STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milford Center	700 Marvel Road Milford, DE 19963

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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 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. 46988 Based on interview, record review and review of other facility documentation, it was determined that for one (R50) out of one reviewed for grievances, the facility failed to ensure that resident concerns received by the facility included prompt efforts to resolve the resident's problems. Findings include: Review of R50's clinical record revealed: 12/19/23 - R50 was admitted to the facility. 5/2024 - A grievance/concern log revealed an entry for 5/17/24 for R50 stated a clinical concern and DON/UM were responsible to investigate. 5/17/24 - A grievance report documented that R50 had concerns that staff did not provide care during the 7:00 AM to 3:00 PM shift on 5/8/24. The report was initially accepted by E4 (SW). The follow up section of the grievance report was blank. 5/17/24 - A grievance report documented that R50 had concerns that staff did not address R50's immediate needs during the 7:00 AM to 3:00 PM shift on this date. This report was completed by E4 (SW). The follow up section was blank. 11/21/24 9:37 AM - An interview with E4 (SW) revealed that E4 was the grievance officer. E4 stated that the process starts when a resident makes a complaint and once the resident is interviewed, the results go to the DON and NHA. E4 stated that when a grievance was considered reportable the process stops. E4 confirmed the grievance forms are incomplete and unaware if the grievances were resolved. 11/21/24 10:35 AM - An interview with E1 (NHA) and E2 (DON) confirmed that the grievances written on 5/17/24 were not resolved and lacked evidence that the grievance was addressed. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 44706 Based on interview and record review, it was determined that for one (R261) out of four residents reviewed for allegation of neglect, the facility failed to immediately report an allegation of neglect within the required timeframe. A five day follow-up report wasn't submitted following the allegation until fifteen days later. Findings include Review of R261's clinical record revealed: 7/30/22 - R261 was admitted to the facility. 6/9/24 - A facility incident report documented, E9 (CNA) alleged E10 (LPN) was neglectful by not responding to the needs of R261 in a timely manner and reported the allegation to E2 (DON). 6/17/24 - An incident report was submitted to the state agency for an allegation of neglect for R261, eight days after the allegation. 7/2/24 - The five day follow up report for R261 was submitted to the state agency for the allegation of neglect on day fifteen. 11/22/24 9:37 AM - During an interview, E2 (DON) confirmed the allegation of neglect was reported late, eight days after the allegation. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 during the exit conference.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 46988 Based on interview, record review, and review of other facility documentation as indicated, it was determined that for four (R12, R50, R6 and R413) out of ten residents reviewed for and allegation of abuse and neglect, the facility failed to have evidence of thorough investigation. 1. Review of R12's clinical record revealed: 9/25/20 - R12 was admitted to the facility. 6/6/24 - A quarterly MDS documented R12 was dependent for ADL's including toileting, dressing, and personal hygiene. 8/2024 - A review of the CNA task flow sheet for August 2024 lacked evidence that staff provided care on 8/25/24. 11/18/24 11:25 AM - A review of the facilities investigative documents for an allegation of neglect lacked evidence of direct care staff interviews for 8/25/24. The packet included the initial report to state agency, the five day follow up and a disciplinary report on alleged employee. 11/21/24 9:37 AM - An interview with E1 (NHA) and E2 (DON) confirmed that the facility lacked evidence of interviews with direct care staff. E1 was unable to provide staff interviews from the facility investigation. 2. Review of R50's clinical record revealed: 12/19/23 - R50 was admitted to the facility. 3/20/24 - A quarterly MDS documented that R50 was dependent for all ADL's including toileting, dressing, and personal hygiene. 11/18/24 11:45 AM - A review of the facilities investigative documents for an allegation of neglect revealed that interviews were not included in the facilities investigation. The packet included a copy of a grievance form and incident reports. 11/21/24 9:37 AM - An interview with E1 (NHA) and E2 (DON) confirmed that the facility lacked evidence of interviews with direct care staff. E1 was unable to provide staff interviews from the facility investigation. 47142 3. Review of R6's clinical record revealed: 3/25/22 - R6 was admitted to the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/16/24 - A facility reported incident was submitted for an allegation of neglect that documented that a wound dressing to R6's right heel was dated 7/8/24 and there was an order for a dressing change to be completed one time every other day. This revealed that eight days had passed without wound treatment. 7/2024 - A review of the treatment administration record (TAR) for July 2024 revealed that on 7/10/24, R6 was away from the facility and did not receive the wound treatment. On 7/12/24, R6 received the wound treatment to the right heel and on 7/14/24, R6 had refused the wound treatment to the right heel. 7/30/24 - The facility investigative follow-up packet included statements from E11 regarding the care from 7:00 AM to 3:00 PM on 7/10/24 and from E24 regarding the care from 7:00 AM to 3:00 PM on 7/12/24. The facility was unable to provide any additional statements from staff from the other shifts for 7/10/24 and 7/14/24 to determine the missed wound treatment to R6's right heel. 48409 4. Review of R413's clinical record revealed: 5/10/24 - R413 was admitted to the facility with diagnoses including major mood disorder and anxiety. 5/17/24 - R413's admission BIMS documented a score of 14, indicating a fully intact cognitive status. 5/23/24 - A facility reported incident for an allegation of verbal abuse to the State Agency documented, . Resident reports that staff member was mad last night 11/22/24 10:15 AM - A review of the facility's investigative documents for this allegation revealed that the facility failed to obtain staff statements. 11/22/24 9:37 AM - An interview with E1 (NHA) and E2 (DON) confirmed that the facility lacked evidence of interviews with direct care staff. 11/22/24 9:37 AM - An interview with E1 (NHA) and E2 (DON) confirmed that the facility lacked evidence of interviews with direct care staff. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 40163 Based on observation, interview and record review it was determined that for three (R6, R12, and R34) out of twelve residents reviewed for activities of daily living (ADL's), the facility failed to provide care and services for dependent residents. Findings include: 1. Cross refer to F656 Review of R33's clinical record revealed: 8/5/22 - R33 was admitted to the facility with dementia. 8/5/22 - R33's care plan included that the resident requires assistance/dependent for ADL care. 6/4/24 - R33's care plan included being resistive to care and refusing medication. The care plan did not include refusal of nail care. 7/5/24 - A significant change MDS documented that R33 required partial/moderate assist for hygeine and bathing and had no rejection of care. Observations on 11/12/24 at 2:42 PM; 11/15/24 at 10:20 AM; 11/22/24 at 10:52 AM; and 11/22/24 at 10:56 AM revealed R33 had black debris underneath all of her nails. 11/22/24 - During an observation and interview, E30 (CNA) stated that it was the responsibility of the CNA's to provide nail care. E30 confirmed that R33 had black debris under her nails. 2. Cross refer to F656 Review of R34's clinical record revealed: 8/28/23 - R34 was admitted to the facility with dementia. 8/29/23 - R34's care plan included R34 was dependent for care. 4/30/24 - R34's care plan included that the resident was resistive to care, refuses to wear extremity protectors, refuses skin assessment, refuse to take medications, and refuses wearing BIPAP r/t (related to) cognitive loss/dementia. R34's care plan did not include refusal of nail care or washing of hair. 9/3/24 - R34's annual MDS assessment documented that R34 was cognitively impaired, required extensive assistance for bathing and hygiene and had no rejection of care. Review of R34's October 2024 and November 2024 progress notes lacked evidence of offers of refusals of nail care or washing of hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/1/24 through 11/24/24 - The CNA task sheet lacked evidence of showers, nail care or having her hair washed. Per the CNA task sheet, R34 had received bed baths. Observations on 11/12/24 10:00 AM, 11/15/24 10:28 AM, 11/15/23 1:349 PM and 11/21/24 2:27 PM, R34 was noted to have long nails with visible blackish brown debris beneath them and R34's hair appeared greasy and disheveled. 11/15/24 1:36 PM - During an interview, E31 (LPN) stated that activities staff were responsible for manicures. The aides (CNA's) were responsible for keeping them (the residents' nails) clean. 11/15/24 1:40 PM - During an interview, E35 (CNA) stated that she was not sure who was responsible for nail care. 11/15/24 1:47 PM - During an interview, E32 (Activities) stated that activity staff were not responsible for nail care. They can paint nails but not cut them because she is not certified as a CNA. 11/21/24 - During an interview, E34 (CNA) confirmed that R34's nails had not been taken care of until the daughter came in yesterday (11/20/24). 11/22/24 9:30 AM - During an interview, E2 (DON) confirmed the facility lacked evidence of offering/attempting to provide nail or hair care. E2 also confirmed there was no evidence of refusal of care. 11/22/24 11:17 AM - During an interview, E33 (CNA) stated that R34 was total care for nails and hair. 47142 3. Cross refer to F842 Review of R6's clinical record revealed: 3/25/22 - R6 was admitted to the facility. 7/28/24 - A quarterly MDS assessment revealed that R6 had no impairment to upper or lower extremities and uses a wheelchair. R6 was dependent for toileting hygiene, partial or moderate assistance for personal hygiene and upper body dressing, substantial/maximal assistance for lower body dressing, dependent for footwear. R6 required supervision or touching assistance for sitting to lying and lying to sitting. R6 required partial/moderate assistance for sitting to stand, transfer from bed/chair to wheelchair and to perform a toilet transfer. 7/18/24 - A care plan revealed that R6 was incontinent of bowel with a goal that the incontinence care needs be met by staff. The care plan further revealed that R6 required assistance for ADL care in bathing, grooming, personal hygiene, dressing, bed mobility, transfer and toileting. The interventions for the ADL care revealed that R6 required extensive assist of one person for dressing, toileting and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/17/24 2:54 PM - The CNA documentation task sheet revealed E25 (CNA) inaccurately documented that R6 independently toileted, was continent of urine and was continent of bowel. The task sheet also showed that R6 was independent to transfer for a sit to stand, chair/bed to chair transfer and toileting transfer. The task sheet also documented that R6 was encouraged to independently turn and reposition and a skin check was completed every 2 hours. The aforementioned note was the only documentation of toileting for R6 on 8/17/24 during the 7:00 AM to 3:00 PM shift. 8/17/24 4:50 PM - A progress note for change in condition by E11 (RN) documented that at 3:00 PM on 8/17/24, R6 was observed sitting on the bed with clothing and bed linens visibly soiled with a noted odor. The progress note continued that R6 was, . Immediately assessed, no new skin issues noted. Buttocks slightly reddened, however, blanchable. Oncoming CNA immediately bathed and changed resident's linens. Calazinc cream applied to buttocks for protection. Transferred to wheelchair. 8/17/24 3:00 PM - A witness statement by E11 documented that R6 was observed at 9:30 AM and at 12:00 PM on 8/17/24. At 3:00 PM, E11 went into R6's room where R6 was sitting on the bed where the bed linens and clothing were soiled. R6 was immediately assessed, cleaned up by E27 (CNA), clothing and bed lines changed and transferred to the wheelchair. E11 also noted that E25 did not report any refusals of care during the 7:00 AM to 3:00 PM shift. 8/17/24 - A witness statement by E27 documented that R6 was observed on 8/17/24 at 3:00 PM with stool on her bottom and the bed sheets were soiled with stool and urine. 11/19/24 at 9:15 AM - An interview with E26 (CNA) revealed that R6 requires assistance of one for dressing, toileting, hygiene and transfers and would not be able to do it themselves. If R6 refuses, then we try to redirect or try again and ultimately will tell the nurse where it would be documented in the record as refused. 11/21/24 2:37 PM - An interview with E11 revealed that R6 was in bed during the entire 7:00 AM to 3:00 PM shift without being transferred. E11 stated she observed R6 at 3:00 PM seated on the side of the bed with brown all around her and her sheets. E11 continued to say that R6 wore a brief and the amount of stool and urine observed absorbed into the bed sheets meant R6 did not receive care in a very long time. R6 required assistance for toileting and is not independent for care. 11/22/24 2:32 PM - An interview with E2 (DON) confirmed that E25 did not provide care for the resident. E2 stated that E25 had completed the shift on 8/17/24 and would not return the facilities calls to investigate and was terminated. The facility lacked evidence of a complete root cause analysis or any action beyond terminating an employee. 46988 4. Review of R12's clinical record revealed: 9/25/20 - R12 was admitted to the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/25/20 - A care plan was initiated for R12 for risk of decreased ability to perform ADL's in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to impaired balance and cognitive decline. Interventions included provide total assist with one for locomotion, toileting and personal hygiene. 9/3/24 - A quarterly MDS documented R12 was dependent for ADL's including toileting, dressing, and personal hygiene. 11/12/24 9:57 AM - An observation of R12 with long nails on bilateral hands with dirt and debris noted under fingernails. 11/13/24 9:45 AM - An observation of R12 with long nails on bilateral hands with dirt and debris noted under fingernails. 11/14/24 8:53 AM - An observation of R12 was OOB to geri chair with long nails on bilateral hands with dirt and debris noted under fingernails. 11/14/24 11:21 AM - An interview with E16 (CNA) stated that the expectation during a shower that the resident gets hair washed, nail care, and grooming needs met. E16 confirmed that R12 received a shower on 11/13/24 during the overnight shift and confirmed that R12's nails were long and had debris noted underneath. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 during the exit conference.

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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. 47142 Based on interview and record review, it was determined that for two (R6 and R5) out of four residents reviewed for pressure ulcers, the facility failed to provided necessary treatment to promote healing of a current pressure ulcer. Cross refer to F842 1. Review of R6's clinical record revealed: 3/25/22 - R6 was admitted to the facility. 3/16/23 - A care plan for R6 was initiated for having skin breakdown related to decreased activity, reluctance to offload heels in bed, impaired cognition and comorbidities. Interventions included but not limited to providing preventative skin care as ordered, encouraging resident to turn and reposition and to check skin every two hours. 7/7/24 - A care plan for R6 was initiated for having a documented pressure ulcer. Interventions included to complete a mini nutritional evaluation and to educate the resident or representative on the importance of keeping skin clean and moisturized. 7/28/24 - A quarterly MDS assessment revealed that R6 required supervision or touching assistance of one person for sitting to lying and lying to sitting. R6 required partial/moderate assistance of one person for sitting to stand, transferring from bed/chair to wheelchair and to perform a toilet transfer. R6 had no range of motion impairments bilaterally to upper or lower extremities and uses a wheelchair. The MDS assessment also identified R6 was at risk for pressure ulcers/injuries and had one or more unhealed pressure ulcers. 7/3/24 - R6's physicians orders documented to cleanse right heel with wound cleanser, apply Medi-honey and cover with Optifoam every other day until healed. 7/10/24 - The treatment administration record (TAR) documented by E11 (RN) that R6 was away from the facility and the treatment to R6's right heel was not able to be completed that shift. 7/12/24 - The treatment administration record (TAR) documented that E24 (LPN) had administered the treatment to R6's right heel. 7/14/24 - The treatment administration record (TAR) documented by E24 that R6 had refused the treatment to the right heel. 7/16/24 - A facility investigative report revealed that the wound dressing to R6's right heel was dated 7/8/24, revealing that 8 days had passed without wound treatment. 7/16/24 - A witness statement by E11 documented that on 7/10/24, R6 was out of the facility for an appointment therefore wound care was not completed. E11 stated that this was relayed to the next shift during the change of shift report. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/16/24 - A witness statement by E24 documented that on 7/12/24, the TAR was signed off prior to the treatment being completed to R6's right heel and then she forgot to go back and complete the treatment later. 11/20/24 8:32 AM - An interview with E28 (LPN) revealed that when a resident is out of the facility for a shift or refuses to have a wound treatment performed, the next shift is told this in the change of shift report and the next shift is to attempt to do the treatment. 11/20/24 9:44 AM - An interview with E2 (DON) confirmed that the wound dressing for R6 was dated 7/8/24 and did not get changed on 7/10/24, 7/12/24 and 7/14/24. E2 stated that if R6 was out for an appointment or refused during that shift, the next shift is supposed to do it. E2 stated that the nurse is to relay the information to the next shift in the change of shift report because if the treatment is signed off as refused or away and not completed, the electronic chart will not prompt the next shift that the treatment needs to be done. 46988 2. Cross refer F657 Review of R5's clinical record revealed: 4/23/14 - R5 was admitted to the facility. 7/24/20 - A CNA task documented preventative skin care: Apply multi-podus boot to left lower extremity (LLE) when pt is in bed. Perform skin checks before/after donning/doffing. Elevate right foot with pillow. 5/31/21 - A physician's order was written for adaptive equipment: multi-podus boot to left foot while in bed. 1/26/24 - A CNA task documented adaptive equipment #2: Apply multi-podus boot to LLE when pt is in bed. Apply Prevalon soft boot to RLE while in bed. Perform skin checks before/after donning/doffing. 11/12/24 2:12 PM - An observation of R5 in bed and wearing Prevalon boots to bilateral feet. 11/13/24 11:30 AM - An observation of R5 out of bed in the wheelchair wearing the multi-podus boots to bilateral feet. 11/14/24 10:40 AM - An observation of R5 out of bed in the wheelchair wearing the multi-podus boots to bilateral feet. 11/15/24 11:53 AM - An interview with E16 revealed that R5 wears the soft boots while in bed and the multi-podus boots while up in the chair. E16 stated she does not know the names of boots she just knows when to put them on for R5. 11/15/24 1:33 PM - An interview with E14 (COTA) confirmed that the multi-podus boots have a harder bottom and the Prevalon boots are soft. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/15/24 - A CNA task documented soft heel boots to bilateral feet while in bed. 11/19/24 3:01 PM - An interview with E14 confirmed that R5 should be wearing the soft heel boots to bilateral feet when in bed and that is the current recommendation from therapy. E14 stated that R5 was ordered the Prevalon boots for prevention and protection related to previous area noted to R5's heels. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 during the exit conference.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40163 Based on interview and record review, it was determined that for one (R89) out of two residents reviewed for falls, the facility failed to assess for and implement interventions to reduce R89's risk for falling. R89 sustained twelve falls which included two falls resulting in head trauma that required transfer to an acute care hospital. Findings include: A facility policy titled Falls Management effective 9/15/01 (last revised 3/15/24) included: Patient will be assessed for risk of falling as part of the nursing assessment process. Interventions to reduce risk and minimize injury will be implemented as appropriate. 1. All patients will be assessed for risk of falls upon admission, with reassessments (e.g. quarterly, post-fall) performed to determine ongoing need for fall prevention precautions. 2. Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care. 2.1 Adjust and document individualized interventions strategies as patient condition changes. Cross refer to F690 Review of R89's clinical record revealed: 2/12/24 - R89 was admitted to the facility with dementia. 2/12/24 5:14 PM - An admission fall risk assessment documented a fall risk score of three indicating that R89 was at low risk for falls, required supervision for ambulation, that R89 had sustained one to two falls in the past three months prior to admission, and lacked evidence of a documented ambulation/elimination status. 2/12/24 5:16 PM - A clinical admission assessment documented that R89 was continent of urine. 2/19/24 - An admission MDS assessment documented that R89 was cognitively intact with a BIMS of 13, required verbal cues or touching/steadying assistance by one staff member for toileting supervision/touching assistance for ambulation, was occasionally incontinent of urine and a trialed toileting program was not attempted. Review of R89's fall and incontinence care plans lacked evidence of an individualized toileting program to reduce R89's risk for falling. 3/3/24 7:48 PM - An incident report documented that R89 was found sitting on floor next to her bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3/5/24 4:30 AM - An incident report documented that nursing responded to the patient's call bell. Upon entry to the room the patient was observed sitting on the floor beside her bed. She stated she had been attempting to go to the restroom when she fell . There was no evidence the facility conducted a urinary continence assessment that included voiding patterns. 3/11/24 Approx. (approximately) 2:15 AM - An incident report documented that the nurse was called to assess the patient s/p (after) falling in her room. Upon entry to the room the patient was observed sitting on the floor beside her bed. 4/9/24 1:00 AM - An incident report documented that R89 was observed sitting on the floor next to her bed. When staff responded, resident stated that she was trying to get to the bathroom. There was no evidence the facility conducted a urinary continence assessment that included voiding patterns. 5/7/24 8:30 PM - An incident report documented that R89 was lying on the floor in her bathroom. There was no evidence the facility conducted a urinary continence assessment that included voiding patterns. 5/11/24 3:30 AM - An incident report documented that the nurse heard R89 yelling from her room, Help, I am on the floor! Upon entering resident's room, R89 was noted sitting on her buttocks on the floor beside her bed. 5/12/24 - R89's fall risk score was 19 which indicated that R89 was at high risk for falling. 5/23/24 - R89's fall risk assessment score was 21 which indicated that R89 was a high risk for falling. 5/24/24 - R89's bowel and bladder assessment included that R89 had urinary incontinence and to implement pelvic floor rehabilitation. This intervention was not individualized related to R89 having severely impaired cognition. In addition, there was no evidence the facility conducted a urinary continence assessment that included voiding patterns. 5/25/24 - A 5-day MDS assessment documented R89 was cognitively impaired with a BIMS of 6, that ambulation was not attempted due to a medical condition or safety concerns and required substantial/maximal assistance with toileting. 6/13/24 10:01 AM - An incident report documented that R89 was observed lying face down on the floor in the bathroom in her room. It was documented that R89 stated, I was getting off the toilet and couldn't stand anymore. There was no evidence the facility conducted a urinary continence assessment that included voiding patterns. 6/21/24 8:37 PM - An incident report documented that R89 was found in her room next to the bed. 6/27/24 6:30 PM - An incident report documented R89 was observed scooting on the floor in the doorway of her room. 7/5/24 7:40 PM - An incident report documented that R89 reported falling from her bed after attempting to get up. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	7/17/24 6:50 PM - An incident report documented that the nurse was notified that R89 had a fall in her room. Upon entry into the room R89 was observed sitting on the floor in the bathroom in front of the toilet. R89 stated that she had attempted to toilet herself but had missed and fallen. There was no evidence the facility conducted a urinary continence assessment that included voiding patterns. 7/18/24 10:55 PM - An incident report documented that the nurse heard a noise and then yelling. R89 was observed laying on the floor between the bed and wheelchair. R89's head was on the base of the bedside table. Once R89 was assisted to a seated position, a large amount of blood was on the floor. It was observed that R89 had a large laceration to the back of her head and was sent 911 to the hospital. There was no evidence the facility conducted a urinary continence assessment that included voiding patterns. 7/19/2024 3:55 PM - A wound progress noted documented that R89 had a laceration to back of her head noted with 2 staples in it. This was as a result of the 7/18/24 fall. 8/14/24 - A quarterly MDS assessment documented that R89 was not assessed for cognition, was frequently incontinent, and was partial/moderate assistance for ambulation and toileting. 8/17/24 6:35 PM - An incident report submitted to the state agency documented that R89 sustained a fall with a forehead laceration with bleeding that was not controlled. R89 required a transfer to the hospital. There was no evidence the facility conducted a urinary continence assessment that included voiding patterns. 11/19/24 9:23 AM - During an interview, E1 (NHA) and E2 (DON) confirmed that the facility was only conducting assessments for voiding patterns on admission and not on residents with repeated falls including when a residents had repeated falls attempting to go to the bathroom. E2 also confirmed that a generic toileting plan is not beneficial to reduce risk for falls if the resident was not assessed for voiding patterns. 11/19/24 9:50 AM - During an interview, E1 (NHA) confirmed that R89 was not assessed for patterns of incontinence and that R89 was not on an individualized toileting program to attempt to reduce R89's risk for falling. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46988 3. Review of R6's clinical record revealed: 3/25/22 - R6 was admitted to the facility. 7/24/24 - A quarterly MDS documented that R6 was frequently incontinent of bowel and bladder and was not on a toileting program. The MDS also documented that R6 was dependent for toileting hygiene and partial/ moderate assist for toileting transfer. 7/2024 - The CNA task flow sheet documented that R6 was incontinent of bladder sixty-one times out of ninety opportunities. 8/2024 - The CNA task flow sheet documented that R6 was incontinent of bladder sixty-seven times out of ninety opportunities. 9/2024 - The CNA task flow sheet documented that R6 was incontinent of bladder seventy-eight times out of ninety-one opportunities. 10/21/24 - A quarterly MDS documented that R6 was always incontinent of bowel and bladder and was not on a toileting program. The MDS also documented that R6 was dependent for toileting hygiene and partial/ moderate assist for toileting transfer. 10/2024 - The CNA task flow sheet documented that R6 was incontinent of bladder eighty-eight times out of nintey-three opportunities. 11/19/24 11:27 AM - An interview with E26 (CNA) stated that R6 was a one assist for toileting and was a mix of continent and incontinent. E26 stated that R6 was not on a toileting program and was assisted to the toilet every two hours. E26 confirmed that R6 can stand and pivot and able to use the toilet with staff assistance. 11/21/24 12:39 PM - An interview with E12 (UM) confirmed R6 was not on a toileting program at this time. 4. Review of R12's clinical record revealed: 9/25/20 - R12 was admitted to the facility. 6/6/24 - A quarterly MDS documented that R12 was frequently incontinent of bladder, always incontinent of bowel and was not on a toileting program. The MDS also documented that R12 was dependent for toileting hygiene and for toileting transfer. 6/2024 - The CNA task flow sheet documented that R12 was incontinent of bladder eighty-one times out of nintey opportunities. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/2024 - The CNA task flow sheet documented that R12 was incontinent of bladder eighty-three times out of nintey-one opportunities. 8/2024 - The CNA task flow sheet documented that R12 was incontinent of bladder eighty-six times out of nintey-three opportunities. 9/3/24 - An annual MDS documented that R12 was always incontinent of bowel and bladder and was not on a toileting program. The MDS also documented that R12 was dependent for toileting hygiene and for toileting transfer. 9/2024 - The CNA task flow sheet documented that R12 was incontinent of bladder ninety times out of nintey opportunities. 11/19/24 12:42 PM - An interview with E16 (CNA) stated that R12 was dependent for toileting and confirmed R12 was not on a toileting program. E16 also stated that R12 was not utilizing a urinal or bed pan for continence. E16 confirmed that R12 does not use the toilet. 5. Review of R43's clinical record revealed: 4/8/24 - R43 was admitted to the facility. 4/9/24 - A care plan was initiated for R43 requires assistance for ADL care in bathing, grooming, person hygiene, transfer, and toileting. Interventions include provide cueing for safety and sequencing to maximize current level of functioning. 7/10/24 - A quarterly MDS documented that R43 is dependent for toileting and toileting hygiene. The MDS also documented that R43 is frequently incontinent of bowel and bladder and is not on a toileting program. 7/2024 - The CNA task flow sheet documented that R43 was incontinent of bladder eighty-one times out of ninety opportunities. 8/2024 - The CNA task flow sheet documented that R43 was incontinent of bladder eighty-three times out of ninety-one opportunities. 9/2024 - The CNA task flow sheet documented that R43 was incontinent of bladder eighty-four times out of ninety-one opportunities. 10/2024 - The CNA task flow sheet documented that R43 was incontinent of bladder eighty-seven times out of nine-three opportunities. 11/12/24 11:06 AM - An interview with R43 stated that she was continent and able to use the bed pan. R43 stated she was aware when she needs to use the bathroom and was often incontinent waiting for staff to answer the call bells. 11/19/24 11:59 AM - An interview with E26 (CNA) confirmed R43 was aware when she needs to use the bathroom. E26 confirmed that R43 was able to use the bed pan and confirmed resident was not on a toileting program. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 during the exit conference. 40163 Based on interview and record review it was determined that for four (R6, R43, R89 and R91) out of four residents reviewed for urinary incontinence, the facility failed to assess and provide care and services to maintain/restore bowel and bladder continence. Findings include: A facility policy titled Continence Management (effective 6/1/96 last revised 6/15/22) included: Patients will be assessed for the need for continence management as part of the nursing assessment process. A urinary incontinence assessment and or bowel incontinence assessment will be completed upon admission or re-admission and with a change in condition or change in continence status. Continence status will be reviewed quarterly as part of the care planning process. Identify patient's incontinence management by conducting a nursing assessment. Assess components include but are not limited to .voiding patterns. Cross refer to F689 1. Review of R89's clinical record revealed: 2/12/24 - R89 was admitted to the facility with dementia. 2/12/24 5:16 PM - A clinical admission assessment documented that R89 was continent of urine. 2/19/24 - An admission MDS assessment documented that R89 was cognitively intact with a BIMs of 13, required verbal cues or touching/steadying assistance by one staff member for toileting, was occasionally incontinent of urine and a trialed toileting program was not attempted. There was no evidence the facility conducted a urinary continence assessment that included voiding patterns. 2/28/24 -R89's care plan included: - Complete an incontinence assessment at intervals according to policy and procedure. - Discuss and plan voiding schedule with resident. - Resident is incontinent of urine with potential for improved control or management of urinary elimination. - Resident will demonstrate improved urinary elimination control as evidenced by experiencing less than one episode of urinary incontinence per day. - Encourage resident to use toilet upon wakening, after meals, nightly and PRN (as needed). There was no evidence of individualized approaches to maintain/restore bladder continence. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	February 2/12/24 through 2/29/24 - Review of R89's continence record revealed that R89 was continent of urine 46 out of 55 opportunities, incontinent six times, and three opportunities the facility lacked evidence of being toileted or offered. March 2024 - Review of R89's continence record revealed that R89 was continent of urine 81 out of 94 opportunities, incontinent seven times, one time not rated, and four opportunities the facility lacked evidence of being toileted or offered. 3/5/24 - R89's CNA tasks included: assist with toileting. 3/12/24 - R89's incontinence care plan included: Toilet upon rising, before meals, and at bedtime as needed. April 2024 - Review of R89's continence record revealed that R89 was continent of urine 74 out of 94 opportunities, incontinent ten times, one time not rated, and nine times lacked evidence of being toileted or offered. May 2024 - Review of R89's continence record revealed that R89 was continent of urine 46 times out of 95 opportunities, incontinent 22 times, and was out to the hospital from 5/15/24 through 5/23/24. 5/13/24 - R89's incontinence care plan included: Assist with toileting upon waking up before meals. The facility lacked evidence of an assessment to create and implement this approach. 5/13/24 - R89's incontinence CNA tasks included to assist with toileting upon waking up, before meals, after meals, and prior to bedtime. This toileting schedule was different than the nursing care plan. 5/15/24 - R89's 5-day MDS documented that R89 was cognitively impaired with a BIMs of 8, required supervision/touching assistance for toileting, partial/moderate assistance for ambulation, was always continent of urine and was not on a toileting program. 5/24/24 - R89's bowel and bladder assessment included that R89 had urinary incontinence and to implement pelvic floor rehabilitation. R89's EHR lacked evidence of this approach. A voiding diary was not a part of the assessment. June 2024 - Review of R89's continence record revealed that R89 was not continent at all out of 94 opportunities and four times lacked evidence of being toileted or offered toileting. July 2024 - Review of R89's continence record revealed that R89 was continent 44 out of 95 opportunities, incontinent 34 times and fifteen lacked evidence of being toileted or offering toileting. August 2024 - Review of R89's continence record revealed that R89 was continent 53 times out of 97 opportunities, incontinent 35 times and eight times lacked evidence of toileting or being offered toileting. 8/14/24 - R89's quarterly MDS documented that R89's BIMs was not assessed, required partial/moderate assistance for toileting, was frequently incontinent, and was not on a toileting program. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	September 2024 - Review of R89's continence record revealed that R89 was continent 17 times out of 90 opportunities, incontinent 64 times, one time inapplicable and eight times lacked evidence of being toileted or being offered toileting. 9/4/24 - R89's fall risk care plan included: Toilet upon rising, before meals at bedtime and when needed as per resident. October 2024 - Review of R89's continence record revealed that R89's continence was unable to be determined. 10/31/24 - R89's fecal and urinary incontinence evaluation documented that R89 had urinary incontinence and a program of prompted voiding as an intervention. The facility lacked evidence of an individualized schedule based on a comprehensive assessment. 11/1/24 - 11/21/24 - Review of R89's continence record revealed that R89 was continent one time out of 63 opportunities, incontinent 61 times and two times lacked evidence of being toileted or being offered toileting. 11/6/24 - R89's quarterly MDS documented that R89 was cognitively impaired with a BIMs of four, required substantial/maximal assist for toileting, did not ambualte, was frequently incontinent and was not on a toileting program. Review of R89's EHR revealed that R89 had become increasingly incontinent of urine during her stay, and that the facility failed to thoroughly assess and implement a comprehensive plan of care to prevent R89 from become becoming more incontinent. 11/19/24 11:25 AM - During an interview, E28 (LPN) confirmed that a 3-day voiding diary was not in the admission assessment. E28 stated that R89's continence assessments were in the CNA tasks. When the surveyor queried regarding who analyzes the CNA data to initiate a personalized plan of care for a toileting program, she could not articulate the process. During the same interview, E17 (RN) stated that she was not familiar with the process of who analyzes the incontinence data. 11/19/24 11:29 AM - During an interview, E1 (NHA) confirmed that a 3-day voiding diary was not completed upon admission and with changes in continence status. E1 also confirmed R89 had only two additional incontinence evaluations since admission on 5/24/24 and 10/31/24. Although R89's EHR revealed a significant change in continence since admission, the assessments were greater than five months apart. 11/22/24 3:18 - During an interview, E1, E2 (DON) and E26 (RCA) confirmed that the facility lacked evidence of a consistent individualized toileting program, and that R89 did experience an increase in urinary incontinence. E26 stated that it is the responsibility of the Unit Managers to review the CNA documentation to discern if a resident would benefit from an incontinence program. In addition, E26 confirmed R89's decline in continence and that the facility lacked evidence in the CNA tasks that R89 was consistently toileted. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/25/24 9:50 AM - During an interview, E37 (MDS) confirmed that the clinical team and the unit managers were to review residents for toileting programs. E3 confirmed that R89 had a decline in continence since admission as evidenced by review of R89's MDS assessments. In addition, E37 confirmed that R89's toileting program was not individualized related to lack of assessment. 11/25/24 10:09 AM - During an interview, E28 confirmed R89 did not have any voiding diaries throughout her stay to assess for an individualized toileting program and had a decline in urinary incontinence. In addition, E28 confirmed that pelvic floor exercises were not an appropriate intervention related to R89's impaired cognition. E28 stated that it was the responsibility of the primary nurses and the unit managers to monitor the need for new toileting interventions when there is a change in continence status. E28 confirmed that those things are being missed due to staffing. 44706 2. Review of R91's clinical record: 3/14/24 - R91 was admitted to the facility. 3/15/24 - A care plan was initiated, decreased mobility to perform ADL's in bathing, grooming, personal hygiene, dressing, eating, bed mobility, locomotion and toileting. Interventions included provide queuing for safety and sequencing to maximize level of function. There were no interventions documented related to incontinence. 3/20/24 - The admission MDS documented R91 was admitted with an indwelling catheter. 3/21/24 - A nursing progress note documented Foley removed .condom cath applied, draining clear yellow urine resident is incontinent of urine . 3/22/24 - A nursing progress note documented, Condom cath removed. 3/25/24 - A nursing progress note documented, no continent episodes. 4/2024 - The CNA task flow sheet documented that R91 was incontinent of bladder seventy-seven times out of ninety opportunities. and four opportunities the facility lacked evidence of being toileted or offered. 5/2024 - The CNA task flow sheet documented that R91 was incontinent of bladder eighty-two times out of ninety- three opportunities, and three opportunities the facility lacked evidence of being toileted or offered. 6/12/24 - A quarterly MDS documented that R91 was frequently incontinent of bowel and bladder and was not on a toileting program. The MDS also documented that R91 was dependant for toileting hygiene and toileting transfer. 6/2024- The CNA task flow sheet documented that R91 was incontinent of bladder eighty- three times out of ninety opportunities. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/2024 - The CNA task flow sheet documented that R91 was incontinent of bladder eighty-two times out of ninety-three opportunities. 8/2024 - The CNA task flow sheet documented that R91 was incontinent of bladder eighty- one times out of eighty-nine opportunities. 9/10/24 - A quarterly MDS documented that R91 was frequently incontinent of bowel and bladder and was not on a toileting program. The MDS also documented that R91 was dependant for toileting hygiene and toileting transfer. 9/2024 - The CNA task flow sheet documented that R91 was incontinent of bladder seventy-six times out of eighty-six opportunities. 11/19/24 10:12 AM - During an interview, E17 (RN) confirmed that the resident was incontinent of urine and upon admission had an indwelling catheter. R91 no longer has the catheter is incontinent of urine and wears adult briefs. E17 confirmed there was no evidence of a urinary assessment including a voiding diary. 11/19/24 10:38 AM - During an interview, E2 (DON) confirmed R91 was dependent for care and a toileting program was never initiated. In addition, E2 was unable to provide evidence of incontinence monitoring. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 during the exit conference.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 48409 Based on observation, record review and interview, it was determined that for three (R89, 411, and 412) out of three residents reviewed for hydration, the facility failed to ensure that R411 and R412 were offered sufficient fluid intake to maintain proper hydration and health. R411 was emergently sent to hospital and was diagnosed with a BUN of 32, and acute kidney Injury. R412 received an order for IV (intravenous) hydration for a sodium level of 156, the facility failed to insert the IV and R412 sodium level rose to 161. R412 was emergently sent to the hospital 36 hours later with facial droop and lethargy. For R89, the facility failed to follow a physician's order and evaluate R89's weight when R89 had a significant weight loss. Findings include: A facility document titled, Nutrition and Hydration Care and Services, dated 1/1/04 and reviewed 2/1/23 included, Staff will provide nutritional and hydration care and service to each patient consistent with each patient's comprehensive assessment Monitor intake and output Diagnoses of dehydration with clinical findings At risk for dehydration R411's clinical records revealed: 6/5/24 - R411 was admitted to the facility with diagnoses including acute kidney injury, acute osteomyelitis [infection of the bone] to the right hip bone and anal/rectal cancer. 6/5/24 - R411's physician's orders included cefepime [antibiotic] 2 gram/IVBP [intravenous piggyback] 100 ml every 12 hours and vancomycin [antibiotic to treat a bacterial infection] 1gram/200 IVBP every 24 hours, . Patient will need vanco trough level [lowest concentration of vancomycin in the blood] 2 times weekly .and weekly CBC . [complete blood count] .colostomy [a surgical opening in the intestinal wall or colon to allow stool to drain into a bag] care every shift. 6/6/24 - R411's care plan documented, Resident exhibits or is at risk for dehydration as evidence by infection and vomiting, diarrhea . The interventions included, Encourage resident to consume all fluids .monitor lab work as ordered and report as indicated. 6/6/24 - R411's admission nutritional assessment documented a fluid goal of 1700 ml/24 hours. 6/10/24 - R411's clinical records documented a vancomycin peak [highest contraction of vancomycin level in the blood] of 9.8, a trough level of 9.8. Vancomycin therapeutic trough level is between 5.0 to 10.0, and the peak level is between 20.0 to 40.0. 6/11/24 - R411's admission MDS documented a BIMS score of 15, indicating a cognitively intact status. R411's MDS lacked documentation of the presence of a colostomy on the left lower abdomen. 6/12/24 3:44 PM - A nursing progress in R411's clinical records documented, Resident has new orders per [E15] NP and Infectious Disease request: Increase Vancomycin .daily until 7/14/2024. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	6/13/24 - R411's clinical records documented a vancomycin peak of 12.3, trough of 12.3 and BUN [a blood test to measure kidney function] of 17, (normal range is between 7-17), and a creatine [a blood test to measure kidney function] level of 1.00 [normal range for women is between 0.6 to 1.1]. 6/17/24 - R411's clinical records documented a vancomycin peak of 12.5, a trough of 12.5, and a BUN level of 19. 6/24/24 - R411's clinical records documented a vancomycin peak of 24.2, trough of 24.2 and BUN of 19. 6/27/24 - R411's clinical records documented a BUN 18, creatine 1.40. The Cefepime was decreased to 1 gram every 12 hours and vancomycin at 1 gram every 24 hours. A review of R411's daily documented fluid intake from 6/7/24 through 6/30/24 revealed: 6/6/24 - 690 ml, 6/7/24 - 1,040 ml, 6/8/24 - 1,020 ml, 6/9/24 - 1,620 ml, 6/10/24 - 950 ml, 6/11/24 - 1,620 ml, 6/12/24 - 500 ml, 6/13/24 - 840 ml, 6/14/23 - 720 ml, 6/15/24 - 1,450 ml, 6/16/24 - 1,450 ml, 6/17/25 - 1,150 ml, 6/18/24 - 1,190 ml, 6/19/24 - 980 ml, 6/20/24 - 1,040 ml, 6/21/24 - 810 ml, 622/24 - 730 ml, (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	6/23/24 - 1,240 ml, 6/24/24 - 1,100 ml, 6/25/24 - 1,190 ml, 6/26/24 - 1,260 ml, 6/27/24 - 1,260 ml, 6/28/24 - 340 ml, 6/29/24 - 960 ml, 6/30/24 - 580 ml R411's did not meet the fluid goals of 1700 ml for 24 out of 24 days. 7/1/24 - R411's clinical records documented a vancomycin peak of 23.1, peak of 23.1, BUN of 32 (above the normal level) and creatine level of 2.60 (above the normal level). 7/1/24 9:17 AM - R411's clinical records documented, Pt [patient] not feeling well this am, BM from colostomy all over bathroom with a very strong odor. Pt lethargic, not answering questions with full responses. Daughter in law came in to visit, also concerned with pt change in mental status. BP [blood pressure] 96/56 .sent to the ER [emergency room] for evaluation. 7/1/24 9:51 AM - R411's clinical records documented (progress note from the NP, Pt seen today for follow up. Pt was found resting in bed, in mild distress. Pt daughter at bedside. Pt stated I don't feel well. Something is wrong. Pt c/o [complaint of] chills, diarrhea, weakness, sob [shortness of breath], BP 96/56 . noted lethargy, sob and appeared ill. Pt was sent to ER for further evaluation. 7/1/24 1:37 PM - R411's clinical records documented, Called Sussex ER for pt update. Per ER nurse-Pt still being evaluated, may be admitted due to abnormal labs . 7/1/24 6:06 PM - R411's emergency hospital records documented, Patient was found to have acute kidney injury her creatinine peaked at 4.3, now trending down to 2.5, patient was seen by nephrology .now improved to 2.5, s/p [status post] IV fluids. Labs show an acute kidney injury .Patient will require admission to medicine service for acute kidney injury likely from volume loss from C. difficile as well . final diagnoses - Acute kidney failure, dehydration. 11/21/24 10:00 AM - A review of R411's fluid intake records from 6/7/24 through 6/30/24 lacked evidence that R411 reached the fluid goals of 1700 ml/24 hours for 24 out of 24 opportunities. During an interview E15 (dietitian) provided the Surveyor with a facility document titled, Week at a glance, menu. The menu documented the fluids served with each meal. 11/22/24 8:45 AM - During an interview, E21 (CNA) stated, We give them {residents] what's on the tray, and they ask if they want anything more. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	11/22/24 1:30 PM - The surveyor asked E13 (MD) during a telephone interview if the residents labs are reviewed by the facility's providers along with the infectious providers, E13 stated, Yes, they are reviewed and signed by the providers in the building as well. 11/25/24 10:00 AM - During a telephone interview C1 (MA) stated, We follow the levels for the antibiotics. The patient is in the building, and they must make sure she is drinking enough. The facility failed to monitor and ensure that R411 received sufficient fluid intake despite the diagnoses of acute kidney injury, the use of nephrotoxic (risk of damaging the kidneys) medications (which placed R411 at higher risk for diarrhea) and the presence of a colostomy. 2. R412's clinical records revealed: 7/20/22 - R412 was admitted to the facility with diagnoses including dementia, hypertension, chronic kidney disease and diabetic mellitus. 7/22/22 - R412's nutritional care plan documented, . Presents with nutritional risk r/t (related to) DM (diabetes mellitus) . CKD (chronic kidney disease). 4/19/24 - R412's quarterly MDS assessment documented a BIMS score of 2, indicating severe cognitive impairment. The MDS assessment also documented that R412 was independent with eating and needed substantial or total help from staff with all other activities of daily living. 6/26/24 9:33 AM - R412's nutritional assessment documented a fluid goal of 2,100 ml per day. 7/1/24 2:48 PM - R412's clinical records documented, .Vomit x 1 episode . 7/3/24 8:47 AM - R412's clinical records documented, Patient to increase fluids today. R412's clinical records lacked evidence of documentation of increased fluids given. 7/4/24 1:27 PM - R412's clinical records titled Interact [a document for a change in condition] documented, . 15.7-pound weight loss since 4/16/23 . R412's clinical records lacked evidence of interventions for the weight loss. 7/6/24 4:37 AM - R412's clinical records documented, Nutrition note: no meals offered this shift, resident id d [did] consume a 240mL of extra fluids . 7/6/24 11:46 AM - R412's clinical records documented, Hypernatremia . [high sodium level in the blood] . Plan Give 1/2 NSS [normal saline] at 75cc/hr [hour] x1 liter. Repeat BMP [Basic Metabolic Panel] on Monday. 7/6/24 12:21 PM - R412's clinical records documented a sodium level of 156, and a BUN of 34. 7/7/24 11:49 AM - R412's clinical records documented, .Resident noted with a poor appetite for lunch. Consumed less than 25% of his lunch requiring assistance with feeding by nursing staff . (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	7/7/24 12:00 AM - R412's clinical records documented, .Attempts to restart iv were unsuccessful. Therefore, a phone call will b [be] made to [Name of IV Company}. R412's clinical records lacked evidence that the IV was started. 7/7/24 3:09 PM - R412's clinical records documented, .Resident has new orders to administer IV fluids sodium chloride 0.45% @ 75ml/hr [hour] X 1 liter for hypernatremia, However, previous shift unable to obtain IV access for fluid hydration. [Name of IV Company] notified by this writer confirmation # 319625. Spoke with [Name of IV Company staff's name]. Who states she doesn't have a ETA as of yet? Also states the technician has been dispatched. Oncoming nurse made aware of all the above mentioned and to follow up. R412's clinical records lacked evidence that the IV company came out to start the IV access. 7/7/24 4:15 PM: E8 (NP) documented in R412's clinical records, Seen today for IV access. Nurse attempted 2 times but unsuccessful to place PIV, Patient ordered for IVF for Hypernatremia of 156 Plan: Attempt to place PIV again, Call the IV team again and get an ETA. The clinical records lacked evidence of fluids given to R412. 7/8/24 10:35 AM - R412's clinical records documented lab results, Sodium- 161 BUN 34.0. 7/8/24 11:37 AM - E8 (NP) documented in R412's clinical records, .Sent to hospital for critical sodium level and to rule out stroke seen today for increased sodium level and right mouth drooping. Nursing reports patient had a sodium level of156 on Saturday, nursing called on-call and patient was started on sodium chloride 0.45% at 75 mL/h IV for the hypernatremia. Nursing staff unable to get IV line started and had to order from outside company to come in and place a midline. Company schedule to come out Monday morning. Sodium rechecked on 7/8/2024 and was at 161 and chloride at 126. Patient found resting in bed and unable to answer questions, patient mumbling. Patient's right lip drooping. No line placed in patient yet for IV solution. Vitals are stable. Patient's sister present and updated that patient will be sent to the hospital to address the hypernatremia and rule out stroke Lab from 7/8/2024-sodium 161 and critical. Sent to the hospital due to no IV access and sodium needing to be addressed. Patient unable to make out words, this is new for patient . 7/8/24 1:43 PM - A facility document reported to the Division documented, During clinical rounds this morning it was noted that an IV order from 7/6/24 was attempted multiple times by nursing staff unsuccessfully. The contracted IV placement specialists had not yet arrived in the facility to place the ordered midline. Investigation initiated and ongoing. 7/9/24 12:30 PM - R412's hospital records documented, Hypernatremia with sodium as high as 158-160, this is improving with D5 water. 7/10/24 2:04 PM - R412 was readmitted to the facility. R412's hospital discharge summary documented, AKI (acute kidney injury) on CKD, Resolved. 7/11/24 - R412 readmission nutrition assessment documented, Readmit s/p [status post] hosp [hospitalization] for hypernatremia .facial droop which corrected per hospital records s/p IV hydration. The assessment also documented, Is there a nutritional problem? And the answer was, No. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R412's readmission care plan and nutritional assessment lacked evidence of interventions for hydration despite the recent hospitalization for increased sodium level. 7/15/24 12:40 PM - E8 (NP) documented in R412's clinical records, readmitted .was sent to emergency for evaluation secondary to elevated sodium levels and right facial droop. Facial droop improved . may have been secondary to hypernatremia Creatinine at baseline was 1.4-1.5 currently at 1.5-2.1. Patient stable and discharged back to facility for care. 7/24/24 - A facility document to the Division titled, 5 day follow up, included, While a delay in treatment occurred, there was no negative outcome for the resident the IV contracting company will be contacted for discussion related to providing timely services and notification to facility. In addition, education was completed with facility licensed nursing staff to include concerns with ability to carry out physicians' orders to follow facility protocol of notifying Director of Nursing or Assistant Director of nursing for further direction and follow up. In addition, medical providers were notified that other types of supplemental hydration can be administered in place of peripheral to include by not limited to Hypodermoclysis [a method to give fluids under the skin for patients who need hydration] therapy. The kits have been ordered to have on hand. Licensed nursing staff have also been educated on this process and procedure. 11/20/24 10:00 PM - During an interview E7 (Dietitian) stated, The residents' weights are reviewed to formulate what their fluids goals are, and that is added to their meal tickets. 11/22/24 10:30 PM - During a telephone interview the Surveyor asked E3 (NP) at what time would the plan of care have to be changed for the resident with a sodium level 156 and the IV hydration could not be started. E3 stated, That would depend on what the nurses tell me, and how long it would take for [Name of IV Company] to come to the building. I don't think it should be longer than 8 hours if the patient is not drinking though. 11/22/24 11:00 AM - During an interview E5 (LPN) stated, The patient would have to go out for treatment really soon if they can't start the IV and he is not drinking. 11/22/24 11:15 AM - During an interview E6 (LPN) stated, The patient would probably have to go out in about 4 hours if they can't get the IV started. 11/22/24 2:30 PM - During a telephone interview, the Surveyor asked E13 (MD) about the timeliness in care and treatment for a patient with a diagnoses of chronic kidney disease and a documented sodium level of 156 on 7/6/24 and a sodium level of 161 on 7/8/24. E13 stated, That depends on if the resident was drinking fluids and if he looked sick. The facility sent him out when he started having symptoms. E13 further stated that R412 did not suffer from any adverse effects from the delay in treatment despite documented of lethargy and facial droop. 11/22/24 2:45 PM - A review of R412's clinical records from 6/20/24 through 7/20/24 lacked evidence that he was monitored for adequate fluid intake. The facility failed to ensure that R411 was offered sufficient fluid intake to maintain proper hydration and health. And that R412 received care and treatment in a timely manner for increasing sodium levels. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	40163 3. Review of R89's clinical record included: 2/12/24 - R89 was admitted to the facility. 2/12/24 - R89 weighed 15.2 pounds on admission. 7/1/24 - A nutrition note documented that R89 had a weight loss of 13.2 pounds (9.1%) in three months. 8/14/24 - A quarterly MDS assessment documented that R89 was a set up assistance for eating and not on a physician prescribed weight loss regimen. 10/1/24 - A physician order included: Weigh every day shift every Thursday for four weeks. 11/7/24 - Review of R89's EHR revealed that there were only initials and a check mark and no weight recorded. The facility lacked evidence of R89s weekly weight being obtained. 11/11/24 10:53 AM - A nutrition progress note documented that R89 has had a significant unplanned, undesired weight loss of 12.6%. R89 had a 19 pound weight loss in six months. Although the facility implemented nutritional interventions, the facility failed to evaluate R89's 11/7/24 weight per physician order. 11/14/24 12:14 PM - During an interview, E28 (LPN) confirmed that the facility lacked evidence that R89's 11/7/24 weekly weight was obtained and that R89 had experienced a significant weight loss. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.

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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. 47142 Based on record review and interview, it was determined that for one (R6) out of forty-six (46) residents in the investigative sample, the facility failed to ensure the clinical record contained accurate documentation. Findings include: 1 A. Cross refer F686. Review of R6's clinical record revealed: 3/25/22 - R6 was admitted to the facility. 7/3/24 - R6's physicians orders documented to cleanse right heel with wound cleanser, apply Medi-honey and cover with Optifoam every other day until healed. 7/12/24 - The treatment administration record (TAR) documented that E24 (LPN) had administered the treatment to R6's right heel. 7/16/24 - A facility investigative report revealed that the wound dressing to R6's right heel was dated 7/8/24, even after 8 days had passed. 7/16/24 - A statement by E24 documented that the TAR was signed off prior to the treatment being completed to R6's right heel and then forgot to go back and complete the treatment later. 11/20/24 9:44 AM - An interview with E2 (DON) confirmed that E24 signed the TAR off as completed and the treatment was not done. The facility provided education to E24 and all the staff. 1 B. Cross refer F677. Review of R6's clinical record revealed: 3/25/22 - R6 was admitted to the facility. 7/18/24 - A care plan revealed that R6 required assistance for ADL care in bathing, grooming, personal hygiene, dressing, bed mobility, transfer and toileting. The interventions for the ADL care revealed that R6 required an extensive assist of one person for dressing, toileting and personal hygiene. 8/17/24 - The CNA task documentation sheet revealed that E25 (CNA) documented R6 independently used the toilet, completed their hygiene, dressed, and transferred without assistance from a helper. 11/19/24 at 9:15 AM - An interview with E26 (CNA) revealed that R6 requires assistance of one for dressing, toileting, hygiene and transfers and would not be able to do it themself. If R6 refuses, then we try to redirect or try again and ultimately will tell the nurse where it would be documented in the record as refused. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/22/24 at 2:32 PM - An interview with E2 confirmed that E25 documented independent as the care received when R6 was not able to perform the task without assistance. 2. Review of R43's clinical record revealed: 4/8/24 - R43 was admitted to the facility. 10/4/24 - A quarterly MDS revealed that R43 is dependent for toileting and toileting hygiene. 11/21/24 12:24 PM - An interview with E16 (CNA) stated the expectation is to document each void and elimination as it occurs in the electronic charting. E16 confirmed that multiple voids would require multiple entries into the system. E16 demonstrated how to document in the system for each void. E16 confirmed that this was not shown to staff during orientation and E16 stated she learned how to document this task by playing with the system. 11/21/24 12:39 PM - An interview with E12 (UM) confirmed the expectation is for the CNA's to document each void and elimation in the system. E12 stated she does not know how to do the documentation for the CNA's. 11/21/24 1:30 PM - An interview with E20 (CNA) stated that she documents one void per shift and did not know the expectation was to document each void. 11/21/24 1:43 PM - An interview with E21 (CNA) stated that she documents one void per shift and did not know the expectation was to document each void. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.