STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105525	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manatee Springs Rehabilitation and Nursing Center	5627 9th St E Bradenton, FL 34203

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observation, interview, and record review, the facility failed to ensure three (#6, #25, and #33) of seven residents observed for assisted dining in hall 100 received a dignified dining experience during two of four days of survey. Findings included: 1. On 06/17/24 at 12:47 p.m., Resident #6 was observed in her room in her wheelchair positioned in front of her bed facing the window. The resident's lunch tray was observed positioned behind her. When asked if she was going to eat her lunch, Resident #6 proceeded to attempt to move herself, but her wheelchair was locked. This resident was not able to position herself in front of her lunch tray. On 06/17/24 at 12:52 p.m., the Social Services Director (SSD) walked into the room. She stated Resident #6 did not ambulate independently. She stated the resident could not unlock her wheelchair. She confirmed the resident needed help to position herself in front of her meal tray. The SSD proceeded to position the resident in front of her tray. She stated resident needed meal set up assistance and sometimes she needed encouragement to eat. Review of the admission record showed Resident #6 was admitted to the facility on [DATE] with diagnoses of unspecified protein-calorie malnutrition and personal history of traumatic brain injury. Review of Resident #6's care plan, dated 01/08/22, under daily care/ADLs (Activities of Daily Living) focus, showed the resident had a self-care deficit related to decline in overall function secondary to illness and hospitalization and decreased activity tolerance. The goal, revised on 04/17/24, showed interventions for eating included , I require set up and as needed assistance from staff to eat. Open packets and cartons and such to set me up for meal. Review of Resident #6's quarterly Minimum Data Set (MDS), dated [DATE], showed in Section C-Cognitive and Patterns, a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. Section GG - Eating, showed the resident required set-up or clean-up assistance. An interview was conducted on 06/17/24 at 12:52 p.m. with Staff R, Registered Nurse (RN). She stated Resident #6 ate on her own, but she needed to be set up. She stated this resident could not open containers. (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: 105525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER Manatee Springs Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5627 9th St E Bradenton, FL 34203	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/18/24 at 12:55 p.m., Resident #6 was observed in her room during lunch. The resident asked this surveyor to open her milk carton and her apple juice. The two items were observed unopened. The resident stated she could not do it herself. (Photographic evidence was obtained). On 06/18/24 at 1:02 p.m., an interview with Staff S, RN confirmed Resident #6 needed assistance with meal set up. She stated meal set up meant position wheelchair accordingly, place tray in front of resident, and open everything. 2. During a facility tour on 06/18/24 at 8:40 a.m., Resident #25 was observed in his bed and stated he needed staff to assist him with his meal. His tray was observed at his bedside. An immediate interview was conducted with Staff O, Certified Nursing Assistant (CNA). She stated they started passing trays between 8:00 a.m. and 8:15 a.m. She stated once they passed the trays, they were to go to the residents they were assigned to assist with meals. Review of the admission record showed Resident #25 was admitted to the facility on [DATE] with diagnoses of unspecified dementia, muscle weakness, contracture of left hand, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of Resident #25's care plan, dated 06/17/22, under ADLs (Activities of Daily Living) focus, showed the resident had a self-care deficit related to impaired mobility with weakness and a history of CVA (Cerebrovascular Accident). The goal, revised on 06/07/24, showed interventions to provide total assistance with meal trays. Review of Resident #25's quarterly Minimum Data Set (MDS), dated [DATE], revealed in Section C-Cognitive and Patterns, a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. Section GG showed the resident was dependent for eating. On 06/18/24 at 8:56 a.m., an interview was conducted with Staff D, Licensed Practical Nurse (LPN)/ Unit Manager. He stated he had seven residents who were dependent on staff for meal assistance. He confirmed Resident #25 was waiting for a CNA to assist him with his meal. He stated he did not know why the resident was not being assisted having waited approximately 45 minutes. He said, I will check. We can warm up his tray if necessary. 3. On 06/18/24 at 12:57 p.m., Resident #33 was observed waiting for meal assistance. The residents in his hall were noted having finished their meal and CNA's were observed removing trays from the resident's rooms. An interview was conducted on 06/18/24 at 1:02 p.m. with Staff S, RN. She stated Resident #33 was dependent on staff for meals. She said, He should be assisted. The aide assigned to the hall is supposed to feed him. I did not know he was waiting. I will look for the aide. Review of the admission record showed Resident #33 was admitted to the facility on [DATE] with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and dementia. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #33's care plan, dated 04/19/22, under daily care/ADLs (Activities of Daily Living) focus, showed the resident had a self-care deficit decline in overall function secondary to illness and hospitalization related to decreased activity tolerance due to weakness and CVA, impaired cognition due to diagnosis of dementia. The goal, revised on 04/18/24, showed interventions for eating included , I require total assistance from staff to eat. Review of Resident #33's annual Minimum Data Set (MDS), dated [DATE], revealed in Section C-Cognitive and Patterns, a Brief Interview for Mental Status (BIMS) score of 08, which indicated moderate cognitive impairment. Section GG showed the resident was dependent for eating. On 06/18/24 at 1:05 p.m., an interview was conducted with Staff A, CNA who was observed assisting residents from the dining room. She stated the staff assigned to hall 100 was supposed to assist with feeders in this hall. She said, I can go see where Resident #33's aide is. Or maybe I should stop pushing people and feed him. On 06/18/24 at 1:07 p.m., an interview was conducted with Staff T, CNA. She said, I know he is waiting. She [her aide] should be here. She confirmed the tray was dropped off to the resident's room approximately 45 minutes earlier. On 06/18/24 at 1:07 p.m., an interview was conducted with Staff D, LPN/UM. He stated, my apologies. He [Resident #33] should not be waiting. I will find out what is going on. A follow -up interview was conducted with Staff D, LPN/UM on 06/19/24 at 1:40 p.m. He stated he was aware there was a problem with ensuring assisted residents received their meals in a timely manner. He confirmed a resident should not be waiting 45 minutes to be assisted. He stated he expected the CNAs to work together as a team and prioritize resident's needs. He stated he would have expected to be notified if there was a reason why a CNA could not assist a resident in a timely manner. He stated their procedure was to bring the tray to the resident when they were ready to feed them and not leave it in the room for extended periods. He stated part of delivering trays included preparing the resident for the meal, seating them up, opening containers, and positioning them accordingly. He stated he would in-service the CNAs. Staff D said, Residents should not be referred to as Feeders it's an undignified term. During an interview on 06/19/24 at 4:30 p.m., the Director of Nursing (DON) and the Regional Nurse Consultant (RNC) stated their expectation was for their residents to receive prompt assistance with their meals. Review of a facility policy titled, Dignity and Respect, dated 04/06/24, showed each resident shall be cared for in a manner that promotes and enhances quality of life dignity respect and individuality . Procedure: (1.) Residents shall be treated with dignity and respect at all times. (2.) Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. (7.) Staff should speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number diagnosis or care needs.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 50836 Based on observation, interview, and record review, the facility did not ensure confidentiality of records was maintained for one resident (#58) of 59 residents on Hall 100, and failed to ensure two of five medication cart computer screens on Hall 100 were locked. Findings included: 1. On 6/17/24 at 1:05 p.m., an observation was made of an MDI (metered dose inhaler) box with Resident #58's chart sticker on the side of it, in the medication cart trash. The medication cart was in the middle of the common hallway on Hall 100 and visible to approximately five non staff persons walking through the hall at the time. During an interview conducted on 6/17/24 at 12:54 p.m. Staff R, Registered Nurse (RN) stated they normally remove PHI (protected health information) from packaging, shred the portion with the PHI and put the rest in the trash. During an interview conducted on 6/19/24 at 11:20 a.m., the Director Of Nursing (DON) stated she would expect the staff would shred all PHI. During an interview conducted on 6/19/24 at 1:47 p.m., Staff D, Licensed Practical Nurse/First Floor Unit Manager (LPN/UM) stated he would expect his staff to obliterate all PHI before putting it in the trash. 43453 2. On 6/18/24 at 1:04 p.m., an observation was made of Staff S, Licensed Practical Nurse (LPN) walking away from the medication cart, leaving the cart and computer unlocked. The cart and computer were positioned outside the nurses' station in Hall 100. A resident's information page on the computer screen was visible to others. During this time residents were observed walking/wheeling to their rooms from the dining room. An observation was made of a family standing at the other end of the nurses' station. Staff S returned approximately three minutes later. Staff S, LPN stated she should have locked the cart and computer before walking away. On 6/19/24 at 9:22 a.m., an observation was made of a medication computer screen open with a resident's information open to the public outside Hall 100. The nurse was not within sight. Staff B, LPN came out of a resident's room and said, I'm sorry, I did not mean to leave the computer unlocked. It was my mistake. I should have locked it before walking away. During an interview on 6/19/24 at 1:36 p.m., Staff D, LPN/UM stated the nurses should lock the computer screen when stepping away and the medication cart should be locked. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled, Health Information Manual, dated 07/01/23, showed the facility will protect and safeguard all medical records; medical records will be maintained . following state and/or federal regulations. Under Procedure (2.) The facility shall protect and safeguard all medical records (a) current medical records are maintained on the nursing unit and/or in an electronic health record. (Photographic Evidence Obtained)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39866 Based on record review and interview, the facility failed to complete the Preadmission Screening and Resident Reviews (PASARRs) for residents with a mental disorder and individuals with intellectual disability following qualifying mental health diagnosis for five (#43, #18,#24, #31 and #56) of nine residents reviewed for PASARRs . Findings included: 1. Review of Resident #43's admission record revealed an admitted [DATE] with diagnoses to include Unspecified Dementia, Anxiety Disorder and Major Depressive disorder. Review of a level I PASARR for Resident #43 dated 09/29/23 revealed the qualifying diagnoses were not checked and recommendations for a level II PASARR were not acted upon. 2. Review of Resident #18's admission record revealed an original admitted [DATE] with diagnoses to include Schizophrenia, Major Depressive disorder and Bipolar disorder and Anxiety disorder. Review of a level I PASARR for Resident #18 dated 04/29/24 revealed the qualifying diagnoses were not checked and recommendations for a level II PASARR were not acted upon. 3. Review of Resident #24's admission record revealed an admitted [DATE] with diagnoses to include Schizophrenia, Major Depressive disorder and generalized anxiety disorder. Review of a level I PASARR for Resident #24 dated 08/26/19 revealed the qualifying diagnoses were not checked and recommendations for a level II PASARR were not acted upon. On 06/18/24 at 3:39 p.m., an interview was conducted with the Regional Nurse Consultant (RNC), Director of Nursing (DON), and the Social Services Director (SSD). The RNC stated they had initiated revising the PASARRs in December with the previous DON. The DON stated they had submitted a bunch of level II PASARRs for review. She said, We do not have any evidence. I cannot pull the record. We are unable to find it. The RNC stated they did not identify their system had an issue until the surveyor requested the PASARRs. The DON stated their expectation was to review the PASARRs prior to admission, when the residents are newly admitted , or if readmitted with newly acquired mental health diagnoses. On 06/18/24 at 3:47 p.m., the RNC stated they did not have a PASARR policy. She stated they follow state regulations. The RNC presented an undated document titled Level I Screen. The document showed an accurate and complete level I screen is required prior to admission into a Medicaid- certified nursing facility. If relevant PASARR information was missing, such as mental health diagnosis, then a new level I and level II if indicated, must be completed prior to admission. 4. Resident #31 was initially admitted to the facility on [DATE] with diagnoses of psychotic disorder with delusions due to known physiological condition, bipolar disorder, and major depressive disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #31's Preadmission Screening and Resident Review (PASARR) dated 5/6/24 revealed qualifying mental health diagnosis of anxiety disorder, bipolar disorder, Psychotic Disorder with delusions due to known physiological condition and no PASARR Level II was required. Review of the admission Minimum Data Set (MDS), Section I, Active Diagnoses, with an Assessment Reference Date (ARD) of 4/17/24 and significant change MDS with ARD of 5/8/24 revealed medical diagnoses of depression, bipolar disorder, and psychotic disorder. Review of Resident #31's medical record revealed Resident #31 was not assessed for PASARR Level II. An interview was conducted on 06/20/24 at 11:44 a.m. with the Director of Nursing (DON). She said the resident had the diagnosis of anxiety on the PASARR because the resident was on hospice services and she received Ativan for agitation and anxiety. She reviewed Resident #31's medical diagnoses and confirmed she did not have a diagnosis of anxiety. 5. Review of Resident #56's Admission Record revealed she was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of post traumatic stress disorder (PTSD), major depressive disorder, mood disorder due to known physiological condition with mixed features, and dementia. Review of Resident #56's PASARR dated 7/14/22 revealed a mental illness diagnoses of Depressive disorder and a recommendation for a level II assessment. Review of Resident #56's PASARR dated 7/27/23 revealed no mental illness diagnoses and no recommendation for a level II assessment. Review of Resident #56's medical record revealed Resident #56 was not assessed for PASARR Level II. An interview was conducted on 06/20/24 at 11:45 a.m. with the DON. She reviewed Resident #56' PASARR and confirmed it was not accurate and Resident #56's mental illnesses were not identified. She also confirmed the resident did not have a PASARR level II assessment completed. 43453

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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** 49227 Based on observation, interview, and record review, the facility failed to ensure negative wound pressure was monitored and maintained for one (#94) of one sampled resident, and failed to ensure an upper extremity elevation support wedge was ordered and monitored after application for one (#47) of two residents sampled for positioning devices. Findings Included: 1. On 6/17/24 at 2:01 p.m., during an interview and observation, Resident #94 was laying in bed. His negative pressure wound machine tubing was hanging on the floor. The machine was not functioning. On 6/18/24 at 10:07 a.m., Resident #94 was observed without the negative pressure wound machine connected. Resident #94 said the negative pressure wound machine causes pain and always comes off the day after replacement. On 6/18/24 at 12:56 p.m., Resident #94 said he had weekly appointments at the wound care center and did not want to continue using the negative pressure wound machine after his next appointment. Resident #94's next appointment was scheduled for 6/21/24. Review of Resident #94's admission record, with an admitted [DATE], showed diagnoses to include necrotizing fasciitis and Fournier gangrene. Review of Resident #94's order dated 6/7/24, start date 6/7/24, showed negative pressure wound therapy dressing change three times per week and as needed. Attach negative pressure wound therapy at [specified setting] [intermittent/ continual] to [specify wound/dressing site] [specify color(s) of foam] as needed for any leaking. Review of Resident #94's order dated 6/7/24, start date 6/10/24, showed negative pressure wound therapy dressing change three times per week and as needed. Attach negative pressure wound therapy at [specified setting] [intermittent/ continual] to [specify wound/dressing site] [specify color(s) of foam] every shift every Monday, Thursday for surgical side scrotal perineum: cleanse with normal saline, pat dry then apply the granulation black foam to cover wound vac and apply the wound vac. Review of Resident #94's Burn and Plastic Surgery Center Discharge Instructions, dated 6/12/24, showed negative pressure wound therapy to the scrotum wound at 125 millimeters of mercury) (mm) pressure (Hg) continuous. Special instructions written showed: in the event you lose suction to negative pressure wound machine, place normal saline wet to dry [dressing] and call for sooner appointment. Review of Resident #94's order dated 6/19/24, showed check for placement, function, seal, and negative pressure wound therapy setting every shift for wound vac therapy/ prevention. (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 #94's eMAR Medication administration note, dated 6/13/24 at 3:35 p.m. showed negative pressure wound therapy dressing change three times a week and PRN. Attach negative pressure wound therapy at [specify setting] [intermittent/ continuous] to [specify wound/dressing site] [specify color (s) of foam] every Monday, Thursday for surgical side scrotal-perineum: cleanse with NS, pat dry then apply the granulation black foam to cover wound vac and apply the wound vac. As per patient wound vac dressing changed yesterday it is working properly and he refuses dressings at this time. Review of Resident #94's care plan initiated on 6/5/24 showed focus, my open skin areas, I have a wound vac dressing on my scrotum .The care plan's goal is to show signs of healing. Interventions to include: -Negative pressure wound therapy dressing change three times a week and PRN. Attach negative pressure wound therapy at 125 mm/hg continual to scrotal/ perineum wound [with] foam as ordered, initiated 6/10/24 -wound vac at 125 mm hg continuous pressure, change Monday /Thursday, dated 6/10/24 On 6/19/24 at 2:55 p.m., an interview was conducted with Staff G, Registered Nurse (RN), the Director of Nursing (DON), and the Assistant Director of Nursing (ADON). The DON said all resident orders should be entered in the resident's medical record. She confirmed orders to document the negative pressure of Resident #94's machine had not been entered into the orders. Staff G said he had tried for several days to contact Resident #94's wound care doctor. 2. On 6/17/24 at 11:34 a.m., during an interview and observation Resident #47 was sitting in a geriatric chair in the 2nd floor activities area watching the television. A black foam forearm and hand elevation support wedge was laying in Resident #47's left armchair rest. Resident #47's flaccid arm was on his lap parallel to the support wedge with a foam strap secured above his elbow. Resident #47 said his left arm paralysis was due to a motor vehicle accident when he was 9 years old. Review of Resident #47's admission record showed 6/14/18, admitted and diagnoses to include unspecified fracture of shaft of humerus and left arm. Review of the Resident #47's task list, dated June 2024 did not reveal directions for the nursing staff to apply positioning devices. Review of Resident #47's care plan, review last completed on 3/12/24 did not show a focus, goal, or interventions related to positioning devices. On 06/17/24 at 12:47 p.m., Resident #47 was in the TV room with his left arm and hand out of the wedge support and laying on his lap. During an interview on 6/18/24 at 1:24 p.m., Staff H, Occupational Therapist (OT) said the last time Resident #47 was evaluated by OT was after a hospitalization in 2023. Staff H, said OT did not follow residents with chronic conditions, the residents were referred for restorative nursing therapy. The expectation was for the restorative care staff to notify the OT department with therapy related concerns. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/18/24 at 1:32 p.m., Staff L, Certified Occupational Therapist Assistant (COTA), Director of Rehabilitation (DOR), said the therapy department staff evaluated or screened residents after admission. Staff L, COTA, DOR said splinting directions and schedule would be added to the nursing staff task list for application and monitoring. During an interview on 6/19/24 at 12:16 p.m., the Director of Nursing (DON) said a Certified Nurse Assistant (CNA) observed Resident #47's girlfriend positioning Resident #47's arm on the positioning device the girlfriend brought to the facility. She said CNAs continued to use the support device for Resident #47. The DON said PT and OT evaluate residents to determine if positioning devices were needed. Residents who required positioning devices were listed on the nursing staff list. Review of facility's policy titled Consultants, last revised 3/5/24 revealed. Policy: .it is the policy of the facility to obtain additional information or assessment form outside source about/for a resident to assist in care and treatment. Procedure upon return and/ or completion of a consultation visit: a) check consult sheet for consultant's findings, diagnosis, recommendations, date and signature of consultant . b) notify attending physician of consultant's findings and recommendations. C) no recommendations by a consultant may be initiated before the attendant physician gives the order. Review of the facility's Care Planning Process and Care Conference policy, last revised on 7/3/23. In the procedure section 11) All resident/patient care and interventions must be carried out per the care plan (ex. Adaptive equipment, such as braces, restraints, dentures, hearing aids; transfers, ADL's, skin care, etc.)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on observation, interview, and record review, the facility failed to ensure splints were applied to prevent the decrease of range of motion for two (#50 and #88) of eight sampled residents. Findings included: 1. On 6/17/2024 at 10:27 a.m. and 3:00 p.m., Resident #50 was observed sitting forward in a recliner watching TV. Resident #50's bilateral feet were pointing down with heel protectors on both feet. Resident #50's bilateral hands were in fist like positions. Nothing was in the resident's palms. 2. On 6/17/2024 at 10:55 a.m., Resident #50 was observed and interviewed in bed. She was lying on her back with her right wrist bent and her hand with her fingers curled toward her palm. Resident #50 stated her hand did not open like it used to. She said she had splints, but the staff did not put them on very often and she forgets to request them. On 6/18/2024 at 10:41 a.m., Resident #50 was observed sitting in a recliner with no splints or rolls in her hands. Both of her hands were observed closed with her fingers bent and touching her palms. On 6/18/2024 at 8:26 a.m. and 2:11 p.m., Resident #50 was observed sitting in a recliner with no splints or rolls in her hands. Both of her hands were observed each time closed, fingers bent, and touching palms. On 6/19/2024 at 11:55 a.m., Resident #50 was observed in bed, lying on her back, with no splint on either hand. Review of Resident #50's Admission Record revealed diagnoses that included hemiplegia (partial paralysis) following cerebral infarction (stroke) affecting right non-dominant side, limitation of activities due to disability and other co-morbidities. Review of the Minimum Data Set (MDS) assessment, dated 10/24/2023, Section GG Functional Status revealed Resident #50 was dependent on staff with mobility and activities of daily living (ADL) performance and had functional limitations in range of motion on one side for upper extremity (shoulder, elbow, wrist, hand) and impairment on both sides for lower extremity (hip, knee, ankle foot). Review of the MDS assessment, dated 4/25/2024, Section GG Functional Status revealed Resident #50 was dependent on staff with mobility and ADL performance and had functional limitations in range of motion on two sides for upper extremity (shoulder, elbow, wrist, hand) and impairment on both sides for lower extremity (hip, knee, ankle foot). Review of the Order Summary Report with active physician orders as of 6/19/2024 for Resident #50 revealed the following: May have restorative/maintenance programs as indicated, order date 9/1/2023; Splint: right palm roll or wash cloth roll or as tolerated every shift, order date 8/3/2023. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Manatee Springs Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5627 9th St E Bradenton, FL 34203	

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan for Resident #50 revealed a focus area for MY DAILY CARE/ADLS: I have an ADL self care deficit r/t reduced mobility, weakness, and pain d/t (due to) dx (diagnosis) of seizure D.O. (disorder), muscle weakness, contractures, and anoxic brain damage r/t (related to) hx (history) of ischemic CVA. (cerebral vascular accident (stroke)). AD-Towel roll(wash cloth) in Rt. hand for skin integrity, On in the am [morning] and out in the pm [evening] or as tolerated. Provide hand hygiene daily before and after use, notify nurse/therapy of any concerns. Always leave resident in reclined position when in recliner to minimize risks for falls. History of refusal of having teeth brushed. Revised 4/28/2024. The following intervention was in place Encourage me to participate with my therapy or restorative programs on a regular basis. The care plan for Resident #50 revealed a focus area for Resident has a restorative program related to contracture management. Revised. 4/28/2024 and Date Initiated: 02/05/2024. The goal for this focus was for Resident #50 to participate in the restorative program as tolerated/as ordered and will improve or maintain present level of contracture through the review date. Date Initiated: 02/05/2024. The interventions showed: Right Palm roll or wash cloth roll as ordered/as tolerated. Date Initiated: 02/05/2024; Inspect skin around and under brace when donning, doffing, and every shift. Date Initiated: 02/05/2024; Restorative program will be reviewed by the interdisciplinary team on a periodic basis. Date Initiated: 02/05/2024; Provide education to resident and family regarding the purpose and benefits of restorative nursing programs. Date Initiated: 02/05/2024; Motivate and encourage by praising effort, not just successes. Date Initiated: 02/05/2024. An interview was conducted with Staff J, Licensed Practical Nurse (LPN) on 6/19/2024 at 12:50 p.m. Staff J, LPN confirmed being assigned to Resident #50. Staff J stated only cleaning Resident #50's hands and did not leave anything in the resident's palm(s). An interview was conducted with Staff A, Restorative CNA, on 6/19/2024 at 2:52 p.m. Staff A explained restorative nursing received direction from therapy on what was needed for each resident who was on the restorative nursing program. Staff A explained, restorative nursing provided treatment to the residents on their list, 3 days per week for 15 minutes. Restorative provided a short recap of what was done with each resident. Staff A continued to state for resident's who had splints, range of motion (ROM) was completed, then the splint was placed on the resident. The CNAs were supposed to put the splints on but we (restorative) usually had to put them (splints) on when we got to the resident. 2. Review of Resident #88's Admission Record revealed diagnoses that included hemiplegia (partial paralysis) following cerebral infarction (stroke) affecting right dominant side, critical illness polyneuropathy, cognitive communication deficit, and other co-morbidities. Review of the MDS assessment, dated 5/4/2024, Section GG Functional Status showed Resident #88 was dependent on staff with mobility and ADL performance and had functional limitations in range of motion on one side for upper extremity (shoulder, elbow, wrist, hand) and impairment on one side for lower extremity (hip, knee, ankle foot). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Order Summary Report with active physician orders as of 6/19/2024 for Resident #88 showed the following: May have restorative/maintenance programs as indicated, order date 8/31/2023; Restorative Nursing: PROM (passive range of motion) bilateral upper extremities and lower extremities, all joints, 15 minute 3x/weekly x 12 weeks, order date 4/15/2023; Restorative Nursing: Resident received gentle PROM 3x/days week to right hand, order date 2/20/2024; Splint: Right resting hand splint with AM care to PM care or as tolerated every shift, order date of 8/3/2023. The care plan for Resident #88 showed a focus area for splinting/ bracing restorative related to prevention of functional decline through daily activity. Resident may refuse to wear splint Rev. 5/6/2024 Date Initiated: 01/08/2024. The goal for this focus was for the resident to participate in the splinting/ bracing restorative program daily, as tolerated/accepted and will improve or maintain present level functional ability through the review date. Date Initiated: 01/08/2024 Target Date: 08/09/2024. The interventions showed Resident has an splinting/ bracing restorative program for: [Splint Program - Right resting hand splint, prevent further deterioration, am-hs (at night) as tolerated. Date Initiated: 01/08/2024. An interview was conducted with Staff N, Certified Nursing Assistant (CNA) on 6/17/2024 at 10:29 a.m. Staff N stated she was responsible for the care of Resident #88. Staff N continued to state splint responsibility was for restorative, she did not have to put the splint on the resident. An interview was conducted with Staff M, Registered Nurse (RN) on 6/17/2024 at 10:34 a.m. Staff M, RN stated restorative placed splints on all residents. An interview was conducted with the Director of Rehabilitation (DOR) on 6/19/2024 at 2:37 p.m. The DOR stated therapy screened all residents not on current case load, quarterly, for position/contracture management and other declines. If any change in status, then therapy would request orders for evaluation and treatment from the physician. Nursing also could give the therapy department a request for therapy to screen based on observation of a problem. An interview was conducted with the Director of Nursing (DON) on 6/19/2024 at 4:09 p.m. The DON stated the CNAs were responsible for placing splints on the residents. Restorative could put them on but the primary responsibility was for the CNA, as restorative was only 3 days per week. The DON continued to state the order should be followed and related care should be on the care plan. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure titled ADL Care Limited Joint Mobility; and Restorative Splint/Brace Program dated 3/12/24 revealed: Policy: a resident who is admitted without a limited range of motion/joint mobility does not experience reduction unless the residents clinical condition demonstrates that a reduction in a range of motion/joint mobility is unavoidable. A resident with a limited range of motion/joint mobility receives appropriate treatment and services to increase range of motion/mobility and/or to prevent further decrease in range of motion/joint mobility. The facility will ensure that the resident reaches and/or maintains their highest level of range of motion/joint mobility to prevent avoidable decline. The resident's comprehensive assessment should identify individuals risk which could impact the residents range of motion/impair joint mobility including, but not limited to: immobilization (e.g., bed fast, reclining in a chair or remaining seated in a chair/wheelchair); neurological conditions causing functional limitations such as cerebral vascular accidents, multiple sclerosis, Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrigsdisease, [NAME] beret syndrome, muscular dystrophy, or cerebral palsy, etc.; any condition where improvement may result in pain, spasms or loss of movement such as cancer, presence of pressure ulcers, arthritis, gout, late stages of Alzheimer's, contractures, dependence on mechanical ventilation, etc.; or clinical conditions such as immobilized limbs or digits because of injury, fractures, or surgical procedures including amputations. a restorative nursing program may be recommended to improve/maintain function of joint mobility. A restorative program can be implemented upon admission, readmission, during course of stay, or after being discharged from therapy services based on needs. Nursing staff will receive education/training from the therapy department on the restorative nursing program(s) prior to the residents participation in the restorative program(s). Procedure: 1. Nursing staff performs/supervises application of splints and or braces based on a wearing schedule established after assessment of need. Physical therapy and Occupational Therapy will educate staff as necessary, if special splint/brace application instructions are required, when resident is discharged from therapy. 5. Based on PT/OT evaluation for joint limitation needs and/or treatment, in collaboration with nursing, the resident may be placed on a restorative nursing program.* The restorative program will provide appropriate treatment and services to improve joint mobility and/or prevent further decline in joint mobility;* a specific restorative nursing plan will be developed for the resident for the splint/brace program as indicated based on assessment needs established by PT/OT;* the splint/brace program includes checking residents skin condition and circulation under the splint/brace device, cleansing the resident's skin, and repositioning the affected limb in correct alignment.* The splint/brace program does not include range of motion before applying the device; Those ROM needs are to be captured in a separate ROM program if the need is identified. * restorative nursing services will be provided at least six days a week with a goal that least 15 minutes of treatment services period time services may be divided over a 24 hour period and or as tolerated by the resident; .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observation, interview, and record review, the facility did not ensure respiratory equipment was stored appropriately on one (1st) of 2 floors, for three (#51, #24 and #6) of nine residents observed. The facility also failed to ensure tracheostomy care and suctioning was provided according to standards of practice for one (#59) of one resident sampled with a tracheostomy tube. Findings included: On 06/17/24 at 9:58 a.m., an observation was made of Resident #51's Nebulizer mask stored on her nightstand. The mask was resting on the top surface, exposed to the elements. The tubing was not labeled/dated. (Photographic evidence was obtained). Review of the admission record showed Resident #51 was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease, unspecified. Review of June 2024 physician orders for Resident #51 showed orders to change nebulizer tubing every night shift every Sunday, please label tubing with date and time. During an observation on 06/17/24 at 10:22 a.m., Resident #24's CPAP (Continuous Positive Airway Pressure) mask was observed on her bedside table, detached from the hose. The hose attachments were observed on the floor. (Photographic evidence was obtained). Review of the admission record showed Resident #24 was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease, unspecified. Review of June 2024 physician orders for Resident #24 showed orders to clean CPAP machine weekly as directed. Every Thursday day shift as resident used the machine at night. Wash mask daily in mild, fragrance-free soap and warm water, then rinse well in warm water and air dry. On 06/17/24 at 10:09 a.m., an observation was made of Resident #6's nebulizer mask stashed inside a drawer, not stored in a bag. (Photographic evidence was obtained). Review of the admission record showed Resident #6 was admitted to the facility on [DATE] with a primary diagnosis of Chronic Obstructive Pulmonary Disease, unspecified. Review of June 2024 physician orders for Resident #6 showed orders to change nebulizer tubing to every night shift every Sunday for hygiene, please label tubing with date and time. On 06/19/24 at 12:40 p.m., an interview was conducted with Staff P, Licensed Practical Nurse (LPN). She stated the nurses should clean respiratory equipment after use and put it in a dated bag. She stated equipment should not be on the floor and it should not be stashed in a drawer without a dated bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 06/19/24 at 12:46 p.m. with Staff A, LPN. She stated the expectation was to store the equipment in a sanitary manner. She stated it should be cleaned and stored in a bag with a date. She stated the tubing should be changed weekly or per orders. On 06/19/24 at 12:53 p.m., an interview was conducted with Staff Q, Registered Nurse (RN)/ Infection Preventionist. She stated she had educated all nurses on appropriate handling and storage of respiratory equipment. She stated the expectation was to prevent infections, therefore store all equipment in a sanitary manner inside a bag that was dated. She stated she expected nurses to clean respiratory machines as directed and replace equipment as ordered. Staff Q reviewed photographic evidence and stated, That's totally unacceptable. The nurses should have the know-how as professionals. she stated she would re-educate the nurses. A follow -up interview was conducted on 06/19/24 at 1:44 p.m. with Staff D, LPN/Unit Manager. He stated all respiratory equipment should be stored appropriately per their policy. Review of a facility policy titled, Handheld nebulizer / small volume nebulizer, revised 03/23, showed (11.) Store nebulizer equipment in a storage bag. Nebulizer tubing should be changed every two weeks or more often if malfunction or is visibly contaminated. Clean compressor per manufacturer's recommendation. 2. An observation and interview was conducted with Resident #59 on 6/17/2024 at 10:51 a.m. Resident #59 was observed sitting in the doorway of her room, in a wheelchair with oxygen via a nasal canula (NC) connected to a concentrator located next to her bed, set at 1 l/m (liter per minute). Resident #59 had a tracheostomy tube, no ties were visible, gauze was surrounding the tube. Resident #59 stated being able to suction herself and the nursing staff changed the dressing. Review of Resident #59's Admission Record revealed resident was admitted on [DATE] with the diagnoses that included acute and chronic respiratory failure with hypoxia, acute on chronic diastolic (congestive) heart failure and other co-morbidities. Review of the Minimum Data Set (MDS) assessment, dated 4/2/2024, Section C - Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated intact cognition. Review of the Order Summary Report with active physician orders as of 6/19/2024 for Resident #59 revealed the following: Suction via trach as needed for excessive secretions, as needed for Trach Care, dated 3/29/2024; Change trach collar, mask & O2 weekly as well as PRN (as needed) for Preventative Measure and as needed for soiled, dated 3/29/2024; Oxygen at 2L/min via NC continuously for SOB, dated 3/29/2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan for Resident #59 revealed a focus are for: BREATHING: I have difficulty breathing related to recent hospitalization for pneumonia, Resp. failure w(with)/hypoxia, asthma, and Congestive Heart Failure (CHF). I am on oxygen and have a tracheostomy w/suctioning as ordered, see current MD orders, date Initiated: 03/29/2024. Interventions include: I am able to let the staff know if I am feeling short of breath, date initiated: 03/29/2024; I am not able to let the staff know when I am short of breath so monitor me for accessory muscle breathing, tachypnea, lethargy, change in mental status, agitation, cyanosis, date initiated: 03/29/2024; Focus Area: I have a tracheostomy r/t (related to) Impaired breathing mechanics, date initiated: 04/01/2024; Interventions include: Change oxygen tubing weekly and PRN (as needed) if soiled, date initiated: 04/01/2024; Change trach collar, mask and o2 weekly as well as PRN every night shift Sunday for preventative measures, date initiated: 04/01/2024; Change trach collar, mask, and o2 weekly and PRN as needed for soiling, date initiated: 04/01/2024; Ensure that trach ties are secured at all times, date initiated: 04/01/2024; Oxygen at 2L/min via NC continuously every shift for SOB, date initiated: 04/01/2024; Suction via trach as needed for excessive secretion as needed for trach care, date initiated: 04/01/2024. No other documentation was provided from the resident's medical record regarding education of suctioning of the tracheostomy. An interview was conducted with Staff J, Licensed Practical Nurse (LPN) on 6/19/2024 at 12:48 p.m. Staff J, LPN stated being Resident #59's primary nurse and had been caring for her since her admission. Staff J stated the resident could suction herself although sometimes we (staff) suction her. Staff J reviewed Resident #59's physician's orders and confirmed no order for trach size, no order for the resident to suction herself, and oxygen was ordered for 2 l/m not 1 l/m. During an interview on 6/19/2024 at 4:09 p.m., the Director of Nursing (DON) stated Resident #59's tracheostomy order should include specifics of type and size. The DON stated the order was incomplete and needed to be fixed. The DON continued to state the resident should have an order to complete self-suctioning and assessment to include education. The DON stated not sure why the orders were not complete. Review of the facility's policy and procedure titled Tracheostomy Care dated 4/14/23 revealed: Policy: this policy will guide the facility to maintain patency of the airway, to prevent infection of the Airways and the area around the tracheostomy tube, to prevent excoriation of the area around the tracheostomy tube and to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas. Tracheostomy care is to be performed at least BID (twice daily) and PRN (as needed) as ordered by a physician. An extra tracheostomy tube should be available at bedside for emergency situations; The tube should be same size as currently used. Also, an additional tube should be available that is one size smaller than current size. Procedure: Preparation and Assessment - 1. Verify physician order for care and treatment. General Guidelines: . 4. Tracheostomy tubes should be changed as ordered and as needed (at least monthly). 5. Tracheostomy care should be provided as often as needed, at least once daily/BID for old, established tracheostomies, and at least every eight hours for residents with unhealed tracheostomies. 7. A suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at the bedside at all times. 48223

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39866 Based on observation, interview, and record review, the facility failed to thoroughly and accurately identify resident specific triggers related to Post Traumatic Stress Disorder (PTSD) and develop a resident specific plan of care to prevent re traumatization for two Residents (#32 and #56) out of two residents reviewed with diagnoses of PTSD. Findings included: 1. Review of Resident #32's Admission Record revealed she was admitted to the facility on [DATE] with diagnoses of post-traumatic stress disorder (PTSD, bipolar disorder, anxiety disorder, schizophrenia,), and major depressive disorder. An interview was conducted on 06/19/24 at 10:20 AM with Resident #32. She said she was very shaky today because she had tardive dyskinesia. Resident #32 became tearful and said she did not know if she saw a psychiatrist or a psychologist. The resident then said she was tired and wanted to lay down. During the interview Resident #32 was observed to have hand tremors. An interview was conducted on 06/17/24 at 10:50 AM with Staff A, Restorative Certified Nursing Assistant (CNA). She said Resident #32 had a behavior of being tearful regarding her diagnoses and she calmed with music or talking about the dogs and horses. She said Resident #32's behaviors could be sporadic. An observation was conducted on 06/17/24 at 10:56 AM of Resident #32. She was observed to be tearful on her way to restorative therapy with Staff A pushing her in the wheelchair. Staff A was overheard saying she would put on some music for the resident in the restorative room. An interview was conducted on 06/19/24 at 10:25 AM with Staff B, Licensed Practical Nurse (LPN). She said she had been taking care of Resident #32 for 2 years and was very familiar with her. She said the resident was very anxious in the morning and she tended to be much better by the afternoon. Staff B confirmed Resident #32 had PTSD. She said she reviewed her record, and it was not very clear as to why she had PTSD other than she was sexually assaulted and the resident said she was kidnapped. Staff B said she did not know what the resident's triggers were and confirmed there was nothing in the record to identify the resident's triggers or how to avoid the triggers to prevent re traumatization. Review of Resident #32's Social Services Admission History (Premier) dated 10/7/2020 revealed section B. Primary Care PTSD Screen. A. Sometimes things can happen to people that are unusually or especially frieghtening[sic], horrible, or traumatic. For Example: A serious accident or fire, a physical or sexual assault[sic] or abuse, an earthquake or flood, a war, seeing someone be killed or seriously injured, having a loved one die through homicide or suicide. 1. Have you ever experienced this kind of event?: Yes (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In the Past Month, have you: 2a. Had nightmares about the event(s) or thought about the event(s) when you did not want to? No 2b. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? Yes 2c. Been constantly on guard, watchful, or easily startled? No 2d. Felt numb or detached from people, activities, or your surroundings? No 2e. Felt guilty or unablet [sic] o[sic] stop blaming yourself or others for the events(s) or any problems the event(s) may have caused? No .Outcome .2. Based on the results of the Primary Care PTSD Screener: Psychology Services consulted . Life Events Checklist .6. Physical Assault (for example being attacked, hit, slapped, kicked, beaten up) Happened to me .8. Sexual Assault (rape, attempted rape, made to perform any sexual act through force or threat of harm) Happened to me .15. Sudden, unexpected death of someone close to you. Happened to me. Based on the information from the Life event Checklist: Psychiatric Services Consulted. Review of Resident #32's psychiatry physician note dated 7/15/22 revealed .As an adult, patient states, I was placed in a sex house, where black men rape white women. She was not able to recall for how long she was held captive or who the men were, she just recall that one of the men who was involved helped her escape because .he felt bad. Patient states she never reported the incident to the police . Review of Resident #32's psychology note dated 6/7/24 revealed .Description of what the psychotherapy entailed and how it addressed the presenting problem: Pt [patient] presents with positive mood. Explored use of coping skills prior to session. Practiced reframing negative thoughts. Engaged in role play to practice reframing negatives. Review of Resident #32's psychology note dated 5/31/24 revealed .Description of what the psychotherapy entailed and how it addressed the presenting problem: (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Explored mood and pt expressed thoughts of death. Explored emotions and assessed for SI. No SI at this time. Discussed pt use of art as coping strategy. Explored link to purpose and self esteem [sic]. An interview was conducted on 06/19/24 at 11:42 AM with Staff C, Social Services Director (SSD). She said she was familiar with Resident #32 and confirmed she had a diagnosis of PTSD. She said when she spoke to Resident #32 about her diagnoses she became tearful and shook. She said Resident #32 received psychology and psychiatry services and when there was an acute concern the psychiatrist and the psychologist would come to her and they would talk about a plan of care. Staff C, SSD also said there was a monthly meeting and psychiatry was involved in the meeting and concerns and plans of care were discussed. Staff C, SSD reviewed the psychiatry note dated 7/15/22 and said she kind of remembers that. She said a care plan was developed to identify Resident #32 had PTSD. Staff C, SSD said an assessment was completed to identify if a resident had PTSD. Psych services were consulted if the resident did have PTSD and psych physicians would come and speak to the social services department if there were concerns. She confirmed there was no documentation related to Resident #32's triggers and how to prevent re traumatization. Review of Resident #32's mood and behavior care plan revised on 4/17/24 showed MOOD/BEHAVIOR: The resident may/may not have a mood/behavior problems r/t [related to] depressed, PTSD, see psych consult/notes. 1/18/2021 Handling and or resolving issues or concerns/thoughts making statements for not knowing how to deal with situations (easily redirected). 3/18/22 indications of financial/material need, life event(s), concerns about daughter's health. The goals revealed o Improve mood state or anxiety level by next review o Will improve/minimize sadness, crying, restlessness, anxiety o Will not harm self o Participate in activities of choice The interventions showed: o Administer psychotropic medications as ordered [Refer to POS for current order]. Report missed or refused medication to physician (Missed doses can lead to an acute event & should be reported to the physician) o Encourage resident, to express feelings. o Speak softly & clearly when communicating o Observe for changes in mood/depression and notify physician o Discuss procedures & mediations prior to administration o Psychiatry Services as needed o Psychological Services o Encourage to talk about problems (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Manatee Springs Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5627 9th St E Bradenton, FL 34203	

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Encourage to participate in activities of choice o Diversional Activity if upset: TV o When restless or anxious, provide calm, quiet atmosphere o Assist the resident, family, caregivers) to identify strengths, positive coping skills and reinforce these. o Observe/record/report immediately to MD prn risk for harm to self: suicidal plan, past attempt at suicide, risky actions (saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, States that life isn't worth living, wishes for death. An interview was conducted on 06/19/24 at 1:00 PM with the Director of Nursing (DON). She said Resident #32 has had PTSD since she was admitted , and she had psychiatry and psychology services. She said she would have to review the record to know what the resident's triggers were and what the facility was doing to prevent re traumatization outside of psychiatry and psychology services. An interview was conducted with Staff D, LPN, first floor Unit Manager (UM). He said he has worked with Resident #32 since her admission and was very familiar with her. He said Resident #32 had a lot of chronic anxiety; she came from another building to be with her with her [family]. Staff D said for the most part Resident #32 had done well but she did get a little anxious at times. He said in his opinion medical things gave her anxiety such as going out to outside doctor's appointments. So, we now send someone with her for the outside doctor appointments. He said Resident #32 went out to a doctor's appointment alone and the doctor's office called the facility and let them know her anxiety got so bad she could not clearly talk. So, after the incident the facility started sending someone with her to all outside doctor appointments and he thinks that had helped her. Staff D confirmed Resident #32 had a diagnosis of PTSD and said I don't know what that is about because she has not shown any triggers. I think she was involved in some bad marital relationships, but we have not gotten into that conversation. Staff D said he did not know what her triggers were. She does like music and coloring. 2. Review of Resident #56's Admission Record revealed she was initially admitted to the facility on [DATE] and readmitted on [DATE] with medical diagnoses of chronic post traumatic stress disorder (PTSD), Major depressive disorder, mood disorder due to known physiological condition with mixed features, and dementia. An interview was conducted on 6/17/24 at 10:50 a.m. with Resident #56. She said PTSD? I don't have that crap. Review of Resident #56's psychology re-assessment note dated 12/13/22, revealed Resident #56 had a diagnosis of PTSD, was raped at 15-had baby. Review of Resident #56's Social Services Admission History (Premier) dated 8/1/23 revealed PTSD screen: Sometimes things can happen to people that are unusually or especially frieghtening [sic], horrible, or traumatic. For Example: A serious accident or fire, a physical or sexual assult [sic] or abuse, an earthquake or flood, a war, seeing someone be killed or seriously injured, having a loved one die through homicide or suicide. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.A2. Have you ever experienced this kind of event? Yes (If Yes, please answer the questions below) The questions below were not completed. .B1. Based on the results of the PTSD Screener: No further intervention is required . Review of the Life events checklist revealed none of the life events happened to Resident #56. Outcome: 1. Based on the information from the Life Event Checklist: Resident requires no further intervention. Review of Resident #56's psychiatry note dated 3/21/24 showed, There is no known history of physical, sexual, emotional abuse, or emotional neglect. Post Traumatic Stress Disorder: Patient denies symptoms of PTSD. Denies experiencing traumatic events that involved actual or threatened death or serious injury . Review of Resident #56's quarterly Minimum Data Set (MDS), dated [DATE], 2/10/24, 11/10/23, 4/20/2023, 1/18/23, and 10/18/2022, section I, Active Diagnoses revealed a Psychiatric/Mood Disorder diagnosis of PTSD. Resident # 56's significant change MDS, dated [DATE], section I, revealed a diagnosis of PTSD. Resident # 56's Medicare 5-day MDS, dated [DATE], section I, revealed a diagnosis of PTSD. Resident # 56's Annual MDS, dated [DATE], section I, revealed a diagnosis of PTSD. Resident # 56's Admission MDS, dated [DATE], section I, did not reveal a diagnosis of PTSD. Resident # 56's 5-day MDS, dated [DATE], section I, did not reveal a diagnosis of PTSD. Review of Resident #56's psychosocial care plan revised on 5/2/24 revealed PSYCHOSOCIAL: The resident has,a [sic] potential/actual psychosocial well-being problem related to may/may not have post-traumatic stress, life event(s) The goals showed Will verbalize feelings related to emotional state by review date and will utilize effective coping mechanisms as through the review date. The interventions showed, Allow the resident, time to answer questions and to verbalize feelings perceptions, and fears o Support/ Encourage/ Assist to set realistic goals o Determine resident's expectations and discuss eah [sic] in realistic terms o Encourage family/friend to remain involved o Psychiatry Services as needed o Psychological Services as needed o Discuss resident's concerns or fears o Discuss with resident feelings, reminiscence, issues Review of Resident #56's mood care plan revised on 5/2/24 revealed MOOD: The resident has a mood problem r/t States with trouble falling asleep or staying asleep. 8/26/22 Depression/anxiety per consult. PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The goals revealed o Participate in activites [sic] of choice o Will receive adequate sleep. The interventions revealed o Encourage resident, to express feelings. o Speak softly & clearly when communicating o Psychiatry Services as needed o Psychological Services as needed o Encourage to talk about problems o Encourage to participate in activites [sic] of choice o When restless or anxious, provide calm, quiet atmosphere o Assist the resident, family, caregivers) to identify strengths, positive coping skills and reinforce these. An interview was conducted on 06/19/24 at 1:47 PM with Staff D, LPN, first floor UM he said he was not aware that Resident #56 had a diagnosis of PTSD. He said he did not know anything about what happened or her triggers. An interview was conducted with the Director of Nursing (DON) on 06/19/24 at 1:50 PM. She said she would have to look at Resident #56's chart to know if she had PTSD and recommended talking to Staff D. An interview was conducted on 06/20/24 at 11:43 AM with the DON. She said she thought she read somewhere in the resident's medical record she had an episode during COVID isolation where she was remembering things from her past. The DON confirmed there were no documented PTSD triggers or an attempt to identify the triggers to prevent re traumatization. Review of the facility's Trauma Informed Care policy, revised on 9/8/22 revealed Policy To ensure that residents who are trauma survivors receive culturally competent trauma informed care in accordance with professional standards of practice and take in account Resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. The facility will provide the necessary behavioral health care services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the individual resident assessment and plan of care. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	To train and assist staff to avoid re-victimization of those residents who have survived trauma and create an environment where the resident feels safe and secure. Individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being. Guidelines: While care and services must always be person-centered and honor residents' choice and preferences, what is different about providing care and services to a trauma survivor is that theses residents may have lost the ability to trust caregivers, and to feel safe in their environment. As a result, the principles of trauma-informed care must be addressed and applied purposefully. .Collaboration-There is an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care. There is recognition that healing that healing happens in relationships and in the meaningful sharing of power and decision-making. .PTSD Post-Traumatic Stress Disorder involves the development of symptoms following exposure to one or More [sic] traumatic, life-threatening events. Symptoms usually develop within the first 3 months after The [sic] trauma occurs, although there may be a delay in months or even years. Symptoms may include, but not limited to, the re-experiencing or re-living of the stressful event . Dissociation (e.g. detachment from reality, avoidance, or social withdrawal), hyperarousal (e.g. Increased[sic] startle response or difficulty sleeping). Symptoms may be severe or long-lasting when the Stressor[sic] is interpersonal and intentional (e.g., torture or sexual violence). .Triggers Facilities must identify triggers which may re-traumatize residents with a history of trauma. A trigger is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening. For many trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. While most triggers are highly individualized, some common triggers may include: Experiencing a lack of privacy or confinement in a crowded or small space; Exposure to loud noises, or bright/flashing lights; Certain sights, such as objects that are associated with those that used to abuse, and/or Sounds, smells, and even physical touch. .Procedure (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On admission an assessment/screening tool will be completed by the Social Service staff to Identify [sic] any trauma, post life events and/or post-traumatic stress disorder that the resident has Experienced or is currently experiencing so that our understanding of their traumatic events can Be [sic] more meaningful. An IDT approach will be used to identify a resident's history of trauma as Well [sic] as his or her cultural preferences. Screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission assessment, history/physical, social service History[sic]/assessment etc will provide information regarding resident's history. Additional Information may be obtained from the medical record, family members or other additional Assessments[sic] completed. 2. Evaluation of the information received will be completed by the Interdisciplinary team and Physicians to identify those risk factors/areas that may need to be included in the resident's plan of care to Mitigate[sic]/eliminate triggers. .4. Facility staff will have education/training in caring for residents identified with mental and Psychological [sic] disorders, as well as residents with a history of trauma and/or post traumatic stress Disorder [sic], including non-pharmacological interventions when appropriate. Trauma informed care Trainings [sic] will be conducted at least annually and will be included in orientation for all new Employees [sic]. .6. Trauma Specific interventions will be placed in their individualized person-centered care plan Upon [sic] admission and revised as necessary. Care plans will be reviewed quarterly and more often If [sic] necessary based on any change in their physician and psychosocial well-being. The facility should collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, and any other health care professionals (such as psychologists, Mental [sic] health professionals) to develop and implement individualized interventions. Facility/Social Services might consider establishing a support group, run by a qualified Professional [sic], or allowing a support group to meet in the facility. If a trauma survivor is reluctant to share his/her history, facility must still try to identify Triggers which may re-traumatize the resident; care plan interventions will be added Which [sic] minimize or eliminate the effect of the trigger on the resident. Trigger-specific interventions should identify ways to decrease the resident's exposure to Triggers [sic] which re-traumatize the resident, as well as identifying ways to mitigate or Decrease [sic] the effect of the trigger on the resident. Staff must understand the cultural preferences of the individual and how it impacts Delivery [sic] of care; .Trauma-specific interventions should recognize the interrelation between trauma and Symptoms [sic] of trauma such as substance abuse, eating disorder, depressions, anxiety; .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49227 Based on observation, record review, and interview, the facility did not ensure complete documentation of narcotic removal to ensured prompt identification of loss or potential diversion of controlled medications for one (#94) out of two sampled residents. Findings included: On 6/19/24 at 9:11 a.m. during medication administration observation, Staff E, Licensed Practical Nurse (LPN) removed one Norco oral tablet 10/325 (Hydrocodone 10 mg and Acetaminophen 325 mg tablet) and administered it to Resident #94. After administration, Staff E documented in the Resident #94's electronic Medication Administration Record (eMAR). After administration, Staff E, LPN was not observed documenting removal of the medication in Resident #94's medication monitoring control record prior to administering medications to a different resident. On 6/19/24 at 11:05 a.m. a request was made for Staff E, LPN to review the documentation record for the Norco administered at 9:11 a.m. A review of Resident #94's Medication Monitoring Control Record row #4 the column for the Name of the person administering the medication did not have an entry, the column for the date, 6/19 is written, the time 0912 is written, [amount]on hand, 11 is written, amount given one is written and amount remaining 10 is written. Staff E, LPN said I forgot to sign my name. On 6/19/24 at 11:34 a.m. during an interview the Director of Nursing (DON) said the facility expects staff to remove the narcotic from the dispensing card, document removal in the medication monitoring control record, administer the medication to the resident and document in the medication administration record. Review of facility's policy titled, Medication Administration; last review date 9/13 /22 showed. Policy: medication shall be administered in a safe and timely manner and as prescribed. Procedure: only persons licensed are permitted by the state to prepare administer and document the administration of medications may do so. 19) For narcotic medication administration, the nurse must sign the Medication Administration Record (MAR) as well as the narcotic book /control substance sheet at the time the medication is administered indicating the date and time the [medication] Med administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observation, interview and record review, the facility did not ensure medications were inaccessible to unauthorized staff, residents, and visitors for four (#24, #111, #58 and #34) of 58 residents sampled, and in one of five medication carts left unlocked on one (1st) of two floors. Findings included: 1. During a facility tour on 06/18/24 at 12:47 p.m., an observation was made of Resident #24's eye drops at the bedside. There were two vials observed on her the bedside table named [brand name of lubricant eye drops]. These medications were not secured. Resident #24 stated she could administer the medications on her own, but she was supposed to keep them locked in her bedside drawer. (Photographic evidence was obtained). Review of the admission record showed Resident #24 was admitted to the facility on [DATE] with a diagnosis of dry eye syndrome of bilateral lacrimal glands. Review of the June 2024 physician orders for Resident #24 showed self-administration orders for three types of eye drops, but not the eyedrops observed at the bedside. Review of the Medication self-administration screener dated 12/21/23 showed Resident #24 was assessed for self-administration of [name of eye drops] multi dose emulsion 0.05% and [Brand name] gel. Section B-Evaluation showed (7.)The resident can demonstrate secure storage of medication. On 06/19/24 at 4:30 p.m., an interview was conducted with the Regional Nurse Consultant (RNC) and the Director of Nursing (DON). The DON stated all medications should be locked up with or without self-administration orders. They stated residents with self-administration orders had lockable drawers at their bedside. (Photographic evidence was obtained). 2. During tour on 06/17/24 at 10:02 a.m., an observation was made of Resident #111's medication at the bedside (name brand inhaler/decongestant). Review of the admission record showed Resident #111 was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease unspecified. Review of June 2024 physician orders for Resident #111 showed there were no orders for the inhaler/decongestant found at the bedside. 3. During a tour of Resident #58's room on 06/17/24 10:04 a.m., an observation was made of a medication, [Brand name of medicated powder] placed on a chair by the resident's bedside. (Photographic evidence was obtained). Review of June 2024 physician orders showed Resident #58 did not have current orders for the [Brand name of medicated powder]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/19/24 at 12:40 p.m., an interview was conducted with Staff P Licensed Practical Nurse (LPN). She stated all medications were to be stored in the medication cart and administered by nurse unless the resident had self-administration orders. An interview was conducted on 06/19/24 at 12:46 p.m. with Staff B, LPN. She stated all medications were to be secured. She stated if she observed a resident with medications at bedside, she would remove them and check with the physician if orders were needed to self-administer. On 06/19/24 at 1:40 p.m., an interview was conducted with Staff D, LPN/Unit Manager. He stated he had one resident on self-administration orders for eye drops. He confirmed residents with self-administration orders had bedside lockable drawers. He reviewed the photographic evidence for the residents of concerned and stated these residents should not be keeping the medications in their rooms. The expectation was to have an assessment completed to ensure the resident was able to self-administer and obtain orders. 49227 4. During medication administration observation on 6/19/24 at approximately 9:05 a.m., Resident #34 appeared short of breath at the doorway to his room. Staff E, Licensed Practical Nurse (LPN) offered to administer his inhaler. Resident #34 said he had already taken the medication. Review of the Medication Administration Record for Resident #34 showed an order, with a start date of 6/6/24, for Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 6 hours as needed for wheezing unsupervised self-administration rinse mouth after use. On 6/19/24 at 11:30 a.m. during an observation, Resident #34's inhaler was in a plastic bag taped to his bed siderails (Photographic Evidence Obtained). On 6/19/24 at 3:36 p.m. an interview was conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON). The DON said medications stored at the resident's bedside should be secured. On 6/20/24 at 10:22 a.m. during an interview, Resident #34 said he liked to keep his inhaler handy, he said he had an attack four days ago. Review of facility's policy titled Medication Administration; last review date 9/13 /22 showed. Policy: medication shall be administered in a safe and timely manner and as prescribed. Procedure: only persons licensed are permitted by the state to prepare administer and document the administration of medications may do so. 19) For narcotic medication administration, the nurse must sign them Medication Administration Record (MAR) as well as the narcotic book /control substance sheet at the time the medication is administered indicating the date and time the [medication] Med administration. 24) residents may self-administer their own medications if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision making capacity to do so safely. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 06/18/24 at 1:04 p.m., an observation was made of Staff S, Licensed Practical Nurse (LPN) walking away from the medication cart, leaving the cart and computer unlocked. The cart and computer were positioned outside the nurse's station in hall 100. A resident's information page was visible to others. During that time, Residents were observed walking/wheeling to their rooms from the dining room. An observation was made of a family standing at the other end of the nurse's station. This surveyor walked to the cart and waited for the nurse to return for approximately 3 minutes. Staff S, LPN stated she should have locked the medication cart and computer before walking away. Review of a facility policy titled, medication storage, Revised 02/24, showed medications and biologicals are to be stored safely, securely, and properly, following manufacturer's recommendations for the supplier. The medication supply is accessible only to nursing personnel, pharmacy personnel, or staff members authorized to administer medications. (2.) The nursing staff shall be responsible for maintaining medication storage (med cart and med room) and preparation areas in a clean, safe and sanitary manner. (8.) compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. (11.) Only persons authorized to prepare and administer medications shall have access to the medication room, including keys. Review of a facility policy titled, Self-Administration of Medications - Resident, dated 03/24, showed to abide by the individual right to self-administer medications unless determined unsafe by the interdisciplinary team. Under procedure (2.) (g.) The resident will have the ability to lock and unlock the storage drawer and manage the key.