STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Rehabilitation & Health Center	3034 South Dupont Blvd Smyrna, DE 19977

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46988 Based on observation, interview and record review, it was determined that the facility failed to promote R18's dignity by keeping R18's urinary collection bag in a privacy bag. Findings include: Review of R18's clinical record revealed: 12/13/20 - R18 was admitted to the facility. 3/26/24 - A significant change MDS indicated R18 has an indwelling urinary catheter. 5/9/24 10:06 AM - An observation of R18 sitting by the nurses station and the urine collection bag was uncovered. 5/10/24 1:16 PM - An observation of R18 sitting by the nurses station and the urine collection bag was uncovered. 5/13/24 9:09 AM - An observation of R18 sitting by the nurses station and the urine collection bag was uncovered. 5/14/24 2:13 PM - An interview with E36 (CNA) confirmed R18's urinary collection bag was covered at this time and confirmed the privacy bag was put in place today. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46988 Based on observations, interviews and record review, it was determined that for one (R65) out of one sampled resident reviewed for choices and preferences, the facility failed to accommodate R65's preference for showers. Findings include: Review of R65's clinical record revealed: 6/2/20 - R65 was admitted to the facility. 11/30/23 - A significant change MDS assessment revealed that R65 was dependent for transfers and showering and also revealed it was very important for R65 to be able to chose a bath or a shower. 5/9/24 11:33 AM - An interview with R65 revealed that R65 has not had a shower or washed her hair since September 2023. R65 stated that staff told her the bariatric shower bed was broken and she was unable to shower. A review of CNA documentation from August 2023, September 2023, October 2023, November 2023, December 2023, January 2024, February 2024, March 2024, April 2024, and May 2024 revealed that R65 has been only receiving bed baths from staff. 5/14/24 10:57 AM - An interview with E19 (RN) revealed that she was unaware of R65's preference for showers and could not confirm if one of the shower beds was bariatric. 5/15/24 9:27 AM - An interview with R65 and E19 confirmed that E65 will receive a shower during this shift and the new schedule for showers is Wednesday and Saturday. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 46988 Based on interview and record review, it was determined that for three (R18, R65 and R116) out of six residents reviewed for Advance Directives, the facility failed to offer an opportunity to formulate an advance directive. Findings include: 1. Review of R18's clinical record revealed: 12/13/20 - R18 was admitted to the facility. 3/26/24 - A significant change MDS revealed R18 was cognitively intact with a BIMs score of 15. 5/9/24 10:06 AM - An interview with R18 confirmed the facility did not offer to assist in formulating an advanced directive for him upon admission. 5/13/24 - A review of the electronic medical records lacked evidence that R18 had an advanced directive on file. 5/14/24 11:47 AM - An interview with E1 (NHA) confirmed that R18 did not have an advanced directive and was not previously offered to formulate one upon admission. 2. Review of R65's clinical record revealed: 6/2/20 - R65 was admitted to the facility. 2/29/24 - A quarterly MDS revealed that R65 was cognitively intact with a BIMs score of 15. 5/9/24 10:42 AM - An interview with R65 confirmed the facility did not offer to assist in formulating an advanced directive for him upon admission. 5/9/24 11:18 AM - A review of the electronic medical records lacked evidence that R65 had an advanced directive on file. 5/14/24 11:47 AM - An interview with E1 (NHA) confirmed that R65 did not have an advanced directive and was not previously offered to formulate one upon admission. 3. Review of R116's clinical record revealed: 2/1/23 - R116 was admitted to the facility. 1/30/24 - A review of an annual MDS revealed that R116 was cognitively intact and had a BIMs score of 15. 5/9/24 11:28 AM - An interview with R116 confirmed the facility did not offer to formulate an advanced directive for him upon admission. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/9/24 11:58 AM - A review of the electronic medical records lacked evidence that R116 had an advanced directive on file. 5/14/24 11:47 AM - An interview with E1 (NHA) confirmed that R116 did not have an advanced directive and was not previously offered the opportunity to formulate one upon admission. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 47621 Based on record review and interviews, it was determined that for one (R80) out of two reviewed for Personal Property, the facility failed to maintain evidence demonstrating the result of R80's grievance regarding her missing personal items. The facility grievance policy also lacked documentation a specific process for how the resident/family were informed of the results of the grievance investigation. Findings include: Resident and Family Grievance Policy .1. Director of Social Services has been designated as the Grievance Official . 4. Grievance may be voiced in the following forums: a. Verbal complaint to a staff member of Grievance Official . Review of the facility Resident and Family Grievance Policy revealed the policy lacked a documented, specific process for how the resident/ family were informed of the results of the grievance investigation. 1/14/24 - R80 was admitted to the facility with diagnoses, including but not limited to, end stage renal disease, diabetes and difficulty walking. 5/10/24 10:53 AM - During an interview, R80 stated that she (R80) was transferred to the hospital two times. She returned to a different room on both occasions, and her belongings were packed by the facility staff. R80 stated that she was missing several items clothing, a bag of correspondence (mail from Social Security, banking), all her toiletries and coloring books. R80 further stated that she informed Social Services, but she still has not recovered some of the items. 5/13/24 11:45 AM - During an interview, E14 (Social Work assistant) stated, When items are reported missing by a resident to Social Work, we tell the director of the department assigned to that missing item. We give them an hour or two to look for the item. If we find it, we give it back to the resident. If we don't find it, we ask the resident for receipts and then replace or pay for the item. We document the grievance in out computer grievance log. 5/13/24 1:25 PM - During an interview, E1 (NHA) confirmed that E7 (Director of Social Work) was the facility's Grievance Official. The surveyor reviewed the Grievance log and found no evidence of a grievance regarding R80's missing personal items, including her bag of correspondence. 5/13/24 3:09 PM - During an interview, E7 stated, The facility knew about the bag of correspondence and we looked for it. We told the daughter and the resident that we could not find the bag [of correspondence]. We called her previous roommate to see if she accidentally took the bag home when she was discharged . The roommate's family claimed they didn't have it .We did not document anything in our grievance log . [R80] did not tell us that she was still missing clothing. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/14/24 10:40 AM - During a telephone interview, F1 (R80's daughter) stated, When mom was admitted [to the facility] in January, I brought her new clothes, a bag of personal mail, which included her new social security card, coloring books, crayons, a fan, bed pads and some Depends briefs as well as toiletries and lotions. The fan had my name on it and Mom's room number. Mom was sent to the hospital on 1/20 until 2/9. They never called me to come get her stuff. It was put in storage. When my Mom came back, they couldn't find the stuff . Mom went out to the hospital again on 2/19 to 2/26, and her stuff was missing again. I looked in one of the storage rooms and I found her fan and bible. All her books have her name in them. I also found Mom's clothes under another resident's name. I got those clothes back for Mom. The facility was not able to provide evidence of R80's written grievance decision regarding her missing correspondence that included the date the grievance was received, a summary statement of the resident's grievance, steps taken to investigate the grievance, a summary of the pertinent findings, a statement of whether the grievance was confirmed or not confirmed, any corrective action taken as a result of the grievance and the date the written decision was issued. 5/16/24 2:45 PM - Findings were discussed with E1 (NHA) and E4 (Corporate Consultant).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 40260 Based on record review and interviews, it was determined for four (R2, R46, R98 and R106) out of thirty residents in the investigative sample, the facility failed to ensure the MDS was accurate. Findings include: 1. Review of R2's clinical record revealed: 7/26/23 - A dental report confirmed that R2 was edentulous (has no teeth). 11/9/23 - An annual MDS revealed that under No natural teeth or tooth fragment(s) (edentulous), the response was recorded as no. 11/30/23 - A dental report confirmed that R2 was edentulous. 2/8/24 - A quarterly MDS was completed and revealed that the above statement was not addressed. Section L for dental was not completed. 5/7/24 - A quarterly MDS was completed and revealed that the above statement was not addressed. Section L for dental was not completed. 5/13/24 8:56 AM - In an interview, R2 confirmed he has no teeth. 5/17/24 9:55 AM - In an interview with E37 (RNAC), it was confirmed that resident was edentulous, yet the MDS does not reflect this. E37 also confirmed that the quarterly assessment was inaccurate. 46988 2. Review of R46's clinical record revealed: 9/11/15 - R46 was admitted to the facility with diagnoses including but not limited to anxiety. 5/7/24 - An quarterly MDS revealed that R46 had no behavioral occurrences during the review period. 5/2024 - A review of the CNA behavior flow sheet revealed that R46 had verbal aggression from 5/1/24 to 5/7/24. 5/16/24 10:35 AM - An interview with E37 (RNAC) revealed that she is not responsible for the section documenting the behaviors in the MDS. 5/16/24 10:42 AM - Interview with E7 (SW) confirmed that social services is responsible for documenting the behavior section of the MDS. E7 confirmed that R46 had documented behaviors and the MDS was inaccurate. 3. Review of R98's clinical record revealed: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/24/23 - R98 was admitted to the facility. 4/25/24 - A quarterly MDS revealed that R98 had no behavioral occurrences during the review period. 4/2024 - 5/2024 - A review of the CNA behavior flow sheet revealed that R98 had verbal and physical aggression from 4/18/24 to 4/25/2024. 5/16/24 10:42 AM - Interview with E7 (SW) confirmed that social services is responsible for documenting behavior section of the MDS. E7 confirmed that R98 had documented behaviors and the MDS was inaccurate. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse). 40264 4. Cross Refer F690 Review of R106's clinical record revealed: 6/23/23 - R106 was admitted to the facility. 6/30/23 - An admission MDS assessment revealed that R106 was always continent of bladder and was not on a toileting program. 5/28/24 12:00 PM - A review of R106's hourly voiding diary from 6/24/23 through 6/30/23 revealed that R106 was found wet in 5 out of 238 opportunities. 5/28/24 12:55 PM - In an interview, E61 (Regional MDS Consultant) stated that R106's 7 day look back period was between 6/24/23-6/30/23. E61 further stated that during the look back period, R106 only had one incontinent episode and E61 thought it was an erroneous coding by the staff. E61 added, I went to the floor and interviewed the staff, they (CNAs) said [R106] was continent of bladder. I did not know there was a voiding diary so I did not see the rest of the CNA documentation where it showed [R106] had more than one incontinent episodes during the look back period. 5/28/24 1:00 PM - During an interview, E21 (Corporate Clinical Nurse) confirmed that R106's MDS admission assessment for bladder incontinence was coded inaccurately. 5/28/24 2:00 PM - Findings were discussed with E1 (NHA), E2 (DON) and E21 (Corporate Clinical Nurse).

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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. 40260 Based on interview and record review, it was determined that for four (R2, R28, R46 and R116) out of six residents reviewed for PASARR, the facility failed to ensure that a referral for a PASARR screening was completed. Findings include: 1. Review of R2's clinical record revealed: 12/1/21 - R2 was admitted to the facility. 8/4/22 - A review of R2's medical record revealed that R2 had a PASRR level 1 that indicated the following: The Level 1 screen indicates that a PASRR disability is not present because of the following reason: A neurocognitive disorder/dementia is primary and progressed . 6/21/23 - A diagnosis of major depressive disorder, recurrent, severe with psychotic symptoms was added to R2's diagnoses, yet there was no request for an updated PASRR since the one completed in 2022. 5/13/24 11:07 AM - S1 (PASRR State Authority) confirmed that a resident review PASRR should have been completed due to this new mental health diagnosis as it suggested a new primary mental illness. 5/14/24 approximately 11:50 AM - An interview, E7 (Social Services Director) and E14 (Social Work Assistant) confirmed that, per S1, an updated screening should have been completed for R2. 47621 2. Review of R28's clinical record revealed: 4/2/21 - R28 was admitted to the facility with diagnoses, including but not limited to, stroke affecting the right dominant side and aphasia (a language disorder). 4/2/21 - R28's Preadmission Screening and Resident Review (PASARR) stated, PASARR Level I Determination: No Level II Required - No SMI (significant mental illness)/ID (intellectual disability). Rationale: The Level I screen indicated that a PASARR disability is not present because of the following reason: There is no evidence of a PASARR condition of an intellectual/developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted. 4/13/23 - E6 (MD) completed and signed a Physician's Affidavit that stated, Based on tests and my examination of this patient [R28], it is my professional opinion that she does have a disability that significantly interferes with the ability to make responsible decisions regarding health care, food, clothing, shelter or finances. In my opinion, the patient [R28] does not have sufficient mental capacity to understand the nature of guardianship in order to consent to the appointment of a guardian. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/16/24 12:40 PM - During an interview, E6 confirmed that she completed the Physician's Affidavit that deemed R28 to have an intellectual disability. When asked about the term intellectual disability, E6 replied, It says it right on the paperwork (pointing to the Physician's Affidavit document that asked describe the disability) . I wrote aphasia due to stroke, poor cognition. When asked if E6 informed Social Services to request a new PASARR evaluation for a new diagnosis of intellectual disability, E6 replied, Twenty years working in long-term care, I don't even know what a PASARR is. 5/16/24 12:49 PM- During an interview when asked if R28 had a new PASARR evaluation after being deemed to have an intellectual disability, E7 (Social Services Director) stated, No, I wasn't told that there was a new diagnosis that warranted an updated PASARR evaluation. 5/16/24 2:45 PM - Findings were discussed with E1 (NHA) and E4 (Corporate consultant). 46988 3. Review of R46's clinical record revealed: 9/11/15 - R46 was admitted to the facility with diagnoses including but not limited to anxiety. 10/1/15 - A level I PASARR revealed that R46 does have a serious mental illness and individual needs can be met in a nursing facility. 6/19/20 - R46 was diagnosed with major depressive disorder recurrent, severe with psychotic symptoms. 2/8/23 - R46 was diagnosed with bipolar disorder and insomnia. 5/16/24 9:26 AM - A review of the progress notes for R46 revealed that the facility submitted an updated PASARR review for R46. 5/17/24 1:15 PM - An interview with E7 (SW) confirmed that an update was submitted to reflect the new diagnoses for R46. 4. Review of R116's clinical record revealed: 1/10/23 - A level I PASARR was submitted for R116 and confirmed no level II required. 2/1/23 - R116 was admitted to the facility. 1/30/24 - R116 was diagnosed with persistent mood (affective) disorder and mood disorder due to unknown physiological condition with mixed features. 5/14/24 10:07 AM - An interview with E7 (SW) confirmed the last PASARR requested for R116 was 1/10/23 prior to admission. E7 confirmed that no further updates have been submitted to the state PASARR authority. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 46988 Based on interview and record review, it was determined that for one (R47) out of six residents sampled for PASARR review, the facility failed to provide evidence that a Delaware State PASARR was obtained prior to admission. Findings include: Review of R47's clinical record revealed: 12/15/15 - R47 was admitted to the facility with diagnoses including but not limited to major depressive disorder. 9/19/16 - R47 was diagnosed with delusional disorder, anxiety disorder and mood disorder due to unknown physiological condition. 2023 - 2024 - A review of clinical records lacked evidence of a level I PASARR and a referral for update to the State PASARR authority. 5/17/24 1:15 PM- An interview with E7 (SW) confirmed that R47 was admitted without a PASARR level I or any PASARR review and will submit one today. E7 confirmed that she contacted the State PASARR authority and a level I was not on file. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44706 Based on record review and interview, it was determined that for two (R40 and R106) out of three residents reviewed for bowel and bladder, the facility failed to develop a person centered care plan to address incontinence. Findings include: 1. Review of R40's clinical record revealed: 1/23/20 - R40 was admitted to the facility. 2/6/24 - An admission assessment documented R40 was cognitively intact , always incontinent of bowel, bladder was not rated, and no toileting plan initiated. 4/30/24 - A quarterly MDS documented R40 was cognitively intact, always incontinent of bowel and bladder, and no toileting plan in place. 5/10/24 - Review of R40's care plan revealed a lack of evidence that a person centered care plan with interventions was developed to address R40's incontinence. 5/13/24 9:23 AM - During an interview, E39 (LPN) confirmed that R40 is incontinent of bowel and bladder she calls for help when she needs to be changed. 5/13/24 approximately 11:30 AM - During an interview E48 (RN/UM) confirmed R40's care plan lacked evidence that a person centered care plan was developed to include incontinence care. 40264 Cross Refer F690 2. Review of R106's clinical record review: 6/23/23 - R106 was admitted to the facility. 6/30/23 - An admission MDS assessment revealed that R106 was cognitively impaired, was always continent of bladder and was not on a toileting program. 9/28/23 - A quarterly MDS assessment revealed that R106 was cognitively impaired, occasionally incontinent of bladder and was not on a toileting program. 12/26/23 - A quarterly MDS assessment revealed that R106 was cognitively impaired, was always incontinent of bladder and was not on a toileting program. 3/26/24 - A quarterly MDS assessment revealed that R106 was cognitively impaired, was always incontinent of bladder and was not on a toileting program. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/28/24 8:30 AM - A review of R106's care plan revealed a lack of evidence that a person centered care plan with interventions was developed to address R106's bladder incontinence. 5/28/24 11:10 AM - During an interview, E35 (LPN Sup) confirmed that R106 did not have a bladder incontinence care plan with interventions. 5/28/24 2:00 PM - Findings were discussed with E1 (NHA), E2 (DON) and E21 (Corporate Clinical Nurse).

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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 five (R2, R32, R55, R88 and R120) out of five sampled residents for care plan timing and revision, the facility failed to have input from all required interdisciplinary team (IDT) members at the residents' care plan meetings. Findings include: The facility policy entitled Comprehensive Care Plans, last reviewed 4/24, indicated 4. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: a. The attending physician or non-physician practitioner designee involved in the resident's care, if the physician is unable to participate in the development of the care plan. b. A registered nurse with responsibility for the resident. c. A nurse aide with responsibility for the resident. d. A member of the food and nutrition services staff. e. The resident and the resident's representative, to the extent practicable. f. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to: i. The RAI Coordinator. ii. Activities Director/Staff. iii. Social Services Director/Social Worker. iv. Licensed therapists Review of R2's clinical record revealed: 12/1/21 - R2 was admitted to the facility. 5/14/24 - A review of the quarterly care plan meeting for 5/25/23 lacked evidence of input from the Physician. A review of the quarterly care plan meetings for 8/17/23, 11/9/23 and 2/15/24 lacked evidence of input from the Physician and certified nursing assistant. 2. Review of R32's clinical record revealed: 5/19/16 - R32 was admitted to the facility. 5/14/24 - A review of the quarterly care plan meeting for 4/27/23 lacked evidence of input from the Physician. A review of the quarterly care plan meeting notes for 7/27/23 and 1/4/24 lacked evidence of input the full interdisciplinary team as sign in sheets were not received. A review of the quarterly care plan meeting for 4/18/24 lacked evidence of input from the Physician and certified nursing assistant. Additionally, the facility lacked evidence that R32 had a quarterly care plan meeting in October, 2023. 3. Review of R55's clinical record revealed: 10/27/16 - R55 was admitted to the facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/14/24 - The facility lacked evidence of that R55 had a quarterly care plan meeting between 7/27/23 through 1/24/24. A review of the quarterly care plan meeting for 1/25/24 lacked evidence of input from the Physician, certified nursing assistant and a member of the food and nutrition services staff. A review of the quarterly care plan meeting for 4/18/24 lacked evidence of input from the Physician and certified nursing assistant. 4. Review of R88's clinical record revealed: 2/14/22 - R88 was admitted to the facility. 5/14/24 - A review of the quarterly care plan meeting for 11/9/23 lacked evidence of input from the Physician, certified nursing assistant and Social Worker. A review of the quarterly care plan meetings for 1/25/24 and 4/18/24 lacked evidence of input from the Physician and certified nursing assistant. 5. Review of R120's clinical record revealed: 7/21/23 - R120 was admitted to the facility. 5/14/24 - A review of the quarterly care plan meeting for 11/2/23 lacked evidence of input from the Physician and certified nursing assistant. Review of the quarterly care plan meetings for 1/25/24 and 4/11/24 lacked evidence of input from the Physician, certified nursing assistant and a member of the food and nutrition services staff. 5/14/24 approximately 11:50 AM - In an interview, E7 (Social Services Director) and E14 (Social Work Assistant) confirmed that they were unaware of all mandatory IDT members that need to provide input at resident care plan meetings. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 47621 Based on record review and interviews, it was determined that for one (R3) out of four residents reviewed for Medication Administration, the facility failed to ensure that R3's care met accepted, professional standards. The nurses documented signing out multiple medications as being administered via the oral route when in fact, the medications were being given via the enteral route due to R3 being NPO. Findings include: Nursing Rights of Medication Administration . It is the standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the five rights or five R's of medication administration .The traditional five rights in traditional sequence include: right drug, right patient, right dose, right route, and right time. National Library of Medicine, September 4, 2023. Review of R3's clinical record revealed: 7/5/18 - R3 was admitted to the facility with diagnoses, including but not limited to, multiple sclerosis. 2/14/24 - R3 was admitted to the hospital for an altered mental status. 3/1/24 - While hospitalized , R3 underwent placement of a percutaneous endoscopic gastrostomy tube (PEG- a feeding tube) for the diagnoses malnutrition/ failure to thrive. 3/7/24 - R3 was readmitted to the facility. 3/7/24 10:26 PM - E15 (RN Nursing supervisor) entered orders for acetaminophen, atorvastatin, bisacodyl, cholecalciferol, clopidogrel, cyanocobalamin, labetolol, losartan, Maalox, metformin, milk of magnesium, pantoprozole, polyethylene glycol and senna. All fourteen medications were ordered to be administered by mouth. 3/10/24- E11(Dietitian) documented in R3's EMR an order, NPO (a medical term that means nothing by mouth). 3/12/24 - E16 (Speech therapist) performed a Cognitive Impairment SLP (Speech Language Pathologist) Screen with R3 and documented R3 as Strictly NPO. 5/14/24 8:25 AM - The surveyor attempted to observe R3's 8:00 AM medication pass. E18 (LPN) stated that she had already given her AM medications via R3's PEG tube. E18 confirmed that R3's 5/14/24 AM medications were in fact given via the enteral [PEG tube] route. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/15/24 9:15 AM - During the observation of R3's 8:00 AM medication pass, E6 (MD) was called for clarification of the medication administration route, and it was changed from by mouth to via PEG Tube. E18 stated that since R3's admission on 3/7/24, the nursing staff, including herself, had been administering R3's medications via the enteral [PEG-Tube] route but were signing the medications out on R3's Medication Administration Record (MAR) under the order that stated by mouth. The facility failed to ensure that the services provided by the nursing staff met the professional standards of quality with regards to the Five Rights of Medication Administration. 5/16/24 2:45 PM - Findings were discussed with E1 (NHA) and E4 (Corporate consultant).

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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. 46988 Based on observation and interviews, it was determined that for four (R18, R54, R65, and R79) out of six residents reviewed for ADLs, the facility failed to ensure ADLs were provided to dependent residents. Findings include: 1. Review of R18's clinical record revealed: 12/13/20 - R18 was admitted to the facility. 3/26/24 - A significant change MDS revealed that R18 was dependent for toileting hygiene which includes perineal hygiene and using the toilet, commode or urinal. R18 was also dependent for chair to bed to chair transfer. R18 has a BIMS score of 15 and is alert and oriented. 5/9/24 10:56 AM - An interview with R18 revealed that he has been up in his chair since 6:00 AM and requested for his CNA to change him. R18 stated, She told me I have to wait until after lunch to be changed. 5/9/24 12:56 PM - An observation of R18 following the CNA to his room to receive care. 5/9/24 - A review of the CNA documentation flow sheet revealed that E43 (CNA) only provided perineal hygiene once during the shift. 5/9/24 1:34 PM - A review of the CNA Kardex revealed that R18 was incontinent of urine and dependent for perineal care. 5/16/24 9:02 AM - An observation of R18 sitting in his wheelchair at the nurses station. 5/16/24 12:02 PM - An observation and interview with R18 revealed he was still sitting at the nurses station and stated he had not been changed this shift. 5/16/24 1:50 PM - An interview with E44 (CNA) confirmed that R18 only gets checked once a shift and provided continence care due to being a Hoyer lift transfer. E44 confirmed that R18 went back to bed at 2 PM and then provided care. 5/16/24 2:04 PM - An interview with E43 (CNA) confirmed that R18 remained in his chair until after lunch on 5/9/24 and continence care was provided once. 2. Review of R54's clinical record revealed: 7/7/23 - R54 was admitted to the facility. 7/13/23 - An admission MDS revealed that R54 was dependent for toileting hygiene which includes perineal hygiene and using the toilet, commode or urinal. R54 was also dependent for transfers in and out of bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/6/23 - A facility grievance form revealed that R54 reported that staff left her in the geri-chair from 11:00 AM to 9:00 PM on 9/5/23. The grievance form stated that R54's brief and clothing were wet and R54 was crying. R54 asked to go back to bed and was told by staff that they were short handed and she would have to wait. 5/16/24 11:30 AM - An interview with E45 (former DON) revealed that R54 was left up in her chair for several hours when the facility started the investigation. E45 stated she cannot recall all the details from the date but remembers investigating. E45 stated that R54 is alert and oriented and the grievance report was accurate. 3. Review of R65's clinical record revealed: 6/2/20 - R65 was admitted to the facility. 2/29/24 - A quarterly MDS assessment revealed that R65 was dependent for transfers and showering. 5/9/24 11:33 AM - An interview with R65 revealed that R65 has not had a shower or washed her hair since September 2023. R65 stated that staff told her the bariatric shower bed was broken and she was unable to shower. A review of CNA documentation from August 2023, September 2023, October 2023, November 2023, December 2023, January 2024, February 2024, March 2024, April 2024, and May 2024 revealed that R65 has only received bed baths from staff and lacked evidence of hair being washed. 5/14/24 10:53 AM - An interview with E24 (CNA) revealed that R65 has been receiving bed baths and hair usually does not get washed during a bed bath. 4. Review of R79's clinical record revealed: 1/2/20 - R79 was admitted to the facility. 2/27/24 - A quarterly MDS revealed that R79 requires substantial/maximal assist with showering. 5/9/24 9:45 AM - An interview with R79 revealed that he needs staff member assist with nail care. An observation of R79 revealed multiple long, overgrown nails on right hand. 5/10/24 2:06 PM - An observation of R79 with multiple, long overgrown nails on right hand. 5/13/24 9:10 AM - An observation of R79 in the shower with the door closed and no staff assistance noted during the time of observation. 5/13/24 10:00 AM - An observation of R79 after shower with multiple, long overgrown nails on right hand. 5/14/24 10:45 AM - An interview with E47 (CNA) revealed on shower day the staff is expected to provide all care including oral care, shaving, nail care, and peri care. E47 confirmed that signing off the shower tasks confirms all tasks involved were completed. E47 confirmed that R79 has not received nail care and had multiple long, overgrown nails on the right hand. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 40260 Based on record review, interview, and review of other facility documentation, it was determined that for three (R294, R106 and R397) out of three sampled residents reviewed for quality of care, the facility failed to ensure that each resident received treatment and care in accordance with professional standards of practice. For R294, the facility failed to provide orders or provision of care for this resident's surgical wound. 1. 10/11/23 - Interagency Discharge Orders revealed that wound care instructions were given for the resident's surgical wound to the left forearm. These instructions also stated that the patient underwent C2-T1 fusion and C2-C7 laminectomy for cervical cord compression. Please follow up with (the doctor) in 2 weeks. 10/11/23 - Resident admitted to facility status post C2-T1 fusion and C2-C7 laminectomy (surgical procedure to the neck). 10/13/23 (Sunday) - A nursing note revealed: There are 7 sutures intact to left forearm. Pt (patient) is wearing cervical neck collar due to post op spinal surgery. Pt requested to wait until Monday to remove the neck stabilizer for skin assessment. The facility lacked evidence of the neck wound. 10/14/23 - A nursing note revealed: Has wounds present: left lower leg Treatment to wound performed on shift as ordered. Scant amt (amount) of drainage. Serous drainage (thin, watery, clear) noted from wound. Turned & repositioned frequently. Offloading of affected area. Skin treatments performed as ordered. The facility lacked evidence of the neck wound. 10/14/23 - Wound care order, as follows: Treatment to LLE (left lower extremity) clean with NSS (normal saline solution), pat dry, apply xeroform then apply ABD (abdominal gauze pad) and cover with Kerlix (gauze bandage roll) every day shift. There was no evidence of treatment ordered for the cervical wound. The facility lacked evidence of the neck wound. 10/14/23 - A nursing note revealed: Resident medicated with oxycodone 5 mg IR as ordered for c/o pronounced Neck, Left, shoulder, and Left arm pain subjectively rated 10/10 by resident .Visual assessment of skin revealed no new areas of concern. Dressing to LLE (left lower extremity) wound changed. The facility lacked evidence of the neck wound. 10/16/23 - A nursing note revealed: Neck brace remains in place. Stitches to left forearm remain intact. The facility lacked evidence of the neck wound. 10/16/23 - A nursing note revealed: s/s of pain: neck Pain medication given .Neck brace remains in place. Stitches to left forearm remain intact (late entry). There is no evidence that the cervical collar was removed to inspect the cervical wound. The facility lacked evidence of the neck wound. 10/17/24 - Note by E7 (Director of Social Work) revealed: (Resident) was able to complete her BIMS assessments she scored 15/15 which indicates she is cognitively intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/17/23 - A nursing note revealed: Skin is warm & dry. Has wounds present: left lower leg Dressing to wound remains clean, dry, and intact. There is no evidence that the cervical collar was removed to inspect the cervical wound. The facility lacked evidence of the neck wound. 10/18/23 - A nursing note revealed: Skin is warm & dry. Has wounds present: left lower leg Dressing to wound remains clean, dry, and intact Skin treatments performed as ordered. There is no evidence that the cervical collar was removed to inspect the cervical wound. The facility lacked evidence of the neck wound. 10/19/23 - An NP note revealed: Wound # 4 Mid upper back Surgical Treatment Recommendations: 1. None. 2. Per Surgeon's request, monitor daily for s/s of infection. 3. Secure with bordered gauze. 4. Change daily. PREVENTATIVE MEASURES: The patient has a surgical wound. There is no evidence of infection noted today upon assessment. If complications arise, staff understands to contact operating surgeon. Keep all surgical follow-up appointments. 10/19/23 - A nursing note revealed: Skin is warm & dry. Has wounds present: LLE Dressing to wound remains clean, dry, and intact. Displays s/s (signs/symptoms) of pain: neck pain level 10 - 10/19/2023 2:48 PM Pain scale: Numerical Pain medication given. Patient resting in bed at start of shift. 10/10 neck pain reported, unchanged with pain medication. No distress noted. Patient picked up for dialysis this am and has not returned yet. There is no evidence that the cervical collar was removed to inspect the cervical wound even with complaints of neck pain. 10/20/23 - A nursing note revealed: Skin is warm & dry. Has wounds present: left lower leg. Dressing to wound remains clean, dry, and intact. s/s of pain: neck pain level 10 - 10/21/2023 1:18 PM Pain scale: Numerical Pain medication given. Pain remains unchanged. There is no evidence that the cervical collar was removed to inspect the cervical wound even with complaints of neck pain. 10/21/23 - A nursing note revealed: Skin is warm & dry. Has wounds present: LLE Dressing to wound remains clean, dry, and intact. Displays s/s of pain: neck pain level 10. There is no evidence that the cervical collar was removed to inspect the cervical wound even with complaints of neck pain. 10/22/23 - A nursing note revealed: Skin is warm & dry. Has wounds present: LLE Dressing to wound remains clean, dry, and intact. Displays s/s of pain: neck pain level 10. There is no evidence that the cervical collar was removed to inspect the cervical wound even with complaints of neck pain. 10/23/23 - A nursing note revealed: Skin is warm & dry. Has wounds present: left lower leg Dressing to wound remains clean, dry, and intact. There is no evidence that the cervical collar was removed to inspect the cervical wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/24/23 - An NP note revealed: Patient was unable to be evaluated by the skin and wound team today; patient was not in facility at the time of visit. Of note, the patient is currently in isolation for active Covid infection, which is likely impeding wound healing. 10/25/23 - A nursing note revealed: Has wounds present: LLE Treatment to wound performed on shift as ordered. Scant amt of drainage. Serosanguinous drainage (thin, red tinged) noted from wound. Peri-wound skin is intact. neck pain level 10 - 10/25/2023 4:18 PM Pain scale: Numerical Pain medication given. Pain remains unchanged. There is no evidence that the cervical collar was removed to inspect the cervical wound even with complaints of neck pain. 10/26/23 - A nursing note revealed: Has wounds present: LLE Treatment to wound performed on shift as ordered. Scant amt of drainage. Serosanguinous drainage (thin, red tinged) noted from wound. s/s of pain: neck pain level 10 - 10/26/2023 2:27 PM Pain scale: Numerical Pain medication given. Pain remains unchanged. There is no evidence that the cervical collar was removed to inspect the cervical wound. 10/27/24 - A nursing note revealed: Patient had offsite appointment today (10/27/23 @1245) at (the hospital) for surgical follow up. Patient was to be taken by facility transport staff, but patient states that she is not feeling well and is refusing to go out for appointment. Unit manager made aware. 10/27/23 - A nursing note revealed: Has wounds present: LLE Treatment to wound performed on shift as ordered. Scant amt of drainage. Serosanguinous drainage (thin, red tinged) noted from wound. Peri-wound skin is intact. Displays s/s of pain: Neck pain level 10 - 10/27/2023 7:28 PM Pain scale: Numerical Pain medication given. Pain remains unchanged. There is no evidence that the cervical collar was removed to inspect the cervical wound. 10/28/23 - A nursing note revealed the following: Late entry . neck brace removed and surgical site to posterior neck assessed with no s/s infection/drainage noted, sutures intact 10/28/23 - A nursing note revealed: Skin is warm & dry. Has wounds present: left lower leg Treatment to wound performed on shift as ordered. No drainage noted. There is no evidence that the cervical collar was removed to inspect the cervical wound. 10/29/23 - A nursing note revealed: skin is warm & dry. Has wounds present: LLE dressing to wound remains clean, dry, and intact. There is no evidence that the cervical collar was removed to inspect the cervical wound. 10/31/23 - A nursing note revealed: s/s of pain: neck pain level 10 - 10/31/2023 3:57 PM Pain scale: Numerical Pain medication given. Pain remains unchanged. Has wounds present: LLE Treatment to wound performed on shift as ordered with no mention made of evaluation of cervical area. The facility lacked evidence that assessment, signs/symptoms of infection and ongoing monitoring of R294's cervical surgical wound. The MAR/TAR for October 2023 lacked evidence that wound care was ordered for R294's cervical wound. Review of R294's records revealed that she was assessed eighteen times for the LLE wound and only once for the cervical wound from 10/11/23 through 10/31/23. Additionally, the records document that the cervical collar was only removed once by nursing staff in the 21 days that R294 was in the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/1/23 6:18 AM - A wound care note written by E40 (NP) revealed the following: Wound: 4: Location: Mid upper back; Primary Etiology: Surgical dehiscence; Wound Status: Reopened; Odor Post Cleansing: None; Stage/Severity: Full Thickness; Size: 15 cm x 8 cm x 8 cm. Calculated area is 120 sq cm. Wound Edges: Unattached. Periwound: Intact; Exposed Tissues: Bone. Exudate: Heavy amount of Sanguineous. Wound # 4 Mid upper back Surgical dehiscence. Treatment Recommendations: 1. immediate referral to ER (emergency room). PREVENTATIVE MEASURES: The patient has a surgical wound. There is no evidence of infection noted today upon assessment. If complications arise, staff understands to contact operating surgeon. Keep all surgical follow-up appointments. This is the first assessment of R294's surgical wounds by me. Patient reports hearing a popping/crack sound yesterday during a transfer but did not report it to staff . Significant surgical dehiscence to the mid-upper back wound was found on exam 911 was called by staff nurse for immediate referral to the hospital. 11/1/23 11:30 AM - A nursing note revealed: Patient resting in bed at start of shift. Tolerated meal and all medication as prescribed. Resident voiced no c/o (complaints of) pain. Resident transferred to hospital for dehiscence of surgical site posterior area of neck. 11/1/23 1:08 PM - A nursing note revealed: Late entry: Resident assessed during wound rounds. Resident's posterior surgical incision found to be acutely dehisced. Resident's shirt and bed linens saturated in fresh red blood. Resident quickly sent to hospital for evaluation. 5/15/24 11:59 AM - In an interview, E9 (NP) stated that whoever does the resident's admission would enter wound care and then wound care NP's would then follow the resident. E9 stated that when surgical glue is used, it doesn't require any overt treatment plan, but staff would still need to ensure that the wound was still intact. E9 would expect the cervical collar to be removed daily for skin inspection. E9 stated that the surgeon drives the care for surgical wounds and facility providers would not make these orders. 5/16/24 11:42 AM - In an interview with E6 (MD), E9, and E6 (NP), E6 stated that the that the wound team follows the orders given by the surgeon and that they come to the facility on ce a week. The wound care providers put orders in, but that nurses can also enter a verbal order. E6 further stated that if nursing had questions about the discharge instructions, the nurse should call the surgeon for clarification. E6 stated that she and her providers do not provide wound care orders for surgical wounds due to legal considerations. 40264 Cross Refer F689 2. Review of R106's clinical records revealed: 6/23/23 - R106 was admitted to the facility. 6/23/23 - R106's hospital discharge summary indicated that R106 was for follow up with neurology as an outpatient. 5/16/24 - During an interview, E21 (Corporate Clinical Nurse) stated that R106's neurologist while at the hospital recommended for R106 to continue his medications to include Seroquel, an antipsychotic and Carbidopa/Levodopa for Parkinson's Disease. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R106's physician's orders lacked evidence that R106 was ordered for a neurology consult. 5/21/24 2:42 PM - In an email correspondence, the surveyor requested copies of R106's neurology consult notes and when R106 was seen by an outpatient neurologist per hospital discharge summary on 6/23/23. 5/23/24 12:26 PM - In an email correspondence, E1 (NHA) documented that the facility was not been able to get our hands on this consult. When [R106] returned from the hospital in August, it wasn't listed as needing follow up. We have asked the hospital for a full release of the hospital records to determine if he was seen in the hospital by neurology. There is work in place currently in coordination with the [clinic] to get an appointment scheduled . 5/23/24 12:26 PM - Findings were confirmed by E1 (NHA). 47142 3. Review of R397's clinical record revealed: 10/26/23 - R397 was admitted to the facility with diagnoses including type II diabetes and morbid obesity due to excess calories. 10/27/23 12:30 PM - A physician's order was written for Humalog quick pen inject 25 units intramuscularly three times a day for diabetes. 10/28/23 - A care plan was written for potential/alteration in Nutritional status related to a need for therapeutic, fluid restricted diet secondary to DM, cardiac dx, morbid obesity. Expected weight variances related to diuretic use. Interventions included record percent of each meal and/or supplement consumed and Record weight and notify physician, patient, family or significant other of any significant change as needed. 11/3/23 to 11/7/23 - A review of the CNA task sheet revealed that R397's meal consumption was documented as 0% from 6 PM on 11/4/23 through 6 PM on 11/7/23. 11/7/23 12:30 PM - A physician's order was written for Humalog quick pen inject 20 units intramuscularly three times a day for diabetes. Blood glucose check revealed a blood glucose level of 99 mg/dL. The MAR indicated the medication was held by the nurse at this time. The physician's order lacked parameters to hold the administration of insulin. 11/7/23 5:30 PM - A review of the MAR revealed that R397's blood glucose was 73 mg/dL and the insulin was signed out as administered. 11/7/23 5:46 PM - A progress note documented R397 had abnormal labs and was being transported to the hospital. 11/8/23 4:38 AM - A progress noted documented R397 was admitted to the hospital with hypoglycemia (low blood glucose) and acute kidney injury. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/23/23 - A discharge summary from the admitting hospital revealed that R397 presented with hypoglycemia after insulin administration from facility. 5/14/24 10:53AM - An interview with E9 (NP) revealed that when R397's blood glucose was 73 mg/dL, .I would have expected to be notified. E9 assessed R397 on 11/7/23 and stated that staff failed to mention R397's low intake and low blood glucose readings. E9 stated he ordered labs and diagnostic tests related to R397's assessment earlier that day. When the labs came back abnormal, R397 was sent to the hospital. 5/14/24 11:32 AM - An interview with E34 revealed that she would administer insulin if the blood glucose is above 70 mg/dL and the resident has eaten. E34 stated that if the blood glucose is below 70 mg/dL and the resident has not eaten, she will call the provider. E34 confirmed that she administered the Humalog to F397 despite a low meal intake. 5/14/24 3:07 PM - An interview with E52 revealed confirmed that she uses nursing judgment when blood glucose levels are in the 80 - 90 mg/dL when administering insulin. E52 confirmed that she held the Humalog for R397 on 11/7/23 at 12:30 PM due to low blood glucose and poor intake. The facility documentation lacked evidence of assessment and nursing judgement related to R397's blood glucose of 73 mg/dL and administration of Humalog. R397 had not consumed a meal in four days and the documentation lacked evidence of consulting a medical provider prior to administering the insulin. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).

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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. 47142 REVISED POST IDR Based on observation, interviews and record review it was determined that for one (R110) out of two residents reviewed for pressure ulcers, the facility failed to provide care and services to prevent an avoidable deep tissue injury from developing, causing harm. Findings include: Review of R110's clinical record revealed: 7/7/23 - R110 was admitted to the facility with diagnoses including but not limited to diabetes mellitus with other circulatory complications, dementia, progressive neuropathy and stroke. 7/7/23 - A care plan, last revised 1/4/24, documented that R110 was at risk for alteration in skin integrity related to diabetes, impaired mobility and incontinence. The care plan included to notify physician and significant other of any change in skin condition, observe skin condition with activities of daily living every day and report abnormalities and turn and reposition with skin checks every two hours. 1/9/24 - A quarterly MDS for R110 documented that R110 was dependent to move from sitting to lying, lying to sitting on the side of the bed, for lower body dressing and putting on/off footwear, required moderate assistance to sit to stand and required substantial assistance (the staff does more than half of the effort) to walk 10 feet. R110 was documented to use a wheelchair with setup assistance. R100 was at risk of developing pressure ulcers with no current ulcers. There were pressure reducing devices for the chair and bed in place and ointments/medications other than to the feet being used. 3/6/24 - A review of the physician's orders revealed a treatment order for the right heel to cleanse with normal saline, air dry, apply hydrogel, calcium alginate and a clean dry dressing every day shift and as needed. The aforementioned treatment order was for R110's right heel for a diabetic foot ulcer. 3/12/24 - A nursing Braden Scale documented R110 with a score of 16 (15 - 18 is considered at risk of skin breakdown). 3/13/24 - A wound evaluation form documented a new pressure related deep tissue injury to the right, top of foot with measurements of 5 cm x 7 cm x 0 cm with 100% epithelial cells in the wound bed and the wound edges are attached. The document listed the treatment to apply skin prep and leave open to air twice a day. No color description of the wound was provided. 3/13/24 - A review of a physician's order revealed a treatment order for R110 for the right, top foot to apply skin prep and leave open to air. Do not wrap with kling. Change every day and evening shift and as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	3/13/24 - A treatment order for R110 for the right heel and left heel to cleanse with normal saline, air dry, apply skin prep and hydrocolloid. Do not wrap with kling. Change every Wednesday and as needed. The aforementioned treatment orders instructed staff not to use kling to wrap around R110's foot. 3/14/24 - A treatment order for R110 for the right heel to cleanse with normal saline, air dry, apply medi-honey and calcium alginate, cover with abdominal pad and wrap lightly with kling every day shift and as needed. 3/20/24 - A wound evaluation form for R110 documented the wound to the right, top of foot as a pressure related, stage 2 with measurements of 4 cm x 5 cm x 0.10 cm with 100% epithelial cells in the wound bed and the wound edges are attached. The document listed the treatment to cleanse with normal saline, apply skin prep and hydrocolloid weekly. No color description of the wound was provided. The wound inaccurately back staged from a deep pressure injury to a pressure ulcer stage 2. 3/27/24 - A wound evaluation form for R110 documented the wound to the right, top of foot as a pressure related, unstageable with measurements of 4 cm x 7 cm x 0.10 cm with 75 - 99% epithelial cells and 1 - 24% of slough in the wound bed and the wound edges are attached. There was a moderate amount of fluid from the wound. The document did not say what type of fluid. The document listed the treatment to cleanse with normal saline, apply medical grade honey and calcium alginate then cover with border gauze weekly. No color description of the wound was provided. 5/8/24 - A wound evaluation form for R110 documented the wound to the right, top of foot as a pressure related, unstageable with measurements of 3.10 cm x 4 cm x 0.10 cm with 1 - 24% epithelial cells and 25 - 49% of slough in the wound bed and the wound edges are attached. There was a moderate amount of serosanguineous (clear to pale yellow liquid mixed with blood) fluid from the wound. The document listed the treatment to use skin prep for the area around the wound and apply a hydrocolloid dressing weekly. No color description of the wound was provided. 5/9/24 9:38 AM - An observation of R110's wound to the right, top foot appears to be on top of the right foot at the bend where the foot meets the right leg. The wound size was approximately 2.5 cm x 5 cm x 0.1 cm and was a rectangular shape. The appearance of the wound showed approximately 75% slough tissue with 25% epithelial cells in the wound bed. There was a small amount of serous (clear to pale yellow liquid) fluid drainage. The wound edges were intact. The wound was yellow in color. 5/14/24 10:38 AM - An interview with E18 (LPN) revealed that there was an order in place to wrap R110's right foot and she is not sure if the wound on the top of the right foot came from wrapping R110's foot. Then, the order changed to not wrap the right foot. 5/15/24 1:00 PM - An interview with E40 (Wound NP) confirmed that R110's wound on the top of the right foot was a result of being wrapped too tight with kling gauze. E40 stated she asked the staff not to wrap the foot. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	5/16/24 10:35 AM - In an interview with E42 (wound RN) confirmed that the treatment order dated 3/6/24, for the right heel, did not include wrapping the right heel at all. E42 stated that staff have two options to use for a clean dry dressing and they are a border gauze (rectangular pad of gauze that has sticky border around the gauze pad; larger sized band-aide) or a kling gauze (a rolled cotton gauze). E42 stated that the staff were wrapping the kling too tight and the wound was pressured related. E42 stated they spoke with E18 about it since that unit is her full-time area. E18 told E42 that she did not want the gauze to fall off. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 40264 Based on record review, observations and interviews, it was determined that for one (R106) out of five residents reviewed for bowel and bladder, the facility failed to ensure appropriate treatment and services to restore and/or maintain bladder function were implemented. Findings include: Review of R106's clinical records revealed: Cross Refer to F641, F656, F689 and F842 The facility's policy titled, Incontinence with a revised date 1/2024, documented, Based on resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services .1. must ensure that residents who are continent of bladder and bowel upon admission receive appropriate treatment, services, and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain .4. Residents .incontinent of bowel and bladder will receive appropriate treatment .and to restore continence to the extent possible .5. Periodically (as required and when there is a change in pattern of elimination), staff will re-evaluate each individual's level of continence using quarterly and significant change re- evaluation tool. 6/23/23 - R 106 was admitted to the facility with diagnoses including but not limited to enlarged prostate and dementia. 6/23/23 - A facility new admission Bladder and Bowel Evaluation documented that R106 was continent of urine. 6/24/23 (revised 7/4/23) - R106 was care planned for risk for alteration in skin integrity related to decline in mental awareness, and decreased mobility. Interventions (initiated 6/24/23) included to check for incontinence and provide incontinent care as needed. 6/30/23 - R106's admission MDS assessment revealed that R106 was cognitively impaired, was always continent of bladder and was not on a toileting program. A review of R106's hourly voiding diary for the following: 6/24/23 - 6/30/23 five episodes of incontinence out of 238 opportunities. 7/1/23 - 7/31/23 fifteen episodes of incontinence out of 1090 opportunities. 8/1/23 - 8/31/23 twenty-five episodes of incontinence out of 500 opportunities. 9/1/23 - 9/30/23 fifty episodes of incontinence out of 803 opportunities. 10/1/23 - 10/20/23 eighty-seven episodes of incontinence out of 529 opportunities. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	There was no evidence of an individualized toileting program initiated for R106 despite the increase of incontinence episodes. A review of R106's CNA bladder continence flow sheet for the following: 6/23/23 - 6/30/23 two episodes of urine incontinence out of 22 opportunities (9%). July 2023 - six episodes of urine incontinence out of 89 opportunities (7%). August 2023 - fourteen episodes of urine incontinence out of 79 opportunities (18%). September 2023 - fifteen episodes of urine incontinence out of 76 opportunities (20%). October 2023 - forty-eight episodes of urine incontinence out of 85 opportunities (56%). November 2023- seventy-eight episodes of urine incontinence out of 89 opportunities (89%). December 2023 - eighty-seven episodes of urine incontinence out of 93 opportunities (93%). January 2024 - ninety-three episodes of urine incontinence out of 94 opportunities (99%). February 2024 - eighty-five episodes of urine incontinence out of 87 opportunities (98%). March 2024 - ninety-three episodes of urine incontinence out of 93 opportunities (100%). April 2024 - seventy-five episodes of urine incontinence out of 86 opportunities (87%). 7/24/23 - R106's care plan intervention for risk for falls due to history of falls was revised to include toileting schedule every 2-3 hours and as needed. 8/17/23 - A facility Admission/Readmission Screener documented that R106 was continent of bladder. 8/17/23 - A facility readmission Bladder and Bowel Evaluation documented that R106 was incontinent of urine, 8/25/23 - R106's risk for falls care plan intervention of toileting schedule every 2-3 hours and as needed was discontinued. 9/1/23 - A facility Bladder and Bowel Evaluation documented that R106 was continent of urine. 9/26/23 - R106 was care planned for physical aggression as evidenced by hitting staff related to cognitive loss with interventions including checking for unmet needs for example toilet, hunger, thirst, fatigue, pain. 9/28/23 - R106's quarterly MDS assessment revealed that R106 was cognitively impaired, was occasionally incontinent of bladder and was not on a toileting program. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	11/8/23 - R106's care plan interventions for risk in alteration in hydration were updated to include [R106] will have two person assist when toileting. 12/26/23 - R106's quarterly MDS assessment revealed that R106 was cognitively impaired, was always incontinent of bladder and was not on a toileting program. Further review of R106's clinical records lacked evidence that a quarterly Bladder and Bowel evaluation was completed during the December 2023 review period. 3/26/24 - R106's quarterly MDS assessment revealed that R106 was cognitively impaired, was always incontinent of bladder and was not on a toileting program. 3/27/24 - R106 was care planned for placing self on floor/slides off chair related as evidenced by resident intentionally sliding out of chair for comfort r/t dementia. Interventions including but not limited to offer toileting. The approach did not include a frequency of toileting. 4/5/24 - A facility Bladder and Bowel Evaluation documented that R106 was incontinent of urine. 4/24/24 - A facility Admission/Readmission Screener documented that R106 was incontinent of bladder and to initiate voiding diary and develop a care plan for bladder incontinence. 5/28/24 9:01 AM - In an interview, E58 (CNA) stated, . Before [R106] broke his ribs in August 2023, he was able to stand up and wet his briefs before he reached the bathroom .or sometimes he would reach the bathroom but he was already peeing on the floor on the way to the bathroom. He needed two staff to assist him with walking. We had to get a urinal and aim it on his genitals so that if he pees while walking to the bathroom the urinal would catch and avoid spilling urine on the floor. We used to check him every two hours because he was continent when he first came, before he had those falls. Then he became an hourly check since his first fall in July 2023 . 5/28/24 9:27 AM - During an interview, E59 (CNA) stated, .I know [R106] since November 2023 and he was always incontinent with bladder. He was always wet with urine. He was not on a voiding diary but we just check on him every two hours and ask him if he wants to go to the bathroom. Sometimes he tells you if he wants to go, other times he was already wet . 5/28/24 9:51 AM - In an interview, E28 (CNA) stated, . Ever since I was assigned in this (unit), I was only able to do 1:1 sitter for [R106]. We would take him to the bathroom every two hours to check if he is wet. Or when ever I see him starting to move a lot and getting anxious, it's a signal for me to know that he may need to pee or has a bowel movement . 5/28/24 10:05 AM - During an interview, E60 (CNA) stated, .When I first had [R106] on my assignment in September 2023, he was both continent and incontinent. Sometimes he was able to tell you that he wanted to use the bathroom and found him dry but will eventually go. Other times, he's already wet when he asks us to take him to the bathroom. We toilet him every two hours .He was not on hourly toileting. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	5/28/24 10:37 AM - In an interview, E39 (LPN) stated that she was not R106's primary nurse but she knew that R106 was continent of bladder and used the toilet in June 2023. E39 further stated that R106 progressively needed more help with his toilet and bathroom use probably after his fracture (broken ribs). When asked for the process when a resident has a change in bladder functional status from always continent to occasionally, frequently and always incontinent, E39 explained that it is an expectation for the floor nurse or charge nurse to assess and evaluate the resident's current bladder status to verify the change that the CNAs reported. E39 continued to state that once assessment was done, interventions will be put into place for example initiating a 3 - Day voiding diary establish a personalized pattern for when a resident would be found wet in his briefs and becomes incontinent and then come up with a toileting program to check the resident based on the voiding patterns. 5/28/24 11:02 AM - During an interview, E35 (LPN) stated that she was the UM (Unit Manager) in the (unit) last year 2023. E35 further stated, [R106] was continent/incontinent of bladder on admission - but mostly continent and was toileted every two hours unless he asked to be brought to the bathroom. He was for the most part to totally continent of bladder. Even if the CNAs were telling me [R106] became incontinent, I did not push for a change in his continent status because he was not wet, and he was always dry with me. He was continent before he fell and broke his ribs. I used to take him to the bathroom every morning and I would find him dry but he was able to go (urinate) and I would give him enough time to finish for at least 5 minutes, and not to rush him so he could completely empty his bladder. 5/28/24 11:54 AM - In an interview, E19 (RN UM/Sup) stated that since she started working in the facility, she has always known R106 to be incontinent of bladder. R19 stated that she was the temporary UM for (unit) in March 2024 and that she completed R106's quarterly bladder and bowel evaluation for the review period 4/5/24. E19 confirmed that R106's December 2023 quarterly bladder and bowel evaluation was not completed. 5/28/24 12:04 PM - During an interview, E21 (Corporate Clinical Nurse) stated that R106 showed a mix bladder continence/incontinence episodes. E21 further explained that there was no no need for a check and change or toileting program on R106 as he was showing different patterns each time. E21 stated that a staff was assigned to do 1:1 supervision on R106 and that the same staff was to take R106 to the bathroom along with another staff as R106 required a sit - to stand - up lift for toilet. 5/28/24 12:15 PM - In a follow up interview, E21 confirmed that R106's December 2024 Bladder and Bowel quarterly evaluation was not completed. Despite the facility's awareness of R106's mixed bladder continent and incontinent status, the facility failed to ensure that R106 received the appropriate treatment and services to restore and/or maintain bladder function were implemented when the facility failed to perform a thorough bladder assessment and establish a person centered toileting program. R106 was continent of bladder on admission on 6/23/23. The subsequent months showed R106's decline in bladder continence from frequently incontinent in August, occasionally incontinent in September, to always incontinent of bladder beginning December 2023. 5/28/24 2:00 PM - Findings were discussed with E1 (NHA), E2 (DON) and E21 (Corporate Clinical Nurse).

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 47621 Based on record review and interviews, it was determined that for one (R3) out of four residents reviewed for Medication Administration, the facility failed to ensure that R3's monthly medication review was completed. Findings include: Medication Regimen Review (MRR) Policy- the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart . 7/5/18 - R3 was admitted to the facility with diagnoses, including but not limited to, multiple sclerosis. 2/14/24 - R3 was admitted to the hospital for an altered mental status. 3/1/24- While hospitalized , R3 underwent placement of a percutaneous endoscopic gastrostomy tube (PEG- a feeding tube) for a diagnosis of malnutrition/failure to thrive. 3/7/24 - R3 was readmitted to the facility. 3/7/24 10:26 PM - E15 (RN Nursing supervisor) entered orders for acetaminophen, atorvastatin, bisacodyl, cholecalciferol, clopidogrel, cyanocobalamin, labetolol, losartan, Maalox, metformin, milk of magnesium, pantoprozole, polyethylene glycol and senna. All fourteen medications were ordered to be administered by mouth. 3/10/24- E11(Dietitian) documented in R3's EMR an order, NPO (a medical term that means nothing by mouth). 3/12/24 - E16 (Speech therapist) performed a Cognitive Impairment SLP (Speech Language Pathologist) Screen with R3 and documented R3 as Strictly NPO. 3/15/24 2:00 PM - E6 (MD) co-signed E11's NPO order on R3's EMR. 3/15/24 2:00 PM - E6 (MD) co-signed R3's medication orders that were ordered to be administered by mouth. The facility lacked evidence of a Medication Regimen Review (MRR) for R3 for the month of March 2024. On 4/27/24 and 5/12/24, E10 (registered pharmacist) documented on R3's medical records for the monthly MRR, no recommendations. 5/16/24 10:35 AM - During a telephone interview, E10 (Pharm D consultant) stated, I do review all the orders when performing a medication review. When asked about having by mouth medication orders for R3, who was strictly NPO, (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E10 stated, 'I did not pick up on that. 5/16/24 2:45 PM - Findings were discussed with E1 (NHA) and E4 (Corporate consultant).

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 40264 Based on record review and interview it was determined that for four (R61, R106, R47, and R98) out of five residents reviewed for medication review, the facility failed to ensure adequate monitoring of adverse effects for R61, R47 and R98. The facility failed to ensure that R106 was free from unnecessary medication. Findings include: 1. Review of R106's clinical records revealed: 4/24/24 - R106 had a physician's order for Seroquel (quetiapine) 25 mg one tablet by mouth two times a day related to persistent mood affective disorder. 5/8/24 11:09 AM - A medical GDR (gradual dose reduction) was completed by P1 (Psych Doctor) and documented, Discontinue Seroquel. Remeron 15 mg at night. 5/9/24 3:03 PM - A nurse progress note by E22 (RN) documented that R106 had a GDR completed and that the recommendation was to start Remeron 15 mg (milligrams) at bedtime. NP (Nurse Practitioner) .made aware. 5/11/24 - A Consultant Pharmacist Report noted for the facility to evaluate quetiapine use for mood disorder. The facility's response signed and dated by the physician on 5/13/24 indicated, NNO (no new order) per psych. 5/15/24 - A review of R106's May 2023, MAR (Medication Administration Record) revealed that R106's order for Seroquel was not discontinued on 5/8/24 and that R106 continued to receive Seroquel 25 mg one tablet by mouth two times a day. 5/16/24 8:37 AM - In an interview, E19 (RN Sup/UM) stated that there was a mishap. E19 also stated that, I did not take notes, it was E2 [DON] who took notes that showed to increase the Remeron to 15 mg but we did not hear him [P1] mention about discontinuing the Seroquel during the GDR meeting . No, I did not D/C (discontinue) the Seroquel. 5/16/24 9:55 AM - In an interview, E2 (DON) stated, I was at the meeting and I took down notes. He (P1) did not mention to discontinue the Seroquel. I called him this morning to clarify the order. He wanted the Seroquel to be discontinued. 5/16/24 12:04 PM - Review of R106's MAR revealed that R106's order for Seroquel was discontinued. 5/16/24 12:31 PM - In an interview, P1 (Psych Doctor) stated, We had a GDR meeting last week and I made [R106's] change to one medication at a time starting with weaning him off Seroquel. I received a call from the facility early this morning telling me that that the recommendation to discontinue the Seroquel was not done. I still want them to discontinue it. 5/16/24 1:03 PM - During an interview, E12 (NP) stated, I do not know about [R106's] 5/8/24 GDR report. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/16/24 1:08 PM - During an interview, E9 (NP) sated, E19 gave me a report and showed me a list of residents on GDR review last week in (unit) but it did not include [R106]. I do not know about [R106's] Seroquel. 2. Review of R61's clinical records revealed the following: 8/24/22 - R61 was admitted to the facility. 4/30/24 1:53 PM - A psych note documented, Resident does have a history of depression and seems somewhat emotionally sensitive. His mood should continue to be monitored. 5/7/24 - R61 had a physician's order for trazodone 100 mg one tablet by mouth at bedtime for insomnia. 5/8/24 - R61 had a physician's order for trazodone 50 mg one tablet by mouth daily for mood. 5/9/24 (initiated 1/23/23)- R61 had a care plan for adjustment disorder with depressed mood and at risk for changes in behavior problems related to depression, tearfulness and suicidal ideation, poor impulse control/destruction, physical aggression towards another resident, making false statements regarding staff and residents, making third party threats to staff Interventions included Administer medications per physician order. Observe for changes in behavior/side effects. 5/14/24 11:00 AM - Review of R61's May 2024 Medication Administration Record lacked evidence that R61's behavior of tearfulness and sadness were monitored for receiving trazodone. 5/14/24 12:45 PM - In an interview, E19 (RN Sup/UM) confirmed that she was not able to include [R61's] behavior monitoring in the MAR. E19 further stated that R61's behavior should still be monitored. 46988 3. Review of R47's clinical record revealed: 12/15/15 - R47 was admitted to the facility. 1/11/16 - A care plan was initiated for R47's use of anticoagulant therapy with an intervention of observing and monitoring for side effects such as blood in urine/stool, gums/nose bleeding, bruising. 10/21/22 - A physician's order for R47 was written for Pradaxa capsule (anticoagulant) one capsule by mouth twice a day related to chronic atrial fibrillation. 8/2023 - A review of the August MAR revealed no documentation related to adverse effects of anticoagulant therapy. 5/20/24 9:27 AM - An interview with E38 (UM) confirmed adverse effects were not being monitored for R47. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of R98's clinical record revealed: 7/24/23 - R98 was admitted to the facility with a diagnosis of major depressive disorder, concurrent. 4/25/24 - A quarterly MDS revealed R98 is prescribed an antidepressant. 5/2024 - A review of R98's MAR revealed a lack of monitoring for adverse effects of trazodone. 5/20/24 9:27 AM - An interview with E38 (UM) confirmed R98 was prescribed trazodone and confirmed lack of monitoring for adverse effects related to trazodone. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46988 Based on observation and interview it was determined the facility failed to receive and document narcotic medications per professional standards of care. Findings include: Review of R65's clinical record revealed: 6/2/20 - R65 was admitted to the facility. 4/4/24 11:15 AM - A physician's order was written for oxycodone (narcotic pain medication) give one tablet by mouth every eight hours. 5/17/24 - A review of R65's narcotic count verification sheets revealed that for the months of November 2023, December 2023, January 2024, February 2024, March 2024, and April 2024 the verification sheets lacked evidence of date, time, and a nurse's signature of receipt. 5/20/24 9:27 AM - An interview with E38 (RN UM) confirmed the narcotic count verification sheets lacked the date, time, and a nurse's signature. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 46988 Based on record review and interview, it was determined, for one (R79) out of one resident sampled for laboratory services, the facility failed to promptly notify the ordering medical practitioner of laboratory results that fell outside of clinical reference ranges. Findings include: Review of R79's clinical record revealed: 1/2/20 - R79 was admitted to the facility. 5/9/24 9:47 AM - In an interview with R79 revealed he had pain when urinating and the facility collected urine this morning for analysis and culture. 5/10/24 3:49 PM - A review of lab results revealed that R79 was positive for a urinary tract infection. The culture was still pending at this time. 5/11/24 (Saturday) 2:52 PM - A review of lab results revealed the urine sample from R79 was positive for growth. 5/13/24 (Monday) - A physicians order was written for Bactrim DS (antibiotic) by mouth daily for urinary tract infection. 5/14/24 11:04 AM - An interview with E39 (LPN) confirmed if lab results posted during weekend hours and were out of range the on call provider should be notified of the results. The facility lacked evidence of promptly reporting abnormal lab results to the medical provider. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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: 5/9/24 9:35 AM - During a tour of the kitchen, the surveyor observed E48 (Dietary Services Manager) test the sanitizer level of the solution in two red sanitizing buckets. When E48 tested the sanitizing solution in both buckets, the test strips from each of the two buckets indicated that the level of chemical concentration in the buckets was not at a sufficient level to provide proper sanitization. 5/9/24 9:42 AM - A container of dry rice was spilled on the floor near the sink in the kitchen and left for over an hour. 5/9/24 10:27 AM - Observation of nourishment refrigerator in the Aspen unit revealed an opened carton of Nutritional Shake that was undated. The instructions on the carton indicate that once opened, any remaining product should be discarded after four (4) days. 5/9/24 11:53 AM - Observation of nourishment refrigerator in the Seaside Unit revealed an opened bottle of thickened juice that was dated 4/1/24. The instructions on the carton indicate that once opened, any remaining product should be discarded after ten (10) days. 5/9/24 1:43 PM - Findings were confirmed with E1 (NHA) 5/20/24 1:35 PM - Findings reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).

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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. 47621 Based on interview, record review and review of other facility documentation it was determined that the facility failed to ensure, in accordance with professional standards and practices, that medical records for two (R40 and R106) out of five residents of the investigative sampled residents were accurate. Findings include: Review of R40's clinical record revealed: 1/23/24 - R40 was admitted to the facility with diagnoses, including but not limited to, bipolar disorder, schizoaffective disorder bipolar type, and depression. 2/22/24 - E8 (NP) documented in R40's electronic medical record (EMR), Risperdal (an anti-psychotic agent) 1 mg (milligram)- Give 1 tablet by mouth at bedtime for total 5 mg and Risperdal 4 mg - Give 1 tablet at bedtime for total 5 mg. 5/16/24 12:45 PM - During an interview, E1(NHA) confirmed that R40's Risperdal orders in the EMR did not contain a diagnosis. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse). 40264 2. Cross Refer F689 and F690 Review of R106's clinical records revealed: 6/23/23 - R106 was admitted to the facility. a. 8/3/23 - R106's care plan interventions for risk for fall was updated to include 1:1 Supervision. 5/15/24 3:30 PM - A review of R106's CNA flowsheets from September 2023 through January 2024 revealed a lack of evidence that the staff documented a 1:1 supervision completed for R106. 5/16/24 9:08 AM - During an interview, E21 (Corporate Clinical Nurse) stated that there were no documentation of R106's hourly 1:1 Supervision for the months starting September 2023 through January 2024. E21 further stated that R106's hourly 1:1 Supervision was indicated in the CNA Kardex as FYI (For Your Information), but the CNAs only started signing it off as assigned task on 1/30/24. b. 8/17/23 - A facility readmission Bladder and Bowel Evaluation documented that R106 was incontinent of urine. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/1/23 - A facility Bladder and Bowel Evaluation documented that R106 was continent of urine .Resident [R106] has occasional bladder incontinence, toileting program initiated . 4/5/24 - A facility Bladder and Bowel Evaluation documented that R106 was incontinent of urine .Incontinent (Initiate Voiding Diary) . 5/28/24 9:00 AM - A review of R106's CNA flowsheets from October 2023 through January 2024 revealed a lack of evidence that R106's voiding diary and hourly toileting program were accurately documented from 10/21/23 - 1/29/24. 5/28/24 2:10 PM - During an interview, E21 (Corporate Clinical Nurse) stated that since R106 was already on the hourly 1:1 staff supervision, the staff was also to take R106 to toilet every hour. E21 stated that the 1:1 supervision was not signed off by the CNAs in their task until 1/30/24. 5/28/24 2:00 PM - Findings were discussed with E1 (NHA), E2 (DON) and E21 (Corporate Clinical Nurse).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 38302 Based on observation and interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment. Findings include: 1. 5/9/24 10:49 AM - Laundry Aide (E41) was observed placing soiled laundry into the washing machine using ungloved hands. An interview revealed that E41 was not aware of safe handling practices for general soiled laundry or for laundry belonging to residents who were on various types of precautions due to illness. 44706 2. A facility policy titled Infection Prevention and Control Program with a revision date of 1/2024 documented This facility has established and maintains an infection prevention and control program designed to provide a .sanitary .environment to help prevent the development and transmission of .infection . Review of R113's clinical record revealed: 9/1/23 - R113 was admitted to the facility. 5/20/24 9:10 AM - During an interview, R113 stated on 10/18/23 E24 (CNA) was cleaning out the toilet bowl from her bedside commode over the sink in her room which is located opposite the bed. R113 had taken a video using her cell phone and proceeded to show it to the surveyor. The video clearly showed a person holding the bedside commode bucket over the sink but the contents were not visible. R113 stated that she spoke to the social worker and also submitted a complaint to the state agency. 5/20/24 9:18 AM - During an interview (E21) (corporate clinical nurse) confirmed that she had been made aware of the incident and that E7 (SW) went to speak with R113. E21 stated that an investigation was conducted and staff education provided. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse). 5/21/24 - A document was submitted via email to the state agency. The document comprised of a telephone interview with E24 and a statement of a brief education regarding the proper procedure for emptying a commode toilet bowl. The document was dated 5/20/24, the incident took place on 10/8/23.