STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105442	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haines City Rehabilitation and Nursing Center	409 S 10th St Haines City, FL 33844

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 0558

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Reasonably accommodate the needs and preferences of each resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 20536

Based on observation, interview, and medical record review, the facility failed to ensure call light cords and buttons were placed within reach for three (#61, #34, and #24) of forty-eight sampled residents.

Findings included:

1. On 11/18/2024 at 2:10 p.m., 11/19/2024 at 8:10 a.m., 3:20 p.m., and on 11/20/2024 at 8:02 a.m. and 9:52 a.m., while Resident #61 was visited in her room, she was observed each time lying in bed flat, under the covers and receiving services to include nourishment via a tube feed system, pressure ulcer care via a wound vacuum system, and also was observed utilizing an indwelling urinary catheter. Further observations revealed each visit included the call light button and cord was either placed hanging off the back of the head of the mattress and between the wall out from her reach or lying on the floor out from her reach. An initial interview attempt was made with Resident #61 on 11/18/2024 at 2:10 p.m., she was noted with cognitive deficits. Resident #61 was able to speak related to her daily routines and simple questions related to her care. Resident #61 said that she called staff for help almost every day. She was asked how she called for staff. She said she tried to use the call light and was observed looking for it. She could not find the call light button and revealed there were times the staff did not put it where she could find it. It was observed at that time to be back and behind her pillow/mattress and between the mattress and the wall, hanging down approximately two feet, well away from Resident #61's reach. Resident #61 could not see the call light button and said she would not be able to locate it and use it if it was behind her and hanging down. Resident #61 was noted in a private room and most of the day she had the door closed. Resident #61 revealed there were times when she could not find her call light button and there were times she had to yell out but staff did not hear her. She said she had mentioned to staff to please place the call light within her reach all the time, but this did not happen all the time. She had spoken to her nurses, (no names given or timeframes), but things had not gotten better.

Review of the electronic medical record to include nurse progress notes dated from 10/17/2024 to current review date 11/21/2024, did not reveal any documentation to support Resident #61 had behaviors of tossing, or throwing the call light button away from her.

There was no documentation to support Resident #61 did not use her call light.

Progress note dated 11/19/2024 18:20 (6:20 p.m.) revealed Resident #61 was observed resting in bed and with the call light placed within her reach.

(continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105442	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Haines City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 409 S 10th St Haines City, FL 33844	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This note supported staff are to place the call light within her reach when she was in bed. Review of the current Admission Minimum Data Set (MDS) assessment dated [DATE], showed: Cognition or Brief Interview for Mental Status (BIMS) score of 5 which indicated severe cognitive impairment; Mood - none documented as observed during timeframe; Behavior - None documented as observed during timeframe; ADL (Activities of Daily Living) - Shower/Bathing including washing, rinsing, and drying self - Substantial/Maximal assistance; Personal Hygiene-the ability to maintain personal hygiene including combing hair, shaving, apply make up, washing/drying hands - Substantial/Maximal assistance. The MDS assessment Showed Resident #61 required maximum assistance with most of her care and services. Review of the current care plans with next review date 1/18/2025 revealed the following but not limited to areas: 1. Risk for falls related to impaired mobility, cognitive impairment with interventions to include but not limited to: Encourage and remind the resident to use the call bell. On 11/20/2024 at 9:55 a.m., an interview with Staff A, Certified Nursing Assistant (CNA), revealed all residents in the building were to have their call light placed within their reach whether they were in bed, or seated in a chair or wheelchair in their room. Staff A confirmed Resident #61 used the call light at times to get staff assistance. Staff A confirmed at 9:55 a.m., the call light was not placed within Resident #61's reach. Staff A said Resident #61 would toss the call light away, but she had not reported that to any nurses in the past. On 11/20/2024 at 10:03 a.m., an interview with Staff B, Licensed Practical Nurse (LPN), Station 1 Unit Manager, revealed she knew Resident #61 and that she required maximum assistance with all her ADL. She further confirmed Resident #61 used the call light button to get staff assistance. Staff B confirmed all residents were to always have their call light button placed within their reach when they were in their rooms and while in bed. Staff B. revealed she had not been made aware from any staff that Resident #61 threw or tossed the call light button away from her, nor could she find documentation in the electronic record to support that. On 11/21/204 at 7:50 a.m., an interview with Staff C, LPN, who was Resident #61's assigned nurse, revealed all residents were to have their call light buttons placed within their reach when they were in their rooms and in bed. Staff C could not remember a time when Resident #61 threw or tossed her call light button on the floor. Staff C verified the resident often used the call light to call for assistance. Staff C could not show in the medical record that Resident #61 had behaviors of displacing the call light button out of her reach. On 11/21/2024 at 7:56 a.m., an interview with Staff D, CNA revealed she did not know the resident well as she floated around the facility. She confirmed she had the resident on her assignment today and she had seen her already. Staff D confirmed that all residents when in bed and if seated in chairs next to their bed, should have call lights placed within their reach. Staff D was not aware of the resident throwing or tossing the call light button out of her reach. She revealed if that were the case, and for every resident, they would report that behavior to the nurse or Director of Nursing. Staff D revealed she had been trained and inserviced to go in the room and look for things related to comfort and safety, and call light placement is one of those things she looks out for. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	37999 2. On 11/18/24 at 10:59 a.m., Resident #34 was observed sitting in a wheelchair between the bed and the wall next to the bathroom. The resident's call light pad was observed on the other side of the bed. On 11/19/24 at 10:02 a.m., Resident #34 was observed lying in bed. The resident's call light pad was observed lying next to the left hip of the resident's roommate and another call light button was hanging on the top of the roommate's mattress. Neither of the room's call light devices were accessible to Resident #34. On 11/19/24 at 10:12 a.m. the Director of Nursing (DON) observed Resident #34 lying on her left side with her right foot hanging out of bed, facing the bathroom wall. The DON moved the folded floor mat to the left side of bed. She reported Resident #34 was able to use the call light and confirmed the resident's call light pad was on the roommate's bed. On 11/20/24 at 8:46 a.m., an unknown staff member was observed assisting Resident #34 with eating the morning meal while the resident was sitting in wheelchair between the bed and the bathroom wall. On 11/20/24 at 9:00 a.m., Resident #34 was observed sitting in a wheelchair in between the bed and the bathroom wall. The resident's call light pad location was unknown and not seen within the resident's reach. On 11/20/24 at 9:03 a.m., Staff L, Certified Nursing Assistant (CNA) located the resident's call light pad behind the floor mat that was in front of the bedside dresser between the bed and the curtain separating the resident's and roommate's beds. The staff member stated the resident must have dropped it. Staff L stated the staff member who had been assisting the resident with eating should have ensured the call light was within reach of the resident prior to leaving the resident. Review of Resident #34's care plan revealed the resident was at risk for falls related to (r/t) cognitive deficit, history of falls, impaired vision, (and) use of anti-hypertensive medications. The related interventions included but not limited to encourage and remind resident to use call bell to wait for staff assistance with transfers, ambulation, toileting, etcetera (etc.) as tolerated, initiated on 10/4/22. 3. On 11/19/24 at 10:05 am., Resident #24 was observed lying in bed with the head of bed slightly raised. The observation showed the resident's call light button was hanging through the resident's raised bed rail and lying against the bedside dresser. The call light was not within reach of the resident. On 11/19/24 at 10:09 a.m., Resident #24 was observed with the Director of Nursing (DON). The DON viewed the resident's call light and stated it must have fallen and reported the resident was unable to use the call light. Review of resident #24's care plan revealed the resident was at risk for falls related to (R/T) history of falls, unsteady gait/ poor balance, use of anti-hypertensive medications. This focus was initiated and revised on 1/16/23. The interventions showed that nursing staff should Encourage and remind resident to use call bell and to wait for staff assistance with transfers, ambulation, toileting, etcetera (etc.) as indicated. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy - Call lights, revised 1/2024, showed the standard was the Resident will have a call light to summon facility personnel to ensure the resident's needs will be met. The guideline was Resident's call light is to be within reach and answered promptly by facility personnel. The procedure instructed: 1. Answer call light promptly. All Facility personnel are expected to respond to call lights. 2. Knock on the room door, announce yourself, and be courteous when entering the room. 3. Turn off the call light. 4. Listen to residents' request. DO NOT Make residents feel that you are too busy. (#5 is missing from the policy) 6. Office services before leaving the resident's room. Insure the call light is within reach. 7. If the call light is defective, report to maintenance. 8. Call lights must remain functional and within reach of each resident. Call lights must not be disabled. Call lights shall not be removed from resident's reach unless this is a therapeutic intervention documented in a resident specific behavior management plan set forth by the physician and/ or mental health clinician in response to problematic and/for attention seeking behavior. 9. Respond to the residents' request, if unable to assist, notify the nurse. Return to the resident promptly with a reply.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37999 Based on observation, record review, and interview, the facility failed to ensure the care plans for eight (#34, #52, #30, #91, #36, #39, #67, and #90) of 48 residents were developed and implemented related to activities, Hospice, and fall devices. Findings included: 1. On 11/18/24 at 10:46 a.m., Resident #34 was observed sitting in a wheelchair between the bed and bathroom wall. The resident was smiling and nodding at this writer, neither of the televisions for the resident or roommate was on or was there radio playing. On 11/19/24 at 9:59 a.m., Resident #34 was observed lying flat in bed, the room did not have a television or radio playing. On 11/20/24 at 9:00 a.m., Resident #34 was observed sitting in wheelchair between the bed and bathroom wall. The observation revealed a Spanish-speaking Activity calendar posted on the wall slightly behind the television which was not turned on. Review of Resident #34's Admission Record showed the resident had diagnoses not limited to primary open-angle glaucoma unspecified eye stage unspecified and unqualified visual loss both eyes. Review of Resident #34's care plan revealed the following care areas and related interventions: - Resident has impaired visual function related to (r/t) blindness, initiated 6/11/23. - Resident has a communication problem related to (r/t) language barrier: Spanish-speaking, understands some English, (and) has some hearing impairment. The interventions instructed staff, including Activity staff, to Provide translator if resident needs and or wants one to communicate with the resident, initiated 9/26/24. - Resident is dependent on staff for emotional, intellectual, physical, and social stimulation r/t cognitive deficits (and) physical limitations. The goal showed The resident will increase/tolerate involvement in cognitive stimulation, social activities as desired through review date. The interventions instructed staff to: o Assist with arranging community activities. Arrange transportation. o Assist/escort to activity functions as needed. o Encourage ongoing family involvement. Invite the resident's family to attend special events, activities, (and) meals. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the annual Minimum Data Set (MDS) dated [DATE], revealed Resident #34 had minimal difficulty with hearing, was usually understood, usually made self understood, and vision was severely impaired, no vision or sees only light, colors or shapes. The comprehensive assessment revealed a daily and activity preferences were discussed with the resident's family member or significant other. The preferences showed that listening to music, doing things with groups of people, doing a favorite activity, going outside for fresh air, and participating in religious services or practices were very important to the resident. Review of Resident #34's Activity documentation showed the resident actively participated in the activity of Friend/Friendly Visit in the resident's room/on unit 20 of 30 opportunities from 10/23 to 11/20/24. The documentation revealed available activity types as animal/pet visits, arts/crafts, audio/visual, beauty/grooming, conversation/social, cooking/baking, exercise/physical/active sport, family/significant other, food as main focus, games/puzzles, knowledge/education, mail, materials/supplies offered/provided, memory stimulation, music, nature/garden/science, and outing away from facility. The documentation did not show the resident had refused any offered activity. Review of Resident #34's Lifestyle and Activity Preferences Evaluation, effective 8/26/24, revealed the resident's religious preference, was Hispanic, vision was impaired and not improved by glasses or contacts, no problem with hearing, had difficulty in finding words, poor reading ability, needed reminder at time of activity, was not bed/room bound, and needed no assistance to/from activity setting. The evaluation showed the resident enjoyed friendly visits by staff, enjoyed crafts in the past, enjoyed church services, enjoyed hand massages, and enjoyed visiting with select staff members. 2. On 11/20/24 at 8:44 a.m., Resident #52 was observed lying in bed, in a room without a roommate. The room did not have a television or radio available for the resident. On 11/21/24 at 8:37 a.m., Resident #52 was lying in bed and wearing a hospital gown. The blinds to the room were closed leaving the room dark with no available television or radio. Review of Resident #52's care plan revealed the following care areas and related interventions: - Has potential for little or no activity involvement related to (r/t): language barrier; Impaired thought process; Dementia. At times chooses to observe activities rather than participate, often chooses to remain in bed. The resident's goal was to increase participation in activities of choice times per week by review date of 2/1/2025. The goal was revised 11/11/24. The interventions instructed activity staff to: o Encourage resident to participate in activities that's tolerated. o Invite/ encourage the residents family members to attend activities with resident as needed/ desired. o Offer friendly visits to promote independent leisure pastimes in socialization. o Remind the resident that the resident may leave activities at any time and is not required to stay for the entire activity. o Resident requires (specific interventions i.e. cueing) to engage in activities of interest, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o The resident needs a variety of activity types and locations to maintain interests. The Certified Nursing Assistants (CNA) were instructed the resident needs assistance/ escort to activity functions. - Has a communication problem related to impaired cognition, primary language is Spanish, revised 11/11/24. The goal was for the resident would maintain current level of communication function through the review date of 2/1/25. The interventions included: o provide a program of activities that accommodates the residents communication abilities, initiated 11/11/24. o Provide translator as necessary to communicate with the resident. Review of Resident #52's annual comprehensive assessment, dated 10/15/24 showed the resident did not have a Brief Interview of Mental Status score as the resident was rarely/never understood. The staff assessment of the resident's cognition showed a short-and long-term memory problem, severe impairment for making decisions regarding tasks of daily life, with no acute change in mental status, the behaviors of inattention, disorganized thinking, and altered level of consciousness were not present. The activity preferences were completed with the resident revealing music and religious services were somewhat important. The quarterly Activity Progress note dated 7/27/24 showed the activity assessment was complete and appropriate. The preferred activities were watching television, people watching, listening to music, and visiting with select staff members. Resident expresses satisfaction with current routine and staff will continue to provide 1:1 visits and encouragement for participation in group programs. Review of Resident #52's Activity documentation showed the resident actively participated in the activity of Friend/Friendly Visit 19 of 30 opportunities and one episode of receiving mail from 10/23 to 11/20/24. The documentation revealed available activity types as animal/pet visits, arts/crafts, audio/visual, beauty/grooming, conversation/social, cooking/baking, exercise/physical/active sport, family/significant other, food as main focus, games/puzzles, knowledge/education, mail, materials/supplies offered/provided, memory stimulation, music, nature/garden/science, and outing away from facility. The documentation did not show the resident had refused any activity. 3. On 11/19/24 at 11:05 a.m., Resident #30 was observed lying in bed. The resident acknowledged going to activities sometimes and reported not being informed of daily activities. On 11/21/24 at 12:31 p.m., Resident #30 stated activity staff did not visit daily for 15-20 minutes per day. Review of Resident #30's care plan showed the resident had little or no activity involvement related to physical limitations, chooses to remain in bed at times. Requires much encouragement for group participation. Resident attends outings. The goal for the resident was the resident would express satisfaction with type of activities and level of activity involvement when asked through the review date. The goal was revised on 7/8/24 with a target date of 12/11/24. The interventions instructed activity staff to: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Encourage participation and activities of potential interest. - Encourage resident to participate in activities as tolerated. - Invite/ encourage the resident's family members to attend activities with resident as needed/ desired. - Offer friendly visits to promote independent leisure pastimes and socialization. - Remind the resident that the resident may leave activities at any time and is not required to stay for the entire activity. The CNA's are instructed the resident needs assistance/ escort to activity functions. Review of Resident #30's quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview of Mental Status score of 15 of 15, indicating an intact cognition. The annual MDS dated [DATE] revealed the resident's activity preferences of having pets around was very important and reading materials, listening to music, keeping up with the news, doing things with groups of people, doing favorite activities, going outside, and participating in religious services were somewhat important. Review of Resident #30's Activity Documentation showed the resident actively participated in the activity of Friend/Friendly Visit 18 of 30 opportunities, one insistence of an animal/pet visit, and one episode of beauty/grooming from 10/23 to 11/20/24. The documentation revealed available activity types as animal/pet visits, arts/crafts, audio/visual, beauty/grooming, conversation/social, cooking/baking, exercise/physical/active sport, family/significant other, food as main focus, games/puzzles, knowledge/education, mail, materials/supplies offered/provided, memory stimulation, music, nature/garden/science, and outing away from facility. The documentation did not show the resident had refused any activity. 4. On 11/19/24 at 11:05 a.m Resident #91 was observed lying in bed, the resident reported attending activities sometimes. The activity calendar was posted on the wall opposite of where the resident's bed was located and behind the television. The resident and roommate (#30) stated they were not informed of daily activities and were unable to read the calendar from it was located. On 11/21/24 at 12:31 p.m., Resident #91 reported Activity staff did not visit daily for 15-20 minutes and they did not read or talk with her daily. Review of Resident #91's care plan revealed the following care areas with related interventions: - The resident is able to make leisure needs and preferences known in participate in facility activities as desired. Prefers independent leisure activities with encouragement. Resident attends outings, revised 9/30/24. The goal for the resident shows the resident will remain engaged in independent leisure activities and participate in facility activity programming as desired through next review. The resident will express satisfaction with leisure routine through next review. The target date was 1/29/25. The interventions were related to this care area instructed activity in nursing staff to: o assist resident to/ from activities as needed. (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

o Encourage in room leisure time such as TV, phone/ video communication with family/ friends, reading books/magazines, etcetera and allow for resident feedback and suggestions on leisure time activities.

o Encourage ongoing family involvement. Invite the residents family to attend special events, activities, (and) meals.

o Encourage participation in activities of interest.

o Honor residents choice to choose only activities, provide reminders/ cues for participation as needed.

- The resident has a psychosocial well-being problem related to self-reporting that (pronoun) not very interested in favorite activities. This area was initiated on 11/11/24.

Review of Resident #91's annual comprehensive assessment showed being around animals was very important to the resident and listening to music, doing things with groups of people, going outside to get fresh air, and participating in religious services was somewhat important to the resident.

Review of Resident #91's Activity Documentation showed the resident actively participated in the activity of Friend/Friendly Visit in the resident's room/on unit 20 of 30 opportunities, from 10/23 to 11/20/24. The documentation revealed available activity types as animal/pet visits, arts/crafts, audio/visual, beauty/grooming, conversation/social, cooking/baking, exercise/physical/active sport, family/significant other, food as main focus, games/puzzles, knowledge/education, mail, materials/supplies offered/provided, memory stimulation, music, nature/garden/science, and outing away from facility. The documentation did not show the resident had refused any activity.

On 11/19/24 at 10:45 a.m., the Activity Room was observed with stacks of boxes and desks around the perimeter of the room. Staff W, Activity Director of sister facility, reported doubting any activities were happening in the Activity Room as it was more of an office and the residents store things in there.

An interview was conducted on 11/21/24 at 9:26 a.m., with Staff O, Licensed Practical Nurse/Unit Manager. The staff member stated Resident #34 did not do things like before, two weeks ago the resident went to music and wanted to be brought back within 5 minutes. Staff O reported the resident spoke English, don't let her fool you. The staff member stated Resident #34 did not want to get up (out of bed) and thought it was in the resident's care plan. Staff O reviewed the resident's care plan reporting the issue with not wanting to get out of bed was not part of the care plan. The staff member stated Activity (staff) came around daily and offered activities.

An interview was conducted on 11/21/24 at 10:15 a.m., with the Activity Director (AD). The AD stated daily visits were done daily and lasted about 10-15 minutes.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/24 at 10:46 a.m. with the AD and Nursing Home Administrator (NHA), the AD reported doing 1:1 activities with music, audiobooks, and singing with Resident #34. She reported playing music yesterday for the resident for 15 minutes. The AD reported activity staff do not speak Spanish but pulled Spanish -speaking staff into the room to speak with the resident. The AD reported Resident #52 was Spanish-speaking and staff performed hand massages and read to the resident every day as the resident did not participate in group activities. The AD reported not reading the activity calendar to residents and said activities were announced through the facility's overhead system (not heard during survey). The NHA stated they had put in a system so the aides brought residents down to activities and were aware of the activities. Resident #91 did not participate in activities and Resident #30 was very specific on activities. Resident #52 liked to have blinds closed in room and the NHA stated the resident would yell out to people in the hallway. 50732 5. On 11/18/2024 at 11:01 a.m., Resident #39 was observed laying in bed under the covers, dressed in a gown, groomed and sleeping. The resident was receiving nutrition via tube feeding. A verbal attempt was made to wake the resident up by calling her name, however, the resident opened her eyes and immediately closed her eyes. No visitors or staff were observed in the room. On 11/19/2024 at 10:27 a.m., Resident #39 was observed laying in bed under the covers, dressed in her personal clothing, groomed and awake. An attempt at verbal communication with the resident was made by calling out her name, however, the resident continued to stare and did not verbalize a response. No visitors or staff were observed in the room. On 11/21/2024 at 3:30 p.m., Resident #39 was observed laying in bed under the covers, dressed in her personal clothing, groomed and awake. An attempt at verbal communication with the resident was made by calling out her name, however, the resident continued to stare and did not verbalize a response. No visitors or staff were observed in the room. Review of the Admission Record showed Resident #39 was admitted to the facility with diagnoses included but not limited to Alzheimer's Disease, gastrostomy, history of falling, need for assistance with personal care, contracture left elbow, contracture left hip, dysphagia, cognitive communication deficit, and contracture right hip. Review of Resident #39's Minimum Data Set (MDS) Quarterly assessment dated [DATE] showed Section C-Cognitive Patterns, Resident #39 had a Brief Interview for Mental Status (BIMS) score of 00 showing severe cognitive impairment. Section GG-Functional Abilities and Goals showed when Resident #39 was seated in a motorized wheelchair/scooter, she had the ability to wheel at least 50 feet and make two turns. Section GG also showed when Resident #39 was seated in a manual wheelchair, she had the ability to wheel at least 150 feet in a corridor or similar space. Review of Resident #39's Care Plan dated 09/24/2024 revealed the resident was dependent on staff for emotional, intellectual, physical, and social stimulation related to cognitive deficits. Resident #39 needed Assist/escort to activity functions as needed. The resident should be invited to scheduled activities. Offer 1:1 bedside/in-room visits/activities if the resident was unable to attend out-of-room events, if the resident chooses. Review of Quarterly Activity Progress note dated 09/25/2024 for Resident #39 showed the following: (continued on next page)

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	105442	A. Building B. Wing	11/21/2024

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Haines City Rehabilitation and Nursing Center	409 S 10th St Haines City, FL 33844

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Assessment Review - activity assessment is complete and appropriate. No changes needed. 2. Activities-related care plan: some elements/interventions were successful: 1:1 visits provided by staff 3. Summary - since the last review the resident has enjoyed these preferred activities: Resident enjoys a variety of activities mainly receiving friendly visits, being read aloud to, hand massages, and listening to music. Resident prefers to stay in bed majority of the time. The positive results included: Resident expresses satisfaction with current routine through facial expressions. Staff will continue to provide 1:1 visits. Review of Resident #39's Activity Participation Report, as completed by the Activities Department staff, showed for the time period 10/23/2024 through 11/20/2024 the section titled Active was checked daily. The other sections were not checked and were titled as follows: Left or In & Out, Passive/Assisted, Present/Observer (difficult to discern response), Therapy Session at time of activity, Visiting with family/other (at time of activity), Resident Not Available, Resident Refused and Not Applicable. Review of Resident #39's Activity Type Report, as completed by the Activities Department staff, showed for the time period 10/23/2024 through 11/20/2024 the section titled Friend/Friendly Visit (e.g. may include by staff, volunteer) was checked daily. All other sections of the report were not checked. The sections not checked included: Memory Stimulation (e.g. reminiscing, photos), Music and Nature/Garden/Science. An interview was conducted on 11/21/2024 at 10:46 a.m. with Staff G, Activities Director (AD) and the Nursing Home Administrator (NHA). Staff G said there were three staff members in the Activities Department, herself and two others. She said friendly visits were done in the morning between 9:30 a.m. and 10:00 a.m. and the visits usually took 15-20 minutes for each resident. She said friendly visits were also completed during any downtime her and her staff might have during the day. Staff G said the resident visits were charted by the activities staff and the charting was usually done at the end of the day. She said the exact times of the visits were sometimes not charted correctly because the facility's electronic medical record automatically records a time and the staff sometimes forgot to change the time when completing their charting. Staff G said the Activities department individually charts what activity they do with the residents. For example, reading, listening to music, etc. were not separately charted because charting as friendly visits encompasses the other activities done on the 1:1 friendly visits. She said the activities staff meet every morning and discuss what types of visits they completed with their assigned residents the day before. Staff G said she did not actually time her staff to ensure they were spending time with their assigned resident, she received the information directly from the staff members. She agreed as a Director of Activities she needed to know exactly how long each staff member was spending with their assigned residents. 46498 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During an observation made on 11/19/24 at 11:46 a.m., and 2:00 p.m., Resident#67 was observed lying down in his bed during an activity. He stated he did not participate in activities because staff did not offer him activities. Review of Quarterly Minimum Data Set (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment Resident #67 had a care plan showing he had potential for little or no activity involvement related to a language barrier, weakness. Date 9/19/2022, Revision on 9/22/2022. The care plan goals were for Resident #67 would increase participation in activities of choice (sic) times per week by review date. Date initiated 9/19/2022, Revision on 7/18/2024, Target date 12/28/2024. The care plan intervention included: Encourage participation in activities of potential interest including (sic). Resident #67 needed assistance/escort to activity functions, the resident needed a variety of activity types and locations to maintain interests. Date initiated 9/19/2022. During an interview on 11/21/2024 at 2:00 p.m., with Staff G, Activity Director. Staff G stated every month they made up packets to hand out to every resident that showed the upcoming activities. She stated on the packet she highlighted what activities she knew each resident would like to attend, so residents could see the activity that would interest them. She stated her and her staff go around to residents' rooms to invite residents to activities every day, but she did not document if a resident refused to participate in activities. She stated Resident #67 always refused activities when they asked him if he would like to participate but she did not document her attempts. She stated she just recently started working in the position and she had not reviewed each resident's care plan to know what their intervention were and to ensure that the resident interventions were followed. 50434 7. During an observation on 11/18/2024 at 9:49 a.m. Resident #90 was observed in bed dressed in a night gown, clean in appearance. An attempt to interview Resident #90 was made and she was not able to answer questions regarding her care. Review of Resident 90's admission Minimum Data Set (MDS) dated [DATE] revealed Section C. Cognitive Patterns, Brief Interview for Mental Status (BIMS) of 04 out of 15 which indicated severe cognitive impairment. Review of Section O. Special Treatments revealed Hospice care. A review of Resident #90's care plan revealed no focus, goal or interventions related to Resident #90 receiving Hospice Services. During an interview on 11/20/2024 at 11:40 a.m., Staff T, Certified Nursing Assistant (CNA), stated Resident #90 needed assistance with all of her care. She stated Resident #90 liked to try to do everything on her own and goes fast. She stated she thought the resident was being seen by the hospice. She stated she thought the Hospice CNA came in and saw her on Tuesdays. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/2024 at 11:40 a.m., Staff U, Licensed Practical Nurse (LPN), stated the paper chart was where they kept the orders for residents on hospice. He stated it could also be found in the resident's profile in [name of computer program]. He stated the Hospice CNAs made their own schedules and did not have set days to come in. He stated the Hospice Nurse came in once a week and would come to the nurse's station to let him know they were seeing the residents. He stated if the nurse had new orders or was changing anything they write it out on an order sheet and gave it to the nurse, who then put the orders into [name of computer program]. During an interview on 11/20/2024 at 1:50 p.m., Staff O, LPN, stated when Hospice notified the facility they were accepting the resident, the nurses add the Hospice order into [name of computer program]. She stated Hospice would do an initial care plan for the residents. She stated the hospice nurse came one or two times a week. Hospice CNAs came in two times a week unless it was requested for more by the family. If staff at the facility had any concerns or if there was a change in condition with the resident, the nurse would notify hospice. She stated Resident #90 was on hospice prior to coming into the facility. She reviewed the orders and was not able to locate the hospice order for Resident #90. She reviewed Resident #90's care plan and stated, the care plan has hospice under nutrition, but it is not clear. She located Hospice's care plan in the document section of Resident #90's chart and stated the facility would not add their own hospice care plan for the resident and would just use the one hospice had. She stated the MDS Director was responsible for doing the care plans for the residents. During an interview on 11/20/2024 at 2:14 p.m., MDS Director, stated Resident #90 was receiving hospice services. She stated the hospice nurses attend the care plan meetings either by phone or in person. She reviewed Resident #90's care plan and stated she saw the hospice under nutrition, but they typically had a care plan for hospice/palliative care that she would add as well. 20536 8. On 11/18/2024 at 9:55 a.m. and 2:00 p.m., 11/19/2024 at 7:30 a.m., 3:15 p.m., 11/20/2024 at 8:07 a.m., 10:00 a.m., 11:30 a.m. 12:21 p.m., 1:45 p.m., 2:00 p.m., 3:00 p.m., and on 11/21/2024 at 7:20 a.m., Resident #36 was observed each time in his room, lying flat in a low bed and completely under the bed linen and covers. He was also noted each time with the linen pulled up over his entire head. It was further observed two very large, long and high raised fall floor mats devices on the floor on each side of the bed. The tops of both the fall mats were observed level to the top of the low bed mattress and appeared to be used should the resident roll out from bed. It was also observed Resident #36 had both 1/4 side rails up and in position while he was in bed. Photographic evidence obtained. On 11/18/2024 at 9:55 a.m., an interview was attempted with Resident #36. He did not respond to any questions. During the dates and times mentioned above, and while Resident #36 was in his bed, on 11/19/2024 at 7:30 a.m. and 3:15 p.m. the right side fall floor mat was observed folded and positioned behind the divider curtain, which was on Resident #36's roommate's side of the room. It was observed there was bare floor space approximately three feet from the edge of Resident #36's side of the bed and to where the fall floor mat was placed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/2024 at 8:07 a.m., the right side raised fall mat for Resident #36 was again observed folded and slid over past the divider curtain, leaving about three feet of bare floor space from the edge of the bed and to the fall mat. On 11/20/2024 at 8:09 a.m., Staff E, a Certified Nursing Assistant (CNA) walked into the room. She revealed the raised fall mats were used for the resident because he sometimes rolled out of bed and onto the floor. She said the side rails were used as enablers and were not restraints. Staff E further revealed she was not sure why the mats were so large other than so he did not roll on to the floor. The bed was in the lowest position but the mats were approximately one to one and a half feet high up off the ground. Staff E said Resident #36 did not get up out of bed on his own and he did not ambulate. Review of the current Physician's Order Sheet dated for the month 11/2024 and 10/2024 did not show any specific order for the use of fall floor mats or any type of special fall/accident devices. Review of the nurse progress notes dated from 6/1/2024 through to 11/21/2024 did not reveal any documented evidence of use of any type of fall floor mats, or any type of special fall/accident devices. Review of the current Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the following; Cognition/Brief Interview Mental Status BIMS score - 00 of 15, which indicated severe cognitive impairment; Mood - None documented as observed during this assessment timeframe; Behaviors - None documented as observed during assessment timeframe. Review of the current Care Plans with a next review date of 12/16/2024, showed the following: 1. Resident has a history of preferring stay in bed on most days. Snacks in bed. Prefers not to be weighed. Refuses showers with interventions to include but not limited to: Acknowledge/commend the resident's progress/improvement in behavior; Administer medications as ordered. Monitor/document for side effects and effectiveness; If reasonable/appropriate, discuss the behaviors with the resident. Explain/reinforce why behavior is inappropriate and/or unacceptable; Monitor behavior episodes and attempt to determine undying cause. Consider location, time of day, person involved, and situations. Document behavior and potential causes. There were no interventions to support the use of any fall floor mats or specialized fall/accident devices. Review of the entire care plan did not reveal any problem areas or interventions related to Resident #36 using fall floor mats or specialized fall/accident devices, while in bed. Further review of the entire medical record, there was no evidence of Resident #36 using these devices while in bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/21/2024 at 9:30 a.m., an interview with Staff F, Care Plan Coordinator, revealed she did know Resident #36 and his general daily care and routines. She said he was declining and received Hospice services and has had falls in the past. Staff F was asked about the large raised fall mat devices on each side Resident #36's bed. She revealed they were used as safety devices to help when he either placed his legs and feet off the side edge of the bed, or when he rolled out of bed. She said the mats were raised to a point that if he rolls off, he would roll onto these devices. Staff F further confirmed Resident #36's bed was always set at the lowest position and he also utilized 1/4 bed rails for enabling/repositioning. Staff F reviewed the electronic medical record to include the current 11/2024 Physician's Orders, all the nurse progress notes for the last three months (11/2024, 10/2024, 9/2024), and the current care plans and could not find evidence of these fall mats documented as ordered and reason for use. She further confirmed these devices were not listed in any of the problem areas in the current care plans. She revealed he had been care planned for use of these devices in the past, but it was confirmed these devices were not brought over during the last care plan meeting, which was in 9/2024. On 11/21/2024 at 10:03 a.m. an interview with the Director of Nursing (DON) confirmed Resident #36 required safety devices related to his risk for falls and history of falls. The DON revealed the large raised fall mat devices were not initially used as a first intervention for falls, but the Interdisciplinary Team had later added these devices. She confirmed the devices were not ordered an [TRUNCATED]

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observation, staff interview, and medical record review, the facility failed to ensure one (#36) of forty-eight sampled residents was offered and assisted to scheduled activities that met his interest. Findings included: On 11/18/2024 at 9:55 a.m., 10:30 a.m., 1:00 p.m., 2:00 p.m.; on 11/19/2024 at 7:30 a.m., 8:20 a.m., 1:00 p.m., 3:00 p.m.; on 11/20/2024 at 8:07 a.m., 10:00 a.m., 11:30 a.m., 12:21 p.m., 1:45 p.m., 2:00 p.m., 3:00 p.m.; and on 11/21/2024 at 8:00 a.m., 10:00 a.m., and 11:45 a.m., Resident #36 was observed in his room, lying flat in his bed with the covers and blanket over him, pulled over, and above his head. When attempting to meet with Resident #36 on 11/18/2024, he did not respond to an interview. During all the dates and times listed above, Resident #36 was observed not up for the day and not dressed. He was also not observed offered or assisted by either his assigned Certified Nursing Assistants (CNAs) or activities staff with the daily scheduled activities. Review of the large posted current month's (11/2024) activities calendar, posted on the wall across from each nurse station, revealed Resident #36 was not offered or assisted with the following posted activities during the 7 a.m. to 3 p.m. shift on 11/18/2024, 11/19/2024, 11/20/2024, and 11/21/2024: 1. On 11/1/24 - Friendly Visits at 9:30 a.m., Movie time at 2:30 p.m. 2. On 11/3/24 - Streaming Religious/Church services at 10:30 a.m., Outdoor visits at 1:00 p.m. 3. On 11/4/24 - Friendly Visits at 9:30 a.m. 4. On 11/5/24 - Friendly Visits at 9:30 a.m., Men's group at 1:30 p.m. 5. On 11/6/24 - Friendly Visits at 9:30 a.m., Therapy Dog visit at 10:30 a.m. 6. On 11/7/24 - Friendly Visits at 9:30 a.m. 7. On 11/8/24 - Friendly Visits at 9:30 a.m., Courtside with Friends, Movie time at 10:30 a.m. 8. On 11/10/24 - Streaming Religious/Church services at 10:30 a.m., Outdoor visits at 1:00 p.m. 9. On 11/11/24 - Friendly Visits at 9:30 a.m., Bible study at 1:30 p.m. 10. On 11/12/24 - Friendly Visits at 9:30 a.m., Musical moment at 10:30 a.m., Men's group at 1:30 p.m. 11. On 11/13/24 - Friendly Visits at 9:30 a.m., Therapy dog visit at 10:30 a.m. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12. On 11/14/24 - Friendly Visits at 9:30 a.m., Ice Cream Social at 2:30 p.m. 13. On 11/15/24 - Friendly Visits at 9:30 a.m., Movie time at 2:30 p.m. 14. On 11/17/24 - Streaming Religious/Church services at 10:30 a.m., Outdoor visits at 1:00 p.m. 15. On 11/18/24 - Friendly Visits at 9:30 a.m., Stretching with friends at 10:30 a.m. 16. On 11/19/24 - Friendly Visits at 9:30 a.m., Men's group at 1:30 p.m. 17. On 11/20/24 - Friendly Visits 9:30 a.m., Therapy dog visit at 10:30 a.m. 18. On 11/21/24 - Friendly Visits at 9:30 a.m., Apple cider social at 2:30 p.m. It was found through review of the medical record, Resident #36 was documented as somewhat interested related to the above listed activities. Further, there was no documentation to support whether he was either offered or assisted to any of them nor was there any documented evidence he refused any of these activities. Review of Resident #36's nurse progress notes and activities notes dated from 6/1/2024 through to 11/21/2024 did not reveal Resident #36 refused to go to activities both group and individual. Review of Resident #36's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the following: Cognition/Brief Interview Mental Status BIMS score - 00 of 15, which indicated Resident #36 was not interviewable and not able to speak related to his daily care and services; Mood - None documented as observed during the assessed timeframe; Behaviors - None documented as observed during the assessed timeframe; Activities/Preference - This section was not completed. Review of Resident #36's Annual MDS assessment dated [DATE], revealed: Activities/Preferences = A. How important is it to you to have books, etc. = Somewhat Important; How important is it to you to listen to music you like = Somewhat Important; How important is it to you to be around animals such as pets = Somewhat Important; How important is it to you to keep up with the news = Somewhat Important; How important is it to you to do things with groups of people = Somewhat Important; How important is it to you to do your favorite activities = Somewhat Important; How important is it to you to go outside to get fresh air when the weather is good = Somewhat Important; How important is it to you to participate in religious service practices = Somewhat Important. Review of Resident #36's Lifestyle & Activity preference evaluation dated 7/15/2022 revealed: Section C; Leisure Preferences = Yes to Entertainment television, music, movies, Yes Catholic activities. Review of the Lifestyle & Activity preference evaluation dated 1/11/2023 revealed: Section C; Leisure Preferences = Yes to Entertainment television, music, movies, Yes Catholic activities. Review of Resident #36's Quarterly Activity Progress notes dated 9/18/2023 revealed; Summary - Resident enjoys a variety of activities including friendly visits from select staff and peers, being read to, listening to music, compassionate touch, listening to the TV. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #36's Quarterly Activity Progress notes dated 12/21/2023, revealed; Summary - Resident enjoys watching television and listening to music. Preferably Hispanic program. Review of Resident #36's Quarterly Activity Progress notes dated 3/15/2024, revealed; 1:1 visits provided by staff #3. Notes - Resident enjoys watching television, listening to music, and visiting with select staff members. Resident expresses satisfaction and staff will continue to provide 1:1 visits. Review of Resident #36's most current Lifestyle & Activity preference evaluation dated 6/21/2024, revealed: Section C. Leisure Preferences - Resident enjoys friendly visits and having books read to him. Resident enjoys watching television and listening to music. Review of Resident #36's current Care Plans with next review date 12/16/2024 revealed the following: (a) Resident is receiving palliative care/Hospice services receiving hospice services with diagnosis Cellulitis of perineum. Interventions in place to include but not limited to: Collaborate with hospice team to ensure the resident's spiritual emotional intellectual and physical and social needs are addressed, Assess resident's coping strategies as needed and respect resident wishes. (b) Resident has potential for little or no activity involvement related to visual impairment, impaired cognitive function/impaired balance. Often remains in bed for comfort/preference with interventions in place to include but limited to: 1. Educate the resident on the importance of social interaction and leisure activity time; 2. Encourage participation in activities of potential interest; 3. Invite/encourage the resident's family members to attend activities with the resident as needed/desired; 4. Offer friendly visits to promote independent leisure past times and socialization; 5. Provide resident 1:1 or bedside activities as needed for support and socialization/stimulation; 6. Remind the resident that the resident may leave activities at any time, and is not required to stay for entire activity; 7. Resident requires specific interventions i.e. cueing and reminders to engage in activities of interest; 8. Resident will benefit from small groups to include sensory, listening to music; 9. Resident needs assistance/escort to activity functions. On 11/21/2024 at 9:48 a.m. an interview with the Activities Director revealed she and her staff provide both monthly and daily scheduled activities to residents who want to participate as well as conduct 1:1 room visits with residents who wish to participate. She revealed she knew Resident #36, and he has had some decline lately and has not participated in activities. She could not remember how long he has not participated but did confirm he has not participated. She confirmed her activities assessments indicated the resident felt music, television, small group outings, religious activities and going outside for fresh air were important to him. She could not show documentation that he had been offered any of those types of activities within the past one month (11/2024) but was able to show 1:1 visits were completed. Her documentation could not identify what type of 1:1 activity was conducted, it just was documented 1:1 was completed. The Activities Director confirmed Resident #36 does refuse to do most of the activities offered but could not show documentation in the resident's record to support this. She also revealed his care plan with regards to Activities and participation needs to be updated to show his lack of activities interest. Further interview with the Activities Director revealed she could not support activities staff or direct care staff of offering him to go to any activities with regards to his assessed activities of interest. She could not support Resident #36 attending or offered any of the above listed calendar activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/2024 at 11:00 a.m. an interview was conducted with Staff D, CNA and Staff A, CNA. Both staff members revealed they knew Resident #36 and did not know if he likes certain group or 1:1 room activities. They both confirmed they have had him on their assignments in the past and do not remember if they had ever offered him to get up out from bed to go to any scheduled activities. They also confirmed they did not know what things he is interested in and also did not know if he likes to listen to music in his room or watch special television programs. They confirmed Resident #36 stays in his room and in his bed all day. On 11/21/2024 at 5:30 p.m. the Nursing Home Administrator revealed the facility did not have a specific policy and procedure related to resident activities. He revealed the facility will follow both State and Federal regulations as part of implementation of its activities program. The Nursing Home Administrator provided the Activities Director Job Description for review. The Job Description revealed the Activities Director reports to the Nursing Home Administrator. The overview of the Job Description revealed; The Director of Activities plans individual and group recreation services, both therapeutic and general, supervises recreation assistants and volunteers. The Director of Activities will also be responsible for developing, implementing, and supervising a full scope of recreation services in the nursing home to stimulate customers to have fuller and richer lives. Some of the Responsibilities the Activities Director holds, included but not limited to: (c) Responsible for developing, implementing & supervising all recreational services. (d) Responsible for all necessary documentation.

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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** 14161 Based on record review and interview, the facility did not ensure medications were administered in a timely manner for two (#815, #763) of forty eight residents and failed to ensure wounds were monitored for signs and symptoms of infections and deterioration, and treatment orders were obtained and implemented for one (#64) of two residents sampled for pressure wounds, surgical incisions, and other skin conditions. Findings Included: 1.Review of the Admission Record for Resident #815 revealed she was admitted to the facility on [DATE] with diagnoses which included Chronic Diastolic Heart Failure, Non-St Elevation Myocardial Infarction, Paroxysmal Afibrillation and Pulmonary Hypertension. Review of November 2024 Physician orders for Resident #815 revealed an order dated 11/4/24 for : Enoxaparin Sodium Injection Solution Prefilled Syringe 80 Mg/0.8 ML.(Enoxaparin Sodium) Inject 0.7 ml subcutaneously two times a day for Deep Vein Thrombosis (DVT) prophylaxis for 60 days. Review of the November Medication Administration Record (MAR) for this medication indicated it was scheduled to be given at 9:00 a.m. and 9:00 p.m. An interview was conducted with Resident #815 on 11/18/24 at 12: 46 p.m. Resident #815 stated she received Lovenox (Brand name of Enoxaparin Sodium) twice a day every 12 hours and she usually received the morning dose at 8:00 a.m. every day. She stated the nurse Staff S, Registered Nurse (RN) told her the medication was not in the medication cart and the nurse could not find it. Resident #815 stated she did not receive the 11/18/24 9:00 a.m. dose of this medication until 11:15 a.m. Resident #815 was concerned that the late administration of the medication would cause a problem with the next dose of the medication scheduled for 9:00 p.m. A review of a Medication Administration Audit Report for 11/18/24 showed the 9:00 a.m. dose of Enoxaparin Sodium Injection Solution Prefilled Syringe 80 Mg/0.8 ML.(Enoxaparin Sodium) Inject 0.7 ml subcutaneously two times a day for Deep Vein Thrombosis (DVT) prophylaxis for 60 days was administered at 11:15 a.m. on 11/18/24 and the 9:00 p.m. dose was administered at 8: 43 p.m. An interview with the Director of Nursing (DON) was conducted on 11/20/24 at 4: 03 p.m. The DON stated it was Staff S RN's first day on the cart by herself. The DON stated she did not see any communication in Resident # 815's record to the physician regarding the medication being administered late. (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 with Staff B, Unit Manager Station 1 on 11/20/24 at 4:25 p.m. Staff B stated Staff S did tell her the medication was not in the medication cart. Staff B stated she went and checked the Emergency Drug Kit (EDK) for the medication however the correct dose was not stocked in the EDK She then called the pharmacy and found out the medication was delivered to the facility on [DATE]. Staff B stated she then went and checked the medication cart herself and found the medication in the cart which was then administered to Resident #815 by Staff S. Staff B stated neither she nor Staff S documented the late administration of the medication in the resident's record on 11/18/24 . She stated she notified the Nurse Practitioner but did not document the notification in the the resident's record. Staff B provided documentation on her phone of the text message that was sent to the Nurse Practitioner on 11/18/24. On 11/20/24, a late entry was recorded in Resident # 18's medical record of the notification to the Nurse Practitioner on 11/18/24. Further interview with the DON and Staff B revealed that the late administration of the 9:00 a.m. dose of Enoxaparin Sodium was not passed on to the 3:00 p.m. to 11:00 pm. nurse who would be administering the 9:00 p.m. dose. Review of a facility policy entitled : Standards and Guidelines : Medication Administration with a revision date of 01/24 revealed : Standard: Medications are ordered and administered safely and as prescribed. Guideline: Medications will be administered safely and as prescribed by only licensed personnel. Procedure: 3. Medications are administered in accordance with prescribe's orders, including any required time frame. 6. Medications are administered within one (1) hour before or after their prescribed time , unless otherwise specified (for example, before and after meal orders, at bedtime). 16. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering shall document the rationale in the resident's medical record and notify the physician and responsible party if indicated. 50732 2. Review of the Admission Record for Resident #763 showed the resident was admitted to the facility on [DATE] and discharged on [DATE]. The admitting diagnoses included type 2 diabetes. Review of the Minimum Data Assessment (MDS) dated [DATE] showed Resident #763 had a Brief Interview for Mental Status (BIMS) score of 7 showing the resident had severe cognitive impairment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #763's Care Plan dated 06/03/2024 showed the resident was at risk for adverse effects of hyper/hypo-glycemia related to a diagnosis of diabetes and insulin use. Monitor blood glucose as ordered - notify physician or nurse practitioner if result exceeds parameters and obtain new orders if applicable. Observe as needed any signs or symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (smells fruity), stupor, coma. Review of Resident #763's Medication Discharge Report dated 05/31/2024 and given to the facility from the hospital upon the resident's admission to the facility showed the resident was prescribed insulin isophane-insulin regular (70/30 subcutaneous suspension) 40 units subcutaneous once a day as needed for hypoglycemia in the morning. Review of the Order Summary Report dated 05/31/2024 for Resident #763 showed the resident's physician in the facility ordered 70/30 suspension (insulin isophane and regular) inject 40 units subcutaneously one time a day for diabetes. Review of Resident #763's Medication Administration Record dated 06/01/2024 through 06/30/24 showed the resident was scheduled to receive 70/30 suspension (insulin isophane and regular) 40 units to be injected subcutaneously at 9:00 AM daily. Review of the Medication Audit Report dated 06/01/2024 through 06/24/2024 for Resident #763's insulin administration showed the resident was given insulin late 20 out of 24 instances as follows: Date Time Scheduled Time Administered 06/01/2024 06/01/2024 09:00 AM 06/01/2024 10:55 AM 06/02/2024 06/02/2024 09:00 AM 06/02/2024 10:47 AM 06/03/2024 06/03/2024 09:00 AM 06/03/2024 09:58 AM 06/04/2024 06/04/2024 09:00 AM 06/04/2024 10:57 AM 06/05/2024 06/05/2025 09:00 AM 06/05/2024 11:31 AM 06/06/2024 06/06/2024 09:00 AM 06/06/2024 11:11 AM 06/07/2024 06/07/2024 09:00 AM 06/07/2024 13:05 AM 06/08/2024 06/08/2024 09:00 AM 06/08/2024 11:07 AM 06/09/2024 06/09/2024 09:00 AM 06/09/2024 10:41 AM 06/10/2024 06/10/2024 09:00 AM 06/10/2024 09:19 AM 06/11/2024 06/11/2024 09:00 AM 06/11/2024 13:44 AM 06/12/2024 06/12/2024 09:00 AM 06/12/2024 09:58 AM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/13/2024 06/13/2024 09:00 AM 06/13/2024 11:09 AM 06/14/2024 06/14/2024 09:00 AM 06/14/2024 10:35 AM 06/15/2024 06/15/2024 09:00 AM 06/15/2024 10:27 AM 06/16/2024 06/16/2024 09:00 AM 06/16/2024 09:24 AM 06/17/2024 06/17/2024 09:00 AM 06/17/2024 10:37 AM 06/18/2024 06/18/2024 09:00 AM 06/18/2024 12:13 AM 06/19/2024 06/19/2024 09:00 AM 06/19/2024 12:20 AM 06/20/2024 06/20/2024 09:00 AM 06/20/2024 10:43 AM 06/21/2024 06/21/2024 09:00 AM 06/21/2024 11:43 AM 06/22/2024 06/22/2024 09:00 AM 06/22/2024 11:33 AM 06/23/2024 06/23/2024 09:00 AM 06/23/2024 14:06 AM 06/24/2024 06/24/2024 09:00 AM 06/24/2024 11:09 AM An interview was conducted on 11/20/2024 at 2:45 PM with Staff B, Licensed Practical Nurse/Unit Manager (LPN/UM). Staff B said she was unaware Resident #763 had received late medications. An interview was conducted on 11/21/2024 at 2:00 PM with the Director of Nursing (DON). The DON said she did not remember any specifics regarding Resident #763. When presented with the Medication Audit Report dated 06/01/2024 through 06/24/2024 for Resident #763's insulin administration she reviewed the report and agreed the insulin was given to the resident late. The DON said she did not know why the medications were given late and she would have to investigate and return with the results. As of the exit conference on 11/21/2024, the DON did not return with results of her investigation. An interview was conducted on 11/21/2024 at 3:20 PM with the Nursing Home Administrator (NHA). The NHA said he was not aware of any issues regarding Resident #763 and the resident's stay at the facility. 37999 3. Review of Resident #64's admission record showed the resident was admitted on [DATE] with diagnoses not limited to nondisplaced fracture of base of neck of right femur subsequent encounter for closed fracture with routine healing, aftercare following joint replacement surgery, type 2 diabetes mellitus with hyperglycemia, and generalized muscle weakness. Review of Resident #64's Admission/Readmission Nursing Evaluation, effective 8/9/24, showed the resident was admitted from an acute care facility, alert and oriented to person, used a urinary catheter, and had the following skin conditions: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Right antecubital - Coccyx - redness open area - Right trochanter (hip) - Left heel - blister The Braden Scale completed with the admission evaluation showed the resident was rarely moist, bedfast, slightly limited, had adequate nutrition, and friction and shearing was a potential problem. The nursing evaluation showed the resident was at risk for skin breakdown and initiated the interventions of Treatments as ordered, Medications as ordered, Promote use of specialty mattress, cushions, and/or wedges as appropriate, and Monitor for pain and medicate as per orders prior to treatment/turning etc. to enhance comfort. Review of Resident #64's post-admission Skin/Wound note, dated 8/10/24 at 12:51 p.m. showed Resident #64 had a deep tissue injury (DTI) to the left heel, measuring 2.5 x 2.5 centimeters (cm) and a right hip incision from surgery with glue and steri-strips in place. The note indicated there was an old wound to coccyx which was not open and healed. Review of Resident #64's Weekly Skin Check, dated 8/12/24 showed redness to the left toe(s) and redness to the buttock area, no open area noticed. Review of Resident #64's Weekly Skin Check, dated 8/14/24 at 10:00 p.m. revealed Existing blister on the left heel, discoloration on the right heel and back of foot, discoloration groin areas. Barrier cream applied to groin and buttocks to prevent skin breakdown. Review of Resident #64's progress note dated 8/16/24 at 10:58 p.m. showed a Braden scale had been completed with the resident scoring a 15 (of 23) revealing the resident was a low risk for skin impairment. Review of Resident #64's Weekly Skin Check dated 8/21/24 at 10:59 p.m. showed the resident had no new skin issues. Review of Resident #64's progress notes from 8/15/24 to 8/23/24 did not show staff were monitoring or had notified the physician or representative of the existing blister on the left heel or the discoloration on the right heel and back of foot as described in the Weekly skin check dated 8/14/24. The notes did not reveal staff were monitoring the resident's right hip surgical incision for signs or symptoms of infection. Review of Resident #64's progress note, dated 8/23/24 at 10:00 p.m. showed a Braden Scale had been completed and the resident scored 14 (of 23) showing a moderate risk form skin impairment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #64's Weekly Skin check, dated 8/24/24 at 8:49 p.m. revealed the resident had an open blister to both right and left heels. The comments reported open blister under bilateral heels. The progress notes did not show any notes by nursing staff as to the description of the wound bed or peri-wound area of the bilateral open blisters. The note did not show the resident representative, or physician was notified of the open areas. The Weekly skin check also did not report on the surgical incision the resident had been admitted with. Review of Resident #64's progress notes did not show staff were monitoring the open blisters between 8/24 and 8/28/24. Review of Resident #64's progress notes showed on 8/28/24 at 9:44 a.m., Resident was initially evaluated by the wound Dr. this morning due to recent eschar noticed on both heels. After the evaluation the doctor ordered to continue to apply betadine on both heels and leave open to air. Resident heels were left offloaded. The resident was educated about the treatment and understand. Review of Resident #64's Wound Evaluation, dated 8/28/24 at 9:36 a.m. showed an In-house Acquired Left heel unstageable pressure ulcer measuring 3.1 x 2.8 x 0 cm. The documentation showed the wound had been identified on 8/23/24 with no exudate, 100% black eschar, defined wound margins, and a treatment of betadine daily and as needed leaving the area open to air (OTA). The note revealed the resident was notified on 8/28/24 at 7:00 a.m. Review of Resident #64's Wound Evaluation, dated 8/28/24 at 9:19 a.m. showed the resident had an In-House Acquired Right heel unstageable pressure ulcer measuring 4.5 x 4.2 x 0 centimeters (cm). The documentation showed the wound had been identified on 8/23/24 with no exudate, 100% black eschar, defined wound margins, and a treatment was obtained on 8/28/24 for betadine daily and as needed leaving the area OTA. The note revealed the resident was notified on 8/28/24 at 00:00 (12:00 a.m.). Review of Resident #64's August 2024 Medication Administration Record (MAR) did not reveal staff were monitoring the resident's surgical incision, discoloration to right heel or the progression to an open blister , or had monitored the existing blister on the left heel. Review of Resident #64's August 2024 Treatment Administration Record (TAR) revealed staff were not monitoring the resident's surgical incision for signs/symptoms of infection, or for changes in the resident's left heel existing blister as reported on the day of admission. The TAR showed wound care orders had been obtained on 8/27/24 for the application of Betadine on the Right/Left heel and instructed to leave open to air every day shift for eschar. Review of Resident #64's care plan revealed the following: - At risk for skin impairment related to (r/t) anemia, diabetes, fragile skin, (and) weakness/decreased mobility, Pressure area to left heel, right heel (and) redness to coccyx. The focus was initiated on 8/10/24. The interventions included but no limited to Monitor/observe skin while providing routine care. Notify the nurse for any area of concern as indicated, initiated 8/10/24. - At risk for adverse effects for hyper/hypo-glycemia r/t diagnosis of diabetes (and) insulin use, initiated 8/12/24. The interventions included but not limited to Monitor feet for open areas, sores, pressure areas, blisters, edema, or redness. Report to MD indicated, initiated 8/12/24. (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 with Staff R, Registered Nurse/Wound Care (RN/WCN), on 11/21/24 at 10:15 a. m. Staff R reported she would have expected to be notified of skin issues on Resident #64's right heel prior to the development of eschar. Staff R reported dressing the resident's wounds daily Monday through Friday and floor nurses were responsible for wound care on the weekends. An interview was conducted with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on 11/21/24 at 1:34 p.m. The DON stated the resident had come in with one pressure area and had developed one while at the facility and mobile. The facility was going to work up the wounds to see if they were vascular. The DON stated eschar could show up and could deteriorate rapidly. Review of the policy - Prevention of Skin Impairments/Pressure Injury, revised 1/2024, revealed The purpose of this policy is to provide information regarding identification of skin wound risk factors and interventions for specific risk factors. The guideline instructed to Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. The risk assessment included: - 1. Assess the resident on admission for existing wound risk factors. - 2. Conduct a comprehensive skin assessment upon a mission, including: - a. Skin integrity- any evidence of existing or developing pressure ulcers or injuries; - b. Areas of impaired circulation due to pressure from positioning or medical devices. - 3. Inspect the skin when performing or assisting with personal care or activities of daily living (ADLs). - a. Identify any signs of developing skin wound (i.e. Non blanchable erythema/rashes). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; - b. Inspect pressure points (sacrum, heels, products, toxics, elbows, ischium, trochanter, etc.). - c. Wash the skin after episodes of incontinence. - d. Reposition resident as indicated on the care plan. The preventions based on the assessment and the resident's clinical condition, choices and identified needs, basic or routine care could include, but is not limited to, interventions to: a. Redistribute pressure (such as repositioning, protecting and/ or offloading heels, etcetera (etc.)); b. Minimize exposure to moisture and keep skin clean, especially a fecal contamination; c. provide appropriate, pressure redistributing, support surface; d. provide non irritating surfaces; and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. maintain or improve nutrition and hydration status, when feasible. Adverse drug reactions related to the residence drug regimen may worsen risk factors for development of, or for non healing pressure ulcers (PU)/ Pressure injuries (PI)s (For example, by causing lethargy or anorexia or creating/ increasing confusion) and should be identified and addressed. These interventions should be incorporated into the plan of care and revised as the condition of the resident indicates. The policy instructed for the Monitoring/Documenting as follows: 1. Evaluate, report, and document potential changes in the skin. 2. Notify the physician and the resident/ resident representative of changes in the skin. 3. Review the interventions and strategies for effectiveness on an ongoing basis. 4. Evaluate open areas (pressure/ surgical areas) per physician orders.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50434 Based on observation, record review and interview, the facility failed to ensure medications were administered at the correct dose for one (Resident #90) out of 26 residents sampled. Findings Included: During an observation on 11/18/2024 at 9:49 a.m. Resident #90 was observed in bed, she was not able to answer questions regarding her care. Review of Resident #90's admission record revealed resident #90 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder and depression. Review of Resident 90's admission Minimum Data Set (MDS) dated [DATE] revealed Section C. Cognitive Patterns, Brief Interview for Mental Status (BIMS) of 04 out of 15 showing severe cognitive impairment. Review of Section N. Medications revealed Antipsychotic and antidepressant. Review of Resident #90's orders revealed on 11/07/2024 an order for Seroquel Oral Tablet 25 milligrams (MG) (Quetiapine Fumarate) Give 3 tablet by mouth in the evening for agitation and an order for Seroquel Oral Tablet 25 MG Give 25 MG by mouth two times a day for Anxiety. Review of Resident #90's Medication Administration Record (MAR) revealed the following: Seroquel Oral Tablet 25 MG one tablet was given on 11/07/2024 at 5:00 p.m. Seroquel Oral Tablet 25 MG one tablet was given daily 11/08/2024 to 11/20/2024 at 9:00 a.m. and 5:00 p.m. Seroquel Oral Tablet, three 25 MG tablets were given daily 11/07/2024 to 11/20/2024 at 8:00 p.m. Review of Resident #90's Behavior Monitoring revealed on 11/07/2024 0 No Behaviors; 11/08/2024 NA (Not Applicable); 11/09/2024 to 11/14/2024 0 No Behaviors;11/15/2024 NA ;11/16/2024 to 11/20/2024 0 No Behaviors. During an interview on 11/21/2024 at 2:00 p.m., with the Director of Nursing (DON), she stated she called psych about the Seroquel order and psych told her they did not write the order for Seroquel at bedtime and must have been ordered by the attending physician. She stated she would need to reach out to the attending physician for clarification. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 11/21/2024 at 3:13 p.m., the Attending Physician, stated that he remembered Resident #90 and did remember ordering Seroquel 25 MG 3 tabs at bedtime for agitation on 11/07/2024 and he was aware that she was also taking Seroquel 25 mg twice daily. He stated the 75 mg dose was only meant for a short period of time and not an ongoing order. He stated this was not a correct intervention. He stated, It probably should have been ordered for her to have 25 MG dose in the morning and then the 75 MG at bedtime. He stated no one from the facility had called him to clarify the order and that he would bring this up in their next Quality Assurance meeting. On 11/21/2024 at 4:45 p.m., the facility was asked to provide a policy for Unnecessary Medication and provided a policy for Gradual Dose Reduction.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 37999 Based on observation, record review, and interview, the facility failed to ensure the medication error rate was less than 5.00%. Thirty-four medication administration opportunities were observed, and three errors were identified for two (#13 and #11) of four residents observed. These errors constituted an 8.82% medication error rate. Findings included: 1. On 11/19/24 at 8:43 a.m., an observation of medication administration with Staff P, Registered Nurse (RN) was conducted with Resident #13. The staff member dispensed the following medications: - Gabapentin 800 milligram (mg) tablet - Zoloft 100 mg tablet - Megestrol AC Suspension 40 mg/milliliter (mL) - 10 mL - Artificial Tears lubricant eye drops (contained glycerin, hypromellose, and poly glycol) -Buspirone (Buspar) 5 mg tablet Staff P confirmed dispensing 3 oral tablets prior to entering Resident #13's room. The resident refused the liquid Megace reporting refusing all along. The staff member obtained a blood pressure of 98/64, administered oral medications, then placed one drop of Artificial Tears in each eye. The staff member left the room and took the Megace to the unit's medication room and disposed of it in a jug of medication disposer. Staff P dispensed the resident's as needed medication, Oxycodone 5 mg tablet, called the attending physician for instructions regarding the resident's bathyspheres medication, then administered the pain medication. Review of Resident #13's November Medication Administration Record (MAR) revealed the following: - Staff P documented that the 9:00 a.m. scheduled dose of Megace had been administered. - Artificial Tears Ophthalmic Solution 1% (Carboxymethylcellulose Sodium) - Instill 1 drop in left eye four times a day for dry eye. The eye drops were administered in both eyes and the ingredients of the administered drops did not contain Carboxymethylcellulose Sodium. 2. On 11/21/24 at 7:48 a.m. an observation of medication administration with Staff Q, Licensed Practical Nurse (LPN) was conducted with Resident #11. The staff member searched the medication cart reporting having to go to the refrigerator for the resident's Lispro insulin and also had to get the laxative. The staff member went to the medication preparation room and did not obtain the resident's Lispro but did obtain the resident's Humalog 70/30. The staff member dispensed the following medications: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- ClearLax polyethylene - in a 5-ounce cup of water - Pantoprazole 40 mg tablet - Tamsulosin 0.4 mg tablet - Lexapro 10 mg tablet - Carvedilol 6.25 mg tablet - Allopurinol 100 mg tablet The staff member confirmed dispensing 5 tablets and the laxative. Staff Q obtained a blood glucose level of 276 from the resident, administered the oral medications followed by the assisting resident with drinking the laxative. Staff Q returned to cart. The resident dialed the resident's Humulin 70/30 pen to 12 units, primed to approximately 6 units then dialed back to 10 units, returning to the resident to inject into the left abdomen at 8:16 a.m. On 11/21/24 at 8:18 a.m., a staff member served Resident #11 the morning meal and the resident was observed feeding himself while sitting in a wheelchair. Staff Q walked to the electronic medication dispenser on the other unit and was unable to obtain the resident's Lispro, stated thinking the facility had a refrigerator kit and would have to check with the unit manager. The staff member searched the refrigerator kit on the unit and was unable to locate the necessary insulin. Staff Q informed Staff O, LPN/Unit Manager of needing to talk to her after Staff O finished assisting a resident with eating. Staff Q notified the Unit Manager at 8:30 a.m. of the situation regarding the insulin. On 11/21/24 at 8:45 a.m., Staff O arrived on the unit and stated the Lispro was in the other kit. Staff O confirmed the insulin was late, I understand. On 11/21/24 at 8:47 a.m. Staff Q reported going to clear off the red and Resident #11 was going to get 6 units of insulin per sliding scale, the staff member primed the insulin Lispro pen, dialed the dosage selector to 6 units and injected into the residents right lower quadrant at 8:51 a.m. Review of Resident #11's Medication Administration Record revealed the Insulin Lispro 100 unit/milliliter solution pen-injector was to be injected per sliding scale subcutaneously with meals for diabetes mellitus at 7:05 a.m. The observation showed Resident #11's insulin Lispro was not available to Staff Q and the medication was administered approximately 30 minutes after the resident had eaten and 1 hour 46 minutes after it was scheduled to be administered. An interview was conducted with the Director of Nursing (DON) on 11/21/24 at 2:03 p.m. The DON was made aware of the observed errors. She stated the procedure (regarding Resident #11) was to notify the physician and the family if the medication was not available. The discussion revealed the medication was available in the other refrigerator and was given late after the resident had eaten breakfast. Review of the policy - Medication Administration, revised 1/2024 revealed medications are ordered in administered safely and as prescribed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Medications are administered in accordance with prescriber orders, including any required time frame. - Medications are administered within one (1) hour before or after their prescribed time, unless otherwise specified (for example, before and after meal orders, at bedtime).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observation, record review and interview, the facility failed to coordinate dental services for one resident (#18) out of eight residents sampled. Findings include: During an observation on 11/18/24 at 2:05 p.m., Resident #18 was observed sitting up on her bed, fully dressed with no signs of distress. She stated her only concerns were that she had missing teeth, and she really wanted to have a set of dentures so she could chew her food. She stated she did not know what happened to her dentures. During an observation on 11/20/2024 at 11:45 am., Resident #18 was observed sitting up in her wheelchair eating her lunch. She said she was not able to eat her green beans because she did not have any teeth. She stated the facility had not assisted her with dental services. On 11/20/2024 at 2:20 p.m., an interview was conducted with Staff M, Certified Nursing Assistant (CNA). Staff M stated every morning she provided oral care to all her residents. For residents who wore dentures she provided them with denture care. She stated she put Resident #18 dentures in her mouth this morning, so she did not know why Resident #18 did not have her dentures. During the interview with Staff M, Resident #18 interrupted and stated she had not had her dentures in a while, and she really needed them because she was having trouble eating her food. Staff M than stated she did not normally work on the side with Resident #18, and she thought she had put Resident #18 dentures in her mouth. Review of an Admission Record date 11/21/2024 showed Resident #18 was admitted to the facility with diagnoses to include but not limited to Chronic Atrial Fibrillation, unspecified, Type 2 Diabetes Mellitus Without Complications, Need for Assistance with Personal Care. Review of a Quarterly Minimum Data Set, (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. Review of a Social Service assessment dated [DATE] showed Resident #18 was marked no to indicate she did not have dentures. Review of a [name of dental service] patient note dated 8/30/2024 showed Resident #18 was seen for a Comprehensive Exam and had an impression for upper lower dentures Resident #18 had a care plan for oral/dental health problems related to Alzheimer's Disease, Depression, Diabetes Mellitus (DM), Functional Impairment limiting ability to perform oral hygiene; wears dentures, prefers to remove them at times, date initiated 6/26/2024, revision date 11/21/2024. The care plan goal was for Resident #18 to be free of infection, pain or bleeding in the oral cavity by through review date. Date initiated 6/26/2021, revision on 7/24/2023, Target date 12/18/2024. The care plan interventions include Coordinate arrangement for dental care, transportation as needed/as ordered, ensure dentures are worn, date initiated 6/26/2021, revision on 6/26/2021. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/2024 at 2:00 p.m., with Staff F, Care plan Coordinator, she stated when a resident was admitted to the facility, nursing, speech and social services did the resident screening to see if the resident had natural teeth or upper or lower partials. As they build the comprehensive care plan, she gathered the information from the assessments, then she care planned the resident's dental status. Resident #18 had a Quarterly last done on 9/18/2024 and it showed the resident did not have broken or loosely fitting dentures. She stated upon review of the social services and dietary assessment, Resident #18 was marked not to have dentures. Which was not accurate because Resident#18 had a care plan showing she had dental problems and she wore dentures. She stated she updated Resident #18's care plan today, 11/21/2024, to reflect the resident did not have her dentures. She stated staff should have told her as soon as the resident lost her dentures, and she should have been notified when resident had impressions taken and was waiting for her dentures, so a note could have been out in the system. During an interview on 11/21/2024 at 2:30 p.m., with the Social Service Director (SSD). She said the resident had dentures but she lost them because she liked to wrap them up in paper napkins and put them in her purse. She stated the resident was last seen on 8/30/2024 by [name of dental service] and they noted they took impressions for upper and lower dentures. She stated she did not follow up with the dentist about the resident's impressions because she was not aware that Resident #18 had impressions taken. She stated when she went to Resident # 18 room, to look for the resident dentures, she was able to confirm that the resident did not have her dentures. During an interview on 11/21/2024 at 3:00 p.m., with the Director of Nurses, DON. She stated if the CNA(s) notice that their residents had issues with their dentures, such as lost or broken, then the aide should report the issues to their nurse. The nurse would report the issue to the nursing supervisor, who would get the resident added to the dental list. If it was a resident that had issues with their dentures, such as broken or lost, then the nurse would assess the resident to make sure there were no issues with the resident having difficulty in swallowing, chewing, or a decrease in oral intake. She stated Resident #18's aides should have reported the resident's missing dentures to their nurse, so they could have assessed the resident to make sure she had no issues until her dentures came in. Review of the facility policy tilted; Dental Consults Revised dated 1/2024 showed Standard: The facility will facilitate dental services through the service of a Consultant Dentist as indicated. Guidelines: 1. Our facility does not have dental providers on staff, and therefore contracts with external providers to provide dental services to residents as indicated. 2. The facility will contract with an external Dental provider to provide Dental Services to residents as indicated and provide the following: 1. Providing consultation to physicians and providing other services relative to dental matters.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 14161 Based on resident meal observation and staff interview, it was determined the facility did not ensure one (Resident #816) of three residents observed during a lunch meal received food presented in an attractive and appealing manner. Findings included: Review of the record for Resident # 816 revealed diagnoses which included Unspecified Alzheimer's disease, Unspecified Dementia, Unspecified Protein-Calorie Malnutrition and Dysphagia Oropharyngeal Phase. Review of the record for Resident # 816 indicated a diet order for Pureed Texture Thin Consistency (Photographic Evidence obtained). An observation of the lunch meal for Resident # 816 was conducted on 11/18/24 at 12:11 p.m. Resident # 816 was observed in her bed and the lunch meal was placed on the overbed table by a CNA (Certified Nursing Assistant) who was observed to remove the lid on the entree and then exit the room. A dinner size plate was located on the tray and was observed to be filled with a soupy consistency of pureed foods running together on the plate (photographic evidence obtained). An interview was conducted with the Dietary Manager on 11/20/24 at 2:15 p.m. She reviewed the photograph of the lunch meal served to Resident # 816 on 11/18/24. The Dietary Manager stated the presentation was not acceptable and said, that was gross. She stated she did not know how the meal got out of the kitchen looking like that.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on observations, interviews, and record review, the facility's Quality Assurance Performance Improvement Program (QAPI) failed to implement an effective plan of action to correct deficient practice identified during the recertification survey and complaint survey originally conducted 11/18/2024 through 11/21/2024 as evidenced by: 1.) failure to provide a safe, clean, and homelike environment for one (B Hall) of two community shower rooms (F584), 2.) failure to ensure blood glucose levels were checked and insulin was administered timely for two residents (#1 and #2) out of three residents reviewed for insulin administration and failed to administer anti-viral medication for one resident (#3) out of one resident reviewed for flu treatment (F684) and 3.) failure to implement an effective Infection Control program as evidenced by staff members not using personal protective equipment (PPE) for two residents (Resident #3 and Resident in room [ROOM NUMBER]) out of 11 on transmission based precautions (TBP) and two out of six residents observed during medication administration (F880). Findings included: Review of the facility's Quality Assurance/Performance Improvement Plan (QAPI), with a revision date February 23, 2021, revealed: Vision To pioneer healthcare by creating a compassionate, memorable and dignified experience for every person we serve. We strive to treat our patients, their families and our staff with the highest level of dignity and respect by promoting an environment of continuous improvement and service excellence. Mission We at [another healthcare facility name] are committed to the physical, emotional and spiritual well-being of our residents. We strive to provide excellent service for residents of every culture in a supportive, caring, homelike environment and to maintain a high level of dignity and individuality. Values Passion: We are strongly compelled to provide great care to every resident we serve. Respect: We feel deep admiration for others and their abilities, qualities and achievements. Integrity: We do the right thing for the right reasons. Dedication: We are committed to providing great care. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The staff will utilize data from industry standards to quantify and benchmark all aspects of performance improvement whenever possible. Any negative trends in data will be addressed utilizing root cause analysis and quality improvement methodologies. The leadership and staff will embrace the evidence-based strategies and utilize PDSA cycles until the desired change is effective and the desired goals are achieved and sustained. Governance and Leadership The governing body and/or administration of the nursing home will develop a culture that involves leadership seeking input from facility staff, residents and their families/representatives. The governing body assures adequate resources exist to conduct QAPI efforts. This includes designating one or more persons to be accountable for QAPI; developing leadership and facility-wide training on QAPI; and ensuring staff time, equipment, and technical training as needed. [Another healthcare facility name] governing body is ultimately responsible for overseeing the QAPI Committee. The owner/CEO has direct oversight responsibility for all functions of the QAPI Committee and reports directly to the governing body. The QAPI Committee, which includes the medical director, is ultimately responsible for assuring compliance with federal and state requirements and continuous improvement in quality of care and customer satisfaction. A facility-wide training will be conducted to inform everyone in the facility about the QAPI Program. These trainings will be conducted often and in multiple ways through (e.g. in services, department head in services, examples, exercises, etc.) Every caregiver will be made to understand that they are expected to raise quality concerns, that it is safe to do so, and that everyone is encouraged to think about systems. The QAPI approach at [another healthcare facility name] will also be communicated to consultants, contractors and collaborating agencies, to make them understand that they each have a role in the QAPI plan. [another healthcare facility name] will ensure that all residents and families are aware of the facility's QAPI program, and that their views are sought, valued and considered in facility decision-making and process improvements. The QAPI program will be announced and discussed at the resident council meetings, and other resident and family events/venues. Feedback, Data Systems and Monitoring [Another healthcare facility name] will put in place systems to monitor care and services, drawing data from multiple sources. Feedback systems will actively incorporate input from staff, residents, families and others as appropriate. It will include using performance indicators to monitor a wide range of care processes and outcomes and reviewing findings against benchmarks and/or goals the facility has established for performance. It also includes tracking, investigation and monitoring events every time they occur, and action plans implemented through the plan, do, study, act (PDSA) cycle of improvement to prevent recurrences. The QAPI team at [another healthcare facility name] will decide what data to monitor routinely. Areas to consider may include, but not be limited to, the following examples: (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Clinical care areas (e.g. pressure ulcers, falls, infections) - Medications (e.g., those that require close monitoring, antipsychotics, narcotics) - Complaints/grievances from residents and families - hospitalization s and other service use - Resident satisfaction - Caregiver satisfaction - Care plans, including ensuring implementation and evaluation of measurable interventions - State survey results and deficiencies - Results from MDS resident assessments - Business and administrative processes (e.g., financial information, caregiver turnover, caregiver competencies and staffing patterns, such as permanent caregiver assignment). Data related to caregivers who call out sick or unable to report to work on short notice, caregiver injuries and compensation claims may also be useful. Targets for performance in the areas that are being monitored will be set by the QAPI team. The target will usually be stated as a percentage. Benchmarks for performance such as Nursing Home Compare (www.medicare.gov/nhcompare), CASPER report, Facility Inhouse Benchmarking, etc. will be used to monitor facility progress. Performance Improvement Projects (PIP) The QAPI committee annually prioritizes activities, endorses or re-endorses policies and procedures, and continually monitors for improvement through the use of a QAPI self-assessment. In addition, the QAPI Steering Committee will implement any PIP topics indicated by date analysis. Quality improvement activities are also developed in collaboration with the support of providers, residents, families and staff. PIPS are implemented in accordance with CMS' protocol for conducting PIPS, including: 1. Measurement of performance using objective quality objective indicators 2. Implementation of system interventions to achieve improvement in quality 3. Evaluation of the effectiveness of the interventions 4. Plan and initiation of activities for increasing or sustaining improvement (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/16/2025 at 5:55 p.m., the Nursing Home Administrator (NHA) stated the Quality Assurance (QA) Committee includes himself, the Medical Director, the Director of Nursing (DON), and other department heads. The NHA said he was the Committee Chairperson and the QA Committee meets on the third Thursday of every month, although they have not met this month. The NHA stated a QAPI meeting was conducted on 12/18/2024 to discuss the survey results and plan of correction that was submitted to the State Agency. The NHA stated the facility did not conduct another QAPI meeting in January, even though the third Thursday had past, but then stated, the month is not over yet, we will have one. The NHA stated during the meeting in December, they spent the entire meeting on going over the 2567 and developed action plans based on the situations referenced in the survey. 1.) On 1/16/2025 at 9:58 a.m., the shower room on B hall was observed with a housekeeping employee packing up their supplies, placing a wet floor sign at the door, and about to exit the room. A shower bed was observed in the room. Upon lifting the foam mat sitting on top of the mesh of the shower bed, the back of the foam mat had unidentifiable black spots and various clumps of hair covering almost the entire middle section. The mesh part of the bed was observed with dried brown, black, and white stains on the majority of the mesh. Next to the shower bed was a shower chair. The chair was observed with brown/black substance with hair clumps intermingled on all four shower legs above the wheels. At the joints of the four legs was a pink colored substance above and below the joints. The mesh backing of the shower chair had a buildup of a black substance on all three straps. During an interview on 1/16/2025 at 5:55 p.m., the NHA and DON stated nursing and housekeeping are responsible for cleaning the shower rooms. The NHA and DON reviewed the photos of the shower room on B hall and acknowledged the equipment was dirty. 2.) An observation was conducted during medication administration on 1/16/25 at 12:05 p.m. with Staff A, Licensed Practical Nurse (LPN). Staff A, LPN was preparing to administer medication to Resident #1 and had to go to the dining room to get the resident to check his blood glucose level and administer insulin. Resident #1 said he had already finished eating lunch. He said the nurses often check his blood glucose after meals and not before, they are usually late. Staff A, LPN checked Resident #1's blood glucose and it was observed to be 309. The nurse told the resident she was going to administer 15 units of Humalog insulin. Staff A, LPN was observed priming the Humalog insulin pen and setting it to 15 units. The resident refused the 15 units of insulin, saying his blood glucose level would drop too low if he had that much. The nurse called the doctor and received a one-time order for 10 units of Humalog insulin, which was administered at 12:24 p.m. Review of the Admission Record showed Resident #1 was admitted on [DATE] with a diagnosis of type 2 diabetes mellitus (DM) with hypoglycemia. Review of Resident #1's Annual Minimum Data Set (MDS) dated [DATE] showed under Section C - Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. Review of Resident #1's January 2025 physician orders showed the following orders: (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Humalog KwikPen Subcutaneous Solution Pen-injector 100 unit/ml (units per milliliter) (Insulin Lispro). Inject 15 unit subcutaneously in the morning for DM. Scheduled for 9:00 a.m. Dated 12/8/24. - Insulin Lispro (1 unit dial) 100 unit/ml solution pen-injector. Inject as per sliding scale. Scheduled at 7:05 a.m., 11:30 a.m., and 4:30 p.m. Dated 4/12/24. Review of the Medication Admin Audit Report from 1/2/25 to 1/16/25 showed Resident #1's Humalog was administered late on 7 of 14 opportunities. Resident #1's Insulin Lispro was administered late on 23 of 42 opportunities. An interview was conducted on 1/16/25 at 5:50 p.m. with Staff C, LPN. She said at the time of the interview, all meals had been delivered to residents. Therefore, all blood glucose checks should have been done, because those should be checked prior to eating. An observation and interview was conducted during medication administration on 1/16/25 at 5:57 p.m. with Staff B, LPN. Staff B, LPN was preparing to administer medication to Resident #2. Staff B, LPN was observed entering Resident #2's room to check her blood glucose level. The resident was already eating her dinner at the time. Staff B, LPN confirmed blood glucose levels should be checked prior to meals. Review of the Admission Record showed Resident #2 was admitted on [DATE] with a diagnosis of type 2 diabetes mellitus with neuropathy. Review of Resident #2's January 2025 physician orders showed the following orders: - Insulin Lispro (1 unit dial) Subcutaneous solution pen-injector 100 unit/ml. Inject per sliding scale for times a day for DM. Dated 10/28/24. Scheduled times were 6:00 a.m., 12:00 p.m., 2:00 p.m., and 10:00 p.m. The order times changed on 1/10/25 to 6:00 a.m., 12:00 p.m., 5:00 p.m., and 10:00 p.m. - Insulin Glargine Subcutaneous Solution pen-injector 100 unit/ml. Inject 12 units subcutaneously one time a day for DM. Dated 10/28/24. Scheduled at 9:00 a.m. Review of the Medication Admin Audit Report from 1/2/25 to 1/16/25 showed Resident #2's Insulin Lispro was administered late 2 times, early 3 times, and not administered 6 times out of 56 opportunities. Insulin Glargine was administered late 5 out of 14 opportunities. An interview was conducted on 1/16/25 at 6:20 p.m. with the DON. The DON reviewed Resident #1's record and confirmed the resident's blood glucose level should have been checked between 8:00-10:00 a.m. and the Humalog should have been administered then. She said the Humalog was scheduled at 9:00 a.m. for Resident #1. She also said typically when a nurse is running behind, herself or the unit managers jump in to help. The DON said blood glucose levels should be checked before a resident eats their meals and the insulin should be given at mealtime. An observation was conducted on 1/16/25 at 9:25 a.m. of Resident #3's room with a droplet precautions sign hanging on the door. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Admission Record showed Resident #3 was admitted on [DATE] with diagnoses including chronic pulmonary edema and dementia. Review of Resident #3's care plan showed a Focus of The resident has infection: flu exposure, initiated 1/11/25. Interventions included droplet precautions, administer anti-viral per MD (medical doctor) orders, and administer treatment per physician orders. Review of Resident #3's January 2025 physician orders showed an order for: - Tamiflu Oral Capsule 75 mg (milligrams). Give 1 capsule by mouth two times a day for exposure to flu for 5 days. Start date 1/13/25. Discontinue date 1/18/25. Review of Resident #3's Medication Administration Record (MAR) for January 2025 showed Tamiflu was not available for the 9:00 a.m. dose on 1/13/25. Tamiflu was signed off as given on 1/13/25 at 9:00 p.m., 1/14/25 at 9:00 a.m. and 9:00 p.m., and 1/15/25 at 9:00 a.m. and 9:00 p.m., and marked not available at 9:00 a.m. on 1/16/25. An interview was conducted on 1/16/25 at 4:55 p.m. with Staff D, Registered Nurse (RN). Staff D, RN said he was assigned to Resident #3. He checked the medication cart and said there was no Tamiflu in the medication cart for Resident #3. An interview was conducted on 1/16/25 at 5:10 p.m. with a representative from the facility's pharmacy. The pharmacy said no Tamiflu was dispensed for Resident #3. An interview was conducted on 1/16/25 at 5:04 p.m. with the DON and Assistant Director of Nursing/Infection Preventionist (ADON/IP). They both reviewed Resident #3's medical record. The DON said she would not expect the Tamiflu to be signed off since it was not given. She said it should have been documented the medication was not administered and the doctor should have been called. The ADON/IP said she did not see any notes in Resident #3's medical record indicating the doctor was notified the Tamiflu was not given or was not available. The DON confirmed there were no notes in the record. Review of a facility policy titled Standards and Guidelines: Medication Administration, with a revision date of 01/2024 revealed the following: Standard: Medications are ordered and administered safely and as prescribed. Guideline: Medications will be administered safely and as prescribed by only licensed personnel. Procedure: 3. Medications are administered in accordance with prescriber's orders, including any required time frame. 6. Medications are administered within one (1) hour before or after their prescribed time, unless otherwise specified (for example, before and after meal orders, at bedtime). (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	16. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering shall document the rationale in the resident's medical record and notify the physician and responsible party if indicated. 3.) An observation was conducted on 1/16/25 at 9:34 a.m. during medication administration with Staff G, LPN. Staff G, LPN was observed completing medication administration for a resident without performing hand hygiene. She began preparing medication for a second resident, entered the second resident's room, and took vital signs. Staff G, LPN exited the room, placing the blood pressure cuff on the medication cart prior to cleaning it. Staff G, LPN put on gloves and cleaned the blood pressure cuff, removed the gloves, and did not perform hand hygiene before continued to prepare and administer medication for the resident. An observation was conducted on 1/16/25 at 11:55 p.m. during medication administration with Staff A, LPN. Staff A, LPN was observed wearing gloves to prepare medication. While dispensing medication, two pills fell on to the medication cart. The nurse picked up the pills and placed them in a medication cup and continued with preparation and administration of medication. The nurse kept the same gloves on to prepare the medication, administer the medication one pill at a time with a spoon, and pick up the resident's water cup for him to drink between each pill. Staff A, LPN removed her gloves but did not perform hand hygiene prior to going to the dining room to get another resident. Staff A, LPN proceeded to gather supplies to check the resident's blood glucose level. The glucometer fell on the floor and Staff A, LPN picked it up and placed it on the medication cart without cleaning it. An observation was conducted on 1/16/25 at 10:08 a.m. while on a tour of C hall. An observation was made of Staff E, Housekeeping (HKG) in Resident #3's room. Resident #3 was in the room and the room door had a Droplet Isolation sign posted, indicating to wear a mask, gown, and gloves at all times and eye protection, if needed. Staff E, HKG was wearing gloves but did not have a mask or gown on while cleaning in Resident #3's room. Staff E, HKG was observed exiting the room while wearing the gloves, pushing the cleaning cart down the hall, picking up a wet floor sign, and re-entering Resident #3's room to continue cleaning. Upon exiting Resident #3's room, Staff E, HKG removed the gloves and exited the room, but no hand hygiene was completed. An interview was conducted with Staff E, HKG on 1/16/25 at 10:15 a.m. Staff E, HKG stated Resident #3's room door had a droplet isolation sign posted and she needed to read the sign to know what PPE to wear. Droplet Isolation would need a gown, gloves and mask. Staff E, HKG stated, I did not, indicating not wearing mask or gown while in Resident #3's room. Staff E, HKG continued to state, I should've washed my hands when I left the room. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/16/25 at 10:12 a.m., Staff F, Certified Nursing Assistant (CNA) was observed in room [ROOM NUMBER]. room [ROOM NUMBER] had a Contact Isolation sign posted on the door. The Contact Isolation sign indicated staff must wear gloves and gowns at all times. Staff F, CNA looked around the corner of the privacy curtain, noted the surveyors in the hallway, and closed the curtain. During this time, Staff F, CNA, was observed wearing gloves but no gown. A second person, later identified by the Director of Nursing as a hospice aide, entered room [ROOM NUMBER] with no PPE on. The hospice aide handed a bag of supplies to Staff F, CNA and exited the room without performing hand hygiene. The hospice aide reentered room [ROOM NUMBER] without donning PPE and leaned across the bedside table with her upper body touching the table. Staff F, CNA returned to the door of the room with no gown on, grabbed another pair of gloves, returned to the bedside to pick up a bag of soiled linens, and took the bag to the soiled utility room. The hospice aide remained in the resident room with no gown or gloves on, talking on her cell phone. An interview was conducted on 1/16/25 at 10:25 a.m. with Staff A, LPN. Staff A, LPN said Resident #3 was on Droplet Precautions and room [ROOM NUMBER] was on Contact Precautions. Staff A, LPN also stated Contact Precautions required a gown and gloves whenever going into the room for any reason and Droplet Precautions required gloves, a gown, and a mask when entering the room. An interview was conducted on 1/16/25 at 2:22 p.m. with Staff F, CNA. Staff F, CNA confirmed being assigned to room [ROOM NUMBER], who was on Contact Isolation. Staff F, CNA also stated Contact Isolation required a gown and gloves when entering the room. Staff F, CNA confirmed she took off a gown while in room [ROOM NUMBER], but did not exit the room, and continued to provide care for the resident. An interview was conducted on 1/16/25 at 5:04 p.m. with the DON and ADON/IP. The DON said all staff should be wearing proper PPE when going into a room with a Contact Precaution sign posted. The ADON/IP said, anybody entering a room on Contact Precautions should be wearing the gear. The ADON/IP also said Droplet Precautions required anyone entering the room to wear a blue mask, a gown, gloves, and a face shield. They both stated precautions apply to anyone entering the room, including visitors, contractors, and housekeeping. The ADON/IP said, we educate no gloves in the hallway, and stated they should be removed prior to exiting a room. The DON confirmed the hospice aide should have worn PPE in room [ROOM NUMBER]. The ADON/IP said blood pressure cuffs and glucometers should be sanitized after each use. She explained the glucometer should be wiped with one wipe, then a second wipe should be wrapped around the glucometer and set in a cup for two minutes. She also said if a glucometer falls on the floor it should not be placed on the medication cart prior to cleaning. She said if a pill is dropped on the medication cart, the nurse should dispose of the pill and it should not be picked up and put in the medication cup for administration. The DON said hand hygiene should be done before and after care and should also be done before and after giving medications. She said it does not matter if gloves are worn or not, anytime gloves come off hand hygiene should be done. Review of policy titled Hand Hygiene Infection Control, revised 6/2023, showed: Standard: Hand hygiene is the single most important measure for preventing the spread of infection. Guideline: This facility shall require facility personnel use accepted hand hygiene after each direct resident contact for which hand hygiene is indicated (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hand hygiene is a general term that applies to washing hands with water and either plain soap or thoroughly applying an alcohol-based hand rub (ABHR). Procedure: Situations that require hand hygiene include, but are not limited to: - Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice). - Before and after entering isolation precaution settings. - Upon and after coming in contact with a resident's intact skin (e.g., when taking a pulse or blood pressure, and lifting a resident). - After removing gloves or aprons. Review of policy titled Transmission Based Precautions, revised 2/2024, showed: All staff receive training on transmission-based precautions upon hire and at least annually. The procedure for Contact Precautions revealed: a. Intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. b. Make decisions regarding private room on a case-by-case basis after considering infections risks to other residents in the room and available alternatives. c. Healthcare personnel caring for residents on contact precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observation, record review, and interview, the facility failed to implement an effective infection control program related to 1. the use of Personal Protective Equipment (PPE) for one (#88) of one sampled resident for transmission-based precautions, 2. failed to ensure fingernails of staff were kept in a manner that prohibited the growth of microorganisms and allowed for sufficient hand hygiene, and 3. failed to ensure the storage of personal hygiene equipment for one resident (#91) out of ten sampled residents related to oral hygiene. Findings included: 1. On 11/18/24 at 9:14 a.m. an observation was made of a Contact precaution sign posted outside of Resident #88's room. The sign showed STOP - CONTACT PRECAUTIONS 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. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. The hallway outside or near the resident's room did not show any PPE was available for staff and/or visitors to don prior to entering the room. During the observation on 11/18/24 at 9:14 a.m., Staff K, Social Work Assistant (SWA) entered the room and stood at the bed of Resident #88's bed without donning any PPE, then Staff J, Licensed Practical Nurse (LPN) entered the room and spoke with the resident. Both staff members left the room and Staff J stated she thought the resident was off precautions since the (PPE) caddy was gone. The staff member read the Contact precaution sign and stated if the sign was still posted staff should dress in PPE. The staff members confirmed the PPE containers were 3-drawer storage unties that were placed in the hallways. Shortly after the observation and interview with Staff K and Staff J, the Infection Preventionist (IP) was seen on B-hall (on other side of the nursing station from Resident #88's room). The IP stated staff got PPE from the shower room and began to walk around the nursing station, stopping at Resident #88's room with the Contact precaution sign posted and stated staff only had to wear PPE when they were providing direct care for the resident. The IP stated staff had to dress in PPE for Resident #88 prior to entering the room. This writer and the IP walked to the shower room at the opposite end of the hall and around the corner. The IP stated PPE was kept in a caddy outside the room for contact precautions and inside the room for Enhanced Barrier Precautions (EBP). The IP stated the PPE kept in the shower room was for restocking the caddies. The IP confirmed there was no PPE available outside of the resident's room. Review of Resident #88's Admission Record showed the resident was admitted to the facility with diagnoses included but not limited to type 2 diabetes mellitus without complications, generalized muscle weakness, and need for assistance with personal care. Review of Resident #88's Order Summary Report showed an order for Contact Precautions: Encourage and assist resident to maintain contact precautions for urinary tract infections (UTI) e.coli every shift for UTI e.coli for 7 days, start date 11/11/24 and end date 11/18/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Photographic evidence was obtained on 11/18/24 at 9:20 a.m. Review of policy - Transmission Based Precautions, revised 2/2024, showed All staff receive training on transmission-based precautions upon hire and at least annually. The procedure for Contact Precautions revealed: a. Intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. b. Make decisions regarding private room on a case-by-case basis after considering infections risks to other residents in the room and available alternatives. c. Healthcare personnel caring for residents on contact precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens. 2. On 11/18/24 at 11:05 a.m., Staff L, Certified Nursing Assistant (CNA) was observed outside of room [ROOM NUMBER]. The staff member reported looking for someone to assist getting a resident up. The observation revealed Staff L's had unnatural fingernails, painted a blush pink color with white tips and a variegated yellow/pink nail on one observed hand. The nails extended a minimal of approximately 1/2 past the tip of the fingertip. Staff L confirmed the fingernails were fake. 3. On 11/20/24 at 2:23 p.m., Staff M, CNA, was observed documenting at a wall-mounted kiosk. The staff members nails were square-cut, painted a pink iridescent color extending approximately 1/4 past the tip of the fingers. 4. On 11/20/24 at 2:24 p.m., Staff N, Licensed Practical Nurse (LPN) was observed with square tip nails with tips painted a light grass green color extending approximately 1/2 past the fingertips. The staff member was observed assisting an unknown resident in the hallway, pulling the resident's wheelchair towards a room. 5. On 11/21/24 at 5:09 p.m. the Director of Nursing (DON) was observed with nails colored a pinkish-nude color with the ends extending slightly past the ends of fingertips. The DON reviewed the statement obtained from the facility regarding staff hygiene acknowledging it came from the staff handbook. She stated fingernails (length) should not interfere with care. The DON read further and acknowledged the handbook reported fingernail length no longer than 1/4 or fingertip length. She stated it would probably encompass all of us and stated also no artificial nails. The staff handbook, section 5-17 - Employee Dress and Personal Appearance revealed Employees are expected to report to work well-groomed, clean, and dressed according to the requirements of their position. Fingernails should be clean and well-manicured. Fingernails length should not interfere with customer care, job performance, or infection control guidelines (1/4 or fingertip length). Nail polish, if worn, should not be chipped. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Centers of Disease Control and Prevention (CDC) guidelines for Clinical Safety: Hand Hygiene for Healthcare Workers, February 27, 2024, (https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html) revealed: - Natural nails should not extend past the fingertip. - Do not where artificial fingernails or extensions when having direct contact with high-risk patients like those at intensive care units or operating rooms. Germs can live under artificial fingernails both before and after using an alcohol-based hand sanitizer and hand washing. - Some studies have shown that skin underneath rings contain more germs than fingers without rings. -Further studies should determine if wearing rings increases the spread of deadly germs. 6. On 11/18/24 at 11:31 a.m., an observation was made of Resident #91's bathroom. The observation showed two toothbrushes lying uncovered behind the sink's faucet with multiple tubes of toothpaste, including one opened tube. On 11/21/24 at 9:01 a.m., Resident #91's bathroom was observed with multiple tubes of toothpaste and two toothbrushes laid behind the sink's faucet. Resident #91 reported wearing dentures and staff did not clean them but did put them in. On 11/21/24 at approximately 9:30 a.m., the oral hygiene items in the bathroom of Resident #91 was observed with Staff O, Licensed Practical Nurse/Unit Manager (LPN/UM). Staff O stated toothbrushes should not be stored like that and that's gross. Review of Resident #91's Functional Abilities and Goals comprehensive assessment, dated 9/16/24, shows the resident required set up assistance with oral hygiene and supervision with transferring from bed to chair. Review of Resident #91's care plan showed the following: - That has potential or intellectual or health concerns. Has cognitive impairments and needs assistance to complete oral care task. Has obvious or suspected cavities or broken natural teeth which may lead to complications such as mouth sores, infection, or pain, dated initiated 7/16/24. The interventions instructed staff to Assist with or provide mouth care as needed to ensure task completion. Review activities of daily living (ADL) care plan interventions for degree of assistance needed. Review of the policy - Infection Control Infection Prevention and Control Program, revised 1/2024, reported An infection prevention and control program (IPCP) are established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Photographic evidence was obtained.