STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085015	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seaford Center	1100 Norman Eskridge Highway Seaford, DE 19973

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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. 46988 Based on observation, interview and record review, it was determined that for one (R18) out of six residents reviewed for activities of daily living (ADLs), the facility failed to get R18 out of bed in accordance with his preference. Findings include: Review of R18's clinical record revealed: 1/31/24 - R18 was admitted to the facility. 8/8/24 - A quartlerly MDS documented that R18 was dependent for transfer and requires a sit to stand lift for transfer. R18 has a BIMS score of 13 and was cognitively intact. 9/16/24 10:58 AM - An observation of R18 laying in bed watching television. 9/17/24 10:45 AM - An observation of R18 laying in bed watching television. 9/18/24 1:06 PM - An observation of R18 laying in bed watching television. 9/19/24 12:41 PM - An observation of R18 laying in bed watching television. 9/20/24 9:25 AM - An observation of R18 laying in bed watching television. 9/23/24 12:00 PM - An interview with R18 revealed that his preference is to get out of bed daily. R18 stated that staff tells him they are too busy to get him out of bed. 9/23/24 12:14 PM - An interview with E7 (CNA) confirmed that R18 was not out of bed and confirmed staff is aware of his preference to get out of bed daily. The facility lacked evidence of R18 getting out of bed daily according to his preference. 9/24/24 2:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate 1) at 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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47142 Based on review of facility documentation and interview it was determined that for two (R10 and R48) out of three Medicare Part A discharges reviewed the facility failed to have evidence of a completed Skilled Nursing Facility Advance Beneficiary Notice (SNFABN). Findings include: Review of surveyor requested Skilled Nursing Facility Beneficiary Protection form for three discharged Medicare A residents the following was revealed: 1. R10 started Medicare Part A skilled services on 2/15/24. The last day of covered services was 4/2/24. The resident stayed at the facility as a long-term care resident. There was no evidence the facility provided the SNFABN when Medicare Part A services ended and the resident converted to another payer source. 2. R48 started Medicare Part A skilled services on 4/29/24. The last day of covered services was 7/2/24. The resident stayed at the facility as a long-term care resident. There was no evidence the facility provided the SNFABN when Medicare Part A services ended and the resident converted to another payer source. 9/23/24 2:00 PM - During an interview, E1 (NHA) stated the reason the SNFABN form was not provided to the resident was that the resident was switching to another payer source and the staff did not realize the form still needed to be given. 9/24/24 2:00 PM - Findings were reviewed with E1, E2 (DON) and E3 (Corporate 1) at the exit conference.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 47114 Based on interview and record review, it has been determined that for one (R64) out of three sampled for PASARR, the facility failed to ensure a referral for a PASARR screening was done for a new mental health diagnosis. Findings include: Review of R64's clinical record revealed: 1/8/23 - R64 was admitted to the facility with the following diagnoses of atrial fibrillation (irregular rapid heart rate), hypertension and major depressive disorder. 1/6/23 - Review of R64's PASARR Level I screen outcome documented . No Level II required 2. No SMI (serious mental illness), ID (intellectual disability or RC (related condition). 12/30/23 - R64's annual MDS (Minimum Data Set) documented a new diagnosis of schizophrenia. 9/23/24 11:50 AM - E6 (SW) was interviewed and stated, I am not sure if a new PASARR application was done for [R64], I wasn't here then, but I can check. I'm not finding her; I'm searching for her and it's not here. It looks like there was not a new one, but it looks like she is due for a PASARR on 9/22/24, and honestly I am working on it now. 9/24/24 11:40 AM - Findings were reviewed with E1 (NHA). The facility lacked evidence that R64, a resident with a mental disorder, was referred to the state agency for a PASARR Level II evaluation and determination. 9/24/24 2:00 PM - Findings were reviewed with E1, E2 (DON) and E3 (Corporate 1) at the exit conference.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40260 Based on record review and interview, it was determined that for four (R7, R22, R43 and R66) out of twenty (20) sampled residents, the facility failed to ensure that the required interdisciplinary team (IDT) members participated in the care plan meetings and that meetings occurred every three months. In addition, R66's care plan had not been reviewed and revised to reflect a behavior of frequently removing his nebulizer equipment from the protective plastic bag. Findings include: 1. Review of R7's clinical record revealed: 4/10/24 - R7 was admitted to the facility. 9/19/24 - A review of the notes for the initial care plan meeting on 4/25/24 lacked evidence of input from the Physician. Additionally, there was no evidence that a quarterly care plan meeting occurred in July, 2024. 2. Review of R22's clinical record revealed: 4/10/14 - R22 was admitted to the facility. 9/19/24 - A review of the notes for the care plan meeting on 10/11/23 lacked evidence of input from R22's nurse. A review of the notes for the care plan meeting on 8/14/24 lacked evidence of input from the Physician. Additionally, there was no evidence that there was a care plan meeting from 11/29/23 to 8/14/24 although an OBRA significant change in status assessment was conducted on 2/15/24. 3. Review of R43's clinical record revealed: 7/25/19 - R43 was admitted to the facility. 9/19/24 - A review of the notes for the care plan meeting on 11/22/23 lacked evidence of input from the certified nursing assistant. There was no evidence that there was a care plan meeting from 2/21/24 to 9/11/24, although a quarterly MDS was conducted on 3/16/24 and 6/16/24. Finally, a review of the care plan meeting notes dated 9/11/24 lacked evidence of input from the Physician. 9/24/24 9:59 AM - In an interview, the Surveyor shared the above information with E1 (NHA), who acknowledged that the missing IDT members and gaps in care plan meetings were likely due to staffing issues and turnover. 47114 4. Cross Refer F695. Review of R66's clinical record revealed: 5/24/23 - R66 was admitted to the facility with the following diagnoses, including, but not limited to, chronic obstructive pulmonary disease (lung disease that blocks air flow and makes it difficult to breathe) and stroke. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/30/24 - A quarterly MDS (Minimum Data Set) assessment revealed R66 was severely cognitively impaired. 9/18/24 10:31 AM - During an interview, E15 (LPN) stated, [R66's] nebulizer treatments are ordered to be given every 6 hours as needed. In addition, E15 revealed R66 turns the nebulizer machine on and off himself and R66 takes the nebulizer tubing and mask out of the protective bag himself all the time. Additionally, E15 reviewed R66's care plan for this behavior and stated, I can't find a care plan for the behavior. 9/18/24 10:54 AM - During an interview, E2 (DON) confirmed she was not aware of E66's behavior of turning the nebulizer machine on and off and removing the nebulizer equipment from the protective plastic bag. E2 confirmed that R66 was not care planned for those behaviors. E2 updated R66's care plan to reflect the behavior. 9/24/24 2:00 PM - Findings were reviewed with E1, E2 and E3 (Corporate 1) at 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46988 Based on observation and interview, it was determined that for two (R39 and R89) out of six residents reviewed for ADLs, the facility failed to ensure ADLs were provided to dependent residents. Findings include: A facility policy and procedure titled, Activities of Daily Living (ADLs) revised 5/1/23 documented . Activities of daily living include, hygiene, bathing, dressing, grooming, and oral care. 1. Review of R39's clinical record revealed: 4/12/21 - R39 was admitted to the facility. 8/24/24 - The CNA task list documented R39's shower schedule was on Tuesday and Friday on the 7 AM to 3 PM shift and prefers a bed bath. 9/8/24 - The quarterly MDS documented that R39 was dependent for bathing and personal hygiene. 9/16/24 10:58 AM - An observation of R39 with overgrown finger nails with debris noted underneath. 9/17/24 11:05 AM - An observation of R39 with overgrown finger nails with debris noted underneath. 9/17/24 - A review of the CNA task flow sheet revealed that R39 had a complete bed bath. 9/18/24 2:06 PM - An observation of R39 with overgrown finger nails with debris noted underneath. 9/19/24 10:54 AM - An observation of R39 with overgrown finger nails with debris noted underneath. 9/19/24 11:20 AM - An interview with E14 (CNA) revealed that the expectation is that nail trimming to be completed every Wednesday. E14 confirmed nail trimming was not completed and stated she did not have enough time to complete the task. The facility lacked evidence of R39 being provided assistance with ADL care specifically nail trimming. 47114 2. R89's clinical record revealed: 6/4/24 - A quarterly MDS assessment documented [R89] required substantial maximal assist for showering, bathing, oral care, personal hygiene, bed mobility and dependent for toileting . 6/21/24 - R89 was admitted back to the facility from the hospital. 6/23/24 - A five day MDS assessment documented [R89] was dependent for eating, oral hygiene, toileting, showering, bathing, personal hygiene and bed mobility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/24/24 - R89 was admitted to hospice care. 6/25/24 - 11:13 AM - Review of R89's facility task sheet documented bathing was provided by E9 (CNA). 6/25/24 1:17 PM - Review of R89's facility task [NAME] documented toileting was provided by E9. 6/25/24 2:30 PM - Review of a facility provided statement from E25 (RN) revealed, [E9 (CNA)] was assigned to [R89] for care. Additionally, E25's statement also revealed, [R89] looked disheveled and later that evening [E25] received a call from [E1 (NHA)] regarding [R89's] family's complaint of his appearance during their visit. 6/25/24 9:18 PM - Review of a facility incident report revealed, there was a concern voiced about [R89's] care. 9/24/24 11:42 AM - During an interview E1 stated, On 6/25/24, [R89's] family came in to visit and he was disheveled his sheets were not clean, this was around 3:30 PM. E1 also stated, [R89] was actively dying, he had not eaten, drank, or took any medications in about three to four days. E1 also stated, [E9] had last seen [R89] at 12:15PM. And that other staff from the 3-11 shift had gone in to immediately clean him up and take care of his needs. Furthermore, E1 confirmed [E9] had been educated on ADL care, abuse, neglect and suspended pending the facility's investigation. The facility failed to ensure that ADLs were provided for a dependent resident. 9/24/24 2:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate 1) at the exit conference.

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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. 46988 Based on observation, interview and record review it was determined that for two (R20 and R45) out of two residents reviewed for pressure ulcers, the facility failed to provide care and services to prevent pressure ulcers and promote healing. For R45 the facility failed to prevent an avoidable deep tissue injury from developing to the bilateral heels causing harm. For R20 the facility failed to ensure that the resident was turned and repositioned to prevent pressure ulcers resulting in an avoidable Stage 3 pressure ulcer to the right heel and an avoidable stage 4 pressure ulcer to the left heel, resulting in harm. Findings include: A policy titled Skin Integrity and Wound Management updated 5/1/24 documented a comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influence skin health, skin/wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of case as needed. 1. Review of R20's clincial record revealed: 5/12/22 - R20 was admitted to the facility. 5/12/22 - A careplan for R20 was intiated for dependence of care related to limited mobility. Interventions included to monitor for complications of limited mobility such as pressure ulcers and monitor for decline in ADL function. 7/16/22 - A careplan for R20 was initiated for being at risk for skin breakdown related to limited mobility, incontinence, and fragile skin. Interventions included turn and reposition every two hours, monitor for skin breakdown, and weekly skin check by licensed nurse. The care plan lacked an approach to off load pressure to the heels. 4/2024 - The CNA task flow sheet documented that R20 was to be turned and repositioned and a skin check every two hours. Ten out of ninety-three opportunities were not documented. Twelve out of ninety-three opportunities indicated R20 had reddened areas on skin that did not go away. The facility documentation lacked evidence that staff reported the reddened areas that would not go away for R20 and lacked evidence of implementing any new approaches related to skin breakdown/prevention. 5/2024 - The CNA task flow sheet documented that R20 was to be turned and repositioned and a skin check every two hours. Nine out of ninety-three opportunities were not documented. Fifteen out of ninety-three opportunities indicated R20 had reddened areas on skin that did not go away. The facility documentation lacked evidence that staff reported the reddened areas that would not go away for R20 and lacked evidence of implementing any new approaches related to skin breakdown/prevention. 5/5/24 - The Annual MDS documented that R20 was dependent for turning, bed mobility, and repositioning with two person physical assist. R20 had range of motion impairments bilaterally of the lower extremities and one side for upper extremities. The MDS assessment also identified R20 was at risk for pressure ulcers/injuries. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Despite R20's dependence on staff for bed mobility and impaired range of motion the facility did not update the care plan to include off loading pressure for the heels. 5/19/24 - A nursing Braden scale documented R20 with a score of 17 indicating R20 was at mild risk for skin breakdown. 5/30/24 - An SBAR identified a skin wound or ulcer to R20's left heel which was unstageable. The SBAR lacked evidence of interventions related to care of a pressure ulcer. 5/30/24 - A skin evaluation documented a pressure ulcer was present to R20's left heel and was a in house acquired wound. The pressure ulcer was unstageable related to eschar or slough present. Descripton was noted as 5.9 cm L x 5.0 cm W, no depth, bleeding, serosanguinous exudate, and no odor. The recommendations for treatment were cover with MediHoney, heel suspension/protection device, turn and reposition. The evaluation stated provider was notified and heel cushion provided. The heel suspension/off loading was not initiated until after the pressure ulcer had developed. 5/31/24 - R20's care plan documented updated interventions to float bilateral heels using a heel up pillow and wound treatments as ordered. 6/11/24 - The SBAR identified a skin wound or ulcer on R20's right heel. The writer E21(RN) documented, wound bed was moist, malodorous, slough present, and periwound reddened and warm to touch. 6/11/24 - The skin evaluation documented a pressure ulcer was present to R20's right heel and was an in house acquired wound. The pressure ulcer was unstageable related to eschar. Desciption was noted as 3.9 cm L x 4.5 cm W, 12.5 cm A, no depth, moderate exudate, seropurulent drainage, and strong odor. The recommendations for treatment were cover with calcium alginate, foam dressing, and to offload heels. This pressure ulcer occurred after the initial offloading/floating of heels was implemented. 6/13/24 00:00 AM - A wound rounds progress note documented R20 had bilateral heel wounds with necrosis, moist tan slough, no foul wound odor noted , and periwound healthy in appearance. The progress note also documented R20 was educated on wound assessment and plan to continue Medi-Honey covered by dry dressing daily as needed. R20 was also educated on importance of floating heels when in bed to promote healing and reduce further breakdown. 7/18/24 - A wound evaluation documented for R20's left heel wound measurements as 8.63 cm L x 4.38 cm W and 28.85 cm A. The left heel remains unstageable related to slough and eschar. The left heel was noted to have seropurulent exudate and intact wound edges. The treament recommended was cleanse with dakins solution, cover with Medi-Honey, and a clean dry dressing. Continue with heel suspension/protection device and turn/repositioning programm. A review of wound evaluation documented for R20's right heel wound measurements as 3.78 cm L x 3.24 cm W and 9.16 cm A. The right heel remains unstageable related to eschar. The treatment recommended was cleanse with dakins solution, cover with calcium alginate, and a clean dry dressing. Continue with heel suspension/protection device and turning/repositioning schedule. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	8/8/24 - A wound evaluation documented for R20's right heel wound measurements as 2.68 cm L x 2.17 cm W and 4.38 cm A. The right heel is now documented as a stage 3 pressure ulcer having serosainguineous exudate with attached edges. The treatment recommended was wet gauze with dakins solution and covered with clean dry dressing. Continue with heel suspension / protection device and turn/repositioning program. 8/15/24 - A wound evaluation documented for R20's left heel wound measurements as 5.56 cm L x 3.85 cm W and 17.26 cm A. The left heel remains unstageable related to eschar and was noted to have bleeding, serosainguineous exudate, and attached edges. The treatment recommended was wet gauze with dakins solution and covered with clean dry dressing. Continue with heel suspension/protection device and turn/repositioning program. 9/17/24 10:35 AM - An observation of R20's bilateral heels resting on mattress with pillow noted under calves. The pillow was not positioned correctly for R20's bilateral heels to be suspended off the mattress. 9/18/24 10:32 AM - An observation of R20's bilateral heels resting on mattress with pillow noted under calves. The pillow was not positioned correctly for R20's bilateral heels to be suspended off the mattress. 9/19/24 9:10 AM - An observation or R20's bilateral heels resting on mattress with pillow noted under calves. The pillow was not positioned correctly for R20's bilateral heels to be suspended off the mattress. 9/19/24 10:31 AM - An observation or R20's bilateral heels resting on mattress with pillow noted under calves. The pillow was not positioned correctly for R20's bilateral heels to be suspended off the mattress. 9/19/24 11:26 AM - An interview with E22 (RN) revealed the purpose of floating heels is to prevent skin breakdown and the nurse on duty will verify every shift that the CNA is floating resident's heels while they are in bed. The CNA is expected to check and reposition at least every two hours. 9/20/24 9:24 AM - An observation of R20's bilateral heels resting on mattress with pillow noted under calves. The pillow was not positioned correctly for R20's bilateral heels to be suspended off the mattress. 9/20/24 10:33 AM - An observation of R20's bilateral heels resting on mattress with pillow noted under calves. The pillow was not positioned correctly for R20's bilateral heels to be suspended off the mattress. 9/20/24 2:09 PM - An interview with E23 (LPN, WCN) revealed the expectation of floating heels is to prevent skin breakdown and/or keep current skin breakdown from worsening. E23 stated that staff should be adjusting pillows for floating heels every two hours or sooner when they go to reposition. E23 confirmed that R20 does not currently have a low air loss mattress at this time and R20's pressure ulcers were in house acquired. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	9/24/24 9:48 AM - An interview with E24 (WC, NP) revealed the expectation of floating heels is to prevent skin breakdown and/or keep current skin breakdown from worsening. E24 confirmed that staff should turn and reposition residents at least every two hours and that heels should be floated while residents are in bed. E24 stated R20's bilateral heel wounds were caused by pressure. 2. Review of R45's clinical record revealed: 7/31/19 - R45 was admitted to the facility. 8/18/19 - A care plan for R45 was intiated for dependence of care related to decline in functional ability. Interventions included to monitor for complications of limited mobility such as pressure ulcers and monitor for decline in ADL function. 8/18/19 - A care plan for R45 was initiated for risk of skin breakdown related to decreased physical mobility and occasional incontinence. Interventions included pat skin when drying and a weekly skin check by a liscensed nurse. The careplan lacked an approach to off load pressure to the heels. 11/10/23 - A nursing Braden scale documented R45 with a score of 19 indicating R45 was at no risk for skin breakdown. 11/10/23 - The quarterly MDS assessment documented that R45 was completely dependent with two physical person assist for bed mobility and turning. R45 had range of motion impairments bilaterally for upper and lower extremities. The MDS assessment also identified R45 was at risk for pressure ulcers/injuries. The MDS indicated that R45 had pressure reducing devices to the bed and chair and did not need a turn/reposition program. The careplan continued to lack approaches to off load pressure from the heels. 12/2023 - The CNA task flow sheet documented that R45 was to be turned and repositioned and a skin check every two hours. Ten out of ninety-three opportunities were not documented. Five out of ninety-three opportunities indicated R45 had reddened areas on skin that did not go away. The facility documentation lacked evidence that staff reported the reddened areas that would not go away for R45 and lacked evidence of implementing any new approaches related to skin breakdown/prevention. 12/20/23 - An SBAR documented that R45 had a DTI (deep tissue injury) to the right heel, unstageable due to sloth or eschar. The SBAR documented the DTI as in house acquired with the following measurements 5. 8 cm L x 5.6cm W and 25.7 cm A. The wound was described as a scab, with no exudate, no odor, attached edges, and with dry/flaky calloused surrounding tissue. The treatment recommendations were sure prep, foam mattress, repositioning device(s), and turn/repositioning program. There were no approaches added to off load pressure from the heels. 12/27/23 - A physician's order was completed for a venous doppler study. The study revealed doppler blood flow detected and no indication of thrombus. 12/28/23 - A skin and wound evaluation documented a DTI to the right heel measuring 7.81 cm L x 7.42 cm W, 43.86 cm A, black in color with eschar, attached edges, and dry flaking peri wound. The following interventions were suggested: heel suspension/protection device, low air loss mattress, positioning wedge, and turn/repositioning program. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1/3/24 - An SBAR documented that R45 had four areas noted for DTI. Treatment recommendations were low air loss mattress and to discontinue heel boot to right foot. The record lacked evidence of another form of offloading/floating of heels. 1/13/24 2:15 AM - A skilled evaluation progress note documented a DTI to the right heel with no exudate, odor, tunneling, and fragile periwound. 4/15/24 - A physician's order for a bilateral duplex study was completed. The results recommended a CT study for further evaluation. The results also revealed a positive note for stenosis in multiple arteries. A diagnosis of PVD (peripheral vascular disease) was added to R45's diagnosis list. The facility lacked evidence that a CT study for further evaluation was completed. 4/25/24 - A wound care evaluation documented R45's right heel with an unstageable pressure ulcer, dry black eschar, with tan moist slough along parameter, mod amount of foul smelling drainage, peri wound is healthy in appearance. Pt consented to debridement of eschar cap, 7mm x 7mm escar cap debrided with scapel down to granulated tissue with tan moist slough, no bleeding noted, no s/s of pain during procedure. Educated patient on wound assessment and of plan to continue dakins moist gauze covered by ABD pad and wrap with Kerlix BID and PRN as well as of importance of at least every two hour turn/repositioning, and of floating his heels when in bed. Patient verbalizes understanding, denies pain with wound assessment. 9/18/24 9:22 AM - An observation of R45 in bed and heels resting directly on the mattress. No pillow noted to float heels. 9/18/24 10:35 AM - An observation of R45 in bed and heels resting directly on the mattress. No pillow noted to float heels. 9/19/24 9:13 AM - An observation of R45 in bed and heels resting directly on mattress and pillow on side of mattress away from feet. 9/19/24 10:30 AM - An observation of R45 laying on back and heels resting directly on mattress. 9/19/24 11:16 AM - An observation of R45 in bed with heels resting directly on mattress. 9/19/24 11:26 AM - An interview with E22 (RN) revealed the purpose of floating heels is to prevent skin breakdown and the nurse on duty will verify every shift that the CNA is floating resident's heels while they are in bed. The CNA is expected to check and reposition at least every two hours. 9/20/24 9:24 AM - An observation of R45's heels laying directly on the mattress. A pillow was placed under legs improperly and the heels are not elevated. 9/20/24 10:36 AM - An observation of R45's heels laying directly on the mattress. A pillow was placed under legs improperly and the heels are not elevated. 9/20/24 2:09 PM - An interview with E23 (LPN WCN) revealed the expectation of floading heels is to prevent skin breakdown and/or keep current skin breakdown from worsening. E23 state that staff should be adjusting pillows for floating heels every two hours or sooner when to go to reposition. E23 confirmed that R45's pressure ulcers were in house acquired (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	9/24/24 9:48 AM - An interview with E24 (WC NP) confirmed she was working with R45 since April 2024. R45 was sent to wound care and no wound care surgeon would take his case. E24 confirmed she debrided wound to right heel and that R45 was educated on positioning and floating heels. E24 confirmed that staff was educated on how to use the float devices. E24 stated the expectation for any resident with wounds should be turned and repositioned every two hours, will not wear shoes, and should maintain no pressure from bed. E24 stated that R45's wound reopened this past week and stated lack of floating heels was very likely why the wound reopened. E24 stated any area that has a wound will be weakened and have greater risk to reopen and import to alleviate pressure especially to those areas. 9/24/24 2:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate 1) at 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 Based on interview and record review it was determined that for three (R20, R38 and R45) out of three residents reviewed for bowel and bladder, the facility failed to respond to or provide services to maintain or restore bladder continence. Findings include: A policy revised on 6/15/22 titled Continence Management documented continence status will be reviewed quarterly as part of the care planning process to provide appropriate treatment and services for patients with urinary incontinence to restore continence to the extent possible. 1. Review of R20's clinical record revealed: 5/12/22 - R20 was admitted to the facility. 5/5/24 - The Annual MDS assessment documented that R20 was dependent for toileting hygiene and not on a toileting program. The MDS also documented that R20 was frequently incontinent of bowel and bladder. 5/2024 - The CNA task sheet documented that R20 was incontinent of urine seventy-three out of eighty-five opportunities. 6/2024 - The CNA task sheet documented that R20 was incontinent of urine seventy-eight out of eighty-four opportunities. 6/12/24 - A skilled evaluation progress note documented that R20 was incontinent of urine. Resident uses adult briefs. New onset incontinence: No. Resident is frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding). 7/2024 - The CNA task sheet documented that R20 was incontinent of urine eighty-six out of eighty-six opportunities. 8/2024 - The CNA task sheet documented that R20 was incontinent of urine seventy-seven out of eighty opportunities. 8/5/24 - The quarterly MDS assessment documented that R20 was dependent for toileting hygiene and not on a toileting program. The MDS also revealed that R20 was always incontinent of bladder and frequently incontinent of bowel. 9/20/24 10:45 AM - An interview with E7 (CNA) confirmed that R20 is dependent for care and was not on a toileting program. E7 states that R20 does not use a bed pain and is not offered one. 9/20/24 11:30 AM - An interview with E19 (UM) confirmed that the residents bowel and bladder are assessed upon admission and then quarterly thereafter. E19 confirmed that nurses can intiate a toileting program if they notice a change or decline during the quarterly assessments. E19 confirmed that R20 is not currently 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	The facility lacked evidence of responding to decreased continence and failed to provide evidence of services to restore continence for R20. The facility lacked evidence of a quarterly bowel and bladder assessment for R20. 2. Review of R38's clinical record revealed: 5/10/23 - R38 was admitted to the facility. 9/29/23 - The significant change MDS documented that R38 required extensive two person assist for toileting and hygiene care. R38 was frequently incontinent of urine and always incontinent of bowel. R38 was not on a toileting program. 10/2023 - The CNA task sheet documented that R38 was incontinent of urine fifty-four out of seventy-three opportunities. 11/2023 - The CNA task sheet documented that R38 was incontinent of urine fifty-seven out of eighty-three opportunities. 12/2023 - The CNA task sheet documented that R38 was incontinent of urine seventy-seven out of eighty-nine opportunities. 12/30/23 - The quarterly MDS documented that R38 was dependent for toileting and hygiene care. R38 was always incontinent of bowel and bladder and not on a toileting plan. 9/16/24 10:49 AM - An interview with R38 confirmed that she used to use a bed pan but has not been using one due to the facility not having a small enough one for her. 9/20/24 11:15 AM - An interview with E20 (CNA) confirmed that R38 is dependent for toileting and hygiene care. E20 also confirmed that R38 did not use a bed pan and was not on a toileting program. 9/20/24 11:30 AM - An interview with E19 (UM) confirmed that R38 was not on a toileting program. The facility lacked evidence of responding to decreased continence and failed to provide evidence of services to restore continence for R38. The facility lacked evidence of a quarterly bowel and bladder assessment for R38. 3. Review of R45's clinical record revealed: 7/13/19 - R45 was admitted to the facility. 11/10/23 - The quarterly MDS assessment documented that R45 was dependent for toileting and hygiene care. R45 was frequently incontient of bowel and bladder, and not on a toileting program. 11/2023 - The CNA task sheet documented that R45 was incontinent of urine fifty-two out of eighty opportunities. 12/2023 - The CNA task sheet documented that R45 was incontinent of urine seventy-two out of eighty-five opportunities. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/2024 - The CNA task sheet documented that R45 was incontinent of urine eighty-nine out of eighty-nine opportunities. 1/11/24 - The quarterly MDS assessment documented that R45 was dependent for toileting and hygiene care. R45 was always incontient of bowel and bladder and not on a toileting program. 9/20/24 11:15 AM - An interview with E20 (CNA) confirmed that R45 is dependent for care and is currently not on a toileting program. E20 states that R45 does not use a bed pain and is not offered one. 9/20/24 11:30 AM - An interview with E19 (UM) confirmed that R45 was not on a toileting program. The facility lacked evidence of responding to decreased continence and failed to provide evidence of services to restore continence for R45. The facility lacked evidence of a quarterly bowel and bladder assessment for R45. 9/24/24 2:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate 1) at the exit conference.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 47114 Based on observation, interview, and record review, it has been determined that for one (R66) out of two residents sampled for respiratory care the facility failed to provide professional standards of practice by ensuring R66's nebulizer equipment was stored in a protective plastic bag. Findings include: Cross refer F657 Review of R66's clinical record revealed: 5/24/23 - R66 was admitted to the facility with diagnoses including, but not limited to, chronic obstructive pulmonary disease (lung disease that blocks air flow and makes it difficult to breathe) and stroke. 12/5/23 2:00 PM - A physician's order written for R66 documented . Albuterol Sulfate Nebulization Solution (2.5 MG/3ML) 0.083% 3 ml inhale as needed for Shortness of Breath Pre-treatment evaluation in supplemental documentation. In progress note document response to instructions and education and any adverse reactions. Notify the provider of any adverse reactions. 8/30/24 - A quarterly MDS (Minimum Data Set) assessment revealed R66 was severely cognitively impaired. 9/16/24 10:09 AM - R66's nebulizer tubing and mask were observed laying on his nightstand table and not placed in a protective plastic bag. 9/17/24 10:00 AM - R66's nebulizer tubing and mask were observed laying on his nightstand table and not placed in a protective plastic bag. 9/18/24 10:41 AM - During an observation and interview, E15 (LPN) stated, No [R66's] nebulizer equipment is not enclosed in a protective plastic bag. It should be but it's not. 9/18/24 10:54 AM - Findings were confirmed with E2 (DON). 9/24/24 2:00 PM - Findings were reviewed with E1 (NHA), E2 and E3 (Corporate 1) at the exit conference.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 40260 Based on record review and interview, it was determined that for five (E7, E8, E9, E10 and E11) out of five certified nursing assistants reviewed, the facility failed to complete an annual evaluation. Findings include: 9/23/24 approximately 8:50 AM - E1 (NHA) provided documentation regarding CNA evaluations for the following employees: E7 (CNA) with a date of hire of 12/6/22; E8 (CNA) with a date of hire of 5/24/22; E9 (CNA) with a date of hire of 11/20/17; E10 (CNA) with a date of hire of 10/14/19; E11 (CNA) with a date of hire of 3/7/23; 9/23/24 11:59 AM - In an interview, E1 stated that there had been a system failure due to turnover with facility staff. The facility was in the process of completing the overdue performance evaluations at the time of the survey. 9/24/24 2:00 PM - Findings were reviewed with E1, E2 (DON) and E3 (Corporate 1) at the exit conference.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 40260 Based on interview and record review, it was determined that for two (R22 and R57) out of five residents reviewed for unnecessary medications, it was determined that psychoactive medications lacked monitoring. For R22, the facility failed to ensure adequate monitoring with an AIMS assessment. Additonally, the facility failed to monitor R57, a resident taking antipsychotic medication, for symptoms of psychosis. Findings include: A policy and procedure titled Behaviors: Management of Symptoms revised 7/1/24 documented . Patients exhibiting behavioral symptoms will be individually evaluated to determine the behavior. The interdisciplinary team identifies underlying medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes that contribute to the patient's behavior. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. 4/10/14 - R22 was admitted to the facility. 8/2023 - R22's MAR reflected that he was ordered Zyprexa (olanzapine) tablet 10 MG Give 0.5 tablet by mouth one time a day. 8/26/23 - An AIMS assessment was conducted. 2/2024 - R22's MAR reflected that he was ordered Zyprexa (olanzapine) tablet 10 MG Give 0.5 tablet by mouth one time a day. 8/2024 - R22's MAR reflected that he was ordered olanzapine Tablet 5 MG Give 2 tablets one time a day. 8/18/24 - An AIMS assessment was conducted. The facility lacked evidence that an AIMS assessment was conducted in February 2024. 9/20/24 approximately 9:50 AM - In an interview, the Surveyor requested a copy of the AIMS assessment that would have occurred between 8/23 and 8/24. E16 (Corporate 2) stated she would check R22's record. E16 stated that this assessment should be done by nursing and should auto-populate into the charting system. 9/20/24 10:21 AM - In an interview, E16 stated she would check R22's chart again and acknowledged that R22 had been hospitalized in February, 2024. E16 again stated that the AIMS assessment should auto-populate. E16 confirmed R22 would have been due for an AIMS in February, 2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/19/24 1:46 PM - In an interview, E17 (NP) stated she was not sure which provider would enter an order for an AIMS assessment, but acknowledged it should be done every 6 months. E17 was not sure why an AIMS assessment was not conducted for R22 between 8/23 and 8/24. E17 stated she would speak with E18 (Medical Director) about who should enter the order. 9/24/24 10:01 AM - In an interview, E1 (NHA) and E3 (Corporate 1) confirmed that an AIMS assessment was not completed for R22 between 8/23 and 8/24. 47114 2. R57's clinical record revealed: 12/1/23 - R57 was admitted to the facility. 1/13/24 - A physician's order for R57 documented . Is resident free from side effects of psychotherapeutic medications? (If no, document side effects in PN (Progress Note) every shift. 5/11/24 - A physician's order for R57 documented . Quetiapine Fumarate Oral Tablet 25mg give one tablet by mouth one time a day for Psychosis. 9/23/24 1:54 PM - During an interview with E15 (LPN), the surveyor asked if (R57) was monitored for symptoms of psychosis. E15 stated, Normally it's linked with the medication in the order. E15 reviewed R57's order for quetiapine 25mg and stated, I don't see anything listed, to monitor for symptoms. There is an order to monitor for side effects on the MAR but not adverse effects. 9/23/24 3:03 PM - E3 (Corporate 1) stated, There is no documentation of monitoring for symptoms of psychosis for [R57]. 9/24/24 11:40 AM- Findings were reviewed with E1 (NHA). 9/24/24 2:00 PM - Findings were reviewed with E1, E2 (DON) and E3 (Corporate 1) at the exit conference.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38302 Based on observation and interview it was determined that the facility failed to ensure food was stored, prepared, and served in a manner that prevents food borne illness to the residents. Findings include: 9/16/24 - 9:15 AM - During the initial tour of the kitchen, an open plactic bag containing lettuce and celery with browned edges and negative changes in quality and texture was observed in the walk-in refrigerator. 9/17/24 - 8:50 AM - During a tour of the kitchen, a puddle of standing water was observed under the ice machine and the water line that supplies the ice machine. 9/17/24 - 9:25 AM - During a tour of the kitchen, the surveyor observed E13 (Dietary Services Manager) test the sanitizer level of the solution in two red sanitizing buckets. When E13 tested the sanitizing solution, the test strips from each of the buckets indicated that the level of chemical concentration in the buckets was not at a sufficient level to provide proper sanitization. 9/24/24 2:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate 1) at the exit conference.