STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105736	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Sun City	3850 Upper Creek Dr Sun City Center, FL 33573

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 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. 48223 Based on interview and record review the facility failed to ensure dignity was maintained for one (Resident #257) out of three residents reviewed for dignity out of a total resident sample of 38. Findings included: During an interview on 09/07/2024 at 10:38 AM Resident #257 stated, I had to sleep on an unmade bed last night. Resident #257 said I needed to use the bathroom, but the urinal was almost full, and had not been emptied from earlier. I pushed the call light, but they did not come quick enough. I had to go. I used the almost full urinal. Of course, it spilled. When the Certified Nursing Assistant (CNA) came in, she had an attitude and said now she would have to shower me. I told her she was crazy. It's 4:30 AM, I want to go back to bed. Resident #257 stated the CNA stripped the bed and never came back. I got my clothes on, with a big sweater and went back to bed as she never came back to make the bed. When my morning CNA came in she said, what are you doing on the mattress. During an interview on 09/07/2024 at 10:45 AM Resident #257's roommate confirmed the events that had occurred with Resident #257 and the CNA. During an interview on 09/07/2024 at 2:30 PM Staff K, CNA, confirmed Resident #257 was lying on the bare mattress, dressed with a large sweater on, when she first went in the resident's room. Review of Resident #257's Admission Record showed he was recently admitted to the facility and had diagnoses to include benign prostatic hyperplasia without lower urinary tract symptoms, other retention of urine, and need for assistance with personal care. During an interview on 09/09/2024 at 3:30 PM the Director of Nursing (DON) stated, This would not be acceptable. The DON said the expectation would be for the CNA to remake the bed and allow the resident to go back to sleep. During an interview on 09/09/2024 at 4:11 PM, the DON stated the facility does not have a policy on dignity or resident rights. The DON said they follow the regulation.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 46234 Based on observations, interviews, and record review the facility failed to protect the right to be free from neglect related to pain management, contracture management, activities of daily living (ADL) care, and seating systems for one resident (#91) out of 38 total sampled residents. Findings included: On 9/7/24 at 3:31 p.m., Resident #91 was lying in bed with bilateral upper extremities contracted. No palm guards or splints were observed on the resident or in the room. No wheelchair or seating system was observed in the room. Her fingernails extended approximately 1/2 inch past the tips of her fingers with debris underneath and she had hair growth on her chin. The resident stated she didn't know if the staff could clip her nails, but she would like them shorter. (Photographic evidence obtained with resident consent). Review of the Admission Record showed Resident #91 was admitted in April of 2024 with diagnoses to include nontraumatic intracerebral hemorrhage, moyamoya disease, adult failure to thrive, unspecified dementia moderate without behavioral/psychotic/or mood disturbance, contracture of muscle right and left lower leg, and type II diabetes mellitus. Review of Resident #91's Minimum Data Set (MDS) assessment for a significant change, dated 7/15/24, showed a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS showed the resident had upper and lower extremity impairment on both sides, used a manual wheelchair, and was dependent on a helper for eating, hygiene, bathing, and dressing. The assessment showed the resident was at risk of developing pressure ulcers/injuries and had a pressure reducing device for her chair. The assessment showed physical therapy (PT) was started and ended on 5/21/24 and occupational therapy (OT) started and ended on 5/20/24. Review of Resident #91's care plan showed a focus area of potential for pain related to stage III pressure ulcer (resolved on 7/11/24) and contractures of left and right lower extremities. Initiated on 7/2/24 and revised on 9/9/24. Interventions included administer and monitor for effectiveness and for possible side effects of pain medication, consultation as needed for PT, OT, mental health, make a referral to resident's physician to consider premedicating for pain prior to treatments to optimize participation, notify the resident's physician if they do not state/demonstrate relief or reduction of pain after one hour of receiving the first intervention, observe and report to nurse: signs and symptoms of pain, worsening of pain, observe for non-verbal behavior cues of pain, and report changes in pain location/type frequency/intensity to physician. There is no mention of the contractures of the left and right upper extremities. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/8/24 at 1:44 p.m., Resident #91 was lying flat in her bed with a left tilt. The resident was quiet while lying still. When she attempted to move her right hand and arm, she screamed out. The resident said she was in pain and needed something. When asked if she had any splints, guards, or anything for her contracted hands, she said she did not but would like something to help. The resident would not volunteer information but would answer questions if directly asked. The resident's nails remained untrimmed and dirty. An interview was conducted on 9/8/24 at 1:46 p.m. with Staff L, Licensed Practical Nurse (LPN). The nurse was informed Resident #91 yelled out, and vocalized she was in pain, and had requested something to help. Staff L said all the resident had ordered was Tylenol, and she didn't know if it would help. She said Resident #91 yelling out when she moved is her norm [normal]. Review of Resident #91's physician orders showed an active order for Tylenol 325 mg x 2 tablets every 4 hours as needed for mild to moderate pain. No other medications were ordered for pain control. There was an order dated 4/4/24 for a Pain Management consult as needed. An interview was conducted on 9/8/24 at 2:13 p.m. with a family member of Resident #91. The family member said when Resident #91 was admitted her left hand was contracted and now both hands and feet are. The family member stated Resident #91 only had a couple days of therapy when she was first admitted , and the therapist said there was no sense in giving the resident therapy. The family member said they were concerned about the resident having sores, that the wound care nurse said were related to the resident sweating a lot. The family member said Resident #91's roommate was always turning the temperature up in the room and making Resident #91 hot. The family member said a few days ago staff told her they would work on moving the resident to a new room, but they also said that a month ago. The family member said she didn't know why the resident's nails were not being cared for; they were long and dirty. The family member said social services told her they were getting a special chair that has a high back and reclines, but the resident was always in bed on her back. The family member said they had never seen Resident #91 in a different position. The family member said Resident #91 can get confused and will not speak up, but if she is asked something, she will answer. An interview was conducted on 9/8/24 at 3:07 p.m. with Staff P, Certified Nursing Assistant (CNA). She said Resident #91 normally screams anytime she was moved. She said when the resident was changed, the resident screams. When the CNAs roll her one way she screams when they roll her back. She said they do put positioning pillows under her. Staff P said she had never seen Resident #91 out of bed. She said every resident should have a wheelchair, but Resident #91 does not. Upon entering Resident #91's room the roommate asked Staff P to turn the temperature up in the room. Staff P was observed going to Resident #91 who was lying in the bed on her back. The CNA attempted to extend the 3rd digit on the resident's right hand from a closed fist. When she did, Resident #91 screamed out in pain and an unpleasant odor was emitted from the resident's hand. The resident's fingers were unable to be extended out without the resident crying out in pain. Staff P said the aides are not able to get a washcloth in the resident's hand to clean it. An interview was conducted on 9/9/24 at 10:06 a.m. with Staff O, CNA. She said she regularly cares for Resident #91 on the day shift, on weekdays. Staff O said when she turned the resident, the resident would say she was in pain and screamed out. Staff O said she was the CNA that provided showers/bed baths to Resident #91. She said, to be honest, I don't really do nail. I can't see very well. She added she did not want to clip the resident's skin and hurt her. Staff O said Resident #91 does not have a wheelchair, and she stays in her bed all the time. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A follow-up interview and observation on 9/9/24 at 12:19 p.m. was conducted with Staff O, CNA with Staff Q, CNA assisting. Staff O was observed trying to move Resident #91's fingers, the resident grimaced and moaned in pain. Staff O said she can not clean under the resident's finger, she just tried to get cream under them. Staff Q was surprised the resident had nothing for her hands and said she needs a carrot. Resident #91 had pressure relieving boots on bilateral feet, the CNA was observed removing the boots and a strong odor was present. The plantar aspect (soles) of the resident's bilateral feet were dry, cracked and skin sloughed off onto the bed when the boots were removed. Both feet were in a dorsiflexed position (backward bending) and had significant edema (swelling) that was non-blanchable to the CNA's touch. Resident #91 also had an open area of the posterior (calf) side of her right lower leg that had no dressing. According to Pisces Health a carrot hand contracture orthosis kit painlessly positions the fingers away from the palm to protect the skin from excessive moisture, pressure, and the risk of nail puncture injuries while helping to prevent bacteria build up and unpleasant odors. (Accessed on 9/16/24 at https://www.pisceshealth.com/original-carrot-blue-one-size) An interview was conducted on 9/9/24 at 9:41 a.m. with Staff G, LPN. She said Resident #91 did not really ask for things and if you asked her a question, she could not give a definite answer. Staff G said she believed the resident had a wheelchair, but she doesn't know where the CNAs put it. She said the resident does scream out in pain and would still scream out in pain after she took Tylenol but not as bad as when she had no medication for pain. Staff G said Resident #91 did not have any palm guards or splints. An interview was conducted on 9/9/24 at 10:29 a.m. with the Wound Care Nurse. She said Resident #91 gets blisters on her skin from moisture. She said the resident's roommate like the air conditioning off and Resident #91 sweats a lot. Staff G heard staff were working on changing roommate, but she did not know where that stood. The Wound Care Nurse said Resident #91 cried out when she was turned or moved. She said she felt like the resident was a little fearful and anticipates turning, and she yells out. The Wound Care Nurse said the resident had contractures on both arms that caused her pain, and she believed the resident only had Tylenol to take for the pain. An interview was conducted on 9/9/24 at 12:23 p.m. with the Director of Nursing (DON). She reviewed Resident #91's record and said she had not been seen by pain management or podiatry, only her primary care provider had seen her. An interview was conducted on 9/9/24 at 2:44 p.m. with the Social Services Director (SSD) and Social Services Assistant (SSA). They both said they knew Resident #91's roommate wanted a room change because of the temperature differences between the two, but no one told them about Resident #91 having issues with sweating and that causing problems. The SSD and SSA said they did not know Resident #91 or the family wanted a room change. They also said they had not spoken to the family regarding any wheelchair or special chair for the resident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of an OT evaluation for Resident #91, dated 4/5/24 showed, Patient demonstrates poor rehab potential at this time. Patient presents with BUE [bilateral upper extremity] multiple deformities secondary to her medical condition and extremely painful upon movement. The evaluation noted the resident had a pain level of 4 out of 10 at rest and an 8 out of 10 with movement. The pain with movement was described as gnawing and excruciating. It showed the pain limited the resident's functional abilities. The resident was not reviewed for OT again until 5/20/24 at re-admission after a hospital stay. Again, no skilled OT intervention was indicated. A pain level of 8 out of 10 on movement was noted and described as heavy, sharp, stabbing, and shooting. Review of a PT evaluation dated 4/5/24 showed Resident #91 demonstrated impaired cognition and extremely low activity tolerance when very limited passive range of motion (PROM) was provided on B (bilateral) knee. It showed the resident was not an appropriate candidate for skilled therapy. The evaluation noted Resident #91 had a pain level of 10 out of 10 with movement and it limited her functional activity. It showed pain interventions were unknown. The resident was not reviewed for PT again until 5/20/24 at re-admission after a hospital stay. Again, no skilled PT intervention was indicated. A pain level of 9 out of 10 on movement was noted. The impressions showed While therapist very slowly slightly moved pt's [patient's] LE [lower extremity] to perform PROM on B knees/B hips: pt screamed and asked to stop. An interview was conducted on 9/9/24 at 11:49 a.m. with the Director of Rehabilitation (DOR) and the Director of Operations for Rehab. The DOR said every resident admitted gets scheduled for an OT, PT and speech therapy (ST) evaluation. She said it is not often they do not pick up a new admission for therapy services. She said if a resident cannot tolerate the therapy evaluations, they would communicate with nursing and do the evaluations at a later time. The DOR said if a resident cannot tolerate touch, they discuss with nursing to see what medication the resident could possibly take. The modalities the therapy department had available to address pain include electrical stimulation (ESTIM), ultrasound, and diathermy. The DOR said they try to screen all resident's quarterly for therapy, and anytime nursing puts in a referral for a therapy screen. The DOR reviewed Resident #91's medical record. She said in April when they did the therapy screen, the resident could not tolerate passive range of motion. She said therapy should have communicated with nursing to see if there was anything going on medication wise and that would have been documented. The DOR confirmed there was no documentation of therapy communicating with nursing regarding Resident #91's pain. She said she did not see anything in the medical record that would contradict the modalities the therapy department had to address pain and those would have been a plausible program to trial with Resident #91. After reviewing the medical record, she said Resident #91 did not get screened at her quarterly review, only on admission in April 2024 and re-admission in May 2024. She stated, I cannot tell you why she wasn't screened on the quarterly unless something didn't trigger it. The DOR said without the therapy screens, therapy would not know the resident needed contracture management. She said nursing could also put in a referral for contracture management, and therapy had not received any referrals for this resident. The DOR said at the time of the therapy evaluations the resident could not tolerate any range of motion therefore, she was not evaluated for a wheelchair. She said Resident #91 would have probably received a high back or broda chair. She said the resident did not have any chair and did not recall ever seeing the resident out of bed. She said during the therapy evaluation for Resident #91, the resident asked them to stop due to the pain. The DOR said there was no documentation that a conversation had taken place with nursing related to the resident's pain. The DOR said therapy could have tried something like splints or palm guards to see if the resident could tolerate anything. The DOR said nothing had been attempted with Resident #91 and contracture management was not addressed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 9/9/24 at 1:37 p.m. with Resident #91's primary care Nurse Practitioner (NP). The NP said when she has seen Resident #91, the resident was typically lying still and not in pain. She said she had tried to talk to the nurses but did not get a lot of information from them. She said no one communicated to her the resident was having pain with movement or that she had pain during her therapy screen and was not getting therapy. The NP said she was under the assumption the resident had been getting PT and nursing did not tell her the resident was not. The NP said on June 20, 2024, she assessed the resident, and a family member was present. The family member mentioned that having only Tylenol was not enough to help the resident. The NP said she ordered Tramadol at that time. The NP reviewed Resident #91's medical record. In her system she was able to see the Tramadol had been ordered; however, it never showed up in the facility's system. The NP reviewed the facility's system and confirmed the Tramadol was not in the system as an active, completed, or discontinued order and the Medication Administration Record (MAR) did not show the resident had been administered Tramadol. The NP said she doesn't know what went wrong because the two systems crossed over. Review of Resident #91's progress notes showed the following: 6/20/24 Provider note from the primary care NP The family member reported she has complained of pain and is unsure that Tylenol is helping. The plan showed Continue to monitor for pain and provide pain relief with p.r.n. [as needed] Tylenol and restarted tramadol. Review of Resident #91's June 2024 physician orders showed Tylenol 325 mg x 2 tablets every 4 hours as needed for mild to moderate pain. There were no other orders related to pain control. Review of Resident #91's progress note also revealed a note dated 7/9/24 showing during a care plan meeting the resident's family member discussed wanting to see the resident out of bed in a chair 2-3 times a week. An interview was conducted on 9/9/24 at 3:25 p.m. with the DON. She said if Resident #91 was not able to do her therapy evaluations due to pain, it should have been reported to nursing so it could be passed along to the primary care provider. The DON said she had not been aware of the family having concerns about Resident #91's pain control in June 2024. She said she did not know what happened with the Tramadol order for the NP, and nurses do not review the doctor's notes. The DON said she was not aware of anyone that reviewed the doctor's plan for the residents' unless the unit managers did. She said her expectation would have been for the nurses to have notified the physician and obtained orders for pain medication and pain management to see the resident, if it was appropriate. The DON said it was not acceptable for Resident #91 to scream in pain when she was changed. She said the resident cannot tolerate being out of bed due to the fact she cannot be moved because of her discomfort. The DON said staff had not tried to get the resident out of bed because therapy couldn't complete the evaluation, and she had not been screened for a wheelchair. The DON said she was not a part of the care plan meeting in July 2024 and did not know there was a discussion with the family about wanting the resident out of bed 2-3 times a week. The DON reported the CNAs should be trimming Resident #91's fingernails when they do baths. She also said nursing could have put in a podiatry consult or a provider could have put it in. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A follow-up interview was conducted on 9/10/24 at 2:38 p.m. with Resident #91. The resident was lying in bed. She said when she moved her pain level was usually 8 out of 10. When asked about being moved from the bed to shower chair she said, that didn't feel good. Review of a facility policy titled Abuse, Neglect, Exploitation, and Misappropriation, revised September 2023, showed the following: Policy: the center recognizes each resident's right to be free from abuse, neglect, and exploitation (ANE), misappropriation of resident property. This includes, but it is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. This includes the centers identification of residents whose personal histories render them at risk for abusing other residents, and development of intervention strategies to prevent occurrences, observing for changes that would trigger abusive behavior, reassessment of the interventions on a regular basis. The center will not employ or otherwise engage individuals who have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; having a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property or have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, misappropriation of property or mistreatment. This center reports suspicions of crimes committed against a resident of this center in accordance with section 1150B of the Social Security Act to at least one law enforcement agency and the State Survey Agency . Neglect Neglect as defined in statute 483.5 is the failure of the center, its team members or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This occurs when the center was aware of or should have been aware of goods or services that the resident(s) required but the center failed to provide them resulting in or may result in physical harm, pain, mental anguish or emotional distress. This does not mean that all services must be provided by the center but that the center is responsible to ensure that the resident receives the necessary/required services. Goods and services fall into categories. Those categories are structures and processes and individual . Review of a facility procedure, dated 07/2023, titled Nail Care (Fingernails) showed: Purpose: To prevent infection and promote healthy fingernails. 16. Provide nail care according to guest/resident preferences and need. 17. Notify the physician of any changes or concerns with nails or surrounding skin.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on record review and interview, the facility failed to complete accurate Preadmission Screening and Resident Review (PASRR) forms for four (Resident #15, #19, #24 and #59) of 38 sampled residents. Findings included: 1. Review of the Admission Record showed Resident #19 was admitted on [DATE] with diagnoses to include Major Depressive Disorder and Dementia. Review of Resident #19's PASRR Level I Screen, dated 08/26/2024 Section I, A did not mark the diagnosis of Depressive Disorder. Section II, #7 was not marked for the diagnosis of Dementia. 46234 2. Review of the Admission Record showed Resident #15 was admitted on [DATE] and readmitted on [DATE] with diagnoses including post-traumatic stress disorder, bipolar disorder, unspecified dementia, major depressive disorder, and unspecified mood (affective) disorder. Review of Resident #15's PASRR Level I Screen, dated 6/5/24, indicated anxiety disorder, bipolar disorder, and depressive disorder. Section II, #7 indicated No to the question asking if the resident had dementia. 3. Review of the Admission Record showed Resident #59 was admitted on [DATE] and readmitted on [DATE] with diagnoses including anxiety disorder, major depressive disorder, and adjustment disorder with mixed anxiety and depressed mood. Review of Resident #59's PASRR Level I Screen, dated 6/15/22, did not indicate any mental illness or suspected mental illness. No updated PASRR was present in the resident's medical record. 49497 4. Review of the Admission Record showed Resident #24 had a primary admission diagnosis of unspecified dementia of unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Review of Resident #24's most recent Minimum Data Set (MDS) assessment dated [DATE] for a significant change revealed the resident was most recently readmitted to the facility on [DATE]. The resident's Brief Interview for Mental Status (BIMS) score was 6 indicating severe cognitive impairment. The active diagnosis included dementia. Review of Resident #24's care plan revealed: (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A focus on cognition was initiated on 1/19/21 and revised on 6/20/24. The care plan showed the resident had impaired cognitive function/thought processes related to Dementia and Cerebral Vascular Accident (CVA) with interventions to include: Administer medications as ordered; Observe/document /report to Medical Doctor (MD) any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. A focus on behavior was initiated on 5/16/24 and most recently revised on 7/12/24. The care plan showed the resident had behavior issues related to a diagnosis of dementia. Resident at times has episodes of hollering, cursing through the halls. Resident has frequent episodes wandering into others rooms and requires to be redirected. History of rummaging and finding food, eating it, and risk of aspiration pneumonia with interventions to include: Medications as ordered and monitor for behaviors. Review of a PASRR dated 06/04/24 completed at a sister facility revealed page 3, question 5 was marked no for does the resident have a primary diagnosis of dementia. Interview was conducted on 09/10/24 at 12:47 PM with Staff T, Care Plan Specialist. She stated in the morning, she checks on any new admissions from the previous day and ensures their PASRR screenings are filled out correctly. She stated if the PASRR received from the hospital for the new admission is incorrect, she will complete a new PASRR for that resident. She stated she checks for any new diagnoses added to the residents' diagnoses list and will update PASRR with new diagnosis if appropriate. Staff T confirmed Resident #24's PASRR was incorrect due to question #5 being marked no as he has a primary diagnosis of dementia. She confirmed Resident #19's PASRR is incorrect because her diagnosis of depression was not marked as a mental illness. She confirmed Resident # 15's PASRR was incorrect due to incorrect information of no on question #7 when it should have been answered yes triggering a request for a Level II to be completed. She confirmed Resident #59's PASRR was incorrect as anxiety and major depressive disorder were not marked as a mental illness as required. On 09/09/24 at 3:35 p.m., the PASRR policy was requested. The Director of Nursing (DON) stated the facility does not have a PASRR policy.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Sun City	3850 Upper Creek Dr Sun City Center, FL 33573

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on observation, record review, and interview the facility failed to develop a care plan for splint management and impaired vision for two residents (#9 and #59) out of 38 sampled residents. Findings included: 1. On 09/07/24 at 1:00 p.m., Resident #9 was lying in bed with a cream-colored palm guard that laid on the bedside table. During an interview on 09/07/24 at 1:00 p.m. Resident # 9 stated I am supposed to wear it (referring to the palm guard) at all the times. Resident #9 stated staff took it off, and I cannot get it back on myself without help. On 09/08/24 at 10:03 a.m., the cream-colored palm guard laid on the bedside table while Resident #9 rested in bed. On 09/08/24 at 1:40 p.m., the cream-colored palm guard laid on the bedside table while Resident #9 watched television in bed. During an interview on 09/08/24 at 1:40 p.m. Resident #9 stated no one put the palm guard on me today. Review of the Admission Record showed Resident #9 was admitted to the facility in February of 2024 with diagnoses to include Diaphragmatic hernia without obstruction or gangrene, chronic pain syndrome, acquired absence of left leg above the knee, major depressive disorder, single episode and primary generalized osteoarthritis. A diagnosis of Contracture of the Right Hand was noted to have occurred during stay. Review of the Quarterly Minimal Data Set (MDS) dated [DATE] showed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 12, indicating mild cognitive impairment. The MDS showed functional limitation in range of motion to one side of the upper extremity. Review of the Order Summary Report showed a physician order for the resident to wear right hand palm protector at all times, off for hygiene. Effective 08/27/2024. Review of the Care Plan revealed no palm protector or splint management was noted. On 09/08/24 at 4:00 p.m., Resident #9 laid in bed with cream-colored palm guard that laid on the bedside table. Resident #9 gave permission to photograph his right hand with the contracture. On 09/09/24 at 9:03 a.m., Resident #9 laid in bed asleep, and the cream-colored palm protector laid in the bed down by Resident #9's legs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/09/24 at 3:33 p.m., the Director of Nursing (DON) stated staff would document an orthotic device or splint usage or refusal from the Kardex. The DON stated that if a Resident would refuse to wear a splint it would be expected the refusal to be documented in a progress note. The DON stated that with splint therapy a resident who was under therapy services would not be care planned; however, as soon as a resident was discharged from therapy with a physician order for splint management, the care plan would need to be developed for splint management. The DON stated it was expected that Resident #9's care plan would have been revised to show Resident #9's refusal of wearing the splint prior to today, if not being administered for refusals. During an interview on 09/09/24 at 4:34 p.m., the DON stated that the facility did not have a care plan policy as the facility only followed the Resident Assessment Instrument (RAI) manual. Photographic evidence was obtained. 46234 2. An observation and interview was conducted on 9/7/24 at 2:36 p.m. with Resident #59. She was observed feeling around her bedside table for her glasses. She asked if they were on the floor because she was unable to find them. She was able to feel around until finding them in a cup of miscellaneous items on her bedside table. The resident stated she had previously had multiple eye surgeries and cannot see very much. She had what appeared to be a facility newsletter in front of her. She said she can't read that or menus and staff do not help her. Review of the Admission Record showed Resident #59 had diagnoses to include type 2 diabetes mellitus, need for assistance with personal care and chronic kidney disease. Review of Resident #59's annual Minimum Data Set (MDS) dated [DATE] revealed moderately impaired vision with no corrective lenses used, and a BIMS score of 15, indicating cognitively intact. Review of Resident #59's care plan revealed no focus area or interventions in place related to vision loss. An interview was conducted on 9/10/24 at 10:05 a.m. with Staff L, Licensed Practical Nurse (LPN). She stated Resident #59 had vision issues and wore glasses. She said the resident does okay with her glasses, but she had never seen her read. An interview was conducted on 9/10/24 at 11:36 a.m. with the MDS Coordinator. She reviewed Resident #59's medical record and confirmed the resident did have vision loss and there was no care plan currently in place. She said a vision care plan had been put in place on 2/22/23 but had been marked as resolved. An interview was conducted on 9/10/24 at 2:15 p.m. with the Regional Reimbursement Specialist. She reviewed Resident #59's medical record and stated the resident's vision care plan was marked as resolved in April 2023. She said the care plan was updated on 9/10/24 and now showed it was initiated on 2/22/23 and revised on 9/10/24.

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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** 41015 Based on observation, interview, and record review the facility failed to ensure one resident (#9) out of four residents reviewed for orthotic devices received physician ordered splint management for prevention and worsening of a contracture. Findings included: On 09/07/24 at 1:00 p.m. Resident #9 laid in bed with a cream-colored palm guard on the bedside table. During an interview on 09/07/24 at 1:00 p.m., Resident # 9 stated I am supposed to wear the palm guard at all the times. Resident #9 stated staff took it off, and I cannot get it back on myself without help. On 09/08/24 at 10:03 a.m., the cream-colored palm guard laid on the bedside table while Resident #9 rested in bed. On 09/08/24 at 1:40 p.m., the cream-colored palm guard laid on the bedside table while Resident #9 watched television in bed. During an interview on 09/08/24 at 1:40 p.m., Resident # 9 stated no one had put the palm guard on me today. Review of the Admission Record showed Resident #9 was admitted to the facility in February 2024 with diagnoses that included Diaphragmatic hernia without obstruction or gangrene, chronic pain syndrome, acquired absence of left leg above the knee, major depressive disorder, single episode and primary generalized osteoarthritis. A diagnosis of Contracture of the Right Hand was noted to have occurred during stay. Review of the Quarterly Minimal Data Set (MDS) dated [DATE] showed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 12 (mildly impaired). Review of the Order Summary Report showed a physician order Patient to wear right hand palm protector at all times, off for hygiene Effective 08/27/2024. Review of the August 2024 and September 2024 Medication Administration Record (MAR) showed no palm protector or splint management noted. Review of the August 2024 and September 2024 Treatment Administration Record (MAR) showed no palm protector or splint management noted. Review of the Care Plan revealed no palm protector or splint management noted. (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 Progress Notes on 09/08/24 at 3:42 p.m., revealed no documentation of a palm protector or splint management noted. Review of the Tasks tab on the electronic medical record showed Right hand palm protector at all times off for hygiene with No progress noted found. On 09/08/24 at 4:00 p.m., Resident #9 laid in bed with the cream-colored palm guard on the bedside table. Resident #9 gave permission to take a picture of his right hand with contracture. On 09/09/24 at 9:03 a.m., Resident #9 laid in bed asleep, and the cream-colored palm protector was in the bed down by Resident #9's legs. During an interview on 09/09/24 at 9:22 a.m., Staff B, Registered Nurse (RN) stated Resident #9 had an orthotic device called a carrot splint that he used daily, and therapy sees him daily to ensure he was using it. During an interview on 09/09/24 at 9:34 a.m., Staff C, Certified Nursing Assistant (CNA) stated Resident #9 used a carrot splint daily. Staff C, CNA stated she knew Resident #9 used the carrot splint daily because Resident #9 would put on his call light when he dropped it and asked for staff to pick it up so he could put it back in his hand again. Staff C, CNA stated Resident #9 used his carrot splint regularly. During an interview on 09/09/24 at 9:40 a.m., Staff D, Certified Occupational Therapist Assistant (COTA) stated that she worked with Resident #9 for about four weeks with his right-hand contracture because Resident #9's nails were embedded into his palms. Staff D, COTA stated Resident #9 was just discharged from occupational therapy about two weeks ago. Staff D, COTA stated she worked closely with the Nurse Practitioner, and it was decided the palm guard would be more beneficial to Resident #9 than the carrot splint. Staff D, COTA stated because Resident #9's nails were embedded in his palms it was decided Resident #9 would best be appropriate to always wear a palm guard except for hygiene time. During an interview on 09/09/24 at 9:50 a.m., Staff B, Registered Nurse (RN) walked into Resident #9's room to show how Resident #9 used the carrot. Staff B, RN looked around Resident #9's room and then stated, Oh, he doesn't have a carrot; he has a palm guard. Staff B, RN stated, if you see his hand is so tight with the contracture, you can't get the palm guard on. Review of the Occupational Therapy Treatment Encounter Notes showed the following: A Summary of Skill note dated 07/31/24 showed, Patient presents with multiple medical condition including Right Upper Extremity (RUE) contractures. Patient is being referred for skilled [Occupational Therapy] O.T. intervention secondary to re-assessment and recommendation of Right-hand orthotic device. Patient used to utilize Right hand carrot orthotic device applied and monitored by the patient. Patient has discontinued to utilize the orthotic device which increase the risk of further contracture development and skin risk breakdown in right hand. Patient will benefit with re-assessment and recommendation of Right-hand orthotic device. A Summary of Skill note dated 08/07/24 showed, Cleaning and gentle stretching of right hand by trail of palm protector. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Summary of Skill note dated 08/12/24 showed, Application of palm protector with good tolerance. A Summary of Skill note dated 08/22/24 showed, Soaking hand in warm soapy water followed by stretching and continued cleaning, increased ability to cut and file nails with nurse practitioner present and happy with progression. Palm protector added with good tolerance. Discussed wearing schedule. A Summary of Skill note dated 08/27/24 showed, Therapist applied manual therapy in association with gentle soft tissue mobilization to Right hand in order to facilitate application of palm guard orthotic device. Review of the Occupational Therapy Discharge Summary dated 08/27/24 showed, Patient and Caregiver Training: Instructed patient and primary caregivers in splinting/orthotic schedule in order to decrease the risk of skin breakdown and further contracture development. Patient and Caregiver Training: Therapist educated the patient and caregiver for donning/doffing of palm protector. Progress and Responses to Treatment: Patient made consistent progress throughout [Plan of Treatment] POT. During an interview on 09/09/24 at 2:04 p.m., Resident #9 stated that he had never refused his palm guard until today because when they tried to open his hand, it hurt. Resident #9 stated I cannot put the palm guard on myself however, staff had not been putting the palm guard on. During an interview on 09/09/24 at 3:33 p.m., the Director of Nursing (DON) stated staff would document an orthotic device or splint usage or refusal from the Kardex. The DON stated that if a Resident would refuse to wear a splint it would be expected the refusal to be documented in a progress note. The DON stated that with splint therapy a resident who was under therapy services would not be care planned; however, as soon as a resident was discharged from therapy with a physician order for splint management, the care plan would need to be developed for splint management. The DON stated it was expected that Resident #9's care plan would have been revised to show Resident #9's refusal of wearing the splint prior to today, if not being administered for refusals. During an interview on 09/09/24 at 4:34 p.m., the DON stated that the facility did not have a care plan policy as the facility only followed the Resident Assessment Instrument (RAI) manual. Review of the facility's policy Restorative Functional Maintenance Nursing Program revised date 05/2022 showed Restorative nursing programming refers to a formal nursing program which includes interventions that serve to assist the resident in restoring or attaining the ability to love as independently and as safely as possible. The programming focuses on achieving optimal, physical, mental and psychosocial functioning. Nursing/restorative/functional programming may include. but is not limited to: - Active and/or passive range of motion - Splint or brace assistance Photographic evidence was obtained.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 46234 Based on observations, interviews, and record review the facility failed to ensure pain was managed for one resident (#91) out of three residents reviewed for pain out of a total sample of 38 residents. Findings included: On 9/7/24 at 3:31 p.m., Resident #91 lying in bed with bilateral upper extremities contracted. No palm guards or splints were observed on the resident or in the room. No wheelchair or seating system was observed in the room. Her fingernails extended approximately 1/2 inch past the tips of her fingers with debris underneath. The resident stated she didn't know if the staff could clip her nails, but she would like them shorter. (Photographic evidence obtained with resident consent). On 9/8/24 at 1:44 p.m., Resident #91 was lying flat in her bed with a left tilt. The resident was quiet while lying still. When she attempted to move her right hand and arm, she screamed out. The resident said she was in pain and needed something. When asked if she had any splints, guards, or anything for her contracted hands, she said she did not but would like something to help. The resident would not volunteer information but would answer questions if directly asked. An interview was conducted on 9/8/24 at 2:13 p.m. with a family member of Resident #91. The family member said when Resident #91 was admitted her left hand was contracted and now both hands and feet are. The family member stated Resident #91 only had a couple days of therapy when she was first admitted , and the therapist said there was no sense in giving the resident therapy. The family member said they were concerned about the resident having sores, that the wound care nurse said were related to the resident sweating a lot. The family member said she didn't know why the resident's nails were not being cared for; they were long and dirty. The family member said social services told her they were getting a special chair that has a high back and reclines, but the resident was always in bed on her back. The family member said they had never seen Resident #91 in a different position. The family member said Resident #91 can get confused and will not speak up, but if she is asked something, she will answer. A follow-up interview was conducted on 9/10/24 at 2:38 p.m. with Resident #91. The resident was lying in bed. She said when she moved her pain level was usually 8 out of 10. When asked about being moved from the bed to shower chair she said, that didn't feel good. Review of the Admission Record showed Resident #91 was admitted in April of 2024 with diagnoses to include nontraumatic intracerebral hemorrhage, moyamoya disease, adult failure to thrive, unspecified dementia moderate without behavioral/psychotic/or mood disturbance, contracture of muscle right and left lower leg, and type II diabetes mellitus. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #91's Minimum Data Set (MDS) assessment for a significant change, dated 7/15/24, showed a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS showed the resident had upper and lower extremity impairment on both sides and was dependent on a helper for activities of daily living (ADL's). The assessment showed in the last 5 days (7/10/24 to 7/15/24) the resident was not on a scheduled pain medication regimen, had not received PRN (as needed) pain medication, and non-medication intervention for pain was provided. The pain assessment interview was conducted with the resident, but she was marked as unable to answer yes or no to pain presence. The staff assessment for pain or possible pain during the last 5 days (7/10/24 to 7/15/24) revealed none of the following had been observed or documented for Resident #91: non-verbal sounds of pain (crying, whining, gasping, moaning or groaning), vocal complaints of pain, facial expressions of pain, or protective body movements or posture. The assessment showed physical therapy (PT) was started and ended on 5/21/24 and occupational therapy (OT) started and ended on 5/20/24. Review of Resident #91's care plan showed a focus area of potential for pain related to stage III pressure ulcer (resolved on 7/11/24) and contractures of left and right lower extremities. Initiated on 7/2/24 and revised on 9/9/24. Interventions included administer and monitor for effectiveness and for possible side effects of pain medication, consultation as needed for PT, OT, mental health, make a referral to resident's physician to consider pre-medicating for pain prior to treatments to optimize participation, notify the resident's physician if they do not state/demonstrate relief or reduction of pain after one hour of receiving the first intervention, observe and report to nurse: signs and symptoms of pain, worsening of pain, observe for non-verbal behavior cues of pain, and report changes in pain location/type frequency/intensity to physician. There is no mention of the contractures of the left and right upper extremities. An interview was conducted on 9/8/24 at 1:46 p.m. with Staff L, Licensed Practical Nurse (LPN). The nurse was informed Resident #91 yelled out, and vocalized she was in pain, and had requested something to help. Staff L said all the resident had ordered was Tylenol, and she didn't know if it would help. She said Resident #91 yelling out when she moved is her norm [normal]. Review of Resident #91's physician orders showed an active order for Tylenol 325 mg x 2 tablets every 4 hours as needed for mild to moderate pain. No other medications were ordered for pain control. There was an order dated 4/4/24 for a Pain Management consult as needed. An interview was conducted on 9/8/24 at 3:07 p.m. with Staff P, Certified Nursing Assistant (CNA). She said Resident #91 normally screams anytime she was moved. She said when the resident was changed, the resident screams. When the CNAs roll her one way she screams when they roll her back. She said they do put positioning pillows under her. Staff P said she had never seen Resident #91 out of bed. She said every resident should have a wheelchair, but Resident #91 does not. Staff P was observed going to Resident #91 who was lying in the bed on her back. The CNA attempted to extend the 3rd digit on the resident's right hand from a closed fist. When she did, Resident #91 screamed out in pain and an unpleasant odor was emitted from the resident's hand. The resident's fingers were unable to be extended out without the resident crying out in pain. Staff P said the aides are not able to get a washcloth in the resident's hand to clean it. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 9/9/24 at 10:06 a.m. with Staff O, CNA. She said she regularly cares for Resident #91 on the day shift, on weekdays. Staff O said when she turned the resident, the resident would say she was in pain and screamed out. Staff O said she was the CNA that provided showers/bed baths to Resident #91. She said, to be honest, I don't really do nail. I can't see very well. She added she did not want to clip the resident's skin and hurt her. Staff O said Resident #91 does not have a wheelchair, and she stays in her bed all the time. A follow-up interview and observation on 9/9/24 at 12:19 p.m. was conducted with Staff O, CNA with Staff Q, CNA assisting. Staff O was observed trying to move Resident #91's fingers, the resident grimaced and moaned in pain. Staff O said she can not clean under the resident's finger, she just tried to get cream under them. Staff Q was surprised the resident had nothing for her hands and said she needs a carrot. Resident #91 had pressure relieving boots on bilateral feet, the CNA was observed removing the boots. The plantar aspect (soles) of the resident's bilateral feet were dry, cracked and skin sloughed off onto the bed when the boots were removed. Both feet were in a dorsiflexed position (backward bending) and had significant edema (swelling) that was non-blanchable to the CNA's touch. Resident #91 also had an open area of the posterior (calf) side of her right lower leg that had no dressing. According to Pisces Health a carrot hand contracture orthosis kit painlessly positions the fingers away from the palm to protect the skin from excessive moisture, pressure, and the risk of nail puncture injuries while helping to prevent bacteria build up and unpleasant odors. (Accessed on 9/16/24 at https://www.pisceshealth.com/original-carrot-blue-one-size) An interview was conducted on 9/9/24 at 9:41 a.m. with Staff G, LPN. She said Resident #91 did not really ask for things and if you asked her a question she couldn't give a definite answer. Staff G said she believed the resident had a wheelchair, but she doesn't know where the CNAs put it. She said the resident does scream out in pain and would still scream out in pain after she took Tylenol but not as bad as when she had nothing. Staff G said Resident #91 did not have any palm guards or splints. An interview was conducted on 9/9/24 at 10:29 a.m. with the Wound Care Nurse. She said Resident #91 gets blisters on her skin from moisture. She said the resident's roommate like the air conditioning off and Resident #91 sweats a lot. The Wound Care Nurse said Resident #91 cried out when she was turned or moved. She said she felt like the resident was a little fearful and anticipates turning, and she yells out. The Wound Care Nurse said the resident had contractures on both arms that caused her pain, and she believed the resident only had Tylenol to take for the pain. An interview was conducted on 9/9/24 at 12:23 p.m. with the Director of Nursing (DON). She reviewed Resident #91's record and confirmed the resident she had not been seen by pain management. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of an OT evaluation for Resident #91, dated 4/5/24 showed, Patient demonstrates poor rehab potential at this time. Patient presents with BUE [bilateral upper extremity] multiple deformities secondary to her medical condition and extremely painful upon movement. The evaluation noted the resident had a pain level of 4 out of 10 at rest and an 8 out of 10 with movement. The pain with movement was described as gnawing and excruciating. It showed the pain limited the resident's functional abilities. The resident was not reviewed for OT again until 5/20/24 at re-admission after a hospital stay. Again, no skilled OT intervention was indicated. A pain level of 8 out of 10 on movement was noted and described as heavy, sharp, stabbing, and shooting. Review of a PT evaluation dated 4/5/24 showed Resident #91 demonstrated impaired cognition and extremely low activity tolerance when very limited passive range of motion (PROM) was provided on B (bilateral) knee. It showed the resident was not an appropriate candidate for skilled therapy. The evaluation noted Resident #91 had a pain level of 10 out of 10 with movement, and it limited her functional activity. It showed pain interventions were unknown. The resident was not reviewed for PT again until 5/20/24 at re-admission after a hospital stay. Again, no skilled PT intervention was indicated. A pain level of 9 out of 10 on movement was noted. The impressions showed While therapist very slowly slightly moved pt's [patient's] LE [lower extremity] to perform PROM on B knees/B hips: pt [patient] screamed and asked to stop. An interview was conducted on 9/9/24 at 11:49 a.m. with the Director of Rehabilitation (DOR) and the Director of Operations for Rehab. The DOR said if a resident cannot tolerate the therapy evaluations, they would communicate with nursing and do the evaluations at a later time. The DOR said if a resident cannot tolerate touch, they discuss with nursing to see what medication the resident could possibly take. The modalities the therapy department had available to address pain included electrical stimulation (ESTIM), ultrasound, and diathermy. The DOR said they try to screen all resident's quarterly for therapy and anytime nursing puts in a referral for a therapy screening. The DOR reviewed Resident #91's medical record. She said in April when they did the therapy screen, the resident could not tolerate passive range of motion. She said therapy should have communicated with nursing to see if there was anything going on medication wise and that would have been documented. The DOR confirmed there was no documentation of therapy communicating with nursing regarding Resident #91's pain. She said she did not see anything in the medical record that would contradict the modalities the therapy department had to address pain and those would have been a plausible program to trial with Resident #91. After reviewing the medical record, she said Resident #91 did not get screened at her quarterly review, only on admission in April 2024 and re-admission in May 2024. She stated, I cannot tell you why she wasn't screened on the quarterly unless something didn't trigger it. The DOR said without the therapy screens, therapy would not know the resident needed contracture management. She said nursing can put in a referral for contracture management, and therapy had not received any referrals for Resident #91. The DOR said at the time of the therapy evaluations the resident could not tolerate any range of motion therefore she was not evaluated for a wheelchair. She said Resident #91 would have probably gotten a high back or broda chair. She said the resident did not have any chair, and she did not recall ever seeing her out of bed. She said during the therapy evaluation for Resident #91, the resident asked them to stop due to the pain. The DOR said there was no documentation that a conversation had taken place with nursing related to the resident's pain. The DOR said therapy could have tried something like splints or palm guards to see if the resident could tolerate anything. The DOR said nothing had been attempted with Resident #91 and contracture management was not addressed. (continued on next page)

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	105736	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Sun City	3850 Upper Creek Dr Sun City Center, FL 33573

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/9/24 at 1:37 p.m. with Resident #91's primary care Nurse Practitioner (NP) it was revealed that when she sees Resident #91, the resident was typically lying still and not in pain. The NP said she had tried to talk to the nurses but did not get a lot of information from them. She said no one communicated to her the resident was having pain with movement or that she had pain during her therapy screen and was not getting therapy. The NP said she was under the assumption the resident had been getting PT and nursing did not tell her the resident was not. The NP said on June 20, 2024, she assessed the resident, and a family member was present. The family member mentioned that having only Tylenol was not enough to help the resident. The NP said she ordered Tramadol at that time. The NP reviewed Resident #91's medical record. In the NP's electronic record system she was able to see the Tramadol had been ordered; however, it never showed up in the facility's electronic system. The NP reviewed the facility's system and confirmed the Tramadol was not in the system as an active, completed, or discontinued order and the Medication Administration Record (MAR) did not show the resident had been administered Tramadol. The NP said she doesn't know what went wrong because the two systems cross over one another. Review of Resident #91's 6/20/24 provider note from the primary care NP revealed the family member reported she [Resident #91] has complained of pain and is unsure that Tylenol is helping. The plan showed Continue to monitor for pain and provide pain relief with p.r.n. [as needed] Tylenol and restarted tramadol. Review of Resident #91's June 2024 physician orders showed Tylenol 325 mg x 2 tablets every 4 hours as needed for mild to moderate pain. There were no other orders related to pain control. Review of Resident #91's progress note also revealed a note dated 7/9/24 showing during a care plan meeting the resident's family member discussed wanting to see the resident out of bed in a chair 2-3 times a week. An interview was conducted on 9/9/24 at 3:25 p.m. with the DON. She said if Resident #91 was not able to do her therapy evaluations due to pain, it should have been reported to nursing so it could be passed along to the primary care provider. The DON said she had not been aware of the family having concerns about Resident #91's pain control in June 2024. She said she did not know what happened with the Tramadol order for the NP, and nurses do not review the doctor's notes. The DON said she was not aware of anyone that reviewed the doctor's plan for the residents' unless the unit managers did. She said her expectation would have been for the nurses to have notified the physician and obtained orders for pain medication and pain management to see the resident, if it was appropriate. The DON said it was not acceptable for Resident #91 to scream in pain when she was changed. She said the resident cannot tolerate being out of bed due to the fact she cannot be moved because of her discomfort. The DON said staff had not tried to get the resident out of bed because therapy couldn't complete the evaluation, and she had not been screened for a wheelchair. The DON said she was not a part of the care plan meeting in July 2024 and did not know there was a discussion with the family about wanting the resident out of bed 2-3 times a week. The DON reported the CNAs should be trimming Resident #91's fingernails when they do baths. She also said nursing could have put in a podiatry consult or a provider could have put it in. Review of a facility policy titled Pain assessment and Management, dated 1/1/20, showed the following: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Recognition and Management of Pain- in order to help a resident attain or maintain his or her highest practicable level of well-being and to prevent or manage pain, the facility, to the extent possible: -Recognizes when the resident is experiencing pain and identify circumstances when pain can be anticipated. -Evaluate the existing pain on a scale from 0-10 with 10 being the worst. -Manages or prevents pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. Strategies for the prevention and management of pain may include but are not limited to the following: -Assessing the potential for pain, recognizing the onset, presence and duration of pain, and assessing the characteristics of pain; -Addressing/treating the underlying causes of the pain, to the extent possible; -Developing and implementing both non-pharmacological and pharmacological interventions/approaches to pain management, depending on factors such as whether the pain is episodic, continuous, or both; -Identifying and using specific strategies for preventing or minimizing different levels or sources of pain or pain-related symptoms based on the resident-specific assessment, preferences and choices, a pertinent clinical rationale, and the resident's goals and; using pain medications judiciously to balance the resident's desired level of pain relief with the avoidance of unacceptable adverse consequences; -Monitoring appropriately for effectiveness and/or adverse consequences (e.g., constipation, sedation) including defining how and when to monitor the resident's symptoms and degree of pain relief; and -Modifying the approaches, as necessary. -Identifying target signs and symptoms (including verbal reports and nonverbal indicators from the resident) and using standardized assessment tools can help the interdisciplinary team evaluate the resident's pain and responses to interventions and determine whether the care plan should be revised,: -If pain has not been adequately controlled, it may be necessary to reconsider the current approaches and revise or supplement them as indicated; or -if pain has resolved or there is no longer an indication or need for pain medication, the facility works with the practitioner to discontinue or taper (as needed to prevent withdrawal symptoms) analgesics.

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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** 46234 Based on observation, interview, and record review the facility did not ensure medications were stored properly on two out of three units and in three out of three medication carts. Findings included: On 9/7/24 at 10:49 a.m., pills in a medication cup were on the bedside table in room [ROOM NUMBER] D. On 9/7/24 at 10:56 a.m., a pill in a medication cup was on the bedside table in room [ROOM NUMBER]. An interview was conducted on 9/8/24 at 9:19 a.m. with Staff R, Registered Nurse (RN). Staff R confirmed she was assigned to room [ROOM NUMBER] and 165 on 9/7/24. She said nurses should stay with the resident until they swallow of their medication. She said the pills in the room on 9/7/24 must have got by me. An audit and interview was conducted on 9/10/24 at 9:42 a.m. of a west unit medication cart with Staff L, Licensed Practical Nurse (LPN). The medication cart drawers contained a total of 4 loose pills. One drawer contained a bottle of Acetaminophen suppository's that expired in June of 2024 and a bottle of Ibuprofen 200 mg that expired in July 2024. One drawer had a blood pressure and pulse oximeter stored with medication. Staff L confirmed the two medications were expired and said they should not be in the cart. She said night shift is supposed to clean out the cart and ensure there are no expired medications or loose pills in the cart. An audit and interview was conducted on 9/10/24 at 10:48 a.m. of the 300-unit medication cart with Staff S, LPN. The medication cart drawer contained a total of 4 loose pills. One drawer contained a bottle Cetirizine 10 mg with no expiration date on the bottle and a bottle of Ibuprofen 200 mg that expired July 2024. Staff S confirmed there was no expiration date on the Cetirizine and said it must have torn off. She also confirmed the Ibuprofen was expired. In the bottom of the medication cart there was a half full bubble pack of Gabapentin for a resident that the nurse said was discharged and an insulin pen for a current resident with multiple syringes. The top drawer contained a pulse oximeter being stored in the drawer with medication. Staff S said there shouldn't be expired or loose medication in the cart. She said on Friday the nurses are supposed to clean the carts. An audit and interview was conducted on 9/10/24 on 10:21 a.m. on an east unit medication cart with Staff B, RN. The top drawer of the cart contained a pulse oximeter being stored with medication. Under the drawer contained debris, multiple lancets, and some crushed medication. One drawer contained medication along with a gait belt, tape, thermometer, pens and other miscellaneous items. Staff B stated night shift should have cleaned the medication cart. 48223 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/8/24 at 9:20 a.m., two pills (one oblong white and one round brownish) were on the floor in the doorway of room [ROOM NUMBER]. An interview was conducted with the Infection Preventionist (IP) on 9/8/24 at 9:21 a.m. The IP confirmed the pills were on the floor and did not know why they would be on the floor. On 9/8/24 at 9:30 a.m., an oblong white pill was on the floor in the middle of the hallway between rooms [ROOM NUMBERS]. An interview was conducted with the Infection Preventionist (IP) on 9/8/24 at 9:34 a.m. The IP confirmed the pill on the floor and stated it should not be. An interview was conducted on 9/10/24 at 12:02 p.m. with the Director of Nursing (DON). The DON had not been made aware of medication storage issues. She said medication should not be left at the bedside unless a resident was approved to self-administer medication. She confirmed the residents in room [ROOM NUMBER] and 165 were not approved to self-administer medication. The DON also stated there should be no loose or expired medication in the medication carts or on the floor. Photographic evidence was obtained. Review of the facility's Policy and Procedure for Storage and Expiration Dating of Medications and Biologicals dated 8/1/24 showed: Procedure: . 2. Facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, refrigerators/freezers of sufficient size to prevent crowding . 10. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier . 12. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged, or missing labels or cautionary instructions . 21. Facility should ensure that medications and biologicals for expired or discharged or hospitalized residents are stored separately, away from use, until destroyed or returned to the provider. 22. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with pharmacy return/destruction guidelines and other applicable law, and in accordance with Policy 8.2 (Disposal/Destruction of Expired or Discontinued Medications) .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49497 Based on observations, record review, and interview, the facility failed to provide a well-balanced special diet for one of two residents (Resident # 25) reviewed for special diets. Findings included: On 09/07/24 at 12:34 p.m., Resident #25's lunch tray revealed the resident was on a vegetarian diet, prefers fish, and was on a select menu. A select menu allows the resident to select/checkmark in advance the items they want served from the meal options offered. On 09/10/24 at 12:45 p.m., Resident #25's lunch tray was observed. The select menu sheet on the meal tray had a checkmark with blue ink for seasoned pasta. Interview with Resident #25 during the observation confirmed the blue checkmarks and handwriting was completed by the resident. The seasoned pasta selected by the resident had a black ink line through it/striking out the item selected. The resident confirmed the black ink markings were done by facility staff. No seasoned pasta was observed on the tray, and a review of the meal options offered revealed no options for protein were present. The meal options offered included: Vegetarian gravy, seasoned pasta (struck through), peas and pearl onions, bread or roll with butter, chocolate bottom key lime dessert, and choice of beverage. In black ink stuffing was handwritten in under the residents choices selected. Review of Resident #25's active physician orders revealed an order for vegetarian diet, regular texture, thin fluid consistency with an original order date of 5/19/23. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15. Review of a care plan last reviewed on 07/18/24 revealed a nutrition focus of Resident is at nutritional risk R/T [related to] diagnoses of Rheumatoid Arthritis; Restrictive Therapeutic diet: Vegetarian diet. Interventions included: Serve diet as ordered. Review of menu selection sheets for 09/15/24 through 09/21/24 provided to Resident #25 to mark her meal choices showed no protein options were offered for lunch and dinner meals. An interview was conducted on 09/07/24 at 2:52 p.m. with Resident #25. She stated there were limited options as a vegetarian for meals. She said she was often hungry after the meal provided was eaten and had to rely on snacks and food her family provided to get full. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Follow-up interview on 09/09/24 at 1:05 p.m. with Resident #25 revealed she was still hungry after eating today's lunch meal. She stated she will have to ask staff to heat up soup that her family brought. She stated she has to do this often as she doesn't get enough to eat, especially for lunch and dinner meals. She stated she was not offered many options, just vegetables. The resident said she eats fish, and it was rarely offered. Resident #25 presented her meal selection ticket options for the upcoming dinner on 09/15/24. It showed her food options for dinner were roasted beet salad and fruit filled oatmeal bar. She stated, this is not enough. The resident had handwritten on the 9/15/24 selection sheet tuna fish sandwich on croissant double portion. The resident stated, that was the regular menu option for 9/15/24, but it was not provided on her selection ticket. An interview was conducted on 09/09/24 at 1:33 p.m. with Staff E, Senior Director of Culinary Operations. She stated her expectation was for all residents to receive a nutritious well-balanced meal that consists of, at a minimum, a protein, a carbohydrate, a vegetable, and a fruit or dessert. She stated meals are tailored to the resident's preference and physician ordered diet. She reported an expectation for a vegetation diet to always be offered a protein, carbohydrate and vegetable along with fruit or dessert, again tailored to resident preferences. After review of Resident #25's tray card revealed her choice of seasoned pasta that she had marked as her preference for lunch was marked out with black marker and provided stuffing, peas and pearls for her lunch meal on 09/09/24. She stated Resident #25 should have been served the seasoned pasta or a pasta alternate. She stated the food options provided on the selection menu for Resident #25 did not include a protein when a meat was provided on the regular menu for the week of 09/15/24 through 09/21/24. She stated she should always have a protein offered for her to choose. She stated only having two vegetable options and no protein was not acceptable. She stated she would correct the selection menu to add a protein option, provide the resident with an always available vegetarian option list, and educate her staff. Photographic evidence was obtained.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41015 Based on observation, interview, and record review the facility failed to ensure dietary staff were wearing hair nets, temperature logs were completed, and food items were labeled, dated, and stored according to professional standards for food safety services in one of one kitchen, one of one dining room, one of two nourishment rooms, and one of one activity room. Findings included: On 09/07/24 at 9:07 a.m., Staff A, Dietary Aide (DA) had no hairnet on while in the kitchen area. Immediate interview with Staff A, Dietary Aide (DA) revealed staff are required to wear hairnets while in the kitchen area. I just forgot to put a hairnet on this morning. On 09/07/24 at 9:11 a.m., a box of bananas was stored on the floor in the dry storage area. On 09/07/24 at 9:16 a.m., the walk-in refrigerator had: three bags of green leafy vegetables and three bags of green beans that were not labeled or dated, and two food items that had other food items stored on top of them breaking the seal and exposing the food items. On 09/07/24 at 9:24 a.m., a Refrigerator and Freezer Temperature Log hanging on the reach-in refrigerator of the dining room was not completed with multiple missing dates. The dates with no temperatures logged were 09/01/24, 09/02/24, 09/03/24, 09/05/24, and 09/06/24. On 09/07/24 at 9:30 a.m., the Activity Room reach-in refrigerator contained a bag of food items from a local restaurant that was not labeled or dated. The Record of Refrigeration Temperatures hanging on the front of the Activity Room reach-in had not been completed on 09/06/24. On 09/07/24 at 9:35 a.m., the 300 hallway nourishment room had a reach-in refrigerator that contained an orange solid food item that was not labeled or dated, and the Nourishment Refrigerator Temperature Monitor form was incomplete for 09/06/24. Further observation of the 300 hallway nourishment room revealed two gallon sized bags filled with packets of brown sugar, and one gallon sized bag filled with creamers not labeled or dated. Photographic evidence was obtained. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 09/09/24 at 12:06 p.m., Staff F, Certified Dietary Manager (CDM) stated all food items should be labeled or dated in the kitchen area and in all nourishment rooms. Staff F, CDM stated that food items should be properly sealed to keep from getting contaminated when stored. Staff F, CDM stated the practice of throwing food items on top of other food items breaking the seal for storage should not be happening. Staff F, CDM provided a copy of the Refrigerator and Freezer Temperature Log from the reach-in refrigerator in the dining room, which was completed. Staff F, CDM was shown photographic evidence of the dining room Refrigerator and Freezer Temperature Log from 09/07/24. Staff F, CDM stated completion of a temperature log for multiple days after not completing the log daily was not ethical. Staff F, CDM stated that someone must have completed the dining room reach-in refrigerator temperature log for the multiple dates, which was not what was expected because that could lead to documentation of inaccurate temperatures. Staff F, CDM stated all temperature logs for the cold food items should be completed daily. Staff F, CDM confirmed any food items, including bananas, stored on the floor was inappropriate. Review of the facility's policy Food Labeling and Dating-Refrigeration dated 2024 showed, Purpose: The center adheres to a labeling and dating system to ensure the safety of ready-to-eat, time/temperature control for food safety . Policy Explanation and Compliance Guidelines for Staffing: 2. The food shall be stored covered, marked for contents, and dated when placed in the refrigerator or freezer. Review of the facility's policy Food Labeling and Dating- Dry Storage dated 2024 showed, Food shall be stored in a manner to prevent bacterial growth, contamination and be easily identified. Procedures: 5. All food should be stored off the floor and away from walls. Review of the facility's policy Monitoring Cooler/Freezer Temperature dated 2024 showed Purpose: It is the policy of this center to maintain temperatures of coolers and freezers at the appropriate temperature to promote food safety. This policy also addressed refrigerated storage. Policy Explanation and Compliance Guidelines: 1. Logs for recording temperatures for each refrigerator or freezer will be posted in a visible location outside the freezer or refrigerator unit. a. Temperatures will be checked and logged at least twice per day by designated team members. Review of the facility's policy Resident Personal Food revised date 01/2018 showed, Policy: All residents have the right for family members and visitors to provide preferred or requested foods and fluids from outside of the facility, except where the health and safety of the individual or other residents would be endangered. Procedure: 2. Labeled and dated perishable items may be stored under refrigeration in the nursing unit consistent with standard food storage.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observation, interview, and record review the facility did not ensure proper infection control practices in two out of three units related to incorrect transmission-based precaution signs, lack of hand hygiene during tray pass, improper storage of respiratory masks, and improper personal protective equipment (PPE) usage. Findings included: On 9/7/24 at 10:56 a.m., a respiratory mask sitting on a bedside table uncovered for Resident #210. The mask remained uncovered throughout the day on 9/7/24 and 9/8/24. On 9/7/24 at 12:09 p.m., a respiratory mask sitting out uncovered in room [ROOM NUMBER]. The mask remained uncovered throughout the day on 9/7/24 and 9/8/24. On 9/7/24 at 11:03 a.m. and 9/8/24 at 1:42 p.m., Resident #210's room had no isolation precaution signage posted. On 9/9/24 at 2:29 p.m., a contact precautions sign was present on Resident #210's door. Review of the Admission Record showed Resident #210 was admitted on [DATE] with diagnoses including pulmonary disease, breast cancer, liver cancer, anal cancer, and lung cancer. Review of Resident #210's physician orders showed a stool sample for enteric pathogen PCR related to loose stools was ordered on 9/6/24 to start on 9/7/24. The resident was not placed on isolation precautions at that time. On 9/9/24 the previous order was discontinued and re-entered as a new order for a stool sample for enteric pathogen PCR related to loose stools. An order for isolation precautions was put in on 9/8/24 with a start date of 9/9/24. An interview was conducted on 9/10/24 at 11:34 a.m. with the facility's Infection Preventionist (IP). She reviewed Resident #210's medical record and stated enteric contact precautions should have been put in place for the resident as soon as the first order for the stool sample was entered. On 9/7/24 at 12:36 p.m., lunch trays were passed on the 100 unit. Two of the Certified Nursing Assistants (CNAs) passing lunch trays were not performing hand hygiene between delivering and setting up each resident's tray. Staff U, CNA was entering Resident #15's room with no PPE on. The room had a contact precaution sign posted on the door. The CNA then exited the room without performing hand hygiene and proceeded to fix a cup of coffee for another resident, and enter that resident's room without performing hand hygiene. Review of the Admission Record showed Resident #15 was admitted to the facility in May 2024 and had a current diagnosis of a urinary tract infection (UTI). Review of Resident #15's orders showed a current antibiotic order for a UTI as well as an active order for Contact Precautions, dated 9/3/24. (continued on next page)

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	105736	A. Building B. Wing	09/10/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 9/7/24 at 1:01 p.m. with Staff U, CNA. When asked about wearing PPE to deliver a lunch tray to Resident #15 she said you did not have to wear PPE if you were just going to set the tray down. She confirmed Resident #15 has a contact precaution sign on the door. She then said staff should wear PPE to enter a contact precaution room, and maybe she forgot. Staff U confirmed hand hygiene should be performed between each resident room when passing lunch trays. Review of the Contact Precaution sign on the door of Resident #15 revealed: Everyone Must: clean hands with soap and water or sanitizer when leave the room. Cover mouth and nose with arm/tissues when coughing/sneezing. Doctors and Staff Must: Gown and glove if soiling likely. Wear mask and eye cover if splashing body fluids is likely. According to the Centers for Disease Control (CDC) and Prevention Contact Precautions is used for patients with known or suspected infections that represent an increased risk for contact transmission . Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. (Accessed on 9/12/24 at https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html) 48223 On 9/7/24 at 12:35 p.m., Resident #263's door had a sign posted that showed Stop, Contact Enteric Precautions, Families and Visitors follow Instructions from information sheet. If you have any questions go to the Nurse Stations. Everyone Must: Wash hands with soap and water when leaving room, Doctors and Staff: Gown and glove at door, use patient dedicated or disposable equipment, and clean and disinfect shared equipment. The bottom of the sign had the name of the facility and a date of 9/10/2021. On 9/7/24 at 12:455 p.m., Staff M, CNA entered Resident #263's room to deliver a meal tray, no PPE was donned. Staff M, CNA moved the resident's bed side table and set up the meal. Staff M, CNA exited the room and utilized the alcohol-based hand sanitizer (ABHS) on the wall. During an interview on 9/7/24 at 1:00 p.m., Staff M, CNA stated she did not have to wear PPE when entering Resident #263's room. Staff M, CNA stated, I follow what the sign says. Staff M was not sure why the resident was on isolation and stated maybe a wound, but nothing different was needed. On 9/9/24 at 10:24 a.m., Staff V, CNA was passing ice water to each room on Resident #263's hall. Staff V, CNA entered Resident #263's room with a new cup of ice water with a straw. Staff V, CNA placed the cup on the resident's bed table. Staff V, CNA then picked up the cup that was in the room and discarded the cup. Staff V, CNA exited the room and completed hand hygiene using ABHS. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/9/24 at 10:28 a.m., Staff V, CNA stated PPE was not needed when entering Resident #263's room due to not providing care and only hand sanitizer was needed. During an interview on 9/9/24 at 10:34 a.m., Staff G, Licensed Practical Nurse (LPN) stated Resident #263 was on precautions for Clostridium Difficile Colitis (C-diff), and Resident #263 required contact precautions. Staff G said staff can enter the room without PPE if they are not going to touch the resident. Staff G, LPN stated, contact precautions means staff only wear a gown when providing direct care to the resident. Staff G, LPN stated the Enhanced Barrier Precautions (EBP) was when you wear a gown. Oh wait, I'm confused. Maybe it is the other way around. Staff G, LPN stated with C-Diff you must utilize soap and water, not ABHS. Review of Resident #263's physician orders revealed an order placed on 9/3/24 for contact isolation for C-Diff and methicillin-resistant staphylococcus aureus (MRSA) bacteremia for 31 days. An interview was conducted with the Director of Nurses (DON) and the Infection Preventionist (IP) on 9/10/24 at 11:32 a.m. The IP stated Transmission Based Precautions were initiated when a known exposure or symptoms occurred and received an order from the physician. An isolation kit was then placed on the resident's room door for precautions. The IP continued, EBP are utilized for residents who have an indwelling device, wound, history of Multidrug-Resistant Organism (MDRO). EBP only require staff to utilize PPE with close/direct contact care, this would be gloves and gown (potentially face shield if employee feels the need). Contact Precautions was required for active infections. Contact precautions required a gown and gloves when entering the resident room for any reason. If a resident has the diagnosis of C-Diff this would be Contact Enteric, which means gown, gloves when entering the room and only the use of soap and water after removal of gloves. ABHS was not to be utilized. Observation of the signage on the door for Resident #263 was made with the IP and DON. The DON stated the sign on Resident #263's door, is worded quite differently. The DON stated we will have to look into the way the sign is worded, as EBP are being explained on the sign. The IP stated the signage utilized was what was here when she took over the position and not being aware if the signs were CDC guidelines. The IP confirmed the respiratory equipment should be stored in bags. She stated usually, the bags were hung on the concentrator or close to the machine. Review of the facility policy and procedure titled, Transmission Based Precautions dated December 2020 showed: Guidelines: Transmission based precautions are used when route of transmission is not completely interrupted using standard precautions alone and the pathogen may have multiple routes of transmission. Transmission based precautions are divided into: Contact precautions, Droplet precautions, and Airborne precautions. 1. Contact Precautions: wear PPE (Personal Protective Equipment) gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident environment. a. Use when micro-organisms are spread with direct or indirect contact with the resident or the resident's environment. b. Apply when excessive blood, wound drainage, bodily fluids or fecal incontinence are present and there is risk of transmission. Suspicion of communicable disease will have transmission-based precautions placed while awaiting lab test results. Residents will remain on appropriate precautions until the attending physician or infection preventionist recommends them discontinued. See Nurse Sign posting will be on resident rooms alerting health care workers (HCW), resident and visitors that they must see the nurse before entering room. The reverse side of the sign will note the type of precaution, method of acceptable hand disinfection and PPE to be utilized. The nurse will provide resident's specific precaution instructions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Photographic evidence was obtained.

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a Compliance and Ethics Program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on observation, interview, and record review the facility failed to ensure staff acted in an ethical manner related to the falsification of documentation presented for one of one dining room reach-in refrigerator temperature log and services documented for one (Resident #91) out of 38 sampled residents. Findings included: 1. On 09/07/24 at 9:24 a.m., a Refrigerator and Freezer Temperature Log hanging on the reach-in refrigerator of the dining room was not completed with multiple missing dates. The dates with no temperatures logged were 09/01/24, 09/02/24, 09/03/24, 09/05/24, and 09/06/24. An observation on 09/09/24 at 12:05 p.m., revealed the Refrigerator and Freezer Temperature Log hanging on the reach-in refrigerator in the dining room had been completed. Further observation showed two sections of the log titled Walk-in Refrigerator and Reach-in Refrigerator were completed for the dates of 09/01/24 through 09/06/24. Further review of the dining room's Refrigerator and Freezer Temperature Log dated 09/07/24 had a morning temperature documented for Walk in Refrigerator, Reach-in Refrigerator, and Walk-in Freezer sections of the log and 09/08/24 was blank. During an interview on 09/09/24 at 12:06 p.m., Staff F, Certified Dietary Manager (CDM) was shown photographic evidence of the dining room Refrigerator and Freezer Temperature Log from 09/07/24 which was incomplete and the same log which was now filled in and had additional information. Staff F, CDM stated completion of a temperature log for multiple days after not completing the log daily was not ethical. Staff F, CDM stated that someone must have completed the dining room reach-in refrigerator temperature log for the multiple dates, which was not what was expected because that could lead to documentation of inaccurate temperatures. Staff F, CDM stated all temperature logs for the cold food items should be completed daily. Staff F, CDM reported whoever unethically completed the temperatures for the multiple days got overzealous because they completed and documented temperatures in the sections for the walk-in refrigerator section too, which was not appropriate, because there was only a reach-in refrigerator located in the dining room. Review of the facility's policy Monitoring Cooler/Freezer Temperature dated 2024 showed Purpose: It is the policy of this center to maintain temperatures of coolers and freezers at the appropriate temperature to promote food safety. This policy also addresses refrigerated storage. Policy Explanation and Compliance Guidelines: 1. Logs for recording temperatures for each refrigerator or freezer will be posted in a visible location outside the freezer or refrigerator unit. a. Temperatures will be checked and logged at least twice per day by designated team members. 46234 2. Review of the Admission Record showed Resident #91 was admitted on [DATE] with diagnoses to include nontraumatic intracerebral hemorrhage, moyamoya disease, adult failure to thrive, dementia, moderate, contracture of muscle right and left lower leg, and type II diabetes mellitus. (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #91's Minimum Data Set (MDS) assessment for a significant change, dated 7/15/24, showed upper and lower extremity impairment on both sides, use of a manual wheelchair, and dependent on a helper for eating, hygiene, bathing, and dressing. Review of Task documentation by the Certified Nursing Assistants (CNAs) for Resident #91 showed the following: September 2024 Locomotion off the Unit Q (every) shift-documented as completed twice a day [DATE]st-[DATE]th Locomotion on the Unit Q shift-documented as completed twice a day [DATE]st-[DATE]th Transferring Q shift-documented as completed twice a day [DATE]st-[DATE]th. Walk in room Q shift-documented as completed twice a day [DATE]st-[DATE]th. August 2024 Chair/Bed-to-Chair transfer Q shift-documented as completed 14 times from [DATE]st-[DATE]th. Wheelchair /Scooter use Q shift-documented as completed 36 times from [DATE]st-[DATE]th. Wheel 150 ft. Q shift-documented as completed 13 times from [DATE]nd-[DATE]th. Transferring Q shift-documented as completed 12 times from [DATE]th- [DATE]st. An interview was conducted on 9/8/24 at 2:13 p.m. with a family member of Resident #91. The family member said social services told her they were getting a special chair that has a high back and reclines, but the resident was always in bed on her back. The family member said they had never seen Resident #91 in a different position. An interview was conducted on 9/8/24 at 3:07 p.m. with Staff P, CNA. Staff P said she had never seen Resident #91 out of bed. She said every resident should have a wheelchair, but Resident #91 does not. An interview was conducted on 9/9/24 at 10:06 a.m. with Staff O, CNA. She said she regularly cares for Resident #91 on weekdays during the day shift. Staff O said she was the CNA that provided showers/bed baths to Resident #91. Staff O said Resident #91 does not have a wheelchair and she stays in her bed all the time. She stated the resident only transfers when she had a shower, but she usually had bed baths. (continued on next page)

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