STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065153	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Grande Rehabilitation and Healthcare Center	680 E Hospital Dr Cortez, CO 81321

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on observations, record review and interviews, the facility failed to ensure care for residents was provided in a manner and in an environment that maintained or enhanced the residents' dignity and respect in full recognition of their individuality for three (#1, #23 and #38) of nine residents reviewed for dignity out of 41 sample residents. Specifically, the facility failed to: -Ensure staff treated Resident #1 with respect and dignity by acknowledging and responding to the resident when she spoke to them; -Ensure Resident #23 was treated with respect and dignity during meals; and, -Ensure Resident #38 was not yelled at or moved hastily when he got stuck on another resident' s chair in the dining room. Findings include I. Facility policy The Dignity policy, revised February 2021, was provided by the corporate consultant (CC) on 5/9/24 at 12: 00 p.m. It read in pertinent part, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. Residents may exercise their rights without interference, coercion, discrimination or reprisal from any person or entity associated with this facility. When assisting with care, residents are supported in exercising their rights. For example residents are allowed to choose when to sleep, eat and conduct activities of daily living (ADLs) and are provided with a dignified dining experience. Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice. II. Resident #1 A. Resident status (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1, age less than 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included anoxic brain damage (caused when the brain was deprived of oxygen), other specified depressive episodes, attention and concentration deficit, a disorder of adult personality and behavior, cognitive communication deficit and impulse disorder. The 3/9/24 minimum data set (MDS) assessment documented Resident #1 was unable to complete a brief interview for mental status (BIMS) because she was rarely or never understood. The staff interview documented Resident #1 had a memory problem and could not recall the current season, the location of her own room, staff names and faces or that she was admitted to a nursing home. Resident #1' s cognitive skills for decision-making were severely impaired. B. Resident interview Resident #1 was interviewed on 5/6/24 at 11:42 a.m. Resident #1 was able to answer yes and no questions and make basic needs known if staff listened closely. Resident #1 was interviewed again on 5/9/24 at 3:45 p.m. Resident #1 said the dietary staff never asked what she wanted for meals and she wanted someone to take her order. C. Observations On 5/6/24 at 3:51 p.m. Resident #1 stood in the B hall without her walker. Certified nurse aide with medication authority (CNA-Med) #1 brought Resident #1 her walker. Resident #1 attempted to talk with CNA-Med #1 but he grabbed the front bar of her walker and pulled her from Hall B past the nurses' station to a recliner on the opposite side of Hall B. Resident #1 held onto the handles of her walker and was trying to keep up with CNA-Med #1 as he pulled her walker. Resident #1 had her arms fully extended in front of her with the top half of her body bent at approximately a 90-degree angle. Resident #1 had a hard time walking. She attempted to communicate with CNA-Med #1 but he did not listen to her and pulled her walker until he had her sit in a recliner. On 5/7/24 at 11:50 a.m. an unidentified staff member brought Resident #1' s tablemate her lunch. The staff member looked at Resident #1 and said Do not touch as she placed the plate in front of the other resident. At 11:54 a.m. an unidentified staff member brought Resident #1 her second plate of food. Resident #1 was excited and told the staff thank you three times but the staff walked away without responding to her. At 5:36 p.m. dietary aide (DA) #1 provided Resident #1 with a drink. Resident #1 said thank you and DA #1 walked away without acknowledging her. At 6:06 p.m. the environmental services director (ESD) brought Resident #1 a cup of juice. Resident #1 said thank you three times but the ESD did not respond to her and walked away. On 5/9/24 at 7:23 a.m. Resident #1 received her breakfast. She said thank you to DA #2 who walked away without responding. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 7:46 a.m. an unidentified staff member brought Resident #1' s tablemate her breakfast. Resident #1 said hi and the staff member did not acknowledge her. At 7:47 a.m. the unidentified staff member returned to give Resident #1' s tablemate water and silverware. Resident #1 again said hi and the staff member did not acknowledge her. At 7:50 a.m. Resident #1 said she did not get enough to eat and was still hungry. She asked for a soda to drink as well. Cook (CK) #2 was serving meals in the dining room and went to get a second plate of food for the resident. Resident #1 began eating her spilled food off of the floor while waiting for her second plate of food. -No staff attempted to redirect the resident from eating food off the floor. At 7:52 a.m. CK #2 brought Resident #1 more breakfast and a soda. Resident #1 laughed excitedly and told CK #2 thank you three times but CK #2 did not respond and walked away. D. Record review Resident #1' s communication care plan, revised on 6/14/23, documented she had impaired communication related to her cognitive impairment. The interventions included allowing ample time for the resident to comprehend what was said and allow time for a response, encouraging conversations in calm, quiet locations with minimal background noise, maintaining eye contact and approaching the resident from the front and paying attention to the resident' s body language and facial expressions. Resident #1' s psychiatric and mood care plan, revised on 6/14/23, documented she had an impaired psychiatric and mood status related to her history of anoxic brain damage and cognitive communication deficit. The pertinent interventions included administering medications and treatments as indicated by the physician's orders, assisting the resident in coping by discussing the possible solutions to conflict, monitoring for signs of mood changes or distress, monitoring the resident' s mood to determine if the problem was related to external causes, offering the resident encouragement, assistance and support to maintain as much independence and control as possible, offering the resident choices whenever possible in order to promote a feeling of self-worth and control over the environment and providing the resident with quality listening time and encourage expression of feeling. Resident #1' s behavioral care plan, revised on 9/12/23, documented she had behaviors which included depressive episodes, a disorder of adult personality and behavior, sexual disorders, an eating disorder where she ate non-food items, attention and concentration deficit and an impulse disorder. The pertinent interventions included offering Resident #1 assistance, encouragement and support to identify problems that were out of her control, offering Resident #1 choices whenever possible to promote a feeling of self-worth and control over the environment and care delivery and providing positive feedback to the resident when her behavior was appropriate and emphasize the positive aspects of compliance. E. Staff interviews (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #3 was interviewed on 5/8/24 at 1:36 p.m. CNA #3 said she worked with Resident #1 and they had a good relationship. She said the resident was not cognitively impaired to the extent other staff thought. CNA #3 said the staff did not always take the time to listen to Resident #1 when she communicated or they did not know how to listen to Resident #1. The nursing home administrator (NHA) was interviewed on 5/8/24 at 1:27 p.m. The NHA said Resident #1 had cognitive impairments. DA #1 was interviewed on 5/8/24 at 5:58 p.m. DA #1 said she was unsure how to communicate with Resident #1. She said she relied on staff who knew the resident well to help her know what the resident preferred. DA #1 said when she interacted with Resident #1 she laughed with or smiled at the resident and walked away for each interaction. DA #1 said it was hard to understand what Resident #1 said. The ESD was interviewed on 5/8/24 at 6:06 p.m. The ESD said he was able to communicate with Resident #1. He said the staff needed to take their time to communicate with the resident. CNA #3 was interviewed again on 5/9/24 at 11:13 a.m. She said staff needed to talk to Resident #1 the way they talked to the other residents because she truly understood, however she could not express herself to show she understood what someone said. She said staff thought Resident #1 had severe cognitive impairment because she had difficulties communicating. CNA #3 said Resident #1 was an intelligent woman and was able to communicate if staff took the time to listen to her. Restorative aide (RA) #1 was interviewed on 5/9/24 at 3:42 p.m. RA #1 said staff should guide Resident #1 when she was walking instead of pulling on the resident's walker. CNA #2 was interviewed on 5/9/24 at 3:47 p.m. She said she communicated with Resident #1 by giving her options and taking her time communicating with her. CNA #2 said she understood Resident #1, but it was hard at times. She said when Resident #1 was provided with time she was able to express herself and make her needs known. Registered nurse (RN) #1 was interviewed on 5/9/24 at 3:49 p.m. She said she communicated with Resident #1 by giving her time and being patient. She said Resident #1 was able to say the word or phrase of what she needed and that Resident #1 understood RN #1. DA #2 was interviewed on 5/9/24 at 3:55 p.m. DA #2 said she never took Resident #1' s orders for meals because she was not able to understand the resident. She said she wrote the resident' s name on a meal ticket and had the kitchen staff decide what to make her. The director of nursing (DON) was interviewed on 5/9/24 at 4:00 p.m. The DON said the staff were not supposed to pull on a resident' s walker when assisting them. She said if the staff were concerned about the resident falling they needed to walk next to the resident while utilizing a gait belt. The DON said she would conduct an in-service reminder to the staff to prompt the resident to walk instead of holding onto her walker. III. Resident group interview (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident group was interviewed on 5/8/24 at 9:00 a.m. The group consisted of five residents (#19, #28, #14, #56 and #24), which included the resident council president. The residents were identified by the facility and assessment as interviewable. Resident #56 said the staff yelled at residents during breakfast if they fell asleep while they were eating their food. He said a lot of the yelling was wake up, eat your breakfast, or sit down and eat your food. Resident #56 said he kept quiet during breakfast so the staff did not yell at him. Resident #28 said staff yelled at or raised their voices at her when they wanted her to eat her food faster. Resident #28 said she did not like the staff yelling at residents and she told the staff how she did not like it. IV. Additional resident interview Resident #50 was interviewed on 5/6/24 at 3:32 p.m. Resident #50 said during meals staff members yelled at residents in the dining room. She said the staff yelled sit down, eat your food, or wake up. She said if the resident was hard of hearing the staff yelled louder. She said 5/6/24 was the quietest her meal had been during breakfast and lunch since she was admitted and that it was nice. Resident #50 said she was a survivor of domestic violence and it scared her when the staff yelled. She said sometimes she had to eat in her room because the yelling triggered her post-traumatic stress disorder (PTSD) and it was overwhelming. V. Failure to treat Resident #38 and #23 with respect and dignity During a continuous observation during the breakfast meal on 5/9/24, beginning at 7:25 a.m. and ending at 8:00 a.m., the following was observed: At 7:25 a.m. Resident #38 was self-propelling his wheelchair between some tables in the dining room. He bumped into an unidentified resident' s chair by accident. Restorative aide (RA) #1 yelled Resident #38 you are bumping into another resident who is trying to eat his breakfast and he cannot enjoy it with you bumping him! Resident #38 did not respond to RA #1 and kept self-propelling. RA #1 grabbed Resident #38' s wheelchair and turned his chair and pushed him away from the resident he bumped into. RA #1 shook her head in frustration and walked away from Resident #38. At 7:30 a.m. Resident #23 fell asleep as she sat in front of her breakfast. RA #1 tapped the resident three times on her right arm and yelled wake up, eat your food! Approximately 30 seconds later, RA #1 tapped Resident #23' s right arm again and yelled wake up honey! At 7:34 a.m. the nursing home administrator (NHA) entered the dining room. While the NHA was in the dining room RA #1 did not yell at any residents. At 7:40 a.m. the NHA left the dining room. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 7:41 a.m. RA #1 attempted to wake up Resident #23 again and yelled Resident #23 wake up! Resident #38 was self-propelling in the wrong direction and RA #1 yelled Resident #38! You are going the wrong direction! Go in a different direction! Resident #38 did not respond to RA #1. RA #1 then grabbed his wheelchair and rotated him in the correct direction. RA #1 shook her head and rolled her eyes as she walked away from Resident #38. At 7:43 a.m. RA #1 sat a table away from Resident #23 and yelled at her if you are not going to eat you can go back to your room. VI. Staff interviews RA #1 was interviewed on 5/9/24 at 3:42 p.m. RA #1 said she had worked for the facility for many years. RA #1 said she assisted with breakfast every day and helped the residents who needed assistance with eating. She said if she felt the resident was not safe falling asleep in the dining room she tried to encourage them to wake up and eat. She said after three attempts at waking up the resident she asked another staff member to take the resident back to their room so they could sleep. She said she did not feel like she was yelling at the residents during breakfast on 5/9/24. She said some residents were hard of hearing and needed staff to increase their voices so the residents heard what was being said. She said it took a lot of encouragement and patience to support the residents during breakfast and sometimes staff needed to make their voices stern but she was not yelling. The NHA was interviewed on 5/9/24 at 4:00 p.m. The NHA said some of the staff were stern with the residents and it was often because of the staff' s misconception that residents had to eat their meals no matter the circumstances. The NHA said some of the staff felt it was in the residents' best interest to eat and drink at each meal so the staff continued to encourage the residents repeatedly. The NHA said she reminded the staff that the residents had the right to refuse breakfast and go back to bed. The NHA said she told the staff it was their job to encourage them politely and if the residents refused then let them leave the dining room. The NHA said the facility had some residents with weight loss and the staff did not want that to continue so they encouraged the residents to wake up and eat their food. Certified nurse aide (CNA) #3 was interviewed on 5/9/24 at 11:13 a.m. She said some staff yelled at residents in the dining room and it really only happened during breakfast. She said the staff yelled at the residents who fell asleep while eating or if they were hard of hearing then the staff raised their voices or yelled at them.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on interviews and record review, the facility failed to ensure consent was obtained for the use of psychotropic medications for two (#15 and #20) of five residents reviewed for unnecessary medications out of 41 sample residents. Specifically, the facility failed to ensure informed consents, which included the risks associated with taking a psychotropic medication, were obtained for Resident #15 and Resident #20. Findings include: I. Professional reference According to the 2020 [NAME] nursing drug reference, trazodone side effects include drowsiness, dizziness, nervousness, fatigue, dry mouth, and constipation. According to the 2020 [NAME] nursing drug reference, seroquel side effects include tachycardia (a fast heart beat), orthostatic hypotension (low blood pressure when changing positions), rash, abdominal pain, back pain, weight gain, headache, drowsiness, and dizziness. Further, seroquel includes a black box warning that the elderly with dementia-related psychosis are at increased risk for death. II. Facility policy and procedure The Antipsychotic Medication Use policy, revised July 2022, was provided by the nursing home administrator (NHA) on 5/13/24 at 1:25 p.m. It read in pertinent part, Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction (GDR) and re-review. The interdisciplinary team will re-evaluate the use of the antipsychotic medication at the time of admission and/or within the first two weeks (at the initial MDS assessment) to consider whether or not the medication can be reduced, tapered, or discontinued. III. Resident #15 A. Resident Status Resident #15, over the age of 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included chronic kidney disease, dementia, and insomnia. The 2/6/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a BIMS assessment score of 15 out of 15. She required supervision or touch assistance with hygiene, dressing, and bathing, and was independent when eating. The assessment documented the resident exhibited delusions and hallucinations, and had no refusal for care. B. Record review (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The May 2024 CPO revealed a physician's order for Trazodone HCl (antidepressant with off-label use for insomnia) oral tablet 50 milligrams (mg), give one tablet by mouth at night for sleep,s ordered on 1/23/24. The hours of sleep monitoring was reviewed from 1/23/24 through 5/9/24 and documented the resident averaged three to seven hours of sleep per night. -The electronic medical record (EMR) failed to reveal a resident or resident representative consent, which included the risks associated with taking a psychotropic medication, was obtained for the ordered Trazodone. Resident medication paper charting was obtained from the NHA on 5/9/24 at 11:32 a.m. The paper documentation failed to include a resident or resident representative consent for ordered Trazodone. IV. Resident #20 A. Resident Status Resident #20, over the age of 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included Parkinson's disease, dementia and anxiety disorder. The 4/4/24 MDS assessment revealed the resident was moderately cognitively impaired with a brief interview for mental score (BIMS) of 12 out of 15. He required substantial or maximum assistance with toileting, showering, dressing, and personal hygiene. The resident required supervision with eating. The assessment did not document any resident behaviors or rejection of care. B. Record review The May 2024 CPO revealed a physician's order for the following medication: Seroquel (antipsychotic medication) 25mg by mouth three times per day for dementia with behaviors, ordered on 4/23/24. -The EMR failed to reveal a resident or resident representative consent, which included the risks associated with taking a psychotropic medication, was obtained for the ordered Seroquel. Resident medication paper charting was obtained from the NHA on 5/9/24 at 11:32 a.m. The paper documentation failed to include a resident consent for ordered Seroquel. Additional resident consent documentation was obtained from the NHA on 5/9/24 at 2:34 p.m. The documentation included a consent for Resident #20's Seroquel that had been signed on 5/9/24 (during the survey). V. Staff interviews (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON), the corporate consultant (CC), and the NHA were interviewed on 5/9/24 at 1:48 p.m. The DON said psychotropic medications were reviewed quarterly which included review by the pharmacist, the physician, the NHA, the DON, the social services director (SSD), the charge nurse,the medical records staff and the activity director. The DON said the entire interdisciplinary team (IDT)discussed how the medications were working for each resident, and the resident's medications were evaluated to see what residents needed an increase or decrease to their medication dose. The NHA and the DON said consents needed to be obtained from residents for all psychotropic medications prior to administration of the medication. The NHA said the facility did not obtain consents for Resident #15's Trazodone or for Resident #20's Seroquel. The NHA said the SSD was new in her role and that was contributing to incomplete documentation. The NHA said the facility needed to improve documentation practices for psychotropic medications.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. 48412 Based on record review and interviews, the facility failed to ensure that personal funds accounts were managed adequately for four (#1, #2, #7 and #28) of five residents reviewed for personal funds accounts out of 41 sample residents. Specifically, the facility failed to: -Have signed written authorizations to manage the personal funds accounts for Resident #7; and, -Have personal funds withdrawal sheets signed to ensure the residents' permission was obtained to withdraw funds from their personal needs accounts for Residents #1, #2, #7 and #28. Findings include: I. Facility policy The Personal Needs Trust Account policy, undated, was provided by the nursing home administrator (NHA) on 5/8/24 at 4:38 p.m. It read in pertinent part, This facility recognizes and honors the requirements as stated in the federal regulations in regard to residents' personal funds. The facility must have written authorization from the resident or authorized person, prior to holding any funds. The receipt or record of transaction shall have a signature or thumbprint of the resident on every receipt or record of the transaction. II. Lack of signed written authorization Written authorizations were provided by the business office manager (BOM) on 5/8/24 at 2:00 p.m. for Resident #7 giving consent for the facility to manage her personal funds. -However, the consents were signed by the previous BOM and not the resident or the resident's legal representative. The current balance in the personal needs account for Resident #7 was $1,867.63 as of 5/9/24. III. Personal funds withdrawals A. Resident #1 The Personal Funds Withdrawal sheet was reviewed for Resident #1. The resident was found to have two withdrawals from her account with no signed authorization. The withdrawals were as follows: -On 11/21/23 a withdrawal wa made for $282.01; and, -On 3/14/24 a withdrawal was made for $24.54. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility provided receipts, however, the facility failed to have Resident #1 or two staff members sign the resident funds request forms. B. Resident #2 The Personal Funds Withdrawal sheet was reviewed for Resident #2. The resident was found to have two withdrawals from her account with no signed authorization. The withdrawals were as follows: -On 8/8/23 a withdrawal was made for $52.12; and, -On 1/16/24 a withdrawal was made for $219.85. -The facility provided receipts, however, the facility failed to have Resident #2 or two staff members sign the resident funds request forms. C. Resident #7 The Personal Funds Withdrawal sheet was reviewed for Resident #7. The resident was found to have two withdrawals from her account with no signed authorization. The withdrawals were as follows: -On 8/11/23 a withdrawal was made for $26.55; and, -On 3/28/24 a withdrawal was made for $120.00. -The facility provided receipts, however, the facility failed to have Resident #7 t or two staff members sign the resident funds request forms. D. Resident #28 The Personal Funds Withdrawal sheet was reviewed for Resident #28. The resident was found to have two withdrawals from her account with no signed authorization. The withdrawals were as follows: -On 8/14/23 a withdrawal was made for $11.50; and, -On 10/10/23 a withdrawal was made for $13.47. -The facility provided receipts, however, the facility failed to have Resident #28 or two staff members sign the resident funds request forms. IV. Staff interviews The NHA and the BOM were interviewed together on 5/8/24 at 1:27 p.m. The BOM said she was unaware the resident or two staff members needed to sign the personal funds withdrawal form when withdrawals were made. The BOM said she was creating a form to go along with the receipts and was going to provide education to the staff. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said the facility was never informed they needed to have the resident or two staff members sign the withdrawal form and it would no longer be an issue going forward. The NHA said the facility switched financial systems and the former BOM needed to complete new consents quickly and that was more than likely the reason why she signed as the legal representative. The NHA said the consent forms to manage a resident's personal funds account had a signature line for the resident's representative payee, guardian, conservator, trustee and legal representative. The NHA said since the facility was the resident's representative payee she thought the facility was able to consent to the accounts. -However, the consent form documented Anyone signing for the resident must sign the certification below. I, the undersigned, certify that I am the legal representative as stated below for the above named resident and agree to all the terms stated above and will provide valid legal supporting documentation of my legal capacity and authority upon the facility's request. The NHA said the facility was not able to provide valid legal supporting documentation of the legal capacity and authority because the facility did not have it.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 48412 Based on record review and interviews, the facility failed to ensure money from personal funds accounts was managed accurately for two (#2 and #7) of five residents reviewed for personal funds accounts out of 41 sample residents. Specifically, the facility failed to notify Resident #2 and Resident #7, who were Medicaid funded, or their legal representative, when the resident's personal funds account reached $200.00 less than the eligibility resource limit for one person. Findings include: I. Facility policy The Personal Needs Trust Account policy, undated, was provided by the nursing home administrator (NHA) on 5/8/24 at 4:38 p.m. It read in pertinent part, This facility recognizes and honors the requirements as stated in the federal regulation in regard to residents' personal funds. The facility shall notify each resident that receives Medicaid benefits if the amount in the account, in addition to the residents' other nonexempt resources, reaches the resource limit for one person. The resident shall be notified as the resident may lose eligibility for Medicaid if they go over the allowed amounts. II. Record review A. Resident #2 A review of the facility's current trust account balance revealed Resident #2 had $2001.71 in her account as of 5/8/24, which was $1.07 over the allotted limit for Medicaid funded residents. -There was no documentation to indicate the facility had notified Resident #2 or her legal representative when her personal funds account reached $200 less than the eligibility resource limit. B. Resident #7 A review of the facility's current trust account balance revealed Resident #7 had $1,867.63 in her account as of 5/8/24. -There was no documentation to indicate the facility had notified Resident #7 or her legal representative when her personal funds account reached $200 less than the eligibility resource limit. III. Staff interviews (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA and business office manager (BOM) were interviewed together on 5/8/24 at 1:27 p.m. The NHA said the BOM had just discovered Resident #2's account was over $2000.00 and Resident #7's account was more than $200 less than the eligibility resource limit. The BOM said she was going to notify the residents or their legal representatives about the funds in their accounts. The BOM said she was going to audit all of the residents' accounts to ensure all notifications were made in the correct amount of time. IV. Facility follow-up Resident fund balance notifications were provided by the BOM on 5/8/24 at 4:01 p.m. The notifications were provided to Resident #2 and Resident #7 on 5/8/24 (during the survey) and documented their account balances were within $200 or exceeding what was allowable under Medicaid Assistance.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on record review and interviews, the facility failed to ensure each residents had the right to formulate an advance directive for three (#36, #37 and #57) of five residents reviewed for advance directives out of 41 sample residents. Specifically, the facility failed to: -Provide written advance directive forms or discussions to Resident #36, #37 and #57; -Re-evaluate Resident #36, #37 and #57 for their decision-making capacity periodically; and -Re-evaluate Resident #36, #37 and #57 periodically to determine if their advance directives were still in line with their wishes. Findings include: I. Facility policy and procedure The Advance Directives policy, revised September 2022, was provided by the corporate consultant (CC) on 5/9/24 at 12:00 p.m. It read in pertinent part, Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The interdisciplinary team conducts ongoing review of the residents decision-making capacity and identifies the primary decision-maker if the resident is determined not to have decision-making capacity. Changes are documented in the care plan and medical record. If the resident does not have an advance directive, the resident or representative is given the option to accept or decline assistance, and care will not be contingent on either decision. II. Resident #36 A. Resident status Resident #36, over the age of 65, was admitted on [DATE]. According to the May 2024 computerized physician order (CPO), diagnoses included cerebral palsy, osteoarthritis, and generalized muscle weakness. According to the 3/9/24 minimum data set (MDS) assessment, Resident #36 was moderately cognitively impaired with a BIMS score of nine out of 15. -The assessment revealed Resident #36 was unable to answer what the correct year or month was and could not recall one of three words during the assessment. B. Resident interview (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #36 was interviewed on 5/6/24 at 2:24 p.m. Resident #36 said he did not know what an advance directive was and he was unsure if he had one. Resident #36 said he liked to make medical decisions with his family when possible but he was unsure when he last asked them for advice or help in medical decisions. Resident #36 said he had not discussed medical decision-making or advance directives since he arrived at the facility (June 2021) C. Record review A physician's visit progress note, dated 3/26/24, documented the resident had cognitive impairment and that the resident was alert and oriented times three. -However, the resident was unable to recall what an advance directive was or if he had one (see resident interview above). A Medical Orders for Scope and Treatment (MOST) form was completed on 5/1/21 and was signed by Resident #36. The comprehensive care plan dated 3/20/23 identified the resident had impaired neurological status. Pertinent interventions included monitoring and reporting to the provider any changes in cognitive function. The care plan dated 3/16/23 identified an activities of daily living (ADL) self-performance deficit related to cognitive impairment. The multidisciplinary care conference progress note, dated 3/14/24, documented Resident #36 was alert and oriented and able to make needs known. -However the resident was unable to recall what an advance directive was or if he had one (see resident interview above). -No medical-durable power of attorney (MDPOA) was documented in Resident #36's electronic medical record (EMR). -There was no written advance directive documented in Resident #36's EMR to indicate an advance directive discussion had been had with Resident #36 or his MDPOA. III. Resident #37 A. Resident status Resident #37, age 83, was admitted on [DATE] and readmitted on [DATE]. According to the May 2024 CPO, diagnoses included dementia, altered mental status, and metabolic encephalopathy (a problem in the brain resulting from blood imbalances). The 3/22/24 MDS assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 10 out of 15. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The assessment revealed Resident #37 was unable to recall the month or day of the week and required cueing to recall words during the assessment. B. Record review A MOST form was completed on 5/7/21 and was signed by Resident #37. A progress note, dated 12/13/23, documented Resident #37's POA verbally consented to the Covid SpikeVac booster. A progress note, dated 1/10/24, documented Resident #37's POA gave consent for the respiratory syncytial virus (RSV) vaccination. A progress note, dated 2/3/24, documented nursing staff requested permission from the resident's POA to send the resident to the emergency room . A progress note, dated 2/13/24, documented a discussion between nursing staff and the POA regarding a new medication order for the resident. The documentation included decisions made by the POA regarding medications for Resident #37. A progress note, dated 3/4/24, documented POA notification by nursing staff for newly identified hip and back pain. A progress note, dated 3/15/24, documented Resident #37's POA signed consent at admission for the resident to receive the Prevnar 20 vaccination. A progress note, dated 3/21/24, documented a nursing staff member called Resident #37's family. The progress note documented the POA understood the appointment and he would be accompanying the resident to her next appointment. A progress note, dated 3/27/24, documented nursing staff membercalled the resident's power of attorney (POA) and reminded him of upcoming appointments for the resident. -There was no medical durable power of attorney (MDPOA) identified or documented in Resident #37's EMR. -Despite multiple progress notes indicating the facility called Resident #37's POA for consents and appointments, there was no documentation to indicate the POA had been notified to discuss the resident's advance directives. IV. Resident #57 A. Resident status Resident #57, over the age of 65, was admitted on [DATE]. According to the May 2024 computerized physician order (CPO), diagnoses included dementia, chronic obstructive pulmonary disease (COPD), and high blood pressure (hypertension). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 4/20/24 MDS assessment, Resident #57 was cognitively intact with a BIMS score of 13 out of 15. B. Record review A MOST form was documented in Resident #57's EMR and signed by a family member identified as the MDPOA. The date the form was signed was unreadable. -However, there was no MDPOA form documented in the EMR. -There was no written advance directive documented in Resident #57's EMR to indicate an advance directive discussion was had with Resident #57, who had a BIMS score of 13 out of 15 C. Resident Interview Resident #57 was interviewed on 5/6/24 at 9:58 a.m. Resident #57 said he received help from his family about medical decisions when he wanted to involve them, but usually made his decisions himself. Resident #57 was aware of the MDPOA identified on his Colorado MOST form, and agreed the identified family member helped him with medical decisions occasionally. Resident #57 could not recall if the facility ever asked him about his advance directive wishes, or if the facility ever helped him complete advance directives. IV. Staff interviews The nursing home administrator (NHA) was interviewed on 5/8/24 at 8:57 a.m. The NHA said Resident #36, Resident #37 and Resident #57 did not have any advance directives on file. The NHA said there was no documentation of advance directive discussions offered to Resident #36, Resident #37 or Resident #57. The social services director (SSD) was interviewed on 5/9/24 at 12:24 p.m. The SSD said there was no MDPOA documentation completed for Resident #36, Resident #37 or Resident #57. The SSD said there was no documentation of advance directive discussions with Resident #36, Resident #37 or Resident #57. The SSD said she interviewed residents about their existing advance directives and offered to complete a MOST form on admission. The SSD said residents who had advance directives needed to make their advance directive needs known to hold an advance directives discussion or complete advance directives. The SSD agreed residents should be re-evaluated for updates to their advance directives. The SSD said Resident #36, Resident #37 and Resident #57 had not been revisited for advance directive discussions. The SSD said she did not know how to approach situations where residents were already moderately cognitively impaired with no written advance directive. The SSD said she would seek more education about how to establish a surrogate decision-maker legally in those situations in the future. The SSD said she did not know if discussions regarding advance directives should be documented. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) and the NHA were interviewed on 5/9/24 at 1:48 p.m. The DON said there was an advance directive discussion with residents upon admission but it was not documented. The DON said it was important for cognitively impaired residents to have an identified decision maker so the care team could honor resident wishes if they were unable to make their own decisions. The NHA said admission advance directive discussions included asking the resident if they had an advance directive and offering to complete the MOST form. The NHA said residents with cognitive impairment should have an identified decision maker. The DON and the NHA said advance directive discussions should be re-offered to residents. The DON and the NHA reviewed the EMR for Resident #36, Resident #37 and Resident #57. The DON and the NHA said no advance directives were in the EMR for Resident #36, Resident #37 or Resident #57. The DON and the NHA said there was no documentation of advance directive discussions being held, or advance directives completion being offered to Resident #36, Resident #37 or Resident #57.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on interviews and record review, the facility failed to ensure two (#1 and #20) of three residents reviewed for abuse were free from abuse out of 41 sample residents. Specifically, the facility failed to ensure Resident #1 was free from potential sexual abuse by Resident #20. Findings include: I. Facility policy and procedure The Resident Safety policy, undated, was provided by the facility on 5/9/24 The policy read in pertinent part, It is the policy of our facility to maintain a work and living environment that is professional and free from threat and/or occurrence of harassment, abuse (verbal, mental or sexual), neglect, corporal punishment, involuntary seclusion and misappropriation of property. Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms. Making reasonable efforts to provide a safe environment for the residents is one of the most basic and essential duties of the facility. It is the responsibility of all supervisors to work together to supervise employees in a manner to improve their effectiveness in dealing with aggressive and/or inappropriate behaviors or reactions of residents. It is the responsibility of the nursing supervisors to monitor that needed care is provided in accordance with the plan of care. The quality assurance manager and or the supervisor on duty will assess the resident and document the date, time and location of the reported or suspected incident. The supervisor will ensure the residents were protected from harm during the investigation. An incident report will be completed. The quality assurance manager and or supervisor on duty will attempt to interview the resident as well as all nursing, housekeeping, laundry, dietary, activity, social service staff, and any visitors or others that may have knowledge of the occurrence or who may have been in the vicinity at the time the incident happened the quality assurance manager and/or supervisor on duty will prepare a written summary of each interview. Upon completion of the investigation a written summary will be prepared by the administrator or designee. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Our safety policy and system cannot and does not guarantee that abuse will never occur. Our facility's goal is to take responsible measures so that abuse can be prevented. According to the policy, sexual abuse was defined as, but not limited to, sexual harassment, sexual coercion or sexual assault. II. Incident of sexual abuse of Resident #1 by Resident #20 A. Incident on 4/19/24 The 4/19/24 abuse summary was provided by the nursing home administrator (NHA) on 5/7/24 at 3:50 p.m. The summary identified Resident #20 inappropriately touched and attempted to kiss Resident #1 in a high visual common area in the facility. The incident occurred for well over 10 minutes. The summary identified certified nurse aide with medication aide authority (CNA-Med) #2 notified the NHA on 4/19/24 at 12:35 p.m. that Resident #20 groped Resident #1. The facility's video surveillance footage identified Resident #20 self propelled his wheelchair towards Resident #1 on 4/19/24 at 12:20 p.m. Resident #1 was positioned in a recliner (in the living room). Resident #20 looked around the area and proceeded to rub Resident #1's left thigh. Then he moved his hand between her legs to her groin area. Both residents were fully clothed. Resident #20 continued to touch and rub Resident #1's groin for several minutes and then began to kiss her. Resident #20 tried to push him away but he continued. Resident #20 placed his finger on her lips to shush her. According to the summary, the inappropriate touching went on for ten minutes until a staff member observed the situation and removed Resident #20 immediately. A physical assessment was performed on Resident #1. She had no obvious injury or signs and symptoms of injury. According to the summary, Resident #1 was not able to speak. Her words were garbled (incomprehensible). Both of the residents were taken to their rooms immediately after the incident. The summary documented Resident #20 was placed on 15 minute checks. According to the summary, staff had been educated to always have two staff when providing care for him and during a shower. A male certified nurse aide (CNA) would help with the shower when available. The summary identified the resident had a history of inappropriate comments and actions towards staff. The facility was actively seeking alternative placement for Resident #20 and would continue to monitor him every 15 minutes. Resident #20 would be redirected by staff when he was inappropriate. The facility, the resident's family and adult protective services were made aware of the incident. According to the summary, residents were interviewed and had not been inappropriately touched or seen anyone inappropriately touch anyone else. Staff members had not seen any inappropriate touching other than the 4/19/24 incident. B. Resident #20 1. Resident status Resident #20, over the age of 65, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnosis included Parkinson's disease without dyskinesia (involuntary movements), dementia with other behavioral disturbances, other sexual dysfunction not due to a substance or known physiological condition, anxiety and depression. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/4/24 minimum data set (MDS) assessment identified Resident #20 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The assessment did not identify he had physical, verbal, or other behavioral symptoms directed at others. The functional ability on admission identified the resident used a wheelchair for mobility. He had impairment to both sides of his lower extremities. He did not have impairment to his upper extremities. 2. Record review The mood and behavior care plan, initiated on 1/11/24 and revised on 5/7/24, identified Resident #20 had behaviors related to anxiety and sadness over his health, agitation, poor impulse control, and inappropriately touching others. The care plan documented the following pertinent interventions that were implemented on 1/11/24: -Keeping the resident safe during episodes of behaviors and redirecting; -Monitoring and documenting episodes of inappropriate behaviors; -Notifying physician when the resident's behaviors persisted or escalated; -Monitoring behavior episodes and attempting to determine the underlying cause with consideration location, time of day, persons involved, and situations; and, -Offering psychologist/psychiatrist services as needed. -A review of the mood and behavior care plan identified there were no new care planned interventions initiated after the 4/19/24 sexual abuse incident to prevent the incident from reoccurring with Resident #1 or other residents. The routine safety check log was provided by the NHA on 5/8/24 at 11:38 a.m. The log indicated Resident #20 was monitored every 15 minutes between 4/19/24 and 5/8/24. The 15 minute checks began at 9:00 p.m. on 4/19/24. A 4/23/24 physician's order (written four days after the incident) instructed staff to monitor the resident's behaviors of poor impulse control and inappropriately touching others. The harm to self and others care plan was initiated on 5/7/24 (during the survey). The care planned interventions directed staff to: -Monitor and manage undesirable behaviors; -Notify provider if the resident poses a potential threat to injure self; -Allow the resident personal space space if safe; -Initiate visual supervision during acute episode if the resident was wandering or pacing; -Maintain consistent schedule with daily routine; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Minimize environmental stimuli; -Monitor for cognitive, emotional or environmental factors that may contribute to violent behaviors; -Monitor the resident for signs/symptoms of agitation; -Offer resident acceptable alternatives to unacceptable situation; -Provide clear, simple instructions; -Provide reorientation to situation; -Provide verbal feedback to Resident regarding behavior; -Utilize calming touch; and, -Utilize diversion techniques as needed. C. Resident #1 1. Resident status Resident #1, age under 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included anoxic brain damage (caused when the brain was deprived of oxygen), other specified depressive episodes, attention and concentration deficit, a disorder of adult personality and behavior, cognitive communication deficit, sexual disorder and impulse disorder. The 3/9/24 MDS assessment documented Resident #1 was unable to complete a BIMS because she was rarely or never understood. The staff assessment for mental status documented Resident #1 had a memory problem and could not recall the current season, the location of her room, staff names and faces, or that she was admitted to a nursing home. Resident #1's cognitive skills for decision-making were severely impaired. 2. Record review Resident #1's communication care plan, revised on 6/14/23, identified she had impaired communication due to her cognitive impairment. Pertinent interventions identified the resident needed: -Ample time for the resident to comprehend what was said and allow time for a response; -Conversations in calm, quiet locations with minimal background noise; -Staff to pay attention to the resident's body language and facial expressions; -Staff to request feedback from the resident to ensure understanding; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Grande Rehabilitation and Healthcare Center	680 E Hospital Dr Cortez, CO 81321

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Simple and direct communication to promote understanding and use gestures or pictures if necessary; and, -The utilization of family or an interpreter for communication as needed. Resident #1's activities of daily (ADL) self-care care plan, revised on 6/14/23, identified she had an ADL self-care performance deficit due to her history of falls, impaired ability to make self-understood, intellectual disabilities and poor coordination. The care plan identified she required assistance with ADLs and assistive devices for mobility. Resident #1's cognition care plan, revised on 6/14/23, identified the resident's impaired cognitive function including inattention and difficulty focusing her attention. She was easily distracted and startled easily to any sound or touch. Resident #1 responded to voice or touch. She had poor safety awareness. She had trouble keeping track of what was being said and had disorganized thinking or incoherent thinking. Resident #1's psychiatric and mood care plan, revised on 6/14/23, documented she had an impaired psychiatric and mood status which referred to anoxic brain damage and cognitive communication deficit. Pertinent interventions identified the resident needed: -Staff to monitor her for signs of mood changes or distress to determine if any identified problems were related to external causes; Staff to offer the resident encouragement, assistance and support to maintain as much independence and control as possible; -Staff to offer the resident choices whenever possible in order to promote a feeling of self-worth and control over the environment; and, -Staff to provide a calm, safe environment when the resident was emotional or frustrated and allow time to voice her feelings. Resident #1's behavioral care plan, revised on 9/12/23, identified she had behaviors which included depressive episodes, a disorder of adult personality and behavior, and sexual disorders. The care plan did not include interventions to keep her safe from potential abuse. III. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 5/8/24 at 9:24 a.m. CNA #2 said she did not work with Resident #20 often other than to occasionally help him use the bathroom. She said was not aware of any specific precautions or awareness pertaining to Resident #20. CNA #1 was interviewed on 5/8/24 at 9:34 a.m. CNA #1 said she was told Resident #20 had been sexually inappropriate with Resident #1. She said she was told just to monitor him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #1 was interviewed on 5/8/24 at 9:40 a.m. RN #1 said she was informed of the incident between Resident #20 and Resident #1. RN #1 said she made sure she always knew where Resident #20 was at all times. She said she was not aware of any other incidents with Resident #20 other than he asked staff if he could compliment them. The NHA was interviewed on 5/8/24 at 9:45 a.m. The NHA said the 4/19/24 incident between Resident #20 and Resident #1 was reported and confirmed. The NHA said the incident was caught on video. She said the police reviewed the video and adult protective services has the only copy of the video. The NHA said her investigation was primarily viewing of the video. She said the camera shot right in the direction of the incident in the living room. She said there was a clear view of what occurred on 4/19/24. She said dietary aide (DA) #2 was the first to see the incident. She said she did not have DA #2 complete a witness statement because the incident was caught on video. The NHA said the staff interviews were random. She said she asked the CNAs who worked on Resident #20's hall about his behavior or concerns. She said the dietary staff came up to her and told her he had touched the back of a dietary aide and he made inappropriate comments to them. The NHA said she did not document her interviews with staff as part of the investigation. The NHA said the staff did not identify Resident #20 had been inappropriate to other residents or had other incidents with Resident #1. The staff said Resident #20 had a history of inappropriate behaviors such as sexual remarks and gestures. The NHA said she had difficulty getting the staff to document Resident #20's behaviors and comments. She said it was a learning curve to teach staff how to document and not be subjective. She said she had to continue to remind them to document. She said she had been trying to initiate a behavior contract with Resident #20 but it was hard to establish the behaviors when she could not refer to the documentation. The NHA said she interviewed three to four alert and oriented residents in the dining room before bingo as part of the investigation. She said she asked them general vague questions and did not use a standard form. The NHA said the residents said they felt safe and were not aware of any concerns. The NHA said she did not document the interviews. The NHA said the 4/19/24 incident between Resident #20 and Resident #1 happened in the living room across from the nursing station which was a high visual area. She said the incident happened at approximately 12:35 p.m. and staff were passing medications, answering call lights and helping residents out of the dining room at the time. The NHA said the review of the camera surveillance on the 4/19/24 incident identified CNA #2 walked past Resident #20 and Resident #1 during the incident. She said CNA #2 was not paying attention to what was going on around her because she was using her cell phone. The NHA said she spoke to CNA #2 and instructed her to pay attention to the residents and be more aware of her surroundings. The NHA said she conducted an informal education huddle with staff after the incident. The NHA said she directed staff to increase their attention and supervision of residents. She said she did not document the education that was provided to the staff. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said interventions implemented after the 4/19/24 incident was the ongoing implementation of checking on Resident #20 every15 minutes (see record above). She said Resident #20 had not had incidents with Resident #1 or any other residents since the 4/19/24 incident. She said two staff members now showered Resident #20 instead of one as an intervention. The NHA said staff redirected Resident #1 when she wandered down the hallways as an intervention to help prevent a similar incident from reoccuring. The NHA said Resident #1 used to have very inappropriate behaviors of touching herself around others so a jumpsuit was incorporated to prevent Resident #1 from taking her clothes off (cross reference F604 for failure to ensure residents were free from physical restraints). She said the jumpsuit intervention was implemented prior to the 4/19/24 incident with Resident #20. The NHA said Resident #20 had no recent concerns of self harm or harm to others. She said the MDS coordinator added Resident #20's new care plan on 5/7/24 (see record review above) because she was reviewing all resident care plans on the week of 5/7/24. 48412

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on observations, record review and interviews, the facility failed to ensure residents were free from physical restraints for two (#1 and #27) of three residents out of 41 sample residents. Specifically, the facility failed to ensure: -Resident #1 was evaluated for the use of a restraint; -Consent was signed for the use of a restraint for Resident #1; -Obtain a physician's order for the use of a restraint for Resident #1; -Quarterly safety risk assessments were completed for the use of restraints for Resident #1; -Less restrictive measures attempted and proven unsuccessful for Resident #1 and Resident #27 were documented; -Risks versus benefits of restraint use were completed by the physician for Resident #1 and Resident #27; and, -Trial periods without the restraints were attempted for Resident #1 and Resident #27 to determine if the restraints were still necessary. Findings include: I. Facility policy The Use of Restraints policy, revised April 2017, was provided by the corporate consultant (CC) on 5/9/24 at 12:00 p.m. It read in pertinent part, Restraints shall only be used for the safety and well-being of the resident and only after other alternatives have been tried unsuccessfully. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation of the need for restraints will be documented. Restraints may only be used if and when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention and a restraint is required to: -Treat the medical symptom; -Protect the resident's safety; and, -Help the resident attain the highest level of his or her physical or psychological well-being. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions that may improve the symptoms. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident or the resident's representative. The order shall include the following: -The specific reason for the restraint as it relates to the resident's medical symptom; -How the restraint will be used to benefit the resident's medical symptoms; and, -The type of restraint and period of time for the use of the restraint. Orders for restraints will not be enforced for longer than twelve (12) hours unless the resident's condition requires continued treatment. Reorders are issued only after a review of the resident's condition by his or her physician. A resident placed in a restraint will be observed at least every thirty (30) minutes by nursing personnel. Residents or resident representatives shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints and the alternatives to restraint use. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraint or total restraint elimination. Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptoms but the underlying problems that may be causing the symptoms. Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use. II. Resident #1 A. Resident status Resident #1, age less than 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included anoxic brain damage (caused when the brain was deprived of oxygen), other specified depressive episodes, attention and concentration deficit, a disorder of adult personality and behavior, cognitive communication deficit, sexual disorder and impulse disorder. The 3/9/24 minimum data set (MDS) assessment documented Resident #1 was unable to complete a brief interview for mental status (BIMS) because she was rarely or never understood. The staff interview documented Resident #1 had a memory problem and could not recall the current season, the location of her room, staff names and faces, or that she was admitted to a nursing home. Resident #1's cognitive skills for decision-making were severely impaired. The assessment did not identify restraints were being used for Resident #1. B. Observations On 5/6/24 at 3:15 p.m., Resident #1 was observed wearing a one piece outfit with a zipper on the back that was out of Resident #1's reach to remove herself. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 3:17 p.m. Resident #1 was observed lying in bed. She sat up and tried communicating. Resident #1 stood up and grabbed at her peri-area and said she had to use the restroom. Due to wearing an outfit with a zipper on her back, she could not use the restroom without staff assistance. On 5/7/24 at 12:57 p.m., Resident #1 was observed wearing an outfit with a zipper on the back that was out of Resident #1's reach to remove herself. On 5/8/24 at 11:15 a.m., Resident #1 was observed wearing an outfit with a zipper on the back that was out of Resident #1's reach to remove herself. On 5/9/24 at 7:23 a.m., Resident #1 was observed wearing an outfit with a zipper on the back that was out of Resident #1's reach to remove herself. C. Record review Resident #1's care plan, revised on 9/12/23, documented she had behaviors due to depressive episodes, a disorder of adult personality and behavior, sexual disorders, an eating disorder where she ate non-food items, attention and concentration deficit and an impulse disorder. The interventions were documented as follows: Wearing clothing that zipped in the back to prevent the resident from removing clothes in public areas. Staff to assist with dressing and toileting routinely and as needed; Monitoring and documenting episodes of inappropriate behavior, notifying the physician when behaviors persisted or did not de-escalate; Monitoring behavior episodes and attempting to determine the underlying cause. Considering location, time of day, persons involved and citations; Offering psychologist or psychiatrist services as needed; Offering resident choices whenever possible in order to promote a feeling of self-worth and control over the environment and care delivery. Encouraging participation from the resident to make her own decisions; and Providing positive feedback to the resident when behavior was appropriate, emphasizing the positive aspects of compliance. -However, the facility failed to document measures taken to systematically reduce or eliminate the need for the restraint (jumpsuit with the zipper in the back which the resident could not reach). A long-term care evaluation, completed on 2/4/24, documented the resident's mood was pleasant with no recent changes. Resident #1 was not experiencing unwanted behaviors. A long-term care evaluation, completed on 3/4/24, documented the resident's mood was pleasant with no recent changes. The resident was experiencing unwanted behaviors, chronic repetitive behaviors, chronic disruptive behaviors and chronic wandering. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The evaluation failed to document what behaviors the resident exhibited. A long-term care evaluation, completed on 4/4/24, documented the resident's mood was pleasant with no recent changes. Resident #1 was not experiencing unwanted behaviors. A long-term care evaluation, completed on 5/4/24, documented the resident's mood was pleasant with no recent changes. The resident was experiencing unwanted behaviors, chronic repetitive behaviors, chronic disruptive behaviors and chronic wandering. -The evaluation failed to document what behaviors the resident exhibited. -Review of Resident #1's EMR failed to reveal a signed consent for Resident #1's restraint. -Review of Resident #1's EMR failed to reveal a physician's order for Resident #1's restraint. -Review of Resident #1's EMR failed to reveal risks versus benefits of the jumpsuit restraint were completed by the physician. -Review of Resident #1's EMR failed to reveal an initial evaluation for the use of Resident #1's restraint or ongoing quarterly assessments for the continued use of the jumpsuit with the zipper in the back. -Review of Resident #1's EMR failed to reveal documentation of less restrictive measures than the jumpsuit to prevent Resident #1 from removing her clothes in public areas. -Review of Resident #1's EMR failed to reveal documentation to indicate the facility had attempted a trial period without the jumpsuit for Resident #1 to see if the resident still had the behavior of removing her clothes in public which warranted the continued use of the jumpsuit. D. Staff interviews The social service director (SSD) was interviewed on 5/9/24 at 11:25 a.m. The SSD said she did not know Resident #1's backward jumpsuits were restraints and she did not have a signed consent from the resident's representative. The SSD said she was new to the position and did not do any sort of audit of restraints or diagnoses when she started at the facility. The SSD said she was going to have Resident #1's representative sign a consent form for the resident's restraint. The nursing home administrator (NHA) was interviewed on 5/8/24 at 1:27 p.m. The NHA said Resident #1 was admitted in 2019 and her representative requested she wear a backward jumpsuit with a zipper on it because she took her clothes off in the common areas. The NHA said there was no documentation of what other interventions were attempted and were unsuccessful to prevent her from removing her clothes in public. She said a physician's order for the backward jumpsuit was not in Resident #1's EMR because she did not realize the outfit was a restraint. The NHA said the facility did not attempt to have Resident #1 not wear the backward jumpsuit to determine if the restraint was still needed. She said she was unaware of all the stipulations for a restraint, like the jumpsuit, because she did not realize it was a restraint. The NHA said the resident was unable to take the jumpsuit off without staff assistance and she realized that was a restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #3 was interviewed on 5/8/24 at 6:11 p.m. She said Resident #1 was very smart and needed staff to be patient with her. CNA #3 said Resident #1 had worn the backward jumpsuit since she was admitted because Resident #1's representative wanted the jumpsuit to be worn. CNA #3 said Resident #1 removed her clothes in common areas and was sexually inappropriate. CNA #3 said she had never seen the facility attempt to not use the backward jumpsuit. CNA #3 said most of Resident #1's behaviors were getting in other people's space or getting close to their faces. She said sometimes Resident #1 yelled at people. CNA #2 was interviewed on 5/9/24 at 3:47 p.m. CNA #2 said she heard Resident #1 had an incident where she removed her clothes in an inappropriate area and had worn the backward jumpsuit since then. CNA #2 said she had always seen Resident #1 in the jumpsuit. Registered nurse (RN) #1 was interviewed on 5/9/24 at 3:49 p.m. RN #1 said Resident #1 had worn the backward jumpsuit since the incident where she removed her clothing. E. Facility follow-up On 5/8/24 at 4:38 p.m., the SSD provided a copy of Resident #1's consent form which indicated the resident's representative gave verbal consent on 5/8/24 (during the survey) for the restraint of the backward jumpsuit. III. Resident #27 A. Resident status Resident #27, age greater than 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included dementia with behavioral disturbance, adult failure to thrive, cognitive-communication deficit and generalized weakness. The 3/9/24 MDS assessment revealed a BIMS was not completed for Resident #27 due to the resident rarely or never being understood. The staff assessment for mental status documented Resident #27 had a problem with short and long-term memory. She was unable to make decisions regarding tasks of daily life because she was severely impaired. The assessment documented Resident #27 did not have any behaviors. The assessment documented Resident #27 used a chair device that prevented her from rising, a bed alarm and a wander alarm daily. B. Observations On 5/6/24 at 3:49 p.m. Resident #27 was observed sleeping on her roommate's side of the room, in her wheelchair with the Lap Buddy in place. On 5/7/24 at 12:57 p.m. Resident #27 was observed sleeping in her wheelchair with the Lap Buddy in place at the nurses'station. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:17 p.m. Resident #27 was observed self-propelling her wheelchair toward the nurses'station. She stopped at the end of the B Hall and fell asleep resting on her Lap Buddy. C. Record review Resident #27's care plan, revised 6/15/23, documented she was at risk for elopement due to exit-seeking behaviors, history of elopement, verbalizing she wanted to leave the facility and wandering. Interventions included calmly redirecting and diverting the resident's attention, evaluating for the need of a wanderguard, promptly checking when the alarm system went off the ensure the resident was safe and remained in the facility, redirecting the resident when wandering or if she was insistent on leaving the facility by offering pleasant diversions, structured activities, food, conversation, television and books, monitoring placement and function of the resident's wanderguard and periodically evaluating for the need of the wanderguard, and setting up meetings with the family or guardian to determine if the resident may need a more appropriate facility if elopement attempts continued. -However, the facility failed to evaluate if the wanderguard was needed for continued use (see below). Resident #27's care plan documented she was at risk for injuries due to a Lap Buddy (physical restraint) being used. The interventions included checking the Lap Buddy every 30 minutes, releasing it every two hours and removing the device during meal times, applying the device as ordered, monitoring the resident for complications related to restraint use and reporting any identified complications to the medical director (MD), periodically completing appropriate restraint or enabler evaluations and reviewing with the resident, family or responsible party regarding the risks versus the benefits of restraint use. -The care plan failed to document what the Lap Buddy was used for. A social service assessment note, completed on 8/25/23, documented Resident #27 was at risk for wandering and had a wanderguard placed on her ankle. A restraint enabler decision note, dated 11/22/23, documented that the wanderguard did not prevent the resident from performing an action that she was otherwise capable of performing. The alarm sounded when the resident was near an exit and alerted staff. A restraint enabler decision note, dated 2/22/24, documented that the wanderguard and lap buddy were ordered restraints. The devices ordered did not prevent the resident from performing an action that she was otherwise capable of performing. The alarm sounded when the resident was near an exit and alerted staff. The Lap Buddy alerted the staff when the resident attempted to self-transfer and the restraints were for the resident's safety. A long-term care evaluation, completed on 1/29/24, documented the resident's mood was pleasant with no recent changes and she experienced no unwanted behaviors. Resident #27 was not wandering at night and slept through the night. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A long-term care evaluation, completed on 2/29/24, documented the resident had a flat affect with no recent changes in her mood. Resident #27 was experiencing unwanted behaviors which included chronic repetitive behaviors, chronic disruptive behaviors, chronic wandering behaviors and chronic behavior of resisting care. The resident was not wandering at night and slept through the night. A long-term care evaluation, completed on 3/31/24, documented the resident's mood was pleasant with no unwanted behaviors. Resident #27 slept through the night. A long-term care evaluation, completed on 5/2/24, documented the resident's mood was pleasant with no unwanted behaviors. Resident #27 slept through the night. -There were no progress notes documented in Resident #27's EMR to indicate the resident continued to wander or attempt to stand up from her wheelchair. -Review of Resident #27's EMR failed to reveal risks versus benefits of the wanderguard and the Lap Buddy restraints were completed by the physician. -Review of Resident #27's EMR failed to reveal documentation to indicate the facility had attempted a trial period without the wanderguard or the lap buddy for Resident #27 to see if the resident still had behaviors to warrant the use of the restraints. D. Staff interviews The NHA was interviewed on 5/8/24 at 1:27 p.m. The NHA said Resident #27's behaviors had gotten better. She said the resident had the lap buddy because she used to try to stand up from her wheelchair and had poor safety awareness. She said Resident #27 was at risk for falls and the facility used the lap buddy as an intervention. The NHA said a wanderguard was in place because the resident wandered and still wandered. She said Resident #27 self-propelled to the main entrance and pushed the door until it alarmed, opened the door and went outside. The NHA said there was no documentation for what other interventions were attempted and were unsuccessful. The NHA said Resident #27 had a physician's order and a representative's consent for the restraints. The NHA was unable to provide risks versus benefits and the previous measures attempted before the facility implemented the restraints. She said the facility never attempted a trial without the Lap Buddy because Resident #27 used the restraint to position her arms and sleep while in her wheelchair. She said the facility never attempted a trial without any of Resident #27's restraints.

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to ensure two (#57 and #36) of six residents with limited range of motion received appropriate treatment and services out of 41 sample residents. Specifically, the facility failed to: -Provide restorative therapy services to Resident #57 and Resident #36; and, -Provide ordered occupational therapy services to Resident #36. Findings include: I. Facility Policy The Activities of Daily Living (ADL) policy, revised March 2018, was provided by the corporate consultant (CC) on 5/9/24 at 12:00 p.m. It read in pertinent part, Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. The existence of a clinical diagnosis or condition does not alone justify a decline in a resident's ability to perform ADL's. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preference, stated goals and recognized standards of care. The Scheduling Therapy Services policy, revised July 2013, was provided by the CC on 5/9/24 at 12:00 p.m. It read in pertinent part, Therapy services shall be scheduled in accordance with the resident's treatment plan. The Restorative nursing services policy, revised July 2017, was provided by the CC on 5/9/24 at 12:00 p.m. It read in pertinent part, Restorative care goals are individualized and resident-centered, and are outlined in the resident's plan of care. II. Resident #57 A. Resident status Resident #57, age greater than 65, was admitted on [DATE]. According to the May 2024 computerized physician order (CPO), diagnoses included dementia, chronic obstructive pulmonary disease (COPD), and high blood pressure (hypertension). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 4/20/24 minimum data set (MDS) assessment, Resident #57 was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. He required partial or moderate assistance with bathing and standing from a sitting position. He required supervision or touching assistance with toileting, oral hygiene, eating and dressing. B. Resident interview Resident #57 was interviewed on 5/6/24 at 9:46 a.m. Resident #57 said he was not receiving enough restorative therapy to maintain his abilities. The resident said he wanted to work on walking more but this was not being done. Resident #57 said moving in the bed and transferring to his wheelchair had become more difficult for him which worried him. C. Record review Review of the comprehensive care plan, initiated 5/6/24, included a goal for the resident to maintain his current level of ADL function. Review of the multidisciplinary care conference note, dated 4/11/24, documented Resident #57 required restorative therapy for bed mobility, passive range of motion, active range of motion, transfers, communication, dressing and grooming. Resident #57 required six days a week, for 15 minutes per session, of each restorative therapy to have no loss in current functional abilities. Restorative therapy documentation was reviewed between 4/11/24 and 5/9/24, a four week period of time representing 24 opportunities for restorative services. -Bed mobility restorative services were documented as being provided three times out of 24 opportunities. -Transfer restorative services were documented as being provided 12 times out of 24 opportunities. -There was no documentation to indicate why the restorative services were not provided as required and there were no documented refusals to participate by the resident. III. Resident #36 A. Resident status Resident #36, age greater than 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included cerebral palsy (a condition that affects movement and posture), osteoarthritis, and generalized muscle weakness. According to the 3/9/24 MDS assessment, Resident #36 had moderate cognitive impairment with a BIMS score of nine out of 15. He required substantial or maximum assistance with oral hygiene, toileting, bathing and dressing. He required supervision or touching assistance only with eating. B. Resident interview (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #36 was interviewed on 5/6/24 at 10:53 a.m. Resident #36 said he was not receiving enough restorative therapy or occupational therapy. Resident #36 said he had a diagnosis of cerebral palsy and it was very important for him to complete as much therapy as possible to prevent his cerebral palsy from progressing more rapidly. Resident #36 said he had been having more difficulty transferring to and from his wheelchair. C. Record review Review of the comprehensive care plan, initiated 3/16/24, included a goal for the resident to maintain his current level of ADL function. Resident #36 had a physician's order for occupational therapy services 48 times per week for 12 weeks, ordered on 4/2/24 by medical doctor (MD) #1. -However, the director of rehabilitation (DOR) and MD #1 said the physician's order was a mistake (see interviews below). Review of the multidisciplinary care conference note dated 3/14/24 documented Resident #36 required restorative therapy for bed mobility, passive range of motion, active range of motion, transfers, communication, dressing and grooming. Resident #36 required restorative services six days a week, for 15 minutes per session, of each restorative therapy to have no loss in current functional abilities. Restorative therapy documentation was reviewed between 3/14/24 and 5/3/24, a seven week period of time representing 42 opportunities for restorative services. -Bed mobility restorative services were documented as being provided seven times out of 42 opportunities. -Transfer restorative services was documented as being provided 14 times out of 42 opportunities. -There was no documentation to indicate why the restorative services were not provided as required and there were no documented refusals to participate by the resident. Occupational therapy (OT) notes were obtained from the NHA on 5/8/24 at 9:21 a.m. The OT notes documented Resident #36 received services on seven occasions between 4/2/24 and 5/7/24, a five week period of time. -There was no documentation to indicate why the OT services were not provided as ordered and there were no documented refusals to participate by the resident. IV. Interviews (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Restorative aide (RA) #1 was interviewed on 5/8/24 at 12:32 p.m. RA #1 reviewed the restorative services documentation for Resident #57 and Resident #36. RA #1 said Resident #57 and Resident #36 did not receive the amount of restorative services they were recommended to have. RA #1 said therapy staff were not present in the facility on the weekends and the certified nurse aides (CNA) were responsible for performing restorative services for residents on the weekends. RA #1 said all restorative documentation was in the resident's electronic medical record (EMR) and there was no paper documentation of restorative services. The DOR was interviewed on 5/8/24 at 12:45 p.m. The DOR said Resident #36 had a physician's order for occupational therapy 48 times per week was a physician error. The DOR said no one in the therapy department or the physician caught or corrected the error. The DOR said Resident #36 did not receive enough therapy even if it was ordered correctly for five therapy sessions per week. The DOR said the therapy department was short staffed in the month of April 2024 and that was why Resident #36 did not receive his scheduled amount of therapy. MD #1 was interviewed on 5/8/24 at 12:54 p.m. MD #1 said the occupational therapy order for services 48 times per week, ordered 4/2/24 by MD #1, was an error that was not caught by the medical team. MD #1 said Resident #36 should have received occupational therapy five times per week for 12 weeks. MD #1 did not know how much occupational therapy Resident #36 had received. Nurse aide (NA) #1 was interviewed on 5/8/24 at 2:20 p.m. NA #1 said she did not know what restorative services were and did not know if NAs or CNAs were involved in providing restorative care for residents. CNA #2 was interviewed on 5/8/24 at 2:24 p.m. CNA #2 said CNAs and NAs did not provide restorative services and that was done by the restorative services department. CNA #2 said CNAs were allowed to chart restorative services electronically in the EMR if they provided those services to the residents. The director of nursing (DON) and the nursing home administrator (NHA) were interviewed together on 5/9/24 at 1:58 p.m. The DON and the NHA reviewed restorative and occupational therapy documentation for Resident #57 and Resident #36. The NHA said Resident #57 and #36 did not receive enough restorative services as recommended. The DON said the occupational therapy order for Resident #36 was an error that should have been corrected. The NHA said Resident #36 did not receive enough occupational therapy services, even if MD #1's medical order had been corrected to five sessions per week. The NHA said she did not know who placed a goal for restorative services six times per week in both multidisciplinary care conferences, as restorative services were not usually offered on the weekend. The NHA said CNAs and NAs could provide restorative services to residents but they did not have time to do so. The NHA said the facility had difficulty maintaining therapy staff in the last few months and she expected the residents to receive less therapy if the facility did not have enough therapy staff.

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F 0689 Level of Harm - 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** 40467 Based on observations, record review and interviews, the facility failed to ensure the residents' environment remained as free of accidents/hazards as possible prevent falls for two residents (#3 and #58) of four residents reviewed for falls out of 41 sample residents. Resident #3, who had a history of falling, was admitted on [DATE] and readmitted on [DATE]. Resident #3's fall care plan, dated 4/5/23, documented the resident was to wear non-skid socks as a fall intervention. On 4/16/23 Resident #3 sustained an unwitnessed fall. There were no new fall interventions added to the resident's care plan until 6/16/23, when an intervention for a scheduled toileting program was implemented. However, the care plan did not specify when the resident was to be toileted. Between 7/1/23 and 1/19/24, Resident #3 sustained six more falls. Several of the falls during that time frame occurred while the resident was attempting to take himself to the bathroom, however, the facility failed to ensure staff was following a toileting schedule for the resident as had been care planned on 6/16/23. Additionally, the facility failed to ensure other care planned interventions were in place at the time of several of the falls, including the intervention for the resident to wear non-skid socks. The facility identified for the resident's falls on 7/1/23 and 7/14/23 that the resident's oxygen levels in his blood were low which potentially was a factor for the falls, however, the facility failed to implement a fall intervention in regards to the resident's use of his oxygen. The facility failed to implement new fall interventions after the resident's falls on 7/1/23, 7/14/23, two falls on 8/2/23 and 8/14/23. On 1/29/24, Resident #3 sustained an unwitnessed fall. At the time of the fall, the care planned intervention of the resident wearing non-skid socks was not followed and the resident's blood oxygen level was again low. The fall resulted in a hip fracture which required the resident to be transferred to the hospital for surgical repair of the fracture. Resident #3 was readmitted to the facility on [DATE]. The facility failed to implement any new fall interventions after the resident returned to the facility following repair of the fracture. On 4/17/24, Resident #3 sustained another fall when he was not wearing non-skid socks. The facility again failed to implement any new fall interventions until 5/7/24 (during the survey). Due to the facility's failures to ensure staff were consistently following care planned fall interventions for Resident #3 and the failure to implement new fall interventions after each fall, Resident #3 sustained a fall which resulted in a major injury. Additionally, the facility failed to consistently identify, implement, review and update Resident #58's fall care plan with effective interventions to prevent further falls from recurring (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Findings include: I. Facility policy The Falls Clinical Protocol policy, revised March 2018, was provided by the corporate consultant (CC) on 5/9/24 at 1:58 p.m. According to the policy, many falls were isolated to individual incidents, however, a few residents fell repeatedly. Those residents often had an identifiable underlying cause.The nurse should assess and document the precipitating factors and details on how the fall occurred. The staff and the physician should identify pertinent interventions to try to prevent subsequent falls and address the risks of clinically significant consequences of the falls. The policy outlined the need and process for the fall cause identification, treatment and management, and monitoring and follow up. The policy read in pertinent part: For an individual who has fallen, the staff and the practitioner will begin to try to identify possible causes within 24 hours of the fall. Often, multiple factors contribute to a falling problem. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions based on assessment of nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation. The staff and the physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed; for example, if the problem that required the intervention has been resolved by addressing the underlying cause. If the individual continues to fall, the staff and the physician will reevaluate the situation and consider possible reasoning for the resident's falling (instead of, or in addition to those that have been identified) and also reconsider the current interventions. II. Resident #3 A. Resident status Resident #3, over the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, history of falling, other abnormalities of the gait and mobility, generalized muscle weakness, age related osteoporosis, chronic obstructive pulmonary disease, hypoxemia, dependence on supplemental oxygen, neurocognitive disorder with Lewy bodies, unspecified intellectual disabilities, cognitive communication deficit and Parkinson's disease with dyskinesia (impairment in voluntary muscle movements). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	According to the 3/21/24 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of four out of 15. The MDS assessment did not identify the resident had any falls or fractures since his last assessment. According to the assessment, the resident was occasionally incontinent of urine. The MDS assessment marked the resident was not on a bowel and bladder toileting program. The resident had no behavioral symptoms or rejections of care. The assessment read the resident did not have alarms in place which monitored the residents movement and alerted staff when movement was detected. B. Observations Resident #3 was assisted out of the dining room by the environmental service director (ESD) on 5/6/24 at 12:03 p.m. He was reminded to use his call light. The resident had a low bed and a fall mat in front of his bed. The ESD left the resident's room. At 12:05 p.m. Resident #3 started to propel himself in his wheelchair into the bathroom. A certified nurse aide (CNA) walking passed the room saw the resident and quickly entered the room asking him to wait for her. The CNA assisted the resident in the bathroom. At 12:12 p.m. the CNA assisted the resident out of his room and into the living room. The resident was not transferred to a recliner (see interview below). Resident #3 was observed in the dining room on 5/7/24 at 2:29 p.m. during a bingo activity. He stood up from his wheelchair. The activity assistant (AA) #1 did not notice the resident standing up. The AA was alerted and assisted him back down to his wheelchair and offered him a tissue/napkin. She locked the resident's right brake and continued with the activity. At 2:37 p.m. Resident #3 stood up from his wheelchair again while he attempted to pull his pants slightly up from the back and sat back down. On 5/8/24 at 2:12 p.m. Resident #3 sat in the living room in a regular upright chair. The resident did not sit in a recliner and he was not wearing his oxygen. On 5/9/24 at 8:35 a.m. Resident #3 attempted to self transfer from his wheelchair to a couch in the front lobby. The resident had one hand on the arm of the wheelchair as he stood. His wheelchair was at an angle and not directly behind him. The resident's arms and legs shook. He was not able to complete the pivot towards the couch. Staff was not present as he attempted to transfer. The resident was not in view of staff or the hallway. The business office manager (BOM) was alerted to the fall risk as she walked down the hallway. The BOM assisted the resident to the couch and notified other staff. C. Record review The fall care plan, dated 4/5/23, read Resident #3 was at risk for falls related to neurocognitive disorder with Lewy bodies, Parkinson's disease, history of falling, and unsteadiness on feet. The care plan goal was to minimize Resident #3's risk for falls and injuries. Care planned interventions initiated on 4/5/23 directed staff to: -Educate the resident and family to call for assistance before transferring; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Ensure food and fluids were within reach; -Implement preventative fall interventions/devices; -Ensure his call light was within reach and educate the resident how to use call light; -Ensure needed items were within reach; -Ensure the resident wore non-skid footwear; and, -Have physical therapy, occupational therapy, evaluate the resident. The activity of daily living (ADL) care plan, initiated 4/5/23, identified Resident #3 had a self-care performance deficit related to unspecified intellectual disabilities, neurocognitive disorder with Lewy bodies, and Parkinson's disease. 1. Fall #1 The 4/16/23 fall occurrence evaluation identified Resident #3 had an unwitnessed fall on 4/16/23 at 5:00 p.m. The CNA was notified by Resident #3's roommate of the fall. The CNA entered the room and observed the resident in his recliner. The resident had a red mark on his right upper back. The resident said he was walking to the bathroom and fell on his buttocks and his back hit the window sill or his recliner. The resident said he slipped out of his wheelchair. The evaluation read the resident was incontinent of his bladder and was unaware of his limitations. -Review of the above care plan did not identify new interventions that were put in place after the 4/16/23 fall. New fall care planned interventions were not initiated until 6/16/23 (two months after the fall). According to the 6/16/24 care plan, a toileting schedule was created for Resident #3. -The care plan did not identify when the resident was scheduled to be toileted. Additional interventions included: -Place the bed against the wall; -Place the wheelchair within reach; and; -The use of a low bed and fall mat. 2. Fall #2 The 7/1/23 fall occurrence evaluation identified Resident #3 had a witnessed fall on 7/1/23 at 5:15 a.m. The resident was not injured. The nurse saw the resident try to walk to the bathroom. Resident #3 lost his balance and fell to the floor on his buttocks. The bed was in a low position at the time of the fall and his call light was within reach. The resident did not attempt to push his call light. The lights were off at the time of the fall. The resident had socks on at the time but the socks were not the non-skid socks. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The evaluation did not identify why the resident was not wearing non-skid socks as was care planned. The resident could not explain why he fell . The evaluation did not identify if the resident was wearing oxygen at the time of his fall. The evaluation read Resident #3's most recent oxygen saturation levels were 79% on room air and 95% on four liters per minute (lpm) of oxygen. -Review of the above care plan did not identify new fall interventions that were put into place after the 7/1/23 fall to the bathroom. 3. Fall #3 The 7/14/23 fall occurrence evaluation identified Resident #3 had an unwitnessed fall on 7/14/23 at 1:30 p.m. No injuries were observed. The resident was observed on the floor in his room laying on his left side in front of his wheelchair and recliner. The wheelchair brakes were locked and the call light was attached to his recliner. The evaluation identified non compliance with transfers, the recliner, the two end tables and a dresser were potential contributing factors to the fall. The resident said he was going to the bathroom when he fell . The evaluation did not identify when the resident was last toileted, despite the care plan documenting that a toileting schedule had been implemented as a fall intervention for the resident on 6/16/24. -The evaluation did not identify what type of footwear the resident had on at the time of his fall. The resident's most recent oxygen saturation levels were 82% on room air. The evaluation read the resident declined to wear his oxygen. The 7/25/23 long term care evaluation read on 7/14/23 the housekeeper found Resident #3 on the floor after she heard a noise from his room. A 7/26/23 health status note identified Resident #3 was injured during the 7/14/23 fall. According to the note, he had fading bruises to his left hip and left shoulder from his previous fall. The review of the above fall care plan did not identify new fall interventions that were put into place after the 7/14/23 fall while attempting to go to the bathroom, including reviewing for new placement of the resident's furniture. -The fall care plan did not include the resident's oxygen use or his refusal to wear oxygen, increasing his fall risk. 4. Fall #4 The 8/2/23 health status note read the resident was shuffling when ambulating to the bathroom. The 8/2/23 fall occurrence evaluation identified Resident #3 had an unwitnessed fall on 8/2/23 at 6:45 p.m. The resident was not injured. The resident was observed sitting on the floor on the side of his wheelchair in front of his recliner. The wheelchair brakes were not locked. His call light was within reach. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #3's pants were around his legs as he laid on his right side. The resident said he needed to go to the bathroom. -The evaluation did not identify when the resident was last toileted, despite the care plan documenting a toileting schedule had been implemented as a fall intervention for the resident on 6/16/24. Contributing factors included a cluttered room and the resident forgot to use the call light. -The review of the above care plan did not identify new fall interventions were care planned, including ensuring the room was clutter free/free of obstacles. 5. Fall #5 The 8/2/23 fall occurrence evaluation identified Resident #3 had a second fall on 8/2/23. The second fall occurred at 8:00 p.m. in his room. The fall was not witnessed. The evaluation read no injuries were observed. The resident was observed sitting on the floor next to his bed. His call light was in reach. -The resident was not wearing non-skid socks, despite the care plan documenting that non-skid socks were implemented as a fall intervention on 4/5/23. The resident said he was going to the bathroom. -The evaluation did not identify when the resident was last toileted, despite the care plan documenting a toileting schedule had been implemented as a fall intervention for the resident on 6/16/24. -The review of the above care plan did not identify new fall interventions were care planned after the two falls on 8/2/23. The 8/3/24 incident note read Resident #3 had a 1 centimeter (cm) by 1 cm bruise on his left buttocks due to his recent fall. The 8/3/23 wound evaluation note read the resident had new treatment orders for scattered bruising due to his recent falls. According to the wound evaluation his right buttocks had a 2 cm by 2.2 cm bruise, a 5.5 cm by 10.5 cm bruise on his left upper arm, a 0.5 cm by 4 cm bruise on his chest, and two bruises to his left shoulder measuring 3 cm by 4.3 cm and 2 cm by 3.5 cm. 6. Fall #6 The 8/14/23 fall occurrence evaluation identified Resident #3 had a witnessed fall on 8/14/23 at 2:00 p.m. The resident was not observed to be injured. He was observed by a staff member to walk unassisted. The resident lost his balance and was lowered to the floor onto his buttocks.The resident was continent of bowel and bladder and was attempting to go into the bathroom. The resident said he needed to go to the bathroom. -The evaluation did not identify when the resident was last toileted, despite the care plan documenting a toileting schedule had been implemented as a fall intervention for the resident on 6/16/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The evaluation did not identify what footwear the resident was wearing at the time. -The evaluation did not identify if the resident was wearing his oxygen at the time of the fall. According to the evaluation, the resident refused to use his walker and would not call for assistance. -The review of the above fall care plan did not identify new fall interventions were care planned after the 8/14/23 fall. -The fall care plan did not identify the resident refused to use his walker. -The care plan did not identify an intervention for frequent monitoring of the resident related to his lack of call light use. The 8/15/23 interdisciplinary (IDT) note read the IDT team reviewed his falls. The nursing recommendations were a bowel and bladder program. The note read most of the falls were due to the resident needing to go to the bathroom. He was placed on a bowel and bladder program so staff would take him to the bathroom at least every two hours. According to the IDT note, the resident continued to attempt to use the bathroom without asking for assistance. Resident #3 was very focused on the task of going to the bathroom and not having an accident. He did not remember to ask for help. The note read the behavior was a usual behavior for the resident for many years, however, he had become more weak. He had tremors and had impaired coordination with his movements. The resident was working with restorative nursing for strengthening. The restorative program would start incorporating call light use prior to the bathroom in attempts to teach him to use the call light. The review of the incontinence care plan, initiated 4/5/23, read Resident #3 had episodes of bowel and bladder incontinence related to cognitive impairment, generalized weakness, pain and Parkinson's disease. The care plan intervention, dated 8/23/23, directed staff to assist Resident #3 with toileting every 2 hours and as needed. The fall care plan identified an added fall intervention on 12/18/23 of wheelchair anti-roll back breaks. 7. Fall #7 The 1/19/24 fall occurrence evaluation identified Resident #3 had an unwitnessed fall on 1/19/24 at 9:05 a.m. The evaluation read there were no injuries observed. The nurse was notified Resident #3 was on the floor in his room. The resident was observed sitting on the floor in front of his recliner. The resident was assisted back into his recliner. The resident said he slid out of his chair. The resident was educated and encouraged to use his call light. -The evaluation did not identify the foot wear the resident wore at the time of the fall. The evaluation read the resident's most saturation levels were at 90% on room air. The evaluation did not identify if the resident had his oxygen on at time of the fall. The evaluation did not identify if the resident had to use the bathroom or was incontinent at the time of the fall. The evaluation did not include if the recliner was reclined back at the time of the fall. The evaluation did not identify the resident's recliner was assessed for safety. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The review of the fall care plan identified wheelchair brake extenders were added to the care plan on 1/19/24 as a fall intervention after the 1/19/24 fall. -However, according to the fall evaluation, Resident #3 fell out of his recliner, not his wheelchair, therefore the wheelchair brake extenders were not an appropriate intervention for the resident's fall from his recliner. -The care plan did not identify new interventions pertaining to the resident's recliner. The 1/22/24 IDT note read the IDT reviewed the 1/19/24 fall. The resident frequently self transferred and had been reminded to ask for assistance with transferring. According to the note, his previous interventions were brake extenders, anti-roll back and anti-tip brakes to his wheelchair. The new intervention would be to add a chair alarm to his wheelchair to notify staff to help the resident transfer one he initiated. -However, according to the fall evaluation, Resident #3 fell out of his recliner, not his wheelchair. -The review of the care plan identified the alarm was not placed on the resident's care plan until after his 1/29/24 fall with major injury. 8. Fall #8 The 1/29/24 fall occurrence evaluation identified Resident #3 had an unwitnessed fall on 1/29/24 at 8:45 p.m. The evaluation read the resident was assessed for injuries and assisted into bed by three staff members. The resident was unable to explain what happened. -The resident was not using oxygen, not calling for assistance and did not have non-skid/slip socks on at the time of the fall, despite the care plan documenting that non-skid socks were implemented as a fall intervention on 4/5/23. The resident's most recent oxygen saturation levels were 86% on room air. The evaluation read there were no injuries observed. The evaluation did not identify if the resident fell from his wheelchair, his recliner, or his bed. -The evaluation did not include when the resident was last checked on or when he was last toileted, despite the care plan documenting a toileting schedule had been implemented as a fall intervention for the resident on 6/16/24. The evaluation did not identify if the resident was incontinent at the time of the fall or if he had to use the bathroom. The evaluation did not identify if the resident's pull alarm was sounding at the time of the fall (see below). The 1/29/24 change in condition note read the resident had several complaints of upper thigh pain. The provider was notified on 1/29/24 at 10:17 p.m. The 1/29/24 health status note read Resident #3 left the facility by ambulance at 10:30 p.m. to the hospital emergency room for an evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 1/30/24 IDT note read Resident #3 was admitted to the hospital with a left hip fracture. He was expected to have surgery. The resident's safety interventions included anti-roll back and anti-tip brakes to his wheelchair and a pull tab alarm. According to the note, the IDT would re-evaluate his interventions once he returned back to the facility. The IDT note did not include additional fall investigation information that was not already included in the fall occurrence evaluation. The 1/30/24 health status note read the facility contacted the intensive care unit (ICU) and was informed the resident would probably have surgery on 1/30/24. The 2/2/24 health status note read Resident #3 was readmitted to the facility on [DATE] from the hospital. The resident was admitted with a diagnosis of a displaced intertrochanteric fracture of left femur. The resident had a large amount of bruising covering his entire left leg. The 2/2/24 hospital discharge instructions read the resident had a left hip fracture and a closed intertrochanteric fracture of the left femur. The review of the fall care plan identified an alarm was added on 1/29/24. -The care plan did not identify the type or where the alarm was placed. The fall care plan did not have additional new fall interventions added to the care plan until 3/11/24, over a month after the resident returned to the facility after a major fall with injury. According to the fall care plan, staff should monitor the resident for changes in his mobility. The ADL care plan interventions, initiated 3/11/24, read the resident required two person assistance for bed mobility, transfers and toileting. The 3/14/24 health status note read the resident had new recommendations from occupational therapy (OT) regarding the resident's wheelchair. A low back wheelchair was recommended for positioning and mobility. According to the note, the resident no longer used a high back wheelchair so his anti tip backs were no longer helpful to him. Therapy discontinued the resident's wheelchair alarm and offered to let him rest in the recliner, which he agreed to. 9. Fall #9 The 4/17/24 fall occurrence evaluation read Resident #3 fell on [DATE] at 9:15 p.m. The fall was unwitnessed. Resident #3 was observed sitting on the floor leaning against the bed. -Resident #3 had regular socks on, despite the care plan documenting that non-skid socks were implemented as a fall intervention on 4/5/23 . Resident #3 did not use the call light prior to getting up. His oxygen was removed. The resident was assisted to bed and his oxygen was placed back on him. The resident did not have injuries observed. The resident said he was trying to get to the bathroom. According to the evaluation, the contributing factors of the fall were poor lighting, wearing of regular socks (not non-skid), and failure to use the call light. He was incontinent but continued to get to the toilet. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The fall care plan after the 4/16/24 fall identified the care plan intervention to mark the residents low bed and fall mat, implemented on 6/16/23 as a fall intervention, was revised on 4/18/24. The 4/18/24 IDT note read staff would add a low bed and a fall mat. -However the care plan identified a fall mat and low bed was already in place as of 6/16/23. The review of the progress notes identified the resident had a low bed as of 3/26/23. -The fall care plan identified no new interventions were put into place until 5/7/24 during the survey period. The care plan read non skid strips were initiated on 5/7/24. -The care plan did not identify where the non-skid strips were added. A 5/7/24 health status note read the resident had a new order for grip tape to the bathroom floor noted due to previous falls. D. Staff interviews The director of nursing (DON) and the nursing home administrator (NHA) were interviewed together on 5/9/24 at 11:23 a.m. The fall investigations were reviewed with the DON and the NHA. The DON said fall investigations should be conducted after each fall. She said she would want a clear investigation so staff could determine what happened to help with the prevention of future falls. Resident #3's 1/29/24 fall with major injury was reviewed with the NHA and DON. The NHA said the resident was found on his hands and knees on the floor. He did not have pain initially and was assisted to bed. The resident was reassessed after later complaints of pain and was sent to the hospital for an evaluation. The NHA said she did not know who found the resident after he had fallen. The NHA said the fall report did not identify when the resident was last checked on or when he was last toileted. She said staff were to do rounds every two hours on the resident. She said when a CNA would start their shift at 6:00 p.m.,after a report was given, the CNA would start rounding every two hours on all residents on their designated hall. The DON and the NHA said the fall documentation did not identify if the resident was incontinent at the time of the fall or if he needed to use the bathroom when he was found. The NHA said the documentation did not identify environmental factors in his room such as lighting. The documentation did not identify where the resident was found in his room such as in front of his wheelchair or bed. The documentation did not identify what the resident was doing before he fell . The NHA said staff interviews pertaining to the fall were not collected. The NHA said the resident was usually able to say what happened or what he was trying to do at the time of fall. The NHA said the fall documentation read that the resident was not able to explain what happened. The NHA and DON said the fall documentation identified the resident did not have his oxygen on or non-skid socks and there were no other fall-related factors documented. The NHA said she did not know why the resident did not have non-skid socks on, other than the possibility he did not want to wear them. She said he was very routine. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-However, the resident was not care planned for refusing to wear non-skid socks. The NHA said the resident had low oxygen saturation levels at the time of the fall. The staff had to remind him to wear his oxygen all the time. The DON said Resident #3 needed to wear oxygen for COPD. She said when he did not wear his oxygen, he was at an increased risk for falls (cross reference F695, respiratory care). The DON said the care plan should include oxygen interventions when he refused. The NHA said the resident preferred to sit in a recliner. She said after the fall the staff started to encourage him to sit in the recliner in the living room for extra supervision. The NHA confirmed the recliner was not care planned as an intervention. She said all interventions should be care planned so staff was aware of the interventions. -Observations during the survey period did not identify the resident sitting in a recliner in the living room. Observations did identify the resident sitting in the living room in a regular chair or his wheelchair without his oxygen on (see observations above). The DON said the 1/29/24 fall investigation should have included staff interviews regarding when the resident was last checked on. She said the investigation should include what the situation was at the time of the fall and what his environment looked like at the time. The DON said staff should document if the interventions were in place when he fell and who found the resident. She said she would want to know why the resident could not express what happened. The NHA said the resident may have had confusion at the time because his oxygen saturation levels were down to 70% at the time. The NHA said most of the time after a fall, new interventions were put in place except when staff felt they tried all interventions and could not think of what else to do. The NHA said most of the resident's falls were due to him getting up to go to the bathroom. She felt Resident #3's attempts to toilet himself was a behavior. She said the behavior was not tracked. The NHA said she did not know why the resident did not want to wear oxygen. The DON said she would look at opportunities to reinforce positive behavior and would observe and ask the resident questions such as why he did not want to wear his oxygen. The DON and the NHA said, moving forward, they would start to look at Resident #3's individual toileting routines to help determine when the resident was mostly needing to void. The DON said all residents were checked on every two hours. She said Resident #3 was on a bowel and bladder toileting program/plan which would have the staff specifically ask the resident if he had to use the bathroom or encourage him to use the bathroom every couple of hours. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #1 was interviewed on 5/9/24 at 3:05 p.m. CNA #1 said she worked full time with twelve hour shifts on Resident #3's hall. She said Resident #3 needed assistance to go to the bathroom but he did not use the call light to inform staff when he needed to go. She said she reminded him not to stand up by himself and to use the call light. She said when she saw him head to his room, she would place him on the toilet when she could but then he would not use the call light when he was done. She said she did not think the resident could remember to wait and use the call light. She said she had found him attempting to walk with his pants down. CNA #1 said the resident had a low bed and tried to get up at night. She said she toileted him routinely before and after meals, however, she saidResident #3 was not on a toileting/bowel and bladder plan. She said residents who were on a toileting plan were to be toileted every two hours. CNA #1 said no residents on her hall, including Resident #1, was on a toileting/bowel and bladder plan. 50314 III. Resident #58 A. Resident status Resident #58, over the age of 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included cerebral infarction

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on observations, record review and interviews, the facility failed to ensure residents received proper respiratory treatment and care for one (#3) of one resident reviewed for supplemental oxygen use out of 41 sample residents. Specifically, the facility failed to: -Administer oxygen in accordance with the physician's order for Resident #3; -Ensure the staff reminded and encouraged Resident #3 to wear his oxygen; and -Ensure clear communication when Resident #3 should use his oxygen. Findings include: I. Facility policy and procedures The Oxygen Administration policy, revised October 2010, was provided by the facility on 5/9/24 at 1:58 p.m. It read in pertinent part, The purpose of the policy was to provide guidelines for safe oxygen administration. Verify there is a physician order for this procedure. Review the physician's order or facility protocol for oxygen administration. Review the resident's care plan to assess any special needs of the resident. Assemble the equipment and supplies as needed. The nasal cannula is a tube that is placed approximately 1/2 inch into the resident's nose. It is held in place by an elastic band placed around the resident's head. Notify the supervisor if the resident refuses the procedure. Report other information in accordance with the facility policy and professional standards of practice. II. Resident status Resident #3, over the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease, hypoxemia (low level of oxygen in the blood), dependence on supplemental oxygen, neurocognitive disorder with Lewy bodies, unspecified intellectual disabilities, cognitive communication deficit, Parkinson's disease with dyskinesia (involuntary movements) and muscle weakness. According to the 3/21/24 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of four out of 15. The assessment indicated the resident received oxygen therapy and had shortness of breath or trouble breathing with exertion and when laying flat. The resident had no behavioral symptoms or rejections of care. III. Resident observations and interview (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 was observed sitting in the dining room on 5/6/24 between 2:35 p.m. and 2:57 p.m. The resident had an oxygen canister on the back of his wheelchair. The resident's nasal cannula tubing was on his lap. The resident was not receiving the oxygen. -At 2:37 p.m. an unidentified staff member walked passed the resident and spoke to a resident near Resident #3. The staff member did not identify the resident was not wearing his oxygen or encourage the resident to wear his oxygen. Resident #3 was interviewed on 5/6/24 at 2:56 p.m. The resident said his oxygen comes off his face sometimes. On 5/7/24 Resident #3 was observed between 1:57 p.m. and 2:56 p.m. Between 1:57 p.m. and 2:12 p.m. Resident #3 propelled himself with his wheelchair into the dining room. The resident had his oxygen cannula attached to the oxygen canister hung on the left side of his wheelchair near his wheel as four staff members walked past him. The staff did not encourage him or assist him to put his oxygen on. -At 2:19 p.m. Resident #3 propelled his wheelchair to the dining room table as the activity assistant (AA) #1 conducted an activity. The resident was not assisted or encouraged to wear his oxygen. -At 2:29 p.m. Resident #3 stood up in front of his chair. AA #1 was alerted to the resident standing up. She assisted the resident to sit back down to his wheelchair and provided him with a tissue. AA #1 did not offer assistance with placing his oxygen in his nares or encouraged him to wear his oxygen. -At 2:41 p.m. an unidentified staff member entered the dining room but did not assist or encourage the resident to wear his oxygen. Resident #3 was interviewed on 5/7/24 at 2:45 p.m. The resident's oxygen canister was turned on. The resident said he did not wear it because he had a cold and requested to use the restroom. -At 2:49 p.m. nurse aide (NA) #2 was informed the resident wanted to use the restroom and did not have his oxygen on for a while. NA #2 entered the dining room and told Resident #3 he should always wear his oxygen and she offered to put the oxygen back on. The resident agreed and NA #2 assisted the resident out of the dining room and into his room with his oxygen on. -At 2:56 p.m. NA #2 was observed coming out of the room of Resident #3. NA #2 said Resident #3 oxygen saturation levels were not checked after he was not wearing oxygen while in the dining room. A certified nurse aide (CNA) or a nurse was not observed to return to his room to check his oxygen saturation levels after he had not had his oxygen on for at least an hour. On 5/8/24 at 2:12 p.m. Resident #3 sat in the living room. He was not wearing his oxygen. -At 2:58 p.m. an unidentified staff was observed helping him put his oxygen on. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 5:13 p.m. CNA #1 assisted Resident #3 out of the dining room and in front of his hallway. The resident was not wearing his oxygen cannula in his nose. The resident proceeded to propel himself slowly toward his room. IV. Record The 9/20/23 CPO for Resident #3 directed staff to provide oxygen (O2) via nasal cannula at 2 liter per minute (lpm). Check O2 saturation levels daily and as needed to maintain a saturation level of 90% or greater every shift related to COPD. -The CPO did not indicate how often the resident needed to wear oxygen. The respiratory care plan, initiated 4/5/23 revised on 6/16/23, read Resident #3 had impaired respiratory status related to COPD, hypoxemia and dependence on supplemental oxygen. The following interventions initiated on 4/5/23 directed staff to: -Administer medications as ordered. Monitor for effectiveness and report adverse side effects to the physician; -Assist with ADLs as needed to reduce anxiety and respiratory fatigue; -Elevate head of bed for comfort and to facilitate optimal breathing to avoid shortness of breath while lying flat related to COPD as the resident will allow; -Encourage the resident to avoid extreme temperatures (hot/cold) that could exacerbate respiratory distress; -Encourage the resident to notify staff if he had increased difficulty with breathing; -Resident #3 would have adequate oxygenation as evidenced by no shortness of breath; -Resident #3 would be free of complications related to COPD/emphysema through the next review; -Labs/diagnostic testing as ordered; and, -Monitor for increased anxiety associated with shortness of breath; provide reassurance. -Monitor for signs/symptoms of respiratory distress and report to physician (increased respirations, low O2 saturation levels, cyanosis, increased heart rate, restlessness, diaphoresis, headaches, increased lethargy, increased confusion, atelectasis, pleuritic pain, accessory muscle usage). -Monitor lung sounds for wheezing or crackles as needed; -Monitor vital signs and pulse oximetry as needed; -Oxygen as ordered by physician; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide oxygen as needed when the resident exhibits signs/symptoms of difficulty breathing (short of breath, cyanosis, low O2 sats); -PT/OT/SLP screen/eval/treat as needed; and, -Treatments as ordered by the physician. The activities of daily living (ADL) care plan, dated 4/5/23, read Resident #3 had a self-care performance deficit related to unspecified intellectual disabilities, neurocognitive disorder with Lewy bodies, and Parkinson's disease. The care plan identified the resident needed assistance with his ADLs and directed staff to provide cueing and assistance as needed. V. Staff interviews NA #2 was interviewed on 5/7/24 at 2:48 p.m. NA #2 said Resident #3 should be wearing his oxygen at all times but he would take it off sometimes. She said staff should remind him to wear the oxygen when he did not have it on. The NHA and the director of nursing (DON) were interviewed together on 5/9/24 at 11:23 a.m. The NHA said Resident #3 needed to wear oxygen. The NHA said the staff should remind Resident #3 to wear his oxygen when he takes his oxygen off. She said staff had to remind him all the time to wear his oxygen. She said he was prone to have his oxygen saturation levels drop when he did not wear his oxygen. The DON said the resident was at a higher risk for falls when he did not wear his oxygen (cross-reference F689 accident hazards). The DON said the resident needed to wear oxygen related to his diagnosis of COPD. She said when he does not wear his oxygen, he was at an increased risk for falls (cross reference F689, accident hazards). The DON said the care plan should include oxygen interventions when he refused. The NHA said the resident often would take off his oxygen. She said his care plan did not identify the Resident #3 would refuse his oxygen or interventions when the resident refused his oxygen such as encouragement, reminders and education of use. The DON said the CN) communication sheet/Kardex (tool for staff to provide person-centered care) did not include to remind and encourage the resident to wear his oxygen. The DON and the NHA said they did not know or ask why the resident took off his oxygen. They said when Resident #3 took off his oxygen staff should be aware and encourage him to put the oxygen back on. Staff should check his oxygen saturation levels to ensure his oxygen levels did not drop too low while he had it off. The NHA said the removal or refusal of his oxygen was not tracked as a behavior. The DON said moving forward she would educate staff to offer the resident positive reinforcement to encourage the use of the oxygen, ask the resident why he takes off the oxygen, and what to do when he does not have his oxygen on. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 was interviewed on 5/9/24 at 3:09 p.m. CNA #1 said Resident #3 had low oxygen saturation levels when he fell in January 2024 and broke his hip. She said the resident only needed his oxygen when his saturation levels were low. The CNA said staff only needed to put on his oxygen when he had low saturation level. She said his saturation levels were checked in the morning or if he was not acting normal and was fatigued. She said his oxygen was just as needed. -The CPO did not indicate how often the resident needed to wear oxygen. The NHA was interviewed again on 5/9/24 at 6:01 p.m. The NHA resident oxygen needs have been discussed in the facility quality assurance meeting but Resident #3 oxygen use, refuses, interventions have not been discussed during the meeting. She said it would be appropriated to discuss Resident #3 oxygen interventions with the interdisciplinary team to review approaches related to him taking off his oxygen. VI. Facility follow up The The 5/9/24 updated CNA communication sheet respiratory care plan intervention, dated 5/9/24, read Resident #3 liked to take his oxygen cannula off. The care plan directed staff to frequently remind the resident to wear his oxygen, provide encouragement to wear his oxygen and/or assist him to wear his oxygen as ordered.

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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** 50314 Based on observations, record review and interviews, the facility failed to ensure all drugs and biologicals were properly stored in accordance with professional standards in two of three medication storage carts and one of one medication rooms. Specifically, the facility failed to: -Ensure all refrigerated medications and biologicals were stored at the appropriate temperature; and, -Ensure medications were not expired. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, pp. 1976, retrieved on 5/13/24, All drugs are secured in designated areas only accessible to nurses. II. Facility Policy The Medication policy, undated, was received from the nursing home administrator (NHA) on 5/13/24 at 1:25 p.m. It read in pertinent part, Medication storage shall be properly and safely maintained in accordance with the security requirements of federal, state, and local laws. No outdated medications will be used. Medications requiring refrigeration will be stored in the medication room refrigerator. The refrigerator will be maintained according to requirements of the State Board of Pharmacy. II. Observations On 5/8/24 at 9:33 a.m., medication storage cart G/H was observed with registered nurse (RN) #1 and contained an opened bottle of milk of magnesia (medication used to treat constipation) that expired in April 2024. On 5/8/24 at 9:38 a.m., medication room [ROOM NUMBER] was observed with RN #1. Refrigerated medications in medication room [ROOM NUMBER] did not have a temperature log in the room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/24 at 10:53 a.m., medication storage cart A/B was observed with certified nurse aide with medication authority (CNA-Med) #2, and held an opened container of alprazolam (medication used to treat anxiety) that expired on 4/1/24 and a container of ondansetron (medication used to treat nausea) that expired on 3/19/24. III. Record Review Refrigerator log documentation for the medication refrigerator from 3/1/24 through 4/30/24 was provided by the NHA on 5/8/24 at 9:38 a.m. The NHA said a temperature log for May 2024 could not be located. -The temperature log documentation was not completed for 5/1/24 to 5/8/24, failed to document the temperature on 14 out of 30 days in April 2024 and failed to document the temperature on nine out of 31 days in March 2024. V. Staff Interviews RN #1 was interviewed on 5/8/24 at 9:36 a.m. RN #1 said the milk of magnesia bottle was expired. RN #1 said the expired medication would be destroyed per facility policy. The NHA was interviewed on 5/8/24 at 9:38 a.m. The NHA said medication refrigerator temperature logging had not been documented from 4/22/24 to 5/8/24. The NHA said many days of temperature refrigeration documentation had not been completed in April 2024 and March 2024. The NHA said it was the responsibility of night shift nursing staff to complete the temperature log. The NHA was not sure why this had not been documented. CNA-Med #2 was interviewed on 5/8/24 at 10:55 a.m. CNA-Med #2 said that the alprazolam and ondansetron were expired medications. CNA-Med #2 said that the expired medications would be destroyed per facility policy. The director of nursing (DON) and the nursing home administrator (NHA) were interviewed together on 5/9/24 at 1:48 p.m. The DON said that medication refrigerator logging had not been completed appropriately. The DON said night shift medication technicians were responsible for looking through medication carts every evening and this had not been done. The DON said that it was important to log the medication refrigerator temperature to make sure stored medications were safe and effective for residents to use. The NHA said there was a recent process change from maintenance checking the medication refrigerator to nursing staff checking the medication refrigerator and as a result, many days were missed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases. Specifically, the facility failed to: -Ensure Resident #22, #24, #16, #29, #47, #53 and #58 were tested for COVID-19 when presenting signs and symptoms of an upper respiratory infection; and, -Ensure Resident #58, #164 and #165 received the COVID-19 vaccination after consenting for it. -Ensure the facility used preventative measures to help reduce the potential risk of COVID-19. Findings include: II. Professional reference Interim for Infection Prevention and Control Recommendations for Healthcare Professional during COVID disease 2019 (COVID-19) pandemic updated 3/18/24, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html on 5/20/24. According to the Center of Disease Control and Prevention (CDC), The recommendations in the following guidance continue to apply after the expiration of the federal COVID-19 Public Health Emergency. The update reflected the high levels of vaccine of infection induced immunity and the availability of effective treatments and prevention tools. The policy read in pertinent part, Encourage everyone to remain up to date with all recommended COVID-19 vaccination doses. Healthcare professionals, patients, and visitors should be offered resources and canceled about the importance of receiving the COVID-19 vaccine. Establish the process to make everyone entering the city aware of recommended actions to prevent transmission to others if they have any of the following three criteria: positive viral test for SARS-CoV-2; symptoms of COVID-19, or close contact with someone with infection. Anyone with even mild symptoms of covid-19 regardless of vaccination status should receive a viral test for SARS-CoV-2, as soon as possible. The CDC's Stay Up to Date with COVID-19 Vaccines, updated 5/14/24 was retrieved on 5/20/24 from https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html and read in pertinent part, The CDC recommends the 2023-2024 updated COVID-19 vaccines. Everyone aged five years and older should get one dose of an updated COVID-19 vaccine to protect against serious illness from COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	People aged 65 and older who received one dose of any updated 2023-2024 COVID-19 vaccination should receive one additional dose of updated covid-19 vaccine at least 4 months after the previous updated dose. 1. Facility policy The Infection Control Program policy, undated, was provided by the facility on 5/6/24. The policy identified the intention of the policy and the infection control program. The policy read in pertinent part, To provide and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and help prevent the development of transmission of disease and infection. The elements of infection control program included but was not limited to: -Investigates, controls, and prevents infections in the facility; -Decides what procedures, such as isolation, should be applied for individual resident; -Maintains a record of incidences and corrective actions related to infections. The director of nursing (DON) would serve as the coordinator of the infection control prevention and control program. The program coordination would include process and outcome infection control surveillance, monitoring and data analysis and documentation. The COVID-19 policy, undated, was provided by the facility on 5/6/24. The policy read in pertinent part, It is the policy of this facility to utilize precautions (and) prevention measures that apply to resident care, regardless of suspected or confirmed infection status of the residents, in any setting where healthcare is being delivered. Precautions are utilized to prevent and control transmission of infectious organisms through direct and indirect contact. This evidence-based practice is designed to protect healthcare staff and residents by preventing the spread of infections among residents and ensuring staff do not carry infectious pathogens on their hands or via equipment during resident care. The Vaccination of Residents policy was provided by the corporate consultant (CC) on 5/9/24 at 3:01 p.m. The policy read in pertinent part, According to the policy all residents would be offered vaccines that aid in the prevention of infectious diseases unless the vaccine was medically contraindicated or the resident had already been vaccinated. The facility COVID Vaccination Immunization Requirements for residents and staff, dated 5/13/21, was provided by the CC on 5/9/24 at 3:01 p.m. The policy read in pertinent part, When the COVID-19 vaccine is available to the facility, the facility shall offer each resident and staff the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized. III. Upper respiratory infections A. Resident status (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The following residents were identified with upper respiratory infections between March 2024 and May 2024: Resident #22, over the age of 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease (COPD) and acute upper respiratory infection. Resident #24, over the age of 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included hypoxemia, personal history of COVID-19 and acute upper respiratory infection. Resident #16, over the age of 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included hypertensive heart and chronic kidney disease without heart failure, shortness of breath, pneumonia, personal history of COVID-19 and acute upper respiratory infection. Resident #29, over the age of 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included chronic respiratory failure with hypoxia, hypoxemia and acute upper respiratory infection. Resident #53, over the age of 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included Alzheimer's disease, personal history of COVID-19 and acute upper respiratory infection. Resident #58, over the age of 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included Alzheimer's disease, chronic kidney disease stage three, hypoxia, and upper respiratory infection. Resident #47, over the age of 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included dementia, personal history of COVID-19 and acute upper respiratory infection. B. Record review The March 2024, April 2024 and May 2024 surveillance mapping for infection was reviewed with the director of nursing (DON) on 5/9/24 at 10:00 a.m. The March 2024 surveillance mapping identified three resident had signs and symptoms of an upper respiratory infections: -Resident #22 was identified with a new upper respiratory infection on 3/25/24. The resident was treated with antibiotics. -Resident #24 was identified with a new upper respiratory infection on 3/25/24. The resident was treated with antibiotics. -Resident #16 was identified with a new upper respiratory infection on 3/25/24. The resident was treated with antibiotics. The review of the electronic medical records (EMR) of Resident #22, #24, and #16 did not document the residents were tested for COVID-19 after exhibiting signs and symptoms of an upper respiratory infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The April 2024 surveillance mapping for infection in April 2024 identified four resident were identified with a new upper respiratory infection: -Resident #29 was identified with a new respiratory infection on 4/8/24. The resident was treated with antibiotics. -Resident #53 was identified with a new respiratory infection on 4/8/24. The resident was treated with antibiotics. -Resident #58 was identified with a new respiratory infection on 4/26/24. The resident was treated with antibiotics. Resident #58 was not provided the COVID-19 vaccination prior to his diagnosis of an upper respiratory infection (see below). -Resident #47 was identified with a new respiratory infection on 4/30/24. The resident was treated with antibiotics. The review of the EMR for Resident #29, #47, #53 and # 58 did not document the residents were tested for COVID-19 after exhibiting signs and symptoms of an upper respiratory infection. The May 2024 surveillance mapping for infection in May 2024 identified no new upper respiratory infections as 5/8/24. IV. Failure to offer the COVID-19 vaccine after consent A. Resident #58 1. Resident status Resident #58, over the age of 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, chronic kidney disease stage three, hypoxia, and upper respiratory infection. The 4/11/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) with a score of three out of 15. 2. Record review The immunization record and immunization report for Resident #58 was provided by the CC 5/9/24 at 2:47 p. m. The immunization record identified the resident's responsible party consented and signed for Resident #58 to receive to COVID-19 vaccination on 3/19/24. The immunization report documented his last COVID-19 booster vaccination was on 8/4/22. The report identified Resident #58 was not provided the vaccination since his admission on 3/19/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident #164 1. Resident status Resident #164, over the age of 65, was admitted on [DATE]. According to the 4/25/24 MDS assessment, diagnoses included hypertension, depression, peripheral vascular or peripheral arterial disease. The assessment indicated the resident had severe cognitive impairment with a BIMS score of seven of 15. 2. Record review The immunization record and immunization report for Resident #164 was provided by the CC 5/9/24 at 2:47 p.m. The immunization record identified the resident's responsible party consented and signed for Resident #164 to receive to COVID-19 vaccination on 4/19/24. The record read the resident had not received a COVID-19 prior to her admission to the facility. The immunization report documented Resident #164 was not provided the vaccination since her admission on 4/19/24. C. Resident #165 1. Resident status Resident #165, over the age of 65, was admitted on [DATE]. The May 2024 CPO did not document her current diagnosis. The staff assessment for mental status identified she had a memory and had moderately impaired decision making skills. 2. Record review The immunization record and immunization report for Resident #164 was provided by the CC 5/9/24 at 2:47 p.m. The immunization record identified the resident's responsible party consented and signed for Resident #165 to receive to COVID-19 vaccination on 4/11/24. The immunization report documented Resident #165 was not provided the vaccination since her admission on 4/11/24. V. Staff interviews (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON, the NHA and the CC were interviewed on 5/9/24 at 10:00 a.m. The DON said the facility's last outbreak was in November 2023. The DON said the residents who had signs and symptoms and had upper respiratory infections on the March 2024 April 2024 and May 2024 surveillance mapping for infection were all treated for antibiotics. The DON said the surveillance mapping did not identify a specific type of upper respiratory infection and the residents were not tested for COVID-19. The DON said the facility would have tested the residents if a staff member had reported positive COVID or if local facilities had cases of a COVID-19 outbreak and the physician recommended testing of COVID-19. The CC said the facility should test every resident with signs and symptoms of a respiratory infection because COVID-19 could mimic the signs of an upper respiratory infection. The CC said it would be appropriate for all residents with an identified upper respiratory infection to be tested to rule out COVID-19. The DON said residents with upper respiratory infections were not placed on droplet precautions because there were no precautions recommended by the providers (physician and the nurse practitioner). The DON said she did not follow-up to ask the provider if precautions were needed and nothing was documented for precautions. The DON said when Resident #58 admitted and family signed his consent on 3/19/24, the resident was not feeling well because he was recovering from a cerebrovascular accident (CVA). The resident was offered the COVID-19 but his family wanted to wait. The resident remained at the facility and was not offered the vaccination again. The NHA said the facility was going to offer the vaccine at the next vaccination clinic. She said the clinic was not scheduled yet but staff were looking to set up the clinic the week after the survey. She said the resident did not have to wait for a vaccination clinic to get the vaccine. She said the resident was last vaccinated on 8/4/22 for COVID-19 but he had not received the latest vaccination booster. The DON said currently the facility did not have the latest vaccination booster to offer. The CC said the facility was able to get the vaccine shipped to the facility in a day and could be available to Resident #1. The DON said when residents admitted to the facility, the residents should be offered vaccinations. The CC said the facility should follow the CDC recommendations. The CC said Resident #58 would be offered the COVID-19 vaccination and she would show the DON how to order the vaccine. The DON said Resident #58 developed signs and symptoms of an upper respiratory infection. He had crackling in his lungs and a productive cough beginning on 4/26/24. Resident #58 was placed on antibiotics and by 5/5/24 he no longer had a cough. The resident was not tested for COVID-19 and droplet precautions were not but in place. The CC said the facility should follow the CDC recommendations to offer COVID-19 vaccinations to all residents and test for COVID-19 when residents present an upper respiratory infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON said the facility would start to review all vaccinations and consents at the morning meeting and start a tracking form to ensure all needed components were in place and residents who consented for the vaccinations were not missed. The CC said she would educate nursing staff to test residents with upper respiratory infection symptoms for COVID-19. The CC was interviewed again on 5/9/24 at 2:10 p.m. The CC said Resident #164, Resident #165 and Resident #58 consented for the COVID-19 vaccine and did not receive the vaccine. The CC she would have Resident #58, Resident #164 and Resident #165 set up to receive the vaccinations, create an action plan and audit all COVID-19 vaccinations and provide nursing staff education to ensure all residents who wanted to be vaccinated were vaccinated. The CC said an admission checklist would also be put in place to ensure vaccinations were offered the vaccine shortly after the resident consented. The CC said she would also conduct an education with the DON and the nursing home administrator (NHA) regarding expectations of COVID-19 testing so any signs and symptoms of COVID-19 could be ruled out. VI. Facility follow up The following facility education was provided by the CC on 5/9/24 at 2:47 p.m. The CC said she was beginning the education on the afternoon of 5/9/24. The CDC COVID-19 Testing: What You Need Know brochure, updated 5/2/24, and the staff education for steps to take when residents were exhibiting signs or symptoms of covid identified the staff would be educated on the CDC list for COVID symptoms and to test for COVID when a resident had potential signs or symptoms for COVID. The education form read: -A PCR (polymerase chain reaction) COVID test needed to be completed and signed out on the MAR (medication administration record) via the PRN (as needed) COVID swab (kit). -If the PCR test is positive, implement isolation and set out PPE (personal protective equipment). -If the test is either positive or negative, notify the provider of assessment and results. -A change of condition needs to be completed. The CDC brochure read in pertinent part: Covid-19 testing can help you know if you have covid-19 so you can decide what to do next, like getting treatment to reduce your risk of severe illness and take steps to lower your chances of spreading the virus to others. The staff education for vaccinations read: -Upon admission or when updated guidance comes out consent will be obtained or refused for all vaccinations for resident choice. -The admitting nurse will get the consent and verify with the resident If they would like to get the musician immediately via Walgreens, Walmart or if they would want to wait until the next batch clinic of COVID boosters. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The nurse will document the resident's response. -The nurse will update immunization under immunization tab to keep the resident's EMR (electronic health record) up-to-date .

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 48412 Based on interviews and record review, the facility failed to ensure certified nurse aides (CNA) received at least 12 hours of annual in-service training that also included dementia management training and resident abuse prevention training to ensure continued competence for five out of five staff reviewed. Specifically, the facility failed to ensure certified nurse aides (CNA) #2, #4, #5 and #6 and certified nurse aide with medication authority (CNA-Med) #1 received 12 hours of continuing education annually in all required training topic areas, including dementia management training and resident abuse prevention training. Findings include: I. Training record review Five randomly selected CNA training records were reviewed on 5/8/24. Of the five employees reviewed, four of the CNAs (#2, #4, #5 and #6) and CNA-Med #1 did not receive a full 12 hours of annual training. A. CNA #2 -CNA #2, hired on 11/13/21, had participated in only six hours of training during the annual training year and had no record of completing abuse, neglect or exploitation training. B. CNA #4 -CNA #4, hired on 6/27/19, had participated in only six hours of training during the annual training year and had no record of completing dementia management training and resident abuse prevention training. C. CNA #5 -CNA #5, hired on 5/3/22, had participated in only eight hours of training during the annual training year. D. CNA #6 -CNA #6, hired on 8/19/21, had participated in only 10 hours of training during the annual training year and had no record of completing dementia management training. E. CNA-Med #1 CNA-Med #1, hired on 11/30/17, had participated in only nine hours of training during the annual training year and had no record of completing dementia management training. (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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Staff interviews The nursing home administrator (NHA) and business office manager (BOM) were interviewed together on 5/8/24 at 1:27 p.m. The BOM said she did not know the facility needed to track the number of training hours CNAs completed annually to ensure they received at least 12 hours of training. The NHA said the facility was approved to get a computerized training system within the next six months and tracking training was going to be easier and more consistent. The BOM said until they implemented the computerized system she would make a tracking system that would keep the training material, post-test results, dates, times, who completed the training and who missed the training. The NHA said the staff were informed when their training was scheduled and offered to be paid to complete the training on their days off. She said they had offered for staff to leave the floor to complete the required training but she felt she was unable to make the staff complete the training if they did not want to. The director of nursing (DON), the corporate consultant (CC) and the NHA were interviewed together on 5/9/24 at 4:00 p.m. The DON said she was responsible for training all of the nursing staff. The DON said she did not know how many hours of training the CNAs needed each year. The CC said CNAs needed to complete 12 hours of training each year. The NHA said if staff missed the training, management provided them with the training material and a quiz at a later date. She said training was offered on two different days in the afternoon so it was easier for everyone to attend. The NHA said the staff were encouraged to clock in and be paid for the training but the facility was unable to track the training process consistently and the BOM was coming up with a new process.