STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105045	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Braden River Rehabilitation Center LLC	2010 Manatee Ave E Bradenton, FL 34208

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50570 Based on observations and interviews, the facility did not ensure a sanitary and homelike environment for four out of five units. Findings included: On 9/23/24 at 9:50 a.m., a tour of Unit 3 East was conducted. Observations of room [ROOM NUMBER] revealed paint and plaster on the right side of the mirror was missing with, an exposed nail head protruding from the wall. On 9/23/24 at 9:53 a.m., an observation of room [ROOM NUMBER] revealed an open drawer that appeared to have multiple holes in the wood laminate, towards the bottom of the drawer. Further observations of room [ROOM NUMBER] revealed missing wood laminate pieces on the closet door. An observation of the bathroom in room [ROOM NUMBER] revealed the right sink handle was missing a piece from the bottom. The drain in the sink appeared rusted and had a black and dark orange colored ring around the drain. On 9/23/2024 at 10:00 a.m., an observation of the bathroom in room [ROOM NUMBER] revealed a large opening in the wall, underneath the sink, which was covered with a plastic bag and blue tape. On 9/23/24 at 10:06 a.m., an observation of the bathroom in room [ROOM NUMBER] revealed the door frame and bottom of the door appeared damaged and frayed. Further observation of the bathroom in room [ROOM NUMBER] revealed damaged dry wall and the border tiles were separated from the wall, leaving gaps between the border tiles and the wall. On 9/23/24 at 10:15 a.m., an observation of room [ROOM NUMBER], bed one, revealed pieces of wood laminate were missing from the bottom of a drawer and the closet door. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/23/24 at 10:27 a.m., an observation of room [ROOM NUMBER] revealed the ceiling vent, between bed one and two, had black spots and stains surround the ceiling vent. The ceiling vent was observed with cracks and missing pieces of plaster/paint. Further observations of room [ROOM NUMBER] revealed the wall border trim behind the door was separated from the wall, which exposed dry wall underneath. The wall border trim to the right of the door, upon entering room [ROOM NUMBER], was observed separated from the wall and dry wall was exposed. The wall border trim on the left corner of room [ROOM NUMBER], on bed two's side, was observed separated from the wall and the dry wall was exposed. An observation of the bathroom in room [ROOM NUMBER] revealed two small tiles, with a black colored substance, were stacked on top of each other to the right side of the toilet. Further observations of the bathroom in room [ROOM NUMBER] revealed the ceiling had black spots and smudges of an unknown substance. On 9/23/24 at 10:41 a.m., an observation of room [ROOM NUMBER] revealed the ceiling vent, between bed one and one, had a piece of plaster on the left side of the vent that was separating from the ceiling. Some areas around the ceiling vent was observed separated from the vent and had small patches of paint, which appeared to be cracked and peeling away. On 9/23/24 at 11:38 a.m., an observation of a long handrail, between room [ROOM NUMBER] and the electrical panel door, revealed it was separated from the wall and appeared loose. On 9/23/24 at 11:46 a.m., an interview with a resident in room [ROOM NUMBER] revealed the sink had been broken for three weeks and resident's that shared that room were not able to use it. On 9/23/24 at 1:25 p.m., an observation of room [ROOM NUMBER] revealed the windowsill was broken and missing a piece of it. An observation of the bathroom in room [ROOM NUMBER] revealed the casing trim and the bottom of the door appeared damaged with frayed edges. On 9/23/24 at 1:49 p.m., an observation of room [ROOM NUMBER], bed two, revealed the closet door and drawers were missing pieces of wood laminate. Further observation of the bathroom in room [ROOM NUMBER] revealed there was no mirror in the bathroom. An interview with a family member revealed she told maintenance about the mirror and concerns related to the closet door and drawers. The family member stated a maintenance staff member told her the following, He said they are busy right now with other things, they have other more important things. On 9/23/24 at 2:06 p.m., an observation of room [ROOM NUMBER] revealed large scratch marks and missing paint on the wall, to left of the headboard, of the bed closest to the window. On 9/24/24 at 9:25 a.m., an observation of room [ROOM NUMBER] revealed a handwritten sign posted on the mirror above the sink. The sign observed included the following message, [Vendor name] will be here 9-24. The resident in the room stated maintenance had been working on the sink and they put that sign today. Further observations of the sink and wall revealed a towel on the floor, which had a faint yellow/orange color on the edge facing the wall border trim. On 10/1/24 at 10:41 a.m., room [ROOM NUMBER] was observed with the same concerns observed on 9/23/24. room [ROOM NUMBER] was observed with the same concerns observed on 9/23/24. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/1/24 at 10:51 a.m., an observation of room [ROOM NUMBER] revealed there was no sink. Further observation of room [ROOM NUMBER], where the sink previously was, revealed two exposed pipes protruding from the wall. A note on the wall was observed which revealed the following, Fix leak 9/25. On 10/1/24 at 10:54 a.m., an observation of a long handrail, between room [ROOM NUMBER] and the electrical panel door, had the same concerns observed on 9/23/24. On 10/1/24 at 11:19 a.m., an observation of room [ROOM NUMBER] revealed the same concerns observed on 9/23/34. Further observation outside of room [ROOM NUMBER] revealed a small handrail, underneath the linen room sign, appeared to be coming off and tilted. An observation of the ceiling vent, between rooms [ROOM NUMBERS], had water droplets from condensation that was dripping on the hallway floor. On 10/1/24 at 12:00 p.m., room [ROOM NUMBER] was observed with the same concerns observed on 9/23/24. On 10/1/24 at 2:40 p.m., room [ROOM NUMBER] was observed with the same concerns observed on 9/23/24. An observation of room [ROOM NUMBER], of the wall under window, revealed a section of white plaster on the green colored wall. It appeared the plaster was recently done, and the wall was not painted yet. On 10/2/24 at 9:15 a.m., room [ROOM NUMBER] was observed with the same concerns observed on 9/23/24. On 10/2/24 at 9:30 a.m., room [ROOM NUMBER] was observed with the same concerns observed on 9/23/24. On 10/2/24 at 10:14 a.m., an observation of the ceiling vent and water droplets on the floor, between rooms [ROOM NUMBERS], revealed the same concerns observed on 10/1/24. The small handrail next to room [ROOM NUMBER], underneath the linen sign, was observed with the same concerns observed on 10/1/24. An observation of room [ROOM NUMBER] revealed the same concerns as observed on 9/23/24, 9/24/24 and 10/1/24. On 10/02/24 at 10:16 a.m., room [ROOM NUMBER] was observed with the same concerns identified on 9/23/24 and 10/1/24. On 10/2/24 at 10:57 a.m., room [ROOM NUMBER] was observed with the same concerns observed on 9/23/24. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/3/24 from 12:45 p.m. to 1:45 p.m., a tour of units 3 west, 3 east, 4 west and 4 east was conducted with the Regional Maintenance Director (MD) and the Nursing Home Administrator (NHA). The following rooms were toured with the Regional MD and NHA: 304, 317, 322, 323, 326, 327, 328, 329, 403, 404, 412, 415, 417, 418, 420, and 422. On 10/3/24 an interview with the Regional MD and NHA, during the tour, regarding room [ROOM NUMBER] revealed the plaster exposed next to the mirror was a result of the removal of the soap dispenser. The Regional MD and NHA were both aware there was no soap dispenser. The NHA stated residents could use the hand sanitizer, located outside the room door, to clean their hands or the shower across the room to include washing their hands and brushing their teeth. During the tour with the Regional MD and NHA, an observation of room [ROOM NUMBER] revealed an air concentrator machine, which had blue tape surrounding a large tube that went from the concentrator machine to the window. The window observed had blue tape that appeared to be coming off and cardboard to the right side of the large tube and against the window. The Regional MD stated there was an issue with the air conditioning unit the facility was already aware of and working on addressing. The NHA stated the residents in the room were offered a room change but refused. On 10/3/24 after the tour was completed, at approximately 1:45 p.m., the Regional MD stated he was not aware seven rooms (322, 323, 329, 403, 412, 417, and 418) had the issues that were identified during the observations. Regarding the other eight rooms that were toured, the Regional MD stated he was aware of the issues and the maintenance team were working on them. The Regional MD stated guardian angel rounds occur daily and help with identifying issues and concerns that required maintenance interventions. He showed blank work orders that were found at the nurse's stations. The Regional MD stated staff were expected to fill out work orders when there were maintenance related issues. He stated he had two to three small boxes of work orders that were not addressed. He stated there were many projects and updates currently taking place in the units. On 10/3/24 at 1:47 p.m. the Regional MD stated the facility did not have a policy related to upkeep/maintenance. He provided weekday, weekly, monthly, and periodic checklists that were titled, Preventive Maintenance. The Regional MD stated the checklists, Tells me what I need to do. Photographic Evidence Obtained. 46498

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observation, record review, and interview, the facility failed to file and follow-up on a grievance regarding Activities of Daily Living (ADL) care for one (#91) of five residents sampled. Finding includes: During an observation made on 09/23/2024 at 11: 47 a.m., and on 10/02/2024 at 1:00 p.m., Resident #91 was observed lying down in bed with her call light within reach. She was observed with no signs of distress. She stated she was very upset because she had not had a shower or her hair washed in two months. She stated she had reported this to everyone, but no one had assisted her. She stated she had told staff she preferred to take bed baths instead of showers because it hurt her when she got up. Review of an Admission Record dated 10/03/2024 revealed Resident #91 was admitted to the facility with diagnoses to include but not limited to Heart Failure, Chronic Pain, Adult Failure to Thrive, Anxiety Disorder, Unspecified. Review of an annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status, BIMS score of 15 which indicated Resident #91 was cognitively intact. Review of a Nursing Progress note dated 9/1/2024 revealed Resident #91 reported to a nurse that she had not had her hair washed in a while. An interview was conducted on 10/3/2024 at 12:00 p.m., with Staff T, Certified Nursing Assistant (CNA) in Resident #91's room. Staff T said the resident told her she would really like to have her hair washed. Staff T stated she had not given Resident #91 a shower because she refused a lot of her care. She stated the resident did not like to take showers. Staff T said she would wash the resident's hair now. During an interview on 10/3/2024 at 12:30 p.m., with Staff R, License Practical Nurse (LPN), she stated she knew Resident #91 refused to take showers because she did not like to get out of the bed. She stated one time in the past Resident #91 complained to her about not getting her showers, so they tried to assist the resident with her shower, but she yelled so bad they had to put her back to bed and gave her a bed bath. So now they gave her bed baths instead of showers. She said she did not file a grievance when the resident complained to her about not getting her showers. During an interview on 10/3/2024 at 12: 45: p.m., with Staff P, License Practical Nurse/ Unit Manager. Staff P stated she just started working on the unit where Resident #91 resided. She stated when the resident reported to the nurse that she was not getting showered, or her hair washed, the nurse should have filed a grievance on the residents' behalf. She stated her expectation were when a resident put in a complaint she expected her nurses or staff to report it to the Interdisciplinary team (IDT) so a grievance could be filed on the resident's behalf. From there, whoever was assigned the grievance could do an investigation and put something in place to resolve the situation. We would also update the residents care plan to show that she would like to have bed baths instead of showers. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/03/2024 at 2:00 p.m., with the Director of Nurses (DON), the DON stated the nurses should have filed a grievance on Resident #91's behalf when they were made aware of her not getting showers or her hair washed. Review of the facility policy titled, Grievances Revised Date 8/2023 showed Purpose: To support each resident's rights to voice grievance and to ensure that after a grievance has been received, the center will actively work through to a conclusion while communicating progress to the resident and /or anyone working on their behalf in a timely manner. This policy shall be made available, upon request, for residents and /or anyone working on their behalf. Procedure 1. When a resident, or anyone acting on behalf of, has a grievance, a staff member shall encourage and assist the resident, or person acting on behalf, to file a grievance with the center using the Grievance Report.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49497 Based on record review and interview, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR) was completed accurately for three (#93, #38, #60) of twenty-nine residents sampled. Findings included: 1. Review of Electronic Medical Record (EMR) for Resident #38 showed an admission to the facility with diagnoses including bipolar disorder, undifferentiated schizophrenia, post traumatic stress disorder, and major depressive disorder. Review of the resident's medication administration record for October 2024 revealed: - SEROquel Oral Tablet 25 MG (Quetiapine Fumarate) Give 0.5 tablet by mouth at bedtime for GDR ATTEMPT related to SCHIZOPHRENIA, UNSPECIFIED (F20.9). - Wellbutrin XL Tablet Extended Release 24 Hour 300 MG (buPROPion HCl ER (XL)) Give 1 tablet by mouth in the morning for Depression related to MAJOR DEPRESSIVE DISORDER. Review of care plan dated 07/17/24 revealed: - A focus of PASRR level one Date Initiated: 10/10/2020 with a goal of PASRR will remain on his medical records Date Initiated: 10/16/2020 and intervention of PASRR Level I Date Initiated: 10/10/2020. - A focus of [Resident #38] uses psychotropic medications r/t bipolar, depressive disorder, schizophrenia 10/19/20 he was started on psychotropic medication Date Initiated: 01/04/2021. With interventions including Discuss with provider ongoing need for use of medication. Date Initiated: 10/11/2020, Resident is on a behavior management program with alternatives to prn medication use Date Initiated: 10/21/2020, Medications as ordered, and Observe ongoing s/s of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance Date Initiated: 05/30/2024. Review of Minimum Data Set, dated dated dated [DATE] revealed: - Section C Brief Interview for Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment. - Section N showed antipsychotic and antidepressant marked yes. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Preadmission Screening and Resident Review (PASRR) Level 1 revealed it was completed at the facility on 10/09/2020. It showed on page two, anxiety, bipolar disorder and depressive disorder were marked. Schizophrenia was not marked. An interview was conducted on 10/03/24 at 11:30 a.m. with the Social Work Director. He stated the Director of Nursing (DON) completed all PASRRs. An interview was conducted on 10/03/24 at 11:50 a.m. with the DON. He stated PASRRs were completed using the [proper name] guidelines. He stated he reviewed all new admission PASRRs for accuracy. He stated if they were incomplete or incorrect he completed a new PASSR. He stated the unit manager would let him know when residents had a new diagnosis added and he would update the PASRR to reflect the added diagnosis. He stated Resident #38's PASRR completed on 10/09/2020 was incorrect due to a Schizophrenia diagnosis that was not marked on page two. He stated the PASRR should have been redone to add the Schizophrenia diagnosis. 2. Review of EMR for Resident #60 showed an admission to facility on 05/01/2024 with diagnoses including dysphagia, major depressive disorder, unspecified protein calorie malnutrition. Review of physician orders revealed: - Citalopram Hydrobromide tablet 10 mg. Give 2 tablets one time a day for depression. Review of care plan dated 08/15/2024 revealed: - A focus of PASRR level Date Initiated: 05/03/2024. With interventions including PASRR Level I Date Initiated: 05/17/2024. - A focus of uses Psychotropic Medication Therapy r/t [related to] Depression. With interventions including Observe for side effects and adverse reactions of psychoactive medications. Review of Minimum Data Set (MDS) dated [DATE] revealed: - Section N showed yes marked for antidepressant. Review of Resident #60's PASRR revealed it was completed on 04/05/2024 at the hospital. It showed on page 2 section A no mental illness boxes marked. An interview was conducted on 10/03/24 at 11:50 a.m. with the DON. He stated Resident #60's PASRR completed on 04/05/2024 was incorrect due to Major Depressive Disorder diagnosis was not marked on page two section A for mental illness. He stated the PASRR should have been redone at admission to add Depressive Disorder on page two to reflect Resident #60 admitting diagnosis. 50570 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. A review of Resident #93's Admission Record showed diagnoses to include: unspecified dementia, unspecified severity, with agitation (onset date of 10/1/22, primary diagnosis), generalized anxiety disorder (onset date of 9/29/20), unspecified mood [affective] disorder (onset date of 10/1/20), unspecified psychosis not due to a substance or known physiological condition (onset date of 10/5/20), and major depressive disorder, single episode, unspecified (onset date of 9/29/20). A review of Resident #93's Medication and Treatment Administration Records (MAR/TAR) for October 2024 showed medication to include: Depakote Sprinkles Capsule Delayed Release Sprinkle 125 MG (milligrams) related to unspecified dementia with behavioral disturbance. Start date 6/21/24. Ativan Tablet 0.5 MG related to generalized anxiety disorder. Start date 10/8/22. A review of Resident #93's current care plan showed a focus to include the following, [Resident name] has impaired cognitive function/impaired thought process r/t [related to] diagnosis of rapid progressive dementia. Further review of the current care plan showed another focus to include the following, [Resident name] uses psychotropic medications r/t anxiety, depressive disorder, also receiving anti-psychotic medication for mood, and psychosis behavior. Anxiety [Resident name] has Schizophrenia. She is at risk for side effect and adverse side effect of psychotropic medications. Further review of Resident #93's current care plan showed another focus to include the following, Resident uses antidepressant medication r/t Depression. Further review of the current care plan showed another focus to include the following, [Resident name] is on taking seizure medications r/t mood disorder. A review of Resident #93's Annual Minimum Data Set (MDS), Section I - Active Diagnoses, showed the following under Neurological: Non-Alzheimer's Dementia. Further review of the Annual MDS, Section I, showed the following under Psychiatric/Mood Disorder to include: Anxiety disorder, Depression, and Psychotic disorder. Further review of Resident #93's Annual MDS, Section I, showed the following under Other: Unspecified Mood [Affective] Disorder. A review was conducted on 10/1/24 of Resident #93's Preadmission Screening and Resident Review (PASRR), dated 9/21/20, showed no documentation of a qualifying mental illness (MI) diagnoses. A review of Resident #93's electronic medical record on 10/1/24, showed no evidence of an updated Level 1 PASRR to include the qualifying MI diagnoses. On 10/2/24 the Director of Nursing (DON) provided a Level 1 PASRR for Resident #93, dated 10/1/24, which included the following diagnoses: Anxiety Disorder, Depressive Disorder, Psychotic Disorder, and Schizophrenia. On 10/03/24 at 11:51 a.m. an interview with the DON revealed he reviewed and updated the PASRR's. He stated he used the program and guidelines from [Vendor name] to update or revise PASRR's. The DON stated if a resident came from the hospital, he reviewed their PASRR. He stated if it was not accurate or needed to be revised/updated, then he created another PASSR through [Vendor name]. If there was a new MI diagnoses from the doctor or psychiatrist, the DON stated he expected the unit manager would communicate with him. He stated, I would re-do the PASSR at that point. A review conducted with the DON of Resident #93's PASRR, from 9/21/20, confirmed there was no MI diagnoses indicated. He stated he expected the qualifying diagnoses Resident #93 had to be listed on the form, and confirmed the PASRR was incorrect at that time. The DON confirmed he updated the PASRR on 10/1/24. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/24 at approximately 3:15 p.m. an interview with the Regional Clinical Nurse revealed there was no PASRR policy, and the facility follows the [Vendor name] website for guidelines.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observations, interviews and medical record review, the facility failed to ensure the revision and accuracy of care plan problem areas for two (#16, #91) of 55 sampled residents. Findings included: 1. On 9/23/2024 at 10:20 a.m., Resident #16 revealed he was at the facility for short term care and has plans to return home with his wife after completing therapy treatment/plan. Resident #16 confirmed he cannot get up out from bed on his own, and requires assistance from staff with dressing, personal hygiene, showering, and transfers. He reported that staff assist him out of bed to the wheelchair and staff take him where he needs to go as he cannot self propel himself in the wheelchair. Resident #16 expressed no desire to leave the facility prior to completing his therapy. Review of Resident #16's admission record he was his own decision maker and had no diagnoses to show he was an elopement risk. Review of the current Physician's Order Sheet for September 2024 and October 2024 revealed no orders related to elopement risk or behaviors Review of the most current Admission Minimum Data Set (MDS) assessment dated [DATE] revealed in Section C - Cognition; Brief Interview Mental Status score (BIMS) of 13, indicating cognitively intact. The resident had no behaviors of wandering risk or a past history of wandering. Review of the nurse progress notes dated from 4/6/2024 to 10/3/2024 revealed no documentation of exit seeking,wandering, or an elopement risk. Review of the medical record revealed elopement screenings on 2/23/2024 3/1/2024, 4/15/2024, 7/15/2024, and 9/6/2024 indicating no risk. Review of Resident #16's current care plans showed: Resident was at risk for Elopement. The intervention in place was to offer reassurance and support as needed. On 10/3/2024 at 11:30 a.m., the Care Plan Coordinator, Licensed Practical Nurse/Staff M confirmed she knew Resident #16 and revealed he needed maximum assistance by staff for transfers, dressers and propelling in his wheelchair. Staff M reviewed Resident #16's medical record and confirmed he was not an elopement risk and this care plan did not accurately reflect Resident #16. 46498 2. On 09/23/2024 at 11:47 a.m. and 10/02/2024 at 1:00 p.m., Resident # 91 was lying down in bed with her call light within reach. She was observed with no signs of distress. She stated she was very upset because she had not had a shower and her hair washed in two months. She stated she has reported this to everyone, but no one has assisted her. She stated she told staff she prefers to take bed baths instead of showers because it hurts her when she gets up. (continued on next page)

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	105045	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Braden River Rehabilitation Center LLC	2010 Manatee Ave E Bradenton, FL 34208

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #91's admission record showed this resident had resided in the facility for several years and was a long term care residents. Review of the annual MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated Resident #91 was cognitively intact. Review of the care plan focus for Activity of Daily Living Self Care Performance related to impaired mobility last revised on 3/15/2022 revealed the resident required the assistance of two staff for bathing. The care plans made no mention of Resident #91's preference for bed baths or performing hair washing. During an interview on 10/3/2024 at 12:30 p.m. with Staff R, LPN, she reported knowing Resident #91 refuses to take showers because she doesn't like to get out of bed. Staff R, LPN recalled one time in the past Resident # 91 complained to her about not getting her showers, so they tried to assist the resident with her shower, but she yelled so bad they had to put her back to bed and gave her a bed bath. Since then, they provide the resident with bed bath instead of showers. During an interview on 10/03/2024 at 3:00 p.m. with Staff M, LPN/Care Plan Coordinator, she said she was not aware of Resident #91's preference for bed baths. Staff M stated if staff had notified her, she would have revised the resident care plan to show the resident's bathing preferences. Review of the facility policy titled, Comprehensive Person-Centered Care Plan revised 8/2023 showed: Policy: The center will develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timetables to meet a resident's medical need, nursing mental and psychological needs that are identified in the comprehensive assessment. iii. Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessment and as changes in the resident's care and treatment occur. Any member of the interdisciplinary team may enter the updates to the comprehensive care plan under the guidance of a registered nurse who is responsible for the resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observations, staff and resident interviews, and medical record review, the facility failed to provide grooming and personal hygiene assistance to one (#198) of four residents reviewed for activities of daily living (ADL's). Findings included: On 9/23/2024 at 10:20 a.m., 9/24/2024 at 8:00 a.m., 10/1/2024 at 9:30 a.m., and 10/2/2024 at 9:30 a.m., Resident #198 was observed with full facial hair to include the lower and upper neck. The facial hair was approximately three quarters to an inch long, and the resident's hair on his head appeared oily and uncombed. On 9/23/24 at 10: 20 a.m., Resident #198 revealed he had been in the facility for about a week and had no hair brush or comb. Resident #198 reported he could not shave and wash his hair on his own and needed staff assistance. On 10/1/2024 at 9:30 a.m., Resident #198 revealed he was having trouble with staff assisting him with shaving and getting him a hair cut since the time of admission. The resident said he was in the military in his past and preferred to keep his hair very short and face clean shaven. Resident #198 stated he had discussed this with various staff on all shifts and nobody has helped him. On 10/2/2024 at 9:30 a.m., Resident #198 reported he told the night nurse and his certified nursing assistant (CNA) on 10/1/2024 that he wanted his face shaven and his hair washed and combed but received no assistance. Resident #198 reported staff had provided showers since admission but no help was offered or provided for shaving of his beard, washing and combing his hair. Resident #198 stated he had not declined any personal hygiene assistance. On 10/2/2024 at 9:40 a.m. the resident's assigned CNA, Staff I, was interviewed related to Resident #198's care and services. Staff I, CNA revealed she had not worked with Resident #198 prior to this day and had not seen the resident yet that morning. On 10/2/2024 at 10:02 a.m. an interview with Staff K, CNA, revealed she normally works on the hall where Resident #198 resides but had not been assigned to Resident #198 often. Staff K, CNA knew the resident but did not know he had requested to be shaved and have his hair washed, cut, and combed. On 10/3/2024 at 9:20 a.m., Resident #198 was cleanly shaven to include his face and neck. The resident's hair appeared clean and combed. The resident reported on 10/2/2024, he was provided with a shower and staff assisted him with shaving and hair care. Review of Resident #198's admission record revealed he was admitted on [DATE] with diagnoses to include osteoarthritis and need for assistance with personal care. Review of the most current Minimum Data Set (MDS) Admission assessment, dated 9/25/2024, revealed a Brief Interview Mental Status (BIMS) score of 14, indicating cognitively intact. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Admission Data Set Nursing assessment dated [DATE] showed the resident required substantial/maximal assistance (Extensive) assist of one for bathing and personal hygiene. Review of Resident #198's care plan for ADL Self Care Performance related to decreased bilateral upper and lower extremity mobility/balance and pain limiting function and decreased activity tolerance initiated on 9/18/24 and revised on 10/1/24 revealed interventions to include substantial/maximal assistance (Extensive) assist of 1 for bathing and personal hygiene. On 10/3/2024 at 9:20 a.m. an interview with Staff J, Unit Manager, revealed she was informed on 10/2/2024 that Resident #198 needed a full facial shave and had not received a shave since his admission. She revealed she had spoken with Resident #198, and he had told her he thought he would receive a shave and hair wash during shower days. Staff J could not provide specific evidence on hair washing or shaving being offered to the resident. Staff J, Unit Manager confirmed the resident had several different CNAs and not the same CNAs each day. She revealed she was unaware of the resident's concern prior to 10/2/2024 after the CNAs informed her of questions from the survey team. On 10/3/2024 the Nursing Home Administrator provided the Resident Rights policy and procedure, with a revised date of 8/2023 for review. The policy showed: The center protects and promotes the rights of each resident. The resident has a right to a dignified existence and self-determination. The Center staff will assist residents in exercising their rights. The fundamental information section of the policy stated; Residents have a freedom of choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the center's rules and regulations affecting resident conduct and those regulations governing protection of resident health and safety.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49497 Based on observation, interview,and record review, the facility failed to ensure a hazard free environment for one (#400) of six residents sampled. Findings included: On 09/23/24 at 11:46 a.m., fall mats were observed on the floor placed on both sides of bed two in room [ROOM NUMBER] with no resident in bed. Observed fall mats on the floor between bed one and bed two and between bed two and bed three, for a total of two fall mats located on each side of bed two. Resident #400 was sitting up in a wheelchair with fall mats on the floor next to her wheelchair. She stated they are a hazard she said she had tripped over them in the past, but they are still there. She stated they were her roommates, pointing to the empty bed. Photographic evidence obtained. On 10/01/24 at 2:11 p.m., fall mats were observed on the floor in room [ROOM NUMBER] on both sides of bed 2 with no resident in bed 2. Resident #400 was sitting up in a wheelchair next to a fall mat for bed 2. On 10/02/24 at 11:03 a.m., fall mats were observed on the floor on both sides of bed 2 in room [ROOM NUMBER] with no resident in bed 2. Resident #400 was sitting up in a wheelchair on the left side of her bed with bed 2's fall mat on the floor next to her wheelchair. Review of care plan dated 07/11/2024 revealed: - A focus [Resident #400] is a risk for falls. Fall risk evaluation Date Initiated: 08/22/2024. With interventions including Educate on locking wheelchair prior to sitting or exiting, Assistive devices as needed (walker) Date Initiated: 06/21/2024, and Education to ask for assistance. A review of Minimum Data Set, dated dated dated [DATE] revealed: - Section C Brief Interview for Mental Status (BIMS) showed a score of 15 which indicated no cognitive impairment. - Section GG marked independent for bed mobility, transfers, Activities of Daily Living and gait up to 150 feet. An interview was conducted with Staff S on 10/02/24 at 3:25 p.m. She stated the process for fall mats was if a resident was a fall risk, an intervention could be to have fall mats next to the bed. She stated she would place the fall mat next to residents' bed on the floor when the resident was in the bed. She stated she removed the fall mat from the floor and placed it against the wall or behind the bed out of the way when she got her residents up. She stated I don't want to trip over it if it was down when the resident was out of bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted on 10/03/2024 at 8:25 a.m. with Staff F. She stated the process for when a resident had fall mats as an intervention was for staff to have fall mats placed next to the bed on the floor when the resident was in the bed. The fall mat(s) would be removed from the floor when resident was out of bed. She stated the fall mats needed to be placed out of the way, against the wall, behind the bed and replaced next to bed on the floor when the resident returned to bed. She stated the expectation was when a resident was out of the bed their ordered fall mats were put away. Requested a fall mat, and/or accident/hazard environment policy on 10/02/24 and on 10/03/24 from facility management staff. The facility did not provide a policy prior to exit on 10/03/24.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39249 Based on observation, interview, and record review, the facility failed to provide one resident (#43), diagnosed with dementia, the treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being out of two residents sampled for dementia care. Findings included: On 9/23/24 at 12:39 p.m. Resident #43 was observed in her room in a wheelchair by the side of the bed. The resident had her head down on her knees. A lunch tray was observed on a bedside table untouched. The room was observed to be dark with no television or other stimulation present in the room. There was no roommate observed in the room. On 9/23/24 at 1:03 p.m. Resident #43 was observed still sitting in the room, crouched down with her head on her knees in a wheelchair. The lunch tray remained untouched. No staff members were observed attempting to assist with the meal. A review of the medical record showed Resident #43 was admitted to the facility with a primary diagnosis of dementia. Other diagnoses included osteoarthritis, neuralgia, edema, agitation, intraocular lens, adjustment disorder with anxiety/depression, mood disorder, and headaches. A review of the active physician orders, dated October 2024, for Resident #43 showed the following: -Regular diet; regular texture, regular consistency, fortified foods, grilled cheese @ lunch every day, ice cream with lunch and dinner -2.0 Calorie supplement three times a day for weight and nutritional support, 120 milliliters (ML) -House shake one time a day for supplement -Snack before meals for nutrition support -Full Code -Depakote oral tablet delayed release 250 milligrams (MG) one by mouth two times a day for mood disorder -Lasix 40 MG one table by mouth in morning for peripheral edema -Mirtazapine table 7.5 MG one tablet by mouth in the evening for appetite -Sertraline 25 MG one tablet by mouth one time a day for depression -Do Not Resuscitate (entered 10/03/2024) (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Do Not Hospitalize (entered 10/03/2024) -Hospice Consult (entered 10/03/2024) A review of the Quarterly Minimum Data Set (MDS), dated [DATE], showed the following: -Section C-Cognitive Patterns: Brief Interview of Mental Status (BIMS) score of 07, which indicated severe cognitive impairment -Section D-Mood: Little interest or pleasure in doing things present and 2-6 days in frequency; social isolation sometimes -Section K-Swallowing/Nutritional Status: Loss of 5% or more in the last moth or loss of 10% or more in the last 6 months-Yes A review of the Comprehensive Care Plan, reviewed in July 2024, showed the following: Focus: Resident #43 has impaired cognitive function/impaired thought process related to dementia. (Initiated: 1/29/2020 Target Date: 10/29/2024) Goal: Will be able to communicate basic needs on a daily basis through the review date. Interventions: -Communicate with family/caregivers regarding residents capabilities and needs -Discuss concerns about confusion and/or disease process with family/caregivers. -Engage resident in simple, structured activities that avoid overly demanding tasks. -Medications as ordered. Focus: Resident #43 is dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits. (Initiated 2/20/2023 Target Date: 10/29/2023) Goal: Resident will maintain involvement in cognitive stimulation, social activities as desired through the review date. Interventions: -All staff to converse with resident while providing care -Assure that the activities are compatible with physical and mental capabilities; compatible with known interests and preferences; adapted as needed; compatible with individual needs and abilities; age appropriate -Establish prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Modify daily schedule, treatment plan as needed to accommodate activity participation Focus: Resident #43 is a nutritional risk related to diagnosis of dementia, trigeminal neuralgia, anxiety, edema. Need for nutritional supplementation due to inadequate/varied intake at meals. (Initiated 1/28/2020 Target Date: 10/29/2024) Goal: Will be free from significant weight loss changes through review date. Will consume at least 5 0-75% of most meals. Will be free from signs and symptoms of dehydration. Interventions: -Assist with meals as needed -Encourage oral fluids -Monitor diet tolerance -Monitor oral intakes -Monitor weights -Evaluate as needed On 10/02/24 at 11:32 a.m. Resident #43 was observed in the room half sitting and half lying on the end of bed. The room was dark and there was no television or other stimulation present in the room. Most of the other residents were in the dining room across the hallway waiting for lunch to be served. No staff members were observed in the room to assist the resident to the dining room for lunch. On 10/02/24 at 12:26 p.m. Resident #43 was observed in the room in the same position previously described. Five minutes after the observation began staff came into the room and attempted to awaken the resident. The resident would not go to the dining room for a meal. The resident would not eat any of the meal tray that was observed on a tray table untouched. The staff offered fruit and cottage cheese, and the resident indicated she would have some fruit. The resident appeared very drowsy and answered only after several attempts to speak to her. On 10/02/24 at 12:48 p.m. Resident #43 was observed with a lunch tray open and in her room containing fruit and cottage cheese. The tray had a few strawberries eaten from the plate. No staff members were observed in the room to assist the resident with eating. The resident was observed still in the same position as previously noted. Staff entered the room after a few minutes and asked if the resident wanted soup and after several attempts the resident agreed. After about ten minutes, the staff delivered soup to the resident. The resident took a spoon full of soup and went right back to the lying position. No staff were observed staying to assist or encourage the resident with the meal. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/24 at 12:55 p.m. an interview was conducted with Staff P, Licensed Practical Nurse, Unit Manager (LPN UM). Staff P stated all nurses, aides, and therapy staff could assist a resident with meals and provide encouragement to eat and drink. She stated focus meeting[s] were done weekly for all residents at risk for falls, weight loss, nutrition, change of status, etc. Staff P, LPN stated Resident #43 had been discussed in the meetings for weight loss and a decline in her condition recently. She stated on 9/19/24 the dietician spoke to the Family Member (FM) and informed the FM of weight loss and a decline in eating for Resident #43. She stated the dietician talked to the FM about a possible peg tube (tube placed into the stomach through the abdomen for enteral feedings) for nutrition. Staff P, LPN stated labs were done on Resident #43 in July 2024, but the resident had not had any labs done since that time. She stated she was not aware of the medical provider having any discussions with the family related to the resident's decline due to her dementia. On 10/02/24 at 1:07 p.m. an interview was conducted with Staff Q, Registered Dietician (RD) and the Director of Nursing (DON). The RD stated she talked with the FMs of Resident #43 a few weeks ago. She stated the FMs knew what was going on with the decline in condition and the weight loss for Resident #43. The RD stated she talked to them about what was being done with nutrition and a possible alternative related to the peg tube. The RD stated she did not discuss the details of palliative or hospice care with the FMs because the doctor needed to sit down with the family to discuss that option. The RD stated she was waiting for the FMs to get back to her. A review of nutrition progress notes for Resident #43 showed the following: -Quarterly Nutrition note, dated 7/23/2024: Regular fortified foods, ice cream lunch and dinner, snack after meals, PO (Oral) intake 0-100%; down 11% in 180 days; Resident likely not meeting nutritional needs r/t (related to) dementia, altered labs, inadequate po intake; need for nutritional supplements and significant wt (weight) decline in 180 days. Anticipate wt/fluid fluctuations d/t (due to) diuretics. Continue POC (plan of care), no recommendations at this time. Goals: consume adequate nutrition to meet daily needs. PO intake >50% for most meals. maintain weight within 1-4% fluctuation. monitor wt, skin, labs, and po intakes. -Weight note, dated 9/17/2024: Regular diet, regular texture, regular liquids, fortified foods, ice cream lunch/dinner, snack before meals three times a day, Med pass supplement 120 ML three times a day, house shade every day. Oral intake this week <50%. Resident not likely meeting nutritional needs related to dementia and poor appetite and intake at meals/need for Mirtazapine, nutritional supplementation and significant weight loss X 30/90 days. Goal to consume adequate nutrition to meet daily nutritional needs, oral intake >50% for meals. Weight to maintain within +/- 1-4%. Continue to monitor weight, skin, labs, and oral intakes as appropriate. -Dietary note, dated 9/19/2024: Called [FM] about significant weight decline. Discussed her intake, diet, supplements, weight and how they feel about resident receiving alternate nutrition.FM states they will be coming on Sundays to take out resident to restaurants again. FM says she will talk about next steps and try to discuss with resident. Will follow up accordingly. A review of the weight history for Resident #43 showed the following: 9/23/24 151.2 lbs, (pounds) 8/19/24 166.6 lbs. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/15/24 177.6 lbs. 6/24/24 178.2 lbs. 3/02/24 198.0 lbs. -On 08/19/2024, the resident weighed 166.6 lbs. On 09/23/2024, the resident weighed 151.2 pounds which is a -9.24 % Loss. (one month) -On 06/24/2024, the resident weighed 178.2 lbs. On 09/23/2024, the resident weighed 151.2 pounds which is a -15.15 % Loss. (three months) -On 03/02/2024, the resident weighed 198.0 lbs. On 09/23/2024, the resident weighed 151.2 pounds which is a -23.64 % Loss. (six months) A review of the Medication Administration Record (MAR), dated August 2024, showed the following: -House shakes one [NAME] a day for supplements were started on 8/23/2024 and administered as ordered. Amount consumed was not recorded. -2.0 Calorie supplement (Med Pass) three times a day for weight /nutritional support 120 ML was started on 7/19/2024 and administered as ordered. Amount consumed ranged from 50 to 120 ML. -Snack before meals for nutrition support was started on 6/27/2024 and administered as ordered. Amount consumed was not recorded. A review of the MAR, dated September 2024, showed the following: -House shakes one [NAME] a day for supplements were started on 8/23/2024 and administered as ordered. Amount consumed was not recorded. -Mirtazapine 7.5 MG one tablet by mouth in the evening for appetite was started on 9/06/2024 and administered as ordered. -2.0 Calorie supplement (Med Pass) three times a day for weight /nutritional support 120 ML was started on 7/19/2024 and administered as ordered. Amount consumed ranged from 0 to 120 ML. -Snack before meals for nutrition support was started on 6/27/2024 and administered as ordered. Amount consumed was not recorded. A review of the Eating Documentation Survey Report dated August 2024 for Resident #43 revealed the resident consumed on average 25-75% of her meals for breakfast, lunch, and dinner. Snacks and fluids were offered to Resident #43 but not always consumed. A review of the Eating Documentation Survey Report dated September 2024 for Resident #43 revealed the resident consumed on average 0-25% of her meals for breakfast, lunch, and dinner. Snacks and fluids were offered to Resident #43 but not always consumed. (continued on next page)

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	105045	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Braden River Rehabilitation Center LLC	2010 Manatee Ave E Bradenton, FL 34208

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/03/24 at 12:25 p.m. an interview was conducted with Staff N, Activities Manager (AM). The AM stated she had two other assistants to help with activities for the building. She stated she had been at the facility since the beginning of the year conducting activities for all the residents. She stated there was a resource cart that was used for residents that were bed bound and there were other activities available for these residents as well. She stated they had activities such as games, cross word puzzles, music, ice cream socials, etc. they could provide. She stated the activity aides chart in the computer whenever they conducted an activity for the residents. She stated the residents in the secured unit got special treatment due to their cognitive abilities and she sent two aides to the unit to try to help keep the residents busy throughout the day. She stated all activities were in the dining room area. She stated she was familiar with Resident #43 and the resident refused to participate in anything. She stated Resident #43 used to like movie time, arts and crafts, and ice cream social was her favorite. She stated Resident #43 loved to go down to arts and crafts and ice cream socials but now she would not. She stated she had noticed Resident #43 had had a decline, and she had not been participating in activities any more. A review of the Activities Documentation Survey Report, dated August 2024, for Resident #43 revealed the following: -Ice Cream/Food Social participation documented 16 out of 31 days -Movies/TV participation documented 18 out of 31 days -Music participation documented 11 out of 31 days -Outdoor activity participation documented 2 out of 31 days -Spiritual activity participation documented 1 out of 31 days -Bingo participation documented 2 out of 31 days -Conversation/Talking participation documented 1 out of 31 days -Crafts participation documented 0 out of 31 days -Exercise/sports participation documented 1 out of 31 days A review of the Activities Documentation Survey Report, dated September 2024, for Resident #43 revealed the following: -Ice Cream/Food Social participation documented 0 out of 30 days -Movies/TV participation documented 0 out of 30 days -Music participation documented 1 out of 30 days -Outdoor activity participation documented 1 out of 30 days -Spiritual activity participation documented 0 out of 30 days (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Bingo participation documented 0 out of 30 days -Conversation/Talking participation documented 0 out of 30 days -Crafts participation documented 0 out of 30 days -Exercise/sports participation documented 0 out of 30 days On 10/02/24 at 1:38 p.m. a telephone interview was conducted with the FM for Resident #43. The FM stated the last time she was contacted by the facility was when the dietician called a couple of weeks ago. She stated prior to that she did not speak to anyone about Resident #43's care for a while. She stated after the call with the dietician she asked if someone from the facility could contact her about the possibility of Palliative Care for Resident #43. She stated when she visited on the weekend Resident #43 was hanging off the bed and the left side of her face was red. She stated it seemed the resident was there for a while. She stated Resident #43 was very afraid of falling and had dementia. She stated the resident had had a decline in the last couple of months. She stated, I could not even tell you the last time we have spoken with a medical doctor about her condition. She stated, We saw her on Sunday and her food tray had been there for a while. She had not eaten any of her food. They could not tell me if she had eaten. She stated the dietician reached out to her and talked about the peg tube and mentioned palliative care. She said the dietician told her she would need to talk to the care team. The FM stated she did not feel like she knew what to do with her decline in her dementia status. She stated she talked with a nurse when she visited and asked if she could arrange a call with the care team. She stated, I would say since the last three months I have seen a substantial decline. The last month has been a big difference. I do not know the other options and if they have tried to reach out to me I am not aware. It has been a while since I have talked to a medical provider. On 10/03/24 at 10:11 a.m. a telephone interview was conducted with the Primary Care Provider (PCP) for Resident #43. The PCP stated he was able to view the medical record for reference during the call. The PCP stated the practice cared for Resident #43 and there were also two Nurse Practitioners (NP) who worked with him to see residents. The PCP stated Resident #43 was cared for by the team on a regular basis. The PCP stated the providers were responsible for Geriatric Care and advocating for the residents. The PCP stated there was a plan of care in place for Resident #43 and on 7/17/2024 the medical record revealed a personal discussion with the family about care for Resident #43. The PCP stated at that time, The family choose to not have any palliative or hospice involvement. The PCP stated, I am not sure it was in July when I talked with them, it could have been before that, but it is documented clearly in the record. The PCP stated they typically go with the standard of care when it came to residents with dementia and laboratory testing. The PCP stated he knew some labs were done back in July but did not see any orders for any other testing since then. The PCP stated, I would be evaluating the patient and looking at the situation to determine if any labs were necessary. The PCP stated he did not recall any other discussions with the family since July 2024. The PCP stated he had reached out to the FM earlier in the morning to discuss the decline in condition and options for care for Resident #43. A review of laboratory results for Resident #43 revealed the following: 7/11/2024 (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Kidney function tests: BUN 25.0 High; Creatinine 0.7; BUN/Creatinine Ratio 35.5 High; eGFR 84 Stage 2 Chronic Kidney Disease. 12/2/2023 Kidney function tests: BUN 18; Creatinine 0.8; BUN/Creatinine Ratio 22.1; eGFR 71 Stage 2 Chronic Kidney Disease. A review of the provider progress notes revealed the following: Visit on 7/17/2024 Chief complaint: [AGE] year old female reported poor oral intake-{PCP} discussed with family. History and Physical (HPI): [AGE] year old female-memory care, BLE (bilateral lower extremities) edema-continues on Lasix-also has poor po (oral) intake-[PCP] discussed with family decline palliative care, decline peg tube-decline hospice. Discussed with staff. Assessment: Edema on Lasix Weakness Weight loss-encourage po [PCP] discussed with family Dementia memory care Mood disorder on Depakote. Followed by psychiatry CKD labs reviewed and stable Leg swelling-continue Lasix Plan: Weight loss Encourage oral intake- [PCP] discussed with family Will revisit with family at later date Discussed with staff Labs reviewed stable (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continue to monitor Wrap legs if necessary continue Lasix Visit on 9/18/2024 Chief complaint: [AGE] year old female dementia weakness sleeping on bed discussed with staff. HPI: [AGE] year old female-memory care, BLE edema-doppler negative treated with antibiotic-also no improvement with sleeping on bed-per staff decline overall. Assessment: Edema doppler negative also treated with antibiotic not much improvement Weakness Weight loss Dementia Memory care Mood disorder on Depakote. Followed by psychiatry CKD labs reviewed and stable Leg swelling-continue Lasix Plan: Finished antibiotic doppler negative not much improvement with legs Encourage po intake Labs reviewed stable Continue to monitor Wrap legs if necessary (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/03/24 at 10:43 a.m. a follow up telephone interview was conducted with the FM of Resident #43. The FM stated, I have never talked with the doctor and had a conversation with him at any time that I can recall. I don't even know who the [PCP] is. I have never declined the offer of hospice and palliative care, and it has never been offered to us by anyone. The first time I knew of this is when I talked with the dietician. I do not have any messages from the doctor, but if I can get in touch with them I really would love to find out about the possibility of palliative or hospice care. I know some about it, but I have some questions and would like to sit down and talk with someone about it. A review of the facility policy titled Nutritional Risk Evaluation, revised 8/2023, revealed the following: Purpose: Each resident receives a nutritional evaluation upon admission, quarterly, annually, and whenever a resident is identified as having a significant change in status. The nutritional evaluation is an approach to screen, define, and treat the resident's nutritional status. The nutritional evaluation encompasses the medical data, physical condition and examination, nutrition history, social history, and nutrient assessments. The evaluation process includes the organization and evaluation of subjective and objective information to make a sound professional judgement. The nutritional evaluation is then utilized in the development of the resident's individualized care plan to demonstrate the residents' needs and priorities. A review of the faciltiy policy titled Procedural Guidelines for Palliative Care, updated 4/4/2024, revealed the following: Purpose: Palliative care is an approach that focuses on improving the quality of life for resident with chronic, debilitating, and/or life-limiting illness. Factors that may suggest eligibility include various clinical manifestation, lab parameter and/or declining functional performance. Early identification is subjective and challenging and is key first step in engaging resident to consider this approach to care. Definitions: Palliative care means patient and family-centered care that optimized quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice. Palliative care focuses on the symptoms and stress of the disease and treatment. It treats a wide range of issues that can include pain, depression, anxiety, fatigue, shortness of breath, constipation, nausea, loss of appetite, difficulty sleeping and many more. Common indicators may include: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Frequent hospitalization s End stage progressive illness or cancer diagnosis Cognitive decline, dementia Progressive weight loss and/or frailty Frequent or high risk for falls Polypharmacy Skin failure Chronic pain Goals of Palliative Care: Management of physical symptoms to achieve the highest quality of life possible Direction and support of physical, psychological, social, and spiritual issues that matters most to the resident, and When eminent, death will be a peaceful, dignified, and as pain-free as possible. These goals are accomplished through person-centered care planning, implementation, and evaluation by the interdisciplinary team of caregivers, the resident, and/or resident representative, and family members.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49227 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than 5.00%. 29 medication administration opportunities were observed, and three errors were identified for two residents (#7 and #85) out of three residents observed. These errors constituted a 10.34% medication error rate. Findings Included: During medication administration on 10/2/24 at 8:39 a.m., Staff E, Licensed Practical Nurse (LPN) was observed preparing and administering the following medications to Resident #85. The medications included: amantadine 100 mg for Parkinson's gabapentin 100 mg for neuropathy fluphenazine HCl 10 mg for schizophrenia esomeprazole magnesium 20 mg for Gastroesophageal reflux disease (GERD) Zoloft 50 mg for depression Olanzapine 10 mg for anxiety aspirin 81 mg for preventative Loradamed 10 mg for allergies Cranberry 400 mg for urinary health Staff E, LPN administered Cranberry 450 mg, failed to administer the correct dose. Photographic Evidence Obtained. Fluticasone-Umeclidinium-Vilanterol- 100-62.5-25 inhalation aerosol for chronic obstructive pulmonary disease (COPD) was administered. A review of Resident #85's medication orders showed administration direction was to rinse mouth with water after each use. Staff E failed to offer Resident #85 water to rinse his mouth and did not observe the resident rinsing his mouth before exiting the room. At the completion of the medication administration, Staff E verified Resident #85 was not offered water to rinse mouth as ordered. During medication administration on 10/2/24 at 9:03 a.m., Staff D, LPN was observed preparing and administering medications to Resident #7. The medications included: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gabapentin 600mg for neuropathy sucralfate 1gm for gastric protection Coreg 3.125 mg for high blood pressure famotidine 10 mg for GERD Robaxin-750 for muscle spasm potassium chloride 20 meq. for supplement oxybutynin chloride 5 mg for bladder spasm Fluticasone-Umeclidinium-Vilanterol- 100-62.5-25 inhalation aerosol for COPD Eliquis 5 mg for blood thinner Buspirone 10 mg for anxiety Artificial Tears for dry eyes A review of Resident #7's MAR showed Lexapro 30 mg (3 tablets) ordered for depression. Staff D, LPN administered Lexapro 10 mg (1 tablet). During an interview conducted on 10/3/24 at 9:34 a.m., the Director of Nursing (DON) said he would look into the cranberry order and check the facility's stock of the medication. The DON was notified that after administering Fluticasone-Umeclidinium-Vilanterol- 100-62.5-25 inhalation aerosol, Staff D, LPN did not offer water for the resident to rinse his mouth as ordered. The DON said okay and had no additional questions. Review of the facility's procedural guidelines, titled Medication Pass and Med Pass with Medication Cart, updated 8/14/24. Showed the purpose to assure the most complete and accurate implementation of physicians' medication orders and to optimize drug therapy for each resident by providing for administration of drugs in an accurate, safe, timely, and sanitary manner . guidance steps in the procedure showed .2) verify the medication label against the medication sheet for accuracy of the drug frequency, duration, strength, and route. 2a) the nurse is responsible for reading and follow precautionary or instructions on prescription labels.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observations, and staff interviews, the facility failed to ensure cooked and prepared food was stored in a manner to prevent food contamination during four of four meal observations observed on 9/23/2024, 9/24/2024, 10/1/2024 and 10/2/2024. Findings included: During lunch and breakfast meal observations in the main dining room on 9/23/2024 at 11:59 a.m.; on 9/24/2024 at 8:20 a.m.; on 10/1/2024 at 8:00 a.m., 12:30 p.m.; and on 10/2/2024 at 8:00 a.m., 12:00 p.m., the dining room was observed with a Satellite steam table in the back of the room, near the kitchen entrance/exit door. The kitchen staff took cooked and prepared food items from the kitchen and placed them into hot service containers on this steam table. From there, a staff member plated the food items and handed them out to the receiving dining staff. Photographic evidence obtained. During all listed observed times, there were over thirty residents seated at tables in the main dining room and either awaiting or being served their meals. Two of the tables where residents eat at, were approximately six feet from the steam table. Further observations revealed the steam table did not have a barrier or sneeze guard that separated the dietary service staff and exposed food items, from the dining room receiving staff. It was observed that Staff O, Dietary Aide took clean plates from the side table, scooped various food items per resident request onto the plates, and then handed the plates to the receiving staff, and then they took the plates of food to residents seated at tables. Several staff would hover over the exposed food items and reach with their hands and arms over the exposed food items on the steam table, to take plates of food from Staff O. There were times when staff were observed with their bodies, arms, hands and head directly over the exposed food items, which had no barrier between them. During the observed listed dates and times, Staff O was observed wearing blue plastic gloves while plating food from the Satellite steam table. There were times she was observed plating food, then removing the gloves and touching her clothing, then opened the kitchen entrance door with her bare hands, went inside and got utensils, touched her clothing and face, and then re-gloved without first washing her hands. She was noted to do this at least ten times. She was also observed to touch other staff member's shoulders with her bare hands and without washing or sanitizing her hands prior to re-gloving. On 9/23/2024 at 12:11 p.m. Staff O brought out a plastic covered plate of prepared salad out into the dining room and placed the plate of salad directly on the side counter of the Satellite steam table. At 12:17 p.m. she moved the plate of salad on the top shelve of a plastic cart, which was sided next to the Satellite table. The Satellite steam table was fully on and heated. The plate of salad remained on this side cart from 12:17 p.m. through to 12:55 p.m. before a staff member took it to a resident seated in the dining room. It was determined this plate of salad, which was cold prepared food, sat on or directly next to a hot steam table from 12:13 p.m. through to 12:55 p.m., which was for forty-two minutes. This was not a good storing method for cold food items. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Staff O revealed she, nor the dining room staff were sure if the resident was going to eat in the dining room or in his room for lunch. She confirmed she should not have left the plate of cold salad next to and at the hot steam table and should have put it in a container of ice, put it back in the refrigerator, or had staff prepare another plate of food. The resident who was served the plate of salad was not interviewable to answer if the cold food items were warm. On 10/2/2024 at 12:23 p.m., while lunch meal dining service was being conducted in the main dining room, the Certified Dietary Manager (CDM) Staff A was observed at the satellite steam table at the back of the room and near the kitchen entrance/exit door. She observed the dietary staff plating food for staff to take to residents seated at tables. She observed dining room staff reach over the steam table with exposed food to grab plates from Staff O. While interviewing Staff A with regards to the steam table, she immediately stated, there is no sneeze guard on the steam table. She confirmed that the table was fairly new and it did not come with a barrier or sneeze guard. She explained they would be getting one but confirmed the current practice of staff who were ungloved, and reaching over the exposed with their bare hands, over the steam table, should not happen and she would need to figure out a better way for staff to get the plates of food without having to [NAME] and reach over the exposed food. She confirmed that the current practice at that time was not the best and it posed risk for food contamination. On 10/3/2024 at 9:00 a.m. an interview with the Nursing Home Administrator confirmed the food service procedure in the dining room should have had a better food plating and food receiving practice. She confirmed the steam table was newer and also confirmed the steam table did not have a barrier or sneeze guard between food items and staff who came to the table. She provided a quote for a sneeze guard dated 9/24/2024, which was after the first two initial observations on 9/23/2024 and 9/24/2024 with regards to improper food service from the steam table. On 10/3/2024 at 12:00 p.m., the Nursing Home Administrator provided the Food Service Policy, with a revised date 8/2023 for review. The policies purpose stated; The center stores, prepares, distributes, and serves food under sanitary conditions.