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Durango Health and Rehabilitation	2911 Junction St Durango, CO 81301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on record review and interviews, the facility failed to ensure the resident's right to be informed of, and participate in his or her treatment for four (#4, #53, #70 and #41) of four residents out of 45 sample residents reviewed for the right to be informed and make treatment decisions. Specifically, the facility failed to inform Resident #4, Resident #53, Resident #70 and Resident #41 and/or their legal representative of the length of time the residents would be in isolation for COVID-19 and when they would be able to leave their rooms. Findings include: I. Facility policy and procedure The Changes In Resident Condition policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 6/27/24 at 7:29 p.m. It read in pertinent part, Purpose: the resident, attending physician and legal representative or interested family member are notified when changes in condition or certain events occur. Changes of condition are communicated from shift to shift through the 24 hour report management system. Changes in resident status that affect the problem/goal or approach on his/her plan of care are documented as revisions and communicated to the IDT team. II. Resident #4 A. Resident status Resident #4, age less than 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia and COVID-19. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 6/27/24 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of five out of 15. B. Resident interview Resident #4 was interviewed on 6/25/24 at 11:18 a.m. Resident #4 was in isolation for COVID-19. He said it would be nice to know when he would be out of isolation. C. Record review The 6/18/24 nursing progress note indicated the resident was moved to another room for cohorting (placing residents with other residents with the same symptoms) due to testing positive for COVID-19. -There was no documentation in Resident #4's electronic medical record (EMR) to indicate that the resident or the resident's legal representative was notified of the room change or gave consent for the room change. -There was no documentation in the resident's EMR to indicate the resident or the resident's legal representative was notified how long the resident would be in isolation and when the resident would be able to leave his room III. Resident #53 A. Resident status: Resident #53, age 70, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, cerebral infarction (stroke) due to thrombosis of unspecified middle cerebral artery (a blood clot blocking blood flow to the brain) and COVID-19. The 6/12/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. B. Resident interviews and observations Resident # 53 was interviewed on 6/25/24 at 11:17 a.m. Resident #53 said he did not know when he would be getting out of isolation. He said the facility told him he would be in isolation for 10 days but he did not know when the 10th day was. Resident #53 was interviewed again on 6/26/24 at 11:03 a.m. Resident #53 said he might be out of isolation in a few days but he was not sure. A sign was posted on the wall above the resident's bed which documented the date the resident would be out of isolation. The sign was behind the resident when he was sitting up and was not easily seen by him. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/24 at 1:47 p.m. Resident #53 was observed asking certified nurse aide (CNA) #3 how long he had to be in isolation. CNA #3 told the resident he had to be in isolation for at least 10 days or until he had a negative COVID-19 test. C. Record review: The comprehensive care plan documented Resident #53 had a diagnosis of COVID-19, initiated 6/17/24. Interventions included to educate/encourage him to stay in his room. A nursing progress note dated 6/18/24 at 4:00 a.m. documented the resident continued in isolation in a semi-private room with a roommate who was also positive for COVID-19. The resident was alert and calling frequently with repeated concerns about when he could get out of isolation so he could play bingo. A nursing progress note dated 6/18/24 at 10:44 p.m. documented the resident was afebrile (no fever), became very agitated during the shift and was refusing to remain in isolation. The resident demanded to go to the dining room for dinner. -There was no documentation in Resident #53's EMR to indicate the resident or his legal representative was notified of how long the resident would be in isolation. IV. Resident #70 A. Resident status: Resident #70, age 74, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included chronic respiratory failure with hypoxia (inadequate levels of oxygen), emphysema, hypertensive heart disease without heart failure, bipolar disorder, anxiety disorder and post-traumatic stress disorder. The 4/22/24 MDS assessment revealed the resident had no cognitive impairment with a BIMS score of 15 out of 15. B. Resident interview Resident #70 was interviewed on 6/24/24 at 3:00 p.m. Resident #70 said his only concern was that he wanted to get out of isolation. He said he did not know when that would be. Resident #70 was interviewed again on 6/25/24 at 3:04 p.m. Resident #70 said he was out of isolation and was very happy about that. He said he had already left his room today (6/25/24). C. Record review A nursing progress note dated 6/15/2024 at 10:54 a.m documented Resident #70 tested positive for COVID-19 on 6/14/24. -There was no documentation in Resident #70's EMR to indicate the resident had been notified how long he would be in isolation. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. Staff interview Assistant director of nursing (ADON) #2 was interviewed on 6/25/24 at 3:10 p.m. ADON #2 said the residents were notified of the length of isolation verbally when they tested positive for COVID-19 and they were told isolation was for 10 days. She said Resident #53 had been told many times when he could come out of isolation. She said a sign was posted in his room to help the resident remember when his isolation would end. 50314 VI. Resident #41 A. Resident status Resident #41, age greater than 65, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included generalized muscle weakness, chronic kidney disease, and cerebral infarction (stroke). According to the 6/3/24 MDS assessment, Resident #41 had moderate cognitive impairment with a BIMS score of 12 out of 15. The resident required moderate assistance with bathing, set-up assistance with eating, and was independent with all other cares. B. Resident observations and interviews Resident #41 was interviewed on 6/24/24 at 11:25 a.m. Resident #41 said he was supposed to stay in his room and could not leave. Resident #41 said he did not know why he had to stay in his room. Resident #41 said no one had informed him of why he was supposed to stay in his room which made him feel very upset. Resident #41 said he felt like he was in prison. -There was no posted notification regarding the reason for isolation or information detailing when the resident was allowed to leave his room observed in Resident #41's room during the interview. Resident #41 was interviewed again on 6/27/24 at 10:04 a.m. Resident #41 said the facility had not informed him why he must remain in his room. Resident #41 said the facility had not informed him when he could leave his room. Resident #41 said the facility had not provided him any documentation or had a discussion with him about the need for his isolation. -There was no posted notification regarding the reason for isolation or information detailing when the resident was allowed to leave his room observed in Resident #41's room during the interview. C. Staff interviews The activity assistant (AA) was interviewed on 6/27/24 at 11:58 a.m. The AA said that residents in isolation should have activities offered to them. The AA said he was unsure if residents in isolation had been told when they could leave their rooms. The AA said since Resident #41 could be forgetful at times it could be helpful to give him a memory aid to help him remember what was happening. The AA said he was unsure if the facility could provide that for Resident #41. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed practical nurse (LPN) #1 was interviewed on 6/27/24 at 4:06 p.m. LPN #1 said residents should know when they were allowed to leave their room for COVID-19 isolation. LPN #1 said the facility did not document when they educated residents about their COVID-19 infections. The director of nursing (DON) was interviewed on 6/27/24 at 4:56 p.m. The DON said residents requiring room isolation should know when they could leave their rooms. The DON said Resident #41 was forgetful and the facility could provide a memory aid to help him remember both the reason for isolation and when he could leave his room safely. The DON said the facility had not provided a memory aid to Resident #41. The DON said the facility could do more to help residents with cognitive impairment remember and understand required isolation.

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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. 50314 Based on record review and interviews, the facility failed to ensure that the personal funds accounts were managed adequately for two (#2 and #30) of three residents reviewed for personal funds out of 45 sample residents. Specifically, the facility failed to notify Resident #2 and Resident #30, 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. Record Review A. Resident #2 A review of the facility's current trust account on 6/27/24 revealed Resident #2 had $2,354.81 in her account, which was $354.81 dollars over the allotted $2000.00 eligibility 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 #30 A review of the facility's current trust account on 6/27/24 revealed Resident #30 had $3683.41in his account, which was $1,683.41 over the allotted $2000.00 eligibility 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. II. Staff interviews The business office manager (BOM) was interviewed on 6/2724 at 7:04 p.m. The BOM said she provided letters notifying residents that they were within $200 of the Medicaid eligibility limit, but did not have documentation of these notifications for Resident #2 or Resident #30. The BOM said she was unable to confirm if Resident #2 and Resident #30, or their legal representatives had received the letters she sent. The BOM said the facility did not keep records of the letters that were sent to residents. The BOM said the facility was responsible for assisting residents with spending down their money. The BOM said she personally assisted residents with spending their money appropriately. The BOM said the facility had an Amazon account to assist residents with spending their money. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The BOM said the facility had been assisting Resident #2 with spending her money for the last few months, but despite facility efforts, the resident was still over the $2,000 Medicaid limit. The BOM said Resident #30 was over the $2,000 Medicaid limit by a significant amount and the facility should have done more to help him spend down his money appropriately. The social services director (SSD) was interviewed on 6/27/24 at 7:14 p.m. The SSD said she, the BOM and the activities department staff worked together to assist residents with spending down their money. The SSD said the activities staff served as a second check to ensure the facility had two different departments overseeing the resident account spending. The SSD said the facility used approved magazine orders as well as a facility Amazon account to assist residents with spending their money. The SSD said Resident #2 and Resident #30 did not have enough of their personal funds spent and were both over the $2,000 Medicaid eligibility limit. The SSD said the facility could have done more to assist Resident #2 and Resident #30 with appropriately spending their money down so their accounts were not over the eligibility limit.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on record review and interviews, the facility failed to inform three (#23, #81 and #82) of three residents reviewed for beneficiary notices out of 45 sample residents in a timely manner of changes to their services covered by Medicare. Specifically, the facility failed to: -Ensure Resident #23's Notice of Medicare Non-Coverage (NOMNC) included the last covered day and the appeal information; and, -Ensure Resident #81 and Resident #82 were provided a NOMNC letter upon changes to their Medicare coverage. Findings include: I. Resident #23 A. Resident status Resident #23, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included hemiplegia (condition that causes partial or complete paralysis on one side of the body, usually due to brain damage) and hemiparesis (symptom of the brain or nerve condition that causes partial weakness or an inability to move one side of the body) following cerebral infarction disrupted blood flow to the brain due to problems with the blood vessels) affecting the left non-dominant side. The 4/25/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required substantial to maximal assistance with toileting, showering and lower body dressing and partial to moderate assistance with upper body dressing, sitting to lying, sitting to standing and transfers. B. Record review The undated Notice of Medicare Non-Coverage letter documented Resident #23's name. -The date indicating when coverage would end was left blank. -The appeal agency name and phone number was left blank. -The notice was signed by Resident #23 on 12/1/23. II. Resident #81 A. Resident status (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #81, age 72, was admitted on [DATE] and discharged on [DATE]. According to the January 2024 CPO, diagnoses included displaced intertrochanteric fracture of the left femur. The 1/28/24 MDS assessment documented the resident was cognitively intact with a BIMS score of 15 out of 15. She was independent or required supervision with all activities of daily living (ADL). B. Record review The 1/27/24 discharge summary documented the resident discharged home with home health due to meeting her goals. A review of the resident's electronic medical record (EMR) did not reveal documentation that the resident had been issued a NOMNC letter to indicate her last covered day of Medicare A services or that the resident was provided with the appeal information if she did not agree with the Medicare A services decision. III. Resident #82 A. Resident status Resident #82, age 73, was admitted on [DATE] and discharged on [DATE]. According to the November 2023 CPO, diagnoses included lumbar spondylolisthesis (vertebra in the lower back slips out of place). The 11/8/23 MDS assessment documented the resident was cognitively intact with a BIMS score of 13 out of 15. She required supervision with ambulation and partial to moderate assistance with transfers. B. Record review The 11/22/23 discharge summary documented the resident was discharged from the facility home with her family. It indicated she received her medications and took all belongings. A review of the resident's EMR did not reveal documentation that the resident had been issued a NOMNC letter to indicate her last covered day of Medicare A services or that the resident was provided with the appeal information if she did not agree with the Medicare A services decision. IV. Staff interviews The social services assistant (SSA) and social services director (SSD) were interviewed on 6/27/24 at 6:33 p. m. The SSD said NOMNC letters should be provided three days prior to the last covered day of Medicare A services. She said the letter should include the last covered day of services and the appeal information. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The SSD confirmed the last covered day and appeal information was not included in the NOMNC notice for Resident #23. She said the resident would not have been able to appeal if he chose to without that information. The SSD said Resident #81 discharged five days after she was admitted . She said she was unable to locate a NOMNC notice for the resident. She said she did not issue a NOMNC notice to Resident #81. The SSD said Resident #82 was admitted to the facility before she worked there. She said she was unable to locate a NOMNC notice. She said it did not appear that the resident was issued a NOMNC notice. The NHA was interviewed on 6/27/24 at 7:10 p.m. The NHA said a NOMNC notice should be provided to the resident and/or responsible party 72 hours prior to Medicare A services being discontinued. He said the prior social services department did not issue the NOMNC notices appropriately. The NHA said Resident #23's notice did not have the proper elements, including the last covered day and appeal information. He said he was unable to locate a NOMNC notice for Resident #81 and Resident #82.

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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** 47818 Based on record review and interviews, the facility failed to ensure three (#42, #52 and #68) of five residents reviewed for abuse out of 45 sample residents were kept free from abuse. Specifically, the facility failed to: -Protect Resident #42 from physical abuse by Resident #25; and, -Protect Resident #52 and Resident #68 from physical abuse by Resident #24. Findings include: I. Facility policy and procedure The Abuse Policy, dated 5/3/23, was provided by the nursing home administrator (NHA) on 6/27/24 at 7:30 p. m. It read in pertinent part, Community does not condone resident abuse and shall take every precaution possible to prevent resident abuse by anyone, including other residents. Residents have the right to be free from abuse. This includes physical abuse. Providing a safe environment for the resident is one of the most basic and essential duties of our facility. Resident abuse is defined as the willful Infliction of injury of a resident resulting in physical harm or pain and mental anguish. Physical abuse is defined as abuse that results in bodily harm with intent. It includes hitting, slapping, pinching and kicking. Willful means the individual must have acted deliberately, not that he or she must have intended to inflict injury or harm. Adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or risk thereof. If a resident experiences a behavior change resulting in aggression towards other residents, the community will implement interventions for protection of alleged assailants and other residents. The residents care plan is revised to include new approaches to reduce or eliminate any further chance of abuse. Recommendations for appropriate interventions, up to and including hospitalization s, can be implemented. II. Facility investigation of physical abuse involving Resident #25 and Resident #42 on 6/6/24. The abuse investigation, dated 6/6/24, revealed Resident #25, who had a diagnosis of dementia with behavioral disturbances pushed Resident #42, who had a diagnosis of Parkinson's disease (degenerative brain condition), resulting in Resident #42 falling. Both residents resided in the memory care unit of the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #5 witnessed the event and reported being in the dining room and seeing Resident #42 walking down the hallway with her walker. Resident #25 exited her room and pushed Resident #42, who fell to the floor. After pushing Resident #42, Resident #25 returned to her room and shut the door. CNA #5 informed licensed practical nurse (LPN) #2 who assessed Resident #42 for injuries. On 6/6/24 the director of nursing (DON) interviewed Resident #25, Resident #42 and staff who were working in the memory care unit. The interview with Resident #25 revealed the resident was unable to recall events, had no injuries and was free from psychosocial distress. The interview with Resident #42 revealed the resident was unable to recall events, had no injuries and was irritable at the time of interview. The interview with CNA #5 revealed the incident between Resident #25 and Resident #42 was believed to be unprovoked as both residents had been free of agitation prior to the incident. On 6/11/24 the facility concluded the investigation and physical abuse was substantiated. III. Resident #25 (assailant) A. Resident status Resident #25, age 78, was admitted on [DATE]. According to the June 2024 computerized physicians orders (CPO), diagnoses included dementia with behavioral disturbances and anxiety. The 4/15/24 minimum data assessment (MDS) revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. She required set up assistance with activities of daily living (ADL) and was independent with mobility without the use of assistive devices. The assessment revealed Resident #25 displayed behavioral symptoms directed at others daily to include hitting, kicking, pushing, scratching and grabbing and behavioral symptoms not directed at others to include physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming and disruptive sounds. B. Record review The 5/23/24 psychotropic pharmacological management review indicated a gradual dose reduction (GDR) was occurring for Resident #25 with her Buspirone (anti-anxiety medication). The 6/6/24 psychotropic pharmacological management review indicated Buspirone was restarted for Resident #25 related to increased behaviors, including aggression towards other residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The behavioral care plan, initiated on 4/8/22 and revised on 6/6/24, revealed Resident #25 had anxiety related to her diagnosis of dementia with behavioral disturbances as evidenced by pacing, repetitive and unrealistic concerns, tearfulness, agitation and aggressive behaviors of striking out during care. Resident #25 had a history of a fixed hallucination of a man who she believed to be her companion. The care plan indicated the resident would have fewer episodes through the review date. Pertinent interventions included administering anti-anxiety medications and monitoring for unexpected side effects of mania, hostility, rage, aggressive or impulsive behaviors and hallucinations. IV. Resident #42 (victim) A. Resident status Resident #42, age 80, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included Parkinson's disease and psychotic disorder with hallucinations and delusions. The 5/17/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of zero out of 15. She required maximum assistance with ADLs and needed supervision when walking short distances and maximum assistance with mobility when using a wheelchair. The assessment revealed Resident #42 displayed behavioral symptoms not directed towards others such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming or disruptive sounds. B. Record review The wander risk care plan, initiated on 2/10/24 and revised on 5/21/24, revealed Resident #42 had a history of wandering aimlessly. It indicated the resident would remain safe through the review date. Pertinent interventions included identifying if wandering was purposeful, aimless or escapist or if the resident was looking for something and wandering indicated the need for exercise and distracting the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television or books. A review of Resident #42's electronic medical record (EMR) and facility investigation revealed no skin issues were identified, nor was pain or mental distress identified verbally or nonverbally, following the incident by Resident #25 on 6/6/24. V. Facility investigation of physical abuse involving Resident #24 and Resident #52 on 6/13/24. The abuse investigation, dated 6/13/24, revealed Resident #24, who had a diagnosis of dementia with behavioral disturbances was exhibiting agitation with exit seeking behaviors to include pushing her walker into Resident #52, who also had a diagnosis of dementia with behavioral disturbances, while Resident #52 was standing up in front of her wheelchair. Both residents resided in the memory care unit of the facility. CNA #4 witnessed the event and reported she separated the residents and provided information to registered nurse (RN) #2 who notified the director of nursing (DON). The DON proceeded with the investigation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 the DON interviewed Resident #24, Resident #52 and staff working in the memory care unit. The interview with Resident #24 revealed the resident was agitated, stating she wanted to go home and wanted out of the facility while moving personal belongings around her room. The investigation revealed Resident #24 was placed on one to one observations. The investigation revealed Resident #52 was confused and only recalled being pushed by Resident #24. The investigation revealed Resident #52 was assessed by the DON and was free of psychosocial distress and had no new injuries as a result of the event and Resident #52 received one to one staff supervision for the duration of the investigation. The investigation revealed CNA #4 witnessed the event and provided the following information to the DON. CNA #4 reported Resident #24 was having increased agitation with staff, pacing the hallway of the memory care unit in an attempt to leave. CNA #4 reported Resident #24 was slamming doors, throwing objects and shoving her walker into staff who were attempting to redirect her. CNA #4 reported Resident #24 attempted to invite another male resident into her room. CNA #4 reported attempting to redirect Resident #24 with a supervised walk throughout the building, however, Resident #24 declined, entered another resident's room and began undressing. CNA #4 reported attempting to assist Resident #24 with dressing but Resident #24 declined and walked into the hallway where she approached Resident #52 standing in front of her wheelchair. Resident #24 pushed her walker into Resident #52 causing Resident #52 to fall back into a seated position in her wheelchair. The investigation summary indicated staff believed Resident #24 was having increased behaviors as a result of a gradual dose reduction (GDR) with her current psychotropic medications. On 6/19/24 the facility concluded the investigation and physical abuse was substantiated. A review of the Resident #52's EMR and the facility investigation revealed no skin issues were identified, nor was pain or mental distress identified verbally or nonverbally, following the incident by Resident #24 on 6/13/24. VI. Resident #24 (assailant) A. Resident status Resident #24, age 88, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included dementia with behavioral disturbances. The 6/4/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of zero out of 15. She required supervision to partial assistance with ADLs and was independent with mobility with the use of a four wheeled walker. The MDS assessment revealed Resident #24 displayed physical and verbal behavioral symptoms directed towards others on one to three days during the assessment period, such as, hitting, kicking, pushing, scratching or grabbing, threatening or screaming and cursing at others. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Record review The 5/30/24 psychotropic pharmacological management review revealed there was a GDR in progress for Resident #24 and she was being titrated off of Seroquel (an antipsychotic medication) and Risperdal (an antipsychotic medication) would be ordered in place of the Seroquel. The 6/13/24 change of condition (COC) evaluation revealed the GDR of Seroquel had failed and Resident #24 was noted to have worsening behavioral symptoms. The dementia care plan, initied on 8/22/17 and revised on 6/1/24, revealed Resident #24 was taking an antipsychotic medication for a diagnosis of dementia with behavioral disturbances. It indicated the resident would remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through the review date. Pertinent interventions included administering antipsychotic medications as ordered and observing for side effects. The behavior care plan, initiated on 2/5/21 and revised on 5/7/24, revealed Resident #24 had behaviors which included pacing to the point of exhaustion, yelling out, cursing, hitting, throwing items, slamming fists on table, making repetitive statements towards staff, inability to focus and becoming hypervigilant resulting in restlessness. It indicated the resident's behaviors would not disturb others. Pertinent interventions included assisting the resident to contact her son as a means of distraction, engaging the resident in activities of enjoyment such as folding laundry or entertaining herself with a balloon or bouncing and trying to keep it in the air, watching movies, participating in crafts, and walking outside or sitting and talking with the resident if she presented with anger. VII. Resident #52 (victim) A. Resident status Resident #52, age greater than 65, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included dementia with behavioral disturbances. The 4/25/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 11 out of 15. She was independent with ADLs and mobility with a wheelchair. The MDS assessment revealed Resident #52 displayed physical and verbal behavioral symptoms directed towards others on four to six days during the assessment period such as, hitting, kicking, pushing, scratching or grabbing, threatening or screaming and cursing at others. B. Record review The fall risk care plan, initiated on 11/1/23, revealed Resident #52 was a moderate fall risk related to confusion, balance problems and was legally blind. It indicated the resident would be free from falls through the review date. Pertinent interventions included increased monitoring to anticipate the resident's needs. VIII. Facility investigation of physical altercation involving Resident #24 and Resident #68 on 6/15/24. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physical abuse investigation dated, 6/15/24, revealed Resident #24, who had a diagnosis of dementia with behavioral disturbances and Resident #68, who had a diagnosis of dementia with behavioral disturbances, both residing in the memory care facility, were observed by staff engaging in a physical altercation. The investigation revealed Resident #24 was walking out to the courtyard of the memory care unit with a baby doll set on top of the seat of her walker and Resident #68 reached out and took the baby doll off the walker of Resident #24. The investigation revealed Resident #24 slapped the hand of Resident #68 in response to the baby doll being taken and Resident #68 slapped Resident #24 in the chest, at which point, staff intervened. The investigation indicated no injuries or distress were noted for Resident #24 or Resident #68 and Resident #24 received one to one supervision for the duration of investigation. The DON proceeded with investigation. On 6/16/24 the DON interviewed Resident #24, Resident #68 and staff working in the memory care unit. The interview with Resident #24 revealed the resident continued to be agitated and irritable without aggression following the interaction. Resident #68 was unable to recall events. CNA #6 was interviewed by the DON and reported Resident #24 began displaying unprovoked agitation during the evening and was pacing the unit, pushing her walker into doors attempting to open the doors and exit the memory care unit. CNA #6 reported attempts at redirection and de-escalation with Resident #24 were unsuccessful and the resident eventually stopped pacing the unit and joined the other residents in the courtyard for dinner for a short period of time before standing and walking back through the doorway to reenter the unit. CNA #6 reported it was when Resident #24 was walking through the doorway back into the unit with a baby doll on her walker that Resident #68 reached out and tried taking the baby doll resulting in Resident #24 slapping the hand of Resident #68 and Resident #68 slapping the chest of Resident #24. CNA #6 intervened and separated the two residents. CNA #6 reported Resident #24 was continuing to display agitation and an unidentified CNA walked for approximately 30 minutes with Resident #24 throughout the facility Upon returning to the memory care unit, Resident #24 was escorted by the unknown CNA to her room where she stayed for the remainder of the evening without issue. CNA #6 reported the unknown CNA provided one to one oversight to Resident #24 while the resident had a snack, took her medication, ate dinner and was assisted to bed. The investigation summary indicated staff believed Resident #24 was having increased behaviors as a result of a gradual dose reduction (GDR) with her current psychotropic medications. On 6/21/24 the facility concluded the investigation and physical abuse was substantiated. A review of Resident #68's EMR and the facility investigation revealed no skin issues were identified, nor was pain or mental distress identified verbally or nonverbally, following the incident by Resident #24 on 6/15/24. IX. Resident #68 (victim) A. Resident status (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #68, age 83, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included dementia and anxiety. The 4/19/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of one out of 15. She required set up for eating and substantial assistance with all other ADLs and was independent with mobility. The MDS assessment revealed Resident #68 displayed physical and verbal behavioral symptoms directed towards others on one to three days during the assessment period, such as, hitting, kicking, pushing, scratching or grabbing, threatening or screaming and cursing at others. X. Staff interviews Certified nurse aide (CNA) #7 was interviewed on 6/27/24 at 1:08 p.m. CNA #7 said she was aware of the resident to resident altercation between Resident #25 and Resident #42 on 6/6/24 but had not witnessed the event. CNA #7 said she had not noticed any changes in behaviors regarding Resident #25 or Resident #42 individually or separately. CNA #7 said she had not witnessed any provoking interaction between the two residents prior to the altercation. CNA #7 said she was made aware of the resident to resident altercation between Resident #24 and Resident #52 on 6/13/24 and the altercation between Resident #24 and Resident #68 on 6/15/24. CNA #7 said she had not personally witnessed either event. CNA #5 was interviewed on 6/27/24 at 1:10 p.m. CNA #5 said she witnessed the resident to resident altercation between Resident #25 and Resident #42 on 6/6/24. CNA #5 she had not noticed any changes in behaviors regarding Resident #25 or Resident #42 individually or separately. CNA #5 said she had not witnessed any provoking interaction between the two residents prior to the altercation. The director of nursing (DON) was interviewed on 6/27/24 at 5:00 p.m. The DON said it was determined the GDR for Resident #24's anti-anxiety medication would be considered a failed trial as the altercation between the resident and Resident #25 was unprovoked and the facility determined the GDR to be a contributing factor. The DON said Resident #24 was in the process of a GDR of her antipsychotic medication at the time of the resident to resident altercations with Resident #52 and Resident #68. The DON said Resident #24 had been stable on the medication and it was determined the GDR was a contributing factor to the altercations and the GDR was considered a failed trial. The DON said increased monitoring was implemented in the memory care unit during the GDR for Resident #24 and there was to be one staff member with eyes on the residents at all times. The DON said there was now the addition of a full time activities assistant dedicated to the memory care unit and the addition of a memory care unit manager to provide more staff to try to prevent further incidents of abuse.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observation and interviews, the facility failed to ensure that professional standards of practice were followed during medication administration for three (#67, #26 and #29) of nine residents reviewed out of 45 sample residents. Specifically, the facility failed to: -Ensure medications and insulin supplies, including sharps, were not left at the bedside; -Ensure medications were not dispensed and stored in medication cups in a nurse's pocket; and, -Ensure medications were not contaminated by placing dispensed medication back into the original bottle. Findings include: I. Facility policy and procedure The Medication Administration policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 6/27/24 at 7:29 p.m. It read in pertinent part, Resident medications are administered in an accurate, safe, timely and sanitary manner. Do not leave medications with the resident. Follow the medication/pharmacy guidelines for storage. II. Resident #67 A. Resident status Resident #67, age less than 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included unspecified severe protein-calorie malnutrition, type 1 diabetes mellitus with other specified complications, alcohol abuse and functional quadriplegia (complete immobility due to severe physical disability or frailty). The 5/14/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. B. Observations On 6/25/24 assistant director of nursing (ADON) #2 was preparing to administer insulin to a resident. After checking the resident's blood sugar, ADON #2 left the room to obtain an insulin syringe from the medication cart. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-ADON #2 left the insulin supply box at the bedside, which contained insulin and sharps for the glucometer. III. Resident #26 A. Resident status Resident #26, age less than 65, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included hemiplegia (paralysis to one side of the body) and hemiparesis (weakness to one side of the body) following unspecified cerebrovascular disease (decreased blood flow to the brain) affecting the right dominant side, unspecified psychosis not due to a substance or known physiological condition, type 2 diabetes mellitus without complications and acute respiratory failure with hypoxia (inadequate oxygen supply). The 6/11/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of eight out of 15. B. Observations On 6/26/24 at 8:59 a.m., registered nurse (RN) #1 was preparing medication for Resident #26. She cut an olanzapine tablet (antipsychotic medication) in half with a pill cutter. She placed the half that was not going to be administered in a medication cup and put the cup containing the medication into her pocket. RN #2 said she would take it to the drug buster (a container used to destroy medications) for disposal later . IV. Resident # 29 A. Resident status Resident #29, age 76, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder (break down of discs between the vertebrae in the back, causing pain), chronic respiratory failure with hypoxia and type 2 diabetes mellitus without complications. The 4/24/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of eight out of 15. B. Observations On 6/27/24 at 8:59 a.m., ADON #1 was preparing medication for Resident #29. She poured two tablets of famotidine 10 milligrams (mg) (medication to treat heartburn) into a medication cup with other medications. She then realized there were 20 mg tablets in the medication cart and that she should administer one 20 mg tablet instead of two 10 mg tablets. -ADON #1 took the two 10 milligram tablets out of the medication cup with a spoon and returned them to the original bottle. The bottle was a stock medication bottle and was utilized for more than one resident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V. Staff interviews ADON #2 was interviewed on 6/27/24 at 4:30 p.m. ADON #2 said there were not drug buster containers in every medication cart so nurses had to take medications for disposal to another area when passing medications. The director of nursing (DON) was interviewed on 6/27/24 at 5:20 p.m. The DON said insulin supplies should not be left in a resident's room unattended. She said pills should not be put back into stock containers after dispensing them into a medication cup with other medications.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, interviews and record review, the facility failed to ensure one (#57) of six residents reviewed for activities out of 45 sample residents received an ongoing program of activities designed to meet needs and interests, and promote physical, medical and psychosocial well-being. Specifically, Resident #57 was not provided with meaningful activities or one-to-one activity staff visits per her individualized plan of care. Findings include: I. Resident #57 A. Resident status Resident #57, age less than 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included non-ischemic myocardial injury (non-traumatic injury to the heart), acute on chronic diastolic (congestive) heart failure, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side and type 2 diabetes mellitus with diabetic chronic kidney disease. The 5/27/24 minimum data set (MDS) assessment revealed the resident was unable to answer any of the questions on the brief interview for mental status (BIMS) which resulted in a BIMS score of zero out of 15. The assessment indicated her activity preferences included animals, going outside, books, magazines, music and keeping up with the news. The assessment documented she had adequate hearing and was sometimes able to make herself understood. II. Observations On 6/25/24 at 11:19 a.m. Resident #57 was lying in bed on her right side in a fetal position. She was in isolation for COVID-19. On 6/25/24 Resident #57 was observed during a continuous observation, beginning at 2:21 p.m. and ending at 4:01 p.m. At 2:21 p.m. the resident was lying in bed on her right side. There was no television on or music playing in her room. At 3:20 p.m. the resident continued lying in bed on her right side. No staff had entered her room and the resident was not engaged in any individual activities. There was no television on and there was no music playing in her room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 3:48 p.m. a certified nurse aide (CNA) entered the room briefly and exited with a trash bag. At 4:01 p.m. Resident #57 was sitting on the side of the bed. There was no television on or music playing in the room and she was not engaged in any individual activities. On 6/26/24 at 10:39 a.m. the resident was lying in bed on her right side with her feet hanging off the side of the bed. There was no television on or music playing in the room and she was not engaged in any individual activities. The resident had been taken off of isolation for COVID-19. On 6/26/24 at 1:05 p.m. Resident #57 was lying in bed on her right side. Assistant director of nursing (ADON) #2 and the corporate consultant (CC) were providing wound care to the resident. The resident did not have the television on or music playing. ADON #2 and the CC did not offer any type of activity to the resident when they left the resident's room. On 6/26/24 at 2:41 p.m. the resident was lying in bed on her right side with her feet dangling off of the bed. There was no television on or music playing in the room and she was not engaged in any individual activities. III. Resident interview Resident #57 was interviewed on 6/25/24 at 2:19 p.m. Resident #57 was lying in bed. She said she did not have any activities to do in her room and she was always bored. She said she liked to read but hadn't been reading because she had been sick. The resident was able to answer questions and was understood during the interview. IV. Record review Resident #57's activities care plan, initiated 5/2/24, identified the resident had little or no involvement in activities due to disinterest and physical limitations. The goal was to have one to one visits one time per week from activities staff. -Review of Resident #57's progress notes for May 2024 and June 2024 did not reveal any one to one activity visit documentation. V. Staff Interview The activity director (AD) was interviewed on 6/27/24 at 4:50 p.m. The AD said she had been the activity director for four months. She said when a resident had one to one activity visits, the visits were documented in the progress notes. She said if a resident refused a one to one visit that would also be documented in the progress notes. The AD said Resident #57 had been refusing one to one visits since her decline in condition a couple of months ago. -The AD was unable to provide documentation for Resident #57 which documented weekly one to one visits or refusals. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The AD said before her decline in condition, Resident #57 was still socializing with people in the hallways. She said the resident liked to talk about her husband who was in the military. The AD said she recently started auditing the activity documentation because the documentation was lacking. She said she had recently started training her staff on documentation expectations.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on record review and interviews, the facility failed to ensure two (#58 and #67) of two sample residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan out of 45 sample residents. Specifically, the facility failed to: -Notify the physician for high blood sugar readings for Resident #58; and, -Consistently monitor blood sugars according to the physician's order for Resident #67. Findings include: I. Facility policy and procedure The Diabetic Management policy, dated 3/19/24, was provided by the nursing home administrator (NHA) on 6/27/24 at 7:29 p.m. It read in pertinent part, Diabetic management involves both preventative measures and treatment of complications. The interdisciplinary team evaluates the diabetic resident and implements a plan of care: to ensure orders are received and are accurate related to blood glucose monitoring and anti-diabetic agents. Blood glucose orders should include parameters to follow in communicating with the physician. If the resident has high blood sugar, follow physician ordered parameters. If the blood sugar is above 'high' parameter, the physician must be contacted for further instructions. For acute complications, documentation should include at least the following information: resident's signs and symptoms, results of blood testing, notification of physician and any new orders, interventions initiated, resident's response to treatment and notification of responsible party if applicable. II. Resident #58 A. Resident status Resident #58, age less than 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus. According to the 5/7/24 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He was independent with most activities of daily living (ADL) but needed supervision with bathing. B. Record review The June 2024 CPO revealed the following orders for diabetic management: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lantus subcutaneous solution 100 units per milliliter (insulin glargine), inject 20 units subcutaneously in the morning for type 2 diabetes mellitus without complications, ordered on 4/8/23. Insulin glargine subcutaneous solution (insulin glargine), inject 10 units subcutaneously in the evening for type 2 diabetes mellitus without complications, ordered on 7/31/23. Fingerstick blood sugar once per day for type 2 diabetes mellitus management, ordered on 11/23/23 and revised on 3/22/24. Hyperglycemia (high blood sugar) protocol, use as needed for hyperglycemia, a blood sugar over 400 milligrams/deciliter (mg/dl), notify the physician, follow the physician's orders and continue to recheck the blood sugar every hour and provide interventions as needed or specified by the provider, ordered on 12/18/2023. -The January 2024 diabetic record revealed missing documentation of physician notification for high blood sugars on 1/26/24 at 7:59 a.m. for a blood sugar of 418 mg/dl and on 1/28/24 at 7:53 a.m. for a blood sugar of 409 mg/dl. -The February 2024 diabetic record revealed missing documentation of physician notification for a high blood sugar on 2/20/24 at 7:59 a.m. for a blood sugar of 420 mg/dl. -The May 2024 diabetic record revealed missing documentation of physician notification for high blood sugars on 5/2/24 at 10:00 a.m. for a blood sugar of 486 mg/dl and on 5/11/24 at 7:04 a.m. for a blood sugar of 599 mg/dl. 50853 III. Resident #67 A. Resident status Resident #67, age less than 65 was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included type 1 diabetes mellitus with other specified complications, unspecified severe protein-calorie malnutrition, alcohol abuse and functional quadriplegia (complete immobility due to severe disability or frailty, not due to a spinal cord injury). The 5/14/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The assessment indicated the resident received insulin injections seven out of seven days during the assessment reference period. B. Record review The 2/22/24 physician ' s order for insulin lispro (Humalog) 100 units/milliliter (ml) pen, inject as per sliding scale. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If blood sugar is: 0 - 199 = 0 units; 200 - 249 = 1 unit; 250 - 299 = 2 units; 300 - 349 = 3 units; 350 - 399 = 4 units; 400 - 449 = 5 units; 450 - 499 = 6 units; 500 - 600 = 8 units, subcutaneously every 4 (four) hours for diabetes mellitus. Notify the physician for blood sugar less than 60 milligrams/deciliter (mg/dl) after carbohydrate supplement or greater than 400. mg/dl. The order date of the medication was 2/2/24. The 1/12/24 physician ' s order indicated for hyperglycemia (high blood sugar) protocol as needed for blood sugar greater than 400 mg/dl. Step one notify the physician, step two follow physician orders and step three continue to recheck blood sugar every one hour and provide interventions as needed or specified by the provider. According to the June 2024 medication administration record (MAR) the resident had high blood sugars, over 400 mg/dl, on the below listed dates. -On 6/1/24 at 9:05 p.m. the resident ' s blood sugar was 600 mg/dl. The staff did not recheck the blood sugar until 6/2/24 at 2:29 a.m. -On 6/3/24 at 1:58 a.m. the resident ' s blood sugar was 417 mg/dl. The staff did not recheck the blood sugar until 5:13 a.m. -On 6/4/24 at 4:55 p.m. the resident ' s blood sugar was 464 mg/dl. The staff did not recheck the blood sugar until 8:02 p.m. -On 6/5/24 at 3:36 p.m. the resident ' s blood sugar was 586 mg/dl. The staff did not recheck the blood sugar until 7:51 p.m. -On 6/5/24 at 7:51 p.m. the resident ' s blood sugar was 600 mg/dl. The staff did not recheck the blood sugar until 6/6/24 at 1:33 a.m. -On 6/8/24 at 4:52 p.m. the resident ' s blood sugar was 600 mg/dl. The staff did not recheck the blood sugar until 7:40 p.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 6/8/24 at 7:40 p.m. the resident ' s blood sugar was 518 mg/dl. The staff did not recheck the blood sugar until 11:54 p.m. -On 6/11/24 at 4:55 p.m. the resident ' s blood sugar was 466 mg/dl. The staff did not recheck the blood sugar until 8:19 p.m. -On 6/12/24 at 8:16 p.m. the resident ' s blood sugar was 407 mg/dl. The staff did not recheck the blood sugar until 6/13/24 at 5:03 a.m. -On 6/13/2024 at 8:56 p.m. the resident ' s blood sugar was 584 mg/dl. The staff did not recheck the blood sugar until 6/14/24 at 12:13 a.m. -On 6/14/24 at 6:00 a.m. the resident ' s blood sugar was 478 mg/dl. The staff did not recheck the blood sugar until 8:38 a.m. -On 6/15/24 at 3:53 a.m. the resident ' s blood sugar was 492 mg/dl. The staff did not recheck the blood sugar until 9:26 a.m. -On 6/16/24 at 9:15 p.m. the resident ' s blood sugar was 461 mg/dl. The staff did not recheck the blood sugar until 6/17/24 at 12:47 a.m. -On 6/22/24 at 5:10 a.m. the resident ' s blood sugar was 407 mg/dl. The staff did not recheck the blood sugar until 9:25 a.m. -On 6/22/24 at 4:16 p.m. the resident ' s blood sugar was 592 mg/dl. The staff did not recheck the blood sugar until 9:14 p.m. -On 6/22/24 at 9:14 p.m. the resident ' s blood sugar was 439 mg/dl. The staff did not recheck the blood sugar until 11:43 p.m. -On 6/23/24 at 11:33 a.m. the resident ' s blood sugar was 519 mg/dl. The staff did not recheck the blood sugar until 4:03 p.m. -On 6/24/24 at 12:18 p.m. the resident ' s blood sugar was 468 mg/dl.The staff did not recheck the blood sugar until 5:35 p.m. -On 6/24/24 at 8:12 p.m. the resident ' s blood sugar was 465 mg/dl. The staff did not recheck the blood sugar until 6/25/24 at 1:12 a.m. -On 6/25/24 at 4:47 p.m. the resident ' s blood sugar reading was greater than 600 mg/dl (high). The staff did not recheck the blood sugar until 8:34 p.m. -On 6/26/24 at 5:27 a.m. the resident ' s blood sugar was 509 mg/dl.The staff did not recheck the blood sugar until 9:03 a.m. -On 6/26/24 at 5:10 p.m. the resident ' s blood sugar was 600 mg/dl. The staff did not recheck the blood sugar until 8:44 p.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A review of the resident ' s electronic medical record (EMR) revealed the nursing staff failed to monitor Resident #67 ' s blood sugar every hour following a blood sugar reading above 400 mg/dl per the protocol in June 2024 (see above). -A review of the June 2024 (6/1/24 to 6/26/24) MAR revealed no documentation indicating the hyperglycemia protocol was followed. IV. Staff interviews Assistant director of nursing (ADON) #2 was interviewed on 6/27/24 at 11:08 a.m. ADON #2 said the hyperglycemia protocol specific to Resident #67 was to give insulin per the sliding scale physician ' s order, notify the physician and follow any new orders that were received. She said she was unsure if the resident ' s blood sugar needed to be rechecked within a certain time frame. The director of nursing (DON) was interviewed on 6/27/24 at 5:20 p.m. The DON said the hyperglycemia protocol needed to be followed if the blood sugar was out of the range of the sliding scale. She said the nurse should notify the provider, recheck the blood sugar within 15 minutes and as often as needed until the resident was stable. She said if the protocol was written in the physician's orders, the nurse should follow the physician ' s ordered protocol. The DON said the licensed nurses were not checking Resident #58's blood sugars hourly for four hours because the physician's order did not prompt the nurses to do so. She said she was unable to find documentation indicating the nurses had followed up on Resident #58's high blood sugars. The DON said the nurses knew they should follow up on the high blood sugar readings. The DON said the nurses should enter a progress note into the resident's EMR and obtain and document the follow-up blood sugars. She said the nurses did not check blood sugars hourly for four hours on Resident #67 as they should have when the resident ' s blood sugars were high in June 2024. She said the nurses may have checked the blood sugars hourly, however, she said because it was not documented, there was no indication that the blood sugars were taken.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review and interviews, the facility failed to ensure one (#57) of five residents reviewed for pressure injuries out of 45 sample residents received care consistent with professional standards of practice to prevent pressure injuries. Specifically the facility failed to implement timely interventions to prevent Resident #57 from developing a Stage 2 pressure injury to her right lateral ankle on 5/25/24 and to prevent the potential for further pressure injuries to occur. Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA (2019), retrieved from https://www.internationalguideline.com/guideline on 7/1/24, Pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. II. Facility policy The Pressure Injury policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 6/27/24 at 7:29 p.m. It read in pertinent part, Purpose: To assess and implement interventions as appropriate to reduce the likelihood of development of pressure injuries. Protecting against the effects of pressure, friction and shear: -Reduce pressure over bony prominences by offloading and positioning; -Develop turning and repositioning plans for residents in bed or chair; -Provide special attention to suspending heels; -Maintain good hydration; and, -Evaluate the need for a pressure-reducing mattress. Encourage optimal nutrition and fluid intake: -Conduct nutritional consultation with registered dietician; -Identify clinical signs of malnutrition (unintended weight loss); (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Offer snacks and fluids between meals; -Consider administration of supplements (vitamins, mineral, calories, protein, fluids); and, -Report and document any concerns in the nutritional plan of care. III. Resident status Resident #57, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included non-ischemic myocardial injury (non-traumatic injury to the heart)), acute on chronic diastolic (congestive) heart failure, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side and type 2 diabetes mellitus with diabetic chronic kidney disease. According to the 5/27/24 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. She needed substantial to maximal assistance with bed mobility, transfers and personal hygiene, but only required set-up assistance with eating. She used a wheelchair for mobility. The assessment did not identify the resident as being at risk of developing pressure ulcers. The assessment documented the resident had one unstageable pressure injury which was not present on admission. The assessment documented the resident had a pressure reducing device for her chair, a pressure reducing device for her bed and received pressure injury care. IV. Observations On 6/25/24 Resident #57 was observed during a continuous observation, beginning at 2:21 p.m. and ending at 4:01 p.m. At 2:21 p.m., the resident was in bed lying on her right side. The resident had an alternating pressure mattress on her bed. -There were no pressure reducing boots on the resident's feet. At 3:48 p.m. Resident #57 continued lying in bed on her right side. A certified nurse aide (CNA) entered the room. -The CNA did not provide any care to the resident or attempt to place pressure reducing boots on the resident's feet. At 4:01 p.m. the resident was sitting on the side of the bed. There were no pressure reducing boots on her feet or observed in the room. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 10:39 a.m. the resident was lying in bed on her right side with her feet hanging off the side of the bed. -One pressure reducing boot was observed on the bed, however, it was not on either of the resident's feet. -On 6/26/24 at 1:05 p.m. the resident was lying in bed with no pressure reducing boots on her feet. On 6/26/24 at 1:05 p.m. the nurse corporate consultant (CC) and assistant director of nursing (ADON) #2 obtained permission from Resident #57 to perform her wound care. The CC removed the dressing on the lateral right ankle and there was minimal drainage on the dressing. The wound bed was pink with no slough and the skin was dry around the wound bed. After the wound care was completed, the CC offered the pressure reducing boot for the right foot and the resident accepted it. -The CC did not put a pressure reducing boot on the resident's left foot and there was not a second pressure reducing boot observed in the room. -However, according to the resident's June 2024 CPO, she was to have pillows or heel protectors to offload the pressure to both of her feet and ankles while she was in bed (see physician's orders below). On 6/26/24 at 2:41 p.m. Resident #57 was lying on her right side in bed and her feet were dangling off of the side of the bed. -There were no pressure reducing boots on either of the resident's feet. One boot was observed on the floor and a second boot was not observed in the room. V. Record review The pressure injury care plan, updated 6/18/24, revealed Resident #4 was at risk for pressure injuries. Pertinent interventions included providing a pressure relieving device to bed and wheelchair, keeping skin clean and dry, using lotion on dry skin, administering treatments as ordered and observing for effectiveness, providing heel protector boots or floating heels on pillows for pressure relief (often declined to wear boots), assisting the resident to reposition and or turn at frequent intervals to provide pressure relief, and encouraging good nutrition and hydration to promote healthy skin. -The care plan did not include any nutritional interventions such as supplements for pressure injury prevention or healing. The nutrition care plan, revised 5/31/24, documented Resident #57 had an unstageable pressure injury to the right ankle. -On 6/25/24, during the survey, a new intervention was added that documented the resident declined the use of nutritional supplements. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A readmission assessment was completed on 5/21/24 when Resident #4 readmitted to the facility following a hospital stay. The admitting nurse documented that Resident #57's skin was warm, normal in color, there was no edema and there were no skin issues present. A pressure ulcer was not identified. A review of Resident #57's June 2024 CPO revealed the following physician's orders: Cleanse wound to the lateral right ankle with normal saline. Apply MediHoney to the wound bed only and cover with Optifoam. Change every other day and as needed for loose, soiled, or excessive drainage, monitor and report abnormalities, ordered 5/25/24. Provide house nutritional supplement between meals. Document amount consumed two times a day, ordered 5/30/24. -The nutritional supplement was not implemented until five days after the right lateral ankle pressure wound was identified on 5/25/24. Apply pressure reducing boots while lying in bed every shift, ordered 5/30/24. -The intervention was not implemented until five days after the right lateral ankle pressure wound was identified on 5/25/24. Use pillows or heel protectors to off load pressure to feet and ankles while in bed, every shift, ordered 6/8/24. -The intervention was not implemented until 14 days after the right lateral ankle pressure wound was identified on 5/25/24. Alternating pressure mattress to the bed. Set at level 30 firmness and check the mattress every shift for proper setting and function, ordered 6/17/24. -The intervention was not implemented until 23 days after the right lateral ankle pressure wound was identified on 5/25/24. A review of Resident #57's electronic medical record (EMR) revealed the following progress notes: The 5/23/24 physician note documented the resident's skin was pale/sallow (gray in color), warm and dry. -The progress note did not identify a pressure injury. The 5/24/24 skilled nursing note documented the resident's skin had multiple bruises related to multiple attempts at drawing blood. -The progress note did not identify a pressure injury. The 5/25/24 nursing wound note documented Resident #57 had a stage 2 pressure injury to the right lateral ankle measuring 4 centimeters (cm) by 1.5 cm. injury. The wound bed contained 100 percent (%) slough (soft yellow or white tissue covering the wound bed). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/30/24 wound note documented the right lateral ankle measurements were 3.8 cm by 0.9 cm. The wound was unstageable due to 100% slough present in the wound bed. The 6/6/24 wound note documented the superior (upper) area of the right lateral ankle wound measured 0.2 cm by 1.0 cm and the inferior (lower) area measured 1.4 cm by 0.7 cm and the wound had macerated (moist or soggy) edges. The 6/13/24 wound note documented the superior area of the right lateral ankle wound measured 1.0 cm by 0.3 cm and the inferior area measured 1.2 cm by 0.7 cm and there was no slough in the wound bed. The wound had macerated edges. The 6/13/24 registered dietitian (RD) assessment did not identify that Resident #57 had a pressure injury. The 6/20/24 wound note documented the superior area of the right lateral ankle wound measured 1.5 cm by 0.3 cm and the inferior area measured 1.5 cm by 0.8 cm. The wound bed was 75% slough and 25% granulated (new, pink) tissue with macerated edges. The 6/27/24 wound note documented the superior area of the right lateral ankle wound measured 0.1 cm by 1.0 cm and the inferior area measured 1.1 cm by 0.5 cm. The CC said there was no slough present in the wound bed. V. Staff interviews ADON #2 was interviewed on 6/27/24 at 11:10 a.m. ADON #2 said upon Resident #57's readmission to the facility on [DATE], the admitting nurse documented the resident had bandages on the right foot, however, the nurse did not remove them to look at her skin. ADON #2 said she discovered the right lateral ankle wound two days later (per the medical record, it was actually identified four days after admission). ADON #2 said the wound was a facility acquired pressure injury because it had not been identified upon the resident's readmission to the facility The director of nursing (DON) was interviewed on 6/27/24 4. The DON said a house supplement was attempted, however, she said Resident #57 would not drink it. The DON said she did not know if any other supplements were tried with the resident. She said she did not know what other supplement options the facility had available.

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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 record review and interviews, the facility failed to ensure one (#45) of two residents with limited range of motion received appropriate treatment and services out of 45 sample residents. Specifically, the facility failed to offer restorative nursing services as recommended by physical therapy to prevent decline in physical function for Resident #45. Findings include: I. Professional Reference According to the American Association of Post-Acute Nursing (AAPACN) Guidelines for Restorative Nursing Programs, retrieved on 7/1/24 from aapacn.org/restorative-programs-guide/, The risk for functional decline in long term care residents is a serious issue that often leads to falls, pressure ulcers/injuries, weight loss, depression, and other negative outcomes. To ensure quality outcomes and to comply with federal regulation, nursing facilities must have a comprehensive and effective restorative therapy program that encourages each resident's highest level of function. II. Resident #45 A. Resident status Resident #45, age greater than 65, was admitted to the facility on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included dementia, Parkinson's disease and anemia. The 3/25/24 minimum data set (MDS) assessment revealed the resident had no cognitive impairments with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required supervision or touching assistance with bathing and set up or clean-up assistance with personal hygiene. B. Resident interview Resident #45 was interviewed on 6/24/24 at 3:14 p.m. Resident #45 said she had not received restorative nursing services for a few weeks. Resident #45 said she felt like she was becoming more stiff and could not move as easily as she used to when getting out of bed. Resident #45 said when she was in physical therapy she could walk longer distances, but felt that it had become more difficult for her to walk since physical therapy services ended in May 2024. Resident #45 said she thought her fall earlier this month (June 2024) could have been because she had become weaker. Resident #45 said she was worried she might fall more in the future if she did not keep her strength up with restorative nursing services. C. Record review (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physical therapy discharge summary dated 5/10/24 documented that physical therapy services ended because Resident #45 completed all physical therapy goals. The discharge summary documented the following regarding Resident #45: -She could walk 100 feet four times per physical therapy session; -She required minimum assistance with transfers in bed and required stand-by assistance to transfer with a four wheel walker; -She had a significant increase in endurance with skilled physical therapy; and, -She had an increase in ambulation ability with skilled physical therapy. The discharge summary recommended a restorative nursing program to include restorative ambulation and a restorative range of motion. The discharge summary documented a good prognosis to maintain current level of function with consistent staff follow-through. -A review of the June 2024 CPO revealed the resident did not have an order for restorative nursing services. A restorative nursing program referral form, dated 5/10/24, was obtained from the director of rehabilitation (DOR) on 6/27/24 at 10:06 a.m. The referral form documented a physical therapy recommendation for Resident #45 to receive restorative nursing services four to five times per week. The referral form documented the restorative goal was to maintain or improve Resident #45's movement and strength in her lower limbs and to enable the resident to continue to transfer and walk. The referral form documented the resident required further services in the areas of active range of motion, transfers, and walking. The referral form documented the resident was able to walk 80 to100 feet three to four times per physical therapy session. A restorative aide progress note dated 5/28/24 documented Resident #45 was on a restorative program including active range of motion for the resident's legs, ambulation with a four wheel walker and for transfers. A restorative aide progress note dated 5/31/24 documented Resident #45 was participating well in the restorative nursing program and was able to ambulate 300 feet per session. A restorative aide progress note dated 6/9/24 documented Resident #45 was participating well in the restorative nursing program and was able to ambulate 30 feet per session. A restorative aide progress note dated 6/14/24 documented Resident #45 was participating well in the restorative nursing program and was able to ambulate 140 feet per session. A restorative aide progress note dated 6/21/24 documented Resident #45 was participating with the restorative nursing program two times per week. The progress note documented the restorative nursing program was on hold because the resident was COVID-19 positive and was not feeling well. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A restorative aide progress note dated 6/23/24 documented the resident's restorative nursing program was on hold because the resident was COVID-19 positive. -The progress note failed to document if restorative nursing services were offered to the resident in her room. A review of the certified nurse aide (CNA) task response history (from 5/25/24 to 6/26/24) revealed Resident #45 received restorative nursing services on 5/30/24, 6/4/24, 6/5/24, 6/8/24, 6/11/24, and 6/13/24. -Resident #45 did not receive restorative nursing services until 5/30/24, 20 days after the resident was referred to a restorative nursing program by physical therapy. -Resident #45 received restorative nursing services six times between 5/30/24 and 6/13/24. -The facility failed to offer restorative nursing services to Resident #45 four to five times per week as recommended by physical therapy (see physical therapy referral form above). -One resident refusal was documented on 6/21/24; however, the facility failed to re-offer restorative nursing services on a different date to Resident #45. III. Staff interviews Registered nurse (RN) #1 was interviewed on 6/26/24 at 4:02 p.m. RN #1 said she worked as needed in the facility and was familiar with all the residents in the building. RN #1 said she had recently noticed Resident #45 had gotten more stiff during transfers and ambulation. RN #1 said she had heard other staff members mention Resident #45 required more assistance with her ADLs (activities of daily living) than she used to. RN #1 said she was not aware what restorative nursing services Resident #45 required because the restorative aides provided restorative services. CNA #3 was interviewed on 6/26/24 at 4:21 p.m. CNA #3 said Resident #45 required the same number of staff for ADLs as before, but needed more assistance from the staff member to assist with transfers. CNA #3 said Resident #45 could walk about 50 feet before she usually got tired and needed a rest. CNA #3 said she knew Resident #45 was receiving restorative nursing services but she was unsure if it was ongoing or discontinued. The MDS coordinator (MDSC) was interviewed on 6/27/24 at 10:19 a.m. The MDSC said she was also the director of restorative nursing services in the facility. The MDSC said restorative nursing services were important to maintain a resident's current level of function. The MDSC said restorative nursing service referrals from physical therapy should always be followed. The MDSC said residents who tested positive for COVID-19 should still have restorative nursing services offered to them in accordance with the physical therapy recommendations. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDSC said the restorative services department had lost a restorative aide recently and the department had to make some hard decisions about how to continue restorative services for all residents. The MDSC said Resident #45's restorative services were reduced to twice per week because of the loss of the restorative aide. The MDSC said the facility's choice to reduce Resident #45's restorative nursing services to two times per week instead of the four to five times per week recommended by physical therapy could have contributed to her decline in physical function. The director of nursing (DON) was interviewed on 6/27/24 at 4:56 p.m. The DON said restorative nursing services were important to maintain a resident's current level of function. The DON said physical therapy recommendations for restorative nursing services should be followed. The DON said restorative nursing services should be offered to residents who had a COVID-19 infection and those services could be provided in the resident's room if needed. The DON said Resident #45 had not been receiving restorative nursing services as was initially recommended by physical therapy.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to ensure an environment free from risk of accident hazards for four (#7, #27, #11 and #22) of five residents out of 45 sample residents. Specifically, the facility failed to: -Ensure neurological checks were completed appropriately for Resident #7 following an unwitnessed fall; -Ensure Resident #7's fall care plan was reviewed and new interventions were added following an unwitnessed fall; -Ensure Resident #27 was appropriately assessed for self-administration of a wart removal medication and eye drops; -Ensure a safety assessments was completed for Resident #27 to determine if she was safe to use a hot tea kettle with a heating element in her room; -Ensure a safety assessment was completed for Resident #11 to determine if he was safe to use a space heater in his room; and, -Ensure a safety assessment was completed for Resident #22 to determine if he was safe to use a coffee maker with a heating element in his room. Findings include: I. Resident #7 A. Facility policy The Fall Management policy was provided by the nursing home administrator (NHA) on 6/26/24 at 11:40 a. m. It documented in pertinent part, A fall reduction program will be established and maintained, to assess all residents to determine their risk for falls. A plan of care will be implemented based on the resident's assessed needs. Research has shown that a structured fall reduction program can substantially reduce the rate of falls and related injuries in nursing facilities. Identifying risk factors, followed by timely and appropriate interventions, is the key to a successful program. Each resident will be re-evaluated quarterly, annually and when a significant change occurs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the environment and make appropriate changes, for example, bed in lowest position, placement of furniture, lighting, personal items within reach, non-slip footwear, night light, walker, wheelchair within reach if applicable. The call light and fluids should be within reach of the resident. If a resident experiences a fall with head injury, the fall is unwitnessed, or the resident self-reports a fall, neurological checks will be initiated. B. Resident status Resident #7, under the age of 65, was admitted on [DATE]. According to the June 2024 computerized physician order (CPO), diagnoses included unspecified diabetes, unspecified disorder of psychological development and muscle wasting with atrophy (gradual decline in function due to underuse or neglect). According to the 6/12/24 minimum data set (MDS) assessment, Resident #7 had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required moderate assistance with bathing, supervision assistance with dressing, set-up assistance with personal hygiene, and was independent with all other cares. C. Observations On 6/24/24 at 10:52 a.m., Resident #7's room was observed. The bathroom call light cord was tightly wrapped around a bathroom grab bar next to the call light. The black connector attaching the call light cord to the wall appeared crooked and scratched. The call light cord did not function correctly (see interview below). D. Resident interview Resident #7 was interviewed on 6/24/24 at 10:52 a.m. Resident #7 said she had fallen in her bathroom earlier this month (June 2024), and could not call for help. Resident #7 said her call light cord did not work correctly. Resident #7 said she could activate her call light by taking her shoe off and hitting the black connector where the call light cord was affixed to the wall. Resident #7 said she could not pull on her bathroom call light cord because it did not work that way. Resident #7 said her call light cord had been wrapped around the grab bar in the bathroom for more than a year. Resident #7 said after her fall she was told to call for help when she needed, but taking her shoe off to hit the call light also made her feel like she might fall in her attempt to call for help. E. Record review A progress notes dated 6/14/24 at 11:15 a.m. documented Resident #7 had an unwitnessed fall at 11:15 a.m. The progress note documented neurological assessments and vital signs were obtained beginning at 11:15 a.m. The progress note documented the resident's call light was activated when nursing staff entered the room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress notes dated 6/14/24 at 11:26 a.m. documented Resident #7 underestimated the distance to her chair and sat back on the floor, missing the chair while self-transferring off the toilet. The progress note documented the resident did not call for staff assistance. -However, the 11:15 a.m. progress note documented the resident's call light was activated when nursing staff entered the room (see progress note above). Resident #7's neurological record documentation, dated 6/14/24, was reviewed in the electronic medical record (EMR). The neurological record documented a full set of neurological assessments required a 72-hour period of time to complete appropriately. The neurological record documented the facility protocol was to document neurological checks every 30 minutes for four assessments, then every one hour for four assessments, then every four hours for six assessments and then every eight hours for the remainder of the 72-hour post-fall period. Resident #7's neurological record documented the resident received a neurological assessment on 6/14/24 at 11:15 a.m., 11:45 a.m., 12:15 p.m., 12:45 p.m. and 1:45 p.m. -However, the neurological assessment documented that at the time for the hourly 2:45 p.m. and 3:45 p.m. neurological assessments, the resident was out of the facility on a pass with the activities department. An activity progress notes dated 6/14/24 documented the activity staff took Resident #7 out for a shopping outing between 2:00 p.m. and 4:30 p.m. -The facility failed to complete neurological checks in accordance with facility protocol. -The facility failed to document neurological checks on 6/17/24. An interdisciplinary team (IDT) post-fall review, dated 6/19/23, was reviewed in the EMR. The post fall-review documented Resident #7 could demonstrate use of her bathroom call light. The post-fall review recommended the resident use a reacher or call for assistance to get objects from the floor, to ensure the resident was aware of safe wheelchair positioning and to provide the resident with education not to have a pillow in her wheelchair. The post-fall review documented a recommendation to revise Resident #7's care plan. -The post fall review failed to identify Resident #7's call light cord could not be appropriately used. Review of Resident #7's care plan, revised 8/22/23, identified the resident as being a high risk for falls. Interventions included ensuring the resident's call light was within reach, encouraging the resident to use a reacher to pick up objects from the floor, ensuring Resident #7 was wearing appropriate footwear, providing education on appropriate wheelchair use, checking the resident's room for wet floors frequently and reviewing information on past falls to determine the root cause of the falls. -The facility failed to update Resident #7's care plan with new interventions following the resident's unwitnessed fall on 6/14/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Staff interviews Registered nurse (RN) #1 was interviewed on 6/27/24 at 4:02 p.m. RN #1 said neurological assessments were a strict protocol and should be followed in accordance with the neurological record. RN #1 said she would never allow a resident who had experienced an unwitnessed fall to leave the facility until all 72-hours of post-fall neurological assessments had been completed. RN #1 said delayed brain bleeds or other important neurological changes could be missed if residents were not assessed appropriately after an unwitnessed fall. Licensed practical nurse (LPN) #1 was interviewed on 6/27/24 at 4:06 p.m. LPN #1 said residents with an unwitnessed fall should receive neurological assessments in accordance with the facility protocol printed on the neurological record. LPN #1 said if a resident was alert and oriented it would be acceptable to allow the resident to leave the facility on pass during the 72-hour post-fall assessment period because the resident could tell him whether or not they hit their head. The director of nursing (DON) was interviewed on 6/27/24 at 4:56 p.m. The DON said bathroom call light cords should not be wrapped up in a grab bar but should instead be readily available for a resident to use. The DON said neurological assessments should be completed in accordance with the facility protocol printed on the neurological record. The DON said nursing staff should not allow a resident who was within the 72-hour time frame following an unwitnessed fall to leave the facility without receiving their neurological assessments. The DON said it was important for nursing staff to assess residents who had an unwitnessed fall because staff did not know exactly what happened during the unwitnessed fall and the facility should remain cautious to ensure residents were kept safe. The DON said if nursing staff did not complete neurological assessments they could miss important neurological changes in the resident. 38185 III. Resident #27 A. Resident status Resident #27, age 81, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 CPO, diagnoses included nonrheumatic aortic valve disorders (inflammation of the heart's chambers and valves). The 4/16/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was independent with activities of daily living (ADL). B. Resident observation and interview On 6/24/24 at 9:37 a.m. Resident #27's had a jar of Freeze Wart Removal sitting on the bedside table in her room. Resident #27 said she had a wart on her finger that bothered her. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #27's middle finger on her left hand was observed to have a wart-like lesion on the digit close to the fingernail. Resident #27 said she had tried to peel off the wart and it bled and bled and bled, so she started putting wart remover on it. During the interview, a box of Refresh Eye Drops and a hot water tea kettle with a heat source were observed on Resident #27's night stand. C. Record review The visual function care plan, initiated on 5/3/23 and revised on 8/14/23, documented Resident #27 had impaired visual function and required glasses. The interventions included providing the resident with glasses as required, ensuring the appropriate visual aids were available to support the resident's participation in activities and reminding the resident to wear her glasses. -A review of Resident #27's electronic medical record (EMR) did not reveal a physician's order for Refresh eye drops or wart remover. -Resident #27's EMR did not document an assessment to determine if the resident was able to self-administer eye drops or wart removal. Additionally, there was no assessment to determine the resident's safety level for the hot tea kettle kept in the resident's room. IV. Resident #11 A. Resident status Resident #11, age 74, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included a transverse fracture of the right humerus shaft (fracture of the upper arm). The 6/6/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. He required partial assistance with ADLs. B. Resident observation and interview On 6/24/24 at 2:12 p.m. a space heater was observed in Resident #11's room. The space heater was turned on and operational. Resident #11 said he was often cold in his room. He said a family member brought him a space heater for his room. He said he used it almost every day. C. Record review -A review of Resident #11's EMR did not reveal documentation that an assessment had been completed to determine the resident's safety level to operate a space heater independently. V. Resident #22 A. Resident status (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #22, age 71, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 CPO, the diagnoses included dementia, heart failure and hypertension (high blood pressure). The 5/3/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. He was independent with ADLs. B. Resident observation and interview On 6/24/24 at 9:51 a.m. a coffee maker with a heating element was observed in Resident #22's room. Resident #22 said he used it almost every day to make himself coffee. C. Record review Resident #22's behavioral care plan, initiated 2/23/23 and revised 5/20/24, documented the resident had a behavioral problem related to a decline in health and a diagnosis of dementia. It documented that the resident had morning irritation, irritation when he needed to smoke or when having a bad day, verbal outbursts, making inappropriate vulgar statements, striking out at staff or making verbal threats. The interventions included providing the resident an opportunity for positive interactions and attention, explaining all procedures to the resident before starting and allowing the resident time to adjust to the changes, explaining why the resident's behavior is inappropriate, intervening as necessary to protect the rights and safety of others and providing a program of activities of interest. -A review of Resident #22's EMR did not reveal documentation that an assessment had been completed to determine the resident's safety level to operate a coffee pot alone and without supervision. VI. Staff interviews LPN #3 was interviewed on 6/27/24 at 2:50 p.m. LPN #3 said medications should not be left at the residents' bedside unless the resident had been assessed to be competent with administering their own medications. He said any medications in the residents' room should be kept in a secure location. LPN #3 said each resident should be assessed for self-administration of any medication, even over the counter medications. He said the self-administration assessment should be kept in the resident's EMR. LPN #3 said he was not aware Resident #27 had medications at the bedside. He said Resident #27's EMR did not have a physician's order for the resident to self-administer medications or a self-administration assessment completed. LPN #3 said a safety assessment should be completed for Resident #27's use of the tea kettle in her room. He said he was unable to locate a safety assessment for Resident #27. RN #2 was interviewed on 6/27/24 at 3:05 p.m. RN #2 said a safety assessment should be completed for Resident #22's use of the coffee pot in his room. She said she did not know anything about safety assessments or where to locate them. RN #2 said the facility's management team should know where the safety assessments were and she was not part of conducting any safety assessments. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #1 was interviewed on 6/27/24 at 3:15 p.m. LPN #1 said he was aware Resident #11 had a space heater in his room. He said he had seen the resident use it. LPN #1 said a safety assessment should have been completed for the resident's use of the space heater. He said he would not know where to find a safety assessment or who was responsible for completing the assessment. The DON was interviewed on 6/27/24 at 3:58 p.m. The DON said medications should not be left at the residents' bedside. She said for any resident to self-administer medications, an assessment should be completed along with obtaining a physician's order for self administration of medications. The DON said a safety assessment should be completed for any resident who wished to have a device with a heating element in their room. She said the nurse was responsible for completing the assessments. The DON said a safety assessment was not completed for Resident #27, Resident #22 or Resident #11 and a self-administration assessment was not completed for Resident #27.

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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** 50853 Based on observations, record review and interviews, the facility failed to provide necessary respiratory care consistent with professional standards of practice in coordination with the resident plan of care for two (#4 and #3) out of four residents reviewed for respiratory care out of 45 sample residents. Specifically, the facility failed to: -Ensure Resident #4 received supplemental oxygen therapy per the physician's orders; and, -Ensure Resident #3 could safely and appropriately perform her tracheostomy care independently. Findings include: I. Supplemental oxygen failure A. Professional reference According to [NAME], B. B. (2022, November 23). Oxygen saturation, retrieved from https://www.ncbi.nlm.nih.gov/books/NBK525974/ on 7/8/24, Cyanosis (bluish discoloration) may not develop until oxygen saturation reaches about 67%. As such, pulse oximetry is extremely useful because the signs and symptoms of hypoxemia may not be visible on physical examination. There is no set standard of oxygen saturation where hypoxemia occurs. The generally accepted standard is that a normal resting oxygen saturation of less than 95% (percent) is considered abnormal. Therefore, it remains vital to observe patients for the clinical markers of hypoxemia. The brain is the most sensitive organ, and visual, cognitive, and electroencephalographic changes develop when the oxyhemoglobin saturation is less than 80% to 85%. It is unclear whether there are long-term deficits from hypoxemia. B. Facility policy and procedure The Oxygen policy and procedure, dated 2/29/24, was provided by the nursing home administrator (NHA) on 6/27/24 at 7:29 p.m. It read in pertinent part, Oxygen is administered and stored to residents who need it, consistent with professional standards of practice, comprehensive person-centered care plans, and the resident's goals and preferences. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen. C. Resident #4 1. Resident status Resident #4, age less than 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia and COVID-19. According to the 4/30/24minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of five out of 15. He required substantial to maximal assistance with bed mobility and transfers. He was not receiving supplemental oxygen. 2. Observations On 6/25/24 Resident #4 was observed during a continuous observation, beginning at 2:03 p.m. and ending at 2:51 p.m -At 2:03 p.m. Resident #4 was lying on his back in bed. He did not have an oxygen cannula in his nose. -At 2:10 p.m. Resident #4 was observed in bed lying on his back with no oxygen cannula in his nose. -At 2:51 p.m. Resident #4 was in bed not wearing an oxygen cannula. -No staff entered Resident #4's room to put the resident's oxygen on during the continuous observation. On 6/26/24 at 11:00 a.m. Resident #4 was observed in bed with an oxygen cannula in his nose. On 6/26/24 at 1:00 p.m. Resident #4 was observed in bed without an oxygen cannula in his nose. -A certified nurse aide (CNA) was observed in his room, however, the CNA did not offer to put Resident #4's oxygen on him. On 6/26/24 Resident #4 was observed during a continuous observation, beginning at 1:20 p.m. and ending at 3:36 p.m. At 1:49 p.m. CNA #1 was in Resident #4's room assisting his roommate. CNA #1 asked Resident #4 if he wanted a pain pill and the resident said no. (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 did not offer Resident #4 his oxygen. At 2:02 p.m. Resident #4 was observed in bed on his left side. The oxygen cannula was not in his nose. At 2:43 p.m. LPN #4 was observed entering Resident #4's room. Resident #4 was lying on his back in bed without his oxygen cannula in his nose. -LPN #4 asked the resident if he wanted her to remove his lunch tray, however, she did not offer the resident his oxygen. At 2:50 p.m. Resident #4 was observed lying in bed on his back. The oxygen cannula was not on his nose. At 3:32 p.m. CNA #1 was asked by the assistant director of nursing (ADON) #2 to check the oxygen saturation level (measure of oxygen in the blood) of Resident #4. CNA #1 reported the resident's oxygen saturation level was 69%. ADON #2 encouraged Resident #4 and he allowed the oxygen cannula to be put in his nose. At 3:36 p.m. Resident #4's oxygen saturation level was 79% with two liters per minute (lpm) of oxygen applied. On 6/26/24 at 4:40 p.m. registered nurse (RN) #2 entered Resident #4's room. RN #2 put the oxygen cannula in Resident #4's nose. The oxygen concentrator was set on 3 lpm. RN #2 checked the resident's oxygen saturation level and it was 83%. His heart rate was 122 beats per minute (BPM). RN #2 listened to Resident #4's lungs and said he had air movement but he had chronic COPD. She said since he was just in bed not moving around, that was why his oxygen saturation level was probably low. -RN #2 did not make any changes to Resident #4's oxygen liter flow. 3. Record review Review of Resident #4's comprehensive care plan, initiated 11/4/23, revealed the care plan did not include the resident's diagnoses of COPD or chronic respiratory failure with hypoxia. -A care plan focus area for COVID-19 was entered on the comprehensive care plan on 6/24/24, however, it did not include the use of oxygen as an intervention. Review of Resident #4's vital signs from 6/2/24 to 6/13/24 revealed the resident's oxygen saturation levels were below 90% on the following days: On 6/2/24 at 12:11 a.m. the resident's oxygen saturation level was 82% on room air. -There was no nurse progress note regarding the low oxygen saturation level. On 6/5/24 at 1:09 a.m. the resident's oxygen saturation level was 82% on room air. -There was no nurse progress note regarding the low oxygen saturation level. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/24 at 12:14 a.m. the resident's oxygen saturation level was 86% on room air,. -There was no nurse progress note regarding the low oxygen saturation level On 6/7/24 at 2:59 a.m. the resident's oxygen saturation level was 82% on room air. -There was no nurse progress note regarding the low oxygen saturation level. On 6/8/24 at 12:08 a.m. the resident's oxygen saturation level was 88% on room air. -There was no nurse progress note regarding the low oxygen saturation level. On 6/11/24 at 1:12 a.m. the resident's oxygen saturation level was 85% on room air. -There was no nurse progress note regarding the low oxygen saturation level. On 6/12/24 at 1:50 a.m. the resident's oxygen saturation level was 87% on room air. -There was no nurse progress note regarding the low oxygen saturation level. On 6/13/24 at 12:11 a.m. the resident's oxygen saturation level was 88% on room air. -There was no nurse progress note regarding the low oxygen saturation level. A review of Resident #4's June 2024 CPO revealed the following physician's order for oxygen: Oxygen at 2 liters per minute (lpm) via nasal cannula at night and while lying in bed napping, ordered 6/13/24. A nurse progress note dated 6/19/24 at 1:30 a.m. documented the resident's pulse oximetry (oxygen saturation level) on room air was 79% and oxygen was applied via nasal cannula at 2 lpm. The resident's oxygen saturation level came up quickly to 96%. He was to wear the oxygen continuously and continue to be monitored for improvement. A nurse progress note dated 6/20/24 at 4:25 a.m. documented the resident was in isolation for COVID-19 in a semi private room with a roommate who was also COVID-19 positive. The resident complained of fatigue and was irritable with interruptions. Resident #4 was removing his oxygen often and his oxygen saturation level dropped to the 70% range, but once the oxygen was replaced it returned to the 90% range. A nurse progress note dated 6/22/24 at 2:45 a.m. documented the resident's oxygen saturation level was at 89% on room air. Resident #4 was in cohort isolation for COVID-19. He was lethargic and showed no interest in anything. His appetite was poor and he was only taking liquids. His urine output was dark and concentrated. He removed his oxygen frequently. His pulse had been running high, in the 120 bpm range. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse progress note dated 6/25/24 documented the resident's oxygen saturation at 1:44 p.m. was 86% on oxygen. A change of condition report was completed and the provider was contacted at 8:22 a.m. due to low oxygen saturation levels and being lethargic. There was no provider response noted in the progress note. A nurse progress note dated 6/26/24 at 3:33 a.m. documented the resident was in cohort isolation for COVID-19. He was more alert and was having more behavioral issues. He yelled at staff and used the call light repetitively with no requests made. He continued to refuse to wear oxygen and his oxygen saturation levels were in the low 70% range. He was only taking sips of liquids and his heart rate was still high at 124 bpm. -There was no progress note indicating the physician had been contacted regarding the resident's condition since the change of condition report on 6/25/24 at 8:22 a.m. A nurse progress note dated 6/26/24 at 4:33 p.m. documented the resident's oxygen saturation level on room air (at 3:32 p.m.) was 69%. The nurse asked the resident if he would allow staff to help him put his oxygen on and the resident reluctantly allowed staff to put his oxygen on. After two minutes of having oxygen on, the resident's oxygen saturation level went up to 79% on 3 lpm. The nurse notified the provider of the resident's low oxygen saturation levels. On 6/26/24 at 4:26 p.m. a physician's order was obtained to monitor for signs and symptoms of respiratory illness/COVID-19 for suspected or confirmed COVID-19 infection or possible COVID-19 exposure and conduct respiratory exam including lung sounds every shift. Staff was to observe for signs or symptoms of respiratory illness: fever greater than100 degrees Fahrenheit (F), shortness of breath, cough, sputum production, sore throat, rhinorrhea, chills, myalgias, fatigue, headache, nausea/diarrhea/vomiting, new loss of taste or smell, and mental status changes. Staff was to document findings in progress notes and notify the provider of changes in condition. 4. Staff Interviews CNA #1 was interviewed on 6/26/24 at 3:30 p.m. CNA#1 said Resident #4 was supposed to be on 2 lpm of oxygen constantly. She said when staff entered his room they should ask him if he wanted the oxygen. She said he would accept the oxygen but then would take it off again. ADON #2 was interviewed on 6/26/24 at 3:31 p.m. ADON #2 said Resident #4 was encouraged to wear his oxygen but he was adamant about not wanting it. She said when staff were in the room, they should offer it and sometimes he would accept it. RN #2 was interviewed on 6/26/24 at 4:11 p.m. RN #2 said staff put Resident #4's oxygen cannula on and he took it back off. She said the resident ran low on his oxygen saturation levels. She said the resident was not doing well since he had gotten COVID-19. The director of nursing (DON) was interviewed on 6/26/24 4:18 p.m. The DON said she was aware of the change of condition completed on 6/25/24 for Resident #4 and the doctor decided not to order anything and just monitor the resident's respiratory status. She said when a resident had COVID-19, staff should be checking vital signs. She said staff should check respirations and temperature every shift and check other vitals once per day. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50314 II. Tracheostomy care failure A. Facility policy and procedure The Tracheostomy Care policy, undated, was obtained from the NHA on 6/26/24 at 4:55 p.m. It documented in pertinent part,Tracheostomy care should be provided as often as needed, at least once daily for old, established tracheostomies, and at least every eight hours for residents with unhealed tracheostomies. B. Resident #3 1. Resident status Resident #3, over the age of 65, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included heart failure, respiratory failure with hypoxia (low levels of oxygen) and generalized muscle weakness. According to the 5/9/24 MDS assessment, the resident had moderate cognitive impairments with a BIMS score of 11 out of 15. She required touching assistance with shower transfers and was independent with all other cares. The assessment documented the resident had a tracheostomy. 2. Resident interview Resident #3 was interviewed on 6/24/24 at 11:10 a.m. Resident #3 said she always performed her own tracheostomy care independently. Resident #3 said nursing staff did not assist or observe her when she was performing tracheostomy care. Resident #3 said she did not know if the facility had assessed her to safely perform tracheostomy care. 3. Record review The care plan, dated 8/2/22 and revised 5/22/24, documented the resident was independent with her tracheostomy care. The tracheostomy care assessment documentation for Resident #3 was received from the corporate consultant (CC) on 6/26/24 at 3:12 p.m. The tracheostomy care assessment documented the CC and a respiratory therapist (RT) discussed tracheostomy care steps with Resident #3 on 6/26/24 (during the survey). -The tracheostomy care assessment documentation did not include a direct observation or return demonstration of Resident #3 performing tracheostomy care. -The facility failed to assess if Resident #3 could safely perform tracheostomy care between admission on 7/28/22 and 6/26/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Staff interviews RN #3 was interviewed on 6/25/24 at 3:04 p.m. RN #3 said Resident #3 did all of her own tracheostomy care independently.She said the nursing staff did not assist or observe the resident when she performed her tracheostomy care. RN #3 said she did not know if the facility had assessed Resident #3 to safely perform her own tracheostomy care. RN #3 said she had not observed Resident #3 perform tracheostomy care. RN #3 said she did not know how often Resident #3 was performing tracheostomy care independently. RN #1 was interviewed on 6/26/24 at 10:12 a.m. RN #1 said the nurses and CNAs did not assist Resident #3 with tracheostomy care. RN #1 said she did not know if the facility had assessed if Resident #3 could safely perform tracheostomy care independently. RN #1 said she had not observed Resident #3 perform tracheostomy care. The CC was interviewed on 6/26/24 at 3:12 p.m. The CC said she and the RT assessed Resident #3 regarding completing tracheostomy care independently. The CC said she and the RT discussed tracheostomy care steps with Resident #3. The CC said Resident #3 did not physically demonstrate any of the steps of tracheostomy care to her or the RT during the assessment on 6/26/24 (during the survey). However, the CC said she had confidence that Resident #3 could perform tracheostomy care appropriately and safely after the assessment. The CC said she was not concerned about the resident performing tracheostomy care appropriately and safely even though she had not watched the resident complete the task. The DON was interviewed on 6/27/24 at 4:56 p.m. The DON said Resident #3 should have been identified as needing a tracheostomy self-care assessment. The DON said the facility did not assess Resident #3's ability to safely and appropriately perform tracheostomy care before 6/26/24 (during the survey). The DON said it was important for residents with documented cognitive decline to be assessed so the nursing staff could ensure the resident's safety. The DON said the facility needed to do more to identify residents who must be self-assessed to complete their own cares.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on interviews and record review, the facility failed to manage pain in a manner consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences for three (#57, #58, #11) of three residents reviewed for pain out of 45 sample residents. Specifically, the facility failed to ensure as needed (PRN) pain medications had established parameters for Resident #57, Resident #58 and Resident #11. Findings include: I. Professional reference The American Medical Directors Association (AMDA) The Society for Post-Acute and Long-Term Care Medicine Pain in the Post-Acute and Long-Term Care Setting Clinical Practice Guideline. [NAME], MD (2021) was retrieved on 7/7/24 from https://paltc.org/sites/default/files/2024-02/PainManagement2021CPGFinal.pdf. It read in pertinent part, PRN doses are offered or considered at specified intervals and given as needed, requested, or determined to be indicated. When several options for administering analgesics are ordered for a patient, nursing staff need adequately detailed guidance concerning how and when to select a PRN medication from among the several options that have been ordered. II. Resident #57 A. Resident status Resident #57 was admitted to the facility on [DATE] and readmitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included non-ischemic myocardial injury (non-traumatic), acute on chronic diastolic (congestive) heart failure, hemiplegia (paralysis on one side of the body), hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side, type 2 diabetes mellitus with diabetic chronic kidney disease, inflammatory spondylopathy (disorder of the vertebrae) of lumbar region and intervertebral disc disorders with radiculopathy (pinching of the nerve) of the lumbar region. According to the 5/27/24 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. She needed substantial to maximal assistance with bed mobility, transfers and personal hygiene. She used a wheelchair for mobility. The assessment documented the resident was unable to answer the pain interview questions and staff indicated there were no non-verbal signs of pain in the previous five days. She had not received any pain medications in the prior five days. She did receive non-pharmacological interventions. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Record review The pain care plan, revised on 8/10/23, indicated the resident had chronic pain related to lumbar radiculopathy and lumbar spondylosis. Interventions included anticipating the resident's needs for pain relief and responding promptly, providing repositioning, cold compresses, therapy services or massage, evaluating the effectiveness of interventions, monitoring for possible side effects of opioid use and notifying the provider if interventions were unsuccessful. According to the June 2024 CPO, Resident #57 had the following physician's orders for pain management: Acetaminophen 325 milligrams (mg), two tablets by mouth every six hours as needed for pain or fever, ordered on 5/21/24. Hydrocodone-acetaminophen tablet 5-325 mg, one tablet by mouth every eight hours as needed for back pain, ordered on 5/21/24. -The physician's order did not specify when to give the acetaminophen 325 mg versus the hydrocodone-acetaminophen 5-325 mg. A review of Resident #57's June 2024 medication administration record (MAR) from 6/1/24 to 6/26/24 revealed the resident was administered acetaminophen 325 mg two tablets when the resident reported her pain level was a 3 out of 10 on a 1-10 numerical pain scale on 6/1/24. The resident was administered hydrocodone-acetaminophen 5-325 mg when she reported her pain level was a 7 out of 10 on 6/4/24. The resident was administered hydrocodone-acetaminophen 5-325 mg when she reported her pain level was a 5 out of 10 on 6/5/24. The resident was administered acetaminophen 325 mg two tablets when the resident reported her pain level was a 4 out of 10 on 6/14/24. The resident was administered acetaminophen 325 mg two tablets when the resident reported her pain level was an 8 out of 10 on 6/15/24. The resident was administered hydrocodone-acetaminophen 5-325 mg when she reported her pain level was an 8 out of 10 on 6/16/24. -There was no consistency for which pain medications were administered for varying pain levels. The physician progress note dated 5/23/24 documented the following medication changes with pain parameters: Hydrocodone-acetaminophen oral tablet 5/325 mg take 1 tablet by mouth every eight hours as needed for back pain of 8 out of 10 on a numerical scale of 1-10. Acetaminophen 650 mg by mouth every six hours as needed for pain of 6 to 7 out of 10. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the pain parameters were not added to the physician's orders to indicate to the licensed nursing staff when to administer the medications. C. Staff interview The consulting pharmacist (CP) was interviewed on 6/27/24 1:59 p.m. The CP said when a resident was prescribed more than one PRN pain medication he would ask the physician to determine parameters for each medication so the licensed nursing staff knew which medication to give depending on the resident's pain level. 50690 II. Resident #58 A. Resident status Resident #58, age less than 65, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included chronic pain syndrome, cervical stenosis and a wedge compression fracture of the lumbar vertebrae. The 5/7/24 MDS assessment revealed the resident was cognitively intact with a BIMS)score of 14 out of 15. He was independent with all activities of daily living (ADL) but needed supervision with bathing. The assessment documented the resident received scheduled pain medications, did not receive PRN pain medications and did receive non-medical interventions for pain relief. B. Record review The June 2024 CPO revealed the following physician's orders for PRN pain medications: Bengay greaseless external cream 10-15 % (percent), apply to lower back topically every six hours as needed for sciatic back pain, ordered on 1/7/24. Dilaudid oral (hydromorphone hcl) tablet 2 milligrams (mg), give 2 mg by mouth every four hours as needed for status-post laminectomy for seven days, ordered on 6/21/2024. Tylenol oral tablet 325 mg (acetaminophen), give two tablets by mouth every six hours as needed for pain or fever, ordered on 6/20/24. -The physician's order did not specify when to give the Dilaudid oral tablet 2 mg versus the Tylenol oral tablet 325 mg versus the Bengay greaseless cream. C. Resident interview Resident #58 was interviewed on 6/24/24 at 3:22 p.m. He said his current pain level was a 7 out of 10. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #58 was interviewed again on 6/26/24 at 9:13 a.m. Resident #58 said he talked to his physician and requested more pain medication. He said he had to ask for all his pain medications. He said he did not think he had any pain medications that were automatically given to him. D. Staff interviews Licensed practical nurse (LPN) #3 was interviewed on 6/27/24 at 4:51 p.m. LPN #3 said when a resident had multiple PRN pain medications, the physician's order needed to specify which medication to administer based on the resident's reported pain level. He said he asked the resident what their pain level was and, depending on their answer, he would give one medication versus another. He said pain was subjective, but he did use his nursing judgment. He said exact parameters or specifications for pain medications provided more clarity. 38185 III. Resident #11 A. Resident status Resident #11, age 74, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included a transverse fracture of the right humerus shaft (fracture of the upper arm). The 6/6/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. He required partial assistance with activities of daily living (ADL). B. Record review The pain care plan, initiated and revised on 6/5/24, documented the resident had pain related to a right humerus fracture, lumbar spinal stenosis (narrowing of the spinal canal in the lower back) and osteoporosis (disease that causes bones to become weak). The interventions included administering medications as ordered, monitoring the effectiveness of the pain medications and monitoring the side effects of the pain medications. The June 2024 CPO documented the following physician orders for pain management: Acetaminophen tablet 325 mg, give two tablets by mouth every four hours as needed for general discomfort, ordered 5/31/24. Hydrocodone-Acetaminophen tablet 5-325 mg, give one tablet by mouth every eight hours as needed for pain, ordered 5/31/24. -A review of the resident's electronic medical record (EMR) on 6/26/24 at 1:07 p.m. did not reveal documentation that pain parameters had been established for PRN pain medications ordered for the resident. C. Staff interviews (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #1 was interviewed on 6/26/24 at 3:15 p.m. LPN #1 said pain parameters should be identified when a resident had more than one PRN pain medication prescribed. He said pain parameters were important to ensure the resident received the correct pain medication. LPN #1 said Resident #11 was prescribed two PRN pain medications, acetaminophen and hydrocodone-acetaminophen. He said the PRN pain medications did not have identified pain parameters. The director of nursing (DON) was interviewed on 6/26/24 at 3:58 p.m. The DON said all PRN pain medications should have identified parameters to ensure the resident received the correct pain medication based on the pain scale. The DON said Resident #11 did not have parameters identified with the two PRN pain medications orders. She said she would have the nurse call the physician to establish the parameters.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review, and interviews, the facility failed to ensure it was free of a medication error rate of five percent (%) or greater. Specifically, the medication administration observation error rate was 10.34%, or three errors out of 29 opportunities for error. Finding 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. 606-607, retrieved on 7/9/24, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. II. Facility policy and procedure The Medication Administration policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 6/27/24 at 7:29 p.m. The policy read in pertinent part, Resident medications are administered in an accurate, safe, timely and sanitary manner. Medication is to be given in compliance with the physician orders and or manufacturer's recommendations. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Verify the medication label against the medication administration record for accuracy of drug frequency, duration, strength and route. Never administer medications from an unmarked container. III. Manufacturer's Guidelines According to the manufacturer's guidelines for insulin lispro (Humalog), retrieved on 7/9/24 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/020563s172,205747s008lbl.pdf, Humalog is a rapid acting human insulin analog indicated to improve glycemic control in adults with diabetes mellitus. Administer Humalog by subcutaneous (under the skin) injection within 15 minutes before a meal or immediately after a meal. According to the manufacturer's guidelines for Humulin R insulin, retrieved on 7/9/24 from https://pi.lilly.com/us/humulin-r-pi.pdf, Humulin R is a short acting human insulin indicated to improve glycemic control in adults with diabetes mellitus. Inject subcutaneously 30 minutes before a meal. According to the manufacturer's guidelines for Lactaid, retrieved on 7/9/24 from https://www.drugs.com/cdi/lactaid-lactase-tablets.html, Lactaid is used to help break down dairy products. Use Lactaid as ordered by your doctor. Take Lactaid with the first bite or drink of a dairy product. According to the manufacturer's guidelines for levothyroxine, retrieved on 7/9/24 from https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=a8db0f7d-8863-9309-e053-2995a90a284a&type=display, Administer once daily, preferably on an empty stomach, one half to one hour before breakfast. IV. Observations On 6/25/24 at 4:41 p.m. assistant director of nursing (ADON) #2 was observed preparing and administering medications to Resident #67. The physician's order was for insulin lispro (Humalog) 100 units/milliliter (ml) pen, inject as per sliding scale. If blood sugar is: 0 - 199 = 0 units; 200 - 249 = 1 unit; 250 - 299 = 2 units; 300 - 349 = 3 units; 350 - 399 = 4 units; 400 - 449 = 5 units; 450 - 499 = 6 units; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	500 - 600 = 8 units, subcutaneously every 4 (four) hours for diabetes mellitus. Notify the physician for blood sugar less than 60 milligrams/deciliter (mg/dl) after carbohydrate supplement or greater than 400. mg/dl. The order date of the medication was 2/2/24. ADON #2 obtained a blood sugar reading of high on the glucometer. ADON #2 said that meant the resident's blood sugar was over 600 mg/dl and she would need to give eight units of insulin. ADON #2 took a vial of insulin from the resident's insulin storage box. The insulin vial read Humulin R and there was not a pharmacy label on the vial. She drew up eight units in an insulin syringe and administered it to Resident #67. -ADON #2 administered the incorrect insulin to Resident #67. Cross-reference F760 for failure to ensure residents were free of significant medication errors. On 6/26/24 at 8:59 a.m. registered nurse (RN) #1 was observed preparing and administering medications to Resident #26, who was lactose intolerant (a condition that prevents the body from digesting lactose, a sugar found in dairy products). The physician's order was for Lactaid 3000 units one tablet by mouth. RN #1 was unable to find the medication in her medication cart. She proceeded to administer Resident #26's other medications mixed in yogurt, which contained dairy. RN #1 gave Resident #26 the remainder of the container of yogurt to eat with his breakfast. She said she would go look for the correct dose of Lactaid in the other medication storage areas. On 6/26/24 at 9:05 a.m. ADON #1 was observed preparing and administering medication to Resident #29. The physician's order was for levothyroxine 275 micrograms (mcg) by mouth in the morning. -The medication was scheduled to be administered at 7:30 a.m., however, ADON #1 administered the medication at 9:05 a.m., which was 90 minutes after it was scheduled and after the resident had already eaten breakfast. V. Additional interviews ADON #2 was interviewed on 6/25/24 at 6:48 p.m. regarding the insulin she had administered to Resident #67. She reviewed the physician's order that was for the insulin lispro pen. ADON #2 said the resident's insurance would not cover the insulin pens so the facility had to use the Humulin R insulin from the vial. She said the physician should have been notified to change the order and she said she would take care of it. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN #1 was interviewed on 6/26/24 at 10:34 a.m. She said she had not found the correct dose of Lactaid (the facility only had the 9000 unit dose available) but had one more place to look. She said she felt bad for giving Resident #26 the yogurt without his Lactaid. On 6/26/24 at 10:45 a.m,.RN #1 said she contacted Resident #26's physician and got his Lactaid order changed to 9000 units. She said she was able to administer the new dose of Lactaid to Resident #26. -However, Resident #26 did not receive the medication timely or per the manufacturer's guidelines (see above). The director of nursing (DON) was interviewed on 6/27/24 at 6:45 pm. The DON said the wrong insulin was administered to Resident #67. The DON said the Lactaid order should have been changed and it had not been administered to Resident #26 at the correct time . She said Resident #26 should not have been given a dairy product when his Lactaid had not been administered. The DON said Resident #29's levothyroxine was administered after breakfast was not given timely. The consulting pharmacist (CP) was interviewed on 6/27/24 at 1:59 p.m. The CP said taking levothyroxine could be affected by specific foods if taken after eating them. He said it was recommended to take the medication on an empty stomach. The CP said the insulin lispro and Humulin R (humalog) were two different insulins. He said the insulin lispro was a rapid acting insulin (was effective in about 15 minutes) and Humulin R was short-acting insulin (was effective in about 30 minutes and lasted longer). He said giving Resident #67 Humulin R insulin instead of the insulin lispro was a medication error.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observation, record review and interviews, the facility failed to ensure one (#67) of nine residents out of 45 sample residents were free from significant medication errors. Specifically, the facility failed to ensure Resident #67 was administered the correct insulin. 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. 606-607, retrieved on 7/9/24, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. The American Diabetes Association Insulin Basics,was retrieved on 7/2/24 from https://diabetes.org/health-wellness/medication/insulin-basics. It read in pertinent part, Rapid-acting insulin, begins to work about 15 minutes after injection, peaks in about one or two hours after injection, and lasts between two to four hours. Types: insulin aspart (Fiasp, NovoLog) Insulin glulisine (Apidra), and insulin lispro (Admelog, Humalog, Lyumjev). Regular or short-acting insulin usually reaches the bloodstream within 30 minutes after injection, peaks anywhere from two to three hours after injection, and is effective for approximately three to six hours. Types: Human Regular (Humulin R, Novolin R, Velosulin R). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. Facility policy and procedure The Diabetic Management policy, dated 3/19/24, was provided by the nursing home administrator (NHA) on 6/27/24 at 7:29 p.m. It read in pertinent part, Upon admission the interdisciplinary team (IDT) evaluates the diabetic resident and implements a plan of care to ensure orders are received and are accurate related to blood glucose monitoring and anti-diabetic agents, antidiabetic agents (insulin or oral) are administered per physician's order and insulin is labeled properly with a pharmacy label. III. Manufacturer's Guidelines According to the manufacturer's guidelines for insulin lispro (Humalog), retrieved on 7/9/24 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/020563s172,205747s008lbl.pdf, Humalog is a rapid acting human insulin analog indicated to improve glycemic control in adults with diabetes mellitus. Administer Humalog by subcutaneous (under the skin) injection within 15 minutes before a meal or immediately after a meal. According to the manufacturer's guidelines for Humulin R insulin, retrieved on 7/9/24 from https://pi.lilly.com/us/humulin-r-pi.pdf, Humulin R is a short acting human insulin indicated to improve glycemic control in adults with diabetes mellitus. Inject subcutaneously 30 minutes before a meal. IV. Observation On 6/25/24 at 4:41 p.m. assistant director of nursing (ADON) #2 was observed preparing and administering medications to Resident #67. The physician's order was for insulin lispro (Humalog) 100 units/milliliter (ml) pen, inject as per sliding scale. If blood sugar is: 0 - 199 = 0 units; 200 - 249 = 1 unit; 250 - 299 = 2 units; 300 - 349 = 3 units; 350 - 399 = 4 units; 400 - 449 = 5 units; 450 - 499 = 6 units; 500 - 600 = 8 units, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	subcutaneously every 4 (four) hours for diabetes mellitus. Notify the physician for blood sugar less than 60 milligrams/deciliter (mg/dl) after carbohydrate supplement or greater than 400. mg/dl. The order date of the medication was 2/2/24. ADON #2 obtained a blood sugar reading of high on the glucometer. ADON #2 said that meant the resident's blood sugar was over 600 mg/dl and she would need to give eight units of insulin. ADON #2 took a vial of insulin from the resident's insulin storage box. The insulin vial read Humulin R and there was not a pharmacy label on the vial. She drew up eight units in an insulin syringe and administered it to Resident #67. -ADON #2 administered the incorrect insulin to Resident #67. C. Interviews ADON #2 was interviewed on 6/25/24 at 6:48 p.m. regarding the insulin she had administered to Resident #67. She reviewed the physician's order that was for the insulin lispro pen. ADON #2 said the resident's insurance would not cover the insulin pens so the facility had to use the Humulin R insulin from the vial. She said the physician should have been notified to change the order and she said she would take care of it. The director of nursing (DON) was interviewed on 6/27/24 at 6:45 pm. The DON said the wrong insulin was administered to Resident #67. The consulting pharmacist (CP) was interviewed on 6/27/24 at 1:59 p.m. The CP said the insulin lispro and Humulin R (humalog) were two different insulins. He said the insulin lispro was a rapid acting insulin (was effective in about 15 minutes) and Humulin R was short-acting insulin (was effective in about 30 minutes and lasted longer). He said giving Resident #67 Humulin R insulin instead of the insulin lispro was a medication error.

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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. 50853 Based on observations and interviews, the facility failed to ensure medications and biologicals were properly stored and labeled in accordance with professional standards in two of six medication carts and one of two medication storage rooms. Specifically, the facility failed to: -Ensure medications were properly labeled with open dates; and, -Ensure expired medications were removed from the medication cart and storage rooms. Findings include: I. Professional reference The United States Food and Drug Administration (USFDA) (2/8/21) Don't Be Tempted to Use Expired Medicines, retrieved on 7/2/24 from https://www.fda.gov/drugs/special-features/dont-be-tempted-use-expired-medicines. It read in pertinent part, Expired medical products can be less effective or risky due to a change in chemical composition or a decrease in strength. Certain expired medications are at risk of bacterial growth and sub-potent antibiotics can fail to treat infections, leading to more serious illnesses and antibiotic resistance. Once the expiration date has passed there is no guarantee that the medicine will be safe and effective. If your medicine has expired, do not use it. II. Observations On 6/27/24 at 2:20 p.m. the medication cart on the Junction hallway was observed with licensed practical nurse (LPN) #1. The following items were found: -An open Tresiba FlexTouch Pen-injector was not labeled with the date opened; and, -An open bottle of isopropyl alcohol had an expiration date of May 2024. On 6/27/24 at 3:30 p.m. the medication storage room on the Sunflower hallway was observed with LPN #3. The following items were found: -One bottle of multivitamin with minerals that expired in October 2023; -One bottle of esomeprazole magnesium that expired in February 2024; -One bottle of vitamin B12 100 micrograms (mcg) that expired in October 2023; -One bottle of loperamide HCL 2 milligrams (mg) expired in January 2024; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-One bottle of spironolactone 50 mg that expired on 2/21/24; -One bottle of omeprazole 20 mg that expired on 4/19/24; and, -One bottle of furosemide 20 mg that expired on 2/21/24. On 6/27/24 at 4:30 p.m. the medication cart on the Primrose hallway was observed with assistant director of nursing (ADON) #2. The following item was found: -One package of omeprazole that expired in May 2024. III. Staff interviews LPN #1 was interviewed on 6/27/24 at 2:20 p.m. LPN #1 said the insulin pens should be dated when they were opened. He said he would dispose of the expired isopropyl alcohol. Registered nurse (RN) #2 was interviewed on 6/27/24 at 3:40 p.m. RN #2 said expired medications should be disposed of. She said she would put the expired medications in the drug buster (a container utilized for destroying medications). ADON #2 was interviewed on 6/27/24 at 4:30 p.m. She said the expired package of omeprazole should have been removed from the medication cart.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47818 Based on observations, record review and interviews, the facility failed to ensure menus were followed to meet the residents' nutritional needs. Specifically, the facility failed to ensure food items served were consistent with the posted daily menu. Findings include: I. Facility policy and procedure The Menus policy, revised October 2022, was provided by the nursing home administrator (NHA) on 6/27/24 at 7:30 p.m. It read in pertinent part, Menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with established national guidelines. Menus will be developed to meet the criteria through the use of an approved menu planning guide. Procedures: Menu cycles will include standardized recipes,menus will be served as written, unless a substitution is provided in a response to preference, unavailability of an item or a special meal. Menu substitution log will be maintained on file. II. Resident interviews Resident #58 and Resident #40 were interviewed together on 6/24/24 at 3:04 p.m. Resident #58 said the facility menus offered a decent selection but the food items did not always match the posted menus. Resident #58 said the menu items were not always available and if they were out of something, the kitchen would just put something else on the plate without informing the residents or asking if it was okay to substitute a listed food item. Resident #40 agreed with the information provided by Resident #58. III. Meal observations and resident interviews The 6/24/24 dinner menu revealed residents were to be served shrimp scampi, spaghetti noodles, sauteed asparagus cuts, Italian herbed dinner roll and chilled peach parfait. Alternative options were cheese pizza and sauteed green beans. During a continuous observation on 6/24/24, beginning at 5:30 p.m. and ending at 7:00 p.m., the dinner being served was plain spaghetti noodles topped with a thick white sauce with cooked shrimp on top of the sauce and snow peas. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The sauteed asparagus or sauteed green beans were not available as the menu indicated, and the shrimp scampi had the addition of the cream, which was not indicated as an ingredient on the recipe (see below). The 6/25/24 lunch menu revealed residents were to be served homestyle meatloaf with ketchup topping, duchess mashed potatoes, broccoli florets, poppy seed dinner roll and cherry cheesecake for dessert. During a continuous observation on 6/25/24, beginning at 12:00 p.m. and ending at 12:45 p.m., the lunch being served did not include broccoli florets and had green beans instead. Resident #37 was interviewed on 6/25/24 at 1:00 p.m. Resident #37 said he did not ask for green beans instead of broccoli florets for lunch. Resident #64 was interviewed on 6/25/24 at 1:10 p.m. Resident #64 said he did not ask for green beans instead of broccoli florets for lunch. Resident #27 was interviewed on 6/25/24 at 1:15 p.m. Resident #27 said she informed the staff member taking her lunch order earlier that she did not want the meatloaf or mashed potatoes but had received it anyway. Resident #27 said she told staff she would make herself a tuna fish sandwich from the personal food items. Resident #27 said she had asked for tuna fish sandwiches from the facility kitchen in the past and was told it was not currently available as a menu item. IV. Shrimp scampi recipe The facility's shrimp scampi recipe was provided by the dietary manager (DM) on 6/27/24 at 4:15 p.m. The recipe revealed the following ingredients: -Hot water; -Chicken soup base; -White wine; -Vegetable oil; -Oregano and black pepper; -Garlic (minced and chopped); -Peeled and deveined shrimp; and, -Fresh lemon. -The shrimp scampi recipe did not indicate to use heavy cream. V. Staff interviews (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DM and the dietary consultant (DC) were interviewed on 6/27/24 at 4:14 p.m. The DM said she followed the recipe for shrimp scampi and added cream which was not listed on the recipe. The DM said she was instructed by the previous kitchen manager to do so. The DM said the residents and the staff were not informed there was the addition of cream to the shrimp scampi recipe. The DM said she did not consider complications for the residents who did not prefer or could not have dairy products. The DM and the DC said they were responsible for authorizing menu changes. The DM said the kitchen had started making more soups from scratch which was using more of the ingredients. The DM said the cooks needed to communicate better to ensure there were enough vegetables and other ingredients. The DC said a poll was recently conducted with the residents regarding what food items should be included on the always available menu. The DM said the poll revealed tuna fish sandwiches were included in the poll but did not get enough votes to be an always available item. The DM said she would speak with Resident #27 regarding her food preference with having tuna fish sandwiches for lunch.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47818 Based on interviews and observations, the facility failed to consistently serve food that was palatable, attractive and at a safe and appetizing temperature. Specifically, the facility failed to ensure resident food was served at palatable temperatures. Findings include: I. Facility policy and procedure The Food: Quality and Palatability policy, revised February 2023, was received by the nursing home administrator (NHA) on 6/27/24 at 7:30 p.m. It read in pertinent part, Food will be prepared by methods that can serve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. Proper (safe and appetizing) temperature: food should be at the appropriate temperature as determined by the type of food to ensure residents satisfaction and minimize the risk for scalding and burns. II. Resident group interview Six alert and oriented Resident's (#27, #37, #63, #32, #64 and #15), who were identified as alert and oriented per the facility and assessment, were interviewed in a group meeting on 6/26/24 at 10:00 a.m. Resident #27 and Resident #37 said the food was cold regardless of eating in either the dining room or being served a room tray. The remaining residents (#63, #32, #64 and #15) all agreed with this information. III. Observation On 4/25/24 at 7:20 p.m. a test tray for a regular diet, which was served immediately after the last resident had been served their room tray, was evaluated by the dietary manager (DM) for serving temperatures. The test tray was plated in the kitchen at 6:10 p.m. and the last tray on the unit was delivered at 7:20 p.m. The test tray meal consisted of shrimp scampi, spaghetti noodles and snow peas for dinner and peach parfait for dessert. Temperatures of the test tray were taken at the delivery cart and were as follows: -The spaghetti noodles were 123 degrees fahrenheit (F). (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The snow peas were 109 degrees F. -The shrimp scampi was 112 degrees F. -The temperatures were all below the palatable temperature of 135 degrees F for hot foods. IV. Staff interview The DM was interviewed on 4/25/24 at 7:20 p.m. The DM said the food carts used for passing room trays were not heated and a plate warmer was used in the kitchen to keep food at a palatable temperature throughout meals services. The DM said a palatable food temperature was at or above 135 degrees F. The DM said the heated plates were not successful with keeping food at the desired temperature.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on observations, interviews and record review, the facility failed to ensure one (#50) out of one resident reviewed for mechanically altered diets out of 45 sample residents received food prepared in a form designed to meet her needs. Specifically, the facility failed to provide Resident #50 the correct mechanically-altered diet as prescribed. Findings include: I. Facility policy and procedure The Diet and Nutrition Care Manual- Chapter two: Consistency alterations, revised in 2019, was provided by the dietary consultant (DC) on 6/27/24 at 12:02 p.m. It read in pertinent part, Dysphagia advanced diets: Vegetables included cooked, tender, chopped, shredded; protein foods included chopped or ground as tolerated. To achieve optimal intake, diets should be planned with the individual's preferences in mind. II. Resident # 50 A. Resident status Resident #50, age 79, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included Parkinson's disease (disorder of the central nervous system that affects movement), malnutrition and gastroesophageal reflux disease (GERD). The 3/27/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required set up and clean up assistance for eating. The assessment indicated the resident had no weight change in the last six months. Resident #50 had no signs of a possible swallowing disorder and was prescribed a mechanically-altered diet. B. Observations On 6/24/24 at 10:59 a.m. Resident #50 was sitting in bed. There was pureed food on her breakfast plate. -However, according to the dysphagia advanced diet, she should not have received pureed foods. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/24 at 6:33 p.m. Resident #50's dinner meal was observed. It consisted of whole spaghetti noodles with small pieces of shrimp, a pureed green vegetable, a pureed dinner roll, a pureed orange dessert and tea. -The resident was served pureed food items instead of dysphagia advanced (see interviews below). On 6/27/24 at 12:54 p.m. Resident #50 finished lunch in her room. Her meal ticket indicated she was prescribed a dysphagia mechanical soft diet. -The resident's meal ticket did not indicate the correct diet of dysphagia advanced (see interviews below). C. Resident interview Resident #50 was interviewed on 6/24/24 at 3:53 p.m. Resident #50 said she had Parkinson's disease. She said the facility mashed all of her food. She said the flavor was not good and had no taste. Resident #50 was interviewed again on 6/24/24 at 5:07 p.m. Resident #50 said the facility ground and mashed all of her food. She said she had no history of choking and did know that she was on a special diet. D. Record review The June 2024 CPO revealed the following diet order: Regular diet, dysphagia advanced texture, regular/thin consistency (resident does not like dairy products), ordered on 12/6/23 and revised on 4/27/24. The 2/13/24 speech therapy discharge summary documented Resident #50's dysphagia outcome and severity score (DOSS) was six out of seven. This indicated mild dysphagia and a recommended diet of soft and bite-sized foods: soft, tender and moist, but with no thin liquid leaking or dripping from the food. The ability to bite off a piece of food was not required. The ability to chew bite-sized pieces so that they were safe to swallow was required. Bite-sized referred to pieces no bigger than 1.5 centimeter (cm) by 1.5 cm in size. Food could be mashed or broken down with pressure from a fork. A knife was not required to cut the food according to the international dysphagia diet standardization initiative (IDDSI). E. Menu extension The menu extensions were provided by the dietary manager (DM) on 6/24/24 at 9:13 a.m. They revealed the following: The menu extensions indicated residents who were prescribed a dysphagia advanced diet were to receive whole bananas foster french toast and a ground sausage patty with brown gravy for breakfast on 6/24/24. -However, Resident #50 received pureed french toast and pureed sausage for breakfast on 6/24/24 (see observation above). (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 6/26/24 at 3:42 p.m. CNA #1 said Resident #50 never had choking issues. CNA #1 said when Resident #50 admitted to the facility staff had supervised her while she ate. She said the resident was fine eating on her own and did not like assistance. The speech language pathologist (SLP) was interviewed on 6/27/24 at 9:06 a.m. The SLP said she had evaluated and treated Resident #50 for dysphagia and voice concerns in the past. She said the resident had Parkinson's disease. The SLP said sometimes residents with Parkinson's disease had or developed oral issues and swallowing difficulty. The SLP said she saw Resident #50 when she first admitted to the facility and worked with her on swallowing and chewing. The SLP said after evaluating and working with Resident #50, she recommended the resident to be on a dysphagia advanced diet. She said that was the diet level below a regular diet and consisted of naturally soft and bite-sized foods. The SLP said when she discontinued working with Resident #50 on 2/12/24, her food did not need to be pureed. The SLP said the diet that was on Resident #50's meal ticket needed to match the physician's order. She said she did not know how or why Resident #50's diet was changed. The SLP said when she was working with the resident, she was served the correct diet at meals. She said examples of food on a dysphagia advanced diet included soft vegetables usually cut-up, meat that was relatively/naturally soft and easy to chew and mashed potatoes. The SLP said the dysphagia mechanical soft diet was mushy soft foods. She said the kitchen made a lot of pureed sides and did not follow the IDDSI framework. Assistant director of nursing (ADON) #1 was interviewed on 6/27/24 at 10:04 a.m. ADON #1 said Resident #50's physician prescribed diet order was a dysphagia advanced diet. ADON #1 said if a diet change was made, nursing staff were notified first. She said the licensed nurses put in the new order, filled-out a diet sheet and gave it to the dietary department to notify them of the diet change. The director of nursing (DON) was interviewed on 6/27/24 at 10:31 a.m. The DON said Resident #50 was prescribed a dysphagia advanced diet. She said the procedure for diet changes involved the facility nurses entering the new order then giving the diet change order to the dietary manager. She said the expectation was for staff to check the meal ticket to ensure it matched the physician's order. She said if there was a discrepancy, then they talked to the kitchen to see if it was the wrong tray or the wrong physician's order. She said if the meal ticket for the resident's order was wrong, the nurses wrote a diet order change and provided it to the kitchen for clarification. The DON said usually what was in the computer was the most updated order. She said the dietary department did not get that information until the nurses did. She said she did not know how the dietary department got information that the resident was on a different type of diet. She said there should be a comparison made between the diets and physician's orders on a regular basis, where she provided a list of all the diet orders to the dietary department, and then the dietary staff ensured the meal tickets were accurate. She said the diet order for Resident #50 should have been clarified and updated on the meal ticket to ensure the resident received the correct mechanically altered diet (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on record review and interviews, the facility failed to maintain medical records on each resident that were accurately documented for one (#78) of one resident out of 45 sample residents. Specifically, the facility failed to ensure Medical Orders for Scope of Treatment (MOST) forms were not destroyed when residents were discharged from the facility. Findings include: I. Facility policy and procedure The Advanced Directives policy and procedure, dated [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 4:24 p.m. It revealed in pertinent part, The resident or legal responsible party will be provided with written information that explains their rights under law to give informed consent and to either refuse or accept health care and treatment. All advanced directives forms shall be kept in a binder at the nurses station. II. Resident #78 A. Resident status Resident #78, age 80, was admitted on [DATE] and passed away on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included atherosclerotic heart disease and chronic obstructive pulmonary disorder (COPD). The February 2024 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. B. Record review The [DATE] CPO documented the following physician's order: COR status (whether or not a person wants cardiopulmonary resuscitation): CPR (cardiopulmonary resuscitation), Full Code (indicates all measures, including CPR to be taken to resuscitate a person), ordered [DATE] and discontinued on [DATE]. The [DATE] CPO documented the following physician's order: ADC (advanced directive care): Do not resuscitate (DNR), ordered on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] nursing progress note documented Resident #78t had been declining over the past month and he had started refusing to eat and began drinking a very little amount. The resident began having air hunger (a feeling of needing to breathe more air), coughing and vomiting mucus. The resident did not want to be sent to the hospital and decided he wanted to change his code status to a DNR. The progress note further documented Resident #78 amended his MOST form to change his full code status to a DNR. It was witnessed by two nurses. -A review of the resident's electronic medical record (EMR) on [DATE] at 2:00 p.m. did not reveal documentation of the initial MOST form documenting Resident #78's wishes to be a full code, nor the amended MOST form on [DATE] indicating the resident wished to change his status to a DNR. III. Staff interviews The NHA was interviewed on [DATE] at 2:25 p.m. The NHA said the facility considered the MOST form a portable document that was given to families upon discharge or shredded in the case of death. He said the facility destroyed all MOST forms from discharged or expired residents approximately one month ago ([DATE]). He said he did not feel the MOST form was part of the resident's medical record. The NHA said the facility did not have record of either of Resident #78's MOST forms. Registered nurse (RN) #2 and the infection preventionist (IP) were interviewed on [DATE] at 3:28 p.m. RN #2 said Resident #78 had been declining prior to his death on [DATE]. She said, on [DATE], the resident had been having difficulty breathing and was refusing to eat and drink. RN #2 said as his condition was deteriorating that day, she discussed with him the facility's responsibility to send him to the hospital because his MOST indicated that he was a full code. RN #2 said Resident #78 did not want to go to the hospital and decided to change his MOST form to reflect he wanted to be a DNR status. She said the IP joined her to witness the resident change his status. The IP said the facility had destroyed the MOST forms of all residents that had discharged or expired. She said Resident #78's MOST form was part of the destruction. The IP said she was told the MOST form was not part of the resident's medical record. The IP said the MOST form was considered a physician's order. She said all other physician's orders had been retained in the resident's EMR. The NHA was interviewed again on [DATE] at 4:08 p.m. The NHA said the facility did not have a policy on destroying the MOST form after a resident had been discharged from the facility. He said the MOST form was not kept in the resident's permanent medical record. The nurse practitioner (NP) was interviewed on [DATE] at 4:26 p.m. She said RN #2 called her and spoke with her regarding Resident #78's declining condition on [DATE]. She said she made sure, on four occasions that day, that Resident #78 had changed his mind and was happy with his decision. The NP said she gave orders to provide the resident with comfort measures. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NP said the MOST form was considered a physician's order and part of the resident's medical record. She said the facility should never have destroyed resident MOST forms. She said the facility had destroyed part of the resident's medical record. The regional clinical consultant (RCC) was interviewed on [DATE] at 5:22 p.m. The RCC said she was not aware who gave the direction to the facility to destroy MOST forms of residents that had discharged or expired from the facility. The RCC said the MOST form was considered part of the resident's permanent medical record and should not have been destroyed. She said she conducted a facility-wide training that day ([DATE]) to ensure the facility staff were aware that any part of the resident's medical record should not be destroyed. The RCC said the MOST form should have been uploaded to Resident #78's EMR when he passed away and not destroyed.

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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** 50314 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 housekeeping staff changed gloves and performed hand hygiene consistently when appropriate; -Ensure housekeeping staff properly sanitized resident rooms; -Dispose of contaminated medication pass water cups; -Offer hand hygiene to residents before meals; and, -Implement an effective water management plan. Findings include: I. Housekeeping failures A. Professional reference The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 7/9/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/appendix-c.html. It read in pertinent part, High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility. Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs. Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Observations On 6/26/24 at 9:32 a.m. housekeeper (HSKP) #1 was observed cleaning room [ROOM NUMBER]. HSKP #1 donned (put on) a pair of gloves and began spraying disinfectant in the bathroom. HSKP #1 then emptied the trash can in the bathroom. Without changing gloves, HSKP #1 began to clean the resident room, the sink and the mirror. After cleaning the resident's room, HSKP #1 changed her cleaning cloth and began cleaning the resident's bathroom. HSKP #1 moved the resident's commode to the opposite side of the bathroom to clean the toilet. When HSKP #1 finished cleaning the resident's bathroom, she removed her gloves for the first time and performed hand hygiene. -The call light cord in the resident's room and the resident's bathroom were not cleaned by HSKP #1 during the room cleaning process. -HSKP #1 failed to sanitize the room properly by moving from clean to dirty surfaces. -HSKP #1 failed to change her gloves and perform hand hygiene after touching potentially contaminated surfaces and items including the resident's trash can. -HSKP #1 failed to sanitize the resident's commode. On 6/11/24 at 9:14 a.m. HSKP #2 was observed cleaning room [ROOM NUMBER]. -HSKP #2 was sanitizing and cleaning the bathroom before she began to clean the resident's room. -HSKP #2 failed to sanitize the room properly by moving from clean to dirty surfaces. -The call light cord in the resident's room and resident's bathroom were not cleaned by HSKP #2 during the room cleaning process. C. Facility documentation Housekeeping in-service documentation, not dated, was obtained from the corporate consultant (CC) on 6/26/24 at 10:42 a.m. It documented the five step daily patient room cleaning procedure included emptying trash, disinfecting horizontal surfaces, spot clean walls, dust mop the floor, and then damp mop the floor. It documented the seven-step washroom cleaning process included checking supplies, emptying trash, dust mop the floor, clean and sanitize the sink and tub, clean and sanitize the commode, spot clean walls and/or partitions, and damp mop the floor. -The documentation failed to identify when housekeepers should perform hand hygiene or change gloves. D. 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	HSKP #1 was interviewed on 6/26/24 at 9:53 a.m. HSKP #1 said she did not need to clean the resident's commode because the resident did not use the commode. HSKP #1 said she cleaned the residents' call lights sometimes but not all the time. HSKP #1 said she needed to put gloves on to clean a room, but did not have to change her gloves between cleaning tasks. HSKP #1 said she was given two days of orientation when she began her housekeeping role. HSKP #1 said she had not received education or training in the last few months. HSKP #2 was interviewed on 6/27/24 at 9:31 a.m. HSKP #2 said housekeepers did not clean resident call lights every day, but only cleaned them on deep clean days that occurred once or twice a week. HSKP #2 said her orientation was very short upon hire. HSKP #2 said she had not received training or education in the last few months. The infection preventionist (IP) and the CC were interviewed together on 6/27/24 at 3:23 p.m. The IP said she had not provided the housekeeping staff with education. The CC said housekeeping staff were contracted outside of the facility. The CC said the facility administration needed to audit the housekeeping company to ensure proper sanitation practices were upheld. II. Failure to offer hand hygiene to residents before meals A. Facility policy and procedure The Hand Hygiene policy, undated, was obtained from the nursing home administrator (NHA) on 6/25/24 at 4:12 p.m. It documented in pertinent part, Hand hygiene will be performed before and after eating. B. Observations During a continuous observation on 6/24/24, beginning at 11:31 a.m. and ending at 12:28 p.m., the following was observed in the main dining room: -At 11:48 a.m. Resident #33 was observed self-propelling himself in a wheelchair to a table. He was not offered hand hygiene before or after his meal. -At 11:58 a.m. Resident #16 was observed self-propelling himself in a wheelchair to a table. He was not offered hand hygiene before or after his meal. -At 12:11 p.m. an unidentified resident wearing a green shirt and red sweatpants, was observed self-propelling himself in a wheelchair. The resident was not offered hand hygiene before or after his meal. The resident was observed eating a sandwich with his hands. During a continuous observation on 6/25/24, beginning at 5:22 p.m. and ending at 6:36 p.m., the following was observed in the main dining room: -At 5:46 p.m. the NHA was offering residents drinks. She did not offer the residents hand hygiene. -At 5:57 p.m. Resident #16 self-propelled himself in a wheelchair to a dining room table. He was not offered hand hygiene before or after his meal. He used his hands to eat two breaded chicken breasts. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 6:04 p.m. Resident #33 self-propelled himself in a wheelchair to a dining table. He was not offered hand hygiene before or after his meal. He used his hands to eat a sandwich. B. Resident interview Resident #16, who was cognitively intact, was interviewed on 6/24/24 at 10:17 a.m. Resident #16 said the facility did not offer hand hygiene before or after meals in the main dining hall. C. Staff interviews The IP was interviewed on 6/27/24 at 3:23 p.m. The IP said hand hygiene was one of the key components of infection prevention. The IP said residents should be offered hand hygiene before and after every meal. III. Failure to dispose of contaminated medication pass water cups A. Observations On 6/26/24 at 3:30 p.m. registered nurse (RN) # 2 was observed by the medication cart. Several medication cups fell off of the cart onto the floor. RN #2 picked up the cups and placed them on top of the medication cart. B. Staff interviews RN #2 was interviewed on 6/26/24 at 3:45 p.m. RN #2 said she should have thrown the cups away that had been on the floor. RN #2 said she would not use the cups and would instead throw them away. -RN #2 disposed of the cups, but did not sanitize the medication cart where the contaminated cups had been placed. The DON was interviewed on 6/27/24 at 3:23 p.m. The DON said the nurses should dispose of medication cups if they fell on the floor. IV. Failure to have an effective water plan A. Professional reference According to The CDC's Legionella (Legionnaires Disease and Pontiac fever), (3/25/21), retrieved on 7/10/24 from https://www.cdc.gov/legionella/wmp/toolkit/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Flegionella%2Fmaintenance%2Fwmp-toolkit.html and https://www.cdc.gov/legionella/wmp/overview.html, Many buildings need a water management program to reduce the risk for Legionella growing and spreading within their water system and devices. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Legionella bacteria are typically found naturally in [NAME] environments, but can become a health concern when they grow and spread in human-made water systems. Legionella can cause a serious type of pneumonia (lung infection) known as Legionnaires disease. Some water systems in buildings have a higher risk for Legionella growth and spread than others. Legionella water management programs are now an industry standard for many buildings in the United States. Legionella bacteria can cause a serious type of pneumonia (lung infection) called Legionnaires disease. Legionella bacteria can also cause a less serious illness called Pontiac fever. The key to preventing Legionnaires disease is to reduce the risk of Legionella growth and spread. Building owners and managers can do this by maintaining building water systems and implementing controls for Legionella. Water management programs identify hazardous conditions and take steps to minimize the growth and transmission of Legionella and other waterborne pathogens in building water systems. Developing and maintaining a water management program is a multi-step process that requires continuous review. Seven key elements of a Legionella water management program are to: -Establish a water management program team -Describe the building water systems using text and flow diagrams -Identify areas where Legionella could grow and spread -Decide where control measures should be applied and how to monitor them -Establish ways to intervene when control limits are not met -Make sure the program is running as designed (verification) and is effective (validation) -Document and communicate all the activities. Principles: In general, the principles of effective water management include: -Maintaining water temperatures outside the ideal range for Legionella growth - Preventing water stagnation -Ensuring adequate disinfection -Maintaining devices to prevent sediment, scale, corrosion, and biofilm, all of which provide a habitat and nutrients for Legionella. Once established, water management programs require regular monitoring of key areas for potentially hazardous conditions and the use of predetermined responses to respond when control measures are not met. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A consultant with Legionella-specific environmental expertise may sometimes be helpful in implementing and operating water management programs. According to the CDC's Controlling Legionella in Potable Water Systems, (2/3/21), retrieved on 7/10/24 from https://www.cdc.gov/control-legionella/media/pdfs/Control-Toolkit-Potable-Water.pdf, Store hot water at temperatures above 140 degrees fahrenheit (F) and ensure hot water in circulation does not fall below 120 degrees F. Recirculate hot water continuously, if possible. Store and circulate cold water at temperatures below the favorable range for Legionella (77 degrees F to 113 degrees F). Legionella may grow at temperatures as low as 68 degrees F. B. Record review The facility's water management plan was obtained from the NHA on 6/27/24 at 3:28 p.m. It documented the water management plan was initiated on 6/27/24. The document was signed by the NHA and the DON The facility's water management plan, dated 2021, was obtained from the NHA on 6/27/24 at 3:49 p.m. It documented the facility tested for Legionella to ensure the water management plan worked effectively. However, the facility failed to test the water for Legionella as stated in the water management plan. (see interview below) -Additionally, the facility's water management plan was not updated annually. C. Staff interviews The NHA was interviewed on 6/27/24 at 3:49 p.m. The NHA said the facility initiated a new water management plan on 6/27/24 (during the survey). The NHA said the facility previously had an effective water management plan. He said the water management plan had not been updated since 2021 and he implemented a new program on 6/27/24 (during the survey). The NHA said he would need to find the testing information for legionella. -The NHA was interviewed again on 6/27/24 at 4:38 p.m. The NHA said he did not have documentation that the facility had been testing for Legionella after 2021.

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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. 38185 Based on record review and interviews, the facility failed to ensure certified nurse aides (CNA) received the required 12 hours of training per year. Specifically, the facility failed to: -Ensure a system was in place to track CNA training to ensure they met the requirements; and, -Ensure CNA #9 and CNA #10 received the required 12 hours of training per year. Findings include: I. Record review A review of the CNA training records was completed on 6/27/24 at 2:00 p.m. -CNA #9's training records documented CNA #9 received seven hours of training in the previous calendar year. -CNA #10's training records documented CNA #10 received eight hours of training in the previous calendar year. II. Staff interviews The staff development coordinator (SDC) was interviewed on 6/27/24 at 4:04 p.m. The SDC said she did not have a system in place to monitor the CNAs yearly training. She said the CNAs were required to receive 12 hours of training per year. She said CNA #9 received seven hours of training in the calendar year and CNA #10 received eight hours of training in the calendar year, which did not meet the 12 hours of annual training requirement.