severity. Their pain scale follows: .Pain Free = 0; Mild Pain = 1-3 (nagging or annoying but doesn't interfere with daily activities) .Moderate Pain = 4-6 (interferes with daily activities) . Severe Pain = 7-10 (disabling or unable to carry out normal daily activities) Ranges from 'impacts your social relationships, or sleep' to 'being bedridden or even delirious (disturbed state of mind resulting from illness or intoxication and characterized by restlessness, illusions, and incoherence of thought and speech).' [https://connect.mayoclinic. org/blog/adult-pain-medicine/newsfeed-post/what-to-expect-at-my-pain-medicine-appointment]. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	Review of Resident 122's medical record on 3/21/24 at 9:41 a.m., revealed March 2024's Medication Administration Report (MAR; nurse documentation of medication and other pertinent information) that indicated Resident 122's pain ranged from #5 to # 8 (moderate to severe) on the pain scale (Pain Scale: a tool health care professionals utilize to help assess a person's pain; the pain scale is from 0 to 10, where 0 is no pain, and 10 is the worst pain imaginable). A Nursing Care Plan (document that contains essential information about a patient's condition, diagnosis, goals, interventions, and outcomes), dated 3/6/2024, indicated, (Resident 122) is at risk for pain or discomfort related to complex medical conditions . The plans goal indicated, (Resident 122) will be relieved of pain or discomfort within 30 mins (minutes) - 1 hour after non-pharmacologic interventions (interventions other than medication) & pain relief measures daily x (for) 90 days . Nursing interventions indicated, Assess for s/s (signs and symptoms) of pain . Administer pain meds as MD (medical doctor) ordered and evaluate effectiveness . Notify MD for any S/S (signs and symptoms) of COC (change of condition) . Review of Resident 122's medical record revealed the following physician order for pain medication, dated 3/5/2024: Hydrocodone-Acetaminophen (Vicodin) oral tablet 5-325 MG (milligrams) . give 1 tablet by mouth every 4 hours as needed (prn) for Severe Pain . During an observation and concurrent interview on 3/21/24 at 10:30 a.m., Resident 122 was sitting on his bed with his legs resting on a wheelchair next to the bed. Resident 122 stated his pain was currently #8 (severe) on his right heel but he also had pain at a #7 on his buttocks. Resident 122 stated he told the nurse about his pain but the Vicodin was not helping. When asked if the physician had been called, he stated he knew of no calls to his doctor. When asked if staff were working with him on pain control, Resident 122 stated, No. During an observation of Resident 122's dressing change by the physician assistant (PA) on 3/21/24 at 12:15 p.m., the PA took the old dressing off and measured the wound. The heel had erythema (redness) over the entire heel. The PA stated the wound looked infected, and she would be starting Resident 122 on antibiotics to treat the infection. During an interview on 3/22/24 at 12:08 p.m., Licensed Staff S (LS S) was asked about Resident 122's pain control. When asked if she pre-medicated him prior to his dressing changes, she stated, No. LS S stated she was told if a medication was prn (given as necessary; the Vicodin was ordered prn), she only gave it if the resident requested it. She stated she was not trained to pre-medicate residents prior to dressing changes, even for a Stage 4 pressure ulcer. During an interview on 3/26/24 at 9:55 a.m., the Nurse Practitioner (NP) stated on the pain scale, #1-3 was mild pain; #4-6 was moderate pain; and #7-10 was severe pain. She stated pressure ulcers could be painful during wound treatment, resident's should be pre-medicated, and a nurse could ask (the doctor/provider) for another order (for medication) if the pain medication was ineffective. During an interview and concurrent medical record review on 3/26/24 at 10:52 a.m., the DSD was asked if Resident 122's pain level ranging from #5-8 was acceptable and he stated, No. The DSD stated pain was not natural, and they should try to get (a resident) pain free. He stated his expectation for residents with complaints of pain was for routine pain medication to be given. He stated residents should be pre-medicated thirty minutes prior to a dressing change, and they should have a prn order for medication for breakthrough (a pain flare-up that, breaks through, regular medication) pain. He stated nursing should call the physician and report (any issues). (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	Review of the Facility policy and procedure titled, pain Management, revised on 1/2024, indicated, To provide guidelines for consistent evaluation, management and documentation of pain, in order to provide the maximum level of comfort and enhanced quality of life for residents having pain or at risk of having pain. Under Procedure of the policy, indicated: - The licensed nurse will evaluate each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. - The licensed nurse and multidisciplinary team will evaluate pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. - The staff will observe the resident (during rest and movement) for evidence of pain; for example, grimacing while being repositioned or having a wound dressing changed. Review of the Facility policy and procedure titled, Prevention of Pressure Ulcers, revised on 1/2024, indicated, If pressure ulcers are not treated when discovered, they quickly get larger, become very painful for the resident, and often times become infected.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46132 Based on interviews and record reviews, the facility failed to ensure it was adequately staffed for Certified Nursing Assistants (CNAs), for 20 out of 30 days, and two out of 21 days for Licensed Nurses, for the month of 1/2024, which resulted in complaints of the facility being inadequately staffed. This could put residents' safety at risk, falls, accidents, late provision of care or care not being rendered at all. During an interview on 1/30/24 at 10:42 a.m., Resident 2 stated staff did not pay attention to residents and that was why, people here fall all the time. He stated, Do you see anyone supervising me or other patients? Resident 2 stated he felt the facility was inadequately staffed, the staff were lazy and did not want to do the work. During an interview on 2/23/24 at 1:31 p.m., Licensed Staff F stated the facility was short staffed but was better compared to before. Licensed Staff F stated the facility did not really like to give overtime and it was hard, but she tried to finish her tasks on time. Licensed Staff F stated short staffing was not good for the residents, and the residents ultimately suffered. Licensed Staff F stated short staffing could result in staff hurrying residents to complete a task which could lead to accidents and residents feeling frustrated. Licensed Staff F stated short staffing also could lead to late provision of care or care not being rendered at all. During an interview on 2/23/24 at 1:48 p.m., Unlicensed Staff D stated the facility needed more staff, and the facility was short staffed at times. Unlicensed Staff D stated short staffing put residents' safety at risk. Unlicensed Staff D stated short staffing could result in falls and injuries. During an interview on 2/23/24 at 1:52 p.m., Licensed Staff E stated the facility could do better with staffing. Licensed Staff E stated the facility was still short staffed at times, and staff just did the best they could. Licensed Staff E stated short staffing could result in falls, accidents and late provision of care. During an interview on 2/23/24 at 2:10 p.m., the Administrator stated the facility used a staffing guideline to ensure the facility was adequately staffed. A review of the facility's staffing guide indicated that for a census of 56 up to 63, the facility had to staff a total of 19 CNAs and 9 Licensed Nurses in a 24-hour period. A review of the facility's Direct Care staffing by shift daily posting, the CNAs were not adequately staffed for 20 out of 30 days during these dates: 1/1/24 Census of 59, 18 CNAs total in 24-hour period 1/2/24 Census of 57, 18 CNAs total in 24-hour period 1/3/24 Census of 57, 18 CNAs total in 24-hour period (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/4/24 Census of 57, 17 CNAs total in 24-hour period 1/5/24 Census of 57, 17 CNAs total in 24-hour period 1/6/24 Census of 59, 18 CNAs total in 24-hour period 1/7/24 Census of 59, 17 CNAs total in 24-hour period 1/8/24 Census of 59, 18 CNAs total in 24-hour period 1/9/24 Census of 59, 18 CNAs total in 24-hour period 1/16/24 Census of 58, 18 CNAs total in 24-hour period 1/17/24 Census of 59, 16 CNAs total in 24-hour period 1/18/24 Census of 59, 18 CNAs total in 24-hour period 1/19/24 Census of 59, 18 CNAs total in 24-hour period 1/21/24 Census of 59, 18 CNAs total in 24-hour period 1/22/24 Census of 59, 18 CNAs total in 24-hour period 1/23/24 Census of 56, 17 CNAs total in 24-hour period 1/24/24 Census of 57, 18 CNAs total in 24-hour period 1/25/24 Census of 57, 18 CNAs total in 24-hour period 1/26/24 Census of 58, 18 CNAs total in 24-hour period 1/30/24 Census of 59, 18 CNAs total in 24-hour period A review of the facility's Direct Care staffing by shift daily posting, the Licensed Nurses were not adequately staffed for two out of 30 days during these dates: 1/27/24 Census of 58, 8 nurses total in 24-hour period 1/28/24 Census of 58, 8 nurses total in 24-hour period (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/19/24 at 3:30 p.m., Anonymous Residents 1, 2, 3, and 4, stated they had to wait for a long time before staff responded to call lights. Anonymous Resident 2 stated one time, her roommate pressed her call button and it had been more than 30 minutes and nobody came to answer the call light. Anonymous Resident 2 stated she had to get up from bed, transfer to the wheelchair by herself and go out of the room to, flag staff down to get their attention. Anonymous Resident 2 stated this was not an isolated incident. Anonymous Resident 2 stated she pressed the call light when she had a Chronic Obstructive Pulmonary Disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems) attack and nobody came to answer her call light. Anonymous Resident 2 stated she had to wake up one staff member to help her because he was sleeping in the activity room. Anonymous Resident 2 stated she wheeled herself to the nursing station to let staff know about her condition. Anonymous Resident 2 stated this terrified her, knowing staff would not be there to help in time in case of emergency. Anonymous Resident 2 stated, sometimes she had to wait for an hour before staff answered her call light on night shift. Anonymous Residents 1, 2, 3, and 4, stated staffing was worse in the afternoon but even worse at night shift. Anonymous Resident 1 stated there were multiple occasions where she had to go out of her room, transfer to her chair and flag staff down because they were taking forever to answer her call light. Anonymous Resident 1 stated she usually had to wait for 45 minutes before staff answered her call light. Anonymous Resident 1 stated it was frustrating and blamed management. Anonymous Resident 1 stated it was not fair for the Certified Nursing Assistants (CNAs) to care for more than 30 residents on night shift. Anonymous Resident 1 stated the facility's lack of staffing was frustrating. Anonymous Resident 1 stated staff were sleeping at night, either in the old shower room, residents' rooms or the activity room. A review of the facility's policy and procedure (P&P) titled, Staffing, undated, the P&P indicated it was the facility's policy to provide adequate staffing to meet the needed care and services for their population.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39792 Based on observation, interview and record, the facility failed to provide one of one sampled resident (Resident 12) follow-up psychiatric services to correspond with anti-depression medications. This failure resulted in Resident 12's depression to increase and failure to participate in therapy services, which now had encouraged Resident 12 to remain bed-bound and subjecting Resident to 12 to contractures and pressure sore development. Findings: During a review of Resident 12's, Admission Record, dated 7/25/22, indicated Resident 12 was admitted to the facility on [DATE], with a history of surgical amputation of left foot, major depression and heart disease. During a concurrent interview on 3/18/24 at 3:43 p.m., with Resident 12 and her Care Giver, the Care Giver indicated Resident 12's depression had gotten worse, and she would not get up out of bed and participate with therapy. The Care Giver indicated Resident 12 would get up out of bed and participate in therapy if the Care Giver was present to encourage Resident 12 to participate. The Care Giver indicated she had requested therapy services for Resident 12 but had not received the services. During an interview on 3/19/24 at 4:39 p.m., with Unlicensed Staff J (USJ), USJ indicated Resident 12 did not get up and stayed in her bed and did not leave her room unless it was for a clinical appointment. During an interview on 3/21/24 at 8:39 a.m., with Director of Rehabilitation (DOR), the DOR indicated Resident 12 had been discharged from rehabilitation services due to lack of progress because Resident 12 did not want to participate in therapy. The DOR indicated he was aware of Resident 12's depression and was aware of the psychological consult, as the rehabilitation department ordered psychological consults for residents. The DOR indicated he was not aware of the follow-up for the psychological consult. The DOR indicated Resident 12 would participate in bed exercises and thought there was an order to continue those exercises. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review on 3/21/24 at 11:23 a.m., with Director of Nursing (DON), the DON indicated Resident 12 had a history of depression, and when she came back from the hospital (approximately 2/6/24), she was more depressed. The DON indicated Resident 12 had been prescribed two anti-depressant medications, Mirtazapine (antidepressant and increases appetite) and Paxil, when Resident 12 returned from the hospital. The DON confirmed Resident 12 had been prescribed Paxil in the past and had a psychological consult in the past. A review of Resident 12's, Psychological Consultation, dated 5/2/23, indicated Resident 12 had mood and thoughts of depression, and, Psychological Consultation, dated, 5/9/23, indicated Resident 12 reported feeling frustrated and worried about the slow progress of rehabilitation and the plan was to continue therapy. The DON could not explain why there was no further follow-up of psychological services when the consultation indicated ongoing therapy would be beneficial for Resident 12. The DON indicated continued therapy would have helped with Resident 12's depression to facilitate a better mood and to better her therapy goals. The DON could not explain why Resident 12 did not have further therapy. The DON indicated the facility did have a contract where a psychologist came to the facility on ce a week, in person, to see residents, and Resident 12 was currently not on the list to be seen by the psychologist. During a review of Resident 12, Clinical Psychology Contact Note, dated 11/2/23 at 2:30 p.m., indicated the encounter occurred remotely through a device and Resident 12 had just woken up and did not feel like talking at that time. The document indicated the psychologist would approach Resident 12 during the next visit to the facility. No further psychological notes were found in the medical record and no further notes were produced, when requested, through Medical Records department. A facility policy and procedure was not available when requested.

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Greenfield Care Center of Fairfield	1260 Travis Blvd Fairfield, CA 94533

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 31424 Based on observation, interview, and record review, the facility failed to ensure safe and accurate medication administration for three of six residents sampled for medication pass (Resident 60, Resident 21, and Resident 43), when the nursing medication error rate was 13.79%. Licensed Staff M (LS M) did not follow manufacturer's directions, nor facility policy, when she administered rapid acting insulin too early and administered one incorrect vitamin. (Insulin is a hormone made by the pancreas to control blood sugar; a person who's pancreas does not make or release insulin has Diabetes, and may need to take synthetic insulin [insulin medication]). These failures placed Resident 60, Resident 21, and Resident 43 at risk for hypoglycemia, and potential harm, when their rapid acting insulin (insulin that begins to lower blood sugar 15 minutes after administration) was administered approximately 35-90 minutes before lunch trays arrived in the residents' rooms and potentially impaired Resident 43's treatment for vitamin D replacement when her physician's orders were not followed. (Hypoglycemia, also called low blood sugar, is a fall in blood sugar to an abnormal level; symptoms include headache, tiredness, clumsiness, trouble talking, confusion, loss of consciousness, seizures, or death; hypoglycemia is most commonly caused by medication like insulin). Findings: During a medication pass observation on 03/20/24 at 11:30 a.m., Licensed Staff M (LS M) gave Resident 60 insulin Lispro (rapid-acting Insulin), 4 unit dose. No food or lunch was present in Resident 60's room. Review of Resident 60's medical record revealed a physician order which indicated Lispro was to be given before meals and at bedtime. During a medication pass observation on 03/20/24 at 11:38 a.m., LS M gave Resident 21 insulin Aspart (rapid-acting Insulin), 6 unit dose. No lunch was present in Resident 21's room. Review of Resident 21's medical record revealed a physician order for insulin Aspart which indicated, . give with meals. During a medication pass observation on 03/20/24 at 11:55 a.m., LS M gave Resident 43 Novolog (Aspart) insulin, 6 unit dose. LS M also administered Resident 43 Vitamin D, 25 microgram (mcg) dose. Review of Resident 43's physician order for Novolog indicated it was to given, before meals. The physician order indicated Resident 43 was to be administered 25 mcg's of Vitamin D3 (not Vitamin D). During an interview on 03/20/24 at 12:02 p.m., LS M stated insulin Aspart should be given with meals and insulin Lispro could be given before meals. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During multiple observations on 3/20/24 at 12:18 p.m., 12:34 p.m., and 12:49 p.m., no food or lunch trays were present in Resident 60's room. At 12:58 p.m., Resident 60's lunch was delivered. At 1:02 p.m., Resident 60's lunch tray was untouched. An unidentified CNA (nursing assistant) began feeding Resident 60 at 1:06 p.m., over 1.5 hours after insulin Lispro was administered. During an observation on 3/20/24 at 12:12 p.m., no food was in Resident 21's room or on his bedside tray. Resident 21's lunch was delivered at 12:37 p.m., approximately 59 minutes after insulin Aspart was administered. During an observation on 3/20/24 at 12:30 p.m., Resident 43's lunch tray was delivered at 12:30 p.m., approximately 35 minutes after her insulin NovoLog (Aspart) was administered. Review of manufacturer's guidelines titled, Highlights of Prescribing Information, subtitled, NovoLog (insulin Aspart .), further subtitled, Dosage and Administration, revised 3/2008, indicated, .NovoLog (Aspart) should generally be given immediately (within 5-10 minutes) prior to the start of a meal . Under subtitle, 5.2 Hypoglycemia, the document indicated, Hypoglycemia is the most common adverse effect of all insulin therapies, including NovoLog. Severe hypoglycemia may lead to unconsciousness and/or convulsions (seizures) and may result in temporary or permanent impairment of brain function or death . Review of manufacturer's guidelines titled, Highlights of Prescribing Information, subtitled, Indications and Usage (revised 3/2013), indicated, Humalog (insulin Lispro) is a rapid-acting human insulin . Under subtitle, Dosage and Administration, the document indicated to, .Administer within 15 minutes before a meal or immediately after a meal . During an interview on 3/20/24 at 5:06 p.m., the Director of Nursing (DON) was asked when Insulin Aspart and Lispro should be administered in relation to resident meals (food intake). The DON stated Aspart and Lispro might decrease blood sugar quickly and should be given a few minutes before residents eat; she stated they should be administered within fifteen minutes of food consumption. The DON stated nursing staff should be aware when the meal trays are coming (being delivered) because residents need to eat so they do not become hypoglycemic; she stated hypoglycemia was dangerous. The DON was queried about vitamin D. When asked what the difference was between vitamin D and vitamin D3, the DON stated there was a difference and the nurse should have, borrowed, vitamin D3 (from facility stock) for administration to Resident 43. Review of facility policy titled, Policy and Procedure in Medication Administration, subtitled, Procedures (Revised 1/2024), indicated, 1. Drugs must be administered in accordance with the written orders of the attending physician (5 Rights) . [5 Rights: Right patient, right drug, right dose, right route (pill versus injection), right time].

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record reviews, the facility failed to: A. ensure a medication order was carried out for one out of two sampled residents (Resident 49), when he continuously received Trazodone (medication used to treat Depression, an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy), 75 milligram (mg, a unit of weight) at bedtime, instead of a new order to decrease Trazodone to 25 mg at bedtime. This failure resulted in Resident 49 receiving Trazodone 75 mg a total of nine times, from 2/21/24 up to 2/29/24, and a total of 19 times, from 3/1/24 up to 3/19/24. B. ensure the medications were administered timely for five out of five sampled residents (Residents 13, 21, 27, 34 and 46). This failure led to residents feeling angry, frustrated, upset and could lead to harm or sub-therapeutic effect of medications. Findings: A. A review of Resident 49's face sheet (demographics) indicated he was initially admitted to the facility on [DATE], with the diagnoses of Hypertension (high blood pressure) and Dysarthria (a speech disorder in which the muscles you use to produce speech are damaged, paralyzed or weakened). His Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 2/5/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 15, indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). A review of Resident 49's Psychiatric Visit report, dated 2/21/24, indicated his Trazodone was due for a gradual dose reduction (GDR, the stepwise tapering of a dose to determine if symptoms, conditions or risks could be managed by a lower dose). The report also indicated the Doctor of Nurse Practitioner (DNP) ordered to decrease his Trazodone from 75 mg at bedtime to 25 mg at bedtime. A review of Resident 49's electronic medication administration record (EMAR, a report that serves as a legal record of the drugs administered to a patient at a facility by a health care professional), from 2/21/24 up to 3/19/24, indicated Resident 49 continued to receive Trazodone 75 mg at bedtime. The EMAR indicated Resident 49 received 75 mg of Trazodone at bedtime a total of nine times on these dates: 2/21/24, 2/22/24, 2/23/24, 2/24/24, 2/25/24, 2/26/24, 2/27/24, 2/28/24 and 2/29/24. The EMAR also indicated Resident 49 received 75 mg of Trazodone a total of 19 times on these dates: 3/1/24, 3/2/24, 3/3/24, 3/4/24, 3/5/24, 3/6/24, 3/7/24, 3/8/24, 3/9/24, 3/10/24, 3/11/24, 3/12/24, 3/13/24, 3/14/24, 3/15/24, 3/16/24, 3/17/24, 3/18/24, and 3/19/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, EMAR for 2/2024 and 3/2024, and Psychiatric Visit Progress report, dated 2/21/24, record review on 3/20/24 at 9:25 a.m., Licensed Staff F verified Resident 49 continued to receive Trazodone 75 mg at bedtime. Licensed Staff F stated, since the Psychiatric Visit Progress report, dated 2/21/24, under medication order indicated to decrease Trazodone 75 mg at bedtime to 25 mg at bedtime, this should have been followed-up and carried out. Licensed Staff F stated, since this was considered a physician's order, a resident continuously receiving Trazodone 75 mg at bedtime was considered a medication error and posed a risk to Resident 49's safety. During an interview on 3/20/24 at 9:30 a.m., the Infection Preventionist (IP) stated, not following a medication order was considered a medication error and was a safety risk for Resident 49. During a concurrent interview, EMAR for 2/2024 and 3/2024, and Psychiatric Visit Progress report, dated 2/21/24, record review on 3/20/24 at 9:35 a.m., Licensed Staff O verified the DNP ordered to decrease his Trazodone from 75 mg to 25 mg at bedtime based on the Psychiatric Visit Progress report, dated 2/21/24. Licensed Staff O verified this order was not carried out, and Resident 49 continued to receive Trazodone 75 mg at bedtime. Licensed Staff O stated this was a medication error and an unnecessary medication dose that could put Resident 49's safety at risk. During a concurrent interview, EMAR for 2/2024 and 3/2024, and Psychiatric Visit Progress report, dated 2/21/24, record review on 3/20/24 at 10:08 a.m., the Minimum Data Set (MDS) Coordinator verified the DNP ordered to decrease Trazodone 75 mg to 25 mg at bedtime based on the Psychiatric Visit Progress report, dated 2/21/24. The MDS coordinator stated this order was not carried out. The MDS coordinator verified Resident 49 continued to receive Trazodone 75 mg at bedtime, from 2/21/24 to 2/29/24, and from 3/1/24 up to 3/19/24. The MDS coordinator stated, since the order to decrease Trazodone to 25 mg at bedtime was not carried out, Resident 49 continuously receiving Trazodone 75 mg was a medication error and an unnecessary medication dose. The MDS coordinator stated this placed Resident 49 at risk for falls, increased risk of side effects and posed a safety risk for Resident 49. During a concurrent interview, EMAR for 2/2024 and 3/2024, and Psychiatric Visit Progress report, dated 2/21/24, record review on 3/20/24 at 10:17 a.m., the Director of nursing (DON) verified Resident 49 was due for GDR based on the Psychiatric Visit Progress report, dated 2/21/24. The DON verified Resident 49 continued to receive Trazodone 75 mg, from 2/21/24 to 2/29/24, and 3/1/24 up to 3/19/24. The DON stated, if the DNP order was not followed, then it became a medication error and a safety risk for Resident 49. During an interview on 3/20/24 at 5:33 p.m., the DON verified she could not find a documentation Resident 49's physician was notified of the DNP's order to decrease Trazodone to 25 mg at bedtime. The DON stated, since Resident 49 continued to receive Trazodone 75 mg at bedtime despite DNP's order to decrease Trazodone to 25 mg at bedtime, this was considered a medication error. A review of the facility's policy and procedure (P&P) titled, Policy and Procedure in Medication Administration, revised 1/2024, the P&P indicated drugs must be administered in accordance with the written order of the attending physician .should there be any doubt of administering the medication the physician should be notified to verify order. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. A review of Resident 13's face sheet (demographics) indicated she was admitted to the facility on [DATE]. Her diagnoses included Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interfered with a person's daily life and activities), History of Falls, Muscle Weakness and Restless Leg Syndrome (RLS, a condition that causes a very strong urge to move the legs). Her Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes,) dated 11/1/23, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive-the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) score was 0, indicating severe cognitive impairment. A review of Resident 13's medication administration history (a report that generates a list of the medication administration-related data) report indicated she received the following medication late on 2/19/24, 2/20/24 and 2/21/24. The medication administration history report indicated she received Aricept (a medication used to treat mild, moderate and severe Alzheimer's, a disease that affects memory, thinking and behavior) late on these date: 2/19/24 and 2/20/24, Calcium-Vitamin D (supplements to sustain healthy bones) late on these date: 2/20/24 and 2/21/24, Depakene (a medication used to treat seizure disorders, mental/mood conditions and to prevent migraine- headache characterized by recurrent attacks of moderate to severe throbbing and pulsating pain on one side of the head) late on 2/19/24, 2/20/24 and 2/21/24, Multivitamin (supplement) late on this date 2/20/24, and Vitamin D (supplement for strong bones and teeth) late on 2/20/24. A review of Resident 21's face sheet indicated he was readmitted on [DATE], with diagnoses of Hyperlipidemia (HLP, an elevated level of lipids like cholesterol and triglycerides in your blood), Type 2 Diabetes Mellitus (DM, a disease that occurs when your blood glucose, also called blood sugar, is too high), Depression (a constant feeling of sadness and loss of interest,) and Muscle Weakness. A review of Resident 21's medication administration history report indicated he received the following medications late on 2/19/24, 2/20/24 and 2/21/24. The medication administration history report indicated he received Atorvastatin (used to treat HLP) late on this date: 2/19/24, Carvedilol (a medication used to treat HTN) late on this date: 2/19/24, Docusate Sodium (for bowel regularity) late on this date: 2/19/24, Insulin (an injection that lowers blood sugar) late on 2/20/24, Latanoprost (an ophthalmic solution used to treat increased eye pressure) late on 2/20/24, Magnesium (supplement to keep blood pressure normal, bones strong, and the heart rhythm steady) late on 2/19/24, and Vitamin D3 (supplement that helps the body absorb calcium, a mineral needed for healthy teeth and bones) late on 2/19/24. A review of Resident 34's face sheet indicated he was admitted to the facility on [DATE]. His diagnoses include DM, Depression and Hypertension (HTN, high blood pressure). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 34's medication administration history report indicated he received the following medications late on 2/19/24, 2/20/24 and 2/21/24. The medication administration history report indicated he received Aspirin (ASA, a medication used to treat pain, fever and prevents blood from clotting) late on 2/23/24, Divalproex Sodium (used to treat seizures) Delayed Release Sprinkle late on 2/21/24 and 2/22/24, Docusate Sodium late on 2/23/24, Donepezil (used to treat Alzheimer's or Dementia) late on 2/21/24 and 2/22/24, Fish oil (supplement that improve liver function and inflammation) late on 2/23/24, Gabapentin (medication that treats seizures) late on 2/23/24, Metoprolol Succinate (medication that treats high blood pressure) late on 2/23/24, Namenda (medication used to treat dementia associated with Alzheimer's disease) late on 2/23/24, Trazodone (a medication used to treat Depression) late on 2/21/24 and 2/22/24, and Vitamin D3 late on 2/23/24. A review of Resident 46's face sheet indicated he was readmitted to the facility on [DATE]. His diagnoses include HTN, Depression and HLP. A review of Resident 46's medication administration history report indicated he received the following medications late on 2/21/24, 2/22/24 and 2/23/24. The medication administration history report indicated he received Atorvastatin Calcium late on 2/22/24, Calcium Citrate on 2/22/24 and 2/23/24, Carbidopa-Levodopa late on 2/22/24 and 2/23/24, Celexa late on 2/22/24 and 2/23/24, Docusate Sodium late on 2/22/24 and 2/24/24, Enoxaparin injection late on 2/21/24, 2/22/24 and 2/23/24, Fenofibrate late on 2/22/24, Metoprolol late on 2/22/24 and 2/23/24, Mirabegron late on 2/22/24, Multivitamin late on 2/22/24 and 2/23/24, Pimavanserin Tartrate on 2/22/24 and 2/23/24, Plavix late on 2/22/24 and 2/23/24, Polyethylene Glycol on 2/22/24 and 2/23/24, Sinemet late on 2/22/24, Sucralfate late on 2/22/24 and 2/23/24, and Trazodone late on 2/22/24 and 2/23/24. A review of Resident 27's MDS assessment, dated 11/5/23, indicated her BIMS score was 15, indicating intact cognition. A review of Resident 27's Physician Order summary indicated her Diagnoses included HTN, Depression and DM. A review of Resident 27's medication administration history report indicated she received the following medications late on 2/19/24, 2/20/24 and 2/21/24: Calcium and Vitamin D late on 2/20/24, Depakene (medication used to treat seizure) late on 2/19/24 and 2/20/24, Multivitamins late on 2/20/24, Vitamin D late on 2/20/24, Atorvastatin late on 2/19/24, Carvedilol late on 2/19/24, Insulin late on 2/20/24, Latanoprost late on 2/20/24, Magnesium late on 2/19/24, Vitamin D3 late on 2/19/24, ASA late on 2/21/24, Calcium with Vitamin D3 late on 2/21/24, Carbamazepine late on 2/21/24, Colace (for bowel regularity) late on 2/19/24, 2/20/24 and 2/21/24, Coreg (used to treat high blood pressure) late on 2/21/24, Empagliflozin (used to treat DM) late on 2/21/24, Ipratropium Albuterol (used to treat Chronic Obstructive Pulmonary Disease, COPD- an inflammatory lung disease that causes obstructed airflow from the lungs) late on 2/19/24, 2/20/24 and 2/21/24, Lasix (used to treat fluid retention and swelling) late on 2/21/24, Lisinopril (used to treat high blood pressure) late on 2/21/24, Oxybutynin (a medicine used to treat symptoms of an overactive bladder, a sudden and urgent need to pee) late on 2/19/24, 2/20/24 and 2/21/24, Paroxetine (used to treat Depression) late on 2/19/24 and 2/20/24, and Plavix (used to prevent blood clot) late on 2/21/24. During an interview on 2/21/24 at 10:54 a.m., Resident 21 was lying on his bed, and stated he was not receiving his medications on time. Resident 21 stated it bothered him receiving his medications late. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/21/24 at 9:47 a.m., Resident 27 stated she was not receiving her medications on time. Resident 27 stated, often she had to wait for a long time before staff administered her medications. Resident 27 stated she was on a medication for bipolar disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme highs (mania or manic episodes) to lows (depression or depressive episodes)), which should be taken at the same time daily. Resident 27 stated it was frustrating not to be receiving her medications on time. During an interview on 2/21/24 at 10 a.m., when asked how she felt about receiving her medications late, Resident 27 stated she felt angry and upset. Resident 27 stated she did not receive her morning medications yet. During a concurrent interview and electronic medication administration (EMAR, an electronic a legal record of the drugs administered to a patient at a facility by a health care professional), dated 2/21/24, record review on 2/21/24 at 10:01 a.m., Licensed Staff K verified Resident 27 had not received her morning medications yet. During an interview on 2/21/24 at 10:18 a.m., Resident 34 stated he was not receiving his medications on time. When asked how he felt receiving his medications late, Resident 34 stated he had been receiving his medications late daily and it was annoying but now he just accepted the fact he would be receiving his medications late all the time. During an interview on 2/21/24 at 10:58 a.m., Resident 46 stated he did not receive his medications on time. When asked how he felt about receiving his medications late, Resident 46 stated he felt frustrated and upset receiving his medications late. During a concurrent interview and EMAR, dated 2/21/24, record review on 2/21/24 at 11:10 a.m., Licensed Staff K stated on time medication administration meant medications should be administered one hour before and one hour after the prescribed time. Licensed Staff K stated Resident 27's medications were not administered on time and were given late since it was already past 10 a.m., when we checked, and the nurse had not administered Resident 27's medications yet. When asked if it was important for residents to receive their medications on time, Licensed Staff K stated, Yes because some medications were time-dependent, it could be a safety risk, especially with blood pressure medications. When asked what could happen if residents received their medications late, Licensed Staff K stated it could be a safety risk, residents could get the same type of medication in a short span of time that could result in underdosing or overdosing. During an interview on 2/21/24 at 12:06 p.m., the Minimum Data Set (MDS) coordinator stated nurses should not document on EMAR at the end of shift or after breaks, for safety. The MDS coordinator stated nurses should be signing the EMAR right after the resident received the medication. When asked what could happen if residents' medications were administered late, the MDS coordinator stated the optimal effect of medications would be affected and it became a safety issue. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/21/24 at 12:42 p.m., Licensed Staff O stated nurses should document on the EMAR once a medication was administered, for accuracy. Licensed Staff O stated, if nurses were not documenting on the EMAR right after a medication was administered, it became a safety issue resulting in underdosing or overdosing. When asked what could happen if residents received their medications late, Licensed Staff O stated it could cause more problems especially for residents with unrelieved pain, residents receiving timed and scheduled medications like blood pressure medications, antibiotics (medicines that fight infection) and insulin. During an interview on 2/23/24 at 1:45 p.m., the Interim DON stated nurses need to sign the EMAR once a medication was administered. When asked what could happen if residents were receiving their medications late, the Interim DON stated late administration of medications could be a safety risk, depending on which medications were given late. The Interim DON stated nurses could administered medications one hour before and one hour after the scheduled time. The Interim DON stated, if medications were ordered to be administered at 9 a.m., and the medication was administered at 10:04 a.m., it would be considered late. A review of the facility's policy and procedure (P&P) titled, Medication Administration Schedule, revised 11/2020, the P&P indicated the scheduled medications are administered within one hour of their prescribed time unless otherwise specified . the exact time of medication administration is documented in the medication administration record (MAR, a drug chart, is the report that serves as a legal record of the drugs administered to a patient at a facility by a health care professional).

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 39792 Based on observation and interview, the facility failed to provide one sampled lunch test tray which had the appropriate temperature for the vegetables and meat, and the vegetables were not palatable. These failures had the potential to increase weight loss and one out of two sampled residents (Resident 7) frustrated that the hot food was served cold. Findings: During an interview on 3/18/24 at 12:08 p.m., Resident 7 indicated the food was not palatable nor was the hot food served hot. Resident 7 indicated the mayonnaise, served to the residents, did not taste like mayonnaise and could not identify what it tasted like. During a concurrent observation and interview on 3/20/24 at 1:03 p.m., with the Surveyor, the Dietary Supervisor (DS) and Registered Dietician (RD), a test tray was sampled regarding the meat and vegetable for temperatures and palatability. The spinach was tested in the conference room and indicated to be 101 degrees. The RD indicated this was not an acceptable range per regulatory guidelines. During a review of the facility's, Food Temperatures, dated 1/2024, Temperatures for hot products should be no less than 140 degrees. Foods failing to register these temperatures must be reheated or chilled until acceptable temperatures reached .Test tray monitoring will be done in accordance with established quality assurance schedules/procedures, to ensure that foods are properly heated/chilled to obtain appropriate serving temperatures to the residents (over 140 degrees for hot foods .The cook will be responsible for monitoring adequate heating time for pellets, plates, and the steam table line system so that temperatures can be maintained during the serving process .Plates and pellets should not be removed from the heated units not more than 2 at a time to maintain proper temperatures. All Concerns with equipment function should be brought to the attention of the Food Services Director.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39792 Based on observation, interview and document review, the facility failed to label items in the freezer with their contents or delivery date and failed to discard expired fresh fruit. These failures had the potential of serving residents food not fit for consumption and enabling residents to become sick by ingesting expired food. The Dietary Supervisor indicated the cause of the colder temperature might be due to the plate being cold and not having resided in a hot plate warmer prior to being served. The meat (meatloaf) entree was tested in the whole form and in the pureed form and both were found to be bland and not palatable. The spinach was watery in texture and not having any taste, also considered not palatable. Findings: During a concurrent observation and record review on [DATE] at 9:58 a.m., with the Dietary Supervisor (DS), the DS indicated the package in the freezer, without a label to identify the contents or the date regarding the receipt of contents, was a package of diced turkey. The DS produced a plastic bag in the freezer with the similar looking contents which had been labeled, diced turkey. The DS indicated the facility process for stocking new shipments of food would be labeling the packages with the contents of the food inside and the date the package had been received or delivery date (DD) to the facility. The DS indicated she could not explain why the package had not been labeled, per the facility policy. A package of, Kielbasa sausage, was marked with two dates, one indicated a DD (delivery date) of [DATE], which was typed, and one was hand written, DD [DATE]. The DS indicated the date of [DATE], indicated the company packaged the contents on [DATE], and the DD handwritten date of [DATE], was the delivery date to the facility. The DS stated the expiration date was per the manufacturer guidelines, but could not specify the date. The DS produced a document titled, Freezer Storage Guidelines, dated 2023, which was reviewed. The documented indicated processed meats, such as sausage, had an expiration date of one month from the date delivered to the facility. The DS explained that Kielbasa sausage was different than just sausage and was not sure of the expiration date; she continued to search further for documents to indicate the expiration date. The refrigerator had fresh (not frozen) blueberries which had a date of [DATE], located on top of the package. The DS could not indicate the expiration date and reviewed the documents stored in a plastic page protector located on the front of the refrigerator. The document titled, Produce Storage Guidelines, dated 2023, indicated blueberries in the refrigerator could be stored for one week. The package was opened to view the contents, and some of the blueberries were round and other had wrinkles or were not completely round. The DS indicated those blueberries were not appropriate to be served to the residents. The DS clarified the date of [DATE], indicated the date the blueberries were placed in the refrigerator. The DS proceeded to throw away the unlabeled diced turkey, the kielbasa sausage, and the blueberries. During an interview on [DATE] at 11:12 a.m., with Dietary Aide G (DAG), DAG indicated he was stocking the dry storage shelves since a delivery to the facility had been made that morning. DAG indicated he would not throw away food unless the DS instructed him to do so. DAG indicated he had been instructed to ensure the oldest dated food was placed up front to be used first and the most recently delivered food would be placed behind, in that order. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Freezer Storage Guidelines, dated 2023, indicated, All Food which need to kept in the Freezer can stored Frozen for six months with the following exceptions: Processed meats: (Bacon, Sausage, Ham, Hot Dogs .) Length of time in Freezer, 1 month. During a review of the facility's policy and procedure titled, Procedure for Freezer Storage, dated 2023, indicated, 6. All frozen food should be labeled and dated . A review of the facility's policy and procedure titled, Produce Storage Guidelines, dated 2023, indicated, May use longer if no signs of spoilage are visible .Blueberries (in refrigerator) one week . During a review of the facility's policy and procedure titled, Labeling and Dating of Foods, (undated), indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated .Food delivered to facility needs to be marked with a received date. Note that the delivery sticker is dated, and it can serve as the delivery date for the product .Newly opened food items will need to be closed and labeled with an open date and used by the date that follows the various storage guidelines within this section-specifically .

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 31424 Based on interview and record review, the facility's Quality Assurance and Performance Improvement Committee (QAPI, a data driven and proactive approach to quality improvement; process used to ensure services are meeting quality standards and assuring care reaches a certain level) failed to identify quality deficiencies and subsequently investigate and act upon the deficiencies, once identified, as evidenced by: 1. Facility leadership failed to identify nursing staff were not providing services, per facility policy and professional standards, regarding bowel care management and RNA (Restorative Nurse Assistants; staff with special knowledge, skills, and techniques in therapeutic rehabilitation; work alongside rehabilitation staff caring for patients with limited mobility and capacity for self care) services (Cross reference F658); 2. Nursing staff repeatedly failed to identify and address pain, and subsequently contact the provider (Physician, Nurse Practitioner, or Physician Assistant) for strategies to improve pain management (Cross reference F697); and, 3. Nursing staff medication error rate was 13.79% (Cross reference F759). These failures prevented the facility from gaining insight into potential system failures (Nursing, RNA services, etc.), thereby impairing facility leadership from implementing changes that would ensure residents attain and/or maintain their highest practicable physical, mental, and social well-being. Findings: During an interview on 3/26/2024 at 2 p.m., the Administrator stated the facility identified (quality) issues at Stand-Up (meetings for healthcare teams to connect at the start of the day to share relevant and time-sensitive information; daily Stand-Up Report can communicate everything a team needs to know) and discussed them at that time. She stated leadership discussed nursing standards, daily (in Stand-Up), but not in the QAPI meetings. When asked if the facility had identified deficiencies related to Nursing's failure to manage bowel movements and ensure that RNA services were provided, the Administrator stated she talked to the nurses, if needed, on a daily basis (not in QAPI). When asked if Nursing's failure to ensure adequate pain management had been identified by the facility, the Administrator stated this issue was, not really, in writing in the QAPI minutes; the Administrator stated she talked to the nurses informally. When asked if the facility had identified a high medication error rate among nurses, the Administrator stated the QAPI committee had not identified that issue. The Administrator confirmed there were no QAPI minutes that reflected the committee discussed nursing professional standards, pain management, and medication accuracy/errors. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled, Quality Assurance and Performance Improvement (QAPI) Program, subtitled, Policy Interpretation and Implementation, (revised 1/2024), indicated, 1. The administrator . is ultimately responsible for the QAPI program, and for interpreting its results and findings to the governing body . 4. The responsibilities of the QAPI committee are to: .b. identify, evaluate, monitor and improve facility systems and processes that support the delivery of care and services; c. identify and help resolve negative outcomes and/or care quality problems identified during the QAPI process; d. utilize root cause analysis to help identify where identified problems point to underlying systemic problems . g. coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals . 44968

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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** 31424 Based on observations, interviews, and record reviews, the facility failed to implement measures to reduce the risk of disease and infection transmission, when: 1. Contact precautions (procedures utilized to reduce the risk of spread of infections through direct or indirect contact; requires use of protective equipment such as gloves, gowns, and masks when touching an infected person or their environment) were not followed, per facility policy, for one resident (Resident 122) with suspected scabies (intensely itchy rash caused by a mite known as Sarcoptes scabiei); 2. Staff used shower chairs (metal or plastic chair used in a shower, allowing residents to sit while showering) as raised toilet seats (piece of equipment that goes on top of a toilet bowl to increase its height); staff then borrowed the raised toilet seats (the shower chairs) to shower residents, and then shared them among residents; 3. CNA's (Certified Nursing Assistants) did not hand wash or hand sanitize, per facility policy; 4. Nursing staff did not sanitize blood pressure cuffs between residents and did not sanitize the top of insulin (medication used to control blood sugar) bottles during medication pass; and, 5. Water utilized in a tube feeding (liquid nutrition and fluids administered via a tube, surgically placed through the skin and into the stomach) was not changed timely, when it was hanging (and used) at the bedside, for approximately 48 hours. Failure to implement an effective Infection Control program could potentially result in the spread of infections and potentially lead to harm for a population of residents with complex medical conditions. Findings: 1. Review of Resident 122's medical record, revealed a physician order, dated 3/6/24, that indicated, Pemethrin External Cream (medication used to treat Scabies) . in the evening every Wed (Wednesday) for possible scabies . Repeat in 7 days x1 (one time; for a total of two doses). Resident 122's Medication Administration Report (MAR; location where nursing staff document medication administration and other interventions) indicated Permethrin was administered on 3/20/24 (approximately fourteen days after the order was written). The MAR revealed an order, dated 3/6/24, that indicated, Contact Isolation (transmission-based precautions designed to prevent the spread of contagious diseases) for possible scabies. 1st treatment of cream tonight . one time only for scabies PPX (prophylaxis; action taken to prevent disease, especially by specified means or against a specified disease) for 1 day . Nursing documented this was completed on 3/6/24 at 8:49 p.m. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/22/24 at 12:05 p.m., Licensed Nurse S (LS S) stated, during Resident 122 scabies treatment (medication administration two times, seven days apart), she had used Standard Precautions (basic level of infection control precautions used, as a minimum, in the care of all patients), not contact precautions. She stated she did not know she was supposed to do something differently. LS S stated she wore gloves, but no gown when she worked with Resident 122 at that time. She stated, during the same timeframe, the treatment nurse wore a gown and gloves when she did the dressing changes. During an interview on 3/25/24 at 2:54 p.m., the Infection Preventionist (IP) stated Resident 122's hospital record (where he had been transferred from) did not have information about scabies. The IP stated his facility physician had told him about potential scabies and wanted to administer scabies medication as prophylaxis. The IP stated Resident 122 was medicated for scabies on 3/6/24, and it was repeated in seven days. He stated Resident 122 was on contact precautions for one day (not seven days, or the duration of the entire treatment). Review of facility policy titled, Scabies, subtitled, Procedures, (revised 1/2024), indicated, 1. Isolation with MD (medical doctor) order of any resident who is diagnosed with scabies . 4. After seven days, the resident application of the elimite (medication) will be repeated . The entire time that the resident is on treatment for scabies (seven days in Resident 122's case), isolation will be continuous . Review of facility policy titled, Isolation-Categories of Transmission-Based Precautions, (revised 1/2024), indicated, . 1. Standard precautions are used when caring for residents at all times regardless of their suspected or confirmed infection status . Under subtitle, Contact Precautions, the policy indicated, 1. 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 the environmental surfaces or resident-care items in the resident's environment . 7. Staff and visitors wear gloves . 8. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room . 2. During an observation on 3/21/24 at 10:15 a.m., a Unlicensed Staff B (Staff B) brought a shower chair into room [ROOM NUMBER]'s bathroom and placed it over the toilet (to be used as a raised toilet seat). During an interview on 3/21/24 at 10:18 a.m., Staff B was asked why she brought a shower chair into room [ROOM NUMBER]'s bathroom. Staff B stated another Certified Nursing Assistant (CNA), who was working in a different hall, wanted to borrow it to give a resident a shower. When asked why staff did not use a shower chair that was not being utilized as a raised toilet seat (that residents use for urine and stool evacuation), she stated that this was, what they do. She stated CNA's shared the shower chairs (being utilized as toilet seats) among residents. During an observation and concurrent interview 3/21/24 at 11:32 a.m., the Maintenance Supervisor (MS) viewed the shower room in Hall C and confirmed the room contained a reclining shower table, a Hoyer lift (equipment used to lift residents), and a small, sitting shower chair (with no wheels); he confirmed no shower chairs with wheels (like the ones being used as raised toilet seats) were located inside the shower room. The MS viewed the shower room in Hall A and confirmed it contained one, small chair without wheels. The MS located two, large shower chairs (without wheels) in the back yard. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/21/24 at 12 p.m., Unlicensed Staff AA (Staff AA) stated the small shower chairs (without wheels; located in the shower rooms) were used for alert and oriented residents who were more independent; she stated these residents needed to be able to walk (with assistance of a walker) to the shower room and be able to transfer to the small shower chair. Staff AA stated staff put more dependent residents into the wheeled shower chairs, took them to the shower room, and showered them in the wheeled shower chair (in which they were transferred). She confirmed staff were using the wheeled-shower chairs as raised toilet seats. During an interview on 3/21/24 at 2:22 p.m., Unlicensed Staff C (Staff C) stated she used the shower chair (raised toilet seat) earlier that day, from room [ROOM NUMBER], to shower a resident (in her hall). Staff C stated a resident (in her hall) did not want her to borrow his raised toilet seat because he had diarrhea and did not want her to take it (as he needed it). Staff C stated she used the raised toilet seat (shower chair), from room [ROOM NUMBER], to shower two of her residents. During an interview on 3/25/24 at 2:54 p.m., the IP stated he was not aware staff were using the shower chairs as raised toilet seats, and then sharing them among residents to transport them to, and perform showers. He stated there was not enough equipment, and they did not have designated shower chairs (not to be used as raised toilet seats) located in the shower rooms. During an interview on 3/25/24 at 4:37 p.m., the Administrator was asked about the lack of designated shower chairs. The Administrator stated maintenance staff cleaned the shower chairs, and she stated she was not aware staff were sharing the shower chairs (utilized as raised toilet seats) among residents. Review of facility policy titled, Shower, (revised 1/2024), indicated, .It is the policy of this facility to promote cleanliness . Under subtitle, Procedures, the policy indicated equipment included shower chairs. Under subtitle, Dependent Residents, the policy indicated, 1. Aid resident to shower room . 10. Cleanse and return shower chair to designated area . The policy did not indicate staff should utilize shower chairs as raised toilet seats and then share and utilize them among residents. Review of facility policy titled, Cleaning and disinfection of Resident-Care Items and Equipment, (revised 1/2024), indicated, 3. Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident . 5. Only equipment that is designated reusable shall be used by more than one resident . The policy did not indicated shower chairs could be utilized as raised toilet seats and then shared among residents. 3. During an interview on 03/22/24 at 11:30 a.m., Confidential Family Member (CFM) stated staff did not (always) change their gloves after providing bowel care to Resident 61. The CFM stated staff would change Resident 61's brief (diaper) after urine or stool and then use the same gloves to apply lotion over his body. The CFM stated it was like putting stool all over his body. The CFM stated she told the nurse, the nurse told the supervisor, and it had gotten, a little better. During an interview on 3/22/24 at 12:05 p.m., Licensed Staff S (LS S) confirmed the CFM reported to her the staff's poor hand hygiene when changing Resident 61. LS S stated she told the CNA's to stop (that behavior) and stated she reported it to the Director of Nursing (DON), the Administrator, and the Director of Staff Development (DSD). LS S stated the CFM reported to her the CNA's hand hygiene was getting better. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/25/24 at 2:54 p.m., the IP was asked if he was aware there was an issue with the CNA's hand hygiene, related to Resident 61's incontinent care (changing his briefs), and he stated, No. When informed of the CNA's hand hygiene practices, the IP stated the CNA's behavior was, not right, and the correct process regarding hand hygiene after incontinent care, was to: change gloves, hand sanitize (wash hands or use an alcohol hand rub), and then put on new (clean) gloves (before applying lotion). He stated he had not given the CNA's an in-service (targeted education) about hand hygiene because he was not told about the issue. Review of job description titled, Infection Preventionist, subtitled, VII. Responsibilities, (revised 2/2020), indicated, . Require that staff use accepted hand hygiene after each direct resident contact for which hand hygiene is indicated . 4. During a medication pass observation 3/20/24 at 11:30 a.m., Licensed Staff M (LS M) gave Resident 60 an insulin (medication to control blood sugar) injection. LS M did not wipe (with alcohol) the insulin bottle (to sanitize the bottle) prior to taking the insulin from the bottle. At 11:38 a.m., LS M took Resident 43's blood pressure (BP); Resident 43 held the blood pressure gauge (indicates numerical BP reading) for LS M (while she took her BP). LS M did not sanitize the BP cuff or gauge after use. During an interview on 3/20/24 at 12:02 p.m., LS M was asked if nurses wiped the tops of insulin bottles prior to use, and she stated, Yes we do. When informed that she did not wipe the insulin top prior to taking Resident 60's insulin from the bottle, LS M stated, I didn't? I usually do. When asked how staff sanitized BP equipment, LS M stated staff sanitized that equipment with, gold bleach wipes (sanitizing wipes located in a container with a gold top; contains bleach) before and after use. When informed she did not sanitize the BP equipment before, nor after, use on Resident 43, LS M stated, No, I didn't. During an interview on 3/25/24 at 2:54 p.m., the IP stated nursing staff should sanitize insulin bottles with alcohol prior to drawing up (removing the medication) insulin. The IP stated BP equipment should be cleaned after use with, gold, bleach wipes. Review of facility policy titled, Cleaning and disinfection of Resident-Care Items and Equipment, (revised 1/2024), indicated, Resident-care equipment, including reusable items will be cleaned and disinfected according to CDC recommendations 1.d. Reusable items are cleaned and disinfected or sterilized between residents .4 .according to manufacturers' instructions . 5. During an observation and concurrent interview on 3/18/24 at 11:08 a.m., Resident 61 had a tube feeding (liquid nutrition and water delivered via a surgically placed tube in a person's abdomen) and water (in a bag) hanging and infusing (into his feeding tube) next to his bed. The water bag was dated 3/16/24 (two days earlier; indicating the day it was started). Confidential Family Member (CFM) stated Resident 61 had a stroke and was non-verbal (did not speak). During an interview on 3/18/24 at 11:25 a.m., Licensed Staff A (LS A) walked into Resident 61's room and confirmed the date on his water bag was 3/16/24, and the date on his tube feeding bag was 3/17/24. LS A stated the tube feeding had been hung (by nursing staff) on evening shift the prior day (3/17/24). LS A stated the water should only hang for twenty-four hours (before it is changed). When asked why this was, LS A stated it was for, infection control, reasons. She stated the water bag should have been changed the previous day (3/17/24). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/26/24 at 3:21 p.m., the DSD stated the water hanging with the tube feeding should only be hanging twenty-four hours, not forty-eight hours. Review of facility policy titled, Enteral Nutrition: General Guidelines, subtitled, Administration Set Handling, (revised 1/2024), indicated, .9. Feeding bags, administration sets and syringes should be changed every 24 hours . The policy did not indicate when water, hanging with the tube feeding, should be changed and/or discarded.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 39792 Based upon observation, interview and record review, the facility failed to have a plate warmer in the kitchen in fully operational condition. Failure to have a functional plate warmer resulted in residents not having hot food for their meals, potentially causing weight loss due to lack of palatability. Findings: During a concurrent observation and interview on 3/20/24 at 12:30 p.m., with Dietary Manager (DM) and Registered Dietician (RD), during the lunch tray line, the plate warmer on one side was empty, and the cook was taking plates from one side of the warmer and placing them on the other side. The DM was standing next to the Surveyor, and a red button on the side the of the plate warmer was off, and the DM was asked if that was why the plates were being loaded to the other side. The DM was attempting to press the button in order for the red light to go on but after multiple attempts, it did not. Surveyor place her hand over the side of the plate warmer which was not lit and no warmth was felt. The DM was asked if one side of the plate warmer was broken. The DM kept pressing the button to turn on the side while Cook K was loading the cold plates on the working side of the plate warmer and then immediately using those plates for tray line. The lunch trays were almost completed, and the kitchen was working on the last food cart to distribute to the residents. The DM indicated the plate warmer had broken on Monday, 3/18/24. During an interview on 3/20/24 at 12:55 p.m., Cook L stated the plate warmer had been broken recently but could not remember the exact day, sometime last week or so. The RD indicated she was not aware of that half of the plate warmer not working and indicated she conducted monthly kitchen inspections. During a concurrent observation and interview on 3/20/24 at 1:03 p.m., during a test tray sample with the RD and DM, the temperature of the vegetable was sampled and indicated to be 101 degrees. The RD indicated that was not warm enough, per the regulations, and agreed the plate was cold and could have contributed to the food being too cool for the residents. During a review of the facility's, Sanitation and Food Safety Check List, dated 2/28/24, indicated to inspect equipment in the kitchen for cleanliness, being free from greasy film and food debris, but the plate warmer was not listed on the four-page document. During a review of the facility's policy and procedure, Sanitation, dated 2023, indicated, The Food & Nutrition Services Department shall have equipment of the type and in the amount necessary for proper preparation, serving .The Maintenance Department will assist Food & Nutrition Services as necessary in maintaining equipment .

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Greenfield Care Center of Fairfield	1260 Travis Blvd Fairfield, CA 94533

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 44968 Based on observations, interviews, and record review, the facility failed to ensure that 28 out of 35 rooms met the 80 square feet (sq. ft.) per resident, in multiple-occupancy resident rooms, when: Twenty four (24) rooms consisted of two beds which measured below 160 square feet; and four rooms consisted of four beds which measure below 320 square feet. This failure had the potential to limit room for the residents' personal belongings and compromise their ability to move freely and receive adequate care in their rooms. Findings: During an interview with the Administrator on 3/26/24 at 2:16 p.m., when the Administrator was asked for a copy of the approved room waiver, she stated she had yet to send the application to the California Department of Public Health. The Administrator stated they had made some room adjustments done in the past. She stated Rooms 8, 9, 21, and 37, which consisted of four beds were converted to three-bed rooms. A review of the document titled, Client Accommodation Analysis, (no date), indicated the following: - Rooms 1, 3, 4, 5, 6, 7, 10, 12, 14, 15, 16, 17, 19, 20, 22, 23, 24, 25, 26, 28, 29, 31, 32, and 33, consisted of two beds. The document indicated the rooms' floor area measurements were 143 square feet, providing 71.5 square feet per resident. - Rooms 8, 9, 21, and 37, consisted of four beds. The document indicated the rooms' floor area measurements were 286 square feet, providing 71.5 square feet per resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observations, interviews and record reviews, the facility failed to ensure the baseboards in residents' rooms were well maintained, were properly sealed and attached firmly to the wall. This failure could result in safety issues, cross-contamination, and pest infestation. Findings: During an environmental round (assessment of residents' environment to ensure the safety and well-being of residents, staff, and visitors) with the Infection Preventionist (IP) on 2/21/24 at 10:39 a.m., a part of the baseboard in the bathroom leading to room [ROOM NUMBER] was broken. During an interview on 2/21/24 at 10:45 a.m., the IP stated base boards should always be firmly attached to the wall. The IP stated, if baseboards were broken, undone and not fully attached to the wall, it could lead to vermin and pests getting inside the facility. The IP stated vermin and pests could bring disease inside the facility and could result in residents getting sick. During an environmental round with the IP on 2/21/24 at 10:49 a.m., it showed a part of the baseboard leading to room [ROOM NUMBER] was undone. During an interview on 2/21/24 at 11:10 a.m., Licensed Staff K stated it was not acceptable for the baseboards to be broken, undone or not firmly attached to the wall. Licensed Staff K stated, if a baseboard was undone, broken and not firmly attached to the wall, it became a safety issue, pests could use the opening to enter the facility and could lead to pest infestation. During an interview on 2/21/24 at 11:38 a.m., Unlicensed Staff C stated it was not acceptable for the baseboards to become broken, undone or not firmly attached to the wall. Unlicensed Staff C stated, if a baseboard was broken, undone or not firmly attached to the wall, it could be a fall safety hazard and could be the entry point for vermin and pests, which could lead to residents getting sick. During an interview on 2/21/24 at 12:06 p.m., the Minimum Data Set (MDS) Coordinator stated it was not acceptable for baseboards to become undone. The MDS coordinator stated baseboards that were broken, undone and not firmly attached to the wall, could be a point of entry for vermin and pests and put residents at risk for getting sick. During an interview on 2/21/24 at 12:42 p.m., Licensed Staff O stated it was not acceptable to have baseboards broken, undone and not attached firmly to the wall. Licensed Staff O stated, openings on baseboards could be a portal for vermin and pests to come inside the facility. Licensed Staff O stated vermin could carry diseases and could result in residents getting sick. During an interview on 2/23/24 at 1:26 p.m., Licensed Staff F stated facility should ensure the building was in good repair. Licensed Staff F stated baseboards had to be well fitted with no holes. Licensed Staff F stated, openings on baseboards could be an entryway for bugs, rats and vermin to come inside the facility. Licensed Staff F stated these bugs carried disease and residents could end up getting sick. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/23/24 at 1:45 p.m., the interim Director of Nursing (DON) stated baseboards should not have holes and should be firmly attached to the wall. The interim DON stated, if the baseboard was not firmly attached to the wall, it became a safety issue, a fall risk, and insects, rodents and vermin could get inside the facility, which could lead to disease and infection. A review of the facility's policy and Procedure (P&P) titled, Maintenance Service, revised 1/2024, the P&P indicated the maintenance department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines .maintaining the building in good repair and free from hazards.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observations, interviews, and record reviews, the facility failed to implement its smoking policy and failed to follow the smoking interventions identified in the Smoking Risks Assessment form (an assessment carried out for people who smoke) and smoking care plan (CP, a formal process that correctly identifies existing needs and recognizes a client's potential needs or risks created for individual residents), for six out of six residents (Residents 7, 27, 47, 54, 62) to promote safety while they were smoking, when: 1. The facility did not ensure Residents 7, 27, 47, 54, 62, and 71's cigarettes and lighters were kept by the facility staff; 2. The facility did not ensure Residents 7, 27, 47, 54, 62, and 71, were wearing aprons while they were smoking; 3. The facility did not ensure Residents 7, 27, 47, 54, 62, and 71, were supervised while they were smoking. 4. The facility did not ensure there was a Smoking Risk Assessment and a Smoking CP created for Resident 47; and, 5. The facility did not ensure there was a Smoking Risk Assessment and a Smoking CP created for Resident 71. These failures were a safety hazard and could result in accidents, burns and smoke inhalation injuries. Findings: A review of Resident 7's face sheet (demographics) indicated she was initially admitted to the facility on [DATE], with the diagnoses of Diabetes Mellitus (a disease in which the body does not control the amount of glucose (a type of sugar) in the blood and the kidneys make a large amount of urine), right hand contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) and Vitamin D deficiency (the state of having inadequate amounts of vitamin D in your body, which may cause health problems like brittle bones and muscle weakness). Her Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 1/5/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 8, indicating moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses. Her MDS assessment also indicated she needed moderate to maximal assistance from staff when performing her activities of daily living--ADL, activities related to personal care). (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 27's face sheet indicated she was initially admitted to the facility on [DATE], with the diagnoses of Type 2 DM, Hypertension and Chronic Obstructive Pulmonary Disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems). Her MDS assessment, dated 2/3/24, BIMS score was 15, indicating intact cognition. Her MDS assessment also indicated she needed moderate to maximal assistance from staff when performing her ADLs. A review of Resident 47's face sheet indicated she was initially admitted to the facility on [DATE]. Her diagnoses included Type 2 DM, Vitamin D deficiency, Hypertension (high blood pressure) and Parkinsonism (conditions with similar, slowed movement-related effects, usually lifelong, and most involve deterioration of your brain). Her MDS assessment, dated 2/22/24, BIMS score was 10, indicating moderately impaired cognition. Her MDS assessment also indicated she needed moderate assistance from staff when performing her ADLs. A review of Resident 54's face sheet indicated she was initially admitted to the facility on [DATE]. Her diagnoses included Hypertension, Hyperlipidemia (high cholesterol, is an excess of lipids or fats in your blood) and Dysphagia (difficulty swallowing). Her MDS assessment, dated 2/18/24, BIMS score was 12, indicating moderately impaired cognition. Her MDS assessment also indicated she needed supervision to maximal assistance from staff when performing her ADLs. A review of Resident 62's face sheet indicated she was initially admitted to the facility on [DATE]. Her diagnoses included Hyperlipidemia, COPD and Aphasia (a disorder that affects how you communicate). Her MDS assessment, dated 1/21/24, BIMS score was 11, indicating moderately impaired cognition. Her MDS assessment also indicated she needed moderate to maximal assistance from staff when performing her ADLs. A review of Resident 71's face sheet indicated he was initially admitted to the facility on [DATE]. His diagnoses included Dysphagia, Acute Pharyngitis (sore throat) and Anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). His MDS assessment, dated 3/8/24, BIMS score was 13, indicating intact cognition. During a concurrent observation and interviews on 3/19/24 at 4:40 p.m., Residents 7, 47, 54 and 62, wheeled themselves towards the back of the activity room. When asked where they were going, they stated they would be smoking. When asked if staff came to supervise them when they smoked, they stated, No. They stated they just smoked when they wanted to. Resident 47, 54, and 62, stated they kept their own cigarettes and lighters to themselves. There was no staff noted to monitor Residents 7, 47, 54, and 62, while they were smoking at the back of the activity room. During an observation on 3/25/24 at 10:10 a.m., Unlicensed Staff T stated Residents 54 and 62, had been under her care and knew they were smokers. Unlicensed Staff T stated she had seen these two residents smoke while not being monitored by staff. Unlicensed Staff T stated Residents 54 and 62, were smokers, and they kept their cigarettes and lighters themselves. Unlicensed Staff T stated, not monitoring the residents while they were smoking and allowing them to keep their cigarettes and lighters themselves, was a safety issue and a fire hazard. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/25/24 at 10:14 a.m., Unlicensed Staff B stated she was aware Residents 47, 54, and 62, were all smokers, and they were keeping their cigarettes and lighters themselves. Unlicensed Staff B stated residents were supposed to be monitored by staff while they were smoking. Unlicensed Staff B stated, if residents were allowed to smoke with no oversight or staff assistance, it became a safety issue and a fire and accident hazard. During an interview on 3/25/24 at 11:15 a.m., Licensed Staff F stated she was aware Residents 47 and 54, were smokers. Licensed Staff F stated Residents 47 and 54, should be monitored and supervised by staff when smoking and should not be keeping their cigarettes and lighters themselves. Licensed Staff F stated residents who smoked would need to have smoking assessments and smoking CP's completed, per facility policy. Licensed Staff F stated, if these were not done, the facility's smoking policy was not followed. Licensed Staff F stated smoking interventions identified in the smoking assessment should be followed because these were in place for residents' safety. Licensed Staff F stated residents' cigarettes and lighters should be kept by the facility staff, and staff should supervise residents while they were smoking, for safety. Licensed Staff F stated, not monitoring or assisting residents while they were smoking could result in residents' catching fire. During an interview on 3/25/24 at 11:20 a.m., the Infection Preventionist (IP) stated interventions identified on residents' smoking assessments should be followed for residents' safety. The IP stated, not following the interventions identified on residents' smoking assessments, was a safety concern that could result in accidents and fire hazards. The IP stated residents were not allowed to keep their cigarettes and lighters themselves. The IP stated it was the activity staff's responsibility to keep residents' cigarettes and lighters. During an interview on 3/25/24 at 11:23 a.m., Resident 47 stated she kept her own lighter and cigarettes. When asked whether staff consistently monitored or supervised residents while they were smoking, she stated, No. During an interview on 3/25/24 at 11:25 a.m., the Activity Director (AD) verified Residents 7, 47, 54, and 62, were smokers and were allowed to keep their own cigarettes and lighters. The AD stated, That's their right. When asked if the facility should be following the interventions in place, based on the residents' smoking assessments, she said, Yes, and it was for residents' safety. The AD stated residents should always be supervised by staff when they smoked. The AD stated, if a resident's smoking assessment indicated staff should keep their lighter and cigarettes, but residents were keeping it themselves, then it was a safety issue and residents could be at risk for accidents and for catching fire. During a concurrent observation and interview on 3/25/24 at 11:33 a.m., Residents 27 and 71, were seen smoking at the back of the activity room, and there were no staff around to supervise these residents while they were smoking. Resident 71 stated he was a smoker, and he kept his own cigarettes and lighter. When asked if there was staff supervising them when they smoked, he stated, No. Resident 71 stated it would be nice to have staff supervise the smokers to ensure they were safe while smoking. During an interview on 3/25/24 at 3:20 p.m., the Medical Records (MR) verified Resident 47 did not have a Smoking Risk Assessment completed. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/25/24 at 3:22 p.m., Resident 47 stated there was no lock box for her cigarettes. Resident 47 stated she kept her cigarettes in a small bag which she carried around when she went out of her room. A review of Resident 71's Smoking Safety Assessment indicated it was initiated today and was still in progress. There was no Smoking Care Plan created for Resident 71. A review of Resident 7's Smoking Safety Assessment, dated 3/19/24, under the Intervention tab indicated: Facility storage of tobacco products and fire materials, facility storage of fire materials only, assistance with lighting tobacco products, secure lock box may be provided to maintain smoking items. Resident 7's smoking CP, dated 3/19/24, indicated: Resident 7 surrender all tobacco and fire equipment to the facility for safe keeping, smoking supplies to be released to the smoking monitor just prior to monitored smoking sessions and then collected from the smoking monitor following smoking sessions for continued safety and safe keeping, smoking monitor is to observe resident when lighting her cigarette and assist as needed. A review of Resident 62's Smoking Risk Assessment, dated 2/21/24, under the Interventions tab, it indicated: A smoking apron, facility storage of tobacco products and fire materials, facility storage of fire materials only, assistance with lighting tobacco products, secure lock box may be provided to maintain smoking items. Resident 62's smoking CP, dated 10/31/23, indicated to supervise resident, per facility smoking policy, to provide smoking apron for resident while smoking and to store smoking materials, per facility policy. A review of Resident 54's Smoking Risk Assessment, dated 2/17/24, under the Interventions tab, it indicated: Smoking apron, facility storage of tobacco products and fire materials, facility storage of fire materials only, assistance with lighting tobacco products, secure lock box may be provided to maintain smoking items. Resident 54's smoking CP, dated 10/27/23, indicated to supervise resident, per facility smoking policy, to provide smoking apron while smoking and to store smoking material, per facility policy-location: Activity office. A review of Resident 27's Smoking Risk Assessment, dated 2/21/24, under Interventions, it indicated: Facility storage of tobacco products and fire materials, facility storage of fire materials only, assistance with lighting tobacco products, secure lock box may be provided to maintain smoking items. Resident 27's smoking CP, dated 11/7/23, indicated to supervise resident, per facility smoking policy and to provide smoking apron while smoking. During an interview on 3/25/24 at 3:40 p.m., the AD stated the facility did not have a smoking monitor form to document residents' refusals to wear smoking aprons. The AD was not able to provide documentation's Residents 7, 27, 47, 54, 62, and 71, were refusing to wear smoking aprons. During an interview on 3/25/24 at 4:01 p.m., the Director of Nursing (DON) stated interventions identified on a residents' smoking CP and the Smoking Risk Assessment should be followed for residents' safety. The DON stated, if these interventions were not followed, it became a safety risk and a hazard for the resident. The DON stated residents could be at risk for accidents and injuries. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure (P&P) titled, Smoking Policy, revised 1/2024, the P&P indicated all cigarettes would be kept in the Activity Office during business hours and after business hours and on weekends, cigarettes were entrusted to the activity staff who released them to the staff who would supervise smoking .a strict count for cigarettes would be kept for each smoker .no cigarettes, lighters or matches would be kept by the resident unless he or she was able to demonstrate complete safety awareness of smoking practice .a resident who was smoking would be reevaluated/reassessed at least quarterly or as often as needed, to determine all safety issues, including using aprons, when smoking.