STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056206	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Healthcare Center	230 E Adams Blvd Los Angeles, CA 90011

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on interview and record review, the facility failed to initiate the process for a resident representative timely for two of eight sampled residents (Resident 48 and Resident 19) when the facility identified the residents were not able to make medical decisions and did not start the application process for conservatorship until months later. This deficient practice had the potential for the residents to not have a responsible party to assist in making medical decisions based on the resident's best interests and wishes. Findings: a. A review of Resident 48's Admission Record indicated Resident 48 was admitted to the facility on [DATE] with diagnoses including hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting left non-dominant side and muscle weakness. A review of Resident 48's Minimum Data Set (MDS, resident assessment tool) dated 12/1/24, indicated the resident had severe cognitive impairments (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving) and required substantial / maximal assistance from staff for personal hygiene, dressing, sit to stand, and bed to chair transfers. A review of Resident 48's Multidisciplinary Care Conference (MCC) dated 12/11/24, indicated the resident had severe cognitive impairment (problems with thinking, memory and understanding) and did not indicate a referral or discussion regarding Resident 48 requiring a Bioethics committee or resident representative to make medical decisions. A review of Resident 48's Bioethics Committee Meeting Minutes (BCMM) dated 1/29/25, indicated the resident's lack of capacity and decision-making abilities, the resident had no known family, could not make medical decisions, and was unable to act as the responsible party. The BCMM did not indicate any information regarding Resident 48 application for an assigned conservator (when a judge appoints a person to act or make decisions for someone who cannot make decisions on their own) by the state or a guardian. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/25 at 12:20 p.m., during an interview, the Social Services Director (SSD) stated Resident 48 could not make any decisions and SSD should have started the process for the Bioethics committee and application for a guardian as a responsible party. The SSD stated since the resident was not able to make decisions and if something happened and Resident 48 needed to make a decision for care, then no one would be able to make a decision for Resident 48. The SSD stated a resident representative needed to assist the resident in making decisions. During an interview and record review on 2/13/25 at 3:43 p.m., with the Medical Records Director (MRD), the facility's policy and procedure titled, Resident Representative, was reviewed. The MRD stated the policy was the only policy the facility had regarding the Bio-Ethics committee and process for delegating a resident representative. During an concurrent interview and record review on 2/14/25 at 12:26 p.m. with SSD, the Bioethics Committee Meeting minutes dated 1/29/25 was reviewed. The SSD stated 1/29/25 was when the process was started for Resident 48 to have a resident representative to assist in making decisions. The SSD stated this process should have started 11/29/24 or close to this time period when SSD assessed that Resident 48 was no longer able to make decisions and resident did not have any family or other responsible party. A review of the facility's policy and procedure dated 2/2021 titled, Resident Representative, the policy indicated, if the resident is determined to be incompetent .the rights of the resident will devolve to and will be exercised by the resident representative appointed to act on the resident's behalf. 49836 b. A review of the Admission Record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a condition where the brain's function is impaired due to an underlying metabolic disturbance), schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). A review of the BCMM dated 11/25/2024, indicated the committee consisted of the Medical Director, the Administrator, the Director of Nursing and the Social Worker. The minutes indicated Resident 19 did not have the capacity to understand and make decisions, resident had no known family, and that the resident was unable to participate in the plan of care and / or act as the responsible party for himself. The BCMM indicated Resident 19 had paranoid schizophrenia, bipolar disorder, and Type II diabetes mellitus. The BCMM indicated the Bioethics Committee would act as Resident 19's responsible party and consented to treat the resident. The BCMM did not indicate any information regarding Resident 19's application for an assigned conservator (when a judge appoints a person to act or make decisions for someone who cannot make decisions on their own) by the state or guardian. A review of the Notice of Referral Receipt dated 1/10/2025 indicated Resident 19 was assigned to a Deputy Public Guardian for investigation, four months after admission to the facility. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a review of the MDS dated [DATE], Resident 19 was cognitively intact (no problems with a person's ability to think, remember, use judgement, and make decisions). The MDS further indicated Resident 19 was diagnosed with dementia, bipolar disorder, schizophrenia, and metabolic encephalopathy. A review of Resident 19's History and Physical (H&P) dated 2/3/2025, indicated Resident 19's was not competent to understand his medical condition. A review of the social services assessment for Resident 19 dated 2/5/2025, indicated Resident 19 did not have family or friends for support. During an interview on 2/12/2025 at 12:45 PM, the facility's Medical Director (MD) stated the role of the Bioethics Committee was to assist residents who were not able to make medical decisions, and the facility was unable to find a family member to become the responsible party. The MD stated the resident would be represented by the Bioethics Committee until the resident was assigned a conservator (when a judge appoints a person to act or make decisions for someone who cannot make decisions on their own) by the state. During a concurrent interview and record review on 2/14/2025 at 9:30 AM, the Administrator (ADM) was asked for a policy on the guidelines of the Bioethics committee, the ADM provided a policy titled, Resident Representative which did not mention the Bioethics Committee. When asked what guidance was being used regarding the Bioethics Committee, the ADM stated there was no specific guidance followed by the committee. During a concurrent interview and record review on 2/14/2025 at 10:12 AM, the Social Services Director (SSD) stated, currently the facility had 13 residents who were being represented by the Bioethics Committee. The SSD stated upon admission, quarterly, or as needed, the SSD would assess whether a resident was able to make decisions for themselves. The SSD stated when residents were identified as having severe cognitive impairment and did not have a representative to make decisions, the SSD would inform the Bioethics Committee, and the Bioethics committee would then have a meeting to determine if the resident's care would be managed by the facility's Bioethics Committee. The SSD stated an application for conservatorship from the state was then submitted and that there was no specific timeline on the process for conservatorship. The SSD stated a form called the Bioethics Committee Meeting Minutes was the form the facility used to indicate the concerns to be discussed, summary of discussion, and outcome. A review of the facilities policy and procedure (P&P) titled, Resident Representative, reviewed 1/16/2025, indicated the term resident representative was defined as: -an individual chosen by the resident to act on behalf of the resident to support the resident in decision-making; access medical, social, or other personal information of the resident; manage financial matters; or receive notifications. -a person authorized by state or federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-legal representative, as used in section 712 of the Older Americans Act and the court-appointed guardian or conservator of a resident.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on interview and record review, the facility failed to ensure one of seven sampled residents (Resident 62) participated in care plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) meetings to discuss care and discharge goals. This deficient practice had the potential to violate Resident 62's right to be an active participant in their care. Findings: A review of the Resident 62's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included anxiety, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbances in thought), and polyneuropathy (a condition where multiple peripheral nerves (nerves outside the brain and spinal cord) are damaged). A review of the Minimum Data Set (MDS- a resident assessment tool), dated 12/21/2024, indicated Resident 62 was cognitively intact (independent with daily decision making). A review of Resident 62's Annual History and Physical (H&P) dated 3/14/2024, indicated Resident 62 had the capacity to understand and make decisions. During an interview on 2/11/2025 at 1:28 PM, Resident 62 stated he felt like the facility was trying to kick him out. Resident 62 stated he was not ready to be discharged and still needed medical attention. Resident 62 stated he knew there were meetings to discuss the resident's care, but Resident 62 had not been involved in those care plan meetings. During a concurrent interview and record review on 2/14/2025 at 10:10 AM with the Social Services Director (SSD), the SSD stated residents were encouraged to attend their care plan meetings. The SSD reviewed Resident 62's Multidisciplinary Care Conference note dated on 12/30/2024 and acknowledged there was no documentation indicating Resident 62 participated in the meetings. The SSD stated it was important for the residents to be involved in their care plan meetings in order to address resident concerns and discuss resident goals while in the facility. A review of the facility's policy and procedure (P&P) titled, Care Planning-Interdisciplinary Team and last revised on 1/16/2025, indicated the resident, the resident's family and/or resident's legal representative/guardian or surrogate were encouraged to participate in the development of and revisions to the resident care plans.

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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. 43851 Based on observation, interview, and record review the facility failed to ensure the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) was within reach for one of 18 sampled Residents (Resident 51). This deficient practice had the potential to result in Resident 51 not having their needs met and not being able to alert and call facility staff for help during an emergency. Findings: During a review of Resident 51's Admission Record, the Admission Record indicated the facility readmitted the resident on 8/24/2022 with diagnoses that included Human Immunodeficiency Virus (HIV, a virus that attacks cells that help the body fight infection), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly into the stomach common for people with swallowing problems), epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures [episodes of abnormal brain activity that causes uncontrolled body movements]) blindness, dysphagia (difficulty swallowing), cerebral infarction (a condition where blood flow to the brain is interrupted, leading to the death of brain tissue), hemiparesis (mild or partial weakness or loss of strength on one side of the body), hemiplegia (Severe or complete loss of strength or paralysis on one side of the body) and chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing). During a review of Resident 51's Minimum Data Set (MDS, a resident assessment tool) dated 11/24/2024, the MDS indicated the resident had severely impaired cognition (impaired ability to think, understand, and reason). The MDS indicated Resident 51 required substantial / maximal assistance (helper does more than half the effort) for eating, oral hygiene, showering / bathing self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 51 was dependent on staff for help with toileting hygiene. During a review of Resident 51's care plan revised on 12/8/2024, the care plan indicated Resident 51 was at risk for injury/accidents and falls related to decreased mobility, impaired physical functions, poor safety awareness, sensory deficits, blindness on both eyes, anticonvulsant medications use, and contributing factors of hemiplegia, hemiparesis, and seizure disorders. The care plan indicated a goal for Resident 51 to not have a major injury. The care plan indicated an intervention for Resident 51 was to have the call light within reach and answered promptly. During an observation on 2/10/2025 at 10:34 AM, in Resident 51's room, the resident was observed lying in bed. Resident 51's adaptable call light (a call light that individuals with physical, cognitive and movement-limiting disabilities can use) was observed on the resident's bed side dresser away from the resident's reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/10/2025 at 10:42 AM, in Resident 51's Room, Resident 51's adaptable call light was observed with the Infection Preventionist (IP). The IP confirmed Resident 51's adaptable call light was not within the resident's reach. The IP was observed moving Resident 51's adaptable call light from the dresser to the resident's bed next to the resident. The IP stated Resident 51's adaptable call light should have been within the resident's reach so the resident could call for assistance when needed. During an interview on 2/13/2025 at 3:07 PM, with the Director of Nursing (DON), the DON stated call lights needed to be placed within the resident's reach, so residents could call for help and staff could assist resident's when needed. The DON stated there was a potential for a delay of care if the call light was not within the resident's reach. During a review of the facility's policy and procedure titled, Answering the Call Light, reviewed 1/16/2025, indicated The purpose of this procedure is to ensure timely responses to the resident's requests and needs . When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 50714 Based on interview and record review, the facility failed respect resident rights to self-determination and resident choice by failing to provide one of 18 residents (Resident 9) with his preference for a daily shave. This deficient practice had the potential to affect Resident 9's quality of life and psychosocial well-being (how good you feel about yourself mentally, emotionally, and in your relationships with others) Findings: A review of Resident 9's Admission Record indicated the facility admitted Resident 9 on 6/6/2024 with diagnoses including seizures, chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), muscle weakness, bipolar disorder (a mental illness that causes extreme mood swings), anxiety, hereditary and idiopathic neuropathy (group of inherited disorders that affect the peripheral nervous system [a network of nerves that runs throughout the head, neck, and body]), exposure to war and other hostilities, abnormal posture (stiff body movements and chronic abnormal positions of the body), and history of traumatic brain injury (brain damage caused by an external force, such as a blow to the head or an object penetrating the brain). A review of Resident 9's History and Physical (H&P) dated 6/7/2024, indicated Resident 9 had the capacity to understand his medical condition and patient bill of rights presented by the facility staff. A review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 6/10/2024, indicated Resident 9 was able to make himself understood and had the ability to understand others. The MDS indicated Resident 9 needed moderate assist from staff with personal hygiene (practices that keep people clean and healthy) such as combing his hair, shaving washing/drying his face and hands. A review of Resident 9's care plan, titled, Self-Care Deficit (when someone is unable to perform daily tasks that support their health and well-being) Assistance Required with Bathing, Hygiene, Dressing and Grooming Related to Impaired Physical Mobility (having difficulty moving around freely and independently), dated 7/1/2024, indicated the facility initiated an intervention on 7/1/2024 for Resident 9 to have a daily shave. During an interview on 2/10/2025 at 3:31 PM with Resident 9, Resident 9 stated he was not getting the daily shave he wanted. Resident 9 stated the facility staff only shaved him twice a week and the resident was upset his preference was not being followed. During an interview on 2/12/2025 at 8:52 AM with Certified Nurse Assistant 12 (CNA 12), CNA 12 stated Resident 9 would get shaved on shower days, which was twice a week. CNA 12 stated she would shave the resident on the date of interview (2/12/2025) since it was a shower day. When asked what CNA 12 would do if Resident 9 asked for a daily shave, CNA 12 stated that if she (CNA 12) had time, she would shave Resident 9 in the afternoon on non-shower days after CNA 12 had finished tasks for other residents. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/2025 at 8:59 AM with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated residents had the right to ask for and get a daily shave. LVN 3 reviewed Resident 9's care plan and confirmed by stating the resident was not receiving the requested daily shaves. LVN 3 stated the facility was violating the resident's rights by not following the resident's care plan. During an interview on 2/12/2025 at 9:07 AM with Registered Nurse 3 (RN 3), RN 3 stated Resident 9 had the right to ask for a daily shave and if the facility did not meet the resident's need, Resident 9 could become emotional and even get upset if he did not get a daily shave. During an interview on 2/12/2025 at 9:11 AM with the Director of Nursing (DON), the DON stated Resident 9 had the right to ask for a daily shave and if it was not done, Resident 9 could be sad. The DON stated that if the morning shift was not able to shave Resident 9, the morning shift could endorse (pass along) the request to the next shift. The DON stated the facility was not following the residents right to request a shave and the facility would educate the staff. During a review of the facility's policy and procedure (P&P) titled, Accommodation of Needs, dated 1/16/2025, indicated the facility would accommodate a resident's individual needs and preferences to the extent possible (as much as possible). The P&P indicated the facility was to accommodate the resident, staff attitudes and behaviors would be directed toward assisting the resident with maintaining independence, dignity, and well-being according to the resident's wishes. During a review of the facility's P&P titled, Activities of Daily Living, Supporting, dated 1/16/2025, indicated the facility would have interventions to improve or minimize a resident's functional abilities (a person's capacity to perform everyday tasks and activities) according to the resident's need, preferences, goals and recognized standards of practice (guidelines that outline how a professional should perform their duties).

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on observation, interview, and record review, the facility failed to notify the resident's physician (MD 1) for one of eight sampled residents (Resident 48) for a change in condition (COC) for multiple continued refusals during Restorative Nursing Aide (RNA, nursing aide program that help residents to maintain their function and joint mobility) by failing to assess, address and report to MD 1 after Restorative Nursing Aide (RNA 3)'s reports of Resident 48's refusals to participate on the RNA Weekly Summary 11/8/24, 11/15/24, 11/22/24, 11/29/24 in accordance with the facility policy and procedure. These deficient practices resulted in the delay in assessment and prevented Resident 48 from receiving alternative interventions and services to improve ROM and prevent worsening left hand contractures (loss of motion of a joint). CROSS REFERENCE to F688 Findings: During a review of Resident 48's Admission Record indicated Resident 48 was admitted to the facility on [DATE] with diagnoses including but not limited to hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting left non-dominant side and muscle weakness. During a review of Resident 48's Minimum Data Set (MDS, a resident assessment tool) dated 9/1/24, the MDS indicated Resident 48 had severe cognitive impairments (problems thinking, remembering, judging, problem-solving). The MDS indicated Resident 48 did not exhibit any behavior for rejection of care that was necessary to achieve health and well-being. The MDS also indicated Resident 48 required substantial/maximal assistance from staff for oral hygiene, bathing, dressing, personal hygiene, sit to stand, and bed to chair transfers. The MDS indicated Resident 48 had functional range of motion (ROM, full movement potential of a joint) impairments on one side of the upper extremity (UE, shoulder, elbow, wrist, hand) and impairments on one side of the lower extremity (LE, hip, knee, ankle, foot). During a review of Resident 48's Care Plan (CP) initiated on 9/15/22 and revised on 2/11/25, the CP indicated Resident 48 had the potential for limitations in joint mobility related to decreased physical mobility, history of cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), osteoporosis (weak and brittle bones) and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). The CP goal indicated Resident 48 will have no further loss of ROM daily for three (3) months. The CP interventions indicated to monitor for pain or stiffness, position resident to prevent further contractures with pillow or splint as needed, RNA to perform passive range of motion (PROM, movement at a given joint with full assistance from another person) to left UE (LUE) in all places as tolerated 5 times a week, RNA to apply left resting hand splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) for one to six (1-6) hours or as tolerated 5 times a week. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 48's CP initiated on 9/15/22 and revised 2/11/25, the CP indicated Resident 48 was at risk for complications due to alteration in musculoskeletal status related to diagnosis of hemiplegia and hemiparesis, osteoarthritis of knee and hip, osteoporosis, advanced age, contractures, joint pain. The CP goal indicated complications related to fracture (broken bone), such as contracture formation, and immobility will be minimized through review date of 3/21/25. The CP interventions included assist the resident with the use of supportive devices (splints) as recommended; monitor/document/report to medical doctor (MD) as needed signs and symptoms or complications related to arthritis (swelling and tenderness of a joint causing pain and stiffness): joint pain, joint stiffness, swelling, decline in mobility, decline in self-care ability, contracture formation/joint shape changes, pain after exercises. During a review of Resident 48's OT Joint Mobility Screen (JMS, brief screen of joint movements) dated 6/1/24, the JMS indicated Resident 48 had full range of motion in both wrists, both hand/fingers, both elbows, and both shoulders. The JMS indicated Resident 48 did not have minimal to severe loss of UE passive ROM and did not have a diagnosis or condition that put Resident 48 at risk for contracture development. The JMS indicated skilled OT evaluation and RNA program was not recommended. During a review of Resident 48's OT JMS dated 8/22/24, the JMS indicated Resident 48 had full range of motion in the right wrist, right hand/fingers, right elbow, and right shoulder. The JMS indicated Resident 48 had moderate loss (26-50 percent (%) loss) of range of motion in the left wrist, left hand/fingers, and left shoulder and minimal loss (less than 25% loss) range of motion in the left elbow. The JMS indicated Resident 48 had minimal to severe loss of UE passive ROM and had a diagnosis or condition that put Resident 48 at risk for contracture development. The JMS indicated skilled OT evaluation was not recommended, and RNA program was recommended. The comments indicated PROM left UE, left resting hand splint, [right]UE AAROM. During a review of Resident 48's Order Summary Report (OSR), the OSR indicated an order dated 8/22/24 for RNA to perform PROM LUE in all planes as tolerated, frequency five (5) times a week and an order for RNA to apply left resting hand splint for 1-6 hours or as tolerated, frequency 5 times a week. During a review of Resident 48's 11/2024 RNA DSR, the DSR indicated Resident 48 did not complete RNA treatment to perform PROM LUE in all planes as tolerated, five times a week on the following days: 11/4/24, 11/7/24, 11/13/24, 11/21/24, 11/25/24. During a review of Resident 48's 11/2024 RNA DSR, the DSR indicated Resident 48 refused RNA treatment to perform PROM LUE in all planes as tolerated, five times a week on the following days: 11/1/24, 11/8/24, 11/11/24, 11/12/24, 11/15/24, 11/19/24, 11/20/24, 11/22/24, 11/26/24, 11/27/24, 11/28/24, 11/29/24. During a review of Resident 48's 11/2024 RNA DSR, the DSR indicated Resident 48 did not complete RNA treatment RNA treatment to apply left resting hand splint for 1-6 hours or as tolerated, 5 times a week on the following days: 11/1/24, 11/4/24, 11/6/24, 11/7/24, 11/13/24, 11/15/24, 11/20/24, 11/21/24, 11/25/24, 11/26/24, 11/27/24. During a review of Resident 48's 11/2024 RNA DSR, the DSR indicated Resident 48 refused RNA treatment RNA treatment to apply left resting hand splint for 1-6 hours or as tolerated, 5 times a week on the following days: 11/8/24, 11/11/24, 11/12/24, 11/14/24, 11/19/24, 11/22/24, 11/28/24, 11/29/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 48's RNA WS dated 11/8/24, 11/15/24, 11/22/24, 11/29/24 indicated Resident 48 completed RNA treatment 5 times in the last week for active assistive range of motion (AAROM, movement at a given joint with a person's own effort and assistance from an external force or another person) of both lower extremities, PROM of LUE, and splint for left hand. The WS did not indicate Resident 48 did not tolerate or had a problem with wearing the splint. The WS indicated refuse in comments. The WS was reviewed and co-signed by an unidentified nursing staff. During an observation and interview on 2/10/25 at 1:15 p.m. in Resident 48's room, Resident 48 was sitting up in bed. Resident 48 was able to move the right arm up and down to about shoulder level. Resident 48 was able to lift the left arm up a little, the left wrist was straight, and the left hand was fully bent in a fisted position. The left thumb was opposed across the palm underneath the second finger and the tip of the thumb was above the third middle finger. Resident 48 stated the left hand was no good and stated she could not really move the lower extremities. Resident 48's hip and knees were bent and rotated towards the right side. Resident 48 was not wearing any splints on the upper extremities. During an observation on 2/11/25 at 8:24 a.m. in Resident 48's room, Resident 48 was laying in the bed and the left hand was in a fisted position with the thumb opposed and inside the palm. Resident 48 was not wearing any splints on the upper extremities. During an observation on 2/12/25 at 8:50 a.m. in Resident 48's room, Resident 48 was laying in bed. Resident 48's right knee was bent and left ankle crossed over the right ankle. Resident 48 was able to move the right arm to move the gown, the left elbow was bent about halfway and left hand was in a fist. RNA 1 asked Resident 48 to move the straighten the right knee and Resident 48 was able to straighten the right knee. Resident 48 did not want to complete exercises with RNA 1. During an observation and interview on 2/12/25 at 12:55 p.m. in Resident 48's room, Resident 48 was laying in bed. Resident 48's left wrist was straight and able to move the left arm a little. Resident 48 stated the left hand was hard to move, tried to open the left fingers a little and observed minimal movement in the left fingers and Resident 48 was not able to open the left hand. Resident 48 stated the left arm was paralyzed. During an interview and record review on 2/12/25 at 2:17 p.m., the Wound Treatment Nurse (LVN 5) stated Resident 48 currently had a contracture related pressure injury on the left middle finger. LVN 5 stated when he first assessed Resident 48 on 1/15/25, the thumb was contracted and underneath the second finger and the thumbnail was digging into the right side of the third middle finger between the large knuckle and middle joint. LVN 5 stated Resident 48's hand was in a fisted position and when LVN 5 opened the thumb out, there was an open wound with slough (layer of dead tissue on surface of wound). LVN 5 stated the Wound Consultant Specialist (WCS) was present and assessed the wound as a Stage 4 (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). LVN 5 stated because Resident 48's hand was in a fist and it was contracted, it put Resident 48 at high risk to develop the wound. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In the same interview and record review, RN 1 reviewed Resident 48's medical records and confirmed there were no COC, nursing documentation, or progress notes completed indicating Resident 48 was refusing or not completing RNA treatments. RN 1 stated Resident 48 missed many days of RNA and absolutely, if Resident 48 was not putting on the left hand splint that was meant to prevent worsening of her contracture, the left hand contracture could get worse. RN 1 stated if Resident 48 was not wearing the hand splint, it defeated the purpose of the splint and caused the left hand to be in a fist. RN 1 stated if Resident 48's hand was in a fist all the time, it could be hard for staff to wash the hand, cut the nails, and put Resident 48 at risk and lead to the wound on the finger. RN 1 stated the left middle finger wound could have been prevented by doing exercises for the left hand and putting on the hand splint, because the purpose of Resident 48's RNA program was to keep the contracture from getting worse and to keep the hand open. RN 1 stated if an RNA reported to a charge nurse Resident 48's refusal to participate in RNA, the charge nurse should go talk to the resident and if the resident still refused, the charge nurse should communicate with the MD and follow up. RN 1 stated both the RNA and charge nurse should document the communication, especially to the MD so the MD could give an order. RN 1 stated the charge nurse would document it in the progress notes if there was any report or communication with RNA or MD. RN 1 stated it was a teamwork and a train of communication from RNA/CNA to the nurses. RN 1 stated if staff reported Resident 48's refusals with RNA, it should be care planned. RN 1 stated if the RNA had reported the refusals to the charge nurse, then the facility could have addressed it and provided other interventions. RN 1 reviewed Resident 48's care plans and stated there were no care plans about Resident 48 refusing RNA interventions. During an interview and record review on 2/13/25 at 12:27 p.m., RNA 3 stated she only helped doing RNA for a little bit last year and was mostly a CNA. RNA 3 reviewed the November 2024 RNA DSR and WS dated 11/8/24, 11/15/24, 11/22/24, and 11/29/24 and confirmed RNA 3 completed the documentation. RNA 3 stated she documented Resident 48 refused RNA treatments and reported it to the charge nurse, but stated she could not remember who the charge nurses were that co-signed the RNA WS on 11/8/24, 11/15/24, 11/22/24, and 11/29/24. RNA 3 stated Resident 48's left hand was in a fist and had pain if she tried to open the hand. During an interview and record review on 2/14/25 at 8:02 a.m., Registered Nurse Supervisor (RN 2) stated the purpose of the RNA program was to maintain a resident's function and preserve their ROM. RN 2 stated an RNA program was specific and individualized for each resident based on their abilities and stated only an RNA could perform the RNA treatment orders. RN 2 stated if a resident was continually refusing RNA, the staff would review the order, reassess the program, see if the goal needed to be changed, document on a progress note, and communicate to the MD and therapy department. RN 2 stated the MD and therapy department should be notified because they would have opinions on what consultations to do or what else should be done. RN 2 stated she was not aware that Resident 48 was refusing or not completing RNA treatments for any reason. During an interview and record review on 2/14/25 at 8:57 a.m., the Director of Nursing (DON) reviewed the RNA WS dated 11/8/24, 11/15/24, 11/22/24, and 11/29/24 and confirmed charge nurses had to co-sign the RNA WS. DON reviewed the 4 signatures and stated she could not recognize the signatures of the nurses. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 2/14/25 at 10:15 a.m., the DON stated the RNA program was for certain residents that needed the program to promote health, move their joints to help prevent stiffness and contractures. The DON stated the RNA program was individualized for each resident depending on their needs and that it was very important for the RNAs to complete the RNA treatments as ordered, because the RNA orders were given to maximize a resident's function. The DON stated if the RNA treatments were not completed, it could delay care and the healing process. The DON stated if a resident refused RNA, then it should be care planned and the staff should also try to encourage the resident, put a plan in place, notify the MD so that the MD was aware of the plan of care. The DON stated the purpose of the care plan was to find other interventions or other approaches for the resident. The DON stated a contracture was a deformity and could not get better and the facility should try to prevent contractures. The DON reviewed Resident 48's RNA DSR and stated staff should notify nursing, therapy department, and MD anytime there was a change in the resident to see if there were any recommendations staff could do for the resident. The DON stated the charge nurse should go to assess the resident to see why the resident was not doing RNA and do a COC if the resident refused three times. The DON stated the nurses should try to find out why first and see the reasons for why the resident was refusing or not doing RNA. The DON reviewed Resident 48's progress notes and IDT care plan meetings and stated there were no comments or any documentation regarding Resident 48 refusing RNA specifically. The DON stated if there was a refusal, staff should immediately take care of the situation. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, last reviewed on 1/16/25, indicated the facility promptly notifies the attending physician of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician or physician on call when there has been a refusal of treatment two or more consecutive times. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff, impacts more than one area of the resident's health status, requires interdisciplinary review and/or revision to the care plan. The P&P indicated prior to notifying the physician, the nurse will make detailed observations and gather relevant and pertinent information for the provider. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50714 Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse (deliberate, aggressive, or violent behavior with the intention to cause harm) for two of eight sampled residents (Resident 9 and Resident 42), who was subjected to Resident 392's physical aggression, who had diagnoses of schizoaffective disorder bipolar type (a mental illness that can affect thoughts, mood, and behavior). The facility failed to: -Implement the facility's policy and procedure titled, Abuse Prevention Program, dated 1/16/2025 to protect residents from abuse by anyone including other residents. -Develop a resident specific schizoaffective disorder bipolar type care plan for Resident 392, with interventions to monitor behavior. As a result, on 2/9/2025 at 8:24 pm, Resident 392 hit Resident 42 in the room they shared. On 2/10/2025, Resident 392 hit Resident 9 (his new roommate) above his right eye while Resident 9 was lying in bed. Resident 392 was transferred to the General Acute Care Hospital (GACH) on 2/10/2025 for altered mental status (a noticeable change in someone's mental state, like being confused, disoriented, not acting like themselves, or having difficulty thinking clearly) and agitation. This deficient practice caused an increased risk for Resident 42's psychological harm and Resident 9 sustained a scratch on his neck and remained angry and upset days after the incident. Findings: A review of the GACH Therapy record dated 1/28/2025, indicated Resident 392 was combative, agitated (a feeling of extreme restlessness, tension, or irritability), and required a sitter for monitoring behavior. A review of Resident 392's GACH Consultation record dated 1/29/2025, indicated the resident had an altered mental state (a noticeable change in someone's mental function, like being confused, disoriented, unusually sleepy, or acting strangely), and had aggressive behavior that required antipsychotic medication (generally used to treat the symptoms of psychosis [a collection of symptoms that affect the mind, where there has been some loss of contact with reality]). The GACH Consultation record indicated Resident 392 had poor attention, was confused, had impoverished thought content (issues with thinking often associated with schizophrenia [a serious mental disorder in which people interpret reality abnormally, may result in delusions and behavior that impairs daily functioning, may have grandiose delusions]), dementia (a chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning), severe depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living), and poor judgement and insight (a person is unable to recognize changes in their own behavior and emotions). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 392's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a change in how your brain works due to an underlying condition), schizoaffective disorder bipolar type (a mental illness that can affect thoughts, mood, and behavior), and unspecified dementia (a chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning). A review of the Physician's Order Summary Report dated 2/7/2025, indicated Resident 392 had an order for Zyprexa (medication used to treat schizophrenia) 5 milligrams (mg- metric unit of measurement) by mouth two times a day for schizoaffective disorder. The physician's order summary report indicated to monitor behavior of wide mood swings every shift for use of Zyprexa (an antipsychotic medication that can treat several mental health conditions like schizophrenia) starting 2/8/2025. A review of Resident 392's History and Physical (H&P) dated 2/8/2025, indicated the resident was not competent to understand his medical condition and bill of rights. The H&P indicated Resident 392 had a diagnosis of anxiety. According to a review of the Progress Note documented by Registered Nurse (RN) 1, dated 2/9/2025 at 8:24 pm, Resident 392 hit Resident 42 in the room they shared on 2/9/2025. The progress note indicated Resident 392 had a small scratch on his face and the facility moved Resident 392 to Resident 9's room on the same day. A review of Resident 392's care plan dated 2/9/2025 indicated the resident was involved in a physical altercation with a resident (Resident 42). The care plan goal was for Resident 392 to verbalize understanding and the need to control his behavior. The care plan intervention indicated to identify Resident 392's behavior and intervene and monitor for signs of psychological distress (when someone is experiencing a lot of negative emotions or mental discomfort that interferes with their daily life). The care plan also indicated that social services would do daily wellness checks for 72 hours and the facility would be attentive/responsive to Resident 392's behavior and would remove and identify behavior triggers (something that brings on or worsens symptoms). A review of Resident 392's Minimum Data Set (MDS - a resident assessment tool), dated 2/10/2025, indicated the resident's preferred language was non-English, and needed or wanted an interpreter for communication with a doctor or health care staff. The MDS indicated Resident 392 sometimes was able to make himself understood and sometimes able to understand others. The MDS indicated Resident 392 was unable to respond when asked about his health literacy, was inattentive (not able to pay attention), and had issues with sleep and trouble concentrating. A review of Resident 392's Psychiatric Consultation Note dated 2/10/2025, indicated a Psychiatric Mental Health Nurse Practitioner (NP) - a registered nurse who specializes in mental health care) saw Resident 392, but did not indicate the time the resident was seen. The note indicated the NP used a translator during his assessment of Resident 392 and that the resident was anxious, uncooperative, and avoiding eye contact. The consultation note indicated Resident 392 stared blankly at the NP when asked about his altercation with Resident 42. The note indicated Resident 392 was disorganized, irritable, and agitated. The note indicated Resident 392 had poor insight, impaired judgement, poor concentration and limited attention span with a diagnosis of schizoaffective disorder and bipolar type. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	According to a review of the Interdisciplinary Team (IDT - a group of people with different areas of expertise, like doctors, therapists, and social workers, who work together to solve a problem by combining their unique knowledge and skills to achieve the best possible outcome, especially when dealing with complex situations) Review notes dated 2/10/2025, Resident 392 had periods of confusion and struck his roommate (Resident 42) on 2/9/2025. The IDT notes indicated the facility would monitor Resident 392's behavior and refer him for a psychiatric evaluation (a mental health assessment that helps identify and treat mental health conditions). The notes indicated the SSD would perform wellness visits for 72 hours, the facility would encourage Resident 392 to attend activities of his choice, encourage Resident 392 to verbalize his feelings, and continue the care plan developed on 2/9/2025. The IDT also indicated Resident 392's primary language was English, which was a discrepancy compared to the MDS. A review of the Change of Condition (COC) Situation, Background, Assessment, Recommendation - SBAR) form dated 2/10/2025 at 7 pm, indicated Resident 392 was having a physical confrontation with his new roommate (Resident 9) on 2/10/2025. The COC SBAR form indicated a Certified Nursing Assistant (CNA) separated the residents and the facility placed Resident 392 on visual monitoring for the safety of other residents. The COC SBAR form indicated Resident 392 was transferred to the hospital at 7:30 pm on 2/10/2025 for altered mental status (a noticeable change in someone's mental state, like being confused, disoriented, not acting like themselves, or having difficulty thinking clearly) and agitation. A review of Resident 42's Admission Record indicated the facility admitted the resident on 9/4/2024 with diagnoses including schizophrenia, lack of coordination (not being able to move different parts of your body smoothly together), muscle weakness, low back pain. A review of the MDS, dated [DATE], indicated Resident 42 was able to make himself understood and had the ability to understand others. According to a review of Resident 42's investigation report titled, Resident to Resident Altercation, a CNA standing near Resident 42's room heard a loud disturbance at approximately 7:15 pm on 2/9/2025. The investigation report indicated the CNA intervened right away. Resident 42 reported he was in his wheelchair when Resident 392 approached him and struck him. The investigation report indicated Resident 392 was moved to another room on the opposite end of the building and Resident 42 did not sustain any injury. The investigation report indicated Resident 392 had a superficial scratch on the left side of his jaw. During an interview on 2/10/2025 at 9:37 am with Resident 42 in his room, Resident 42 stated he was done talking about the incident with his former roommate, Resident 392 who had hit him. Resident 42 stated he did not want to talk to anyone anymore. A review of Resident 9's Admission Record indicated the facility admitted Resident 9 on 6/6/2024 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), muscle weakness, and history of traumatic brain injury (brain damage caused by an external force, such as a blow to the head or an object penetrating the brain). A review of Resident 9's MDS, dated [DATE], indicated Resident 9 was able to make himself understood and had the ability to understand others. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the Resident 9's investigation report titled, Resident on Resident Altercation, indicated on 2/10/2025 a CNA heard a loud voice from Resident 9's room and immediately responded. The CNA observed Resident 392 holding Resident 9's necklace and was striking Resident 9 in the face. The investigation report indicated Resident 392 had an order to transfer to a hospital on 2/10/2025 and was waiting for transportation. During an interview on 2/11/2025 at 10:44 am, in Resident 9's room, Resident 9 stated that his roommate, Resident 392, pulled the necklace from Resident 9's neck and punched him over his right eye on 2/10/2025. Resident 9 stated he was angry and upset that Resident 392 hit him and that he would be upset if Resident 392 returned to the facility. Resident 9 used curse words when talking about Resident 392, that he would hurt Resident 392 after what Resident 392 did to him, and that the attack was unprovoked. Resident 9's face was red, and his voice elevated when describing what happened. During a concurrent observation and interview on 2/13/2025 at 8:59 am, in Resident 9's room, Resident 9 was irritable. Resident 9 stated he remained upset regarding the incident when Resident 392 hit him. Resident 9 stated Resident 392 hit him without provocation (something happened for no reason). During an interview on 2/13/2025 at 10:10 am in Resident 42's room, Resident 42 stated that Resident 392 was acting weird, would go between the curtain and the window that was next to Resident 42's bed on 2/9/2025. Resident 42 stated Resident 392 was on the right side of his bed, then Resident 392 hit Resident 42 without warning. Resident 42 then stated he no longer wanted to talk about what happened since he had already spoken about it with others. During an interview on 2/14/2025 at 11:49 am, CNA 11 stated she heard a sound from Resident 9's and Resident 392's room on 2/10/2025. CNA 11 stated she witnessed Resident 392 pulling Resident 9's necklace and stated she separated the residents right away. On 2/14/2025 at 11:55 am during an interview with the Director of Nursing (DON) and the facility Administrator (ADM), the DON and ADM stated they made arrangements for Resident 392 to be transferred to the hospital and while waiting for the ambulance, Resident 392 hit his roommate, Resident 9. The ADM stated the facility had a care plan (the physical altercation care plan with Resident 42) and a sitter was not needed. During an interview on 2/14/2025 at 2:24 pm, Registered Nurse Consultant 1 (RNC 1), stated the diagnosis of schizoaffective disorder for Zyprexa was not present on Resident 392's admission record, and the facility should have clarified with the Medical Doctor (MD). RNC 1 stated once clarified they would have assessed Resident 392 and created a care plan for schizoaffective disorder on admission. RNC 1 stated since the facility did not verify the diagnosis of schizoaffective disorder, there was no care plan in place for the resident and the interventions may not have been appropriate for Resident 392. The RNC 1 stated the facility staff should have verified the diagnosis to make sure the treatment Resident 392 received was appropriate. The RNC 1 stated there was a risk of Resident 392 to decline in behaviors since there was no schizoaffective care plan developed in accordance with facility policy and the facility may not be able to manage the resident's changes of behavior. During an interview on 2/14/2025 at 2:42 PM, regarding Resident 392 not having a care plan for schizoaffective disorder RNC 1 stated the care plan was important because it guided the staff to follow the interventions for the resident's care needs and to re-evaluate for effectiveness. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/14/2025 at 2:59 pm, when asked about Resident 392 receiving Zyprexa for schizoaffective disorder dated 2/7/2025, but the admission record did not have the diagnosis of schizoaffective disorder indicated until 2/14/2025, the DON stated the facility staff should have verified the diagnosis with the MD. The DON stated once verified, the facility staff should have developed a care plan for schizoaffective disorder to better care for Resident 392. The DON stated since there was no care plan in place, this affected how the staff cared for Resident 392. When asked about the consequences of not managing Resident 392's behavior, the DON declined to answer. A review of the facility's policy and procedure (P&P) titled, Abuse Prevention Program, dated 1/16/2025, indicated the residents have a right to be free from abuse and the facility would protect residents from abuse by anyone including other residents. The P&P indicated the facility would implement measures to address factors that may lead to abusive situations. A review of the facility's P&P titled, Care Planning - Interdisciplinary Team (IDT), dated 1/16/2025, indicated the IDT would be responsible for developing an individualized comprehensive care plan for each individual. A review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated 1/16/2025, indicated the IDT and the resident and his/her family or legal representative would develop and implement a person-centered care plan for each resident. The P&P indicated the care plan would have measurable objectives and timeframes, describe the services to be furnished to help the resident maintain their highest practicable level in regard to physical, mental, and psychosocial well-being. The P&P indicated the care plan would have goals, timetables, objectives, interventions, and desired/measurable outcomes. The P&P indicated the care plan would include problem areas and risk factors associated with identified problems. The P&P indicated the care plan would help in preventing or reducing a resident's decline, identify problem areas, and develop interventions that the facility targeted and was meaningful to the resident. The P&P indicated the facility would revise the care plan when a resident's condition changes.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43851 Based on interview and record review, the facility failed to develop an individualized person-centered care plan for one of 18 sampled residents (Resident 60) to meet the resident's needs. The facility failed to develop a care plan for Resident 60's allegation of abuse on 2/10/2025. This deficient practice had the potential lead to the inadequate and delay of the delivery of care of Resident 60. Findings: During a review of Resident 60's Admission Record, the record indicated the facility readmitted the resident on 11/12/2024 with diagnoses that included end stage renal disease (loss of kidney function in which the kidneys no long work to meet the body's needs), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), hypertension (high blood pressure), hemiplegia (severe or complete loss of strength or paralysis on one side of the body), and hemiparesis (mild or partial weakness or loss of strength on one side of the body). During a review of Resident 60's Minimum Data Set (MDS, a resident assessment tool) dated 12/1/2024, the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 60 required set-up or clean up assistance with eating and oral hygiene. The MDS indicated Resident 60 required supervision or touching assistance with upper body dressing and personal hygiene. The MDS indicated Resident 60 required partial/moderate assistance with toileting hygiene, showering/bathing self, lower body dressing, and putting on/taking off footwear. During an interview on 2/10/2025 at 10:59 AM, in Resident 60's room, the resident stated on 2/3/2025 the Director of Nursing (DON) and Social Services Director (SSD) came to his room to talk to him about an incident that occurred with his roommate. Resident 60 stated the DON verbally harassed him. Resident 60 stated the DON was very aggressive with her tone, she was talking to me and told me if anything happened in this room don't involve myself and let it go. Resident 60 stated the DON yelled at him which made him upset. Resident 60 stated he felt like the DON was trying to intimidate him. During an interview on 2/10/2025 at 12:15 PM with the Administrator, the Administrator was informed of Resident 60's allegation of verbal harassment by the DON. The Administrator stated this was the first time he was made aware of the incident between Resident 60 and the DON. The Administrator stated he would look into the incident immediately. During a review of Resident 60's Report of Suspected Dependent Adult/Elder Abuse completed 2/10/2025, the report indicated at approximately 12:15 PM the resident informed the surveyor that he was allegedly verbally abused by the DON on 2/3/2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's follow up letter to the department dated 2/10/2025, the letter indicated the incident between Resident 60 and the DON was reported to the surveyor. The letter indicated Resident 60 stated on 2/3/2025 the DON seemed angry while speaking to the resident during an investigation. The letter indicated Resident 60 stated he felt comfortable and safe at the facility and would like to continue to reside there. The letter indicated the SSD was present during the DON's interview with Resident 60. The letter indicated the SSD sated the DON was professional during the interview. The letter further indicated the facility was not able to substantiate the allegation of abuse. During a review of Resident 60's care plans, there was no indication a care plan was created or implemented for Resident 60's allegation of verbal harassment and abuse by the DON. During a concurrent interview and record review on 2/13/2025 at 12:30 PM, Resident 60's care plan was reviewed with the MDS Nurse (MDSN). The MDSN confirmed Resident 60 did not have a care plan that was initiated for alleged abuse. The MDSN stated a care plan should be initiated when a resident has an allegation of abuse, so staff know to monitor for emotional symptoms. The MDSN stated there was a potential for Resident 60 to experience a delay in the treatment and psychosocial symptoms without a care plan for alleged abuse. During an interview on 2/13/2025 at 3:07 PM, the DON stated a care plan had to be initiated with an allegation of abuse. The DON stated a care plan tells staff how to address a resident's needed. The DON stated there was a potential for a resident to not have their needs met if a care plan is not initiated for alleged abuse. During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, reviewed 1/16/2025, the policy indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The comprehensive, person-centered care plan will include measurable objectives and timeframes; describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; describe any specialized services to be provided as a result of PASSAR recommendations. The policy indicated to include the resident's stated goals upon admission and desired outcomes; include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire; incorporate identified problem areas; incorporate risk factors associated with identified problems; build on the resident's strengths; reflect the resident's expressed wishes regarding care and treatment goals; reflect treatment goals, timetables and objectives in measurable outcomes; identify the professional services that are responsible for each element of care; aid in preventing or reducing decline in the resident's functional status and/or functional levels; enhance the optimal functioning of the resident by focusing on a rehabilitative program; and reflect currently recognized standards of practice for problem areas and conditions.

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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** 49836 Based on interview and record review, the facility failed to ensure one sampled resident (Resident 77), who had diagnoses pneumonia (an infection / inflammation in the lungs that causes inflammation, leads to the accumulation of fluid and pus in the lungs, making it difficult to breathe) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), received necessary care and services in accordance with professional standards of practice by failing to: -Implement the Speech Therapy at Risk for Aspiration care plan interventions dated [DATE], for Resident 77 to receive oral pharyngeal stimulation and exercises (a series of movements designed to strengthen the muscles in the mouth and throat). -Develop a comprehensive, person-centered care plan to include the Physician's Order, for Resident 77 to receive oxygen at two liters per minute via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as needed for shortness of breath related to COPD and include the oxygen use in the comprehensive assessment. -Ensure Resident 77's vital signs documented by the Licensed Vocational Nurse (LVN 4) were accurate on , d+[DATE], ,d+[DATE] and [DATE]. -Implement the facility's policy and procedure (P&P) titled Routine Resident Checks as there was no routine resident check at least once per each 8-hour shift for Resident 77. The last skilled nursing assessment was documented on [DATE] at 1:45 PM. As a result, Resident 77 was found unresponsive in his room on [DATE] at 7:32 AM by LVN 3. Cardiopulmonary Resuscitation (CPR, consisting of chest compressions, combined with artificial ventilation [breathing], or mouth-to-mouth in an effort to manually preserve the brain) was initiated and Emergency Medical Services (EMS - immediate medical assistance via ambulance) was called. At 8:08 AM Resident 77 was pronounced dead by the paramedics. Findings: A review of Resident 77's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including pneumonia, COPD, bacteremia (condition where bacteria are present in the bloodstream, an abnormal infection in the blood), and dysphagia. A review of Resident 77's History and Physical (H&P) dated [DATE] indicated the resident was not competent to understand his medical condition. A review of the Physician's Orders for Life-Sustaining Treatment (POLST, provides seriously ill patients more control over their end-of-life care) dated [DATE], indicated Resident 77 was a 'Full Code' (a medical term that indicates a patient's wish to receive all possible life-saving measures in the event of a cardiac or respiratory arrest). The POLST was signed by the Attending Physician and Resident 77's responsible party (RP 1). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the Physician's Order dated [DATE] indicated Resident 77 to receive oxygen at two liters per minute via nasal cannula, as needed for shortness of breath related to COPD. According to a review of Resident 77's Speech Therapy (ST) care plan dated [DATE], the resident was at risk for aspiration (the accidental inhalation of foreign substances, such as food, liquid, or vomit, into the lungs). The care plan interventions indicated for Resident 77 to receive oral pharyngeal stimulation and exercises (a series of movements designed to strengthen the muscles in the mouth and throat), safe swallowing strategies, and patient and caregiver education. A review of Resident 77's Pneumonia Care Plan dated [DATE] indicated the goal was for the resident's pneumonia to be resolved without any complications. The care plan interventions indicated to elevate the head of the bed for comfort and lung expansion. The care plan did not indicate Oxygen Use interventions for the physician ordered oxygen at two liters per minute as needed. A review of the Acute Respiratory Failure with Hypoxia (low oxygen in the blood) care plan dated [DATE], indicated the goal for Resident 77 was to not have complications related to shortness of breath (SOB). The care plan interventions indicated to encourage sustained deep breaths using an incentive spirometer (a medical device used to help patients improve their lung function with deep inhale and exhale) and asking the resident to yawn. The care plan did not indicate Oxygen Use interventions for the physician ordered oxygen at two liters per minute as needed. A review of the medical record indicated Resident 77 did not have an Oxygen Use care plan with person-centered interventions. A review of the Dysphagia Care Plan dated [DATE], indicated staff interventions to provide Resident 77 with a healthy heart, pureed texture, honey consistency diet as ordered, and a ST evaluation and treatment as ordered. According to a review of the Minimum Data Set (MDS - a resident assessment tool) dated [DATE], Resident 77 had severe cognitive impairment (problems with a person's ability to think, remember, use judgement, and make decisions) and was dependent on facility staff with showering and transfers. The MDS indicated Resident 77 had diagnoses of pneumonia, septicemia (blood poisoning, especially that caused by bacteria or their toxins), hypertension (HTN, high blood pressure), COPD, respiratory failure (a condition where the lungs cannot adequately exchange oxygen), and dysphagia. The MDS did not indicate that Resident 77 was on oxygen therapy. A review of the Medication Administration Record (MAR) dated [DATE] indicated Resident 77's vital signs during the 3 PM -11:30 PM shift was noted as Blood Pressure (BP): ,d+[DATE], Temperature (Temp): 97.1, Pulse: 72, Respirations (Resp): 18, and Oxygen Saturation (O2 Sats): 97. All within normal limits. A review of the MAR dated [DATE] indicated Resident 77 vital signs during the 11 PM - 7:30 AM shift were Blood Pressure (BP): ,d+[DATE], Temperature (Temp): 97.1, Pulse: 72, Respirations (Resp): 18, and Oxygen Saturation (O2 Sats): 97, exactly the same as the prior shift (3 PM - 11:30 PM). All within normal limits. A review of the MAR dated [DATE] indicated Resident 77's vital signs during the 3 PM - 11:30 PM was noted as BP: ,d+[DATE], Temp: 97.8, Pulse: 74, Resp: 18, O2 Sats: 98. A review of the MAR dated [DATE] for the 11 PM - 7:30 AM shift for Resident 77, were exactly the same as the shift prior (3 PM - 11:30 PM). All within normal limits. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the Medication Administration Record (MAR) dated [DATE] indicated Resident 77's vital signs during the 3 PM -11:30 PM shift was noted as BP: ,d+[DATE], Temp: 97.1, Pulse: 72, Resp: 18, O2 Sats: 96. A review of the MAR dated [DATE] indicated Resident 77 vital signs during the 11 PM- 7:30 AM shift were exactly the same as the prior shift (3 PM - 11:30 PM). All within normal limits. The MAR's for Resident 77 dated ,d+[DATE], ,d+[DATE] and [DATE] during the 11 PM - 7:30 AM shift were documented by the same LVN (LVN 4). A review of the Medication Administration Record (MAR) dated ,d+[DATE], ,d+[DATE], ,d+[DATE] and [DATE] indicated Resident's 341, 32, 62, 21, and 19 (five additional residents) vital signs during 11 PM - 7:30 AM shift were exactly the same as the prior shift (3 PM - 11:30 PM). All within normal limits and all documented by the same LVN (LVN 4). According to a review of the Nurses Note dated [DATE] at 1:45 PM, Resident 77 was alert and able to follow directions. Resident 77's breathing was regular, had normal breath sounds, and had no cough. The nurses note indicated vital signs were within normal limits and the resident had no pain or discomfort. This was the last nursing note documented for Resident 77 (excluding the vital signs) as there was no nursing notes during the 3 PM - 11:30 PM shift, nor the 11 PM - 7:30 AM shift (approximately 16 hours), A review of the Change of Condition (COC) report, dated on [DATE] at 7:32 AM indicated Resident 77 was found unresponsive in his room by LVN 3. The COC indicated further assessment by LVN 3 included Resident 77 had no pulse, was not breathing, and vital signs were unobtainable. Cardiopulmonary Resuscitation (CPR) was initiated, and EMS was called. A review of the Paramedic Care Report dated [DATE] at 7:38 AM indicated EMS arrived on site with Resident 77 laying in the bed without a pulse and apneic (a condition where breathing stops or is severely reduced). The report indicated the last know well time for Resident 77 was approximately one hour prior to arrival and CPR was initiated. The Paramedic Report indicated EMS administered Resident 77, 15 liters of oxygen per minute via bag valve mask and three rounds of epinephrine (also known as adrenaline, plays an important role in your body's fight-or-flight response, a medication to treat many life-threatening conditions). The Paramedic Report indicated Resident 77 was in asystole (a medical condition where the heart stops to produce electrical activity and contractions, the heart no longer pumps blood throughout the body) and remained in asystole for the duration of CPR. The Paramedic Report indicated Resident 77 had a severe distress level, pupils were fixed and dilated and Resident 77's time of death was 8:08 AM. During an interview on [DATE] on 12:45 PM with the Medical Director (MD, who was also Resident 77's physician), the MD stated he believed that an assessment for Resident 77 should have been conducted every shift and that it was another form of communication. The last skilled nursing assessment was documented on [DATE] at 1:45 PM (two shifts missing documentation prior to Resident 77's death). The MD stated when there was no documentation staff would not know the resident's condition or needs and would not understand the trends of the resident's condition. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 1:57 PM, with the Director of Nursing (DON), Resident's 77's MARs were reviewed. The DON stated that she could not consider the vital sign documentation for Resident 77 and the additional five residents as falsification (the act of deliberately lying about or misrepresenting something) of records. The DON stated and agreed the vital sign records for Resident 77 for ,d+[DATE], ,d+[DATE] and [DATE] on the 3 PM-11:30 PM and 11 PM-7:30 AM shift were exactly the same. The DON stated and agreed the vital sign records for Residents 341, 32, 62, 21, and 19 (five additional residents) during the 11 PM - 7:30 AM shift were exactly the same as the prior shift (3 PM - 11:30 PM). The DON stated the Nursing Note documentation was required by the LVN to be done daily and did not need to be completed for each shift. The DON stated she did not have a policy that stated this specifically and could not provide a policy that showed how often documentation needed to be done for Resident 77. A review of the facility's policy and procedure (P&P) titled, Routine Resident Checks, indicated that nursing staff shall make routine resident checks at least once per 8-hour shift. It further stated the nursing supervisor or charge nurse shall keep documentation related to these routine checks, including the time, identity of the person making checks, and any outcomes of each check. This P&P indicated a discrepancy with the DON's statement regarding documentation. During a telephone interview on [DATE] at 2:47 PM, LVN 4 stated he worked the 11 PM -7:30 AM shift on , d+[DATE], ,d+[DATE], ,d+[DATE] and [DATE] and documented the vital signs for Resident 77 (including the vital signs for the additional five residents). LVN 4 stated he could not explain how the vital signs on , d+[DATE], ,d+[DATE], ,d+[DATE] and [DATE] from his shift were exactly the same as the prior shift 3 PM -11:30 PM. During an interview on [DATE] at 11:24 AM, Registered Nurse (RN) 1 stated he received Resident 77 upon admission on [DATE] receiving oxygen via nasal cannula at two liters per minute (LPM). RN 1 stated there was no need to continue Resident 77 on oxygen and there was no need for an incentive spirometer because the resident did not have any respiratory issues. RN 1 stated he placed Resident 77's head of bed up and instructed Resident 77 to take deep breaths, but there was no documentation indicating this. During an interview on [DATE] at 1:42 PM, CNA 5 stated Resident 77's meal card indicated he had swallowing issues and to feed with small bites. CNA 5 stated she was not informed regarding any speech therapy recommendations required for Resident 77 and that she did not document the interventions that she completed with the resident. CNA 5 stated that it was important to document because if it was not documented it means it was not done. During an interview on [DATE] at 2:35 PM, the DON stated Resident 77 was on oxygen as needed at the General Acute Care Hospital (GACH). The DON stated the Acute Respiratory Failure care plan and the Pneumonia care plan was not required to include the as needed (PRN) order of oxygen use for Resident 77. During an interview on [DATE] at 2:26 PM the Minimum Data Set Nurse (MDSN) stated Resident 77 had an as needed (PRN) order for oxygen and a care plan should have been initiated. The MDSN stated and confirmed Resident 77's comprehensive assessment (MDS dated [DATE]) did not include the oxygen use but should have been included. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Administrator (ADM) on [DATE] at 8:30 AM, the ADM stated that LVN 4 was suspended as of [DATE] pending the facility's internal investigation. When asked the reason of LVN 4's suspension, the ADM stated it was for charting and documentation. During a concurrent interview, the DON stated that an in-service meeting was done with staff on [DATE] regarding accurate documentation of resident vital signs. During a telephone interview on [DATE] at 10:05 AM, the Speech Therapist stated Resident 77 was assessed upon admission due to the dysphagia diagnosis. The ST stated she saw Resident 77 during mealtimes with the CNAs and she gave the CNAs her recommendations to have the head of bed in an upright posture, observe any coughing, and to report any issues to the ST, but this was not documented. The ST stated sometimes Resident 77 would feed himself and sometimes he would need feeding. During a telephone interview on [DATE] at 12:13 PM, the MD stated, in his opinion Resident 77 could have aspirated. The Medical Director stated Resident 77 had some cognitive decline which may have contributed to the aspiration. A review of the facility's P&P titled, Charting and Documentation, reviewed on [DATE], indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team (IDT) regarding the resident's condition. The P&P indicated that documentation in the medical record would be objective, complete, and accurate. A review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, reviewed on [DATE], indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on observation, interview and record review, the facility failed to provide therapy services for two of eight sampled residents (Residents 48 and 6) who had limited range of motion (ROM, full movement potential of a joint [where two bones meet]) by failing to: -Provide Occupational Therapy (OT, rehabilitative profession aimed to increase or maintain a person's capability to participate in everyday life activities) evaluation after identifying a decline in Resident 48's range of motion in the left shoulder, left elbow, left wrist, and left hand during the OT Joint Mobility Screen (JMS, brief assessment of a resident's ROM) dated 8/22/2024. -Provide OT Evaluation and treatment for Resident 48 prior to the application of a left resting hand splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) for one to six (1-6) hours in accordance with professional standards of practice on 8/22/2024. -Provide Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility) treatment from 8/2024 to 2/2025 (over five months) to Resident 48 for passive range of motion (PROM, movement at a given joint with full assistance from another person) to left upper extremity (UE, shoulder, elbow, wrist, hand/fingers) in all planes (all possible joint movements) five (5) times a week in accordance with the physician's order dated 8/22/2024 . -Provide RNA treatment from 8/2024 to 2/2025 (over five months) for the application of a left resting hand splint for 1-6 hours as tolerated five times a week in accordance with the physician's order dated 8/22/2024. -Report Resident 48's refusals and missed RNA treatments on 9/2024, 10/2024, 12/2024, 1/2025, and 2/2025 to the Charge Nurse and Therapy staff in accordance with the facility's job description titled, Restorative Nursing Assistant/CNA. -Provide Resident 48 with a nursing assessment after Restorative Nursing Aide (RNA 3) reported Resident 48's refusals to participate in RNA throughout 11/2024 in accordance with facility policy and procedure. -Provide an appropriate RNA order for Resident 6 who wore left ankle foot orthotics (AFO, an orthotic device designed to correct or address problems with the ankle and foot) for no more than four (4) hours as established by physical therapy (PT, a profession aimed in restoration, maintenance, and promotion of optimal physical function). -Ensure Resident 6 did not have a delay in the start of RNA services for PROM with both lower extremities (LE, hip, knee, ankle, foot) five times a week and application of left AFO five times a week ordered on 2/4/2025 to start on 2/5/2025. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	These failures resulted in Resident 48's worsening contracture (loss of motion of a joint) of the left hand from 9/2024 to 1/2025 (over four months) into a fisted position with the left thumb positioned under the left index finger and over the middle finger. This fisted position resulted in the development of Resident 48's Stage IV pressure injury (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) on the left middle finger, which was identified on 1/15/2025. These failures had the potential for Resident 6 to be injured due to the application of the left AFO. Findings: a. A review of Resident 48's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting left non-dominant side and muscle weakness. A review of Resident 48's Care Plan initiated on 9/15/2022 indicated the resident had the potential for limitations in joint mobility related to decreased physical mobility, history of cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), osteoporosis (weak and brittle bones) and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). The care plan goal indicated Resident 48 would have no further loss of ROM daily for three months. The care plan interventions indicated to monitor for pain or stiffness, position resident to prevent further contractures with pillow or splint as needed, RNA to perform PROM to left UE (LUE) in all places as tolerated 5 times a week, RNA to apply left resting hand splint for 1-6 hours or as tolerated 5 times a week. A review of Resident 48's Care Plan initiated on 9/15/2022 indicated the resident was at risk for complications due to alteration in musculoskeletal status related to diagnosis of hemiplegia and hemiparesis, osteoarthritis of knee and hip, osteoporosis, advanced age, contractures, joint pain. The care plan goal indicated complications related to fracture (broken bone), such as contracture formation, and immobility would be minimized. The care plan interventions included to assist the resident with the use of supportive devices (splints) as recommended; monitor/document/report to medical doctor (MD) as needed signs and symptoms or complications related to arthritis (swelling and tenderness of a joint causing pain and stiffness): joint pain, joint stiffness, swelling, decline in mobility, decline in self-care ability, contracture formation/joint shape changes, pain after exercises. A review of Resident 48's OT Joint Mobility Screening (JMS) dated 2/14/2024 indicated the resident had full range of motion in both wrists, both hand/fingers, both elbows, and both shoulders. The JMS indicated Resident 48 did not have minimal to severe loss of UE passive ROM and did not have a diagnosis or condition that placed Resident 48 at risk for contracture development. The JMS indicated skilled OT evaluation and RNA program was not recommended. A review of Resident 48's OT JMS dated 6/1/2024, indicated the resident had full range of motion in both wrists, both hand/fingers, both elbows, and both shoulders. The JMS indicated Resident 48 did not have minimal to severe loss of UE passive ROM and did not have a diagnosis or condition that placed Resident 48 at risk for contracture development. The JMS indicated skilled OT evaluation and RNA program was not recommended. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 48's OT JMS dated 8/22/2024, indicated the resident had full range of motion in the right wrist, right hand/fingers, right elbow, and right shoulder. The JMS indicated Resident 48 had moderate loss (26-50 percent (%) loss) of range of motion in the left wrist, left hand/fingers, and left shoulder and minimal loss (less than 25% loss) range of motion in the left elbow. The JMS indicated Resident 48 had minimal to severe loss of UE passive ROM and had a diagnosis or condition that placed Resident 48 at risk for contracture development. The JMS indicated skilled OT evaluation was not recommended, and RNA program was recommended. The comments indicated PROM left UE, left resting hand splint, [right]UE AAROM. According to a review of the Physician's Order Summary Report (OSR) dated 8/22/2024, Resident 48 was to receive RNA services, perform PROM LUE in all planes as tolerated, frequency five times a week. The OSR indicated the RNA to apply left resting hand splint for 1-6 hours or as tolerated, frequency 5 times a week. A review of Resident 48's 8/2024 RNA Daily Survey Report (DSR), the DSR indicated Resident 48 did not complete RNA treatment (RNA entry was blank or not available) to perform PROM LUE in all planes as tolerated, 5 times a week on the following days: 8/30/24. During a review of Resident 48's 8/2024 RNA DSR, the DSR indicated Resident 48 refused RNA treatment to perform PROM LUE in all planes as tolerated, 5 times a week on 8/26/24. Resident 48 did not complete RNA treatment to apply left resting hand splint for 1-6 hours or as tolerated, 5 times a week on 8/30/24. The DSR indicated Resident 48 refused RNA treatment to apply left resting hand splint for 1-6 hours or as tolerated, 5 times a week on 8/26/24. During a review of Resident 48's OT JMS dated 9/1/24, the JMS indicated Resident 48 had full range of motion in the right wrist, right hand/fingers, right elbow, and right shoulder. The JMS indicated Resident 48 had moderate loss of motion in the left wrist, left hand/fingers, and left shoulder and minimal loss of motion in the left elbow. The JMS indicated Resident 48 had minimal to severe loss of UE passive ROM and had a diagnosis or condition that put Resident 48 at risk for contracture development. The JMS indicated skilled OT evaluation was not recommended. During a review of Resident 48's Minimum Data Set (MDS, a resident assessment tool) dated 9/1/24, the MDS indicated Resident 48 had severe cognitive impairments. The MDS indicated Resident 48 did not exhibit any behavior for rejection of care that was necessary to achieve health and well-being. The MDS also indicated Resident 48 required substantial/maximal assistance from staff for oral hygiene, bathing, dressing, personal hygiene, sit to stand, and bed to chair transfers. The MDS indicated Resident 48 had functional range of motion impairments on one side of the upper extremity and impairments on one side of the lower extremity. During a review of Resident 48's 9/2024 RNA DSR, the DSR indicated Resident 48 did not complete RNA treatment to perform PROM LUE in all planes as tolerated, 5 times a week on the following days: 9/2, 9/4, 9/5, 9/11, 9/17, 9/18, 9/24, 9/25, and 9/30/2024. During a review of Resident 48's 9/2024 RNA DSR, the DSR indicated Resident 48 refused RNA treatment to perform PROM LUE in all planes as tolerated, 5 times a week on 9/13/24. The DSR indicated Resident 48 did not complete RNA treatment to apply left resting hand splint for 1-6 hours or as tolerated, 5 times a week on the following days: 9/2 - 9/5, 9/11, 9/13, 9/16, 9/17, 9/18, 9/20, 9/24 - 9/27 and 9/30/2024. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	According to a review of Resident 48's 10/2024 RNA DSR, Resident 48 did not complete RNA treatment to perform PROM LUE in all planes as tolerated, 5 times a week on the following days: 10/1, 10/2, 10/4, 10/8, 10/11, 10/14, 10/18, 10/21, 10/22, 10/25, 10/28 and 10/31/2024. The DSR indicated Resident 48 did not refuse RNA treatment to perform PROM LUE in all planes as tolerated, five times a week. During a review of Resident 48's 10/2024 RNA DSR, the DSR indicated Resident 48 did not complete RNA treatment to apply left resting hand splint for 1-6 hours or as tolerated, 5 times a week on the following days: 10/1, 10/4, 10/8, 10/11, 10/14, 10/18, 10/21, 10/22, 10/25, 10/28 and 10/31/2024. The DSR indicated Resident 48 refused RNA treatment to apply left resting hand splint for 1-6 hours or as tolerated, 5 times a week on the following days: 10/7, 10/15, 10/17, 10/23 and 10/24/2024. During a review of Resident 48's RNA Weekly Summary (WS) dated 10/1/24, the WS indicated Resident 48 completed RNA treatment 5 times in the last week for AAROM, PROM, and splint application. The WS did not indicate Resident 48 did not tolerate or had a problem with wearing the splint. During a review of Resident 48's RNA WS dated 10/8/24, the WS indicated Resident 48 completed RNA treatment 5 times in the last week for AAROM, PROM, and splint application for left hand. The WS did not indicate Resident 48 did not tolerate or had a problem with wearing the splint. During a review of Resident 48's RNA WS dated 10/22/24 an 10/30/2024 the WS indicated Resident 48 completed RNA treatment for AAROM and PROM. The WS did not indicate Resident 48 did not tolerate or had a problem with wearing the splint. During a review of Resident 48's 11/2024 RNA DSR, the DSR indicated Resident 48 did not complete RNA treatment to perform PROM LUE in all planes as tolerated, five times a week on the following days: 11/4, 11/7, 11/13, 11/21 and 11/25/2024 and refused RNA treatment to perform PROM LUE in all planes as tolerated, five times a week on the following days: 11/1/24, 11/8/24, 11/11/24, 11/12/24, 11/15/24, 11/19/24, 11/20/24, 11/22/24, 11/26 - 11/29/24 During a review of Resident 48's 11/2024 RNA DSR, the DSR indicated Resident 48 did not complete RNA treatment to apply left resting hand splint for 1-6 hours or as tolerated, 5 times a week on the following days: 11/1/24, 11/4/24, 11/6/24, 11/7/24, 11/13/24, 11/15/24, 11/20/24, 11/21/24, 11/25/24, 11/26/24, 11/27/24 and refused RNA treatment to apply left resting hand splint for 1-6 hours or as tolerated, 5 times a week on the following days: 11/8/24, 11/11/24, 11/12/24, 11/14/24, 11/19/24, 11/22/24, 11/28/24, 11/29/24. According to a review of Resident 48's RNA WS dated 11/1/24, Resident 48 completed RNA treatment 5 times in the last week for AAROM and splint for left hand. The WS did not indicate Resident 48 did not tolerate or had a problem with wearing the splint. During a review of Resident 48's RNA WS dated 11/8/24 and 11/15/2024, the WS indicated Resident 48 completed RNA treatment 5 times in the last week for AAROM of both lower extremities, PROM of LUE, and splint for left hand. The WS did not indicate Resident 48 did not tolerate or had a problem with wearing the splint. The WS indicated refuse in comments. The WS was reviewed and co-signed by an unidentified nursing staff. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 48's RNA WS dated 11/22/2024 and 11/29/2024, the WS indicated Resident 48 completed RNA treatment 5 times in the last week for AAROM of both lower extremities and PROM of LUE. The WS did not indicate Resident 48 did not tolerate or had a problem with wearing the splint. The WS indicated refuse in comments. The WS was reviewed and co-signed by an unidentified nursing staff. During a review of Resident 48's MDS dated [DATE], the MDS indicated Resident 48 had severe cognitive impairments. The MDS indicated Resident 48 did not exhibit any behavior for rejection of care that was necessary to achieve health and well-being. The MDS also indicated Resident 48 required substantial/maximal assistance from staff for oral hygiene, bathing, dressing, personal hygiene, sit to stand, and bed to chair transfers. The MDS indicated Resident 48 had functional limitations in range of motion impairments on one side of the upper extremity and impairments on one side of the lower extremity. During a review of Resident 48's OT JMS dated 12/3/24, the JMS indicated Resident 48 had full range of motion in the right wrist, right hand/fingers, right elbow, and right shoulder. The JMS indicated Resident 48 had moderate loss of motion in the left wrist, left hand/fingers, and left shoulder and minimal loss of motion in the left elbow. The JMS indicated Resident 48 did not have minimal to severe loss of UE passive ROM and had a diagnosis or condition that put Resident 48 at risk for contracture development. The JMS indicated skilled OT evaluation was not recommended, and an RNA program was recommended. During a review of Resident 48's 12/2024 RNA DSR, the DSR indicated Resident 48 did not complete RNA treatment to perform PROM LUE in all planes as tolerated, five times a week on the following days: 12/3 - 12/5/24, 12/9/24, 12/10/24, 12/18/24 and refused RNA treatment to perform PROM LUE in all planes as tolerated, five times a week on the following days: 12/2/24, 12/6/24, 12/16/24, 12/24/24. During a review of Resident 48's 12/2024 RNA DSR, the DSR indicated Resident 48 did not complete RNA treatment RNA treatment to apply left resting hand splint for 1-6 hours or as tolerated, 5 times a week on the following days: 12/3 - 12/5/24, 12/9/24, 12/10/24, 12/18/24 and refused RNA treatment RNA treatment to apply left resting hand splint for 1-6 hours or as tolerated, 5 times a week on the following days: 12/2/24, 12/6/24, 12/11 - 12/13/24, 12/16/24, 12/17/24, 12/19/24, 12/23/24, 12/24/24, 12/26/24, 12/27/24, 12/31/24. According to a review of Resident 48's RNA WS dated 12/3/24, Resident 48 completed RNA treatment 5 times in the last week for AAROM and splint for left hand. The WS did not indicate Resident 48 did not tolerate or had a problem with wearing the splint. During a review of Resident 48's RNA WS dated 12/9/24, 12/16/24 and 12/23/24 the WS indicated Resident 48 completed RNA treatment 5 times in the last week for AAROM, PROM, and splint for left hand. The WS did not indicate Resident 48 did not tolerate or had a problem with wearing the splint. During a review of Resident 48's 1/2025 RNA DSR, the DSR indicated Resident 48 did not complete RNA treatment to perform PROM LUE in all planes as tolerated, five times a week on the following days: 1/3/25, 1/6/25, 1/8/25, 1/9/25, 1/13/25, 1/17/25, 1/20/25, 1/24/25, 1/27/25, 1/28/25, 1/30/25, 1/31/25 and did not refuse RNA treatment to perform PROM LUE in all planes as tolerated, five times a week. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 48's 1/2025 RNA DSR, the DSR indicated Resident 48 did not complete RNA treatment RNA treatment to apply left resting hand splint for 1-6 hours or as tolerated, 5 times a week on the following days: 1/1/25, 1/3/25, 1/6/25, 1/7/25, 1/8/25, 1/9/25, 1/13/25, 1/15/25, 1/20/25, 1/27/25, 1/28/25, 1/30/25, 1/31/25 and refused RNA treatment to apply left resting hand splint for 1-6 hours or as tolerated, 5 times a week on the following days: 1/2/25, 1/14/25. During a review of Resident 48's RNA WS dated 1/2/25 and 1/9/25, the WS indicated Resident 48 completed RNA treatment 5 times in the last week for AAROM, PROM, and splint for left hand. The WS did not indicate Resident 48 did not tolerate or had a problem with wearing the splint. During a review of Resident 48's Change of Condition (COC) dated 1/15/25, the COC indicated Resident 48 had a contracture related pressure injury Stage 4 to inferior left middle finger. The COC indicated Resident 48 had pain to left hand middle finger when moved due to contracture. The COC indicated Resident 48 had a Stage 4 pressure wound 1 centimeter (cm) in length, 1.2 cm in width, and 0.3 cm in depth. The COC indicated Resident 48 was in pain when the affected hand was moved. The COC also indicated a CNA informed charge nurse that Resident 48's left hand appeared different than normal and upon assessment of left hand, observed the hand with existing contracture with thumb between middle finger and index finger. The COC indicated per resident facial grimacing and body language, the wound site was painful when moved or manipulated. The COC indicated Wound Consultant Specialist (WCS) visited resident same day and assessed site with measurement of 1 cm x 1 cm x 0.3 cm and classified the wound as Stage 4 with new orders for wound treatment. During a review of Resident 48's WCS's visit note dated 1/15/25, the WCS visit note indicated Resident 48 had a contracture related Stage 4 pressure wound on inferior left middle finger. The visit note indicated WCS performed a procedure to remove devitalized necrotic (dead tissue) subcutaneous (beneath the skin) tissue and muscle tissue to promote healing and a topical spray solution was provided for anesthesia. According to a review of Resident 48's RNA WS dated 1/16/25 and 1/23/25, Resident 48 completed RNA treatment five times in the last week for AAROM, PROM, and splint for left hand. The WS did not indicate Resident 48 did not tolerate or had a problem with wearing the splint. During a review of Resident 48's OT JMS dated 1/28/25, the JMS indicated Resident 48 had full range of motion in the right wrist, right hand/fingers, right elbow, and right shoulder. The JMS indicated Resident 48 had moderate loss of motion in the left wrist, left hand/fingers, and left shoulder and minimal loss of motion in the left elbow. The JMS indicated Resident 48 did not have minimal to severe loss of UE passive ROM and did not have a diagnosis or condition that put Resident 48 at risk for contracture development. The JMS indicated skilled OT evaluation was not recommended, and an RNA program was recommended. During a review of Resident 48's 2/2025 RNA DSR, the DSR indicated Resident 48 missed RNA treatment to perform PROM LUE in all planes as tolerated, 5 times a week on the following days: 2/3/25, 2/4/25, 2/6/25, 2/7/25 and did not refuse RNA treatment to perform PROM LUE in all planes as tolerated, five times a week. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 48's 2/2025 RNA DSR, the DSR indicated Resident 48 missed RNA treatment to apply left resting hand splint for 1-6 hours or as tolerated, 5 times a week on the following days: 2/3/25, 2/4/25, 2/7/25 and refused RNA treatment to apply left resting hand splint for 1-6 hours or as tolerated, 5 times a week on the following days: 2/10/25, 2/11/25. During a review of Resident 48's RNA WS dated 2/4/25, the WS indicated Resident 48 completed RNA treatment 5 times in the last week for AAROM and splint for left hand. The WS did not indicate Resident 48 did not tolerate or had a problem with wearing the splint. The WS indicated Resident 48 complained of pain during ROM exercises. During a review of Resident 48's OT JMS dated 2/13/25, the JMS indicated Resident 48 had full range of motion in the right wrist, left wrist, right hand/fingers, right elbow, and right shoulder. The JMS indicated Resident 48 had minimal loss of range of motion in the left shoulder, moderate loss of range of motion in the left elbow, and severe loss (more than 50% loss) of range of motion in the left hand/fingers. The JMS indicated Resident 48 had minimal to severe loss of UE passive ROM and had a diagnosis or condition that put Resident 48 at risk for contracture development. The JMS indicated skilled OT evaluation was recommended, and an RNA program was not recommended. During an observation and interview on 2/10/25 at 1:15 p.m. in Resident 48's room, Resident 48 was sitting up in bed. Resident 48 was able to move the right arm up and down to about shoulder level. Resident 48 was able to lift the left arm up a little, the left wrist was straight, and the left hand was fully bent in a fisted position. The left thumb was opposed across the palm underneath the second finger and the tip of the thumb was above the third middle finger. Resident 48 stated the left hand was no good and stated she could not really move the lower extremities. Resident 48's hip and knees were bent and rotated towards the right side. Resident 48 was not wearing any splints on the upper extremities. During an observation on 2/11/25 at 8:24 a.m. in Resident 48's room, Resident 48 was laying in the bed and the left hand was in a fisted position with the thumb opposed and inside the palm. Resident 48 was not wearing any splints on the upper extremities. During an interview on 2/11/25 at 8:35 a.m., Restorative Nursing Aide (RNA 1) stated he was an RNA and central supply, which included ordering and stacking up supplies. RNA 1 stated on Mondays, he completed RNA treatments for residents in bed A, Tuesdays he completed RNA treatments for residents in bed B, Wednesdays he completed RNA treatments for resident in bed C, and then goes back to residents in bed A on Thursdays, bed B Fridays, and bed C on Saturdays. During an observation on 2/11/25 at 1:53 p.m., Resident 48 was lying on a geriatric chair (a large, padded chair designed to help persons with limited mobility) in the hallway outside Resident 48's room and Resident 48's eyes were closed. Resident 48 was not wearing any splints on the upper extremities. On 2/12/25 at 8:50 a.m. during an observation in Resident 48's room, Resident 48 was laying in bed. Resident 48's right knee was bent, and left ankle crossed over the right ankle. Resident 48 was able to move the right arm to move the gown, the left elbow was bent about halfway and left hand was in a fist. RNA 1 asked Resident 48 to move and straighten the right knee and Resident 48 was able to straighten the right knee. Resident 48 did not want to complete exercises with RNA 1. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/12/25 at 9 a.m., RNA 1 stated when Resident 48 agreed to RNA treatment, RNA 1 performed ROM on BUE and BLE and wore a hand roll, a soft one with a cushion. RNA 1 stated the hand roll was in the laundry. RNA 1 stated he also put on boots for both feet. RNA 1 stated on the right side, he did AROM, and on the left side, both he and Resident 48 moved the arms and legs. RNA 1 stated when Resident 48 refused, he would tell the charge nurse and therapy department. RNA 1 stated Resident 48 refused about two times a week. RNA 1 stated if Resident 48 refused, he would document that Resident 48 refused RNA. During an observation and interview on 2/12/25 at 12:55 p.m. in Resident 48's room, Resident 48 was laying in bed. Resident 48's left wrist was straight and able to move the left arm a little. Resident 48 stated the left hand was hard to move. Resident 48 tried to open the left fingers a little and observed minimal movement in the left fingers, but Resident 48 was not able to open the left hand. Resident 48 stated the left arm was paralyzed. During a record review and concurrent interview on 2/12/25 at 1:32 p.m. in the therapy gym, the Director of Rehabilitation (DOR) reviewed Resident 48's therapy records and stated there were no Occupational Therapy records for Resident 48 since 2022 when the new company started. The DOR stated Resident 48 had not received any skilled OT evaluations or treatments in 2022, 2023, 2024, or 2025. During an interview on 2/12/25 at 1:39 p.m., Licensed Vocational Nurse (LVN 6) stated she was Resident 48's charge nurse. LVN 6 stated she had never received any reports from RNA staff about Resident 48 refusing RNA treatment. LVN 6 stated Resident 48 usually did not refuse and had never received any reports about Resident 48 refusing any kind of care. LVN 6 stated Resident 48's left hand was contracted so it was especially important to perform hand hygiene and nail care, because there could be germs inside the hands. During an interview on 2/12/25 at 2:05 p.m., Certified Nursing Assistant (CNA 3) stated Resident 48's left hand was in a fist now and stated it was about 2 to 3 months when Resident 48's left hand started to be in a fist. CNA 3 stated it was harder to clean the left hand now because it was in a fist. CNA 3 stated Resident 48 could now barely open the fingers (CNA 3 demonstrated a clawed hand) and stated Resident 48 either would not let staff open her fingers more than that or Resident 48 could not open the hand more than that. CNA 3 stated she could not remember the last time she saw Resident 48 wear a hand splint with RNA. During an interview and concurrent record review on 2/12/25 at 2:17 p.m., the Wound Treatment Nurse (LVN 5) stated Resident 48 currently had a contracture related pressure injury on the left middle finger. LVN 5 stated when he first assessed Resident 48 on 1/15/25, the thumb was contracted and underneath the second finger and the thumbnail was digging into the right side of the third middle finger between the large knuckle and middle joint. LVN 5 stated Resident 48's hand was in a fisted position and when LVN 5 opened the thumb out, there was an open wound with slough (layer of dead tissue on surface of wound). LVN 5 stated the Wound Consultant Specialist (WCS) was present and assessed the wound as a Stage 4. LVN 5 stated there were Stages 1 through 4 (4 being worse). LVN 5 stated because Resident 48's hand was in a fist and it was contracted, it put Resident 48 at high risk to develop the wound. LVN 5 stated when LVN 5 completed the wound treatments, Resident 48 could not open the left hand fully. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	LVN 5 stated Resident 48 was in pain when LVN 5 tried to open the hand. LVN 5 stated to prevent the wound from developing, staff should constantly check Resident 48's hand, keep the thumb from touching the other fingers, and keep the fingernails trimmed. LVN 5 stated a wound was not a condition a resident should have, because when a resident had a wound, there was a risk of infection, risk for further skin breakdown, and it was painful. LVN 5 stated he should have informed the therapy department and included therapy in the wound interdisciplinary team (IDT) because the wound was contracture related and therapy could have offered an alternative other than the splint that Resident 48 had and may have accepted. LVN 5 stated for residents that refuse any type of intervention including RNA and splints, the facility should complete a COC assessment, notify the primary MD, document the refusals and update the care plan. LVN 5 reviewed Resident 48's care plans and stated there were no care plans regarding Resident 48 refusing RNA or splints. During an interview and record review on 2/12/25 at 3:21 p.m., Occupational Therapist (OT 2) stated for residents with contracture, including hand contracture, OT would treat the resident for ROM, assess to see if the resident would benefit from a splint and determine the splint that would work best for that specific resident, monitor and establish splint wear time, and establish an RNA program for splinting and ROM to prevent the contracture from getting worse. OT 2 stated contractures should be prevented because contractures were painful, limit ROM, and limit independence in activities of daily living. OT 2 stated contractures also put residents at risk for skin breakdown, especially if a finger was digging into the palm. OT 2 stated if a resident refused RNA, the facility could train Certified Nursing Assistants (CNA) and RNAs to monitor the resident, reposition the resident if there were redness and make sure nails were trimmed. OT 2 stated if a resident refused to wear splints during RNA, OT could reassess the resident and assess the splint, ask RNA about the splint, and maybe order another type of splint, add a finger separator, try a carrot (finger or hand apparatus shaped like a carrot to position the finger away from palm) or hand rolls. OT 2 stated it would be helpful to have the IDT discuss the resident together. OT 2 stated for example, if Resident 48 had a hand contracture in a fist and you put a carrot inside the palm, the carrot would keep the thumb apart and not touch that part of the finger. OT 2 stated Resident 48 refusing RNA ROM or splinting, and developing a wound because of a hand contracture was something OT would want to be informed about so that OT could assess and see if there were any possible interventions. OT 2 stated OT 2 did not have any knowledge of Resident 48 developing a wound in the left finger due to a fisted position. During an interview on 2/12/25 at 3:37 p.m., DOR stated she attended all the RNA meetings and stated RNAs did not report anything regarding Resident 48 continually refusing to wear the left hand splint. DOR stated to therapy's knowledge, Resident 48 had been wearing the left resting hand splint as ordered with RNA. During an interview on 2/12/25 at 3:40 p.m., Certified Nursing Assistant (CNA 2) stated Resident 48 could only open one hand and the other hand was in a fist. CNA 2 stated she tried to open the left hand, but Resident 48 told her she did not like it. During an interview on 2/12/25 at 3:45 p.m., Licensed Vocational Nurse (LVN 2) observed Resident 48 in the room and stated Resident 48's left hand was in a fist. LVN 2 stated Resident 48 would benefit from something inside her hand to help Resident 48. LVN 2 stated Resident 48 sometimes refused care, but not really. LVN 2 stated if you take time with Resident 48, the resident will do the care. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview and concurrent record review on 2/13/25 at 8:24 a.m. with RNA 1, Resident 48's RNA DSR was reviewed. RNA 1 confirmed his initials on the RNA DSR in 9/2024, 10/2024, 11/2024, 12/2024, 1/2025, and 2/2025. RNA 1 stated if the DSR indicated a number, it meant Resident 48 completed RNA that day and the number was how long RNA took to complete RNA as a whole. RNA 1 stated if the box was blank, it meant no RNA was completed that day. RNA 1 stated RR indicated Resident 48 refused RNA that day. RNA 1 stated NA was not applicable and it could mean Resident 48 was not in the facility or Resident 48 was in the activity room and meant Resident 48 did not complete the RNA treatment that day. RNA 1 confirmed Resident 48 put on the left resting hand splint 2 times total in 11[TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851 Based on observation, interview, and record review, the facility failed to ensure one of 18 sampled residents (Resident 292) received the necessary care and services to prevent accidents and falls as evidenced by failing to accurately assess Resident 292 when completing fall risk assessments. This deficient practice had the potential to place Resident 292 at an increased risk for recurrent falls. Findings: During a review of Resident 292's Admission Record, the record indicated the facility admitted the resident on 1/29/2025 with diagnoses that included hemiplegia (severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (mild or partial weakness or loss of strength on one side of the body) following cerebral infarction (stroke, occurs when blood flow to the brain is interrupted, causing brain cells to die), lack of coordination, acute respiratory failure (a condition in which your blood doesn't have enough oxygen causing shortness of breath and difficulty breathing, often caused by a disease or injury), hypertension (high blood pressure), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), abnormal posture, and acute kidney failure (a sudden and significant decline in kidney function that occurs over a short period). During a review of Resident 292's Fall Risk Assessment (an assessment tool used to determine a person's likelihood of falling) dated 1/31/2025, the assessment indicated the resident was a low risk for falling with a score of 5 (a score between 18-29 indicates a resident is considered high risk, a score of 9-17 a resident is considered moderate risk, and a score between 0-8 a resident is considered low risk for falls). The assessment indicated Resident 292 had intermittent confusion/forgetfulness at times; had no falls in the past 3 months; was chairbound and/or needed assistance with elimination; had adequate vision with or without glasses; required the use of assistive devices (i.e. cane, walker, wheelchair, furniture), did not take antihypertensives (medication used to lower high blood pressure) and narcotics (medication used to relieve pain) currently or within the last 7 days, and did not have a predisposing condition of cerebrovascular accident (CVA, also known as a stroke). During a review of Resident 292's Order Summary Report, the report indicated the resident had physician orders for the following: -Low bed and floor mat (a mat placed at the bedside or chair side to reduce the risk of injury from a fall) dated 1/31/2025. -Amlodipine Besylate (antihypertensive medication) 10 milligrams (mg) one time a day for hypertension dated 1/29/2025. -Carvedilol (antihypertensive medication) 25 mg two times a day for hypertension dated 1/29/2025. -Losartan Potassium (antihypertensive medication) 50 mg one time a day for hypertension dated 1/29/2025. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Tramadol (narcotic medication) 50 mg every 6 hours as needed for moderate to severe pain. During a review of Resident 292's Minimum Data Set (MDS, a resident assessment tool) dated 2/2/2025, the MDS indicated the resident had severely impaired cognition (impairment ability to think, understand, and reason). The MDS indicated resident 292 was dependent on help for eating, oral hygiene, toileting hygiene, showering/bathing self, upper/lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 292 walking 10 feet was not attempted due to medical condition or safety concerns. During a review of Resident 292's care plan revised on 2/3/2025, the care plan indicated the resident was high risk for falls related to confusion, deconditioning, gait/balance problems, incontinence, and being unaware of safety needs. The care plan indicated a goal for Resident 292 to not sustain serious injury. The care plan further indicated interventions to anticipate and meet the resident's needs, educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, and to follow fall protocol. During an observation on 2/11/2025 at 2:01 PM, in Resident 292's room, the resident was observed lying in bed. Resident 292's bed was observed low with floor mats to both side of the bed. Resident 292's call light was observed within reach. During an interview on 2/13/2025 at 10:00 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was taking care of Resident 292. LVN 1 stated Resident 292 was a high risk for falls and had interventions to help prevent falls such as a low bed, floor mats, and bilateral upper side rails. During a concurrent interview and record review on 2/13/2025 Resident 292's Fall Risk assessment dated [DATE] was reviewed with the MDS Nurse (MDSN). The MDSN stated Resident 292's Fall Risk assessment dated [DATE] indicated the resident was at low risk for falls with a score of 5.0. The MDSN stated Resident 292's score was incorrect. The MDSN stated the medication and diagnosis section of Resident 292's Fall Risk Assessment was done incorrectly. The MDSN stated Resident 292 was taking antihypertensive and narcotic medications at the time or within the last 7 days and had a diagnosis of CVA present. The MDSN stated the correction to the medication and diagnosis section of Resident 292's Fall Risk Assessment would add an additional 4 points to the resident's score bring the score up to 9 which meant the resident was at moderate risk for falls. The MDSN stated there was a potential for Resident 292 to not receive the appropriate interventions to help prevent falls if the fall risk assessment was not done correctly. During an interview with the Director of Nursing (DON) on 2/13/2025 at 3:07 PM, the DON stated the fall risk assessment score indicated if the resident was at low, moderate, or high risk for falls. The DON stated the fall risk assessment assisted with the development of a resident's plan of care and would help staff provide interventions to prevent falls from happening. The DON stated if a fall risk assessment was not done accurately and correctly, there was a potential for the resident to experience falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Assessing Falls and Their Causes, reviewed 1/16/2025, indicated General Guidelines: Falls are a leading cause of morbidity and mortality among the elderly in nursing homes .Falling may be related to underlying clinical or medical conditions, overall functional decline, medication side effects, and/or environmental risk factors. Residents must be assessed upon admission and regularly afterward for potential risk for falls. Relevant risk factors must be addressed promptly. During a review of the facility's policy and procedure titled, Falls and Fall Risk, managing, reviewed 1/16/2025, indicated Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. During a review of the facility's policy and procedure titled Fall Risk Assessment reviewed 1/16/2025, the policy indicated The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information . The nursing staff, attending physician, and consultant pharmacist will review for mediation or medication combinations that could relate to falls or fall risk, such as those that have side effects of dizziness, ataxia, or hypotension .The attending physician and nursing staff will evaluate the resident's vital signs, assess the resident for medical conditions (such as those that cause dizziness or vertigo) or sensory impairments (such as decreased vision and peripheral neuropathy) that may predispose falls. Assessment data shall be used to identify underlying medical conditions that may increase the risk for injury from falls (such as osteoporosis). The staff with the support of the attending physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, activities of daily living (ADL) capabilities, activity tolerance, continence, and cognition.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50714 Based on observation, interview and record review, the facility failed to provide the care and services necessary to prevent complications from colostomy (a surgical procedure that creates an opening in the abdomen that allows waste to pass out of the body) for one out of 18 sampled residents (Resident 4) by failing to: -Ensure orders were in place for colostomy care for Resident 4 was readmitted to the facility on [DATE] with a colostomy, there we no orders in place for colostomy care until 2/10/2025. -Ensure staff documented colostomy care given to Resident 4 in the resident's electronic health record (EHR). -Ensure staff dated Resident 4's colostomy bag with the date and time the bag was changed. This deficient practice had the potential for Resident 4 to not receive timely colostomy care and treatment resulting in infection, skin irritation, bleeding from the colostomy stoma (an opening on the abdomen connected to the digestive system [breaks down the food we eat into tiny parts to give us fuel and the nutrients we need to live]), and obstruction (blockage). Findings: During a review of Resident 4's Admission Record, the record indicated the facility initially admitted the resident on 6/19/2020 and readmitted the resident on 6/8/2023 with diagnoses that included quadriplegia (condition in which both the arms and legs are paralyzed and lose normal function), ulcer (a painful, open sore that develops on the lining of an organ, like the skin, where the top layers of tissue have been damaged or worn away) of the left buttock (butt, back of a hip that forms one of the fleshy parts on which a person sits), obesity (a chronic disease that occurs when someone has too much body fat), type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and colostomy. The Admission Record indicated Resident 4's colostomy onset date (the date when a medical condition or injury first started) was 3/8/2023. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 11/1/2024, the MDS indicated Resident 4 could make himself understood and had the ability to understand others. The MDS indicated Resident 4's upper extremities (shoulders, elbow, wrists, hands) and lower extremities (hips, knees, ankles, feet) were impaired (something is damaged, diminished, or weakened). The MDS indicated Resident 4 needed maximal assistance with eating and oral hygiene (the practice of keeping your mouth clean and healthy by brushing, flossing). The MDS indicated Resident 4 was dependent on staff for toileting, showering/bathing, personal hygiene (combing hair, shaving, washing/drying face and hands), and dressing. During a review of Resident 4's Order Summary Report (OSR), printed on 2/11/2025 at 2:24 PM, the order summary report indicated Resident 4 did not have an order to clean, apply skin prep around the stoma (cleaning the skin around the stoma, and using a skin barrier wipe or film to protect the skin), and change the colostomy bag as needed until 2/10/2025 (date survey began). (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/10/2025 at 11:15 AM with the Infection Preventionist (IP) in Resident 4's room, the surveyor and IP observed Resident 4's colostomy bag missing a date and time the facility staff who last provided colostomy care and changed Resident 4's colostomy bag. The IP stated, the facility staff should have documented the date on Resident 4's colostomy. The IP stated she would verify with the facility policy. During a review of Resident 4's physical chart and electronic medical record (EMR - a digital version of the resident's medical chart) on 2/10/2025, the physical chart and EMR did not show the facility documented Resident 4's colostomy care/bag replacement. During an interview on 2/10/2025 at 11:32 AM with the IP and Licensed Vocational Nurse 5 (LVN 5), the IP stated she checked the facility's policy, and the facility staff should have documented Resident 4's colostomy care in Resident 4's chart. LVN 5 stated he could not explain why Resident 4's colostomy did not have a date and time on it. LVN 5 stated he was not aware of the facility's policy regarding documenting the colostomy care/bag replacement in the resident's chart. During an interview on 2/11/2025 at 1:57 PM with the Director of Nursing (DON), the DON stated if the facility staff did not document the colostomy care/bag replacement, the colostomy care/bag replacement was not done. The DON stated Resident 4's skin could be affected and would be an infection control (stopping the spread of infections) issue if the facility staff did not document the colostomy care/bag replacement per the facility's policy. During a review of the facility's policy and procedure (P&P), titled Colostomy/Ileostomy (a surgical procedure that creates an opening in the abdomen to divert waste from the small intestine), dated 1/16/2025, the policy indicated the P&P's purpose was to provide guidelines to aid in preventing exposure of the resident's skin to fecal matter (the waste product left after digestion, poop). The P&P indicated the steps for the colostomy care/bag replacement such as washing hands, cleansing and evaluating the resident's skin for signs of skin excoriation (where the top layer has been scraped off, often causing redness, irritation, and sometimes small wounds), and signs of infection. The P&P indicated the facility staff would document the date and time the facility provided the colostomy care, the name and title of the individual providing the care, any signs of infection, signs skin breaks (that the surface layers of the skin has been broken), signs of excoriation, as well as the signature and title of the person recording the data.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 43851 Based on interview and record review, the facility failed to perform weekly weights and provide a Magic Cup supplement (a frozen dessert that can be served as ice cream or pudding and is used to help residents gain or maintain weight, or to add calories and protein to meals) twice a day with meals for one of 18 sampled residents (Resident 61), who had a history of significant weight loss. This deficient practice had the potential for Resident 61 to experience additional weight loss. Findings: During a review of Resident 61's Admission Record, the Admission Record indicated the facility admitted the resident on 9/6/2024 with diagnoses that included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), blindness to the left and right eye, glaucoma (an eye disease that occurs when fluid builds up in the eye, damaging the optic nerve), anemia (a condition where the body does not have enough healthy red blood cells) and psychosis (a severe mental condition in which thought and emotions are so affect that contact is lost with reality). During a review of Resident 61's Minimum Data Set (MDS, a resident assessment tool) dated 12/12/2024, the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 61 required supervision or touch assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating. The MDS indicated Resident 61 had weight loss of 5% or more in the last month. During a review of Resident 61's Physician Orders dated 12/28/2024, the physician orders indicated the following: -Resident 61 was to receive a Magic Cup supplement twice a day with meals. The physician order did not specify whether to provide Resident 61 with the Magic Cup at breakfast, lunch, or dinner. -Weekly weights for four weeks. During a review of Resident's 61's Nutrition Assessment Form dated 12/31/2024, the form indicated the resident had a nutritional risk related to schizoaffective disorder, depression, and anemia. The form indicated Resident 61 had 10.2 lbs. or 8.9% weight loss in 1 month (a weight loss greater than 5% in 1 month indicates severe weight loss) and 13.2 lbs. or 11.3% weight loss in 3 months (a weight loss greater than 7.5% indicates severe weight loss). The form indicated Resident 61 was not meeting her nutritional needs as evidenced by weight loss and poor PO (by mouth) intake related to depression and reports of low appetite. The form indicated Resident 61 had nourishment orders for a Magic Cup twice a day with meals. During a review of Resident 61's electronic weight log, the weight log indicated on 11/12/2024 the resident weighed 114.2 pounds (lbs.), on 12/5/2024 the resident weighed 104.0 lbs., and on 2/4/2025 the resident weighed 106.0 lbs. The weight log did not indicate there was documentation for Resident 61's weight for the month of 1/2025. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/10/2025 at 1:09 PM, in Resident 61's room, the resident was observed eating lunch. Resident 61 was observed eating with her hands and refusing assistance from staff. Resident 61 stated the food was good. Resident 61's meal tray card did not indicate the resident was to receive a Magic Cup supplement. Further observation indicated there was no Magic Cup supplement on Resident 61's meal tray. During an observation on 2/12/2025 at 12:42 PM, in Resident 61's Room, the resident was observed eating lunch. Resident 61's meal tray card did not indicate the resident was to receive a Magic Cup supplement. Further observation indicated there was no Magic Cup supplement on Resident 61's meal tray. During a concurrent interview and record review on 2/12/2025 at 12:58 PM, Resident 61's lunch meal tray card was reviewed with the Dietary Supervisor (DS). The DS stated a Magic Cup was a supplement and if the physician order did not specify when to give the resident a Magic Cup, the magic cup would be provided for lunch and dinner. The DS stated if a resident was receiving a Magic Cup, it would be indicated on the resident's meal tray card. The DS reviewed Resident 61's meal tray card and confirmed the meal tray card did not indicate to provide the resident with a Magic Cup. The DS stated she would provide Resident 61 with a Magic Cup immediately. During a follow up interview on 2/12/2025 at 1:40 PM with Resident 61, the resident stated she was just provided with a Magic Cup. Resident 61 stated it tasted like frozen yogurt. Resident 61 stated she hadn't received a Magic Cup with her meals before. Resident 61 stated she did not receive a Magic Cup on her meal tray for breakfast earlier in the day or for dinner the previous night. Resident 61 stated 2/12/25 was the first time receiving a Magic Cup. During a concurrent interview and record review on 2/12/2025 at 2:21 PM, Resident 61's electronic weight log was reviewed with Licensed Vocational Nurse (LVN) 3. LVN 3 stated Resident 61 had physician orders for weekly weights for 4 weeks dated 12/28/2024. LVN 3 stated weekly weights for Resident 61 were not done. LVN 3 stated the last weights recorded for Resident 61 in the electronic weight log were dated 12/5/2024 and 2/4/2025. LVN 3 stated Restorative Nursing Aides (RNA) were responsible for weighing the residents. LVN 3 further stated the RNAs also document resident weights in the RNA Book. During a concurrent interview and record review on 2/12/2025 at 2:28 PM, the RNA Book for station 1 and station 2 were reviewed with RNA 2. RNA 2 stated Resident 61 did not have any weekly weights documented for 12/2024 or 1/2025 in the RNA Books for station 1 or station 2. During a review of the facility's Weekly Weights Log for 1/2025, the log indicated Resident 61 weighed 104.2 lbs. on 1/8/2025. The log did not indicate weights for Resident 61 after 1/8/2025. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/12/2025 at 2:57 PM, Resident 61's physician orders and weight logs were reviewed with the Minimum Data Set Nurse (MDSN). The MDSN stated Resident 61 had a history of weight loss but was now maintaining weight. The MDSN stated Resident 61 had physician orders for weekly weights for 4 weeks. The MDSN reviewed Resident 61's documented weights and stated the resident's weight was not taken or documented weekly. The MDSN stated Resident 61 should have had her weight taken on 1/15/2025 and 1/22/2025. The MDSN stated weekly weights were done to monitor the resident and the appropriate care could be provided to the resident to help prevent further weight loss. The MDSN stated not performing weekly weights for Resident 61 as ordered by the physician put the resident at risk for additional weight loss. During a telephone interview on 2/13/2025 at 11:53 AM with the Registered Dietitian (RD), the RD stated Resident 61 was having weight loss due a low appetite. The RD stated Resident 61 was initially losing weight but was maintaining her weight. The RD stated Resident 61 had physician orders in 12/2024 for weekly weights for 4 weeks. The RD stated that Resident 61 had her weight documented for 12/2024 and 2/2024. The RD stated weekly weights for Resident 61 were not done in 12/2024 or 1/2025. The RD stated she provided recommendations for Resident 61 to receive a Magic Cup twice a day to help Resident 61 gain weight. The RD stated Resident 61 should have been receiving a Magic Cup twice a day with meals. The RD further stated if weekly weights were not done, and the resident did not receive the Magic Cup with meals there could be a lapse in care, and Resident 61 could have potentially experienced additional weight loss. During a concurrent interview and record review on 2/13/2025 at 3:07 PM, Resident 61's physician orders and weight logs were reviewed with the Director of Nursing (DON). The DON stated Resident 61 was previously losing weight but was maintaining her weight. The DON stated Resident 61 had physician orders for a Magic Cup twice a day with meals and weekly weights for 4 weeks. The DON stated weekly weights for Resident 61 were not performed as ordered on 12/28/24. The DON stated Resident 61 should have been receiving Magic Cups twice a day. The stated weekly weights were performed to monitor the resident for weight loss so the appropriate care and interventions could be provided if weight loss was identified. The DON stated Resident 61 was supposed to receive a magic cup with meals to help provide additional nourishment. The DON stated if the weekly weights were not performed and a Magic Cup not provided twice a day, there could be a potential for Resident 61 to have had additional weight loss. During a review of the facility's policy and procedure titled, Weight Assessment and Intervention, reviewed 1/16/2025, indicated Resident weights are monitored for undesirable or unintended weight loss or gain. Residents are weights upon admission and at intervals established by the interdisciplinary team. Weights are recorded in each unit's weight record chart and in the individual's medical record .Interventions for undesirable weight loss are based on careful consideration of the following: Resident choice and preferences; nutrition and hydration needs of the resident; functional factors that may inhibit independent eating; environmental factors that may inhibit appetite or desire to participate in meals; chewing and swallowing abnormalities and the need for diet modifications; medications that may interfere with appetite, chewing, swallowing, or digestion; the use of supplementation and/or feeding tubes; and end of live decisions and advance directive.

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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** 50714 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for two of 18 sampled residents (Resident 55 and 291) as evidenced by: -Failing to ensure the facility staff changed Resident 55's nasal cannula was changed weekly, the nasal cannula tubing was not on the floor and ensure the facility staff dated and changed Resident 55's oxygen humidifier (a medical device that adds moisture to oxygen to make it more comfortable to breathe) after 24 hours. -Failing to ensure Resident 291's nasal cannula tubing was changed weekly. These deficient practices had the potential for Resident 55 and 291 to experience complications associated with oxygen therapy, such as infection and respiratory distress. Findings: a. During a review of Resident 55's Admission Record, the Admission Record indicated the facility admitted the resident on 6/24/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 55's Minimum Data Set (MDS, a resident assessment tool), dated 12/24/2024, indicated the resident had the ability to make herself understood and had the ability to understand others. During a review of Resident 55's Order Summary Report, the order summary report indicated the resident had a physician order for oxygen 2 liters per minute (2 liters of oxygen flow into a patient's nose every minute) via nasal cannula as needed (PRN) for shortness of breath (uncomfortable feeling that you are running out of air) or wheezing related to COPD. During an observation on 2/10/2025 at 10:14 AM, in Resident 55's room, the resident was observed in her bed resting with the resident's oxygen cannula tubing on the floor. The oxygen tubing was observed to be dated 1/27/2025. The oxygen humidifier was observed to be attached to the oxygen cannula with the oxygen humidifier missing the date and time the staff placed it. Photos were taken. During a concurrent observation and interview on 2/10/2025 at 10:22 AM with Certified Nursing Assistant 7 (CNA 7) in Resident 55's room, CNA 7 and the surveyor observed Resident 55's oxygen tubing on the floor. CNA 7 stated Resident 55's tubing was on the floor, was dirty and she would throw it away because it was dirty. CNA 7 was observed throwing away the dirty oxygen tubing. During an interview on 2/13/2025 at 8:10 AM with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated oxygen tubing left on the floor could put the resident at risk for a respiratory infection should the staff allow a resident to use tubing from the floor. LVN 2 stated using oxygen tubing left on the floor is an infection control issue. (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 interview on 2/13/2025 at 8:16 AM with the Infection Preventionist (IP), the IP stated oxygen tubing left on the floor would put a resident at risk for a respiratory infection if a staff member allowed the resident to use the tubing from the floor. The IP stated it would be an infection control issue. During an interview on 2/13/2025 at 8:29 AM with Registered Nurse 1 (RN 1), RN 1 stated a resident would be at risk for a lung infection if the facility staff allowed a resident to use oxygen tubing that was on the floor. RN 1 stated the oxygen tubing would need to be replaced and dated so staff would know when to change the oxygen tubing next. During an interview with the Director of Nursing (DON), the DON stated the facility staff would need to replace oxygen tubing found on the floor with a new one. The DON stated using oxygen tubing that was left on the floor was an infection control issue and could result in a resident getting a lung infection. The DON stated the staff would need to date the oxygen tubing so they would know when to replace it. 43851 b. During a review of Resident 291's Admission Record, the Admission Record indicated the facility admitted the resident on 1/23/2025 with diagnoses that included acute respiratory failure (a condition in which your blood doesn't have enough oxygen causing shortness of breath and difficulty breathing, often caused by a disease or injury) with hypoxia (low levels of oxygen in the body tissues) and dependence on supplemental oxygen (when an individual requires additional oxygen to support normal organ function). During a review of Resident 291's MDS, dated [DATE], the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS did not indicate if Resident 291 was on oxygen therapy. During a review of Resident 291's Order Summary Report, the order summary report indicated the resident had physician orders for oxygen 2 liters per minute (L/min) via nasal cannula continuously. The order summary report further indicated Resident 291 had physician orders to change the oxygen tubing every Saturday and as needed (PRN). During an observation on 2/10/2025 at 10 AM, in Resident 291's room, the resident was observed sitting up in bed with oxygen at 2 L/min via NC. Resident 291's oxygen tubing was observed dated 1/29/2025. During a concurrent observation and interview on 2/10/2025 at 10:51 AM, in Resident 291's room, the resident's oxygen tubing dated 1/29/2025 was observed with the IP. The IP confirmed Resident 291's oxygen tubing was dated 1/29/2025. The IP stated typically oxygen tubing is changed every Saturday. The IP stated Resident 291's oxygen tubing should have been changed weekly on 2/5/2025. The IP stated oxygen tubing is changed for infection control. During an interview on 2/13/2025 at 3:07 PM with the DON, the DON stated oxygen tubing should be changed weekly. The DON stated there was a potential for Resident 291 to experience infection control issues if the oxygen tubing is not changed weekly. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled Oxygen Administration reviewed 1/16/2025, the policy indicated The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. During a review of the facility' s P&P titled, Departmental (Respiratory Therapy) - Prevention of Infection, reviewed 1/16/2025, the policy indicated The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff . Change the oxygen cannula and tubing every seven (7) days, or as needed. The P&P indicated the facility used distilled water (water, created by boiling regular water to turn it into steam, then collecting that steam as it cools back into liquid, which leaves behind any impurities like minerals and salts, resulting in a very clean water with no added flavor or minerals) for humidification (adding moisture to the oxygen). The P&P indicated the facility staff would need to date and initial the distilled water when opened and discard it after 24 hours.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 50714 Based on interview and record review, the facility failed to provide a Restorative Nursing Assistant (a Certified Nursing Assistant who has completed an additional training program that allows them to work with a resident and provide skill practice in such activities as walking and mobility, dressing, and grooming, eating and swallowing, transferring, amputation care, and communication in order to improve and maintain function in physical abilities and activities and prevent further loss of those abilities) Certificate for one of two sampled Restorative Nursing Assistants (Restorative Nursing Assistant 1 [RNA 1]). This failure resulted in RNA 1 providing care to residents without proof RNA 1 had the education or skills to provide restorative nursing aid care placing residents at risk for injury or reducing in their functional abilities (a person's capacity to perform everyday tasks and activities). Findings: During concurrent interview and record review on 2/14/2025 at 7:59 AM with the Director of Staff Development (DSD), RNA 1's employee record was review. RNA 1's employee record indicated there was no record of RNA 1's RNA certificate. The DSD stated she had been on the job for 7 days and was trying to organize the facility's files. The DSD stated RNA 1 was trying to find his certificate because the facility did not have a copy of it in their records. During an interview on 2/14/2025 at 8:33 AM, the DSD stated it was important for RNA 1 to have an RNA certification to show he had the ability to perform as an RNA. During an interview on 2/14/2025 at 11:27 AM with Registered Nurse Consultant 2 (RNC 2), the RNC 2 stated the facility would not be able to verify RNA 1 was competent (having the necessary ability, knowledge, or skill to do something successfully) to perform tasks/duties as an RNA without proof of their certification. The RNC 2 stated the facility should have been keeping track of RNA 1's certification status before allowing him to work as an RNA. During an interview on 2/14/2025 at 11:55 AM with the Director of Nursing (DON) and facility Administrator (ADM), the DON and ADM stated without RNA 1's certificate, the facility could not prove RNA 1 was competent to perform as an RNA. The DON and the ADM stated they would continue to look for RNA 1's RNA certificate. During an interview on 2/14/2025 at 2:00 PM with the DSD, the DSD stated she could not locate RNA 1's RNA certificate. A review of the facility's policy and procedure (P&P) titled, Competency of Nursing Staff, dated 1/116/2025, indicated the facility nursing staff must meet specific competency requirements for their respective (individual) license and certification requirements. The P&P indicated staff should be able to demonstrate to perform activities that are within their scope of practice (hose activities that a person licensed to practice as a health professional is permitted to perform) an individual is licensed or certified to perform.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Six medication errors out of 27 total opportunities contributed to an overall medication error rate of 22.22 % affecting three of four residents observed for medication administration (Residents 5, 34, and 191.) The medication errors noted were as follows: 1. Omitted or late administration of vitamin D (a vitamin supplement) to Resident 191 2. Omitted or late administration of artificial tears (a medication used to treat dry eyes) to Resident 34. 3. Attempted to administer crushed escitalopram (a medication used to treat mental illness) along with a mixture of crushed hydrochlorothiazide (a medication used to treat high blood pressure), losartan (a medication used to treat high blood pressure) and aspirin (a medication used to prevent blood clots.) 4. Attempted to administer crushed hydrochlorothiazide along with a mixture of crushed escitalopram, losartan, and aspirin. 5. Attempted to administer crushed losartan along with a mixture of crushed escitalopram, hydrochlorothiazide, and aspirin. 6. Attempted to administer crushed aspirin along with a mixture of crushed escitalopram, hydrochlorothiazide, and losartan. The deficient practice of failing to administer medications in accordance with professional standards and the physician's orders, including any required time frame, increased the risk that Residents 5, 34, and 191 may have experienced medical complications possibly resulting in hospitalization . Findings: A review of Resident 191's Admission Record, dated 2/12/25, indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a group of conditions characterized by a decline in mental function including memory loss and judgement) and schizoaffective disorder (a mental illness characterized by hearing and seeing things that are not there, believing things that are not true, and mood swings). A review of Resident 191's undated History and Physical (H&P - a record of a comprehensive physician's assessment), indicated the resident did not have the capacity to understand and make decisions. A review of Resident 191's Order Summary Report (a monthly summary of all active physician orders), dated 2/11/25, indicated the resident was also due to receive one capsule of vitamin D 25 mcg by mouth during the 9:00 AM medication pass. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/11/25 at 8:06 AM with the Licensed Vocational Nurse (LVN 1), LVN 1 was observed preparing the following medications for Resident 191: 1. One tablet of memantine (a medication used to treat dementia) 10 milligrams (mg - a unit of measure for mass). 2. Three tablets of divalproex (a medication used to treat seizures) 125 mg 3. One tablet of Eliquis (a medication used to prevent blood clots) 2.5 mg 4. Four capsules of divalproex 125 mg sprinkle capsules 5. One tablet of clonazepam (a medication used to treat mental illness) 1 mg During an observation on 2/11/25 at 8:18 AM, LVN 1 was observed crushing the medications listed above and mixing each medication with a small amount of apple sauce in separate dosage cups. LVN 1 was then observed explaining each medication to Resident 191 and spoon feeding the memantine, divalproex capsules, Eliquis, and clonazepam each mixed with apple sauce separately to the resident. LVN 1 was observed struggling to explain the divalproex tablets to the resident as she had already administered divalproex in the sprinkle capsules form. During an interview on 2/11/25 at 8:30 AM, LVN 1 stated, after checking the orders, the divalproex 125 mg order with three tablets was discontinued the day prior (2/10/25) and the facility staff failed to remove the discontinued medication from the cart. LVN 1 stated the four medications already administered to Resident 191 were the only medications due at the time. A review of Resident 34's Admission Record, dated 2/12/25, indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including essential (primary) hypertension (high blood pressure) and dry eye syndrome bilateral (dryness in both eyes.) A review of Resident 34's H&P indicated the resident had the capacity to understand and make decisions. A review of Resident 34's Order Summary Report, dated 2/11/25, indicated the resident was also due to receive artificial tears one drop in both eyes for eye dryness during the 9:00 AM medication pass. During an observation on 2/11/25 at 8:36 AM, LVN 1 was observed preparing the following medications for Resident 34: 1. One tablet of oyster shell calcium (a supplement) 500 mg 2. One tablet of Edarbi (a medication used to treat high blood pressure) 80 mg 3. One capsule of gabapentin (a medication used to treat nerve pain) 400 mg 4. One tablet of hydralazine (a medication used to treat high blood pressure) 50 mg (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. One tablet of nifedipine ER (a medication used to treat high blood pressure) 30 mg 6. One tablet of chlorthalidone (a medication used to treat high blood pressure) 50 mg 7. One tablet of [NAME]-Vite (a vitamin supplement) 8. Five tablets of vitamin B12 (a supplement) 100 micrograms (mcg - a unit of measure for mass) During an interview on 2/11/25 at 8:43 AM with LVN 1, LVN 1 stated the eight medications listed above were the only medications due for Resident 34 at the time. During an observation on 2/11/25 at 8:45 AM, Resident 34 was observed taking all eight medications listed above by mouth with water. A review of Resident 5's Admission Record, dated 2/12/25, indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including essential (primary) hypertension. A review of Resident 5's H&P indicated the resident did not have the capacity to understand and make decisions. A review of Resident 5's Order Summary Report, dated 2/11/25, indicated there were no physician's orders to crush and mix escitalopram (medication used to treat anxiety), hydrochlorothiazide (medication used to remove excess fluids from the body), losartan (medication used to treat high blood pressure), and aspirin together for oral administration. During an observation on 2/11/25 at 9:07 AM, LVN 2 was observed preparing the following medications for Resident 5: 1. Three and one-half tablets of escitalopram 5 mg 2. One tablet of hydrochlorothiazide 25 mg 3. One tablet of losartan 50 mg 4. One tablet of aspirin 81 mg chewable During an observation on 2/11/25 at 9:19 AM, LVN 2 was observed placing all four medications listed above into a small plastic bag and using a crushing device to crush all four medications together. LVN 2 was then observed adding the crushed mixture with applesauce into one dosage cup. During an observation on 2/11/25 at 9:20 AM, LVN 2 was observed attempting to administer the crushed medication and applesauce mixture to Resident 5 and was stopped by the surveyor before the medication was administered and advised to discuss the medication preparation with the surveyor in the hallway. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/25 at 9:22 AM with LVN 2, LVN 2 stated she crushed all four of Resident 5's medications together and mixed them with applesauce. LVN 2 stated she believed some crushed medications could be mixed but she did not know exactly which ones and would have to check with another nurse. LVN 2 stated she did not know whether the crushed combination of medications she prepared for Resident 5 was safe to administer. LVN 2 stated she did not check with any other nurse or check any other reference about whether the medications could be crushed together prior to preparing the medications and attempting to administer them to Resident 5. LVN 2 stated crushing medications and mixing them together could cause them not to work as intended. LVN 2 stated if crushed medications were mixed and given to the resident, it could cause medical complications possibly resulting in hospitalization . During an interview on 2/11/25 at 10:18 AM with LVN 1, LVN 1 stated she failed to administer vitamin D to Resident 191. LVN 1 stated I missed it. LVN 1 stated vitamin D was usually used because residents may not have had a lot of exposure to sunlight and needed a supplement for vitamin D. LVN 1 stated missing the vitamin D supplement for the resident could increase his risk of bone fractures or other medical complications caused by a low vitamin D level. LVN 1 stated she also failed to administer the artificial tears to Resident 34. LVN 1 stated not administering the artificial tears could cause irritation to his eyes from dryness which could adversely affect the resident's quality of life. A review of the facility's policy Administering Medications, revised April 2019, indicated Medication are administered in a safe and timely manner, and as prescribed . Medications are administered in accordance with prescriber orders, including any time frame . Medications are administered within one (1) hour of their prescribed time, unless otherwise specified . A review of the facility's policy Crushing Medications, revised April 2018, indicated Crushing each medication separately and administering each with food is considered best practice. However, separating and administering crushed medication is not appropriate for all residents. Issues related to safety, needs, preferences, medication schedule, and functional ability will determine the most resident-centered approach .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to: 1. Remove 36 doses of discontinued divalproex (a medication used to treat seizures) 125 milligrams (mg - a unit of measurement for mass) tablets one of two inspected medication carts (Medication Cart 2.) 2. Store dronabinol (a medication used to increase appetite) 10 mg capsules in the refrigerator per the manufacturer's requirements in one of two inspected medication carts (Medication Cart 1.) The deficient practices of failing to store medications per the manufacturers' requirements and remove discontinued medications from the medication cart increased the risk of residents experiencing adverse effects (dangerous, unwanted side effects of medication) due to improper storage of medication possibly leading to health complications resulting in hospitalization or death. Findings: During an observation on [DATE] at 8:06 AM with the Licensed Vocational Nurse (LVN 1), LVN 1 was observed preparing the following medications for Resident 191: 1. One tablet of memantine (a medication used to treat dementia) 10 milligrams (mg - a unit of measure for mass). 2. Three tablets of divalproex (a medication used to treat seizures) 125 mg 3. One tablet of Eliquis (a medication used to prevent blood clots) 2.5 mg 4. Four capsules of divalproex 125 mg sprinkle capsules 5. One tablet of clonazepam 1 mg (a medication used to treat mental illness) During an observation on [DATE] at 8:18 AM, LVN 1 was observed crushing the medications listed above and mixing each medication with a small amount of apple sauce in separate dosage cups. LVN 1 was then observed explaining each medication to Resident 191 and spoon feeding the memantine, divalproex sprinkle capsules, Eliquis, and clonazepam each mixed with apple sauce separately to the resident. LVN 1 was observed struggling to explain the divalproex tablets to the resident as she had already administered divalproex in the sprinkle capsules form. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 8:30 AM, LVN 1 stated, after checking the orders, the divalproex 125 mg order with three tablets was discontinued the day prior ([DATE]) and the facility staff failed to remove the discontinued medication from the cart. LVN 1 stated if medications were not removed from the cart once they were discontinued there was a risk the resident would receive medications that had been discontinued, LVN 1 stated there was a risk that Resident 191 could have received too much divalproex possibly causing additional drowsiness, dizziness, or other adverse effects. During a concurrent observation and interview on [DATE] at 11:00 AM of Medication Cart 1 with LVN 3, the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 1. One bottle of dronabinol 10 mg capsules for Resident 23 was found stored at room temperature. According to the manufacturer's product labeling, dronabinol capsules had to be stored in the refrigerator. LVN 3 stated she was unaware that dronabinol capsules needed to be kept in the refrigerator. LVN 3 stated not storing them in the refrigerator as required by the manufacturer could cause them not to work to stimulate appetite and residents might not eat as a result. LVN 3 stated if residents did not eat they could lose weight which could lead to a decline in overall quality of life. A review of the facility's policy Storage of Medications, revised [DATE], indicated The facility stores all drugs and biologicals in a safe, secure, and orderly manner . discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed . medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured locations .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38740 Based on observation, interview and record review, the facility failed to ensure staff followed fortified diet (diet to increase caloric intake) guidelines during lunch preparation and tray line observation on 2/10/2025 (a system of food preparation, in which trays move along an assembly line) when: -Fortified diets were not prepared and were not served to residents who were on fortified diets. This deficient practice had the potential to result in meal dissatisfaction, decreased caloric intake and weight loss for seven residents who required a fortified diet. Findings: During the tray line observation on 2/10/2025 at 12:10 PM, Dietary Aide (DA1) did not communicate the fortified diet orders written on the meal tickets during tray line for lunch service. A review of resident's tray or meal tickets on the food carts indicated orders for fortified diets. DA1 did not read out loud the fortified diet and Cook1 who was serving the food did not add any additional food items per the fortified menu. During a concurrent observation and interview with Cook1 on 2/10/2025 at 12:40PM, Cook1 stated when there was a fortified diet, melted margarine was to be added to the vegetables or starches during lunch. Cook1 stated during lunch service DA1 would read out the fortified diets that were written on the meal tickets and cook1 would then add melted margarine to the meal. Cook1 stated DA1 did not announce or read out the fortified diets during the lunch service and cook1 did not add any margarine to food. Cook1 stated fortified diets were for residents who had weight loss and fortified diets added calories. Cook1 stated when residents did not get the ordered fortified diets the residents could lose weight. During a concurrent observation and interview with DA1 on 2/10/2025 at 12:45PM, DA1 stated fortified diets were written on the meal tickets. DA1 stated fortified diets were for residents who were losing weight. DA1 stated Cook1 would add margarine or more gravy for fortified diets. DA1 stated the cooks would add more gravy or margarine when DA1 would tell the cooks the tray was for a fortified diet. DA1 confirmed by stating, she forgot to read the fortified diets and did not tell the cooks today. During an interview with Registered Dietitian (RD) on 2/10/2025 at 12:50PM, RD stated fortified diet add extra calories and protein to food. Fortified is for residents who are experiencing weight loss and additional calories can help. RD stated residents on fortified diet did not receive additional calories. During an interview with dietary Supervisor (DS) on 2/10/2025 at 1:00PM, DS stated cooks, and staff should always follow the menu. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility policy titled Fortification of Food (Increasing Calories and or Protein in the Diet) (dated 2023), The goal to increase the calorie and or protein density of the foods commonly consumed by the resident to promote improvement in their nutrition status .Calories and protein will be added to selected food .Food and Nutrition services staff will be familiar with the fortification process for each item chosen to be used at the facility .Adding Calories-1/2 oz. melted margarine is added to 1 food item for breakfast, 2 items at lunch and 1 at dinner . adds 100 calorie per 1/2 oz. During a review of facility policy titled Menu Planning (dated 2023) indicated, The menus are planned to meet nutritional needs of residents in accordance with established national guidelines, physician's orders and .recommended dietary allowances.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 38740 Based on observation, interview and record review, the facility failed to ensure: -15 residents on pureed diet received the pureed corn salad in the correct texture (pureed texture is smooth and free of lumps, hold their shape, while not being too firm or sticky, and should not weep) when the dietary aide prepared and served thin and soupy corn salad instead of pureed corn salad that held its shape and had pudding like consistency. -Two residents on finely chopped diet (modified diet with food prepared approximately 1/8-1/4 inches) and three residents on ground meat diet (hamburger meat consistency) received meat texture in the form that met their needs when [NAME] 1 served flaked fish instead of finely chopped and ground fish per resident diet orders. This deficiency had the potential to result in decreased intake related to inconsistent and large size meats, meal dissatisfaction and increased choking and aspiration (inhalation of food or liquids into the lungs) food risk for residents on pureed diet. Findings: a. During an observation of the tray line service for lunch on 2/10/2025 at 12:09 PM, Dietary Aide (DA 2) was plating corn salad. DA 2 stated [NAME] 1 asked DA 2 to prepare the pureed corn salad. DA 2 removed a portion of the regular corn salad into the blender, added water then blended the mixture. DA 2 then poured the liquid mixture into cups for the pureed diet. The liquid salad was not smooth had pulps. During a concurrent observation and interview with DA 2 on 2/10/2025 at 12:15 PM DA 2 stated she mixed the corn salad with some water and blended. DA 2 stated the salad was watery and the texture was not like pudding. DA 2 stated the salad should have been smooth and less watery. During an interview with Registered Dietitian (RD) on 2/10/2025 at 12:50 PM, RD stated the pureed corn salad was not smooth and was watery in texture. RD stated liquid texture of the corn salad could have been a problem for residents who were on pureed diet and thickened liquids. RD stated the pureed salad should have been smooth with no lumps and had a pudding like consistency. During an interview with cook 1 on 2/10/2025 at 12:40 PM, cook 1 confirmed asking DA 2 to make pureed corn salad. [NAME] 1 stated she did not check to see if the pureed salad was at the correct consistency. [NAME] 1 stated the puree had to be smooth and with a pudding consistency, not runny. During a review of facility policy titled, Regular Pureed Diet, (dated 2024) indicated, The pureed diet has been designed for residents who have difficulty chewing and or swallowing. The texture .should be smooth and free of lumps, hold their shape, while not being too firm or sticky and should not weep. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's pureed salad recipe indicated to remove a portion from regular salad add to blender, slowly blend and in small amounts add milk and blend, then add thickener if needed. the finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm or sticky and should not weep. A review of job description for [NAME] 1 (dated 2023) indicated, [NAME] is Responsible for the preparation of food for breakfast and noon meals .Supervise dietary aides, relief cook, and the afternoon cook b. During an observation of lunch service in the kitchen on 2/10/2025 at 12:10 PM, residents who were on finely chopped diet received flaked fish instead of fish that was finely chopped (modified diet with food prepared approximately 1/8 - 1/4 inches) and residents who were on ground texture diet (hamburger meat texture) received flaked fish instead of ground fish. During an interview with cook 1 on 2/10/2025 at 12:40 PM, [NAME] 1 stated she only prepared regular fish and flaked fish. [NAME] 1 stated she did not chop the fish into smaller pieces for the finely chopped and she did not grind fish for the residents with diet orders of ground fish. [NAME] 1 stated finely chopped and ground diet is not on the menu. During an interview with Registered Dietitian (RD) on 2/10/2025 at 12:50 PM, the RD stated the ground fish diet means the consistency must be ground and the final chopped means the fish must be chopped into very small pieces. The RD stated the current facility menu and spreadsheet (food portions and serving guide) do not have serving guidance for ground and finely chopped diets. The RD stated the diet orders for residents on finely chopped and ground need to be reevaluated and clarified. The RD stated the cook did not prepare finely chopped or ground fish today. The RD stated this could potentially be a problem with chewing or swallowing for residents who need to be on ground or finely chopped diet. During an interview with on 2/10/2025 at 1 PM, the DS stated cook did not prepare ground or finely chopped diet. The DS stated the ground and finely chopped diet was not on the menu. The DS stated residents who were on ground meat and finely chopped diet can have chewing and swallowing problem. A review of facility policy titled, Menu Planning, dated 2023 indicated, The facility's diet manual; and the diet ordered by the physician should mirror the nutritional care provided by the facility.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38740 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage practices in the kitchen when: -Several food items located in the reach in refrigerator were not dated: four turkey and cheese sandwiches, one plate of salad with chopped ham. -One tuna salad sandwich and one turkey and cheese sandwich were stored in the reach in refrigerator with date of [DATE] exceeding storage periods for prepared sandwiches. -One bag of deli meat in a plastic bag stored in the reach in freezer with no label or date. Ice crystals were observed in the plastic bag with the deli meat. These deficient practices had the potential to result in harmful bacteria growth that could lead to food borne illness in 83 out of 84 residents and decreased quality of food stored in the freezer due to frost bite and no date. Findings: During an observation in the kitchen on [DATE] at 8:30 AM there were four turkey and cheese sandwiches and one plate of chopped lettuce with chopped ham stored in the reach in refrigerator with no date. During the same observation on [DATE] at 8:30 AM, there was one tuna salad sandwich and one turkey and cheese sandwich with a date of [DATE] stored in the reach in refrigerator. During a concurrent observation and interview with [NAME] (Cook 1) on [DATE] at 8:45 AM, [NAME] 1 denied preparing the sandwiches and the salad and did not know when the sandwiches and salads were prepared because there was no date. [NAME] 1 stated she would discard the sandwiches and salad and make new ones. [NAME] 1 stated the sandwiches were made for either same day serving or for next day. [NAME] 1 stated the sandwich from [DATE] should have been discarded. During an observation in the kitchen on [DATE] at 9 AM, there was one bag of sliced deli meat stored in the reach in freezer with no label or date. The deli meat was not in its original container and had ice crystals on it. During the same observation and interview with [NAME] 1 on [DATE] at 9 AM. [NAME] 1 stated the bag containing deli meat should have been labeled and dated. [NAME] 1 did not know if the deli meat was sliced ham or turkey. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Dietary Supervisor (DS) on [DATE] at 10:30 AM, the DS stated all prepared salads and sandwiches had to be dated on the date they were made. The DS stated the salads and sandwiches were used on the same day prepared or the next day and then discarded. The DS stated salads and sandwiches that were not dated had to be discarded. The DS stated the prepared tuna salad, and the turkey sandwich dated [DATE] would be discarded because the sandwiches were not used on the same day or day after and were expired. During an interview on [DATE] at 10:30 AM, the Registered Dietitian (RD 1) stated the facility kept tuna salad for about three days per storage guidelines. The RD did not know when the tuna salad for the tuna sandwich was prepared. During a review of facility policy titled, Labeling and Dating of Foods (dated 2023) indicated, All food items in the storeroom, refrigerator and freezer need to be labeled and dated .All prepared foods need to be covered, labeled, and dated. Items can be dated individually or in bulk . Leftovers will be covered, labeled and dated. During a review of facility policy titled, Leftover foods (dated 2023) indicated, Leftover foods are those that have been prepared for a meal and not served. Label and date, use refrigerator leftovers within 72 hours, use frozen leftovers within one month. During a review of facility refrigerated storage guide (dated 2023) indicated, Tuna salad, maximum refrigeration time is 3 days. A review of the 2022 U.S. Food and Drug Administration Food Code titled, Ready to Eat, Time/Temperature control for safety food, Date Marking Code#,d+[DATE].17, indicated, Ready to eat, time temperature control for safety food prepared and packaged by food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed, sold, or discarded.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on interview and record review, the facility failed to have a policy and procedure for their Bioethics Committee (a multidisciplinary group within a healthcare institution that is consulted when difficult medical decisions need to be made for patients who lack the capacity to make informed choices themselves). This deficient practice placed 13 residents (Residents 84, 48, 27, 25, 3, 20, 28, 41, 12, 11, 86, 19, and 2), who were represented by the facility's Bioethics committee, at risk for ineffective care, needs not being met, and a decline in health. Cross Reference F551 Findings: A review of the Admission Record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a condition where the brain's function is impaired due to an underlying metabolic disturbance), schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). A review of the Bioethics Committee Meeting Minutes (BCMM) dated 11/25/2024, indicated the committee consisted of the Medical Director, the Administrator, the Director of Nursing and the Social Worker. The minutes indicated Resident 19 did not have the capacity to understand and make decisions, resident had no known family, and that the resident was unable to participate in the plan of care and / or act as the responsible party for himself. The BCMM indicated Resident 19 had paranoid schizophrenia, bipolar disorder, and Type II diabetes mellitus. The BCMM indicated the Bioethics Committee would act as Resident 19's responsible party and consented to treat the resident. The BCMM did not indicate any information regarding Resident 19's application for an assigned conservator (when a judge appoints a person to act or make decisions for someone who cannot make decisions on their own) by the state or guardian. A review of the Notice of Referral Receipt dated 1/10/2025 indicated Resident 19 was assigned to a Deputy Public Guardian for investigation, four months after admission to the facility. A review of the quarterly Minimum Data Set (MDS - a resident assessment tool) dated 12/13/2024, indicated Resident 19 was cognitively intact (no problems with a person's ability to think, remember, use judgement, and make decisions). The MDS further indicated Resident 19 was diagnosed with dementia, bipolar disorder, schizophrenia, and metabolic encephalopathy. A review of Resident 19's History and Physical (H&P) dated 2/3/2025, indicated Resident 19's was not competent to understand his medical condition. A review of the social services assessment for Resident 19 dated 2/5/2025, indicated Resident 19 did not have family or friends for support. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/2025 at 12:45 PM, the facility's Medical Director (MD) stated the role of the Bioethics Committee was to assist residents who were not able to make medical decisions, and the facility was unable to find a family member to become the responsible party. The MD stated the resident would be represented by the Bioethics Committee until the resident was assigned a conservator (when a judge appoints a person to act or make decisions for someone who cannot make decisions on their own) by the state. During a concurrent interview and record review on 2/14/2025 at 9:30 AM, the Administrator (ADM) was asked for a policy on the guidelines of the Bioethics committee, the ADM provided a policy titled, Resident Representative which did not mention the Bioethics Committee. When asked what guidance was being used regarding the Bioethics Committee, the ADM stated there was no specific guidance followed by the committee. During a concurrent interview and record review on 2/14/2025 at 10:12 AM, the Social Services Director (SSD) stated, currently the facility had 13 residents who were being represented by the Bioethics Committee. The SSD stated upon admission, quarterly, or as needed, the SSD would assess whether a resident was able to make decisions for themselves. The SSD stated when residents were identified as having severe cognitive impairment and did not have a representative to make decisions, the SSD would inform the Bioethics Committee, and the Bioethics committee would then have a meeting to determine if the resident's care would be managed by the facility's Bioethics Committee. The SSD stated an application for conservatorship from the state was then submitted and that there was no specific timeline on the process for conservatorship. The SSD stated a form called the Bioethics Committee Meeting Minutes was the form the facility used to indicate the concerns to be discussed, summary of discussion, and outcome. A review of 12 additional residents (Residents 84, 27, 25, 3, 20, 28, 41, 12, 11, 86, 48, and 2) were represented by the facility's Bioethics committee. A review of the facilities policy and procedure (P&P) titled, Resident Representative, reviewed 1/16/2025, indicated the term resident representative was defined as: -an individual chosen by the resident to act on behalf of the resident to support the resident in decision-making; access medical, social, or other personal information of the resident; manage financial matters; or receive notifications. -a person authorized by state or federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications. -legal representative, as used in section 712 of the Older Americans Act and the court-appointed guardian or conservator of a resident.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on interview and record review, the facility failed to ensure medical records for seven sampled residents (Residents 77, 53, 341, 32, 62, 21, and 19) were accurately documented. These seven residents had the exact same vital signs documented by the same Licensed Vocational Nurse (LVN) 4 as the previous shift, on dates 2/8, 2/9, 2/10 and 2/11/2025. This deficient practice caused an increased risk for inadequate care of the residents. Cross Reference F684 Findings: A review of the Admission Record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a condition where the brain's function is impaired due to an underlying metabolic disturbance), schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). A review of Resident 53's MAR indicated the vital signs taken on the 3:00 PM -11:30 PM shift was noted as follows: 2/8/2025 -BP: 127/74 -Temp: 97.1 -Pulse: 72 -Resp: 18 -O2 Sats: 96 2/9/2025 -BP: 124/72 -Temp: 97.8 -Pulse: 72 -Resp: 17 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-O2 Sats: 96 2/10/2025 -BP: 119/82 -Temp: 97.1 -Pulse: 78 -Resp: 18 -O2 Sats: 97 2/11/2025 -BP: 118/76 -Temp: 97.2 -Pulse: 71 -Resp: 18 -O2 Sats: 97 A review of Resident 53's MAR indicated the vital signs taken on the 11:00 PM-7:30 AM shift was noted as follows: 2/8/2025 -BP: 127/74 -Temp: 97.1 -Pulse: 72 -Resp: 18 -O2 Sats: 96 2/9/2025 -BP: 124/72 -Temp: 97.8 -Pulse: 72 (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resp: 17 -O2 Sats: 96 2/10/2025 -BP: 119/82 -Temp: 97.1 -Pulse: 78 -Resp: 18 -O2 Sats: 97 2/11/2025 -BP: 118/76 -Temp: 97.2 -Pulse: 71 -Resp: 18 -O2 Sats: 97 A review of Resident 341's MAR indicated the vital signs taken on the 3:00 PM -11:30 PM shift was noted as follows: 2/8/2025 -BP: 128/77 -Temp: 97.3 -Pulse: 73 -Resp: 18 -O2 Sats: 97 2/9/2025 -BP: 127/72 -Temp: 97.7 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056206	A. Building B. Wing	02/13/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pulse: 74 -Resp: 18 -O2 Sats: 98 2/10/2025 -BP: 126/73 -Temp: 97.2 -Pulse: 74 -Resp: 18 -O2 Sats: 97 2/11/2025 -BP: 126/71 -Temp: 97.4 -Pulse: 75 -Resp: 18 -O2 Sats: 97 A review of Resident 341's MAR indicated the vital signs taken on the 11:00 PM-7:30 AM shift was noted as follows: 2/8/2025 -BP: 128/77 -Temp: 97.3 -Pulse: 73 -Resp: 18 -O2 Sats: 97 2/9/2025 -BP: 127/72 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056206	A. Building B. Wing	02/13/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Temp: 97.7 -Pulse: 74 -Resp: 18 -O2 Sats: 98 2/10/2025 -BP: 126/73 -Temp: 97.2 -Pulse: 74 -Resp: 18 -O2 Sats: 97 2/11/2025 -BP: 126/71 -Temp: 97.4 -Pulse: 75 -Resp: 18 -O2 Sats: 97 A review of Resident 32's MAR indicated the vital signs taken on 2/8/2025, 2/9/2025, 2/10/2025 and 2/11/2025 on the 3:00 PM -11:30 PM shift was noted as follows: 2/8/2025 -BP: 124/70 -Temp: 97.3 -Pulse: 74 -Resp: 18 -O2 Sats: 97 2/9/2025 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056206	A. Building B. Wing	02/13/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-BP: 127/68 -Temp: 97.8 -Pulse: 72 -Resp: 18 -O2 Sats: 98 2/10/2025 -BP: 126/73 -Temp: 97.2 -Pulse: 73 -Resp: 18 -O2 Sats: 97 2/11/2025 -BP: 126/71 -Temp: 97.3 -Pulse: 78 -Resp: 18 -O2 Sats: 97 A review of Resident 32's MAR indicated the vital signs taken on 2/8/2025, 2/9/2025, 2/10/2025 and 2/11/2025 on the 11:00 PM-7:30 AM shift was noted as follows: 2/8/2025 -BP: 124/70 -Temp: 97.3 -Pulse: 74 -Resp: 18 -O2 Sats: 97 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056206	A. Building B. Wing	02/13/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/9/2025 -BP: 127/68 -Temp: 97.8 -Pulse: 72 -Resp: 18 -O2 Sats: 98 2/10/2025 -BP: 126/73 -Temp: 97.2 -Pulse: 73 -Resp: 18 -O2 Sats: 97 2/11/2025 -BP: 126/71 -Temp: 97.3 -Pulse: 78 -Resp: 18 -O2 Sats: 97 3 additional resident's (Resident's 62, 21, and 19) MARs were reviewed and indicated the vital signs taken on 2/8/2025, 2/9/2025, 2/10/2025 and 2/11/2025 on the 3:00 PM -11:30 PM shift and the 11:00 PM-7:30 AM shift had showed the same vital sign patterns as Resident's 77, 53, 341, and 32. During a concurrent interview and record review on 2/12/2025 at 1:57 PM with the Director of Nursing (DON), reviewed Resident's 77, 53, 341, 32, 62, 21, and 19 MAR with the DON. Reviewed the vital signs taken on 2/8/2025 through 2/11/2025 for the 3:00 PM-11:30 PM and the 11:00 PM-7:30 AM shift for Resident's 77, 53, 341, 32, 62, 21, and 19. The DON stated that she could not consider the vital sign documentation for Resident 77, 53,341, 32, 62, 21, and 19 as falsification of records because it was not her assessment. However, DON agreed that the vital sign records from 2/8/2025 through 2/11/2025 on the 3:00 PM-11:30 PM and 11:00 PM-7:30 AM shift for Resident's 77, 53, 341, 32, 62, 21, and 19 were the same. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/2025 at 1:57 PM with the Director of Nursing (DON), the DON stated that the Skilled Nursing Note documentation was required by the LVN to be done daily and did not need to be done for each shift. The DON stated she did not have a policy that stated this specifically and could not provide a policy that showed how often documentation needed to be done. A review of the facility's policy and procedure (P&P) titled, Routine Resident Checks, it indicated that nursing staff shall make a routine resident check on each unit at least once per each 8-hour shift. It further stated the nursing supervisor or charge nurse shall keep documentation related to these routine checks, including the time, identity of the person making checks, and any outcomes of each check. This P&P showed a discrepancy with the DON's statement regarding documentation. During a telephone interview on 2/12/2025 at 2:47 PM with LVN 4, LVN 4 stated that he worked the 11:00 PM-7:30 AM shift on 2/8/2025 through 2/11/2025. LVN 4 stated that he took Resident's 77, 53, 341, 32, 62, 21, and 19 vital signs at the start of their shift. LVN 4 stated the vital signs that were documented on the electronic health record (EHR) were taken by him and were accurate. LVN 4 could not explain how the vital signs on 2/8/2025 through 2/11/2025 from his shift (11:00 PM-7:30 AM) and the 3:00 PM-11:30 PM were the same.