STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105351	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concordia Village of Tampa	4100 E Fletcher Ave Tampa, FL 33613

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observations, record review and interviews, the facility failed to ensure a change in condition was addressed for one resident (#51) of a total sample of 46 residents. Findings included: Review of the Admission Record revealed Resident #51 was admitted to the facility on [DATE] with diagnoses to include cerebral infarction, unspecified, unspecified atrial fibrillation, dysphagia, and need for assistance with personal care. On 04/10/24 at 8:31 a.m. an interview was conducted with Resident #51. She stated she did not feel well and did not know what was wrong with her. She said, I don't feel well. I feel like crawling out of my skin. The resident stated she has been having this feeling for a long time. She stated she notified the staff and her POA (power of attorney). She stated she was not sure what was being done about it. On 04/09/24 at 12:11 p.m., an interview was conducted with Resident #51's POA. She stated she noticed the resident had declined. She used to be in the front side of the building, they moved about 10 residents. She stated the resident has not been herself since then. She stated the residents on the second floor were long-term residents who were very close and use to the staff. She stated they did not move the staff. The POA stated the resident had different CNAs (certified nursing assistants). She said, She (Resident #51) does not do the things she used to do. I have been telling the nurses that I think she has depression; she needs to be seen. The POA stated the resident has had a change which had been going on for at least three weeks, if not more. She restated the resident had not been herself since the move. The POA stated the resident has had no appetite and she reported feeling like her skin was crawling out. During this interview, Resident #51 stated she reported this to the CNA (Staff Q). During an interview on 04/09/24 at 12:15 p.m. with Staff Q, CNA she stated she noticed a change in the resident. She stated the resident had been eating less. She said, Yes, she told me she is not feeling like herself. I think it was last week. I notified the nurse. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 04/09/24 at 12:22 p.m. was conducted with the Food Service Coordinator (FSC). She confirmed she noticed a change in the resident, but she did not know what it was. She stated it had to do with the move. She is more depressed. She is not her jovial self, she is eating less. She stated she would notify the Director of Nursing (DON) if she noted a change. She stated she had not notified anyone prior to this. The FSC stated she had just mentioned it to Staff S, Registered Nurse (RN). An interview on 04/09/24 12:38 p.m. was conducted with Staff S, RN. He stated Resident #51 sometimes ate and sometimes she did not. He stated sometimes she had expressed some concerns related to wounds. He stated he noticed sometimes she slept too much. He stated he monitors the resident. He stated over the weekend the resident had problems with her blood pressure and he notified the doctor. He stated she had not said anything about her skin crawling. He stated the FSC just notified him. An interview on 04/09/24 at 05:07 p.m. was conducted with Staff E, Licensed Practical Nurse (LPN)/ Unit Manager (UM). She stated if a resident had reported a change, they would do a head-to-toe assessment, ask the resident what they were feeling, assess, complete an SBAR (Situation, Background, Assessment, Recommendation), notify doctor and family and follow -up accordingly. She stated she was not aware this resident had a change. A follow-up interview was conducted on 04/10/24 at 10:04 a.m. with Staff E, LPN/UM. She stated she spoke with the resident. She said, She (Resident #51) did tell me that she has not been feeling herself, and she feels her skin is crawling in her neck. She stated it had been going on for a while. She could not identify how long. Staff E stated the Advanced Registered Nurse Practitioner (ARNP) went to see her this morning. Staff E stated the resident had a change in condition on Saturday related to her blood pressure and they started her on IV (Intravenous). She confirmed there was not much follow up until yesterday. Staff E, LPN/UM stated the resident was agreeable for a psych consult which they had scheduled a consult. Staff E stated staff did not do a note for the skin crawling concern. She said, It could be a medication reaction or a psych issue. I would have expected an SBAR or Change in Condition to be documented and to get orders and follow up with the responsible party and make me aware or the DON. I would be upset if I felt like my skin was crawling. Staff E stated staff should have documented her concerns prior to this and contacted the physician for orders. Review of a facility policy titled, Notification of Changes, dated 10/17/22, showed the purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43453 Based on observations, interviews and review of facility policy, the facility failed to ensure four resident rooms (212, 216, 217 and 218) were maintained in a clean and sanitary for one of two floors. Findings included: During a tour of Resident room [ROOM NUMBER] on 04/08/24 at 10:16 a.m., an observation was made of the resident's bathroom with dirt and dust on the floor corners. The floors and bathroom walls were stained with brown and dark matter and the toilet was observed with brown stains around the base. A plastic storage bin under the toilet was observed with dust on the surface. The resident in the window bed stated the cleaning could be better. She stated she had seen a cockroach in the bathroom. She stated the toilet was always dirty. She stated they had a nice housekeeping staff member who was no longer there. She stated it had not been the same. An observation of the resident's drinking cup was made with a small insect on the drinking straw. The resident stated she had observed the insects in her room before. During a tour of Resident room [ROOM NUMBER] on 04/08/24 at 10:30 a.m. the toilet was observed with dust, debris, and particles around the floor corners. The floors were observed with stains and the toilet base with brown matter on the surface. The resident in the door bed stated they did not clean very well, the bathroom was always dirty. During an interview on 04/09/24 at 11:10 a.m. with Staff P, Housekeeping, she stated she cleaned all the rooms. She stated if the floors were stained and if she could not get the stains off, she would notify her supervisor. She stated if there were bugs anywhere, she would notify her supervisor. During a tour of Resident room [ROOM NUMBER] on 04/09/24 at 11:17 a.m., two urinals were observed on the resident's head of bed, hooked to the bedside rail. They were observed with urine, stained and with a foul order. The resident in the window bed stated it was always like that. An interview was conducted on 04/10/24 at 9:06 a.m. with Staff M, Housekeeping, Staff P, Housekeeping, and the Housekeeping Manager (Manager). The Manager stated sometimes they have problems with the caulking around the toilet bases in the bathrooms. She said, There is a rust appearance on the toilets' bases, it is hard to come off. Staff P said, I try to use bleach and brush to get it off. Staff M stated it was the first time she saw the small flying insects. The Manager stated no one said anything about the flying insects. She stated she would call maintenance to come and spray. She stated the facility had a pest control contractor who comes on Wednesdays. She stated the problem with the small flying insects was because the showers don't get used often and it could be the drain issue. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/24 at 10:09 a.m. an interview was conducted with Staff E, Licensed Practical Nurse (LPN)/ Unit Manager. She stated the small flying insects were all around the building. She stated there should not be flying insects on residents' drinking cups, on themselves or in their spaces. She stated the CNAs (Certified Nursing Assistants), and nurses should replace the residents' urinals daily if needed. Staff E observed photographic evidence and said, Insects on resident's plate, that is gross, I can't imagine about the residents who cannot swish the insects off themselves. Staff E stated maintenance knew. She said, We told them. I am not sure what they have done about it. I spoke to him last week Wednesday. Review of a facility policy titled, Daily Resident Room Cleaning Procedure, dated 1/30/23, showed to (b.) clean the bathroom (see bathroom cleaning policy). [This policy was not provided.] (d.) Utilize bathroom cleaner to disinfect the sink, handrails, toilet, and all other surfaces in the bathroom. (l.) Mop the floor if it is not carpeted. 46234 An observation was made on 04/08/24 at 1:47 p.m. of Resident room [ROOM NUMBER]. The wall behind the head of the bed had long scrape marks and baseboards that were cracked with several chunks of wood missing. Review of a facility policy titled, Resident Environment Quality, dated 10/17/22, showed it was the policy of this facility to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. (Photographic Evidence Obtained)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438 Based on observation, record review, interview, and review of the policy and procedure, the facility failed to ensure an unwitnessed fall that resulted in serious bodily injury (nondisplaced fracture of second cervical vertebra) was reported to the appropriate agencies for one resident (#44) out of the sampled two residents. Findings included: On 04/08/24 at 11:15 a.m. Resident #44 was observed in bed with a cervical collar around her neck. During an attempt to interview her, the resident did not speak. On 04/10/24 at 9:12 a.m. Resident #44 was observed in bed with a cervical collar around her neck. Fall mats were observed on both sides of the bed on the floor. A review of the Transfer/Discharge Report showed Resident #44 was admitted on [DATE] and had diagnoses to include nondisplaced fracture of second cervical vertebra, subsequent encounter for fracture with routine healing, bipolar disorder, dementia, psychotic disturbance, mood disturbance, anxiety disorder, contracture of the muscle, history of falling, abnormalities of the gait and mobility, contracture of the right hip, left hip, left hand, left knee, and right knee, depression, other fracture of upper and lower end of left fibula, reduced mobility, and unsteadiness on feet. Section C- Cognitive Patterns of the Minimum Data Set (MDS), dated [DATE], showed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 06 out of 15 indicating severe impairment. Section GG- Functional Abilities and Goals showed Resident #44 was dependent for self-care and mobility. A review of the Order Summary Report with active physician orders as of 04/10/24 revealed the following: Air mattress for prevention (08/09/23), and resident to wear cervical collar at all times, may remove for care and reapply every shift for pain (04/05/24). The Incident by Incident Type log provided by the facility showed the resident had an unwitnessed fall on 03/09/24 at 4:40 a.m. (actual time per progress note 3:50 a.m.) and an unwitnessed fall on 04/04/24 at 11:45 p.m. A review of the progress notes from 03/01/24 to 04/10/24 showed the following: 03/09/24 04:27- Resident found on the floor next to the bed at 03:50. 03/09/24 05:10- Situation- Resident was observed lying on her side on the floor next to the bed. Possible and/or actual contributing factors: Pressure reducing mattress too inflated. Assessment and Appearance: vital signs, ortho blood pressure, pain, and/or injuries: within normal limits. The resident complained of pain but unable to state where. Sent to the emergency room for evaluation and further treatment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/9/24 09:25- Resident found on floor face down next to bed at 03:50, resident was responsive when asked about pain. No visible cuts or bruises. Certified Nursing Assistant (CNA) assisted writer with getting resident back in bed, resident was lying on sheet that was on her bed which was used to lift from floor back into lowered bed. No visual injuries, 911 call, family member notified, hospice, and doctor notified. Emergency Medical Technician (EMT) arrived around 04:20. Ambulance service transported to local hospital to be evaluated. 03/13/24 14:14 (2:14 p.m.)- Resident was received at 1:45 pm back from a local hospital by ambulance with a diagnosis of cervical compression fracture due to a fall. Using Percocet for as needed (prn) pain every 6 hours. Resident was received with a collar that should only be removed for care and comfort. Results showed compression fracture in cervical vertebra (c2). 03/15/24 20:16 (8:00 p.m.)- She presented to a local hospital on 03/09/24 for an unwitnessed fall. Per hospital records, computed tomography (CT) of the neck showed acute c2 compression fracture. A neck collar was placed, and she was stable. CT of the cervical spine showed c2 with inferior and anterior osteophyte and vertebral body fracture. Continue cervical collar. The patient was seen today for acute/chronic care management. 03/22/24 13:41(1:41 p.m.)- No gross findings from C1 to C5. Non-diagnostic cervical spine series with non-visualization of the remainder of the inferior cervical spine. Fracture was not excluded. Recommend repeat diagnostic exam to include the inferior cervical spine or CT if unable to obtain appropriate images. 03/22/24 13:56 (1:56 p.m.)- Reviewed cervical spine x-ray. No gross findings from C1 to C5. Non-diagnostic cervical spine series with non-visualization of the remainder of the inferior cervical spine. Fracture was not excluded. Cervical collar in place. 04/05/24 05:43- Resident returned to facility at 05:00 with no new order. 04/05/24 00:01(12:01 a.m.)- Resident found on floor at 11:35 p.m., assessed for injuries, nothing visible observed, and no complaints of pain. 911 called and the resident was sent to a local hospital. 04/05/24 08:30- She was seen for follow up for a fall. She was sent to the hospital and returned with negative findings. Patient was placed on 15-minute checks per facility. Cervical collar in place. She was laying on her side with head of bed elevated. She denied any pain or discomfort. No edema. 04/05/24 09:21- Fall Risk: History of falls (past 3 months): 1-2 falls in past 3 months. Level of consciousness / mental status: intermittent confusion. Resident was chairbound / incontinent. Vision status: Poor (with or without glasses). Recent hospitalization history in last 30 days: Yes. Gait / balance: Decreased muscular coordination. Gait / balance: Requires use of assistive devices (i.e. cane, wheelchair, walker, furniture). Fall Risk Score: 14.0. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/05/24 14:44 (2:44 p.m.)- Resident was reviewed this morning for being found on floor next to bed. The resident was on an air mattress with bolsters to provide spatial awareness. There was no injury noted. She denies pain at this time. She was unable to state what happened. She was sent out to the emergency room with negative findings. Care plan reviewed. Will place resident on 15-minute checks. Will provide mats at bedside bilaterally. Staff to post outside of door on all shifts. Care plan updated. 04/08/24 11:18- The resident was alert, on an air mattress, and good positioning on bed with 15-minute checks Check to prevent falls. The care plan with a Focus area of falls/injury showed Resident #44 was at risk for falls or injury related to history of transient ischemic attack (TIA) and falls initiated on 11/15/21 and revised on10/19/22. Interventions included the following: Assist to wear non-slick footwear that fits, initiated: 11/15/21. Call bell in reach, initiated: 11/15/21. Ensure adequate lighting for all activities, initiated: 11/15/21. Evaluate risk for falls with Fall Assessment Tool, initiated: 11/15/21. Keep areas free of obstructions to reduce the risk of falls or injury, initiated: 11/15/21. Maintain safety precautions as ordered, initiated: 11/15/21. Medication dose adjustment as ordered, initiated: 11/15/21. The resident uses a high back reclining wheelchair with L board for legs when out of bed, initiated: 10/19/22. Physician follow-up prn, initiated: 11/15/21. Staff to post outside room when charting, initiated: 04/05/24. Transferring - Full body lift assist of 2, initiated: 07/15/22. The care plan showed no new interventions after Resident #44 had an unwitnessed fall and sustained a nondisplaced fracture of the second cervical vertebra on 03/9/24. It was not updated until she had another fall on 04/04/24. An additional Focus Area for Resident #44 revealed: (Resident #44) has an ADL self-care performance deficit r/t (related to) CVA and decreased mobility, revised on 10/19/22. The interventions included: Bed Mobility - (Resident #44) requires total assistance from staff for bed mobility and use of bilateral 1/4 rails, Transfer - The resident is totally dependent on (X2) staff with full body lift for transferring. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/24 at 1:42 p.m. a telephonic interview was conducted with Staff F, Certified Nursing Assistant (CNA). He stated he worked the shift Resident #44 had a fall (3/9/24). It was a regular night and before he left for break, he checked on her and she was asleep. It was a quiet night. When he came from break, Resident #44 was observed on the floor and he went to get the nurse, Staff W, Licensed Practical Nurse (LPN). The resident was talking. Staff W, LPN checked her and they got her back in bed. Staff F, CNA, stated he changed her brief before EMS (Emergency Medical Services) came. She was really contracted. He was still working there (no longer works at the facility) when she returned from the hospital. She had a neck brace and a low bed. He never looked at the mattress. She was really small and didn't notice anything wrong with the mattress at that time. On 04/10/24 at 10:06 a.m. the Regional Nurse Consultant (RNC-1) reported Resident #44's family member presented to the building. He was upset, loud, and stated she was neglected and that caused her to fall. She and Staff E, LPN/Unit Manager met with the family member. They went through her care plan and showed him interventions they had in place. He talked about Resident #44's history with anxiety and was concerned she was having anxiety at night, so they ordered Sertraline. On 04/10/24 at 9:41 a.m. the Director of Nursing (DON) stated Staff F, CNA was the assigned aide for the first fall. Staff had just gone in to check on her and shortly after she was on the floor. Staff W, LPN called 911 and they came to pick her up. She was diagnosed with a nondisplaced C2 cervical fracture. Resident #44 had an air mattress and there were no bolsters on the air mattress at the time of the first fall. After looking at the air mattress, it seemed like it was a hospice air mattress and looked like it was over inflated. They think the air mattress caused her to slide off the bed. The initial air mattress came from hospice. She replaced the air mattress with one of their air mattresses. The DON did not know if hospice was checking the air mattress or not. She looked at the air mattress and could not tell what the air mattress was set on. There were no numbers on the dial for her to see. The numbers were faded. For the air mattresses provided by the facility, they have push buttons. She did not know if the staff were checking the air mattresses. The DON stated she had hospice come pick up the air mattress while Resident #44 was at the hospital and replaced it with one of their air mattresses. Staff X, CNA, was the assigned aide for the second fall (4/4/24). Staff X, CNA reported in her statement that she heard talking and when she went in the room Resident #44 was on the floor. She yelled for the nurse. Staff W, LPN came down and she (Staff X) stayed with the resident while he called 911. Any forward motion such as a sneeze or cough, was determined to cause the second fall. Her body alignment was the issue. They do not use side rails, so bolsters were added to the air mattress after the second fall. When staff are not doing care, someone needs to be posted outside of Resident #44's door when charting. This was added to the care plan as an intervention after the second fall. She talked to her Administration about reporting the incident and because they didn't do anything to cause the accident, the first unwitnessed fall which resulted in a nondisplaced fracture of the second cervical vertebra was not reported. When asked why the second fall was reported and there were no injuries, the DON stated because a family member threatened to call the State Agency. She wanted to make sure she was covered so she reported the second fall. Review of the policy titled, Abuse Prevention and Prohibition, revised on 05/22, revealed the following: 7. Reporting/Response: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Report all alleged violations immediately to 1-800-96-ABUSE. In addition, an immediate report must be made to the Survey Agency in Tallahassee. The Elders Justice Act states that the report must not be later than 2 hours after forming the suspicion that resulted in serious bodily injury, or not later than 24 hours if the events that caused the suspicion did not result in serious bodily injury. A one day/five day notification form to be completed and sent to the State Agency in Tallahassee. All necessary corrective actions will be taken depending on the results of the investigation. Analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences . The facility will also notify the appropriate agencies, based on the nature of the abuse allegation in accordance with State and Federal statute.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observations, interview, and record review the facility failed to develop and implement care plan for two residents (#23 and #670) out of 25 sampled residents. Findings included: 1. An observation was conducted on 4/8/24 at 12:05 p.m. of Resident #23 in the dining room. The resident was asked about her lunch, and she stated she didn't have hearing aids and could not hear. An interview was conducted on 4/8/24 at 2:05 p.m. with Resident #23's family member. He said the resident had hearing aids that had been lost. He was upset Resident #23 was unable to hear him and communicate. Review of the Admission Record showed Resident #23 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, dysphagia, major depressive disorder, chronic kidney disease, and dementia. Review of an Audiology Testing report, dated 7/6/23, showed Resident #23 had severe-profound sloping hearing loss on the left and right side. Recommendations showed the resident could benefit from amplification in both ears. Review of Resident #23's medical record revealed a progress note, dated 3/11/24, from audiology. The note showed audiology spoke with the nurse and, the nurse had the resident's hearing aid bag and case, but she didn't know where the hearing aids were. An interview was conducted on 4/9/24 at 2:11 p.m. with Staff Q, Certified Nursing Assistant (CNA). She said Resident #23 had hearing issues, but her hearing aids did help her when she had them. She said without them the resident could not hear. Review of Resident #23's active care plan did not show a care plan or interventions in place related to hearing impairment. An observation was made on 4/10/24 at 11:18 a.m. of Resident #23 in the dining room. A staff member was trying to communicate with Resident #23. She placed her mouth about 4 inches from the resident's ear and yelled very loudly trying to get the resident to hear her. The staff member repeated this process three times. An interview was conducted on 4/10/24 at 2:24 p.m. with Staff K, Licensed Practical Nurse (LPN)/Minimum Data Set (MDS) Coordinator. Staff K said she was not aware Resident #23 had a hearing impairment or hearing aids. She said nursing staff should have informed her about the resident's impairment and she would have put in a care plan with interventions. Staff K said she would put a care plan in place with interventions to assist the resident in communicating with staff and family. She confirmed the resident should have already had a care plan related to hearing impairment in place. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concordia Village of Tampa	4100 E Fletcher Ave Tampa, FL 33613

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An interview was conducted on 4/8/24 at 10:13 a.m. with Resident #670. The resident stated she had recently had a fall in the facility. Review of the facility's Accident Log showed Resident #670 had a fall on 3/25/24. Review of progress notes for Resident #670 showed a Health Status Note, dated 3/25/24 at 7:23 p.m. showing: At 6.18pm [sic] CNA assigned to resident observed her sitting on the floor in front of her wheelchair by the bedside and notified writer. Write checked on resident denies pain. Resident slide down from the wheelchair ,ROM [Range of motion] done and assisted back to bed, POA [Power of Attorney] and Physician notified no new order extensive assistance with ADL [Activities of Daily Living] provided will cont [continue] to monitor. Review of Admission Record showed Resident #670 was admitted on [DATE] with diagnoses including severe protein-calorie malnutrition, muscle wasting and atrophy, abnormalities of gait and mobility, and unsteadiness on feet. Review of Resident #670's Fall Risk Evaluation, dated 2/20/24, showed the resident had a fall risk score of 13. The evaluation showed, If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented in the care plan. Review of Resident #670's Baseline Care Plan, dated 2/20/24, did not indicate the resident was at risk for falls. Review of Resident #670's Comprehensive Care Plan showed a care plan for risk for falls/injury was not put in place until 3/26/24, the day after the resident had a fall. An interview was conducted on 4/9/24 at 3:39 p.m. with Staff E, LPN/Unit Manager (UM). She said a resident that was a fall risk typically had a care plan initiated with interventions to prevent falls, then it is revised, and new interventions added after they had a fall. Staff E reviewed Resident #670's medical record and said she did not see a care plan in place for being at risk for falls prior to her fall. Staff E said she was going to investigate it and provide an update. A follow-up interview was conducted on 4/9/24 at 3:52 p.m. with Staff E, LPN/UM. Staff E said she reviewed Resident #670's care plans since admission looking to see if there was a discontinued fall risk care plan and, Unfortunately she didn't have one. She confirmed Resident #670 should have had a falls risk care plan with interventions in place to prevent falls. An interview was conducted on 4/9/24 at 5:10 p.m. with the Director of Nursing (DON). She said she was made aware of Resident #670's lack of fall risk care plan prior to her fall on 3/25/24. The DON reviewed the resident's care plans, interventions, and baseline care plan. She confirmed there should have been a fall care plan in place and there was not. Review of a facility policy titled, Comprehensive Care Plans, undated, showed the following: Policy: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is the policy of this facility to develop and implement A comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally-competent and trauma informed. . 2. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. . Review of a facility policy titled, Hearing and Vision Services, implemented 10/17/22, showed the following: Policy: It is the policy of this facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated. Policy Explanation and Compliance Guidelines: 1. The facility will utilize the comprehensive assessment process for identifying and assessing a resident's vision and hearing abilities in order to provide person-centered care. This process includes: a. Obtain history from medical records the family and the resident regarding hearing and vision abilities; b. MDS [Minimum Data Set] and care area assessments; c. Ongoing monitoring of sensory problems; d. Care plan development and implantation, and e. Evaluation. 2. Employees should refer any identified need for hearing or vision services/appliances to the social worker/social services designee. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled, Fall Prevention Program, implemented 10/17/22, showed the following: Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines: 3. The nurse will indicate on the Care Profile the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. 5. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care.

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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** 20311 Based on observations, record review and interview the facility failed to provide Activities Of Daily Living (ADLs) for two residents (#122 and #123) of five residents sampled for ADL care related to personal hygiene. Findings included: 1. An observation of Resident #122 on 04/08/24 at 10:09 a.m. revealed the resident sitting up in her bed watching television. The resident was observed to have strands of white facial hair on her chin. Interview with Resident #122 at this time revealed she does not like the hair on her chin and that she would like the facial hair to be gone. An observation of Resident #122 on 04/09/24 at 8:54 a.m. revealed the resident sitting in bed. The resident was observed to still have white strands hair on her chin. An interview with the resident at this time revealed she prefers to have her face clear with no facial hair. The resident reported the staff have helped her get washed up, but no one has asked or offered her assistance with the hair on her chin. Review of Resident #122's Admission Record revealed the resident was admitted to the facility on [DATE] and had diagnoses that included muscle wasting and atrophy, unsteadiness on feet, and need for assistance with personal care. Review of the Resident #122's 5-day Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview For Mental Status (BIMS) score of 12 (Moderate Cognitive Impairment). Continued review of the MDS revealed the Resident is dependent with substantial/maximal assist with Shower bath self. Review of the Resident #122's medical record revealed there was no care plan in place to address the resident's need for assistance with ADLs. 2. An observation of Resident #123 on 04/08/24 at 10:09 a.m. revealed the resident sitting up in her bed reading a book. The resident was observed to have strands of white facial hair visible on her chin. An interview with Resident #123 revealed she does not like to have hair on her chin and that she would like the facial hair plucked. An observation on 04/09/24 at 8:57 a.m. of Resident #123 revealed the resident sitting up in her bed reading a book. An interview with the resident at this time revealed the resident does not like hair on her face. She reported that if they gave me a mirror and tweezers I could pluck it myself. Review of Resident #123's Admission Record revealed this resident was admitted to the facility on [DATE] with diagnoses that included muscle wasting, and atrophy, need for assistance with personal care, and unsteadiness on feet. Review of a BIMS Evaluation progress note, dated 4/3/24, revealed Resident #123's BIMS score of a 14 (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 undated therapy dashboard page revealed this page reflected treatment diagnosis that included Z74.1 (OT) Need for assistance with personal care. Review of the Occupational Therapy Treatment Encounter, dated 4/5/24 and maintained by the therapy vendor, revealed the following: Patient exhibits new onset of decrease in strength, decrease in functional mobility, decrease in transfers, reduced balance, reduced functional activity tolerance, increased need for assistance from others and pain indicating the need for OT to increase (I) w/ADLs. The document revealed the following in the area of hygiene and grooming Hygiene / Grooming = MI (modified independence). Review of the resident's medical record revealed there was no care plan in place that would be available for staff to access to address the resident's need for assistance with ADL's. An interview was conducted on 04/09/24 at 12:55 p.m. with the Director of Rehabilitation. He reported Resident #123 was being seen by Occupational Therapy (OT) and Physical Therapy (PT) and personal care was being addressed by OT. He reported that he was unsure as to what care is provided on the health side. During an interview on 04/09/24 at 9:21 a.m. Staff J, Registered Nurse (RN) revealed staff should take care of the residents' ADLs. She reported that typically if she goes into the resident rooms and sees anything that needs to be done for the resident that she will let the certified nursing assistant (CNA) know. During an interview on 04/09/24 at 12:47 p.m. with the Director of Nursing (DON) she revealed that her expectation was if the resident is independent with their ADLs staff should ask residents if they need assistance with their ADLs, and if the resident refuses assistance staff are to document and let the nurse know. The DON reported if the resident is dependent on staff for assistance with ADLs staff should anticipate the resident's needs and assist them with their ADL needs. The DON reported if the ADL need is facial hair, staff should address it unless the resident refuses. During an interview on 04/09/24 at 2:17 p.m. with Staff K, MDS Coordinator she revealed a care plan should be in place to address the resident's ADL needs. She reported that usually on admission the admitting nurse will put a baseline care plan in place related to the resident's ADL needs, and then the clinical team will review the orders and diagnosis the day after admission. She reported if anything was needed to be added it is added. She reported she was not sure why Residents' #122 and #123 care plans related to ADLs were missed. Review of the facility policy titled, Activities of Daily Living (ADLs), dated 10/17/2022 revealed the following: Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; Under the section titled, Policy Explanation and Compliance Guidelines: revealed the following: 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. (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 facility policy titled, Promoting/Maintaining Resident Dignity, dated 10/17/2022, revealed the following: 9. Groom and dress residents according to resident preference.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observations, record review and interviews, the facility failed to ensure failed to ensure an order was in place for pressure relieving boots being utilized for one resident (#670) of three residents reviewed for post fall intervention and 2) failed to follow-up on an order for a swallow test for one resident (#43) of a total sample of 46 residents. Findings included: 1. An observation was made on 04/08/24 at 10:08 a.m. of Resident #670 in bed lying down with pressure-relieving boots on both feet. (Photographic Evidence Obtained) The resident stated she cannot get out of the bed because staff are keeping the pressure-relieving boots on her feet. Review of Admission Records showed Resident #670 was admitted on [DATE] with diagnoses including severe protein-calorie malnutrition, muscle wasting and atrophy, edema, and unsteadiness on feet. Review of Resident #670's Skin Observation Tool, dated 02/20/24, showed the resident had bilateral purple boots for pressure relief of heels. Review of Resident #670's care plan showed a plan in place for Skin Integrity, Risk for Alteration Impaired Mobility, dated 03/07/24. Interventions included boots bilateral in bed. Another plan was in place for Skin Impairment: Impaired skin integrity related to wounds present, dated 03/12/24. Interventions included heel boots on qs (a sufficient quantity). Review of Resident #670's Visual/Bedside Kardex Report showed under Resident Care, Staff will float heels with heels up cushion/pillow under calves while in bed. Under the Monitoring/Safety section it documented, Heel protectors while in bed. Review of Resident #670's active physician orders did not show an order in place for pressure-relieving boots. An interview was conducted on 4/10/24 at 1:06 p.m. with Staff V, Registered Nurse (RN). She confirmed she was assigned to care for Resident #670. Staff V said Resident #670 wears pressure-relieving boots to prevent pressure ulcers. She said when she thinks a resident needs the boots, she tells the Unit Manager (UM) and the UM gives her the boots. Staff V said it isn't like medication; you don't need an order for the pressure-relieving boots. She said she thinks Resident #670 had them on anytime she was in bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 04/10/24 at 1:31 p.m. with Staff E, Licensed Practical Nurse/Unit Manager (LPN/UM). She stated pressure-relieving boots could be used as an intervention on a care plan and a doctor could give orders for them. When asked how long the boots should stay on a resident the Staff E said, I would say could be based on nurses' judgment. As long as they are getting them out of bed appropriately. Staff E stated they would need to get clarification from the doctor to see how long a resident should have the boots on each day. Staff E stated she recently went through all residents that had pressure-relieving boots to make sure they had orders in place. Staff E reviewed Resident #670's record and confirmed the resident had no orders or specific instructions for use of the pressure-relieving boots. Staff E stated she should have put in an order and asked the doctor to specify instructions. 48823 2. On 04/08/24 at 11:45 a.m. Resident #43 was observed lying in bed with her tube feeding disconnected and hanging on the poll. The feeding was dated 4/7/2024. On 4/9/2024 at 8:30 a.m. Resident #43 was observed lying in bed and appeared to be sleeping. Her tube feeding was connected to the resident and was running at 60 milliliters. On 4/9/2024 at 1:45 p.m. Resident #43 was observed lying in bed with her tube feeding connected at this time. Resident #43 was awake, she stated that she has not been out of bed and that she does not want to get out of bed, she prefers to stay in bed. Review of the Admission Record for Resident #43 revealed an admitted [DATE]. The diagnoses included cerebrovascular disease, aphasia, hemiplegia and hemiparesis of right side, chronic obstructive pulmonary disease, dysphagia, gastrostomy, anxiety disorder, hypertension, and bipolar disorder. Review of the Quarterly Minimum Data Set (MDS) for Resident #43, dated 3/13/2024, revealed: Section A - identification information - reentry date of 1/7/2023 with original entry date of 10/16/2019. Review of the active physician orders, dated 4/10/2024, for Resident #43 revealed: Resident #43 is to have nothing by mouth (NPO), enteral feeding order is Jevity 1.2 to run at 60 milliliters every hour for 20 hours, start at 2:00 PM and run/stop at 10:00 AM. Physical therapy, occupational therapy and speech therapy evaluation and treatment as needed. Schedule resident for swallow test (dated 3/26/2024), occupational therapy to evaluate and treat for sitting abilities (dated 4/5/2024). Review of the progress notes for Resident #43, dated 3/26/2024, revealed Resident #43 to have a swallow test. Review of a progress note for Resident #43, dated 4/4/2024, signed by physician revealed, resident was eating well by mouth before last admission. I am trying to do a new evaluation, discussed today with speech therapy, she will need previous evaluation by occupational therapy, she is always in bed, she needs to position in the chair, resident needs to be out of bed for meals. Review of the active care plan Focus for Resident #43, dated 4/10/2024, revealed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nutrition Focus for altered nutritional status (date of revision 7/6/2023). Interventions included of offer menu selections, adjust food preference as needed, receive adjusted texture, supplements as ordered (date initiated 12/20/2021), potential for complications related to feeding tube (date of revision 12/5/2022). Review of the census report dated 6/5/2023, 7/2/2023 and 11/2/2023 for Resident #43 showed hospital admissions related to the feeding tube malfunction (6/5/2023), related to cellulitis of feeding tube (7/2/2023), and was for evaluation for complaint of abdominal pain (11/2/2023). Review of a therapy screen, dated 4/2/2024, for Resident #43 revealed a physician order in place for speech evaluation for possible oral diet, plan was discussed with Resident #43 and resident agreed with plan. Review of the medical record therapy screen/occupational interaction note, dated 4/4/2024, for Resident #43 revealed communication was done with the primary care physician that the resident needed occupational therapy for positioning. An interview was conducted with Staff E, Licensed Practical Nurse (LPN), Unit Manager (UM), Infection Control (IC) on 4/9/2024 at 2:08 p.m. Staff E revealed the resident is able to remove her oxygen and refuses to get out of bed. The resident was to have a swallow test completed by speech. She verbalized the resident does not want to take oral foods. Staff E was not sure if it was the texture or not. An interview was conducted with Staff E, LPN/UM/IC, and Staff O, Speech Therapy (ST) and Staff L, Director of Rehabilitation on 04/10/24 at 11:15 a.m. It was revealed the order was for 3/26/2024 (swallow test). ST saw the resident on 4/2/2024 and 4/4/2024. OT saw the resident on 4/5/2024 and full service was to begin on 4/10/2024. During the interview Staff E LPN/UM/ IC revealed the delay in follow-up was related to poor communication during morning meeting. On 4/10/2024 at 10:00 a.m. a request was made to review a policy and procedure for morning clinical meeting. The policy and procedure was not provided by the last day of survey (4/10/24). Review of a policy titled, Referral to Therapy, dated 1/18/2023, revealed: Policy: To ensure clinically appropriate care will be provided a Therapy Request Form may be completed for long term care (LTC) patients. Procedure: 1. The therapy request form is completed and provided to the rehabilitation department. A therapy request form or another similar form/process should be completed for any patient that has change in condition or may need therapy services for prevention, compensatory strategies, or caregiver education. 2. This referral is coordinator with other disciplines and/or nursing referral for therapy possibly warranting a therapy evaluation 3. Upon review, the therapist will make the determination if an evaluation is indicated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Once this form is completed, the results will be shared with the interdisciplinary team members. 5. If a therapy evaluation is indicated the therapy order process will be followed.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438 Based on observation, interview, record review and policy review, the facility failed to ensure adequate supervision and assistive devices to prevent an unwitnessed fall that resulted in serious bodily injury (nondisplaced fracture of second cervical vertebra) as a result of an over inflated air mattress that was not monitored by staff for one dependent resident (#44) out of the sampled two residents. Findings included: On 04/08/24 at 11:15 a.m. Resident #44 was observed in bed with a cervical collar around her neck. During an attempt to interview her, the resident did not speak. On 04/10/24 at 9:12 a.m. Resident #44 was observed in bed with a cervical collar around her neck. Fall mats were observed on both sides of the bed on the floor. A review of the Transfer/Discharge Report showed Resident #44 was admitted on [DATE] and had diagnoses to include nondisplaced fracture of second cervical vertebra, subsequent encounter for fracture with routine healing, bipolar disorder, dementia, psychotic disturbance, mood disturbance, anxiety disorder, contracture of the muscle, history of falling, abnormalities of the gait and mobility, contracture of the right hip, left hip, left hand, left knee, and right knee, depression, other fracture of upper and lower end of left fibula, reduced mobility, and unsteadiness on feet. Section C- Cognitive Patterns of the Minimum Data Set (MDS), dated [DATE], showed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 06 out of 15 indicating severe impairment. Section GG- Functional Abilities and Goals showed Resident #44 was dependent for self-care and mobility. A review of the Order Summary Report with active physician orders as of 04/10/24 revealed the following: Air mattress for prevention (08/09/23), and resident to wear cervical collar at all times, may remove for care and reapply every shift for pain (04/05/24). The Incident by Incident Type log provided by the facility showed the resident had an unwitnessed fall on 03/09/24 at 4:40 a.m. (actual time per progress note 3:50 a.m.) and an unwitnessed fall on 04/04/24 at 11:45 p.m. A review of the progress notes with an effective date range for 03/01/24 to 04/10/24 showed the following: 03/09/24 04:27- Resident found on the floor next to the bed at 03:50. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	03/09/24 05:10- Situation- Resident was observed lying on her side on the floor next to the bed. Possible and/or actual contributing factors: Pressure reducing mattress too inflated. Assessment and Appearance: vital signs, ortho blood pressure, pain, and/or injuries: within normal limits. The resident complained of pain but unable to state where. Sent to the emergency room for evaluation and further treatment. 03/9/24 09:25- Resident found on floor face down next to bed at 03:50, resident was responsive when asked about pain. No visible cuts or bruises. Certified Nursing Assistant (CNA) assisted writer with getting resident back in bed, resident was lying on sheet that was on her bed which was used to lift from floor back into lowered bed. No visual injuries, 911 call, family member notified, hospice, and doctor notified. Emergency Medical Technician (EMT) arrived around 04:20. Ambulance service transported to local hospital to be evaluated. 03/13/24 14:14 (2:14 p.m.)- Resident was received at 1:45 pm back from a local hospital by ambulance with a diagnosis of cervical compression fracture due to a fall. Using Percocet for as needed (prn) pain every 6 hours. Resident was received with a collar that should only be removed for care and comfort. Results showed compression fracture in cervical vertebra (c2). 03/15/24 20:16 (8:00 p.m.)- She presented to a local hospital on 03/09/24 for an unwitnessed fall. Per hospital records, computed tomography (CT) of the neck showed acute c2 compression fracture. A neck collar was placed, and she was stable. CT of the cervical spine showed c2 with inferior and anterior osteophyte and vertebral body fracture. Continue cervical collar. The patient was seen today for acute/chronic care management. 03/22/24 13:41(1:41 p.m.)- No gross findings from C1 to C5. Non-diagnostic cervical spine series with non-visualization of the remainder of the inferior cervical spine. Fracture was not excluded. Recommend repeat diagnostic exam to include the inferior cervical spine or CT if unable to obtain appropriate images. 03/22/24 13:56 (1:56 p.m.)- Reviewed cervical spine x-ray. No gross findings from C1 to C5. Non-diagnostic cervical spine series with non-visualization of the remainder of the inferior cervical spine. Fracture was not excluded. Cervical collar in place. 04/05/24 05:43- Resident returned to facility at 05:00 with no new order. 04/05/24 00:01(12:01 a.m.)- Resident found on floor at 11:35 p.m., assessed for injuries, nothing visible observed, and no complaints of pain. 911 called and the resident was sent to a local hospital. 04/05/24 08:30- She was seen for follow up for a fall. She was sent to the hospital and returned with negative findings. Patient was placed on 15-minute checks per facility. Cervical collar in place. She was laying on her side with head of bed elevated. She denied any pain or discomfort. No edema. 04/05/24 09:21- Fall Risk: History of falls (past 3 months): 1-2 falls in past 3 months. Level of consciousness / mental status: intermittent confusion. Resident was chairbound / incontinent. Vision status: Poor (with or without glasses). Recent hospitalization history in last 30 days: Yes. Gait / balance: Decreased muscular coordination. Gait / balance: Requires use of assistive devices (i.e. cane, wheelchair, walker, furniture). Fall Risk Score: 14.0. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	04/05/24 14:44 (2:44 p.m.)- Resident was reviewed this morning for being found on floor next to bed. The resident was on an air mattress with bolsters to provide spatial awareness. There was no injury noted. She denies pain at this time. She was unable to state what happened. She was sent out to the emergency room with negative findings. Care plan reviewed. Will place resident on 15-minute checks. Will provide mats at bedside bilaterally. Staff to post outside of door on all shifts. Care plan updated. 04/08/24 11:18- The resident was alert, on an air mattress, and good positioning on bed with 15-minute checks Check to prevent falls. The care plan with a Focus area of falls/injury showed Resident #44 was at risk for falls or injury related to history of transient ischemic attack (TIA) and falls initiated on 11/15/21 and revised on10/19/22. Interventions included the following: Assist to wear non-slick footwear that fits, initiated: 11/15/21. Call bell in reach, initiated: 11/15/21. Ensure adequate lighting for all activities, initiated: 11/15/21. Evaluate risk for falls with Fall Assessment Tool, initiated: 11/15/21. Keep areas free of obstructions to reduce the risk of falls or injury, initiated: 11/15/21. Maintain safety precautions as ordered, initiated: 11/15/21. Medication dose adjustment as ordered, initiated: 11/15/21. The resident uses a high back reclining wheelchair with L board for legs when out of bed, initiated: 10/19/22. Physician follow-up prn, initiated: 11/15/21. Staff to post outside room when charting, initiated: 04/05/24. Transferring - Full body lift assist of 2, initiated: 07/15/22. The care plan showed no new interventions after Resident #44 had an unwitnessed fall and sustained a nondisplaced fracture of the second cervical vertebra on 03/9/24. It was not updated until she had another fall on 04/04/24. An additional Focus Area for Resident #44 revealed: (Resident #44) has an ADL self-care performance deficit r/t (related to) CVA and decreased mobility, revised on 10/19/22. The interventions included: Bed Mobility - (Resident #44) requires total assistance from staff for bed mobility and use of bilateral 1/4 rails, Transfer - The resident is totally dependent on (X2) staff with full body lift for transferring. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 04/10/24 at 1:42 p.m. a telephonic interview was conducted with Staff F, Certified Nursing Assistant (CNA). He stated he worked the shift Resident #44 had a fall (3/9/24). It was a regular night and before he left for break, he checked on her and she was asleep. It was a quiet night. When he came from break, Resident #44 was observed on the floor and he went to get the nurse, Staff W, Licensed Practical Nurse (LPN). The resident was talking. Staff W, LPN checked her and they got her back in bed. Staff F, CNA, stated he changed her brief before EMS (Emergency Medical Services) came. She was really contracted. He was still working there (no longer works at the facility) when she returned from the hospital. She had a neck brace and a low bed. He never looked at the mattress. She was really small and didn't notice anything wrong with the mattress at that time. On 04/10/24 at 10:06 a.m. the Regional Nurse Consultant (RNC-1) reported Resident #44's family member presented to the building. He was upset, loud, and stated she was neglected and that caused her to fall. She and Staff E, LPN/Unit Manager met with the family member. They went through her care plan and showed him interventions they had in place. He talked about Resident #44's history with anxiety and was concerned she was having anxiety at night, so they ordered Sertraline. On 04/10/24 at 9:41 a.m. the Director of Nursing (DON) stated Resident #44 does not speak good English. She was very contracted and does not like to lay on her left side. She likes to lay on the right side and only wants to look out the door. The resident likes to look at her roommate because she thinks the roommate was her mother. Staff F, CNA was the assigned aide for the first fall. Staff had just gone in to check on her and shortly after she was on the floor. Staff W, LPN called 911 and they came to pick her up. She was diagnosed with a nondisplaced C2 cervical fracture. Resident #44 had an air mattress and there were no bolsters on the air mattress at the time of the first fall. After looking at the air mattress, it seemed like it was a hospice air mattress and looked like it was over inflated. They think the air mattress caused her to slide off the bed. The initial air mattress came from hospice. She replaced the air mattress with one of their air mattresses. The DON did not know if hospice was checking the air mattress or not. She looked at the air mattress and could not tell what the air mattress was set on. There were no numbers on the dial for her to see. The numbers were faded. For the air mattresses provided by the facility, they have push buttons. She did not know if the staff were checking the air mattresses. No one could tell her when she asked. The DON reported she spoke with staff and told them to make sure they checked the air mattresses but there was no documentation. The DON stated she had hospice come pick up the air mattress while Resident #44 was at the hospital and replaced it with one of their air mattresses. With the mattress she has now, she can see how it was adjusted. She now checks the air mattresses when she sees one in the room. The DON stated they added intervention to keep the bed in the lowest position. She confirmed the interventions were not reflected on the care plan and stated she would expect the care plan to be updated. Staff X, CNA, was the assigned aide for the second fall (4/4/24). Staff X, CNA reported in her statement that she heard talking and when she went in the room Resident #44 was on the floor. She yelled for the nurse. Staff W, LPN came down and she (Staff X) stayed with the resident while he called 911. Any forward motion such as a sneeze or cough, was determined to cause the second fall. Her body alignment was the issue. They do not use side rails, so bolsters were added to the air mattress after the second fall. When staff are not doing care, someone needs to be posted outside of Resident #44's door when charting. This was added to the care plan as an intervention after the second fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	She talked to her Administration about reporting the incident and because they didn't do anything to cause the accident, the first unwitnessed fall which resulted in a nondisplaced fracture of the second cervical vertebra was not reported. When asked why the second fall was reported and there were no injuries, the DON stated because a family member threatened to call the State Agency. She wanted to make sure she was covered so she reported the second fall. On 4/10/24 at 10:16 a message was left for Staff W, LPN. Staff W did not return the call. On 4/10/24 at 10:17 a.m. a message was left for Staff X, Certified Nursing Assistant (CNA), who was assigned to Resident #44 on the night (11:00 p.m. - 7:00 a.m.) of 4/4/24. Staff X did not return the call. On 04/10/24 at 1:08 p.m. the RNC-1 stated they did not have a policy related to checking air mattresses. If there was an issue they would contact Maintenance. Education was requested and was not provided related to checking the air mattress. Review of a policy titled, Fall Prevention Program, implemented on 10/17/22, revealed the following: Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. 5. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan or care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed . 6. When any resident experiences a fall, the facility will: d. Review the resident's care plan and update as indicated.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48823 Based on observations, record review and interviews, the facility failed to provide care consistent with professional standards of practice related to oxygen therapy for one resident (#21) of two residents reviewed for oxygen therapy. Findings included: An observation on 04/08/24 at 9:55 a.m. revealed Resident #21 was receiving oxygen via a nasal cannula, the oxygen concentrator was set at two liters per minute. The oxygen tubing was touching the floor and the storage bag was dated 04/01/2024. An observation on 04/08/2024 at 2:00 p.m. revealed Resident #21 in bed and oxygen was in place. An observation on 04/09/2024 at 8:00 a.m. revealed Resident #21 in bed, oral care had been provided and oxygen tubing was removed off the floor, the bag and tubing had been changed and dated 04/08/2024. An observation on 04/10/2024 8:00 a.m. revealed Resident #21 resting in bed receiving oxygen via a nasal cannula at two liters per minute. Review of Admission Record for Resident #21 revealed a date of admission as 9/4/2020. The diagnoses included cerebral infarction, shortness of breath, anxiety, pneumonia, and chronic obstructive pulmonary disease. Review of active physician orders as of 04/10/2024 for Resident #21 revealed no orders for oxygen therapy. Review of Medication Administration Record (MAR) dated 03/01/24 - 03/31/24 for Resident #21 revealed no administration of oxygen therapy. Review of the Treatment Administration Record (TAR) dated 03/01/24 - 03/31/24 for Resident #21 revealed no administration of oxygen therapy. Review of the MAR dated 04/01/24 - 04/09/24 for Resident #21 revealed no administration of oxygen therapy. Review of the TAR dated 04/01/24 - 04/09/24 for Resident #21 revealed no administration of oxygen therapy. Review of the active care plan revealed, date initiated 12/30/2023, revised on 06/2023 and printed on 04/10/2024 for Resident #21 revealed no focus, goal or interventions related to oxygen therapy. During an interview on 04/09/2024 at 2:15 p.m. with, she revealed that Resident #21 prefers to remain in bed and confirmed there was no physician order for the observed oxygen use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/2024 at 4:00 p.m. Staff E, Licensed Practical Nurse (LPN), Unit Manager (UM), Infection Control (IC) verified Resident #21 did not have a physician order for oxygen. Review of the policy titled, Oxygen Administration, dated 10/17/2022, revealed: Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, comprehensive person-centered care plans, and the resident's goals and preferences. Policy Explanation and compliance Guidelines: 1. Oxygen is administered under the orders of a physician, except in the case of an emergency. 2. Personnel authorized to initiate oxygen therapy include physicians, registered nurses, licensed practical nurses and respiratory. 3. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. 4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observations, interviews with residents and facility staff, and review of the facility's records and policies, the facility failed to provide sufficient staff to provide meal assistance on one floor (second floor) of two floors for six (#32, #15, #30, #3, #18 and #54) of 17 dependent residents, and failed to respond to a call light for Resident #20 for two days (04/09/2024 and 04/10/2024) of a three day survey. Findings included: An observation on 04/09/24 of the lunch meal service revealed the residents in the dining room received their trays starting at 11:34 a.m. Resident #32 was the last one to receive her tray in her room at 12:45 p.m., having waited approximately one hour and twenty minutes. During a facility tour on 04/09/24 at 11:43 a.m. an observation was made of staff distributing trays on the facility's second floor dining room. The residents who eat in their rooms were observed waiting for their trays. An observation was made of Staff R, Certified Nursing Assistant (CNA) on 04/09/24 at 12:25 p.m. passing resident lunch trays on the 200 hall. He stated (Resident #15) was a feeder and he would be feeding him shortly. He walked into the resident's room with the tray, dropped off the tray and walked out. Staff R stated he did not assist him with the meal because (Hospice Staff-1) took over. Staff R stated (Hospice Staff-1) was willing to help feed the resident. On 04/09/24 at 12:38 p.m. an interview was conducted with Hospice Staff #1. She stated she did not know this resident ([#15). She stated she did not know how much he normally ate, she said, I'm here to see him for other things. I decided to assist with his meal because he was waiting. On 04/09/24 at 12:27 p.m. Staff R, CNA dropped off a tray for Resident #48. The resident was waiting to be assisted with meal. After approximately 5 minutes, the resident was observed being assisted by Hospice Staff-2. Staff R stated the Hospice staff was willing to feed the resident. On 04/09/24 at 12:28 p.m. Hospice Staff-1 was observed looking for towels. She was observed walking down the halls looking for linen carts. She asked, Where are the staff? Hospice Staff-1 found the towels and a gown and returned to change Resident #15. During this timeframe, Staff T, Licensed Practical Nurse (LPN) was observed on 04/09/24 from 12:11 p.m. to 12:35 p.m. at the nurses' station on the phone. On 04/09/24 at 12:29 p.m. Staff Q, CNA was observed grabbing a tray from the cart. She stated she was going to feed Resident #30. She stated there were two CNAs and one nurse working in this hall. She stated there were about seven residents that needed to be assisted with meals on her assignment. She stated sometimes it takes them a long time to feed all the residents. She stated she did not know if the food was cold. She stated the residents did not say anything about the food being cold. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/09/24 at 12:30 p.m. the Director of Nursing (DON) was observed assisting Resident #18 with a meal while standing. She was heard saying to the resident, It's the blind leading the blind. The DON stated she had come to assist with lunch. On 04/09/24 at 12:36 p.m. an observation was made of two residents' meal trays still waiting to be delivered. Resident #32 was one of the recipients. She was observed sitting in her wheelchair in the middle of her room. Resident #32 was not interviewable. She had not had lunch. An immediate interview was conducted with Staff S, Registered Nurse (RN) on 04/09/24 at 12:37 p.m The nurse confirmed Resident #32 was waiting to be assisted. He pulled the tray out, confirmed the meal ticket and put the tray back in the cart. He stated he had about six residents who needed to be assisted with their meal on his assignment. He stated it was tight during meals. He said, There are not enough hands. On 04/09/24 at 12:39 p.m. an interview was conducted with Staff C, CNA. She confirmed Resident #32 was still waiting to be assisted with her meal. She looked inside the meal cart and saw two trays. She said, Yes, they are still waiting to be assisted. The CNAs on this floor had been assisting other residents in the dining room. They just have to wait. On 04/09/24 at 12:41 p.m. Staff R, CNA stated Resident #32 waited over 45 minutes today. Staff R said, Yes, sometimes they wait an hour. There are too many residents that need assistance. There is no way to get everyone in a timely manner. The CNA stated they needed more help, especially during meal service. On 04/09/24 at12:45 p.m. Staff R, CNA was observed grabbing a chair from the nurses' station and proceeded to Resident #32's room. He was observed assisting her with the meal. An observation on 04/10/24 of the breakfast meal service revealed the residents on the second floor received their trays starting at 7:30 a.m. Resident #54 was the last one to receive his tray in his room at 9:01 a.m. having waited 1.5 hours. On 04/10/24 at 8:23 a.m. Resident #3 was observed receiving meal assistance from Staff U, CNA. The resident's roommate, Resident #30, was observed waiting to receive her breakfast meal. On 04/10/23 at 8:24 a.m. Resident #32 was observed sitting on her bed, awake. The resident was waiting for her breakfast meal. On 04/10/24 at 8:26 a.m. an observation was made of Staff C, CNA grabbing a meal tray and going into room [ROOM NUMBER]. She stated both residents were still waiting to be assisted with their breakfast meal. Staff C set a tray by the door bed. She walked back to the cart and grabbed another tray and set it by the window bed. On 04/10/24 08:43 AM an observation was made of Staff C assisting the resident in the door bed with her meal. Her roommate was observed waiting for her breakfast meal. On 04/10/24 at 8:29 a.m. an observation was made of Staff R, CNA assisting Resident #17 with her meal. Her roommate, Resident #18 was observed waiting for her breakfast meal. On 04/10/24 at 8:31 a.m. an interview was conducted with Staff A, CNA. She stated Resident #51 had been assisted with her breakfast, but they still had a few trays left. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/10/24 at 8:37 a.m. Staff R, CNA confirmed there were trays left in the cart. He confirmed he had helped one resident so far. He stated it had been approximately 30 minutes since the trays arrived on the unit. On 04/10/24 at 8:39 a.m., an observation was made of Staff R, CNA grab Resident #18's tray and proceeding to assist her. In an interview Staff R stated there were a few more trays left. On 04/10/24 at 8:40 a.m. an observation was made of Staff U, CNA assisting Resident #32. Across the hall, Resident #3 was observed spooning food to her mouth by herself and dropping a substantial amount on the floor and herself. Staff U had been assisting her earlier, but left her to assist another resident. Staff U stated she left her to finish up while she started assisting Resident #32 who had been waiting. An interview was conducted with Staff R, CNA on 04/10/24 at 8:44 a.m. He stated all the independent residents had eaten breakfast or were just finishing up. Staff R stated the first breakfast trays were delivered about 30 minutes earlier. On 04/10/24 at 8:45 a.m. an interview was conducted with Staff U as she walked out of Resident #32's room. She stated she still had Resident #54 and Resident #15 left. She said, They are waiting. There are four CNAs for the second floor. She stated it takes a long time to assist each resident. She said, if everyone would pitch in, it would help. She stated they assisted in the dining room first and then in the resident rooms. Staff U said, It can be a while. I don't want to give it a timeframe, but it takes very long. On 04/10/24 at 8:57 a.m. an interview was conducted with Staff A, CNA. She said, It takes a long time for the residents to receive their meal because we have four CNAs with 20 feeders. She said, It takes more time for the residents to eat so we need more people. That's a lot. Some need more help than others. On 04/10/24 at 9:01 a.m. an observation was made of Staff R, CNA assisting Resident #54 with his breakfast. On 04/10/24 at 9:25 a.m., an interview was conducted with the Food Service General Manager, (FSGM). He stated breakfast was delivered upstairs at 7:30 a.m. and lunch on 04/09/10 was delivered to the dining room at 11:34 a.m. He stated his expectation was that the resident should receive their meal immediately after it is plated, and no more than 30 minutes after the trays go. He stated he was aware there was a problem. He stated he had conducted an audit and identified the test tray on the cart returned to him at 1:35 p.m. He stated the residents should be served and eating within 30 - 45 minutes of the meal being plated. He stated he had attended a Resident Council meeting and the residents complained of trays taking a long time and food temps not being at par. He stated those complaints had lessened. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Staff E, Licensed Practical Nurse/Unit Manager (LPN/ Unit Manager) on 04/10/24 at 9:45 a.m. She stated they had 17 assisted diners on the second floor and provided the list. She stated the expectation was for the CNAs and nurses to identify who needed to be assisted with dining and provide them the assistance. She stated the trays should not be left in the room until the resident is ready to receive assistance with the meal. Staff E LPN/UM said, We usually have about five to six CNAs. This morning, we had four CNAs and the unit secretary who is also a CNA should help. She stated it should take 30-45 minutes to have everyone fed from the time the trays come up. She said, There were a lot of assisted diners. She said, I can see how there can be short without the additional help. Staff E stated they looked at this issue in the past and decided certain staff should go upstairs and assist. She stated that a staff member who was supposed to help was out of the office and another one was in a meeting. Staff E said, We did not get them to help this week. The residents should not wait that long for their meal. On 04/10/24 at 9:53 a.m. an interview was conducted with the Food Service Coordinator (FSC). She said, We try to get the trays to the resident as quick as possible. There is a little interruptions. She stated they start with the independent people then the assisted residents. She stated the meal trays should be distributed within 10 minutes of receipt. She confirmed an hour, or more was not acceptable wait time. An interview was conducted with the Staffing Coordinator on 04/10/24 at 1:12 p.m She stated residents' acuity did not determine staffing numbers. She said, No, I go by what they tell me. I have a calculation sheet. I split the staff among the whole day. For the CNAs, the ratio is 1-20 and for the nurses the ratio is 1-40. She stated they were running with the new staffing mandate. She said every once in a while, I don't meet it, but it is never two days back to back. She stated this only happened when they had a late call -in and were unsuccessful trying to cover it. She stated they did not use agency staff. She stated if there were staffing shortages, she would always communicate with the Director of Nursing (DON) and the Nursing Home Administrator (NHA). She said, If staff haven't picked up or I have a lot of open shifts I let them know ahead of time. She stated she was a CNA and she assisted if they were short or if we cannot get someone to come in. The Staffing Coordinator said, During meals other staff take turns assisting on the floor, including department heads. She stated they split up between the first and second floors. She stated there was no schedule. She said, We all jump in and pitch. I was not there yesterday for lunch, and was not here to assist with breakfast. She stated there were two staff members who could have assisted, but they were absent. She stated she had been told as long as they hit the numbers, they were okay. The Staffing Coordinator said, I understand we also need to be aware about the quality of care and meeting the residents' needs. On 04/10/24 at 1:40 p.m. an interview was conducted with the NHA, Regional Clinical nurses (RNC)- 1 and RNC- 2. The NHA stated he was notified as of yesterday there were meal assistance concerns. He said, I became aware as of yesterday. They said it is taking a long time, we have someone that is off, therapy should be assisting. It will be a true practice going forward. He stated on 03/11/24 they did not meet the staffing numbers due to call offs. It was not two days in a row. He said in that case they try and replace as best as they can. Leadership should step in and assist. He stated he had not been notified of concerns with residents waiting to be assisted with toileting. He stated he did not know. The NHA said, That is not our practice. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an undated facility document titled, Facility Assessment showed on page 15 of 46, B.2. Acuity - care requirements, [name of facility] staffs above state minimum requirements, with the specific focus on adequate CNA staffing to accommodate this greater need for additional assistance with the number of ADL's including daily care, bed mobility, transfers walk in room, toilet use, eating, dressing, and hygiene/grooming. The population at [name of facility] and the staffing levels provided are deemed sufficient based on resident satisfaction, QA/compliance committee data, resident council feedback, resident interviews and observations, clinical outcomes, and functional improvements. Review of a facility policy titled, Serving a Meal, dated 10/17/22, showed (12.) Remember that some residents take a long time to eat. Provide adequate time for the resident to consume the meal and offer to reheat foods as needed. Review of a facility policy titled, Nursing Services and Sufficient Staff, dated 10/17/22, showed it is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure residents safety and attain or maintain the highest practicable physical mental and psychosocial well-being of each resident. The facility's census, acuity and diagnosis of the resident population will be considered based on the facility assessment. Under policy explanation and compliance guidelines, (1) the facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with the resident care plans. A. Except when waved licensed nurses and B. Other nursing personnel including but not limited to nurse aides. (5) providing care includes but is not limited to assessing evaluating planning and implementing resident care plans and responding to resident's needs. 46234 An observation was made on 4/9/24 at 12:09 p.m. of the call light being activated in Resident #20's room. The call light remained on until Staff Q, CNA went to the room at 12:27 p.m.,18 minutes after it was activated. The call light was turned off and the CNA immediately exited Resident #20's room. A nurse was observed sitting at the nurses' station during this time. An interview was conducted on 4/9/24 at 12:28 p.m. with Resident #20. He said he needed to be changed because he was soiled. He said he is a quick change he just needed assistance. Resident #20 said the CNA came in and turned the call light off and told him staff were doing something with lunch and she would be back. Resident #20 said it always takes a while for call bells to be answered. Resident #20 reactivated his call light. An observation was made on 4/9/24 at 12:31 p.m. of Staff Q, CNA entering Resident #20's room, turning the light off. The resident was asked what the staff member told him. He said the CNA didn't say a word to him, they just turned the light off and walked back out. An observation was made on 4/9/24 at 12:48 p.m. of Staff R, CNA entering Resident #20's room to pick up his lunch tray. The resident was overheard asking the CNA if he was going to change him. The CNA said, Let me check and see which one [CNA] is down here. The CNA left the room and walked away. An observation was made on 4/9/24 at 12:54 p.m. of Resident #20 yelling out hello repeatedly from his bed. At 12:56 p.m. the Activities Director stopped and asked Resident #20 what he needed. He said, I've been waiting a while and he explained he needed to be changed. The Activities Director walked out of the room to find a CNA. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was made on 4/9/24 at 1:00 p.m. of Staff R, CNA returning to Resident #24's room and telling the resident, I can't find her so I will go ahead and change you. As Staff R was getting ready, Staff Q, the resident's assigned CAN, came out of a room from helping a resident eat lunch and said she would assist. Review of the Admission Record showed Resident #20 was admitted on [DATE] with diagnoses including hemiplegia and hemiparesis following a cerebral infarction, contractures, abnormal posture, and need for assistance with personal care. Review of Resident #20's Minimum Data Set (MDS) Section C - Cognitive Patterns, dated 2/27/24, showed the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating he was cognitively intact. Section GG, Functional Abilities and Goals, showed he was dependent for toileting hygiene. Section H, Bladder and Bowel, showed the resident was always incontinent of bowel and bladder. An interview was conducted on 4/10/24 at 9:54 a.m. with Staff E, LPN/UM. She said call lights should be answered immediately if staff are able, but at most within two to three minutes. She said during lunch there is one nurse and two CNAs helping residents in the dining room and one nurse and two CNAs helping assisted diners in their room. When asked who was left to answer call lights and assist residents if all available staff are assisting other residents with eating she said, When you put it that way. No one is left to answer call bells. An interview was conducted on 4/10/24 at 3:56 p.m. with the Director of Nursing (DON). She said she expected call lights to be answered in 10 minutes or less. She said any staff member can answer a call light. The DON said she would not expect a CNA to turn off a call light and leave without assisting the resident. She said if a CNA checked on a resident and that resident needed changing, she would expect that CNA to do the work, even if they are not assigned to the resident. The DON said it is not acceptable for a resident to wait 50 minutes to be changed.

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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. 20311 Based on observation, record review and interview the facility failed to appropriately store and secure medications related to one (1st floor) of two units for medication at the bedside and one (200 hall, cart 1) of four medication carts left unlocked. Findings included: 1. Observation of Resident #120's room on 04/08/24 at 10:28 a.m. revealed there was a white cream in a medicine cup in a tissue box on the resident's over bed table which was located to the right side of the resident's bed. The cup was not labeled with the name of the substance and there was no indication for the direction of the use of the substance. Interview with the resident at this time revealed the resident indicated that is icy hot from last night. Also noted in the tissue box was a bottle of eye drops and a container of Icy Hot. There was no direction for use of the eyedrops or the Icy Hot. Resident #120 said, Those are mine that I paid for because my eyes get dry. Continued observation of Resident #120's room revealed a green substance in a disposable 4 oz (ounce) juice cup with a vinyl glove covered over the top of the cup. The cup was on the resident's nightstand located to the left of the resident's bed. Interview with the resident, at this time, revealed she cannot remember what the substance was and that it had been at the bedside since the night before. She was not sure what the green stuff is. (Photographic Evidence Obtained) Review of Resident #120's electronic record revealed there was no physician order for eyedrops, or mentholated topical creams. Additionally, there was no documentation that would indicate the resident had been assessed to independently store and self-administer her medication. An interview on 04/08/24 at 10:32 a.m. with Staff G, Registered Nurse (RN) revealed she had already administered medication to the resident that morning but had not left any topicals at the bedside. Staff G entered Resident #120's room with the state surveyor present and obtained the bottle of eye drops, white cream and green cream. It was noted at this time, the green cream had a mentholated scent and the white cream did not have a mentholated scent. Staff G reported she was not sure what the creams were and discarded them in the garbage. Staff G gave the resident the eyedrops back after the resident indicated they were hers and that she paid for them. An interview on 04/09/24 at 1:53 p.m. with the Director of Nursing (DON) revealed that residents are allowed to keep medications at the bedside if they have an order for the medication, and are assessed to self-administer medication, and are provided with a Medication Administration Record (MAR) at the bedside. An interview with the DON on 04/09/24 at 4:15 p.m. revealed the resident now has an assessment for self-administrating medication and has physician orders for the eyedrops and Icy Hot medication at the bedside. She reported she was not aware of the topicals that were left at bedside in cups, and the green substance was probably from therapy because nursing has no green topicals. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 04/10/24 at 10:48 a.m. with the DON revealed she found out from therapy the substance that was left in the cup was bio-freeze and she was sure that the other substance was barrier cream. The DON reported no one admitted to leaving any substance at the resident's bedside. 46234 2. An observation was made on 4/10/24 at 11:06 a.m. on the 200 unit of an unlocked medication cart. The cart was observed to be unlocked with the keys hanging from the open lock while sitting in a resident hall with no staff members in sight. (Photographic Evidence Obtained.) An interview was conducted on 4/10/24 at 11:10 a.m. with Staff V, RN. She confirmed the unlocked medication cart was assigned to her. She said the medication cart should always be locked when the nurse isn't using it. Staff V said she shouldn't have left the keys in her cart; they should be in her pocket. She said sometimes she gets busy and forgets.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50434 Based on record review and interview, the facility failed to ensure the binding arbitration agreement explicitly informed the resident or their representative of the right to not sign it for three residents (#6, #120, and #122) of three residents sampled. Findings included: 1. Review of the Admission Record for Resident #6 revealed an admitted [DATE]. Resident #6 was noted as her own responsible party. Review of an Admission Minimum Data Set (MDS), dated [DATE], showed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. On 04/10/2024 at 10:45 a.m. an interview was conducted with Resident #6. Resident #6 stated she signed so many forms when she was admitted that she does not remember each one. Upon review of the Arbitration Agreement she signed on 04/05/2024, she stated she remembered signing the Arbitration Agreement. She was not aware the Arbitration Agreement was optional, and she was giving up her right to seek legal action. She stated had she known the Arbitration Agreement was (optional) she wouldn't have signed the Arbitration Agreement. 2. Review of the Admission Record for Resident #120 revealed an admitted [DATE]. Resident #120 was noted as her own responsible party. Review of an MDS, dated [DATE], showed Resident #120 had a BIMS score of 14 out of 15, indicating intact cognition. On 04/10/2024 at 10:50 a.m. an interview was conducted with Resident #120. Resident #120 stated when she was asked to sign forms, she was given a tablet where the signature line was only visible. Upon review of the Arbitration Agreement she signed on 04/05/2024, she stated she remembered signing the Arbitration Agreement. She was not aware the Arbitration Agreement was optional, and she was giving up her right to seek legal action. She stated had she known that the Arbitration Agreement was (optional) she would have signed the Arbitration Agreement. 3. Review of the Admission Record for Resident #122 revealed an admitted [DATE]. Resident #122 was noted as her own responsible party. Review of an MDS for Resident #122, dated 03/28/2024, showed Resident #122 had a BIMS score of 12 out of 15, indicating intact cognition. On 04/10/2024 at 10:55 a.m. an interview was conducted with Resident #122. Resident #122 reviewed a copy of the Arbitration Agreement she signed on 04/05/2024. Resident #122 stated she did not know what the agreement meant. She was not aware the Arbitration Agreement was optional, and she was giving up her right to seek legal action. She stated had she known the Arbitration Agreement was (optional) she wouldn't have signed the Arbitration Agreement. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Arbitration Agreement revealed the agreement did not show an explicit statement the resident or representative did not have to sign the arbitration agreement. The Arbitration Agreement, page 3 of 4 paragraph 4 read: I hereby agree and acknowledge that I have read this Agreement, have understood it, and have been given the opportunity to see legal counsel regarding this agreement. I hereby acknowledge that I agree and wish to be bound by the provisions of the agreement. On 04/10/2024 at 10:15 a.m. an interview was conducted with the Admissions Coordinator. She stated the Arbitration Agreement is verbally explained to the resident as they are admitted to the facility. Residents are verbally told they have the right to have legal counsel review the Arbitration Agreement. She stated the Arbitration Agreement is optional. She reviewed the form and confirmed the form did not inform the resident that signing the Arbitration Agreement was optional.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observations, interviews, and record reviews, the facility failed to implement an effective infection prevention and control program related to: 1) failing to ensure a contact precautions sign was displayed timely for one resident (#24) diagnosed with Clostridioides difficile (C-Diff), 2) failing to ensure proper usage of personal protective equipment (PPE) by staff and volunteers (I, Q, R, V, and Dog Handler), 3) failing to ensure four staff members (Staff Q, B, C, Director of Nursing) performed hand hygiene, and 4) failing to ensure staff provided hand hygiene for 14 residents (#54, #19, #3, #1, #36, #670, #23, #10, #2, #53, #37, #17, #57, and #33) prior to dining for three days of a three day survey. Findings included: An observation was conducted on 4/8/24 at 10:15 a.m. of Resident #24 in bed with no precaution sign on his door. Throughout the day on 4/8/24 staff were observed entering and exiting the room without donning and doffing PPE. Review of Resident #24's progress notes showed a note from the resident's primary care provider, dated 4/4/24 at 10:38 a.m., revealing the nurse called to notify her Resident #24 had new onset, foul smelling, liquid diarrhea for the past two days. The doctor ordered a stool sample to be collected and tested for C-diff. Review of lab results for Resident #24 showed a positive C-Diff Molecular lab, dated 4/7/24. The lab report showed critical lab results were reported to Staff G, Registered Nurse (RN) on 4/7/24 at 2:30 p.m. Review of the Admission Record showed Resident #24 was admitted on [DATE] with diagnoses to include dementia, cognitive communication deficit, and constipation. Review of Resident #24's Minimum Data Set (MDS) Section C, Cognitive Patterns, dated 1/31/24, showed a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. Review of the progress notes for Resident #24, dated 4/8/24 at 12:48 p.m. from Staff E, Licensed Practical Nurse (LPN)/Unit Manager (UM), revealed labs were reviewed by the resident's PCP and new orders for Vancomycin 125 mg (milligrams) by mouth every 6 hours for 14 days. Review of orders showed an order for Contact Isolation Precautions and an order for Vancomycin HCL Oral Capsule 125 mg every 6 hours for Clostridioides difficile (C-diff), dated 4/8/24 at 12:51 p.m. Review of the active care plan for Resident #24 showed a plan in place for Contact Precautions for C-Diff, dated 4/8/24. Interventions included staff will follow contact precautions. An observation was made on 4/9/24 at 11:54 a.m. of Staff R, Certified Nursing Assistant (CNA) and Staff Q, CNA entering Resident #24's room to deliver lunch trays. The door had a contact precaution sign as well as a PPE door hanger with supplies. Staff Q, CNA exited the room and did not perform hand hygiene before entering another resident room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was made on 4/9/24 at 11:56 a.m. of Staff Q, CNA entering room [ROOM NUMBER] to deliver a lunch tray, which also had a contact precaution sign and PPE door hanger with supplies. The CNA was observed setting up the resident's lunch tray, arranging the position of the tray table and adjusting the bed with no PPE on. An interview was conducted on 4/9/24 at 12:09 p.m. with Staff R, CNA. He said he did not know Resident #24 was on contact precautions when he delivered the lunch tray. He said he is not assigned to that hall and the nurse didn't tell him. Staff R said he did not notice the sign on the door. He confirmed he did not put on PPE. Staff R said normally for a resident on contact precautions he would set the tray on the table right inside the door, put a gown and gloves on, then enter the room, deliver, and set up the tray. An interview was conducted on 4/9/24 at 2:05 p.m. with Staff Q, CNA. She said she currently had two rooms on contact precautions, Resident #24's room related to C-diff and room [ROOM NUMBER] related to MRSA (Methicillin-Resistant Staphylococcus Aureus). She said for rooms on contact precautions staff should put on a gown and gloves all the time no matter what. Staff Q said for food tray delivery some people say staff should wear PPE all the time and some say staff can carry the tray in, set in down, then walk out without PPE on. An observation was made on 4/10/24 at 11:06 a.m. of Staff V, Registered Nurse (RN). Staff V was in the hallway standing at the medication cart with PPE (gown and gloves) on. She then walked away from the cart and was observed caring for a resident. An interview was conducted on 4/10/24 11:10 a.m. with Staff V, RN. She confirmed she had PPE on in the hall and said she should not have. She said she should have taken the PPE of inside the room at the door. An interview was conducted on 4/9/24 at 4:51 p.m. with Staff E, Licensed Practical Nurse/Unit Manager (LPN/UM). She said when critical labs are called to the facility by the lab, the nurse should get the results and call the doctor for orders. She said if they suspect C-diff for a resident, they put them on prophylactic isolation precautions until the lab results come back. Staff E said she was not aware Resident #24 had loose stools and was being tested and if she would have been notified she would have placed him on precautions. She confirmed Resident #24 should have been on precautions Sunday (4/7/24) when the results came back if not sooner. Regarding food trays being delivered to residents on contact precautions Staff E said one CNA should be inside the room with PPE on and another CNA should pass them the tray at the door. The CNA inside the room would set the tray up for the resident and assist if needed, they would then take off the PPE, exit the room and perform hand hygiene. An interview was conducted on 4/9/24 at 5:03 p.m. with the Director of Nursing (DON). She said if a person is on contact precautions for a wound infection and the infection is covered, she would not expect people to put on all of that [PPE] just to pass a tray. She said if the resident is on contact precautions for C-diff she would expect staff to wear PPE anytime they enter the room. The DON said she was not aware that Resident #24 had tested positive for C-Diff on 4/7/24. She was made aware on 4/8/24. The DON said normally if someone is suspected of having C-Diff they are put on contact precautions until it is ruled out. She said she would have expected the resident to have been on precautions while being tested and definitely after the nurse found out the resident was positive for C-Diff. (continued on next page)

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	105351	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concordia Village of Tampa	4100 E Fletcher Ave Tampa, FL 33613

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Contact Precautions sign the facility posted showed: Everyone must: Clean their hands, including before entering and when leaving the room. Providers and Staff must also: put on gloves before room entry, discard gloves before room exit, put on gown before room entry, discard gown before room exit . Review of the policy titled, Management of C. Difficile Infection, implemented 10/17/22, showed the following: Policy: This facility implements facility-wide strategies for the prevention and spread of Clostridioides difficile infections. Policy Explanation and Compliance Guidelines: 4. Licensed nurses may implement preemptive contact precautions when C. difficile infection is suspected, pending results of testing. Once confirmed, contact precautions shall be implemented in accordance with a physician order and facility policy for transmission-based precautions. 5. General principles related to contact precautions for C. difficile: a. All staff are to wear gloves and a gown upon entry into the resident's room and while providing care for the resident with C. difficile. b. Hand hygiene shall be performed by handwashing with soap and water in accordance with facility policy for hand hygiene. c. Maintain on contact precautions for the duration of the illness, but no less than 48 hours after diarrhea has resolved. d. Encourage/assist residents to wash hands frequently. Bathe daily with soap and water. Review of a policy titled, MDRO [Multidrug resistant organism] Infection, implemented 10/17/22. Policy: This facility implements facility-wide strategies for preventing the spread of infections with multidrug-resistant organisms. Policy Explanation and Compliance Guidelines: 3. Infection Control Precautions: a. Staff will use contact precautions in addition to standard precautions when caring for a resident with MDRO infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Signage at entry of the resident's room shall indicate Contact Precautions, and the type of personal protective equipment in required upon entry into the room. 20311 Review of Resident #121's Admission Record revealed she was admitted to the facility on [DATE]. Review of the Resident's 5-day Minimum Data Set (MDS,) dated 3/29/24, revealed a Brief Interview For Mental Status (BIMS) score of 09 (Moderate Cognitive Impairment). Review of Resident #121's physician orders revealed a current order for Doxycycline Hyclate 100 mg every morning and bedtime for MRSA left hip for 28 days, start date 4/8/24, and a physician order for Isolation contact MRSA lt (left) hip wound every shift-4/1/2024. Observations on 4/08/24 at 10:26 a.m. of Resident #121's room revealed an isolation kit hanging on the outside of the door and the room door was open. It was also noted that a sign was posted on the door indicating the room was under Enhanced Barrier Precautions. The sign directed what those who entered the room must do for Enhanced Barrier Precautions. (Photographic Evidence Obtained) Continued observation of Resident #121's room at this time revealed that there were 3 dogs being escorted down the hallway by 3 dog handlers (2 large, 1 small). The group was noted to go in and out of resident rooms on the hallway. During this observation a dog handler with a small dog was noted to enter Resident #121's room without regard to the isolation kit and sign mounted on the door. The dog handler was observed to place the small dog onto Resident #121's lap and Resident #121 hugged, stroked and kissed the dog as the dog licked at the resident. Continued observation on 04/08/24 at 10:27 a.m. revealed the dog handler left Resident #121's room with the dog and entered the room of another resident with the dog, which physically interacted with the second resident. During an interview on 04/08/24 at 10:35 a.m. with Staff G, RN she revealed Resident #121 had a current diagnosis of MRSA in a wound and the resident was on isolation and that visitors should check with the nurse before entering the room. Observations on 4/09/24 at 9:21 a.m. of Resident #121's room revealed Staff I, CNA was noted to walk into the resident room, assisted the resident with organizing her over bed table and nightstand and assist with positioning of resident in the bed. Staff I, CNA was noted to then put on latex gloves then take the resident's meal tray and handed the tray to another staff member. An interview with Staff I at this time revealed that when a resident was on enhanced precautions, and he is performing care that he should be fully gloved up and have on a gown. He reported he should have used a gown and gloves, but that it skipped his mind. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/09/24 at 11:51 a.m. the Director of Nursing (DON) was observed standing assisting Resident #23 with her meal. Her cell phone rang, she pulled the phone from her pocket, stated I don't know who this person is, and placed the cell phone back in her pocket. She did not sanitize her hands before starting back to assist Resident #23 with her meal. On 4/09/24 at 11:59 a.m. the DON rolled her sleeves up, her cell phone rang, she pulled the cell phone from her pocket again, ignored the call, sat down at the table with Resident #54, picked up the utensil, and proceeded to assist Resident #54 with his meal without performing hand hygiene. On 4/09/24 at 12:06 p.m. Staff C, Staffing Coordinator/CNA was observed seated at a table continuously assisting two residents (Resident #37 & #17) with their meal at the same time, with the same hand (right), with no hand hygiene in between. At 12:11 p.m. she was continuously observed assisting the residents with the same hand. She then stated to Resident #17 last bite and then gave her some of the drink from a cup with two handles. Staff C, Staffing Coordinator/CNA, then stated you ate all your food as she wiped Resident #17's mouth. She then started assisting Resident #37 with the same hand with no hand hygiene in between until she finished her meal. On 4/09/24 at 12:07 p.m. Staff D, CNA stated she assists with meals in the dining room two to three days a week. She stated she did not clean the residents' hands prior to lunch. On 4/09/24 at 12:18 p.m. Staff A, CNA stated she assists with meals in the dining room two to three days per week. Activity staff would usually do hand hygiene. When asked who did hygiene today, she stated the CNAs assist with hand hygiene as well. Staff A, CNA then stated she did not clean the residents' hand prior to lunch today because ADL care was provided right before the residents came to the dining room and their hands were clean. On 4/09/24 at 12:23 p.m. Staff C, Staffing Coordinator/CNA stated she was educated to use different hands when assisting two residents with meals at the same time. When asked if she used different hands today, she stated no, and it was because of the way the residents were positioned at the table. On 4/10/24 at 9:29 a.m. Staff E, Licensed Practical Nurse (LPN)/Unit Manager/Infection Preventionist stated the residents do activities and therapy prior to eating lunch. She expects staff to sanitize or wash their hands before eating. She expects hand hygiene after touching anything. Before touching the resident's tray, there should be hand hygiene. Staff should not use the same hand when assisting two residents with their meals at the same time due to cross contamination. Review of the policy titled, Hand Hygiene, implemented on 10/17/22, revealed the following: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.