STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065358	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Westminster	7751 Zenobia CT Westminster, CO 80030

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to honor resident choices for two (#53 and #26) of four residents reviewed out of 33 sample residents. Specifically, the facility failed to ensure Resident #53 and Resident #26's recevied showers consistently according to the resident's choices and plan of care. Findings include: I. Facility policy and procedure The Resident Rights policy, undated, was provided by the nursing home administrator (NHA) on 5/1/25 at 5:47 p.m. It read in pertinent part, A resident is afforded certain rights while residing in a long-term care facility. The facility and its associates have the responsibility for ensuring these rights are always upheld by the resident in their care. The facility must provide equal access to quality care regardless of diagnosis, severity of condition or payment source. II. Resident #53 A. Resident status Resident #53, age [AGE], was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included inflammatory and immune myopathies (inflammation and damage to muscles due to abnormal immune response), arthrodesis status (surgical procedure to manage severe joint pain) and myopathy (disease that affects movement). The 4/1/25 minimum data set (MDS) revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He was independent with his activities of daily living (ADLs). He required supervision with showers. B. Resident interview (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #53 was interviewed 4/30/25 at 1:00 p.m. Resident #53 said that he had requested showers on Saturdays and Wednesday mornings, since his admission. He said he continued to receive showers on Mondays and Thursdays. He said his family visited on Saturdays and he liked to be cleaned up and not smell for the visit. He said one Thursday a month he had a standing appointment and could not take a shower on that day so he would only receive one shower that week. He said he had asked for showers on different days during his appointment week, but did not receive one. Resident #53 was interviewed 5/1/25 at 2:10 p.m. Resident #53 said he had been waiting for a shower that day. He said he had been waiting all day to receive a shower and had not received it. C. Record review The ADL care plan, initiated 7/24/24 and revised 9/16/24 revealed the resident had an ADL self care performance deficit related to immune myopathy, decreased mobility and muscle weakness. Pertinent interventions included Resident #53 preferred to shower every Monday and Wednesday in the evening. Resident #53's May 2025 point of care (POC) response history for the bathing task revealed Resident #53 preferred to shower on Monday and Thursday, day shift after breakfast. Resident #53's POC bathing task documentation from 4/3/25 through 5/1/25 revealed the resident did not consistently receive showers on his preferred days of Wednesday and Saturdays. Review of Resident #53's POC bathing documentation from 4/3/25 to 5/1/25 revealed the resident received a shower on 4/3/25, 4/12/25, 4/14/25, 4/17/25, 4/21/25, 4/28/25 and 4/29/25. The resident received seven showers out of 11 opportunities. The POC bathing documentation indicated the resident received a shower on 5/1/25. However, certified nurse aide (CNA) #2 said she did not provide Resident #53 a shower on 5/1/25 (see interviews below). -However, Resident #53 preferred to shower on Saturday and Wednesday mornings (see resident interview above). III. Resident #26 A. Resident #26, age [AGE], was admitted on [DATE]. According to the May 2025 CPO, diagnoses included multiple sclerosis (MS), spinal stenosis and chronic obstructive pulmonary disease (COPD - breathing difficulties). The 4/9/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was incontinent of bowel and bladder and was dependent on staff for all of her ADLs. B. Resident interview (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #26 was interviewed 4/30/25 at 1:00 p.m. Resident #26 said she was scheduled for one shower a week because she required a long time. She said sometimes it took up to two hours for her to shower because of her physical condition. She said she first agreed to receiving showers on Sundays, however if her shower was missed on a Sunday she would not receive another shower until the following Sunday, which she did not like. C. Record review The ADL care plan, initiated 11/11/20 and revised on 7/26/24, Resident #26 had an ADL self-care deficit with end-stage MS and quadriplegia (no movement of the limbs). Interventions included providing showers on Sundays and as needed. The care plan indicated Resident #26 was totally dependent on one to two staff members to provide showering. The progress note, dated 4/20/25, documented Resident #26 was scheduled for her shower, however the shower chair that she preferred could not be located. She was offered other chairs or a bed bath which she declined. She was told that she could not have a shower since she declined all other options. The POC bathing task documented that Resident #26 did not receive a shower on 4/20/25 or on 4/27/25. IV. Staff interviews CNA #2 was interviewed 5/1/25 at 2:30 p.m. She said Resident #53 was not given a shower on 5/1/24. CNA #3 said Resident #53 was on her list but she missed him and the POC response history was marked wrong. -However, the POC response history indicated that Resident #53 had been given a shower on 5/1/25 (see record review above). The director of nursing (DON) was interviewed 5/1/25 at 3:44 p.m. She said the facility tried to honor the residents' requested days for showers. She said the facility could provide a shower as needed, if there were enough staff to fill the request. The DON said Resident #53 changed his shower day preference often but was able to tell staff when he wanted a shower. She said she was not aware that he requested Saturday showers for family visits and he could not take showers one Thursday a month. The DON said Resident #26 could take up to two hours and she had agreed to Sunday showers. She had not been aware of the two missed showers in April 2025.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and interviews, the facility failed to ensure prompt action was taken to resolve grievances from a group. Specifically, the facility failed to resolve residents' concerns regarding not enough floor staff to provide care such as showers, call light wait times and no hot water for showers. Findings include: I. Facility policy and procedure The Grievance Program (Concern and Comment) policy, reviewed 9/25/23, was provided by the nursing home administrator (NHA) on 5/1/25 at 5:47 p.m. It read in pertinent part, Residents and their families have the right to file a complaint without fear of reprisal. Upon request, the facility must give a copy of the grievance policy to the resident. Resident's rights should be protected when voicing complaints to maximize the quality of life for each individual and to promote customer satisfaction with facility care and services. The Concern and Comment Program is utilized to address the concerns of the residents, family members and visitors. Ensure that residents and families receive upon admission information on the facility grievance procedure, including their right to file a complaint orally or in writing without fear of reprisal. Facilitate meetings and/or conversations with residents and families who have repeated concerns to better meet their needs. Follow up with the resident and family to communicate resolution or explanation and ensure that the issue was handled to the resident and family's satisfaction. The Resident Council policy, reviewed 9/26/24, was provided by the NHA on 5/1/25 at 5:47 p.m. It read in pertinent part, The group is defined as resident members that meet regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment and quality of life. II. Resident group interview Six residents (#1, #71, #17, #5, #53 and #26), who were identified as interviewable by the facility and assessment, were interviewed on 4/30/25 at 1:00 p.m. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1 said she attended resident council meetings. She said the unit used to have four certified nurses aides (CNA), but they were cut to three CNAs and if one CNA did not show up, there were only two CNAs to provide care. She said CNA call offs happened a lot for the evening and weekend shifts. Resident #1 said the facility needed more floor staff on the units because she sometimes had to wait for 30 minutes to one hour for assistance. She said there were still a lot of agency staff working on the units and they did not know how to care for the residents. Resident #1 said staff did not check on residents who were more independent with their activities of daily living (ADL). She said the water in the shower room was still cold, even though the concern had been brought up at resident council meetings. Resident #1 said the facility did not feel like a home anymore. Resident #71 said she attended resident council meetings. She said she had to wait a very long time for pain medication and she had to get out of bed to find a nurse on occasion. She said she felt like staff did not check on her because she was more independent than other residents. Resident #71 said the water in the shower room continued to be cold. Resident #17, who was the facility's resident council president, said she attended resident council meetings. She said the facility was always short staffed. She said she and her husband did not get enough assistance with transfers and ADLs and they sometimes had to wait a long time when they used the call light. Resident #5, who was the facility's resident council vice president, said she attended resident council meetings. Resident #5 said the water was still cold when she took showers. She said the concern had been brought up several times during resident council meetings. She said there were not enough CNAs on the unit to assist residents. Resident #5 said she was a resident who required CNA assistance and she had to wait a long time for the light to be answered. She said there were a lot of agency staff that did not know the residents. Resident #5 said the facility did not feel like a home. Resident #53 said he attended resident council meetings. He said the weekends seemed to be short staffed. He said he did not feel like there was enough nursing staff to provide the needed care for residents. Resident #53 said he felt like a lot of the permanent facility staff had quit. Resident #53 said he believed the corporation cut the budget, to include CNA hours and food and the residents felt that. He said the water took a long time to warm up for showers and showers were not given on schedules. Resident #53 said the facility did not feel like the residents' home. Resident #26 said that she attended resident council meetings. She said she did not feel like there were enough staff members to care for her and the other residents. Resident #26 said she took a lot of time because of her physical limitations and she did not feel like the CNAs were able to take the time she needed for her care, especially the agency staff who did not know her. She said water temperature for showers had not improved. Resident #26 said the facility did not feel like a home. III. Resident council meeting minutes The following resident council meeting minutes were provided by the NHA on 4/29/25 at 3:00 p.m: The 9/18/24 resident council meeting minutes documented the residents were not happy about the shower schedule. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) informed the residents that they could change their shower days and could ask for an additional shower. However, the DON informed the residents that if they changed a shower day, there was no guarantee that the resident would get a shower that day because of scheduling. The 10/17/24 resident council meeting minutes documented the facility continued to have staff openings and had now received permission to bring on agency staff. The 11/18/24 resident council meeting minutes documented the residents were not getting their scheduled showers and the shower room water was cold. The residents were concerned that weekends were short staffed. The NHA informed the residents there were going to be changes on how the call lights were handled. The DON informed the residents the shower schedule was updated regularly and instructed the residents to communicate with the DON or the NHA if they had not received a shower. She said the shower water was to be turned on ahead of time so it would be warm. The 12/18/24 resident council meeting minutes documented the residents were not getting their scheduled showers. Residents said there was not enough nursing staff to cover all the units. The DON informed the residents the facility was continuing to hire permanent staff and agency staff was being utilized. -The minutes did not indicate how the facility would address the current problem of ensuring residents received their scheduled showers. The 1/15/25 resident council meeting minutes documented the NHA had resigned and the regional vice president would be the interim executive director (ED). The minutes documented the residents were concerned about the lack of CNA coverage, especially during the weekends and showers were not getting done. The interim ED informed the residents the facility continued to work on hiring CNAs. The DON informed the residents the facility was working with CNAs to give showers as scheduled. The 2/18/25 resident council meeting minutes documented the residents were concerned about call lights not being answered timely in the mornings and on weekends. Residents reported call lights had taken up to two hours to be answered. Residents were concerned the weekend CNAs did not seem to be trained on how to take care of the residents. Residents reported the showers did not have hot water. The interim ED informed the residents that the corporate office was aware of the water situation and was working on getting the boilers replaced. The DON informed the residents that she had instructed staff to fill bowls with hot water to mix in to make the shower water warm. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON informed the residents she would be meeting with the CNAs to provide education on call lights and review resident care. The 3/19/25 resident council meeting minutes documented the introduction of the new NHA. A resident reported they waited over two hours for staff assistance and there was no hot water for showers. The DON informed the residents she was having a staff meeting to address these issues. -However, the DON had informed the residents in the 2/18/25 resident council meeting (one month prior) that she would be meeting with the CNAs to provide education regarding call lights and resident care (see above). -Maintenance director (MTD) #1 informed the residents the facility was working on the hot water issue and there was one more section to fix. The 4/16/26 resident council meeting minutes documented residents' concern about the lack of hot water during showers, CNAs being seen on their phones and not answering call lights, CNAs reluctance to assist on halls they were not assigned to and the tardiness of staff. The NHA acknowledged the hot water issue and said it was actively being addressed. The DON informed the residents a skills day would be implemented to re-educate staff on expectations emphasizing teamwork and accountability across all units. IV. Call light observation logs The facility's call light observation logs were provided by the NHA on 4/30/25 at 1:20 p.m. The call light logs indicated call light observations were to be performed three to five times per week for 90 days, to include different shifts and hallways. The call light logs revealed the following: The December 2024 call light log documented 11 call light observations on eight different days for the month. There were no call lights observed for weekend days and only two night shifts were observed. The call light wait times documented were between seven and 20 minutes. The 2/26/25 call light log documented call light wait times were between one minute to 51 minutes. The call light observations took place between 1:58 p.m. and 3:10 p.m. Evening and night shift call lights were not observed. The 2/27/25 call light log documented call light wait times were between one minute to 33 minutes. The observations were completed between 2:04 p.m. and 3:19 p.m. Evening and night shift call lights were not observed. The 3/5/25 call light log documented call light wait times were between one minute to 16 minutes. The observations were completed between 2:22 p.m. and 3:57 p.m. Evening and night shift call lights were not observed. -The call light logs were not completed over evening, night or weekend shifts. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure one (#28) of five residents reviewed for grievances out of 33 sample residents was provided prompt efforts by the facility to resolve grievances. Specifically, the facility failed to promptly resolve Resident #28's grievance regarding care provided by certified nurse aide (CNA) #3. Findings include: I. Facility policy and procedure The Grievances policy and procedure, reviewed June 2022, was provided by the nursing home administrator (NHA) on 5/1/25 at 4:00 p.m. It revealed in pertinent part, Residents and their families have the right to file a complaint without fear of reprisal. Upon request, the facility must give a copy of the grievance policy to the resident. Residents' rights should be protected when voicing complaints to maximize the quality of life for each individual and to promote customer satisfaction with facility care and services. The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment that has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their long term care facility stay. The resident has the right to, and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph: -Upon request, the provider must give a copy of the grievance policy to the resident; -Resolve the concern, if possible; and, -If resolution is not possible at that time, explain to the individual that another staff member will be assigned to investigate the concern and will contact them in a timely manner; and, -Immediately report all alleged violations involving neglect and abuse, including injuries of unknown source and misappropriation of resident property, by anyone furnishing services on behalf of the provider to the executive director, and as required by state law. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The executive director is responsible for ensuring that all grievances and concerns have been reviewed and addressed in a timely and appropriate manner and that concerned individuals feel that some resolution has been communicated, achieved, and maintained, and taking appropriate corrective action in accordance with state law if the facility confirms the alleged violation of the resident's rights, or if an outside entity having jurisdiction, such as the state survey agency, quality improvement organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility. II. Resident #28 A. Resident status Resident #28, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease with exacerbation, morbid obesity, asthma, paroxysmal atrial fibrillation, congestive heart failure, anxiety disorder, depression, chronic kidney disease, insomnia and obstructive sleep apnea. The 2/11/25 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 maximum assistance of two staff members with repositioning and dressing and one person assistance with personal hygiene. B. Resident interview Resident #28 was interviewed on 4/28/25 at 11:28 a.m. Resident #28 said she had concerns about the care provided to her by CNA #3. She said CNA #3 only changed her twice every eight-hour shift and did not talk to her. She said she requested in January 2025 that CNA #3 no longer provide care to her, but she said CNA #3 continued to provide her care. She said CNA #3 did not have enough time for her so she had to wait until 10 p.m. so someone else could help her prepare for bed. Resident #28 said she reported her concerns about CNA #3 to multiple people. She said licensed practical nurse (LPN) #2, who was the unit manager, was aware of her concern. She said she had left a message on the NHA's phone, but she said he had not provided her with feedback or a resolution on her concern. C. Observations On 4/29/25 at 2:05 p.m. CNA #3 was observed checking Resident #28. CNA #3 asked the resident if she needed something since CNA #3 was designated for her care. Resident #28 said she did not need any assistance. On 4/29/25 at 3:10 p.m. Resident #28 was toileted by CNA #3 and another staff member. D. Record review (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/7/25 Concern and Comments form submitted by Resident #28 revealed the resident had concerns regarding the care that CNA #3 provided to her. The grievance documented that Resident #28 had concerns with CNA #3 is taking too long to change her or CNA #3 was not changing her at all. Resident #28 indicated CNA #3 was rude and did not speak to the resident when she came in to assist the resident. The grievance indicated the concern was reported to LPN #2 on the same date (4/7/25). The concern form did not indicate what actions were taken to resolve Resident #28'sconcerns regarding CNA #3. On 4/29/25 at 10:15 a.m. the NHA provided notes that was completed by CNA #3. The documentation, dated 4/7/25 to 4/23/25, revealed CNA #3 changed the resident an average of two times during each eight-hour shift and she changed the resident three times during two shifts during the documented period. III. Staff interviews CNA #3 was interviewed on 4/29/25 at 2:29 p.m. CNA #3 said she provided personal care for Resident #28, including toileting, hygiene, bringing meal trays and opening the window. CNA #3 said she changed the resident two to three times per shift. LPN #2 was interviewed on 4/29/25 at 4:13 p.m. LPN #2 said the facility staff did not follow up with the resident about her concerns until today, 4/29/25. She said Resident #28 asked her to remove CNA #3 from providing care for her. LPN #2 said CNA #3 was removed from the resident'scare team today (4/29/25). -However, Resident #28 had brought her concern to other staff members in January 2025 (see resident interview above and RN #1's interview below). Registered nurse (RN) #1 was interviewed on 4/29/25 at 4:40 p.m. RN #1 said she was aware of the Resident #28'sconcerns regarding the care provided to her by CNA #3. RN #1 said she remembered hearing about the resident'sconcern two or three months prior. She said she did not know what actions were taken or what the resolution of the concern was. The NHA was interviewed on 4/29/25 at 4:05 p.m. The NHA said he had talked to Resident #28 several times, but he said she did not express any concerns regarding CNA #3. He said that yesterday (4/28/25), he had heard about the resident'sconcern for the first time since he started his position in March 2025. He said he gave cell his phone number to most, if not all, of the residents in the facility and he had not received calls or messages from Resident #28 or from any of the other residents in the facility. -However, a Concern and Comment form was completed for Resident #28 on 4/7/25 (see record review above).

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** V. Resident #28 A. Resident status Resident #28, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the April 2025 CPO, diagnoses included chronic obstructive pulmonary disease with exacerbation, anxiety disorder, depression, insomnia and obstructive sleep apnea. The 2/11/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required maximum assistance of two staff members with repositioning and dressing and one person assistance with personal hygiene. The MDS assessment revealed the resident was receiving antidepressant medications. B. Record review Review of Resident #28's April 2025 CPO revealed the following physician's orders: Duloxetine (an antidepressant medication) 60 mg by mouth one time a day for depression, ordered 2/18/25. Sertraline (an antidepressant medication) 25 mg by mouth one time per day for anxiety and panic, ordered 2/18/25. Trazodone (an antidepressant medication) 100 mg at bedtime for insomnia, ordered 2/18/25. Resident #28's April 2025 medication administration record (MAR) revealed drowsiness was a side effect of the duloxetine, sertraline and trazodone. Review of Resident #28's April 2025 TAR revealed that the resident slept a minimum of eight hours and a maximum of sixteen hours per day. -Review of Resident #28's electronic medical record (EMR) revealed there was no documented rationale from the resident's physician to justify why the resident was on three antidepressant medications. -Additionally, the EMR did not document a physician's rationale for the continued use of trazodone when the resident slept more than eight hours per day. C. Staff interviews LPN #2 was interviewed on 5/1/25 at 4:14 p.m. LPN #2 said she could not recall the reason why Resident #28 was currently taking three antidepressant medications. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Primary care physician (PCP) #1 was interviewed by phone on 5/1/25 at 10:15 a.m. PCP #1 said Resident #28 was on duloxetine for neuropathic pain, sertraline for panic attacks and trazodone for insomnia. She said the resident wanted to keep taking trazodone. PCP #1 said she would talk to Resident #28 regarding her sleeping up to 16 hours per day. She said she could not recall if she documented the rationale for the use of two or more antidepressant medications for the resident. The medical director (MD) was interviewed over the phone on 5/1/25 at 5:15 p.m. The MD said all residents on psychotropic medications should be reviewed quarterly to ensure the continued use of psychotropic medications was justified. He said he participated in the facility's psychotropic review meeting but he could not recall the details about Resident #28's medications. He said it was the responsibility of the resident's PCP to document details to justify the use of multiple psychotropic medications or a gradual dose reduction should be attempted. Based on record review and interviews, the facility failed to ensure three (#61, #15 and #28) of five residents reviewed for psychotropic medications out of 33 sample residents were as free from unnecessary medication as possible. Specifically, the facility failed to: -Ensure Resident #15 and Resident #61 had appropriate mood and behavior monitoring in place for their psychotropic medication in order to justify and determine effectiveness of the medications; -Ensure Resident #15 had the proper diagnoses for the use of an antipsychotic (a class of drugs used to treat psychosis, particularly in conditions like schizophrenia and bipolar disorder) medication; -Provide a physician's clinical rationale to justify the use of two antidepressant medications for Resident #28; and, -Ensure Resident #28, who slept eight to 16 hours per day, was appropriately monitored and reassessed by the physician to provide a justification for the ongoing use of trazodone (an antidepressant medication often used for insomnia) together with two other antidepressant medications which had sleepiness as a side effect of the medications. Findings include: I. Facility policy and procedure The Unnecessary Medication policy, revised 4/22/25, was provided by the nursing home administrator (NHA) on 5/1/25 at 5:28 p.m. It read in pertinent part, The facility will ensure only medications required to treat the resident's assessed condition are being used, reducing the need for and maximizing the effectiveness of medications. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility will assess the resident's underlying condition, current signs, symptoms and expressions, and preferences and goals for treatment. This will assist the facility in determining if there are any indications for initiating, withdrawing, or withholding medication(s), as well as the use of non-pharmacological approaches. The facility's medication management process will support and promote: Monitoring of medications for efficacy and adverse consequences. The resident's medical record should show documentation of adequate indications for a medication's use and the diagnosed condition for which a medication is prescribed. The facility will ensure proper monitoring and accurate documentation to a medication in order to evaluate the ongoing benefits as well as risks of various medications. II. Resident #61 A. Resident status Resident #61, age [AGE], was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included schizophrenia (mental health disorder), bipolar disorder (mental health disorder) and unspecified depression. The 4/19/25 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 was dependent on staff for dressing, toilet hygiene and bathing. The MDS assessment revealed the resident had mild depression with a score of six out of 27. The MDS assessment revealed the resident received antidepressant and antipsychotic medications. B. Record review Review of Resident #61's May 2025 CPO revealed the following physician's orders: Lexapro (antidepressant medication) 10 milligrams (mg). Give one tablet by mouth one time a day for depression, ordered 10/23/24. Abilify (antipsychotic medication) 15 mg. Give one tablet by mouth one time a day for bipolar disorder, ordered 10/23/24. Resident #61's antidepressant medication care plan, initiated 2/20/24 and revised 3/31/25 (during the survey process), documented the resident used antidepressant medication related to depression. The interventions included administering antidepressant medication as ordered by the physician, observing for side effects and effectiveness, observing for and reporting PRN (as needed) adverse reactions to antidepressant therapy to include changes in mood/behavior/cognition, hallucinations or delusions, suicidal thoughts, decline in activities of daily living (ADL) ability, constipation, diarrhea, muscle cramps, gait changes, dizziness/vertigo, insomnia and tremors. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The care plan failed to document specific target behaviors to monitor for the resident to justify the use of the medication. Resident #61's antipsychotic medication care plan, initiated 4/29/25 (during the survey process), documented the resident used antipsychotic medication, Abilify, related to behavior management. The interventions included administering antipsychotic medications as ordered by physician, observing for side effects and effectiveness, observing for any adverse reactions to antipsychotic medication to include rigid muscles, dry mouth, depression, blurred vision, muscle cramps, refusal to eat, difficulty swallowing and behavior symptoms not usual to the person. -The care plan failed to document specific target behaviors to monitor for the resident to justify the use of the medication. -Review of Resident 61's May 2025 treatment administration record (TAR) revealed there was no mood or behavior tracking documented related to the diagnoses of bipolar disorder, schizophrenia or depression. III. Resident #15 A. Resident status Resident #15, age [AGE], was admitted on [DATE]. According to the May 2025 CPO, diagnoses included altered mental status and depression. The 3/5/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. She required set-up assistance for oral hygiene and upper body dressing. She required supervision for lower body dressing. The MDS assessment revealed the resident had mild depression with a score of six out of 27. The MDS assessment revealed the resident received antidepressant and antipsychotic medications. B. Record review Review of Resident #15's May 2025 CPO revealed the following physician's orders: Fluoxetine (antidepressant medication) 10 mg. Give one capsule by mouth one time a day for depression, ordered 11/14/24. Quetiapine (antipsychotic medication) 25 mg. Give one tablet by mouth at bedtime for depression, ordered 11/14/24. Resident #15's antidepressant medication care plan, initiated 10/30/24 and revised 4/28/25 (during the survey process), documented Resident #15 was taking fluoxetine related to depression. The interventions included observing and reporting adverse reactions to antidepressant therapy including change in behavior/mood/cognition, suicidal thoughts, continence, constipation, gait changes, hallucinations/delusions, social isolation, withdrawal, decline in ADL function, falls, insomnia, tremors and muscle cramps. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #15's antipsychotic medication care plan, initiated 11/21/24 and revised 4/28/25 (during the survey process), documented Resident #15 used antipsychotic medication related to depression. The interventions included observing for adverse reactions including unsteady gait, tardive dyskinesia (involuntary, repetitive movements), frequent falls, fatigue, insomnia, insomnia, loss of appetite, behavior symptoms not usual to the person, depression observing for occurrence of target behavior symptoms included wandering, disrobing, pacing and inappropriate response to verbal communication. -The care plan failed to document specific target behaviors to monitor for the resident to justify the use of the medication. -Review of Resident #15's May 2025 TAR revealed there was no mood or behavior tracking documented related to the depression diagnosis. The pharmacy consultation reports for January 2025, February 2025, March 2025 and April 2025 revealed Resident #15 received an antipsychotic without documentation of diagnosis and adequate indication for use in the medical record. IV. Staff interviews The social services assistant (SSA) was interviewed on 4/30/25 at 4:56 p.m. The SSA said there should be mood and behavior care plans and tracking that were specific to the residents' diagnoses related to the psychotropic (primarily used to treat mental health conditions and related symptoms) medication for Resident #61 and Resident #15. She said the psychotropic medication side effects should additionally be tracked. She said that mood and behavior tracking should be on the TARs in order to track if the medications were effective. The SSA said the behavior and side effect information was used at monthly psychotropic pharmacological medication meetings where physicians could review if the psychotropic medications were effective. The SSA said that social services, the director of nursing (DON), the NHA, physicians and pharmacists attended the monthly meetings. The pharmacy consultant (PC) was interviewed on 5/1/25 at 12:05 p.m. The PC said she would expect to see mood and behavior tracking related to the specific diagnoses of bipolar, schizophrenia and depression on a resident's care plan and TAR, separate from the medication's potential side effects care plan and TAR. She said she would expect to see the mood and behavior tracking at the monthly pharmacological meetings in order to be reviewed by the interdisciplinary team (IDT) when monitoring the effectiveness of a medication. Licensed practical nurse (LPN) #1 was interviewed on 5/1/25 at 1:36 p.m. LPN #1 said she monitored for psychotropic medication side effects because the MAR prompted her to document side effects. She said there was no prompt specifically for daily tracking of residents' mood or behaviors. LPN #1 said she wrote a progress note if she witnessed a change in a resident's mood or behavior. The director of nursing (DON) was interviewed on 5/1/25 at 3:44 p.m. The DON said the facility did not have mood or behavior tracking for specific psychotropic medication diagnoses. She said the facility only had medication side effects tracking. She said she would expect specific mood and behavior care plans and tracking related to the residents' diagnoses, as these would have different symptoms related to the diagnoses than the psychotropic medication tracking.

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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** Based on record review and interviews, the facility failed to provide services in accordance with currently accepted professional principles for one (#28) of five residents reviewed for medication management out of 33 sample residents. Specifically, the facility failed to ensure Resident #28 was administered medications per physician's orders in April 2025. Findings include: I. Resident #28 A. Resident status Resident #28, age [AGE], was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease with exacerbations, morbid obesity, asthma, paroxysmal atrial fibrillation (abnormal heart rate), congestive heart failure, anxiety disorder, depression, chronic kidney disease, insomnia and obstructive sleep apnea. The 2/11/25 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. II. Resident interview Resident #28 was interviewed on 4/28/25 at 11:28 a.m. She said the staff did not administer multiple of her medications this month. She said the staff constantly ran out of prescription and over the counter medications. She said her antidepressant, pain medication and inhalers were not available on several occasions in April 2025. III. Record review Review of the April 2025 CPO revealed the following physician's orders: Cetirizine HCL oral tablet 210 milligrams (mg), give 10 mg by mouth in the evening for allergies, ordered 2/19/25; Biofrreeze Cool The Pain external gel 4% (menthol - topical pain medication), apply to bilateral knees topically every morning and at bedtime for pain, ordered 2/18/25; D-Mannose oral powder (supplement), give 599 mg by mouth two times a day for urinary health, ordered 2/19/25; Flovent HFA Inhalation Aerosol 220 micrograms (mcg), ACT (Fluticasone Propriante HFA) (medication used to help with breathing), one puff inhale orally every morning and at betime for chronic obstructive pulmonary disease (COPD), ordered 2/18/25; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Potassium Citrate ER (extended release) oral tablet 5 milliequivalents (meq) (540 mg) (Potassium Citrate (Alkalinizer), give two tablet by mouth three times a day for supplement take with meals, ordered 2/18/25; and, Norco Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen), give one tablet by mouth every morning and at bedtime for chronic pain, ordered 2/18/25. Review of the April 2025 (4/1/25 to 4/30/25) medication administration record (EMR) revealed the following: Cetrizine HCL oral tablet was not administered on 4/15/25, 4/20/25, 4/21/25 and 4/23/25. Biofreeze external gel was not administered on 4/10/25, 4/11/25, 4/12/25 and 4/13/25. D-Mannose oral powder was not administered on 4/25/25, 4/29/25 and 4/30/25. Lovent HFA inhalation aerosol was not administered on 4/27/25, 4/28/25, 4/29/25 and 4/30/25. Potassium citrate was not administered on 4/13/25 and 4/14/25. Norco oral tablet was not administered on 4/25/25. Review of the April 2025 (4/1/25 to 4/30/25) progress notes revealed documentation that indicated the above medications were not available and were not administered. The 4/28/25 nursing note documented the on call physician was notified that the Flovent medication was not available and the resident had to pay $155 per the pharmacy. -Review of Resident #28's electronic medical record (EMR) did not reveal further documentation regarding why Resident #28 was not consistently administered her medications in April 2025 or documentation indicating the physician was notified. IV. Staff interviews The pharmacy consultant (PC) was interviewed on 5/1/25 at 12:04 p.m. The PC said she would not comment on potential side effects or consequences of not administering Resident #28's medications as scheduled. The central supply coordinator (CSC) was interviewed on 5/11/25 12:27 p.m. The CSC said the nurses and the unit managers would tell her when over the counter medications were not available. She said when she was notified she would run to the store and get them. The CSC said she did not know what system was in place to ensure there was no lapse in available medications. Licensed practical nurse (LPN) #2, who was the unit manager, was interviewed on 5/1/25 12:31 p.m. LPN #2 said there was no formal way to track over the counter medications to ensure medications were available consistently. She said once the medication was missing she would get notified and order from central supply. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The pharmacy manager (PM) was interviewed on 5/1/25 at 1:30 p.m. The PM said he reviewed the records for Resident #28's medications. He said all medications were refilled as ordered and it was unclear why some of the medications were not available at the facility. He said Flovent was delivered on time and he did not see any associated cost for the medication or delay in delivery. The director of nursing (DON) was interviewed on 5/1/25 at 3:22 p.m. She said she relied on the unit managers, the central supply coordinator and the floor nurses to maintain communication to ensure the medications were available without interruptions. She said she was not aware of any formal system of tracking availability of over the counter medications. She said when medication was not administered the physician should be notified. Primary care physician (PCP) #1 was interviewed on 5/1/25 at 4:15 p.m. She said it was reported to her that some medications were not available and the resident was in communication with the pharmacy regarding the co-payment for some inhalers. She said she was not aware that the resident was not consistently administered potassium in April 2025. She said perhaps other on call providers were notified. She said not administering the medications as ordered would not result in a significant outcome for the resident.

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F 0686 Level of Harm - 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** Based on observations, record review and interviews, the facility failed to ensure one (#41) of five residents reviewed for pressure injuries out of 33 sample residents received care consistent with professional standards of practice to prevent pressure ulcers from developing. Resident #41 was admitted on [DATE] for long term care. At the time of his admission, the resident was identified as being at risk for developing pressure injuries and he did not have any pressure injuries upon admission. On 12/2/24 the facility documented Resident #41 had a new wound with an open area on his left inner heel measuring 3.0 centimeters (cm) by 0.9 cm. The facility failed to implement preventative measures to protect the resident's heels after the development of the left heel wound on 12/2/24. On 12/4/24 a nurse progress note indicated Resident #41 had an unstageable pressure wound to his left heel. On 12/10/24 the resident was seen by a wound care physician (WCP) who classified the resident's left heel wound as an unstageable pressure ulcer. Due to the facility's failure to implement personalized effective pressure injury interventions to offload and protect the resident's heels in a timely manner, Resident #41 developed a facility-acquired unstageable pressure injury to his left heel. 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 on 5/2/25 from https://www.internationalguideline.com/guideline, 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 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	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. 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 and procedure The Skin Integrity and Pressure Ulcer/Injury Prevention and Management policy and procedure, revised 7/9/24, was provided by the nursing home administrator (NHA) on 5/1/24 at 5:50 p.m. It read in pertinent part, A comprehensive skin inspection/assessment is completed on admission and readmission to the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A skin assessment/inspection should be performed weekly by a licensed nurse. Measures to maintain and improve the resident's tissue tolerance to pressure are implemented in the plan of care. All residents upon admission are considered to be at risk for pressure injury development due to medical issues requiring nursing care related to disease process and illness or need for rehabilitation services. Measures to protect the resident against the adverse effects of external mechanical forces, such as pressure, friction, and shear are implemented in the plan of care. III. Resident #41 A. Resident status Resident #41, age greater than 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included diabetes mellitus (high blood sugar), muscle weakness, difficulty walking and prostate abscess with urinary tract infection. According to the 4/8/25 minimum data set (MDS) assessment, Resident #41 was cognitively impaired with a brief interview for mental status (BIMS) score of four out of 15. He required substantial/maximal assistance of two staff for showering/bathing, dressing and transferring. The MDS assessment documented he was impaired on both sides of his upper extremities (shoulder, elbow, wrist and hand) and lower extremities (hip, knee, ankle and foot). The MDS assessment documented that the resident was at risk of developing pressure ulcers and had one Stage 3 pressure ulcer that was not present upon admission or reentry. -However, the WCP documented the resident's left heel wound was an unstageable wound (see record review below). The MDS assessment indicated the resident had pressure reducing devices for his bed and chair and was receiving pressure ulcer care. B. Observations On 4/29/25 at 12:00 p.m. Resident #41 was eating his lunch meal in bed with his clothes and socks on. The resident was lying on an air mattress, however, did not have heel protection devices on either of his feet. -However, the resident's care plan was not updated to indicate the resident had an air mattress (see care plan below). On 4/30/25 at 10:03 a.m. Resident #41 was sitting in his wheelchair with socks on. There were no heel protection devices on either foot. Both heels were resting directly on the metal wheelchair foot rests. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/30/25 at 10:29 a.m. registered nurse (RN) #1 was performing wound care on Resident #41's left heel wound with the assistance of certified nurse aide (CNA) #1. Resident #41's heel was noted to have black necrotic tissue (dead tissue) with yellow slough (yellow/white non-viable tissue) covering the length and width of his left heel with a foul odor. While RN #1 was performing the resident's wound dressing change, the resident was observed to have facial grimacing and he said Oh my god that hurts. -RN #1 and CNA #1 did not provide the resident with heel protection devices or offload the resident's heels after completing the wound care. C. Record review A skin assessment, dated 5/28/24, documented Resident #41 was admitted without any pressure injuries and no current wounds were noted. A progress note, dated 10/3/24 at 1:39 p.m., revealed a new physician's order was obtained which instructed staff to apply skin prep (a skin protectant) to Resident #41's left inner heel which had a slightly darkened 0.5 cm round area. -Review of Resident #41's electronic medical record (EMR) between 10/3/24 and 12/2/24 revealed there was no further documentation to indicate the facility was monitoring the slightly darkened round area that was noted to the resident's left inner heel on 10/3/24. Resident #41's skin integrity care plan, initiated on 10/22/24, revealed the resident was at risk for pressure injury related to ADL/functional/mobility impairment, pain, psychotropic medications, end of life and incontinence. Interventions included cleaning and drying the resident's skin after each incontinence episode, providing treatment as ordered and conducting weekly skin checks. -The care plan failed to include interventions for protection of the resident's heels. A nurse progress note, dated 12/2/24 documented Resident #41 had a new wound with an open area on his left inner heel measuring 3.0 cm by 0.9 cm. The actions taken included cleaning the left heel with normal saline and a border dressing was applied. The note did not indicate a wound stage. -However, the facility failed to implement interventions to protect the resident's heel from further injury while the resident was in his wheelchair after the discovery of the wound. A nurse progress note, dated 12/4/24, documented Resident #41 had an unstageable pressure ulcer on his left heel. -However, Resident #41's care plan was not updated with any new interventions to protect the resident's heels while he was in his wheelchair after the wound was discovered. An initial wound care physician (WCP) report, dated 12/10/24, revealed the wound to Resident #41's left heel was classified as an unstageable ulcer by the WCP. Review of Resident #41's April 2025 CPO revealed the following physician's orders related to the resident's left heel wound: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Wound care for left heel: Clean with wound cleanser, hydrofera blue, border foam, change daily and PRN (as needed), ordered 12/10/24. Apply crushed Flagyl (antibiotic) for odor, ordered 3/25/25. -Review of Resident #41's electronic medical record (EMR) revealed there were no physician's orders for a pressure relieving mattress or heel protection'offloading devices prior to or after the resident developed the unstageable pressure wound to his left heel. IV. Staff interviews Licensed practical nurse (LPN) #3 was interviewed on 4/29/25 at 11:50 a.m. LPN #3 said Resident #41 had a wound on his left foot but it was getting better because of the topical antibiotic he was receiving. LPN #3 said she was not sure how the wound started, but she said she had noticed Resident #41 becoming very weak over the past few months. LPN #3 said the resident was not able to get up independently from a sitting position and was transferred by staff with a mechanical hoyer lift. CNA #1 was interviewed on 4/30/25 at 10:45 a.m. CNA #1 said she did not know a lot about Resident #41's wound, but she said she knew that he could not stand up by himself and it required two staff members to transfer him into bed. RN #1 was interviewed on 4/30/25 at 3:00 p.m. RN #1 said the nursing staff were offloading Resident #41's left foot. RN #1 said the resident's physician's orders and care plan instructed staff to offload the resident's foot. RN #1 said it was important to have heel offloading interventions in the care plan so the nursing staff was aware of how to manage the resident's needs. -However, review of the physician's orders and care plan did not identify heel protection offloading devices and observations revealed the resident's heels were not offloaded (see record review and observations above). RN #1 said she thought Resident #41's left heel wound was because the resident was not moving in bed due to his medical decline. RN #1 said Resident #41 had an offloading boot, but it was sent to the laundry and she did not know how long it had been missing. She said the boot was not used when the resident was in the chair because the boot did not have a gripping surface. RN #1 said options for padding the surface of the foot rests of the resident's wheelchair were not considered and when the resident was in the chair he was only wearing socks. The WCP was interviewed on 4/30/25 at 4:36 p.m. The WCP said the wound on Resident #41's left heel could have been caused by constant pressure on the heel area. The WCP said it could have been prevented with interventions, such as offloading the heel with foam booties or repositioning the resident. Primary care physician (PCP) #1 was interviewed on 5/1/25 at 10:13 a.m. PCP #1 said Resident #41 was taking Flagyl to treat the foul odor coming from his left heel wound. She said the resident was on hospice care services and the Flagyl was implemented for his dignity to keep the wound from smelling so bad. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 5/1/25 at 3:53 p.m. The DON said offloading and using soft pressure relieving devices on bony areas for residents, including Resident ##41, who were at high risk for skin breakdown should be used. She said interventions would include the use of a pillow to offload the heels and repositioning. The DON said the nursing staff were to monitor residents for any redness to their skin and do weekly skin assessments.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to act upon recommendations by the pharmacist in a timely manner for one (#15) of five residents out of 33 sample residents. Specifically, the facility failed to ensure the physician documented that he or she reviewed the pharmacist's identified monthly drug regimen review irregularities and documented the actions taken or not taken to address the irregularities for Resident #15. Findings include: I. Resident #15 A. Resident status Resident #15, age [AGE], was admitted on [DATE]. According to the May 2025 CPO, diagnoses included altered mental status and depression. The 3/5/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. She required set-up assistance for oral hygiene and upper body dressing. She required supervision for lower body dressing. The MDS assessment revealed the resident had mild depression with a score of six out of 27. The MDS assessment revealed the resident received antidepressant and antipsychotic medications. B. Record review Review of Resident #15's May 2025 CPO revealed the following physician's order: Quetiapine (antipsychotic medication) 25 mg. Give one tablet by mouth at bedtime for depression, ordered 10/14/24. Resident #15's antipsychotic medication care plan, initiated 11/21/24 and revised 4/28/25 (during the survey process), documented Resident #15 used antipsychotic medication related to depression. The interventions included observing for adverse reactions including unsteady gait, tardive dyskinesia (involuntary, repetitive movements), frequent falls, fatigue, insomnia, insomnia, loss of appetite, behavior symptoms not usual to the person, depression observing for occurrence of target behavior symptoms included wandering, disrobing, pacing and inappropriate response to verbal communication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/12/25 pharmacy consultation report revealed Resident #15 received an antipsychotic medication without documentation of diagnosis and adequate indication for use in the electronic medical record (EMR). Recommendations included updating the EMR to the specific diagnosis/indication requiring treatment, a list of symptoms or target behaviors, including their impact on the resident and documentation that other causes and medications had been considered, that individualized non-pharmacological interventions were in place and that ongoing monitoring had been ordered. -There was no physician's signature on the pharmacist's recommendations and no documentation to indicate the physician had reviewed the recommendations and what actions were taken regarding the pharmacist's recommendations. The 2/4/25 pharmacy consultation report revealed Resident #15 received an antipsychotic medication without documentation of diagnosis and adequate indication for use in the EMR. Recommendations included updating the EMR to the specific diagnosis/indication requiring treatment, a list of symptoms or target behaviors including their impact on the resident and documentation that other causes and medications had been considered, that individualized non-pharmacological interventions were in place and that ongoing monitoring had been ordered. -There was no physician's signature on the pharmacist's recommendations and no documentation to indicate the physician had reviewed the recommendations and what actions were taken regarding the pharmacist's recommendations. The 3/4/25 pharmacy consultation report revealed Resident #15 received an antipsychotic medication without documentation of diagnosis and adequate indication for use in the EMR. Recommendations included updating the EMR to the specific diagnosis/indication requiring treatment, a list of symptoms or target behaviors including their impact on the resident and documentation that other causes and medications had been considered, that individualized non-pharmacological interventions were in place and that ongoing monitoring had been ordered. -There was no physician's signature on the pharmacist's recommendations and no documentation to indicate the physician had reviewed the recommendations and what actions were taken regarding the pharmacist's recommendations. The 4/21/25 pharmacy consultation report revealed Resident #15 received an antipsychotic medication without documentation of diagnosis and adequate indication for use in the EMR Recommendations included updating the EMR to the specific diagnosis/indication requiring treatment, a list of symptoms or target behaviors including their impact on the resident and documentation that other causes and medications had been considered, that individualized non-pharmacological interventions were in place and that ongoing monitoring had been ordered. -There was no physician's signature on the pharmacist's recommendations and no documentation to indicate the physician had reviewed the recommendations and what actions were taken regarding the pharmacist's recommendations. II. Staff interviews (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 5/30/25 at 6:00 p.m. The DON said she received the pharmacist's recommendations monthly and then distributed the recommendations to the physicians for review. She said the recommendations were reviewed at the monthly pharmacological meetings. She said the physicians took the recommendations for review and would make the appropriate changes and sign the recommendations. She said the recommendations were then scanned into the residents' EMRs. The DON said she had received the January 2025, February 2025, March 2025 and April 2025 pharmacist's recommendations for Resident #15, however, she said she had not distributed them to the physicians to review for the past four months due to being behind on other tasks.

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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** Based on observations, record review and interviews, the facility failed to ensure the medication error rate was less than five percent (%). Specifically, the facility's medication error rate was 13%, which was four errors out of 29 opportunities for error. 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, page 606-607, retrieved on 4/16/24, 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: the right medication, the right dose, the right patient, the right route, the right time, the right documentation and the right indication. II. Observations and interviews On 4/29/25 at 9:30 a m. licensed practical nurse (LPN) #3 was administering medications to Resident #126. The physician's order read: -Vitamin A oral tablet 2400 micrograms (mcg) once a day for deficiency. LPN #3 said she was not able to locate the medication in the medication cart. She did not administer the medication. She did not notify the physician. At 9:39 a.m. LPN #3 was administering medications to Resident #34. The physician's order read: -Cranberry tablet 250 milligram (mg) once a day for urinary tract health. LPN #3 said she was not able to locate the medication in the medication cart. She did not administer the medication. She did not notify the physician. On 4/30/25 at 9:45 LPN #1 was administering medications to Resident #15. The physician's orders read: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Amlodipine 10 mg once a day for hypertension (high blood pressure). -Sodium bicarbonate (baking soda) 650 mg, two tables for upset stomach. LPN #1 said she was not able to locate the amlodipine in the medication cart. She did not administer the medication. LPN #1 pulled a bottle of Simethicone (over the counter medication used to treat bloating and gas) 80 mg tablets out of the medication cart and put two tablets in the medication cup to administer to the resident. When asked about the Simethicone LPN #1 said she made a mistake and she thought it was sodium bicarbonate. III. Staff interviews LPN #3 was interviewed on 4/29/25 at 11:30 a.m. She said both over the counter medications (cranberry and Vitamin A) and she checked the medication room and was not able to locate any additional supplies. LPN #1 was interviewed on 4/30/25 at 11:30 a.m. She said the amlodipine was not available and she did not know why. She said she called the physician and notified him that it was not available. The director of nursing (DON) was interviewed on 5/1/25 at 3:22 p.m. She said she relied on the unit managers, central supply person and the floor nurses to maintain communication to ensure all medications were available without interruptions. She said she was not aware of any formal system of tracking availability of over the counter medications. She said when a medication was not administered the physician should be notified.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to develop an antibiotic stewardship program that promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance for two (#41 and #35) of five residents out of 33 sample residents. Specifically, the facility failed to ensure a physician's rationale for the use of long-term antibiotics was provided for Resident #41 and Resident #35. Findings include: I. Professional reference The Centers for Disease Control and Prevention (CDC) Antibiotic Prescribing and Usage in Hospitals and Long-term Care, dated 2019, was retrieved on 5/2/25 from https://www.cdc.gov/antibiotic-use/hcp/core-elements/hospital.html. It read in pertinent part, Implement policies that apply in all situations to support antibiotic prescribing to include specifying the dose, duration and indication for all courses of antibiotics so that they are readily identifiable. Implement facility specific treatment recommendations, based upon the national guidelines and local susceptibilities and formulary options that optimizes antibiotic selections, duration, and common indications for the usage of community acquired pneumonia, urinary tract infections, skin and soft tissue infections. II. Facility policy and procedure The Antibiotic Stewardship policy and procedure, reviewed on 5/16/24, was provided by the nursing home administrator (NHA) on 5/1/25 at 5:50 p.m. It read in pertinent part, The antibiotic stewardship program promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance. This means that the antibiotic is prescribed for the correct indication, dose, and duration to appropriately treat the resident while also attempting to reduce the development of antibiotic-resistant organisms and/or other adverse events. The program will be managed and overseen by the infection preventionist (IP). Leadership commitment and accountability: The IP, director of nursing (DON), pharmacy consultant and medical director (MD) are the facility leads responsible for promoting and overseeing antibiotic stewardship activities. The above members of the AST (Antibiotic Stewardship Team) will demonstrate support and commitment to safe and appropriate antibiotic use. Annually, the facility leadership will complete a Written Statement of Support to improve antibiotic use. Consultant pharmacists facilitate antibiotic stewardship interventions through antibiotic drug regimen reviews and participation in QAPI (quality assurance and performance improvement) meetings. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Action taken includes prescription record keeping. Dose, duration, and indication of each antibiotic prescription will be documented in the medical record for each resident. Assessment of residents suspected of having an infection. The facility will utilize the McGeer Criteria when considering initiation of antibiotics. At 72 hours after antibiotic initiation or first dose in the facility, each resident should be reassessed for consideration of antibiotic need. At this time, laboratory testing results, response to therapy and resident condition will be considered. Interventions for syndrome-specific antibiotic use and antibiotic prophylaxis: The AST will identify actions to directly impact inappropriate antibiotic use for specific syndromes and for prophylactic indications. The tracking process measures for tracking antibiotic stewardship and tracks how and why antibiotics are prescribed. Process measures include review of clinical documentation during clinical meetings and ongoing reviews of the completeness of prescribing documentation to include dose, route, duration and indication for use. III. Resident #41 A. Resident status Resident #41, age greater than 65, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included diabetes mellitus, muscle weakness, difficulty walking and prostate abscess with urinary tract infection (UTI). According to the 4/8/25 minimum data set (MDS) assessment, Resident #41 was cognitively impaired with a brief interview for mental status (BIMS) score of four out of 15. He required substantial/maximal assistance of two staff for showering/bathing, dressing and transferring. The assessment documented he was impaired on both sides of his upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot). The MDS assessment revealed the resident was receiving an antibiotic medication. B. Record review Review of Resident #41's April 2025 CPO revealed the following physician's order: Macrobid (antibiotic) oral tablet 100 milligrams (mg). Give one tablet by mouth once a day as a prophylactic (action taken to prevent infection) for chronic UTIs, ordered 10/18/24. The 10/18/24 nursing progress notes documented Resident #41 had a new physician's order to start antibiotics for prophylactic chronic UTIs. -The physician's order for the Macrobid failed to indicate the duration for the use of the antibiotic. -There was no documentation in the resident's electronic medical record (EMR) to indicate the physician's rationale for the long-term use of the prophylactic antibiotic. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was no documentation in the resident's EMR to indicate the facility was monitoring the long-term use of the antibiotic and reassessing the appropriateness of the continued use of the antibiotic. -Review of Resident #41's comprehensive care plan revealed the facility failed to document a care plan focus to address the need for the long-term use of an antibiotic. IV. Resident #35 A. Resident status Resident #35, age [AGE], was admitted on [DATE]. According to the April 2025 CPO, diagnoses include respiratory failure, congestive heart failure and infection and inflammatory reaction to internal right knee prosthesis The 2/27/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required supervision or touching assistance with oral hygiene but was dependent on the assistance of two or more helpers for chair to bed transfers. The MDS assessment revealed the resident was receiving an antibiotic medication. B. Record review Review of Resident #35's April 2025 CPO revealed the following physician's order: Doxycycline (antibiotic) oral tablet 100 mg. Give one tablet by mouth two times a day prophylactic for right knee prosthesis, ordered 3/25/25. -The physician's order for the doxycycline failed to indicate the duration for the use of the antibiotic. -There was no documentation in the resident's EMR to indicate the physician's rationale for the long-term use of the prophylactic antibiotic. -There was no documentation in the resident's EMR to indicate the facility was monitoring the long-term use of the antibiotic and reassessing the appropriateness of the continued use of the antibiotic. -Review of Resident #35's comprehensive care plan revealed the facility failed to document a care plan focus area to address the need for the long-term use of an antibiotic. V. Staff interviews Licensed practical nurse (LPN) #3 was interviewed on 4/29/25 11:50 a.m. LPN #3 said there was no specific monitoring or documentation that needed to be done for residents on long-term antibiotics. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065358	A. Building B. Wing	05/01/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON, who was also the facility's IP, was interviewed on 5/1/25 at 2:53 p.m. The DON said she used the McGeer's criteria when assessing residents who may need antibiotics. The DON said she monitored residents who started antibiotics for the first three days and then for 10 days after completion of the antibiotic. The DON said she reviewed residents on antibiotics monthly with the interdisciplinary team (IDT) and made sure she had an updated list of residents on antibiotics. The DON said she noticed some residents were on long-term antibiotics when she started working at the facility. She said she contacted the medical director (MD) and was advised to get a note from the original prescriber which indicated that the residents should be on the antibiotics indefinitely. The DON said the facility did not really monitor the use of antibiotics after the completion of the antibiotic for 10 days, but only if they started showing symptoms of an infection, such as a fever, redness and pain. The DON said residents who were on antibiotics should have a care plan for long-term antibiotic use and documentation of the rationale for the antibiotic. -However, there was no documentation in Resident #41 or Resident #35's EMRs to indicate the residents had received monthly assessments of their prophylactic antibiotic or a 72-hour monitoring assessment after the start of the antibiotics (see record review above). -Additionally, there was no documentation from a physician to justify the long-term use of the antibiotics for Resident #41 and Resident #35 (see record review above). The MD was interviewed on 5/1/25 at 4:56 p.m. The MD said all residents who were taking antibiotics for long-term or chronic issues should have an indication for use and diagnosis with continued monitoring from the facility. The MD said the prescribing physician should review chronic antibiotics at a minimum every month to determine the appropriateness of the continued use of the antibiotic.

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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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on record review and interviews, the facility failed to provide training to their staff that at a minimum educates staff on activities that constitute abuse, neglect, exploitation and misappropriation of resident property as set forth, procedures for reporting incidents of abuse, neglect, exploitation or misappropriation of resident property and resident abuse prevention for five of five staff members reviewed. Specifically, the facility failed to ensure certified nurse aide (CNA) #1, CNA #2, CNA #3, registered nurse (RN) #1 and licensed practical nurse (LPN) #1 received annual abuse identification, prevention and reporting training in the past 12 calendar months. Findings include: I. Facility policy and procedure The Abuse Prevention policy, last reviewed on 6/17/24, was provided by the nursing home administrator (NHA) on 4/28/25 at 4:06 p.m. It revealed in pertinent part, All employees will receive orientation and ongoing training on abuse prevention and reporting. Orientation program will include a review of facility's policy on what constitutes abuse, neglect, misappropriation of resident property, how to recognize abuse, appropriate interventions to deal with aggressive and/or catastrophic reactions of residents, assure that residents are free from neglect by having the structures and processes to provide needed care and services to all residents, which includes, but is not limited to, the provision of a facility assessment to determine what resources are necessary to care for its residents competently. All employees/caregivers will be oriented to their role in abuse prevention as mandated reporters and that abuse will not be tolerated in this facility. Bi-annual and as necessary in-service training will be provided for review of facility's r's policy on abuse prevention and mandated reporting. II. Record review A request was made for CNA #1, CNA #2, CNA #3, RN #1 and LPN #1's abuse training records on 4/30/25. The NHA said the facility did not have documentation that indicated CNA #1, CNA #2, CNA #3, RN #1 and LPN #1 had completed annual abuse training. III. Staff interviews The NHA was interviewed on 4/30/25 at 4:04 p.m. The NHA said abuse in-service training was completed on the staff's first day working at the facility The NHA said he began working at the facility three months ago. He said he was unable to locate the abuse in-service training for CNA #1, CNA #2, CA #3, RN #1 and LPN #1 (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 5/1/25 at 2:54 p.m. The DON said she began working at the facility in August 2024. The DON said she and the NHA were responsible for completing abuse in-service education for the staff. The DON said she assumed the training was done by the previous staffing coordinator. The DON said the previous staffing coordinator resigned in February 2025 and the DON has taken on that role since then.