STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115020	A. Building B. Wing	03/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bell Minor Home, The	2200 Old Hamilton Place NE Gainesville, GA 30507

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's policy titled Change in a Resident's Condition or Status, the facility failed to ensure that two of 40 sampled residents (R) (R159 and R9), medical providers, and family were timely notified of a change in condition. R159's medical provider was not notified of any changes in the resident's condition, including the lack of pedal pulses. Additionally, R159's family was not made aware of the resident's condition from 8/28/2024 until 9/7/2024. On 9/7/2024, R159's family was concerned about the resident's condition and requested that the resident be transferred to the hospital; however, the facility denied the request. Additionally, on 5/15/2024, the facility identified a change in R9's diabetic foot ulcer; however, the facility did not notify the resident's wound practitioner, who was treating the wound, until 5/16/2024, when the resident was transferred to the hospital. In addition, the facility failed to notify R9's family of a wound that had been treated since 4/15/2024. R9's family did not become aware of the resident's wound until 5/16/2024, when the resident was emergently transferred to the hospital. These failures caused death to R159 and actual harm to R9. On 3/28/2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator and Regional Director of Clinical Operations (RDCO) were informed of the Immediate Jeopardy (IJ) for F580, F600, F658, F686, and F835 on 3/28/2025 at 6:27 pm. The facility was unable to provide an acceptable IJ Removal Plan before the survey team's exit on 3/30/2025, and the IJ remained ongoing. Findings included: (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's policy titled Change in a Resident's Condition or Status, revised February 2021, revealed .policy interpretation and implementation 1. The nurse will notify the resident's attending physician or physician on call when there has been a . d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; .g. need to transfer the resident to a hospital/treatment center . i. specific instruction to notify the physician of changes in the resident's condition . 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observation and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form . 5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status . 1. A review of the electronic medical record (EMR) revealed that R159 was admitted to the facility on [DATE] with diagnoses including, but not limited to, angioneurotic edema, diastolic congestive heart failure (CHF), deep vein thrombosis (DVT), hypercholesterolemia, and type 2 diabetes without complications. A review of R159's N [Nursing] Adv [Advanced] Skilled Evaluations dated 8/26/2024 revealed, Skin warm and pink with brisk capillary refill (< (less than) three seconds. No Edema present. A review of R159's N Adv Skilled Evaluation dated 8/27/2024 revealed, Skin warm and pink with brisk capillary refill (< three seconds). No edema present. A review of R159's Progress Note dated 8/28/2024 revealed, visit type: Acute . Pitting edema to BLE (bilateral lower extremities, bruising to the left foot. History of Present Illnesses .Staff concerned regarding worsening edema to BLE for the past 2-3 days, +2 to 3 pitting edema bilaterally. The patient spends most of the day in a wheelchair with feet down, and discussed with staff elevating the patient's feet to help with edema reduction as well. Bruise to the left foot that was noticed yesterday. Unsure how the bruise was acquired. Patient does not elicit a painful response to the bruised area .Skin/Breast-Positive: Swelling, Bruises .Bruise to [NAME] surface of left foot .Edema .Pitting, Edema in lower left extremities, Edema in lower right extremities . A review of the resident's progress notes prior to 8/28/2024 revealed no documented evidence that the resident's medical provider was notified of any edema or bruising to the resident's foot. A review of R159's Physician's Order dated 8/29/2024 revealed an order for Lasix oral tablet [a diuretic medication] 20 milligrams (MG) give one tablet by mouth one time a day for CHF/fluid retention. A review of R159's N Adv Skilled Evaluation dated 8/30/2024 revealed .Skin warm and pink with brisk capillary refill (< three seconds). No edema present . Calf tenderness is not present. Negative bilaterally for Homan's sign. Left pedal pulse: +2 normal. Right pedal pulse: +2 normal A review of R159's N Adv Skilled Evaluation dated 8/31/2024 revealed Pain: Indicators of pain: None . Cardiovascular: Skin warm and pink with brisk capillary refill (< 3 seconds). No edema present . Calf tenderness is not present. Left pedal pulse: absent. Right pedal pulse: Absent . Skin: Skin warm & dry, skin color WNL [within normal limits] and turgor is normal . The evaluation was completed by Licensed Practical Nurse (LPN) 1. There was no documented evidence that the resident's medical provider was notified of the resident not having pedal pulses. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R159's N Adv Skilled Evaluation dated 9/1/2024 revealed . Skin warm and pink with brisk capillary refill (< three seconds). No edema present . Calf tenderness is not present. Negative bilaterally for Homan's sign. Left pedal pulse: +2 normal. Right pedal pulse: +2 normal A review of R159's N Adv Skilled Evaluation dated 9/3/2024 revealed . Pain: Indicators of pain: None . Cardiovascular: Skin warm and pink with brisk capillary refill (< 3 seconds). No edema present . Calf tenderness is not present. Left pedal pulse: absent. Right pedal pulse: Absent . Skin: Skin warm & dry, skin color WNL, and turgor is normal . There was no documented evidence that the resident's medical provider was notified that pedal pulses were absent. A review of R159's Progress Notes dated 9/4/2024 revealed Visit Type: Acute . Chief complaint . follow up on medication changes. History of Present Illnesses . patient napping in wheelchair, arouses to verbal stimuli . continued pitting edema of BLE . staff deny any current concerns or complaints . Positive: pitting, edema in lower left extremities, edema in lower right extremities . Lasix 40 mg tablet: Administer 1 tablet PO Q Day [every day] for edema. The evaluation was completed by LPN1. A review of the EMR revealed no documentation that the medical provider was made aware of the lack of pedal pulses identified on 8/31/2024 and 9/3/2024. A review of R159's Encounter Note dated 9/7/2024 revealed, Telehealth-Asynchronous . Nurse reports resident has a fluid-filled blister on the back of the left calf. She has a history of cellulitis. Denies redness and swelling of the left calf. However, the family is requesting the resident be transferred to the ED [Emergency Department]. Request denied. Resident asymptomatic. Vital signs are stable. Augmentin 875 mg every 12 hours for seven days, ordered, and wound culture. Follow up with wound care and rounding provider. A review of R159's Telehealth Notes dated 9/7/2024 revealed Situation: bilateral edema to lower extremities and left leg weeping. C/O [complaints of] pain. The nurse was notified the patient was moaning really loudly. - Treatment: Tylenol 325 MG two tablets PO [by mouth] BID [twice a day] PRN [as needed] for pain x [times] five days. Keep the left leg clean and dry. Will schedule rounding provider. A review of R159's N Adv - Skin Only Evaluation dated 9/7/2024 revealed . Skin Issue: #001: New. Issue type: Open lesion . Location: left lower leg . Painful: Yes - constant pain. #002: New. Issue type: Open lesion . Location: Left foot . Painful: Yes - constant pain. Skin note: +4 [plus 4] edema with two closed blisters to the left lower leg, and one opened blister to the left foot. Review of the EMR revealed no documented evidence that the medical provider was made aware of the increase in edema from 2-3+ bilaterally on 8/28/2024 to 4+ to the left lower leg on 9/7/2024 despite the Lasix being increased to 40mg every day on 9/4/2024. A review of R159's Nurses Note dated 9/7/2024 revealed CNA made this writer aware that the resident has swelling to BLLE. Resident assessed: Right leg +2 edema, left leg +4 edema with blisters and weeping noted. Resident c/o pain to LLE. PRN medication administered. Resident being treated for edema as of 9/5/2024 with Lasix. A review of R159's Nurses Note dated 9/7/2024 revealed [Nurse Practitioner (NP) 2], notified. N/o [new order] PRN Tylenol 650 MG PRN BID for pain. And cleanse LLE with NNS [normal saline], pat dry, cover with ABD [abdominal], and wrap loosely QD [every day]. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R159's N Adv Skilled Evaluation dated 9/7/2024 revealed . Cardiovascular: Circulation check: Extremities are warm and pink. Capillary refill: Sluggish, less than 3 seconds. Edema Issue #001: No change. Location: Left Lower leg. +2 pitting. New onset edema: No, Edema is not dependent on positioning. #002: NO change. Location: left foot . Calf tenderness is not present. Negative bilaterally for Homan's sign. Left pedal pulse: +2 normal. Right pedal pulse: +2 normal . Skin note: has a skin irritation on top of left foot, blister to back of the left calf . A review of R159's Infection Note dated 9/7/2024 revealed culture taken from top of left foot wound, serous drainage noted. A review of R159's N Adv Skilled Evaluation dated 9/8/2024 revealed .Cardiovascular check: extremities are warm and pink . Edema issue #001: no change. Location: left lower leg. +2 pitting . #002: no change. Location: left foot . Calf tenderness is not present. Negative bilaterally for Homan's sign. Left pedal pulse: +2 normal. Right pedal pulse: +2 normal . A review of R159's Progress Note dated 9/9/2024 revealed R159 had discolored areas to the digits of the right lower extremity (RLE), and pulses were not palpable due to edema. The note also indicated that an ankle brachial index (ABI) was ordered. R159's Progress Notes dated 9/9/2024, revealed . patient is noted to be moving RLE, edema to BLE has improved. Weeping edema to the left lower extremity noted. The patient started on antibiotics over the weekend by an on-call provider for concerns of cellulitis. Discolored areas to RLE, pulses not palpable due to edema. Order ABI [ankle brachial index test compares blood pressures in the upper and lower limbs to diagnose and assess the severity of peripheral artery disease (PAD). A review of R159's Encounter dated 9/10/2024, revealed . was seen and examined for a leg condition that apparently evolved over the course of 24 hours. Nursing had reported a rash over her lower extremities, and she was being treated with antibiotics for cellulitis. Discussed patient's condition with her family on Monday, 9/9/2024. Family had some grievances regarding care . Ext RLE, LLE a few black areas on toes, and lateral/medial aspect of both feet, DP pulses unpalpable B/L . Imaging: Doppler result c/w arterial occlusion bilaterally . in view of patients chronic debility, h/o [history of] sepsis, gangrene on both extremities, and rapid decline, it was decided to send her to the ED immediately. Family was informed accordingly and expressed agreement. During an interview on 3/27/2025 at 12:36 pm, the Director of Nursing (DON) stated she expected the nurses to notify the physician anytime there was a change in a resident's condition. The DON also stated there were agency nurses working in the facility, and they received the same training as the full-time nurses, which included change of condition notification and documentation of a change in condition on the Situation Background Assessment Recommendation (SBAR) communication form in the EMR. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/26/2025 at 1:28 pm, Family Member (F) 159, when she visited R159 on 9/7/2024, she notified the nursing staff that R159 had a blister on the back of her calf. F159 also stated she requested that R159 be sent out to the hospital because nursing staff were not aware of the blister on the back of the resident's calf, and so the resident could be treated for cellulitis because she knew it could lead to gangrene. F159 stated R159 was sent to the hospital on 9/10/2024 around 1:30 pm after she had an occlusion in her legs and was pronounced dead at 9:13 pm. F159 indicated the death certificate noted the cause of death was from acute hypoxic respiratory failure due to sepsis, acute renal failure, tubular necrosis, septic shock, and atherosclerosis of the native arteries of the extremities of gangrene. During an interview on 3/27/2025 at 8:42 am, NP1 stated that when R159's pedal pulses were absent on 08/31/24, the nurses should have informed the on-call provider and sent the R159 to the hospital since there was no in-house laboratory or imaging at the facility. NP1 stated she was not working at the facility at the time but confirmed that not notifying the provider timely could have led to the residents' demise from not getting enough oxygen to the brain and circulation to the feet due to the occlusion in the lower extremities. During an interview on 3/27/2025 at 11:01 am, NP2 confirmed nursing staff notified her on 09/07/24 that R159 had drainage to the top of the foot, so she ordered an antibiotic to prevent infection. NP2 also stated that had she been notified on 8/31/2024 that R159 did not have palpable pedal pulses, she would have requested a more thorough assessment of the resident. NP2 further stated she would have ordered the resident to be the hospital for more aggressive treatment of the resident's condition to prevent the condition from worsening. The NP did not explain why she did not ask the nurse any other questions about the resident's foot. During an interview on 3/27/2025 at 1:47 pm, the incoming Medical Director stated it was his expectation the nursing staff would have informed the provider on 8/31/2024 and 9/3/2024 of R159's change in condition when the resident was without pedal pulses so that a more thorough assessment could have been conducted, or so the resident could have been sent to the hospital for treatment. During an interview on 3/28/2025 at 10:37 am, the outgoing Medical Director stated it was his expectation that NP3 would have honored the family's request to send R159 to the hospital. The continuing interview revealed as the facility's Medical Director, he was responsible for the residents' care in the facility; however, he needed the nursing staff to communicate changes in conditions to him. An interview was attempted with NP3 on 3/27/2025 at 10:52 am, 11:25 am, and 11:30 am, however, a message could not be left to return the phone call. An interview was attempted with LPN1 on 3/25/2025 at 3:11 pm, 3:15 pm, and 3:30 pm. Voicemail messages were left, however, LPN1 did not return the phone calls. 2. A review of R9's admission Record revealed he was admitted to the facility on [DATE] and had a hospital stay from 5/16/2024 to 5/23/2024. He had diagnoses which included diabetes and Alzheimer's disease on admission. A review of R9's quarterly MDS with an ARD of 5/9/2024 revealed R9 had a BIMS score of six out of 15, which indicated severe cognitive impairment. It failed to document any diabetic foot ulcer or treatment. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R9's Order Recap Report dated 4/12/2024 to 5/16/2024 revealed an order dated 4/15/2024 for betadine to the right lateral foot from 4/15/2024 to 4/22/2024, when another order was entered for betadine daily to the right lateral foot, which continued until R9 was hospitalized on [DATE]. A review of a Skin/Wound Note dated 4/18/2024 at 2:34 pm revealed R9 was seen for wound care management of a diabetic ulcer to his right lateral foot. Betadine was ordered for the treatment of the area. A review of an Evaluation and Management Report with date of service 4/18/2024 revealed a note written by a contracted wound Nurse Practitioner, NP5. NP5 documented the right foot wound as a diabetic ulcer, which measured 4 centimeters (cm) x 4.5cm x 0.2cm. The wound was 100% necrotic (dead) tissue. This was the first description of the wound since Betadine was ordered as the treatment on 4/15/2024. Further review of the EMR revealed Wound Progress Notes with dates of service by the wound Nurse Practitioner of 4/25/2024, 5/2/2024, and 5/9/2024. Measurements of the diabetic ulcer were: On 4/25/2024 4cm x 4.5cm x 0.2cm of black, necrotic tissue and mild serous drainage On 5/2/2024 3.8cm x 4.1cm x 0.2cm of dermis tissue and no drainage On 5/9/2024 3.8cm x 4.1cm x 0.2cm of black necrotic tissue with no drainage. A review of a Nurse's Note dated 5/15/2024 at 11:08 revealed that during wound care for the diabetic ulcer, LPN2 observed that the side of R9's right foot and right pinky toe were black and bruised. R9 denied pain and was unaware of how the bruising occurred. R9 was educated to keep the foot elevated and to stay off the foot as much as possible. Writer will notify Wound Care [Doctor] in AM [morning] of observations. UM [Unit Manager] and Nurse made aware of findings. A review of a Nurse's Note dated 5/16/2024 at 12:38 pm revealed R9 was seen by NP5. R9's had discoloration on his right foot and pinky toe with slight bleeding. An arterial and venous Doppler was completed on the right foot. A review of a Wound Progress Note dated 5/16/2024 and located in the Misc tab of the EMR revealed his diabetic ulcer had increased in size to 13cm x 10cm x 0.2cm. It had 40% necrotic tissue, was 60% was deep tissue injury (DTI). An arterial and venous Doppler was ordered, and the primary nurse practitioner (NP4) was notified. A review of a Progress Note by NP4 with date of service 5/16/2024 revealed NP4 was unable to palpate a pedal (top of foot), posterior tibial (behind the ankle bone), or popliteal (behind the knee) pulse in the right lower extremity. The right lateral foot had a black eschar, had slightly malodorous drainage, and underneath the foot felt boggy. NP4 notified R9's representative, Family Member (F)9, by phone, that the foot was suspected to be gangrene. NP4 recommended immediate transfer to the ER for further evaluation. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R9's hospital records for 5/16/2024 to 5/23/2024 revealed R9 had an incision and drainage (I&D) completed on 5/17/2024, which showed the wounds tracked to the bone in all areas with significant tissue loss of the right foot. On 5/20/2024, a right below-the-knee amputation was completed. R9 was diagnosed with gangrene of the right foot and necrotizing cellulitis. A review of a facility provided statement by LPN2 dated 5/21/2024 revealed she saw R9 on 5/15/2024 and noticed his toe was discolored and the diabetic ulcer site to the right of his foot increased in size, measuring 13cm x 10cm x 0.2cm. LPN2 notified the unit manager and charge nurse but did not notify a practitioner until she rounded with NP5 on 5/16/2024 of the increase in size and spreading of discoloration to the right foot. During an observation on 3/25/2025 at 1:10 pm, R9 sat on the edge of his bed eating lunch. His right leg was amputated below the knee. R9 was unable to answer questions related to his leg or foot wound. During an interview on 3/26/2025 at 2:00 pm, F9, listed as R9's responsible party in his EMR, reported that her first knowledge of the foot wound was when she received the phone call that he was going out to the ER on [DATE]. F9 had no idea how long he had had the wound and was not involved in his care for it before 5/16/2024. During an interview on 3/27/2025 at 12:42 pm, the DON stated LPN2 should have completed an SBAR form and then called the doctor on 5/15/2024 when the change in condition occurred. The DON expected the family to be notified immediately of any wound or change in a wound.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interviews, record review, and a review of the facility's policies titled Abuse Prevention Policy, Pressure Ulcer Treatment, and Prevention of Pressure Ulcers, the facility failed to ensure residents were free from abuse and neglect for three of six residents (R) (R159, R9, and R360) reviewed for abuse and neglect. (1) The facility neglected to emergently transfer R159 to the hospital per the family's request and failed to notify R159's physician after a change in condition, which resulted in a delay in treatment. (2) The facility failed to notify R9's wound treatment provider of the worsening of the resident's diabetic ulcer. (3) R360 was physically abused by her roommate (R46), who had a history of abusing other residents. These failures caused actual harm and death to the residents. On [DATE], R159 was emergently transferred to the hospital, where she expired from complications related to the facility's failure to notify the resident's physician of her change in condition. On [DATE], the facility failed to report the worsening of R9's diabetic ulcer, and on [DATE], the resident sustained a below-the-knee amputation. On [DATE], R360 was a victim of abuse when R46 had wrapped a call light cord around R360's neck and then tied the call light cord to the bedrail. On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator and Regional Director of Clinical Operations (RDCO) were informed of the Immediate Jeopardy (IJ) for F580, F600, F658, F686, and F835 on [DATE] at 6:27 pm. The facility was unable to provide an acceptable IJ Removal Plan before the survey team's exit on [DATE], and the IJ remained ongoing. Findings included: A review of the facility's policy titled Abuse Prevention Policy, reviewed [DATE], revealed, It is the responsibility of all staff to provide a safe environment for the residents. Resident care and treatments shall be monitored by all staff on an ongoing basis so that residents are free from abuse, neglect, or mistreatment. Care will be monitored so that the resident's care plan is followed. Examples of ways to protect a resident from harm during an investigation of abuse, neglect and exploitation may include but are not limited to: a) Temporary (less than 24 hours) separation from other residents if a resident's behavior poses a threat of abuse or violence b) Temporary or permanent room or roommate change, where incompatibility creates the potential for abuse (follow change of room or roommate procedures) c) Safeguard valuables in a locked area (provide receipts to resident) d) involve family members to sit with resident e) Temporary one on one supervision of a resident f) Engage a resident in diversionary activities g) Reassignment of nursing staff duties h) Time off for nursing staff i) involve clergy, social services and counselors, as appropriate . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's Pressure Ulcer Treatment policy dated [DATE] revealed that the staff, Measure wound weekly, to include a. Current measurements of the wound(s); b. Current visual stage(s) of the wound(s); c. Any drainage, odor, progress, or decline of wound(s). All pressure ulcers and other wounds should be listed weekly in the medical record. A review of the facility's Prevention of Pressure Ulcers policy dated [DATE] revealed that Any residents with wounds will be documented on the Weekly Wound Information Sheet. Weekly documentation should include: 1. Current measurements of the wound; 2. Current visual stage of the wound(s); 3. Any drainage, odor, progress, or decline of the wound; 4. Current treatment regimen: 5. Pain; 6. Wound bed; 7. Description of wound and surrounding tissue. 1. A review of the electronic medical record (EMR) revealed that R159 was admitted to the facility on [DATE] with diagnoses including angioneurotic edema, diastolic congestive heart failure (CHF), deep vein thrombosis (DVT), hypercholesterolemia, and type 2 diabetes without complications. A review of R159's Progress Note dated [DATE] revealed R159 had pitting edema to the bilateral lower extremities (BLE) and a bruised area to the left foot. A review of R159's N [Nursing] Adv [Advanced] Skilled Evaluation dated [DATE] and [DATE] revealed R159 did not have palpable pedal pulses. A continued review of the evaluation revealed that there was no documented evidence of nursing intervention or that R159's physician was notified. The evaluation was completed by Licensed Practical Nurse (LPN) 1. A review of R159's Encounter Note dated [DATE] revealed the nurse reported R159 had a fluid-filled blister on the back of her left calf. R159's family requested R159 be transferred to the ED (emergency department) for treatment, which was denied by Nurse Practitioner (NP) 3. A review of R159's Progress Note dated [DATE] revealed R159 had discolored areas to the digits of the right lower extremity (RLE), and pedal pulses were not palpable due to edema. The note also indicated that an ankle brachial index (ABI) was ordered. However, there was no documented evidence that the resident's medical provider was notified that the resident was without pedal pulses. A review of R159's Encounter note dated [DATE] revealed that a few black areas were on the toes, and the lateral/medial aspect of both feet, pulses were unpalpable, and the Doppler imaging results were consistent with arterial occlusion bilaterally. The outgoing Medical Director was notified, and R159 was emergently transferred to the hospital. During an interview on [DATE] at 6:43 pm, the RDCO stated the facility's policy was to try to provide treatment to residents, but ultimately, the family decided to send the resident to the hospital. The RDCO also stated that NP3 should have sent R159 to the hospital as requested on [DATE]. During an interview on [DATE] at 12:36 pm, the Director of Nursing (DON) stated she expected the nurses to notify the physician when there was a change in the resident's condition to prevent the worsening of R159's skin condition. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:28 pm, F159 stated that on [DATE], she notified the nursing staff that R159 had a blister on the back of her calf. F159 indicated she asked the nursing staff and NP3 to send the R159 to the hospital because the nursing staff was not aware of the blister and was not receiving any treatment for the blister, but NP3 denied the request because she stated the resident could be taken care of at the facility. During an interview on [DATE] at 8:42 am, NP1 stated she expected the nursing staff to inform her when residents had a change in condition. NP1 also stated that when R159's pedal pulses were absent on [DATE], the nurses should have informed the on-call provider and sent the R159 to the hospital since there wasn't an in-house laboratory or imaging at the facility. During an interview on [DATE] at 11:01 am, NP2 confirmed nursing staff notified her on [DATE] that R159 had drainage to the top of the foot; however, the nursing staff did not report any other changes, which indicated worsening of the resident's foot. NP2 also stated that she would have requested a more thorough assessment of the resident and then sent her to the hospital for more aggressive treatment of the resident if she had been notified that R159 did not have palpable pedal pulses on [DATE] and [DATE]. During an interview on [DATE] at 1:47 pm, the incoming Medical Director stated he expected the nursing staff to be a medical provider on [DATE] when R159 had a change in condition when she was without pedal pulses. The incoming Medical Director also stated that the resident should have been sent to the hospital, where aggressive treatment could have been provided to prevent sepsis and gangrene of the resident's foot. During an interview on [DATE] at 10:37 am, the outgoing Medical Director stated he expected NP3 to honor the family's request to send R159 to the hospital. The Medical Director explained that he was responsible for residents' care in the facility, but to do that, he needed the nursing staff to communicate with him when residents had changes in their conditions. 2. A review of R9's EMR revealed he was admitted to the facility on [DATE] and had a hospital stay from [DATE] to [DATE]. He had diagnoses which included diabetes and Alzheimer's disease on admission. A review of R9's Order Recap Report dated [DATE] to [DATE] revealed an order dated [DATE] for betadine to the right lateral foot from [DATE] to [DATE], when another order was entered for betadine daily to the right lateral foot, which continued until R9 was hospitalized on [DATE]. The order dated [DATE] was written by a nurse and signed by the resident's physician. A review of an undated statement written by LPN 11 revealed that she was notified on [DATE] that R9 had a wound on the right lateral side of his foot. It was approximately three to four inches in length. It had hard eschar, black in color and dry. It was pink around the outside of the area. I cleaned it with normal saline, patted it dry, and painted it with betadine per facility protocol, and it was left open to air. He had pedal pulses, it was not hot to the touch. Arrangements that the wound care provider (NP5) to see the resident the next day. Cross Reference: F580 Notification. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a Skin/Wound Note dated [DATE] revealed R9 was seen for wound care management of a diabetic ulcer to his right lateral foot. Betadine was ordered for the treatment of the area. This was the first note written related to the wound being seen and assessed by a medical provider, three days after the wound was identified by nursing. A review of an Evaluation and Management Report with date of service [DATE] revealed R9 was seen by a contracted wound Nurse Practitioner, NP5. NP5 documented the right foot wound as a diabetic ulcer, which measured 4 centimeters (cm) x 4.5cm x 0.2cm. The wound was 100% necrotic tissue. Further review of the Misc tab revealed Wound Progress Notes with the following dates of service: * [DATE] Measurements of the diabetic ulcer were 4cm x 4.5cm x 0.2cm of black, necrotic tissue and mild serous drainage. * [DATE] measurements were 3.8cm x 4.1cm x 0.2cm of dermis tissue and no drainage. * [DATE] measurements were 3.8cm x 4.1cm x 0.2cm of black necrotic tissue with no drainage. In all three reports, the NP5 documented that R9's heels were not floated, nor were the heel suspension boots used, and for the facility to: Monitor patient for any clinical signs and symptoms of infection or any further skin breakdown. Notify myself or the PCP [primary care provider] of any changes. Make sure the patient is being turned and repositioned frequently to help with wound healing and to help prevent any further skin breakdown. On [DATE], NP5 added that he Educated treatment staff to use heel boots to relieve pressure to the heels and will aid in wound healing. This can also relieve pain from constant pressure. On [DATE], NP5 also instructed the resident not to apply any pressure to the wound area as this may cause further skin breakdown. A review of the Orders, Progress Notes, Care Plan, and Tasks tabs of the EMR revealed no order or documentation that heel boots or turning and repositioning were implemented. A review of R9's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of [DATE] revealed R9 had a Brief Interview of Mental Status (BIMS) score of six out of 15, which indicated severe cognitive impairment. It failed to document any diabetic foot ulcer or treatment. R9 needed partial/moderate assistance to roll and substantial/maximal assistance to transfer. A review of a Physician's Progress Note dated [DATE] revealed the physician saw R9 after staff reported he was not eating, was withdrawn, and was refusing medications. R9 stated he was not sick. Staff were directed to check labs if symptoms persisted, monitor closely, and provide wound care. The note did not document the observation of the wound by the physician. A review of a Nurse's Note dated [DATE] at 6:13 pm revealed the physician had been notified that R9 refused most of his meals over the weekend, refused his blood sugar check that morning, as well as his scheduled medications and insulin. The note further documented that the resident spent a lot of his day in bed, covered with a sheet; that he covers his head with a sheet; noted a jerking movement, and had a strange affect; and altered mental issues. There was no mention of the wound on R9's foot in this progress note. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a Nurse's Note dated [DATE] at 11:08 am revealed that during wound care for the diabetic ulcer, LPN2 observed that the side of R9's right foot and right pinky toe were black and bruised. R9 denied pain and was unaware of how the bruising occurred. R9 was educated to keep the foot elevated and to stay off the foot as much as possible. Writer will notify Wound Care [Doctor] in [morning] of observations. UM [Unit Manager] and Nurse made aware of findings. The note did not give wound measurements or a description/assessment to include any drainage, or if pedal pulses were palpable. Cross Reference: F580 Notification. A review of a Nurse's Note dated [DATE] at 12:38 pm revealed R9 was seen by NP5. R9's had discoloration on his right foot and pinky toe with slight bleeding. An arterial and venous Doppler was completed on the right foot. The Doppler results were not available prior to the resident being transferred to the hospital. A review of a Wound Progress Note dated [DATE] revealed his diabetic ulcer had increased in size to 13cm x 10cm x 0.2cm. It had 40% necrotic tissue, was 60% was deep tissue injury (DTI). An arterial and venous Doppler was ordered, and the primary nurse practitioner (NP4) was notified. A review of a Dietary Note on [DATE] at 1:01 pm revealed the Registered Dietitian noted a significant weight loss for one and six months. No pressure sores notes. No changes. There was no indication that the dietitian was made aware of the wound, and no supplements for wound healing were ordered. A call was made to the dietitian for an interview, with no response. A review of a Progress Note by NP4 with date of service [DATE] revealed NP4 was unable to palpate a pedal (top of foot), posterior tibial (behind ankle bone), or popliteal (behind the knee) pulse in the right lower extremity. The right lateral foot had a black eschar, had slightly malodorous drainage, and underneath the foot felt boggy. NP4 notified R9's representative, Family Member (F)9, by phone that the foot was suspected to be gangrene. NP4 recommended immediate transfer to the ER (emergency room) for further evaluation. A review of R9's hospital records for [DATE] to [DATE] revealed R9 had an incision and drainage (I&D) completed on [DATE], which showed the wounds tracked to the bone in all areas with significant tissue loss of the right foot. On [DATE], a right below-the-knee amputation was completed. R9 was diagnosed with gangrene of the right foot and necrotizing cellulitis. A review of R9's Care Plan revealed that a focus area was not added to R9's Care Plan for the diabetic ulcer until [DATE], after R9 was discharged to the hospital with gangrene. Interventions dated [DATE] included seeing a wound provider and monitoring/documenting the wound weekly, as well as ensuring appropriate protective devices are applied to affected areas and reporting symptoms of infection. It did not include avoiding pressure to the wound area, turning and positioning frequently, or using heel boots. No pressure-relieving interventions were implemented, even though recommended by the wound NP5. The area was resolved on [DATE] when R9 returned from the hospital with a right below-the-knee amputation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a facility provided statement by LPN2 dated [DATE] revealed she saw R9 on [DATE] and noticed his toe was discolored and the diabetic ulcer site to the right of his foot increased in size, measuring 13cm x 10cm x 0.2cm. LPN2 notified the unit manager and charge nurse. On [DATE], LPN2 rounded with NP5 and informed him of the increase in size and spreading of discoloration to the right foot. Measurement was 13cm x 10cm x 0.2cm. NP5 ordered an arterial and venous Doppler of the right leg. During an observation on [DATE] at 1:10 pm, R9 sat on the edge of his bed eating lunch. His right leg was amputated below the knee. R9 was unable to answer questions related to his leg or foot wound. During an interview on [DATE] at 9:40 am, the Assistant DON stated the wound care provider made general recommendations when he rounded, such as floating heels, heel booties, turning every two hours, and applying an air mattress, and the facility followed them. The recommendations made for R9 were expected to be in his Care Plan. Assistant DON transcribed the measurements of R9's wound from NP5 to the Initial and Weekly Skin Assessments but did not recall that she visualized or assessed the wound. During an interview on [DATE] at 12:42 pm, the DON expected interventions to be in place, ordered, and care-planned to prevent further breakdown. The physician was unavailable for interview during the survey despite attempts to reach him via telephone. 3. A review of R46's EMR revealed R46 was admitted to the facility on [DATE] with multiple diagnoses of Alzheimer's Disease, dementia with behavioral disturbances, major depressive disorder, and generalized anxiety disorder. A review of R46's quarterly MDS assessment with an ARD of [DATE] revealed R46 had a BIMS score of 14 out of 15, which indicated she was cognitively intact. A review of R46's quarterly MDS with an ARD of [DATE] revealed the facility assessed that R46 had a BIMS score of four, which indicated she was severely cognitively impaired. A review of R46's comprehensive Care Plan dated [DATE] revealed a focus area for Risk for Harm: Self-directed or other directed with interventions of if resident poses a potential threat to injure self or others, notify provider and if safe allow resident personal space. A review of R46's comprehensive Care Plan dated [DATE] revealed a focus area for history of exhibiting manipulative behaviors and making false accusations toward staff, other residents, and family members . with interventions of [DATE] educate the resident and family/caregivers on successful coping and interaction strategies. The resident needs encouragement and active support to assist in developing more appropriate methods of coping and interacting. Encourage me to express feelings appropriately. Document behaviors and residents' responses to interventions. followed by Care Now services. A review of R46's Behavior Note dated [DATE] revealed Resident noted to be hiding roommates' call bell from resident and not allowing roommate to have lights on per roommate request. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R46's Nurses Note dated [DATE] revealed that R46 continued to track down her roommate's whereabouts and continued with her verbal abuse anytime staff were in the room to provide care for her roommate. She continued to put her roommate in a wheelchair every time her roommate wanted to go to the restroom and wheeled her to the toilet without requesting assistance from staff. She would come to the common area and demand that her roommate be taken back to her room, stating that she needs the resident in the room with her. She was upset that her roommate was taken for a shower or to eat in the dining room. It was documented that it is a toxic obsession that will cause harm to (the) roommate and will not allow (the) roommate to thrive in (a) social setting. At about 12:20 she came to common area and we thought she was ready for her shower, [sic] I went and to start wheeling her to shower and she swapped me with her hands and then at yelled for me to not hit her. I advised management to pull up cameras and ask all the CNAs and a resident that was right by her. The situation with this resident is completely out of control and is ramping up on a daily. A review of R46's Psychosocial/Social Service Note dated [DATE] revealed R46's roommate was offered a room change by multiple staff members and adamantly declines/refuses room change. A review of R46's Psychosocial/Social Service Note dated [DATE] revealed [behavioral health provider] notified of resident's behaviors. Med review to be conducted. A review of R46's admission Note dated [DATE] revealed Resident will be receiving a new roommate on [DATE]. Resident was notified in person on [DATE] and was in acceptance of new roommate. Resident's R/P was notified via telephone on [DATE] and was in acceptance of new roommate. A review of R46's Behavior Note dated [DATE] revealed Resident is exhibiting behaviors toward roommate that is making roommate tearful. Staff spoke with the resident to be mindful of the co-living situation and to respect the privacy of the roommate while staff are giving personal care. The resident has been observed pulling back the privacy curtain while staff is speaking with the roommate. Resident states, If she needs help, I just help her. Staff informed the resident that we are here to care for her and her roommate, but if her roommate needs help, she can help her by pushing her call light. Resident verbalized understanding. A review of R46's admission Note dated [DATE] revealed Resident will receive a new roommate on [DATE]. Resident was notified in person on [DATE] and was in acceptance of new roommate. Resident's R/P [Resident Representative] was notified via telephone, was unable to reach but VM [voicemail] was left notifying her that her mother was getting a new roommate and to contact me with any questions or concerns, if any. A review of R46's Nurses Note dated [DATE] revealed Resident noted to be standing over roommate. Resident noted to be verbally antagonizing roommate telling her 'you can't stay in here. You are going to have to go.' Nurse asked resident if R46 was bothering her and resident states 'yes she is. I'm just not feeling well and I don't want to talk to anyone right now.' Nurse advised R46 that her roommate did not wish to talk to her. R46 states this was my room first and you can't tell me what to do. Resident continued to be verbally aggressive towards staff and roommate while she was receiving her medications. Resident behaviors are reported to the proper administration. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R46's Patient At Risk Progress Note dated [DATE] revealed ([DATE]) Resident was observed standing over roommate after roommate verbalized that 'she did not want to talk to anyone right now.' ([DATE]) Staff observed the resident harassing the previous roommate and not letting her leave the room until she agreed to move back into her room. Action: IDT [Interdisciplinary Team] to discuss R46 behaviors toward other residents. The resident was reeducated on co-living situations, informed of other residents' right to privacy, and to make their own decisions. Response: Resident verbalized understanding of the privacy of others and co co-living situation. Staff will continue to redirect residents as needed and monitor/report any behaviors. A review of R46's admission Note dated [DATE] revealed Resident will receive a new roommate on [DATE]. Resident was notified in person of new roommate on [DATE], and the resident's R/P was notified via telephone on [DATE] and was in acceptance of the new roommate. A review of R46's Psychosocial/Social Service Note dated [DATE] revealed New admit into R46's room today. R46 stated that she was unhappy with the roommate and 'this was her room. SSD [social services director] explained the co-living situation with the resident and that she would have to move rooms if she was unhappy. R46 declined . A review of R46's Behavior Note dated [DATE] revealed R46 received a new roommate on [DATE]. The new roommate's granddaughter states that her grandmother told her she was very uncomfortable in the room because R46 would not stop touching her and kept turning the volume off on her phone. The granddaughter states that when she came to see the resident, R46 would not let them in the room and then began slamming her drawers shut and turning the TV volume up. She states that she then saw her grab her grandmother's phone and turn the volume off. Staff had a conversation with R46, and she denied touching her or her phone. The SSD informed the resident of their right to privacy and the co-living situation. She asked if the new roommate could move out and the rates for a private room. The Admissions Director was notified of interest in the private room. A review of R46's Psychosocial/Social Service Note dated [DATE] revealed SSD discussed with daughter resident's continuous behaviors. Daughter was informed of R46 making false accusations toward staff and exhibiting verbal behaviors toward previous and new roommates. Daughter states that she has always been controlling and manipulative. A review of R46's Nurses Note dated [DATE] revealed Resident returned from hospital via ambulance. No s\s [signs and symptoms] of distress or discomfort noted. The resident was transferred to the hospital related to behaviors. A review of R46's Psychosocial/Social Service Note dated [DATE] revealed [Hospital] accepted the referral on [DATE] . The resident was transferred to the hospital related to behaviors. A review of R46's Activities Note dated [DATE] revealed R46 was readmitted to the facility. A review of R46's admission Note dated [DATE] revealed Resident will receive new roommate on [DATE]. Resident was notified in person on ([DATE]) and resident's R/P, was notified via telephone on [DATE] and was in acceptance of new roommate. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R46's Behavior Note dated [DATE] revealed Resident is vocally upset with new roommate, stating that she believes clothing has been stolen. New roommate is bedbound. Resident is turning up heat in room and keeping main door closed. Roommate states she feels uncomfortable due to negative comments R46 made she was infringing on her space. A review of R46's Nurses Note dated [DATE] revealed Resident notified of new roommate and in agreement. A review of R360's undated admission Record revealed she was admitted to the facility on [DATE] with diagnoses of chronic respiratory failure, epilepsy, anxiety disorder, and major depressive disorder. A review of R360's quarterly MDS assessment with an ARD of [DATE] revealed she had a BIMS score of 15, indicating she was cognitively intact. A review of R360's Census Note revealed she was moved into the room with R46 on [DATE]. A review of R46's Behavior Note dated [DATE] revealed that the social worker (SW) was called to the resident's room due to a situation that was occurring. The resident was stating that the TV in her room was her personal TV. The note documented that the resident had taken the remote and hid it so the roommate could not watch television; the resident struck the SW and became angry during redirection. The SW then made a phone call to the resident's family, who validated that the TV was not the resident's and attempted to speak to the resident, but the resident was not listening. The resident's behavior has escalated, and the SW documented that she would continue to monitor the resident and follow up with the medical director for further intervention. A review of R46's Physician's Orders dated [DATE] revealed an order for Haldol Injection Solution (Haloperidol Lactate) Inject 2 mg intramuscularly STAT [immediately] for anxiety. There was no nursing note indicating the behavior exhibited for this medication. A review of R46's Nurses Note dated [DATE] revealed CNA7 reported that the call light cord was around her neck. I immediately went into the room, and the cord was lying across her chest. Upon inspection, the neck was normal in color. No redness, pain, bruising, swelling, or indentations of any kind were noted. The resident denied any pain. Resident continued with her normal ADLs [activities of daily living] throughout the day. A review of R46's Nurses Note dated [DATE] revealed that the CNA reported that the call light cord was lying across the resident in bed A. The two roommates exchanged profanities back and forth this (morning). A review of R46's Behavior Note dated [DATE] revealed SW informed by CNA7 of R360 that she removed the call light cord from around her, stating that R46 allegedly placed the cord around her. Profanity was exchanged between both residents. Follow up with MD [physician] to clinically intervene. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R46's Psychosocial/Social Service Note dated [DATE] revealed that the SW met with the resident in the room to interview after the CNA stated she had removed the call light cord from the resident's neck in the room. The SW asked the resident to tell her about what happened. The resident stated that (pointing fingers at she did it), referring to the roommate in the room. The SW restated, Are you sure? SW stated to the resident, You guys were getting into it, [360's Name] She stated, But I would not hurt anyone. She further asked, Are you going to do anything about it? SW then left the room and continued to follow through with necessary interventions. A review of R46's Behavior Note dated [DATE] revealed Resident was 1013 [legal form used to initiate involuntary hospitalization for mental health evaluation] by Medical Director. 911 was called and transported to [the hospital] for medical clearance and a second signature for commitment. A review of R46's Hospital Discharge Record dated [DATE] revealed that R46 had no recollection of the incident involving the roommate or past incidents; there were no observed behavioral disturbance while in ER; given level of nursing needs and medical acuity, R46 would not be a safe candidate for a psychiatric facility, and given dementia etiology of behaviors, would likely gain minimal therapeutic benefit; there were no recommended changes to current medications at that time; they strongly encouraged environmental augmentation to assist with behaviors; the family was aware of private room recommendations; no further psychiatric interventions were recommender at that time; R46 was discharged back to the facility. The Record was signed by the Consultation Liaison Psychiatry. A review of a facility document dated [DATE] revealed interviews with LPN10 and the SSD indicated R46 was observed by staff until she was transported to the ER for evaluation. The document also revealed that an interview with CNA7 revealed she entered R360 and R46's room on [DATE] at 8:30 am and observed the call light cord wrapped once loosely around R360's neck, and R360 pointed towards R46 when asked what happened, and then R46 started cursing at R360. During an interview on [DATE] at 2:20 pm, the Administrator confirmed he began employment after the incident occurred, but knew R46 had roommates and did not get along with them in the past, and since then, had been in a p[TRUNCATED]

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and a review of the facility policy titled MDS Submissions, the facility failed to complete a Significant Change Minimum Data Set (MDS) Assessment following the initiation of hospice services for one of two sampled residents (R) (R62) reviewed for hospice services. Findings included: A review of the facility's undated MDS Submissions policy revealed, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes . Submission timeframes for the MDS records will be consistent with the requirements for submission as provided in the MDS RAI [Resident Assessment Instrument] Manual. A review of the online MDS 3.0 RAI Manual dated 2023 revealed that the facility must complete a significant change MDS within 14 days after there has been a significant change in the resident's physical or mental condition. A significant change in MDS is required when a resident enrolls in a hospice program. A review of the electronic medical record (EMR) revealed R62 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease. A review of the Order Summary Report, current as of 3/29/2025, revealed R62 was admitted to hospice services on 11/25/2024 with Alzheimer's, AV [atrioventricular] block, second degree block of heart, hypertension. A review of the MDS tab revealed that a Significant Change Assessment had not been completed following R62's initiation of hospice on 11/25/2024. A review of the past MDS assessments revealed that a quarterly assessment had been completed after 11/15/2024, with an assessment reference date (ARD) of 1/24/2025. During an interview on 3/26/2025 at 2:39 pm, the MDS Coordinator verified she was a Licensed Practical Nurse (LPN) and either a corporate Registered Nurse (RN) or the Director of Nursing (DON) signed off on the MDS assessments she completed. The MDS Coordinator stated she followed the guidance in the RAI manual for the timing of MDS assessments. During an interview on 3/29/2025 at 12:24 pm, Unit Manager/Infection Preventionist (IP)2 stated the MDS Coordinator was unavailable for an interview. Unit Manager/IP2 reviewed R62's EMR and verified R62 was on hospice, and that a Significant Change Assessment had not been completed following R62's initiation of hospice.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, a review of the facility policy titled MDS Submissions, and review of Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, the facility failed to ensure that quarterly Minimum Data Set (MDS) assessments were completed at least once every three months for three of 52 residents (R) (R18, R36, and R65). This failure placed the residents at risk for unmet care needs due to the lack of a timely assessment to track any changes in the residents' status. Findings included: A review of the facility's policy titled MDS Submissions dated January 2023 revealed, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. A review of the RAI (Resident Assessment Instrument) Manual dated 10/1/2024 revealed The Quarterly assessment is an OBRA [Omnibus Budget Reconciliation Act] non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. 1. A review of R18's electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease and a collapsed vertebra. A review of R18's MDS revealed the most recent assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 10/17/2024. 2. A review of R36's EMR revealed she was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease and myasthenia gravis. A review of R36's MDS revealed the most recent assessment was a quarterly assessment with an ARD date of 10/19/2024. 3. A review of R65's EMR revealed she was admitted to the facility on [DATE] with diagnoses including heart failure and atrial fibrillation. A review of R65's MDS tab revealed the most recent assessment was an annual assessment with an ARD date of 10/10/2024. During an interview on 3/26/2025 at 2:39 pm, the MDS Coordinator reported that annual or comprehensive assessments were completed every year, with quarterly assessments completed every three months between comprehensive assessments. The MDS Coordinator reported using the EMR system to track when residents were due for their assessments and stated she was not behind in completing assessments. When the MDS Coordinator was asked to review the timing of the assessments for R18, R36, and R65, she confirmed that the three were past due for the quarterly assessments. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/2025 at 1:53 pm, the Regional Remote MDS nurse reported that either she or the Director of Nursing (DON) signed the MDS assessments as a Registered Nurse (RN), but that she did not track the timing. She stated that it should not be longer than 92 days between quarterly assessments. During an interview on 3/27/2025 at 1:02 pm, the DON reported she expected the MDS Coordinator to complete the assessments in a timely manner.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and a policy titled, MDS Assessment Coordinator, the facility failed to ensure that the Minimum Data Sets (MDS) assessments were accurate for two of 40 sampled residents (R)(R104 and R9) related to (1) not coding the presence of R104's pressure ulcer (to the sacrum) on a significant change MDS assessment; and (2) accurately coding the stage of the sacrum pressure ulcer on a subsequent quarterly MDS assessment for R9's diabetic foot ulcer. Findings included: A review of the facility's policy titled MDS Assessment Coordinator policy, dated January 2023, revealed that Each individual who completes a portion of the assessment (MDS) must certify the accuracy of that portion of the assessment. A review of the RAI (Resident Assessment Instrument) Manual, dated 10/1/2024 revealed that It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [interdisciplinary team] completing the assessment. 1. A review of the electronic medical record (EMR) revealed that R104 was admitted to the facility on [DATE] with atherosclerotic heart disease and dementia. A review of a Skin Wound Note dated 10/2/2024 revealed R104 had a pressure ulcer to the sacrum. There was no description of the wound. A review of a Nurse Practitioner (NP) Progress Note dated 10/2/2024 confirmed New breakdown to sacrum noted. A review of a Nurse's Note dated 10/7/2024 revealed, Nurse and NP noted two small open areas to sacrum. A review of R104's significant change MDS with an assessment reference date (ARD) of 10/17/2024 revealed the resident did not have any pressure ulcers and was not at risk of developing them. A review of the first descriptive assessment of R104's pressure ulcers from a Wound Care Physician on a document titled Wound Evaluation & Management Summary dated 10/25/2024 revealed there were two pressure ulcers: Unstageable (due to necrosis) sacrum full thickness; Wound Size: (L [length] x [by] W [width] x D [depth]) 3 x 1.2 x. 0.2 cm; Surface area 3.6 cm (squared); exudate light serous; Unstageable DTI [deep tissue injury] of the left heel undetermined thickness; etiology pressure; Wound size: 2.2 x 1.8 x not measurable cm; surface area 3.96 cm; and intact with purple/maroon discoloration. A review of the Wound Evaluation & Management Summary dated 11/8/2024 revealed, Stage 4 Pressure Wound Sacrum Full Thickness; Wound size: 3 x 3 x 0.3; Surface area of 9.0 cm (squared); Unstageable DTI of the left heel undetermined thickness; Wound Size: 2.2 x 2.8 x Not measurable cm; and Surface area: 6.16 cm (squared). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Wound Evaluation & Management Summary dated 11/22/2024 revealed, Stage 4 Pressure Wound Sacrum Full Thickness; Wound Size: 2.5 x 2 x 0.3 cm; Surface Area: 5.00 cm (squared); Thick adherent devitalized necrotic tissue; Wound progress: Not at Goal; Unstageable DTI of the left heel undetermined thickness; Wound size: 2.5 x 1.8 x Not measurable; and Surface area: 4.5 cm (squared). A review of the quarterly MDS with an ARD of 11/22/2024 revealed R104 had two DTIs. The Stage 4 pressure ulcer of the sacrum was coded incorrectly as a DTI. During an interview on 3/26/2025 at 2:39 pm, the MDS Coordinator verified she was a Licensed Practical Nurse (LPN) and stated either the Director of Nursing (DON) or Corporate Registered Nurse (RN) signed off on all the MDS documents. The MDS Coordinator verified that the MDS assessments should be timely and accurate. During an interview on 3/29/2025 at 12:24 pm, the Unit Manager (UM)/Infection Preventionist (IP)2 stated the MDS Coordinator was off and not available to be interviewed. The UM/IP2 verified R104's sacral pressure ulcer was first noted on 10/2/2024, and R104's Stage 4 pressure ulcer present on 11/22/2024 was not a DTI. UM/IP2 verified that the staging of the sacral pressure ulcer was coded incorrectly on the quarterly MDS dated [DATE]. The UM/IP2 stated R104 was documented with a Stage 4 to the sacrum as of 11/8/2024. 2. A review of the EMR revealed that R9 was admitted to the facility on [DATE] and had diagnoses that included diabetes and Alzheimer's disease. A review of R9's Order Recap Report from 4/12/2024 to 5/16/2024 revealed that R9 had orders for betadine to his right lateral foot starting 4/15/2024 and ending 5/20/2024. A review of a Skin/Wound Note dated 4/18/2024 at 2:34 pm revealed R9 was seen for wound care management of a diabetic ulcer on his right lateral foot. Betadine was ordered to treat the area. A review of the Wound Progress Notes with dates of service 4/18/2024, 4/25/2024, 5/2/2024, 5/9/2024, and 5/16/2024 documented that R9 had a right foot diabetic ulcer for which treatment was ordered. A review of R9's annual MDS assessment, with an ARD of 5/7/2024 revealed R9 had a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated severe cognitive impairment; that R9 had no pressure ulcers and no other ulcers, wounds, or skin problems, including diabetic foot ulcers; and R9 was recorded to have no skin treatments. During an interview on 3/26/2025 at 2:39 pm, the MDS Coordinator reported she completed the nursing portions of the MDS assessments, and either the DON or the Regional Remote MDS nurse signed the assessments as an RN. During an interview on 3/26/2025 at 1:53 pm, the Regional Remote MDS nurse stated she used the scrubber tool to see if anything popped up with coding, but did not specifically review the whole MDS assessment for accuracy before signing. During an interview on 3/27/2025 at 1:02 pm, the DON reported she reviewed the assessments prior to signing them. The DON stated R9's MDS assessment dated [DATE] should have reflected his diabetic foot ulcer with treatment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and review of the policies titled Care Plan Policy and Prevention of Pressure Ulcers, the facility failed to develop a person-centered care plan related to a diabetic foot ulcer for one of nine residents (R) (R9). This had the potential for the residents to have unmet care needs. Findings included: A review of the policy titled Care Plan Policy, reviewed 11/15/2022 revealed that Each resident will have a plan of care to identify problems, needs, and strengths that will identify how the facility staff will provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. A review of the policy titled Prevention of Pressure Ulcers dated April 2022 revealed that skin observations are completed, and any residents with wounds will have documentation on the Weekly Wound Information Sheet, including Care Plan revised/updated. A review of R9's electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] and had diagnoses that included diabetes and Alzheimer's disease. A review of R9's Order Recap Report from 4/12/2024 through 5/16/2024 revealed that R9 had orders for betadine to his right lateral foot starting 4/15/2024 and ending 5/20/2024. A review of Skin/Wound Note dated 4/18/2024 at 2:34 pm revealed R9 was seen for wound care management of a diabetic ulcer to his right lateral foot. Betadine was ordered for the treatment of the area. A review of the Wound Progress Notes dated 4/18/2024, 4/25/2024, 5/2/2024, 5/9/2024, and 5/16/2024 documented that R9 had a right foot diabetic ulcer for which a treatment was ordered. In the section labeled facility treatment staff education, it was recorded for the following dates: * On 4/25/2024, Monitor patient for any clinical signs and symptoms of infection or any further skin breakdown. Notify myself or the PCP [primary care provider] of any changes. Make sure the patient is being turned and repositioned frequently to help with wound healing and to help prevent any further skin breakdown. * On 5/2/2024, Monitor patient for any clinical signs and symptoms of infection or any further skin breakdown. Notify myself or the PCP [primary care provider] of any changes. Make sure the patient is being turned and repositioned frequently to help with wound healing and to help prevent any further skin breakdown. Educated treatment staff to use heel boots to relieve pressure on the heels, which will aid wound healing. This can also relieve pain from constant pressure. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* On 5/9/2024, Educated treatment staff to use heel boots to relieve pressure on the heels and will aid in wound healing. This can also relieve pain from constant pressure. Monitor the patient for any clinical signs and symptoms of infection or any further skin breakdown. Notify myself or the PCP [primary care provider] of any changes. Make sure the patient is being turned and repositioned frequently to help with wound healing and to help prevent any further skin breakdown. In addition, the note stated, Instructed patient not to apply any pressure to the wound area as this may cause further skin breakdown. A review of R9's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/7/2024 and located in the resident's EMR section titled MDS revealed R9 had a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated severe cognitive impairment. The MDS did not indicate R9 had a diabetic foot ulcer or treatment. A review of a Nurse's Note dated 5/16/2024 at 4:37 pm revealed R9 went to the hospital with suspected infection of the right foot and gangrene. A review of R9's Care Plan tab revealed that a focus area was initiated for the diabetic ulcer on 5/17/2024, after R9 was discharged to the hospital with gangrene. Interventions dated 5/17/2024 included seeing a wound provider and monitoring/documenting the wound weekly, as well as ensuring appropriate protective devices are applied to affected areas and reporting symptoms of infection. It did not include avoiding pressure to the wound area, turning and positioning frequently, or using heel boots. The area was resolved on 5/24/2024 when R9 returned from the hospital with a right below-the-knee amputation. During an interview on 3/27/2025 at 9:40 am, the Assistant Director of Nursing (ADON) stated the wound care provider made recommendations such as floating heels, heel booties, turning every two hours, and applying an air mattress, and the facility followed them. The recommendations made for R9 should have been in his Care Plan. Resident changes such as falls, behaviors, and wounds were discussed in the morning meeting with the appropriate department, updating the care plans as needed. The treatment nurse was at the morning meeting and notified everyone of anything new or any changes. Additionally, the MDS Coordinator updated care plans with her assessments. During an interview on 3/27/2025 at 12:42 pm, the Director of Nursing (DON) reported she expected interventions in place to prevent further skin breakdown for residents with wounds. The interventions were expected to be ordered and care planned.

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's policy titled Change in a Resident's Condition or Status, the facility failed to ensure the nursing staff used their clinical skills and judgement to identify and notify the resident's medical provider of the worsening of skin condition for one of three sampled residents (R) (R159). On [DATE] and [DATE], R159 had a change in condition when pedal pulses were unpalpable; however, nursing staff did not identify this as a change in condition, and the resident's medical provider was not notified. On [DATE], R159 was emergently transferred to the hospital, where she expired hours after arriving at the hospital due to complications from the worsening of her skin condition. On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator and Regional Director of Clinical Operations (RDCO) were informed of the Immediate Jeopardy (IJ) for F580, F600, F658, F686, and F835 on [DATE] at 6:27 pm. The facility was unable to provide an acceptable IJ Removal Plan before the survey team's exit on [DATE], and the IJ remained ongoing. Findings included: A review of the facility's policy titled Change in a Resident's Condition or Status, revised February 2021, revealed policy interpretation and implementation 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an). d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; g. need to transfer the resident to a hospital/treatment center; i. specific instruction to notify the physician of changes in the resident's condition. 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. 5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. A review of R159's undated admission Record revealed she was admitted on [DATE] with multiple diagnoses, including angioneurotic edema, diastolic congestive heart failure (CHF), deep vein thrombosis (DVT), hypercholesterolemia, and type 2 diabetes without complications. A review of R159's medical provider Progress Note revealed R159 had pitting edema to the bilateral lower extremities (BLE) and a bruised area to the left foot. The Progress Note documented that the nursing staff reported that the edema had been worsening for two to three days prior to the provider's visit and evaluation of R159. A review of the resident's EMR revealed no documented evidence that the resident's medical provider was notified of the worsening edema or the bruising before [DATE]. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R159's N [Nursing] Adv [Advanced] Skilled Evaluations, dated [DATE] and [DATE], revealed that Licensed Practical Nurse (LPN) 1 documented that R159 did not have palpable pedal pulses. The evaluation did not reveal any documented evidence of any nursing interventions, including the notification of R159's physician about the worsening of the resident's condition. A review of R159's Encounter Note, dated [DATE], revealed the nurse reported F159 had a fluid-filled blister on the back of her left calf. R159's family requested the resident be transferred to the emergency department (ED) for treatment; however, the request was denied by Nurse Practitioner (NP)3 even though the provider ordered an antibiotic for the treatment of cellulitis. A review of R159's Progress Note dated [DATE] revealed R159 had discolored areas to the digits of the right lower extremity (RLE), and pulses were not palpable due to edema. The note also indicated that an ankle brachial index (ABI) was ordered. A review of R159's medical provider Encounter dated [DATE], revealed was seen and examined for a leg condition that apparently evolved over the course of 24 hours. Nursing had reported a rash over her lower extremities, and she was being treated with antibiotics for cellulitis. Discussed the patient's condition with her family on Monday, [DATE]. Family had some grievances regarding care . a few black areas on toes, and lateral/medial aspect of both feet, DP pulses unpalpable B/L . Imaging: Doppler result c/w [consistent with] arterial occlusion bilaterally . in view of the patient's chronic debility, h/o [history of] sepsis, gangrene on both extremities, and rapid decline, it was decided to send her to the ED immediately. The family was informed accordingly and expressed agreement. During an interview on [DATE] at 12:36 pm, the Director of Nursing (DON) stated nurses who worked at the facility had been educated on changes of conditions, documenting changes in resident conditions, and notifying medical providers of the changes in conditions. The DON stated it was her expectation that the nurses would have identified the resident's change in condition and would have notified the physician when the change in condition was identified. During an interview on [DATE] at 1:28 pm, the Family Member (F)159 stated [DATE], she notified the nursing staff that R159 had a blister on the back of her calf. F159 stated nursing was not aware of the blister, and she requested the resident be sent to the hospital for treatment, in fear that the cellulitis would progress to gangrene. F159 also stated the facility denied the request for the resident to be transferred to the hospital; however, on [DATE], the facility emergently transferred the resident to the hospital at approximately 1:30 pm. F159 further stated it was determined R159 had an occlusion in her leg and was pronounced dead at 9:13 pm, hours after she was transferred to the hospital. During an interview on [DATE] at 8:42 am, Nurse Practitioner (NP)1 stated that had she been notified on [DATE] when R159's pedal pulses were absent, she would have requested the nurse to conduct a further assessment of the resident for circulation in the legs and feet. NP1 indicated the nurses should have informed the on-call provider when the R159's pulses were unpalpable and/or sent the R159 to the hospital for treatment. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:01 am, NP2 confirmed nursing staff notified her on [DATE] that R159 had drainage to the top of the foot, and she ordered an antibiotic to prevent infection. NP2 also stated she was not made aware by nursing of the other worsening conditions, such as the absence of pedal pulses. She stated that had she been made aware of these changes, she would have requested a more thorough assessment of the resident and then sent her to the hospital for aggressive treatment. During an interview on [DATE] at 1:47 pm, the incoming Medical Director stated he expected that the nursing staff would have notified the provider when R159 had a change in condition on [DATE]. The incoming Medical Director also stated that R159 should have been transferred to the hospital for aggressive treatment in the early phase of the resident's medical condition. During an interview on [DATE] at 10:37 am, the outgoing Medical Director explained that he was responsible for the residents' care in the facility, but to do that, he needed the nursing staff to communicate changes in residents' conditions to him. The Medical Director stated he saw R159 on [DATE] and due to her chronic debility, gangrene on both extremities, and rapid decline, it was decided to send her to the ED immediately. Cross Reference F580

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and a review of the facility policy titled ADL Care - Bath (shower) Hygiene Care, the facility failed to provide showers to one of nine dependent residents (R) (R23) reviewed for activities of daily living (ADL) care. The failure to provide showers created the potential for poor hygiene and odor. Findings included: A review of the policy titled ADL Care - Bath (shower) Hygiene Care dated November 2022, revealed The bath (shower) will be given for cleanliness, increased circulation, and comfort of the resident. The policy indicated that staff were to document completion of the bath/shower. A review of the electronic medical record (EMR) revealed that R23 was admitted to the facility on [DATE]. Diagnoses included congestive heart failure (CHF) and dementia. A review of the quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/22/2025 revealed R23 was severely impaired in cognition with a Brief Interview for Mental Status (BIMS) score of three out of 15. It was recorded that R23 required moderate assistance for toileting/hygiene, showers, dressing, and was frequently incontinent with bowel and bladder. A review of the Care Plan dated 9/5/2024 revealed a problem of [R23] has bladder incontinence r/t [related to] Alzheimer's. Interventions included in pertinent part, Incontinent: Check [R23] (q2h) [every two hours] and as required for incontinence. Wash, rinse, and dry the perineum. Change clothing PRN [as needed] after incontinence episodes. A review of the Care Plan dated 8/13/2024 revealed that R23 was Resistive to treatment/care related to refusing showers but can be persuaded to comply. The goal was for R23 to accept care. Interventions included in pertinent part, If [R23] refuses care, leave [R23] and return in 5-10 minutes. A review of the Care Plan dated 12/4/2023 revealed that R23 had an ADL self-care performance deficit related to activity intolerance. The goal was for R23 to maintain her current level of function. Interventions included Bathing: [R23] requires (1) staff participation with bathing; Bathing: Provide me with a sponge bath when a full bath or shower cannot be tolerated; and Bathing on Tuesday, Friday. An observation on 3/25/2025 at 11:24 am revealed R23's short hair was greasy, and she was walking around the facility using a walker, and the back of her sweatpants and the inside of her thighs were saturated with urine. R23 was confused and was not a resident-interview candidate. During an interview on 3/26/2025 at 3:35 pm, Certified Nursing Assistant (CNA) 3 stated she checked on R23 every two hours, and R23 was known to be a heavy wetter. CNA 3 stated it was not uncommon for R23 to saturate her pants with urine, and she changed her quickly if that occurred. C3 stated R23 had an attitude about being changed and showered; however, she had always gotten R23 to cooperate and could provide the care. CNA3 stated R23 was to be showered twice a week. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/2025 at 2:43 pm, CNA4 stated R23 required a lot of assistance with ADLs, and she checked/changed her brief every two hours, adding that R23 was a heavy wetter. CNA4 stated there were instances where two staff were needed to change the resident's brief, but she was always able to complete the task. CNA4 stated showers were given twice a week. CNA4 stated R23 was at times resistant to showers, but they were able to complete the task. During an interview on 3/28/2025 at 9:51 am, Licensed Practical Nurse (LPN) 9 showers did not always get done due to staffing, such as when there were call-outs. A review of the CNA Shower Sheets, provided by the facility, revealed that showers were given as follows for November 2024 - March 2025 (records for February 2025 were not provided): -November: Showers were provided on 11/7/2024, 11/11/2024, 11/14/2024, 11/18/2024, 11/24/2024, and 11/28/2024. R23 received six out of the eight showers scheduled in November. -December: Showers were provided on 12/2/2024, 12/9/2024, 12/12/2024 (refused), 12/16/2024, 12/19/2024, 12/23/2024, and 12/30/2024. R23 received seven (counting refusal) out of nine showers scheduled in December. -January: Showers were provided on 1/2/2025, 1/6/2025, 1/7/2025, 1/21/2025, and 1/30/2025. R23 received five out of nine showers scheduled in January. -March: Showers were provided on 3/6/2025, 3/21/2025, 3/25/2025, and 3/27/2025. R23 received four out of eight showers scheduled through 3/27/2025.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and a review of the facility's policies titled Prevention of Pressure Ulcers and Pressure Ulcer Treatment, the facility failed to ensure that three of three sampled residents (R) (R104, R2, and R307) did not develop facility-acquired pressure ulcers. The facility failed to prevent the development of significant pressure ulcers for two of the three residents reviewed (R104 and R2). The facility failed to provide oversight, ensuring pressure ulcer assessments were completed, and ensure pressure ulcer treatment was provided in a timely manner and per the physician's orders. 1. R104 did not have preventive interventions in place before [DATE], when a pressure ulcer to the sacrum was identified. There were no treatment orders until [DATE] for the sacrum, at which time the wound was to be cleansed, and a honey cover with border dressing was to be applied. R104 was admitted to hospice on [DATE]. There was no assessment of the pressure ulcer on R104's sacrum with a description of the wound and with measurements until [DATE] (23 days after it was first noted). The first assessment of the sacrum pressure ulcer revealed it was unstageable due to necrosis and was 3 centimeters (cm) by (x) 1.2 cm x 0.2 cm, and R104 was also noted with a left heel unstageable pressure ulcer 2.2 x 1.8 in size at this time. On [DATE], the sacrum pressure ulcer was assessed by the wound care provider to be a stage 4, 3 cm x 3 cm x .02 cm depth. The left heel pressure ulcer was 2.2 cm x 2.8 cm. A review of the quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of [DATE] did not document pressure-reducing devices being in effect. The Wound Care Provider continued to treat R104's sacrum and left heel wounds on [DATE] and [DATE]. Then there was a 21-day gap between [DATE] through[DATE] when there was no assessment or measurements taken of the pressure ulcers by either the Wound Care Provider or facility nursing staff. On [DATE], the sacrum wound (which combined with a laceration) was 7.4 cm x 7.5 cm, by 2.2 cm, with 4.3 cm of undermining, and the deep tissue injury (DTI) of the left heel was 0.7 x 0.4 cm. The last Wound Care Provider note on [DATE] revealed the sacrum pressure ulcer had further deteriorated and was 7 cm x 16.2 cm x 2.2 cm with 6.3 cm of undermining, and the left heel DTI was 0.9 x 0.8 x 0.1 cm. The resident passed away on [DATE]. Although the Wound Care Provider recommended protective boots for the left heel DTI, this was not implemented, and there was no evidence of a specialty pressure relief mattress being provided. R104's pressure ulcer to the sacrum progressed to a stage 4 within the first month and got larger, deeper, and more severe with undermining and infection during her stay. According to R104's Physician, the pressure ulcer likely contributed to her death on [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. R2 developed a new open area on her sacrum on [DATE], and treatment orders were obtained from a wound doctor for medical honey. R2 had a hospital stay from [DATE] to [DATE]. When R2 returned from the hospital, there were no evaluations of the coccyx/sacral wound until [DATE], when the wound was documented as a stage two buttock wound. R2 had no treatment orders from [DATE] until [DATE] when calcium alginate was ordered. A review of R2's Misc tab revealed notes from the physician with the facility-contracted wound company dated [DATE], [DATE], and [DATE] with wound assessments completed to areas other than a sacral/coccyx/buttock wound. There was no documentation of a sacral/coccyx/buttock wound. The assessment completed by the wound doctor on [DATE] for R2 documented an unstageable sacral ulcer measuring 3.5cm x 4.5cm x 0.1cm with 100 percent necrotic tissue. A surgical excisional debridement was completed, and on [DATE], the wound measured 5cm x 5cm x 0.1cm and had 100 percent necrotic tissue. A review of the hospital Discharge Summary, dated [DATE], revealed R2 was hospitalized for an infected sacral decubitus ulcer. Surgical debridement was done, and R2 was discharged on an intravenous (IV) antibiotic. The failures to implement preventive interventions, assess pressure ulcers once identified, provide treatment per the physician's orders, and provide oversight of wound care contributed to R104's death and put R2 at risk of additional infection, worsening of the pressure ulcer, and potentially death. On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator and Regional Director of Clinical Operations (RDCO) were informed of the Immediate Jeopardy (IJ) for F580, F600, F658, F686, and F835 on [DATE] at 6:27 pm. The facility was unable to provide an acceptable IJ Removal Plan before the survey team's exit on [DATE], and the IJ remained ongoing. Findings included: A review of the facility's Prevention of Pressure Ulcers policy, dated [DATE], revealed, The purpose of this procedure is to provide guidelines for residents identified to be at risk. Any residents with wounds will be documented on the Weekly Wound Information Sheet. Weekly documentation should include: (1) Current measurements of the wound (L [length]x [by] W [width] x D [depth]); (2) Current visual stage of the wound(s); (3) Any drainage, odor, progress or decline of wound; current treatment regimen; (5) pain; (6) Wound bed; (7) Description of wound and surrounding tissue . Preventive Protocol . Turn and reposition as needed . Pressure reduction mattress to the resident's bed . Assess dietary and hydration needs. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's Pressure Ulcer Treatment policy, dated [DATE], revealed that the purpose of the policy was to provide guidelines for the treatment of pressure ulcers to facilitate healing and to prevent further deterioration. It was recorded, Assess the pressure ulcer(s) for location, size . sinus tracts, undermining, tunneling, exudate/odor, necrotic tissue, peri wound, pain, and the absence of granulation tissue and epithelialization. Determine the ulcer's current stage of development . Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed . Stage III - Full thickness tissue loss. Subcutaneous fat may be visible . May include undermining or tunneling . Stage IV full thickness tissue loss with exposed bone, tendon, or muscle. Slough [non-viable yellow, tan, gray, green or brown tissue . may be adherent to the base of the wound or present in clumps] or eschar [dead or devitalized tissue . usually black, brown, or tan in color, and may appear scab-like] may be present on some parts of the wound bed. Often includes undermining and tunneling . Unstageable - Deep Tissue Injury - Purple or maroon area of discolored intact skin due to damage of underlying soft tissue . Use protective pressure-reducing devices as ordered . The following information may be documented in the resident's electronic medical record: If the resident refused the treatment and the reason(s) why . Weekly documentation in the medical record for resident-specific wounds. All pressure ulcers and other wounds will be listed weekly in the medical record. 1. A review of R104's electronic medical record (EMR) revealed R104 was admitted to the facility on [DATE] with diagnoses that included atherosclerotic heart disease, hypertension, and dementia. A review of the significant change MDS assessment with an ARD of [DATE] revealed R104 was intact in cognition with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the resident was cognitively intact; that R104 was always incontinent of bowel and bladder; that R104 was identified with medically complex conditions; and that R104 was coded as not being at risk for pressure ulcers and none were present at this time. A review of R104's Care Plan initiated on [DATE] revealed a problem of I have an ADL [activities of daily living] self-care performance deficit r/t [related to] fatigue, impaired balance. The goal was to improve the level of ADL function. Interventions included explaining all procedures/tasks before starting, one-to-two-person assistance with toileting, transfers, repositioning, and turning in bed, and one-person assistance with personal hygiene. A review of R104's Care Plan initiated on [DATE] revealed R104 had the potential/actual impairment to skin integrity related to fragile skin. The goal was for R104 to have no complications. Interventions included, Encourage good nutrition and hydration to promote healthier skin . Follow facility protocols for treatment of injury . Keep skin clean and dry, use lotion on dry skin. The care plan did not specifically address pressure ulcer risk. A review of the significant change MDS, with an ARD of [DATE], revealed that R104 did not have preventive interventions in place to prevent the development of pressure ulcers before [DATE]. A review of the Nurse's Note dated [DATE] revealed, two small openings to sacrum. NP [Nurse Practitioner] made aware . The writer asked NP to assess the resident's sacrum. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the NP's Progress Note dated [DATE] revealed, New breakdown to sacrum noted. No description of the breakdown was documented, or treatment prescribed. The NP indicated discussing the plan of care and hospice with the R104's family. R104 was also noted with dark stool in her brief, and an order was placed for an occult stool test, which was positive. A review of the Nurse's Note dated [DATE] revealed, DON [Director of Nursing] notified writer via telephone that resident was testing positive for blood in her stool. Writer notified [family member]/emergency contact and 911 to have resident sent to hospital for evaluation . Resident left facility around 2010 [8:10 pm] on [DATE]. It was recorded that R104 returned to the facility on [DATE]. A review of the Nurse's Note dated [DATE] revealed, Nurse and NP noted two small open areas to sacrum, area cleansed, and protective dressing applied, to be evaluated by wound care MD [Medical Doctor] on Friday There was no description of the open areas to the sacrum by nursing or the NP. A review of the Medicaid Hospice Election Form dated [DATE] revealed R104 was admitted to hospice on [DATE] with a diagnosis of senile degeneration disease. A review of the Order Summary Report dated [DATE] and the Treatment Administration Record (TAR) for [DATE] revealed there were no treatment orders until [DATE], a total of nine days after the sacral pressure ulcer was first observed. A review of the Order Summary Report revealed an order to cleanse the sacrum wound with cleanser/saline, pat dry, apply honey, and cover with border dressing to be completed every shift (there were two shifts daily from 7:00 am - 7:00 pm and from 7:00 pm to 7:00 am) on Monday, Wednesday, and Friday. This order ran from [DATE] through [DATE]. A review of the Treatment Administration Record (TAR) for [DATE] and [DATE] revealed that the treatment was missing on both shifts on [DATE] and [DATE]. A review of the significant change MDS with an ARD of [DATE] revealed R104 exhibited a cognition decline, presenting with a BIMS score of nine, indicating moderate cognitive impairment. Even though the sacral pressure ulcer was first noted on [DATE], the MDS did not document the presence of any pressure ulcers and indicated R104 was at low risk for developing pressure ulcers. A review of the Order Summary Report dated [DATE] revealed 30 milliliters (ml) of Liquid Protein supplement was prescribed twice a day and was continued until [DATE]. A review of the Care Plan dated [DATE] revealed a care plan was initiated for R104 due to having an actual impairment to skin integrity related to a [DATE]- sacral wound; [DATE]-DTI [deep tissue injury]. The goal was to be free from injury to her skin. New interventions included application of skin prep to the right heel and covered with dressing, added on [DATE]; sacral wound: Medi honey and dressing added on [DATE]. There were no interventions related to turning and repositioning, keeping the sacrum clean and dry, or floating R104's right heel with the advent of the DTI. A review of the Order Summary Report dated [DATE] revealed an order to cleanse the right heel with normal saline/wound cleanser, to pat dry, apply skin prep, cover with abd, and secure with Kerlix one time a day every Monday, Wednesday, and Friday for the right heel wound. This order was discontinued on [DATE]. A review of the TARs dated [DATE], [DATE], and [DATE] revealed that the treatment was not completed (no documentation) numerous times as follows: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-[DATE]: The treatment was not completed on any of the four dates it should have been ([DATE], [DATE], [DATE], and [DATE]). -[DATE]: The treatment was not completed on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. -[DATE]: The treatment was not completed on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. A review of the EMR revealed there was no assessment of the pressure ulcer on the sacrum with a description of the wound and with measurements or DTI to the heel until [DATE] (23 days after the pressure ulcer to the sacrum was first noted) at which time the wound care provider was notified and assumed primary oversight of the wound with weekly visits. A review of the Wound Care Physician's Wound Evaluation & Management Summary dated [DATE] revealed this was the first assessment of the sacrum pressure ulcer with a description and measurements. The sacral pressure ulcer was unstageable due to necrosis and was 3 cm x 1.2 cm x 0.2, with light, serious exudate. The sacral pressure ulcer was debrided. R104 was also noted with a left heel unstageable pressure ulcer (2.2 x 1.8 in size). The dressing treatment plan included Leptospermum honey applied three times a week for 24 days; gauze island with bdr applied three times per week for 24 days. In addition, recommendations of limiting sitting to 60 minutes, off-loading the wound, floating heels in bed, and repositioning per facility protocol were made; however, these interventions were not added to the care plan at this time or any time before her death. A review of a Dietary Note dated [DATE] revealed No weight this month due to refusal. Last month was 138 (pounds), which was relatively stable from her wt [weight] history. She receives tx [treatment] for unstageable wounds to her L [left] heel and sacrum. Diet is Regular. Liquid Protein provided at 30 cc BID [twice daily] for 200 kcals [calories] and 30 gm [grams] protein. Her meal intake is 45-70% average. We will continue with the current diet and supplement. Continue to make efforts to obtain weight. FU [follow up]as needed. A review of the Wound Care Physician's Wound Evaluation & Management Summary dated [DATE] revealed the sacrum pressure ulcer had progressed to a stage 4 and was 3 cm x 3 cm x 0.3 cm in depth with light serous exudate. Surgical debridement was conducted on the sacrum, and a single-use PICO dressing (single-use negative pressure wound therapy) was applied. The left heel was an unstageable DTI, 2.2 cm x 2. 8 cm, intact with purple/maroon discoloration. Treatment for the heel included skin prep application three times per week for 10 days. Recommendations of limiting sitting to 60 minutes and offloading the wound, floating heels in bed, and repositioning per facility policy continued; these interventions were not care planned. A review of the Order Summary report dated [DATE] revealed an order for Cleanse left buttock wound cleanser/saline pat dry apply honey cover with border dressing every shift (twice a day) every Mon, Tue, Wed, Thu, Fri, Sat, Sun for wound. The order was discontinued on [DATE]. A review of the TAR for [DATE] revealed the treatment was not completed (no documentation) in [DATE] at all on [DATE], [DATE], or [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the quarterly MDS with an ARD of [DATE] revealed R104's cognition had declined, with a BIMS of nine out of 15 showing moderate cognitive impairment. R104 was coded as having two DTIs (the stage 4 pressure ulcer was not identified), pressure ulcer care was being provided with turning and repositioning; however, no pressure reducing devices or nutritional interventions were coded as being in place. A review of the Wound Care Physician's Wound Evaluation & Management Summary dated [DATE] revealed a pressure ulcer stage 4 to the sacrum with measurements of 2.5 cm x 2 cm x 0.3 cm with light serous exudate, 80% necrotic tissue. The wound was treated with ultrasound mist therapy due to it being a non-healing wound and a lack of improvement in surface area or depth over the past 30 days. The left heel continued to be an unstageable DTI 2.5 cm x 1.8 cm x not measurable, intact with purple/maroon discoloration. A non-pressure wound of the left buttock with etiology of trauma/injury was also documented on the left buttock that was 3.1cm x 5.5 cm x 0.3 cm, noted to have 100% necrotic tissue. Recommendations of floating heels in bed, offloading the wound, and repositioning continued. A review of the Wound Care Physician's Wound Evaluation & Management Summary dated [DATE] revealed a pressure ulcer stage 4 to the sacrum, measurements were 2 cm x 1.6 cm x 0.3 cm with light serous exudate. Surgical debridement was conducted. Treatment and recommendations remain unchanged from the prior assessment, and the wound was identified as improved. The unstageable DTI to the left heel was 1 cm x 0.9 cm x not measurable. It was intact with purple discoloration and was also noted to have improved by having a decreased surface area. A review of the Wound Care Physician's Wound Evaluation & Management Summary dated [DATE] revealed a pressure ulcer stage 4 to the sacrum had combined with the non-pressure wound of the left buttock that was measured to be 6 cm x 7 cm x 2.2 cm, with undermining of 4.3 cm and light serous exudate. Single-use PICO was applied; negative pressure wound therapy was provided, and surgical debridement was completed. The unstageable DTI of the left heel was measured at 1 cm x 0.5 cm x not measurable. The heel was noted to be undergoing autolytic debridement. Evaluation was to continue weekly, or sooner as needed, with further intervention, which would be based on response to current treatment. A review of the EMR revealed that following the Wound Care Physician's visit on [DATE], a three-week (21-day) period elapsed until the Wound Care Physician made his next visit. Neither the facility nursing staff nor the Wound Care Physician assessed R104's pressure ulcers until [DATE]. During the timeframe, the Wound Care Physician and the nursing facility failed to assess the pressure ulcers. The Hospice Physician's Order showed an order dated [DATE], for Pack wound with Dakins damp gauze-calamine cream on edges, change daily. Pre-medicate with Ativan (anti-anxiety medication) and hydrocodone (narcotic pain medication) before care, daily. The order was discontinued on [DATE]. A review of the TARs for [DATE] and [DATE] revealed that the treatment was not completed (no documentation) as follows: -[DATE]: The treatment was not completed on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. -[DATE]: The treatment was not completed on [DATE], [DATE], and [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a Hospice Nurse's Note dated [DATE] revealed R104 was reported to be sleeping during the day and night, refusing most meals but drinking one to two protein shakes throughout the day. Staff reported to the hospice nurse that R104 refused bed baths and wound care. Ativan was to be given before care. The sacral wound was noted to be significantly worse. The facility no longer has a treatment nurse available. MD contacted, and wound care orders were left with the facility. Patient was premedicated, and HRN [Hospice Registered Nurse] did wound care today. There were no wound measurements or a description of the condition of R104's pressure ulcers. A review of a Hospice Nurse's Note dated [DATE] revealed R104's coccyx dressing was changed and noted Area is approximately 8.0 x 8.0 and down to the bone. Inside the wound is pink with some slough that is yellowish white. The dressing was partially off and saturated with drainage or urine. The odor is foul. The area is cleaned with wound cleanser and packed with gauze soaked with sterile water and med honey gel. Dry 4x4 on top and apply dressing. Patient tolerated well. A review of the Order Summary report dated [DATE] revealed that House Supplement, 120 ml, was prescribed two times a day and continued until [DATE]. A review of the Wound Care Physician's Wound Evaluation & Management Summary dated [DATE] revealed the pressure ulcer stage 4 to the sacrum (which combined with a laceration) was 7.4 cm x 7.5 cm, by 2.2 cm with 4.3 cm of undermining and light serous exudate. Treatment of low-frequency ultrasound was provided, and a fresh bandage was applied. The DTI of the left heel was 0.7 x 0.4 cm. A review of a Hospice Nurse's Note dated [DATE] revealed R104's sacrum dressing was changed by the Hospice Nurse on this date. A review of the Order Summary report dated [DATE] revealed Wound care to sacral wound once a day to include cleaning the wound with wound cleanser or Dakins solution. Wound bed to be coated with Triad cream and contents of charcaps (for odor). Pack with roll gauze, cover with ABD pads, foam dressing, and secure with tape one time a day for Wound care and odor control. The order was discontinued on [DATE]. A review of the TAR for [DATE] revealed the treatment was not completed (no documentation) on [DATE], [DATE], and [DATE]. A review of the last Wound Care Physician's Wound Evaluation & Management Summary dated [DATE] revealed the pressure ulcer stage 4 to the sacrum had further deteriorated and was 7 cm x 16.2 cm x 2.2 cm with 6.3 cm of undermining, and the left heel DTI was 0.9 x 0.8 x 0.1 cm. The resident passed away on [DATE]. During an interview on [DATE] at 8:57 am, NP1 stated R104's pressure ulcer treatment was directed by the Wound Care Physician, who was not the same person who currently provided wound care at the facility. NP1 stated that the Wound Care Physician came in weekly. NP1 stated R104 was also a hospice patient, and she had seen R104 twice during her stay. NP1 stated that the facility nurses were responsible for completing wound care/dressing changes. NP1 stated that the Assistant Director of Nursing (ADON) performed wound care for R104. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:57 am, the ADON/Infection Preventionist (IP)1 stated that in [DATE], there were no nursing Unit Managers. The ADON/IP1 stated that typically, the Unit Manager went with the Wound Care Physician on the weekly skin rounds. The ADON/IP1 stated that before [DATE], when Unit Managers were hired and in place, she documented the weekly nursing wound assessments but did not see R104's pressure ulcers herself. ADON/IP1 stated she obtained the measurements from the Wound Care Physician's documentation. The ADON/IP1 verified that the first nursing documentation of the sacral pressure ulcer was dated [DATE]. The ADONIP1 verified the first pressure ulcer assessment with staging measurements, and a description for R104 was on [DATE]. ADON/IP1 verified a lack of weekly pressure ulcer/wound assessments after [DATE] until wound care was initiated by the Wound Care Physician. The ADON/IP1 stated that the LPNs could not measure wounds and stage them; the doctor staged wounds. The ADON/IP1 stated that the initial and weekly wound form should be completed weekly by nursing from the start of the wounds and should track all of them throughout the course of the wound/s. The ADON/IP1 stated R104 refused care, and it was documented in EMAR notes; however, the EMAR notes did not indicate what was refused, for example, a medication or treatment. The ADON/IP1 verified that the EMAR Notes and Progress Notes did not document that wound care had been refused. The ADON/IP1 stated the EMR showed a lot of medication refusals, but there was a lack of documentation of refusing dressing change on specific dates and times. The ADON/IP1 verified that there were many blanks on the TARs for pressure ulcer treatment, such as dressing changes. The ADON/IP1 stated that a blank meant the nurses did not document providing the treatment, and she could not say if it was a failure to document or a failure to complete the treatment. The ADON/IP1 looked through Progress Notes and stated that on [DATE], a refusal of R104's sacrum dressing change was documented in notes. The ADON/IP1 was unable to find any additional documentation of wound care refusals for specific dates/times. During an interview on [DATE] at 10:57 am, Unit Manager/Infection Preventionist (IP)2 stated she took over at the end of [DATE] as Unit Manager. She stated R104's pressure ulcer to the sacrum advanced, and she went into hospice. Unit Manager/IP2 stated R104's refusals of treatment should have been documented, and there was a code of 2 on the TAR that should have been used. Unit Manager/IP2 stated Hospice could do dressing changes and should verbally alert the nurse if that was the case. Unit Manager/IP2 reviewed the EMR and stated the hospice nurse changed the dressing on [DATE]. She stated that Hospice and the Wound Care Physician should have had communication regarding R104's pressure ulcer care. Unit Manager/IP2 stated there was an EMAR Note dated [DATE] indicating R104's sacral wound was packed; however, this was not documented on the TAR. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:04 pm, Certified Nursing Assistant (CNA)6 stated she worked at the facility with R104 one day in [DATE] and one day in [DATE]. She stated that the first time she was assigned R104, she could smell her odor from the pressure ulcer coming down the hall. CNA6 stated R104 did not want to be changed, but she was able to do it. CNA6 stated that when she turned R104 to her side, there was a hole, golf ball size, deep hole. CNA6 stated it was stuffed with gauze and had not been changed in a while. She stated the gauze was black and falling out. CNA6 stated she was so concerned that she went to find the wound care nurse. CNA6 was told by a different nurse that there was no wound care nurse. CNA6 stated she saw a doctor and asked him to look at the wound, but neither the doctor nor any other nurse came to assess it as she worked with R104 for 12 hours that day. CNA6 stated she came back to the facility a couple of weeks later (approximately [DATE]) and was assigned to R104 and saw the same thing. She stated R104 had not been changed, and her brief was soaked with fluid from the wound, and the wound did not have any packing or a dressing. CNA6 stated R104 was bedridden and was unable to do anything for herself. CNA6 stated R104 allowed her to provide care to her on those two days. CNA6 stated there was nothing in place for R104's left heel, but she elevated her feet with pillows and knew to reposition her every two hours. CNA6 stated R104's sacrum wound was the worst bedsore she had ever seen, and it smelled worse the second time. During an interview on [DATE] at 1:21 pm, the DON stated that pressure ulcer prevention consisted of educating staff on repositioning. She stated preventive interventions were utilized, such as boots to float heels or pillows. The DON stated these interventions should be care-planned. The DON stated there were weekly meetings called PAR in which residents with wounds or at risk were discussed by the care team. The DON stated that a treatment order should have been put into place immediately after R104's pressure ulcer to the sacrum was noted on [DATE]. The DON stated R104 should have been turned every two hours, and if a boot was needed for a heel wound, it was ordered, and pillows were used to float the heels. The DON stated that weekly skin assessments should be completed. The Wound Care Nurse completed the initial and weekly pressure ulcer form. She stated a referral would be made for the Wound Care Physician to see the resident on weekly rounds. The DON stated LPNs could not assess pressure ulcers, but they could describe and document their observations. The DON stated blanks on the TAR could indicate that treatment was not provided or was not documented. The DON stated nurses should document with a code on the TAR if there was a wound care refusal and should not leave it blank. The DON stated she had observed R104's pressure ulcer to the sacrum and stated it had become infected. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:16 am, R104's Physician (Outgoing Medical Director (OGMD)) stated treatment should have been initiated right away ([DATE]) with the development of R104's pressure ulcer to the sacrum, and it should have been assessed with measurements right away as well. OGMD stated interventions such as boots for the left heel pressure ulcer would be initiated by the wound team or the Director of Nursing (DON). OGMD stated that a repositioning schedule should have been implemented with repositioning as frequently as possible. OGMD stated the facility had staffing issues preventing repositioning from being done. OGMD stated he noticed R104's pressure ulcer treatments were not being completed by the nursing staff. OGMD stated he was concerned that the facility did not have a Wound Care Nurse to oversee wound care during the time R104 developed and had pressure ulcers. OGMD stated he insisted to the Administrator that the facility hire a Wound Care Nurse. OGMD stated weekly assessment of pressure ulcers by nursing staff was very important; nurses should notify the Wound Care Physician of any changes. OGMD stated the Wound Care Physician was responsible for assessing and providing treatment and orders once they assumed care. OGMD stated he had not been aware of the three-week gap in the Wound Care Physician's not evaluating R104's wounds. OGMD stated that if there were blanks on the TARs for wound care by nursing staff, chances were it was not getting done. OGMD stated it was his expectation for nurses to document the provision of wound care. OGMD stated he did not remember R104 refusing treatment, but she might have. OGMD stated R104's death was likely a result of the pressure ulcer to her sacrum; he stated she had a deep wound that could lead to sepsis and infection. OGMD stated R104 was also over [AGE] years old, was frail, and had pneumonia in [DATE] of which could have also contributed to her death. During an interview on [DATE] at 12:36 pm, Unit Manager/IP2 verified the three-week period when the Wound Care Physician did not come and oversee R104's pressure ulcers. Unit Manager/IP2 stated that the nurses called, but the Wound Care Physician did not come, and that was why the facility got a different Wound Care Physician. Unit Manager/IP2 also verified the initial gap of 23 days following R104's pressure ulcer being discovered until it was assessed on [DATE]. She stated the nurses could not have completed the nursing pressure ulcer form without the Wou[TRUNCATED]

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and a review of the facility policy titled Bed Safety and Bed Rails, the facility failed to complete quarterly assessments for the continued use and safety of the bedrail for one of 40 sampled residents (R) (R22). This failure had the potential to affect all residents in the facility with bed rails and increase their risk of accidents. Findings included: A review of the facility's policy titled Bed Safety and Bed Rails, revised in August 2022, provided by the facility revealed Policy Statement: Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met. The resident assessment to determine risk of entrapment includes, but is not limited to, medical diagnosis, conditions, symptoms, and/or behavioral symptoms; size and weight; sleep habits; medication(s); acute medical or surgical interventions; underlying medical conditions; existence of delirium; ability to toilet safely; cognition; communication; mobility (in and out of bed); and risk of falling. The resident assessment also determines potential risks to the resident associated with the use of bed rails, including the following: a. Accident hazards: The resident could attempt to climb over, around, between, or through the rails, or over the foot board; and/or a resident or part of his/her body could be caught between rails, the openings of the rails or between the bed rails and mattress . A review of the electronic medical record (EMR) revealed R22 was admitted to the facility on [DATE] with diagnoses that included abnormal posture and kyphosis of the cervicothoracic region. A review of R22's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 3/10/2025 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact and that R22 required setup or clean up assistance with rolling from left to right: the ability to roll from lying on back to left and right side and return to lying on back on the bed. A review of R22's Physician's Orders revealed an order for bed rails x2 [times two] to bed for positioning dated 11/19/2024 and an order for Side rails: full rails up as per doctor's order for safety while in bed, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition PRN [as needed] to avoid injury, dated 4/13/2022. A review of R22's Care Plan dated 11/18/2024 revealed a focus area of risk for falls related to impairment of bilateral lower extremities (BLE) with interventions that included siderail for repositioning. A review of R22's Bed Environment assessment dated [DATE] revealed a bed rail assessment that alternatives were discussed with the resident, the bed rail attached firmly to the bed, the resident could show them how they used the bed rail, the bed rail did not limit the resident's movement and the bed rails were used due to weakness, fear of rolling out of bed, avoid rolling out of bed, and provide a sense of security. There were no other documented bed rail assessments in the EMR. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 3/25/2025 at 11:11 am and on 3/29/2025 at 9:24 am revealed R22 lying in the bed with two pillows behind her head, her neck and head leaning to the left of the pillow, with bilateral full-length side rails raised on the bed. There were no observed gaps between the bed rail and mattress. During an interview on 3/25/2025 at 11:15 am, R22 stated she wanted the side rails up due to her neck deformity, which caused her to lean to the left side of the bed, and for her fear of falling out of bed due to the medical condition. During an interview on 3/29/2025 at 9:27 am, the Certified Nursing Assistant (CNA)8 stated R22 refused to get out of bed, and she could not move her legs because they were contracted, but she could use her hands to turn and reposition in the bed using the side rails. CNA8 also stated she would let maintenance know if the bed rail was not in good repair, and she had not seen or heard of R22 having any accidents due to the side rails. During an interview on 3/29/2025 at 9:31 am, the Licensed Practical Nurse (LPN)3 stated she had worked at the facility for seven weeks. She stated that she was not aware of the bed rail assessment and had not completed a bed rail assessment for R22. During an interview on 3/29/2025 at 9:35 am, the Director of Nursing (DON) stated that the nurses should complete a side rail assessment quarterly to ensure R22's safety and due to the risk of entrapment. The DON also stated that it was discovered that when the order for the bed rails was entered into their EMR, the bed rail assessment was not activated to be completed, and this was not identified until this week. The DON confirmed that no side rail assessments were completed in the EMR, but she found some old paper side rail assessments from before 2024. During an interview on 3/29/2025 at 10:11 am, the Regional Director of Clinical Operations (RDCO) stated she expected nurses to complete a bed rail assessment to ensure the resident's safety. The RDCO stated the facility staff found some paper side rail assessments, but none were completed in 2024.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and a policy titled Medication Ordering and Receiving from Pharmacy Provider, the facility failed to have antibiotic and pain medications available to administer as ordered for three of five sampled residents (R) (R2, R78, and R10). Findings included: A review of the facility's policy titled Medication Ordering and Receiving from Pharmacy Provider dated January 2023 revealed, The provider pharmacy establishes a daily delivery and pick-up schedule for medications and supplies. It states that new medications, except for emergency or stat medications, were to be called in or transmitted to the pharmacy immediately upon receipt to inform the pharmacy of the need for prompt delivery if the first dose is due before the next scheduled delivery. During regular pharmacy hours, the emergency or 'stat' order is transmitted to the pharmacy immediately upon receipt. Such medications are delivered and administered in a timely manner. 1. A review of the electronic medical record (EMR) revealed R2 was admitted to the facility on [DATE] and had a recent hospitalization from 3/1/2025 to 3/14/2025. R2 had diagnoses that included hypertensive heart disease, heart failure, and dementia. A review of R2's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/19/2025 revealed R2 scored a two out of 15 on her Brief Interview for Mental Status (BIMS), which indicated severe cognitive impairment. A review of R2's Order Recap Report for March 2024 revealed orders that included daptomycin intravenous (IV) solution 550 milligram (mg) (IV daily for bloodstream infection starting 3/15/2025 until 4/14/2025. The 3/15/2025 order was discontinued on 3/17/2025 to start 3/18/2025 and end 4/16/2025, adding two days of antibiotics. A review of R2's Medication Administration Record (MAR) for March 2025 revealed that daptomycin was recorded as refused on 3/15/2025 and not administered/see progress note on 3/16/2025, 3/17/2025, and 3/23/2025. A review of R2's Prog Note revealed an eMAR (electronic MAR) note on 3/16/2025 documenting medications are not in stock, and an eMAR note on 3/17/2025 documenting pharmacy notified and will be arriving 3/17 on first delivery. On 3/23/2025, an eMAR note regarding daptomycin read, Did not have login, to administer. 2. A review of the EMR revealed R78 was admitted to the facility on [DATE] and readmitted from the hospital on 3/3/2025. R78 was diagnosed with enterocolitis due to Clostridium difficile (C-diff) on 3/3/2025. A review of R78's admission MDS assessment with an ARD of 2/26/2025 revealed R78 scored a four out of 15 on the BIMS, which indicated severe cognitive impairment. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R78's MAR for March 2025 revealed an order for vancomycin HCl oral suspension 50 mg/mL, give 2.5 mL (milliliters) by mouth four times a day (9:00 am, 1:00 pm, 5:00 pm, and 9:00 pm) for C. Difficile for nine days, starting 3/3/2025 at 9:00 pm. Doses for 3/7/2025 at 9:00 pm, 3/8/2025 at 9:00 am, and 3/8/2025 at 5:00 pm were documented as not administered/see progress note. A review of the Prog Note revealed an eMAR note on 3/7/2025, which recorded that vancomycin was on order. On 3/8/2025 at 12:33 pm and 6:49 pm, eMAR notes documented Medication pending from pharmacy. Medication to arrive on the next run. A review of the Pyxis (contingency supply of medications) Inventory Summary supplied by the facility and dated 3/14/2025, revealed that neither the daptomycin nor the vancomycin was available in it. During an interview on 3/26/2025 with Licensed Practical Nurse (LPN)4, she reported the facility sometimes had issues getting medications from the pharmacy timely manner. During an interview on 3/26/2025 with LPN5, she reported that if a medication had not been delivered by the pharmacy, it might be in the Pyxis. If it is not there, the staff are to let the pharmacy and doctor know. During an interview on 3/27/2025 with Nurse Practitioner (NP)1, she stated the pharmacy does not always send medications. When asked if that was an issue for the facility, NP1 responded, It's 100 percent an issue here. NP1 reported she expected medications in the Pyxis to be used if available. During an interview on 3/27/2025 at 1:08 pm, the Director of Nursing (DON) reported that the unit managers, the Assistant Director of Nursing (ADON), and she reviewed missed medications. The DON reported she has spoken to the pharmacy director and the pharmacist about concerns of not getting medications delivered on time. The DON expected medications to be pulled from the Pyxis if it is stocked there. The company pays for a service that, if the pharmacy does not have a medication, will have a local pharmacy supply it. The DON expected nurses to contact the pharmacy if a medication was not available and alert the physician or nurse practitioner, and document what was done. 3. A review of the EMR revealed that R10 was admitted to the facility on [DATE] with diagnoses including neuropathy, type two diabetes mellitus, and hemiplegia (paralysis of the limbs on one side of the body) and hemiparesis (partial weakness on one side of the body) following a cerebral infarction (stroke). A review of R10's quarterly MDS with an ARD of 1/12/2025 revealed R10 was unimpaired in cognition with a BIMS score of 15 out of 15, that R10 was prescribed an opioid medication, and received as-needed (PRN) pain medications within the last five days. A review of R10's Order Summary current through 3/29/2025 revealed R10 had current orders for pain medications, including Baclofen oral tablet 10 milligrams (mg), one tablet by mouth twice a day for signs and symptoms involving the skeletal system; and Tramadol CHL oral tablet, 50 mg, one tablet by mouth four times a day for chronic spine pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R10's MAR for January 2025 revealed Baclofen oral tablet 10 mg was prescribed on 12/9/2024 to be administered twice a day for muscle spasms. The MAR revealed R10 did not receive Baclofen doses three times: on 1/7/2025 for the am dose with a code of 13 (not administered/see progress notes); on 1/19/2025 for the pm dose a code of 5 (hold/see nursing notes); and on 1/21/2025 for the pm dose a code of 13 was documented. A review of the Orders Administration Note dated 1/7/2025 revealed that a reorder was documented on 1/7/2025. A review of the Orders Administration Note dated 1/19/2025 revealed R10 was out of the medication Baclofen tablet 10 mg. A review of the Orders Administration Note dated 1/21/2025 revealed the Baclofen 10 mg tablet, medication on order from pharmacy. A review of R10's MAR for February 2025 revealed Tramadol HCl tablet 50 mg was prescribed every six hours on 2/13/2025 for back pain. The MAR revealed R10 did not receive Tramadol over three days and a total of six doses. On the MAR, the 2/14/2025, 2/15/2025, and 2/16/2025 6:00 am doses were coded with 13. On 2/15/2025, for the noon dose and the 6:00 pm dose, the MAR was coded with a 9 (Not administered). On the MAR, the 2/16/2025 6:00 pm dose was coded with a 13. A review of the Orders Administration Note dated 2/14/2025 revealed the facility was awaiting pharmacy delivery of the Tramadol. A review of the Orders Administration Note dated 2/15/2025 revealed that Tramadol was not available, and the pharmacy had been notified. A review of the Orders Administration Note dated 2/16/2025 revealed that Tramadol was not available. During an interview on 3/25/2025 at 2:57 pm and an interview on 3/26/2025 at 2:32 pm, R10 stated there were instances when she did not receive her pain medications due to the medications not being reordered timely. R10 stated she had pain in her back and legs, and the facility did not have her narcotic pain medication, Tramadol, in stock, and also, there were instances when Baclofen was not available. R10 stated she had gone three days without Tramadol about a month ago. During an interview on 3/26/2025 at 2:59 pm, LPN5 stated R10 had been prescribed Tramadol for a while. LPN5 stated that if medications were not available, she could not access the Pyxis system because she was an agency and not a regular facility employee. LPN5 stated there was always at least one nurse in the facility who could access the Pyxis system so medications could be dispensed. LPN5 stated they called the pharmacy and were given a code so the medication could be pulled from Pyxis. During an interview on 3/27/2025 at 1:09 pm, the DON stated there had been concerns with medication availability and she had talked to the Pharmacist and Pharmacy Director regarding things not coming in timely. The DON stated she had to call the pharmacy a few times to find out where things were. The DON stated the facility had Pyxis, and she could pull medications, but she needed to call in and get a code to get into it. During an interview on 3/29/2025 at 1:16 pm, the Unit Manager/Infection Preventionist (IP)2 stated Baclofen could be pulled out of Pyxis, and she had pulled it for R10 previously. The Unit Manager/IP2 stated there was a time when R10 was readmitted to the facility from the hospital, and the Tramadol was not available in a timely manner. The Unit Manager/IP2 stated they informed the resident and continued to contact the pharmacy to get the medication, noting it did not always come when the pharmacy said it would. The Unit Manager/IP2 stated they typically reordered medication when they had about eight pills left (for a medication with several doses daily). She stated that if they tried to order it sooner than that, the pharmacy would not send it.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and the policy titled Medication Monitoring Medication Regimen Review and Reporting the facility failed to ensure the physician responded timely to the pharmacist's recommendations made during the monthly drug regimen reviews for four of five residents (R) (R2, R21, R77, and R63) reviewed for unnecessary medication. Findings included: A review of the facility's Medication Monitoring Medication Regimen Review and Reporting policy dated January 2024, Resident-specific MRR [Medication Regimen Review] recommendations and findings are documented and acted upon by the nursing care center and/or physician. The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days or per facility-specific protocols. For those issues that require physician intervention, the attending physician either accepts and acts upon the report and recommendations or rejects all or some of the report and should document his or her rationale for why the recommendation is rejected in the resident's medical record. 1. A review of the electronic medical record (EMR) revealed R2 was admitted to the facility on [DATE]. R2 had diagnoses that included generalized anxiety disorder, major depressive disorder, and dementia with agitation. A review of R2's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/19/2025 revealed R2 scored a two out of 15 on her Brief Interview for Mental Status (BIMS), which indicated severe cognitive impairment. R2 received scheduled anti-psychotic medication and antidepressant medication. A review of R2's Order Summary Report dated 3/25/2025 revealed an order for duloxetine HCl (Cymbalta-antidepressant) dated 3/14/2025 when R2 was re-admitted from the hospital. During an interview on 3/27/2025 at 4:14 pm, the Director of Nursing (DON) stated she was missing some physician responses to the pharmacist's recommendations because the Outgoing Medical Director (OG Medical Director) had not been getting them back to her. During an interview on 3/28/2025 at 11:34 am, the DON reported she was not able to locate any pharmacist recommendations or physician responses to the recommendations for R2 from October 2024 through the present. During an interview on 3/28/2025 at 3:00 pm, the Pharmacist stated R2 had a recommendation for Cymbalta (antidepressant) in October 2024 to consider a Gradual Dose Reduction (GDR) and Zyprexa (antipsychotic) in December 2024. He saw in the EMR that the Zyprexa was changed, but the Cymbalta was not changed. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/28/2025 at 5:22 pm the Regional Director of Clinical Operations (RDCO), in response to being asked to look for any follow-up to the pharmacy recommendations that the Pharmacist reported giving in October 2024 and December 2024, stated she went into the EMR and could see R2's Zyprexa was discontinued on 1/16/2025. The RDCO saw no changes in the Cymbalta. 2. A review of the EMR revealed R21 was admitted to the facility on [DATE] and had diagnoses that included dementia with psychotic disturbance. A review of R21's quarterly MDS assessment with an ARD of 2/19/2025 revealed R21 was rarely/never understood and had short-term and long-term memory problems. R21 received scheduled anti-psychotic medication and anti-depressant medication. A review of facility-provided pharmacist recommendations revealed two recommendations dated 10/17/2024. One requested a duration for R21s as needed (PRN), Ativan. The second step was to evaluate the current dose of Seroquel 25 mg twice daily that R21 had received since April 2024 and to consider a dose reduction. The responses to both were signed by a nurse practitioner and were dated 3/25/2025, five months after the print date. A diagnosis was provided for the Ativan, but no duration was provided on the recommendation form, and the GDR was declined on the Seroquel, with maintain the current dose checked. A review of R21's Order Summary Report dated 3/27/2025 revealed R21 no longer received PRN Ativan and had an order for Seroquel, which had increased in dosage on 2/28/2025 to 50 mg twice daily. During an interview on 3/27/2025 at 4:14 pm, the DON stated she was missing some physician responses to the pharmacist's recommendations because the Outgoing Medical Director (OG Medical Director) had not been getting them back to her. The nurse practitioner reviewed what she was able to do. 3. A review of the EMR revealed R77 was admitted to the facility on [DATE] and had diagnoses that included retention of urine, anxiety, and dementia with mood disturbance. A review of the quarterly MDS assessment with an ARD of 1/13/2025 revealed R77 scored 11 out of 15 on her BIMS, which indicated moderate cognitive impairment and that R77 received anti-anxiety and anti-depressant medications. A review of facility-provided pharmacist recommendations revealed R77 had a recommendation for a GDR on Zoloft (an antidepressant medication) 50 mg daily and clonazepam (an anti-anxiety medication) 0.25 mg twice daily, dated 6/29/2024. There was no documented physician response. On 9/28/2024, the pharmacist recommended evaluating the PRN clonazepam order. There was no documented physician response. On 8/19/2024, the pharmacist recommended changing R77's oxybutynin (an anticholinergic drug used for bladder control) to a different medication. There was no documented physician response. During an interview on 3/27/2025 at 4:14 pm, the DON stated she was missing some physician responses to the pharmacist's recommendations because the Outgoing Medical Director (OG Medical Director) had not been getting them back to her. During an interview on 3/28/2025 at 11:34 am, the DON reported she was not able to locate any pharmacist recommendations or physician responses to the recommendations for R77 from October 2024 through the present. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/28/2025 at 3:00 pm, the Pharmacist stated he made recommendations for a GDR on R77's Clonazepam in November and, when it had not been addressed, he recommended a GDR again in January. He made a recommendation for Seroquel in December and for Buspar in January, which was changed in the EMR. 4. A review of the admission MDS assessment with an ARD of 1/19/2025 revealed R63 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, anxiety, and dementia. R63 was moderately impaired in cognition with a BIMS of 9 out of 15. A review of R63's Order Summary Report, current as of 3/28/2025, revealed R63 was prescribed an antipsychotic medication, quetiapine (Seroquel) fumarate tablet 100 milligrams (mg) at bedtime for dementia with psychotic disturbance, prescribed on 1/15/2025. A review of the Pharmacy Recommendation Note to Attending Physician/Prescriber, dated 1/30/2025 and provided by the facility, revealed the Pharmacist made the following recommendation: This resident was recently admitted with an order for Seroquel [quetiapine Fumarate] 100 mg q hs [at bedtime]. Please consider a trial dose reduction to assess continued need for treatment . There was no physician prescriber response on the form indicating whether or not the physician agreed with the recommendation, or if not, what the rationale was to decline the recommendation. Although the dose of Seroquel was reordered on 1/30/2025, it continued as originally prescribed at 100 mg per day. During an interview on 3/28/2025 10:01 am, Licensed Practical Nurse (LPN)9 stated R63 exhibited behaviors in the evening and did not cooperate with caregivers. During an interview on 3/28/2025 at 3:24 pm, the Pharmacist stated he sent a recommendation regarding Seroquel to the facility on 1/30/2025 and recommended a dose reduction. The Pharmacist stated this was his practice when residents were admitted from the hospital on antipsychotic medications, due to not knowing if it had been added to the hospital. The Pharmacist stated he emailed the recommendation for a gradual dose reduction (GDR) to the Director of Nursing (DON), and she then dispersed it to the medical provider. The Pharmacist stated he did not have a response to the recommendation from the Physician, and the medication remained at the same dose from admission. The Pharmacist stated he did not always get a provider response to the recommendations. The Pharmacist stated he was just finishing the recommendations for March 2025 today and was resubmitting the same recommendation for a GDR of Seroquel for R63. During an interview on 3/29/2025 at 5:15 pm, the RDCO stated the facility had identified a concern with the Physician not giving the pharmacy recommendations back to the facility with his response and signature. The RDCO reviewed R63's EMR and stated the Physician should respond to the Pharmacist's recommendations within a few days.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and a review of the facility's policies titled Medication Ordering and Receiving from Pharmacy Provider, Administration of Drugs, and Medication Errors and Adverse Reactions, the facility failed to ensure that two of six sampled residents (R) (R2 and R72) were free from significant medication error. Findings included: A review of the facility's Medication Ordering and Receiving from Pharmacy Provider policy dated January 2023 revealed, When medication is available in the emergency kit, remove the emergency/STAT dose needed for administration prior to the next pharmacy delivery. A review of the facility's Administration of Drugs policy dated April 2022 revealed that Unless otherwise specified by the resident's attending physician, routine drugs should be administered as scheduled. The nurse should enter an explanatory note in the progress notes for eMAR (Electronic Medical Administration Record) when drugs are withheld, refused, or given other than at scheduled times. The physician should be notified of drugs that are withheld and or repeated refusal of drugs. A review of the facility's Medication Errors and Adverse Reactions police dated April 2022, revealed Drug errors and adverse drug reactions should be reported to the resident's attending physician. 1. A review of the electronic medical record (EMR) revealed that R2 was admitted to the facility on [DATE] and had a recent hospitalization from 3/1/2025 to 3/14/2025. R2 had diagnoses that included hypertensive heart disease, heart failure, and dementia. A review of R2's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/19/2025 revealed R2 scored a two out of 15 on her Brief Interview for Mental Status (BIMS), which indicated severe cognitive impairment. A review of R2's Order Summary Report dated 3/25/2025 revealed orders that included isosorbide dinitrate 10 milligrams (mg) three times a day for angina (chest pain) and metoprolol succinate extended release 25mg daily for hypertension (high blood pressure). A review of R2's Medication Administration Record (MAR) for March 2025 revealed that isosorbide dinitrate was ordered to be administered at 9:00 am, 1:00 pm, and 5:00 pm. It was documented as not administered/see progress note on 3/14/2025 for the 5:00 pm dose, refused for all three doses on 3/15/2025, not administered/see progress note for all three doses on both 3/16/2025 and 3/17/2025. The metoprolol succinate was scheduled for 5:00 pm and was documented as not administered/see progress note on 3/14/2025, refused on 3/15/2025, and not administered/see progress note on both 3/16/2025 and 3/17/2025. A review of R2's Prog Note written by Licensed Practical Nurse (LPN)4 on 3/14/2025 at 5:33 pm and 5:34 pm documenting new admission, pending pharmacy delivery. NP [nurse practitioner] notified for both the isosorbide dinitrate and metoprolol succinate. On 3/16/2025 at 1:06 pm, an eMAR note documented, medications are not in stock, and an eMAR note on 3/17/2025 at 8:41 pm documented Medications on order. Pharmacy notified and is sending on 3/17/2025. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Pyxis (contingency supply of medications) Inventory Summary supplied by the facility and dated 3/14/2025, revealed that both the metoprolol succinate 25mg and the isosorbide dinitrate 10mg were available in it. During an interview on 3/26/2025 with LPN4, she reported that the facility sometimes had issues getting medications from the pharmacy timely. There was a Pyxis with medications in it, but she did not have access as an agency nurse. LPN4 stated she brought it to management's attention if she had issues getting medications from the pharmacy and asked for assistance to get medications from the Pyxis. During an interview on 3/26/2025 with LPN5, she reported that if a medication has not been delivered by the pharmacy, it might be in the Pyxis. LPN5 did not have access to the Pyxis but asked management to assist when needed. If a medication was not in the Pyxis, staff were to let the pharmacy and doctor know. During an interview on 3/27/2025 with Nurse Practitioner (NP)1, she stated the pharmacy does not always send medications. When asked if that was an issue for the facility, NP1 responded, It's 100 percent an issue here. NP1 reported she expected medications in the Pyxis to be used if available. During an interview on 3/27/2025 at 1:08 pm, the Director of Nursing (DON) reported that the unit managers, the Assistant Director of Nursing (ADON), and she reviewed missed medications. The DON reported she has spoken to the pharmacy director and the pharmacist about concerns with medications not being delivered timely. The DON expected medications to be pulled from the Pyxis if stocked there. The DON expected nurses to contact the pharmacy if a medication was not available and alert the physician or nurse practitioner, and document what was done. 2. A review of the EMR revealed R72 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus with diabetic polyneuropathy. A review of the quarterly MDS with an ARD of 12/22/2024 revealed R72 was intact in cognition with a BIMS score of 13 out of 15. R72 had received insulin injections for all seven days of the assessment period. During an interview on 3/29/2025 at 11:12 am, R72 stated she was prescribed 15 units of insulin to be administered before 8:00 am every day. R72 stated she was told this morning by LPN9 that he did not have insulin on his cart, and she had not been administered insulin. R72 stated she was concerned and she read her glucose monitor, which indicated her blood sugar was high at 258, and she showed the surveyor the monitor, which read 258. A review of R72's Order Summary Report dated 3/29/2025 revealed R72 had an order for Insulin Aspart Prot & Aspart Subcutaneous Suspension (70-30) 100 unit/ML[milliliter] (Insulin Aspart Protamine & Aspart (Human)), Inject 15 units subcutaneously one time a day related to type 2 diabetes mellitus with diabetic polyneuropathy. A review of R72's MAR dated March 2025 revealed that on 3/29/2025, R72 was not administered her am dose of Insulin Aspart Prot & Aspart Subcutaneous Suspension (70-30) 100 units/ml, and a code of 13 (not administered/see progress notes) was entered. The MAR revealed R72's blood sugar on 3/29/2025 at 6:30 am was 155, and at 11:30 am it was 255. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Orders Administration Note dated 3/29/2025 at 11:47 am revealed Insulin Aspart Prot & Aspart Subcutaneous Suspension (70-30) 100 unit/ml, Inject 15 units subcutaneously one time a day related to type 2 diabetes mellitus with diabetic polyneuropathy, Medication gone beyond 28 days, called pharmacy for reorder and on-call made aware. During an interview on 3/29/2025 at 11:18 am, LPN9 stated that the Insulin Aspart Prot & Aspart Subcutaneous Suspension (70-30) that should have been administered to R72 before breakfast had expired, and that was why he did not administer it this morning. LPN9 stated it had been opened more than 28 days ago, which was the maximum allowed time the vial could be opened and used. LPN9 stated he called the on-call Physician, and the replacement insulin was ordered stat (needed urgently). He stated that once it came in, he would administer it before R72's next meal. LPN9 stated he checked R72's blood sugars before each meal and would check her before lunch blood sugar now. LPN9 stated the insulin should be delivered within the next hour. During an interview on 3/29/25 at 12:45 pm, the Unit Manager/Infection Preventionist (IP)2 stated she was not sure if the Insulin Aspart Prot & Aspart Subcutaneous Suspension (70-30) was in the emergency (E)-kit. The Unit Manager/IP2 went and looked in the E-kit and stated it was not included in the emergency kit. She stated the insulin order should be stat because it was important that R72 receive it. During a follow-up interview on 3/29/2025 at 3:43 pm, Unit Manager/IP2 stated nursing had been monitoring R72's blood sugars today and would call the on-call Physician if they were off. The Unit Manager/IP2 stated the insulin would not be coming today until around 7:30 pm. The Unit Manager/IP2 stated R72's morning dose of insulin was important to control her blood sugar throughout the day. During a follow-up interview on 3/29/2025 at 4:25 pm, Unit Manager/IP2 stated R72 had not been administered any insulin today because R72's sliding scale insulin was the same insulin as her morning insulin, and the facility did not have any in stock. The Unit Manager/IP2 stated that the sliding scale insulin should be Aspart Novolog, but it had been incorrectly transcribed yesterday. The Unit Manager/IP2 stated R72's before-dinner blood sugar had just been checked and was 125, and R72 reported feeling fine. During an interview on 3/29/2025 at 6:45 pm, the Regional Director of Clinical Operations (RDCO) stated she was in the process of dealing with the pharmacy about the E-kit. She stated they were looking at other pharmacies to contract with. The RDCO stated the medication carts were checked a couple of times a week, and medications were reordered to stay on top of expired medications.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, record reviews, and a review of the facility's policy titled Test Tray, the facility failed to ensure the food was palatable for five out of 40 sampled residents (R) (R72, R31, R10, R14, and R30) and for residents who attended resident council meetings. Specifically, the food was not served at palatable temperatures; the food was bland; leftovers were routinely served in place of freshly prepared food; and condiments such as salt, pepper, sugar, and sugar substitute were not served in accordance with the menu. Findings included: A policy for food palatability was requested, and the undated Test Tray policy was provided by the facility. Review of the Test Tray policy revealed the facility would audit meal trays to ensure proper temperatures and acceptable quality of all foods served. Standards included residents being served their trays within 20 minutes of assembly. The standard for food temperatures on the tray 20 minutes after dishing up the trays was: 150 degrees Fahrenheit (F) for soup; 130 degrees F for the entrée, starch, and vegetable, and 150 degrees F for hot beverages. Cold food standards were fruit 50 degrees F, dessert 50 degrees F, and milk 41 degrees F. The Test Tray policy indicated, Any hot food items <120 [degrees] or potentially hazardous cold food items>55 [degrees] yield an unacceptable tray. 1. A review of the quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/22/2024 revealed R72 was intact in cognition with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. During an interview on 3/25/2025 at 11:51 am, R72 stated she did not like the food. R72 stated the food was not hot, and she had been told hot food could not be provided because it would burn her. R72 stated the facility did not provide salt and pepper, so she kept her own salt and pepper shakers in her purse and brought them down to the dining room for meals. 2. A review of the quarterly MDS assessment with an ARD of 2/22/2025 revealed R31 was intact in cognition with a BIMS score of 15 out of 15. During an interview on 3/26/2025 at 11:31 am, R31 stated that the food was lacking in flavor, and it was not hot. R31 stated she had not been served a hot meal since coming to the facility. 3. A review of R10's quarterly MDS with an ARD of 1/12/2025 revealed R10 was unimpaired in cognition with a BIMS score of 15 out of 15. During an interview on 3/25/2025 at 2:21 pm, R10 stated that the main complaint at the resident council meeting was food. R10 stated that the food was not good and was not hot. 4. A review of the quarterly MDS with an ARD of 1/18/2025 revealed R14 was intact in cognition with a BIMS score of 15. During an interview on 3/26/2025 at 3:49 pm, R14 stated, The food is so nasty. R14 stated that the facility served foods such as onion soup that were inedible. R14 stated that salt and pepper were not provided. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. A review of the admission MDS with an ARD of 2/24/2025 revealed R30 was intact in cognition with a BIMS score of 14 out of 15. During an interview on 3/26/2025 at 8:39 am, R30 stated that the pureed diet food he received did not taste or look good. 6. A review of Resident Council Minutes from November 2024 through March 2025 revealed concerns with food palatability as follows: a. The Resident Council Minutes dated 11/16/2024 revealed, under the heading of New Business, a concern about cold food. b. The Resident Council Minutes dated 12/4/2024 revealed, under the heading of the Old Business Review, that cold food was still an issue. c. The Resident Council Minutes dated 1/8/2025 revealed, under the heading of the Old Business Review, that cold food was an ongoing issue. d. The Resident Council Minutes dated February 2025 (no specific date documented) revealed under the heading of the Old Business Review that the food was cold and was an ongoing issue. e. The Resident Council Minutes dated 3/5/2025, revealed under the heading of New Business Review, that the pork chops were tough. A review of the Fall/Winter Week at a Glance Menu, Week 1, provided by the facility, revealed lunch consisting of ham steak with pineapple glaze, collard greens, baked sweet potato, a dinner roll, and baked cinnamon-sliced apples. In addition, salt, pepper, and sugar (one packet each) were included for the lunch meal. A review of the Fall/Winter Week at a Glance Menu, Week 1, provided by the facility, revealed dinner on 3/27/2025 consisting of vegetable soup with crackers, Philly cheesesteak, chips, and fruit cocktail. In addition, salt, pepper, and sugar (one packet each) were to be included for the dinner meal. Kitchen and dining observations revealed concerns with food palatability as follows: During the initial kitchen inspection on 3/25/2025 from 10:05 am through 10:40 am, the following was observed: -There were two trays full of poured glasses of tea and a pink/red colored beverage sitting on the counter at room temperature at 10:07 am. The beverages were in the same location at the end of the inspection at 10:40 am. -There was a large resealable bag containing scrambled eggs on the counter. The food was warm from breakfast, with condensation noted in the bag, and it was dated 3/25/2025. -In the reach in refrigerator, there were steam table pans, one with leftover pureed eggs and one with leftover pureed sausage, both dated 3/25/2025. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bell Minor Home, The	2200 Old Hamilton Place NE Gainesville, GA 30507

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a lunch meal observation on 3/25/2025 at 12:11 pm in the main dining room, residents were waiting for lunch, which was served starting at 12:21 pm. The meal consisted of dried pieces of ham without evidence of a pineapple glaze, cooked greens, canned sweet potatoes, a roll with margarine, and either canned peaches or canned pears. The peaches had not been drained and were observed floating in the juice from the can in the individual bowls served to residents. During an observation and interview on 3/25/2025 at 12:32 pm, R72 had not eaten the ham and stated it was too hard. R72 had eaten less than 25% of the meal of ham, greens, sweet potato, roll, and peaches. The meal observation revealed that residents eating in the main dining room were not offered salt or pepper with the meal. An observation in the kitchen on 3/27/2025 at 4:59 pm revealed the tray line contained hoagie rolls, cheese steak filling, potato chips, vegetable soup (peas, carrots, corn, green beans, and lima beans in broth), and canned fruit. There were no salt, pepper, or sugar packets on the tray line, and the tables in the dining room did not have condiments available. There was no plate warmer or pellet system for keeping food hot. Insulated plastic bases and lids were used. The meal service to the dining room consisted of placing residents' trays on a sheet pan cart that was not enclosed, and once the cart was full, it was wheeled into the dining room, and residents were served. An observation of the contents of the reach in the refrigerator was made with the Dietary Manager (DM) on 3/27/2025 at 5:08 pm. There were steam table pans of leftover oatmeal dated 3/27/2025 and leftover scrambled eggs dated 3/27/2025. The DM stated that the dietary staff held leftovers for three days. He stated they reused scrambled eggs, oatmeal, and pureed foods from previous days to serve first, before using fresh food. The tray line meal service was observed for the main dining room and for the first cart beginning at 5:14 pm. The dining room was served first, and then A Hall Cart, which held 30 trays, and a test tray was added as the last tray on the cart to be evaluated by the DM and surveyor. The A Hall Cart start time for loading trays was 5:40 pm. The cart was full at 5:58 pm and was wheeled to the A Hall. An observation revealed that nursing staff started to serve trays from the A Hall Cart at 6:01 pm. There were no condiments such as salt, pepper, or sugar on the trays or food cart. The nursing staff who were serving the trays did not offer residents salt, pepper, or sugar/sugar substitute (cold tea was served as a beverage). During an interview on 3/27/2025 at 6:06 pm, the DM stated the nursing staff should offer salt and pepper and verified that there was no salt or pepper available. The DM stated that if a resident wanted salt or pepper, the nursing staff should go to the kitchen and get it. The DM verified that residents in the dining room were also not offered salt or pepper, but they could also ask for it. The DM stated he received food complaints from the resident council about cold food, and getting the food carts unloaded on time was a concern. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations revealed all residents had been served their meals on 3/27/2025 at 6:18 pm from the A Hall Cart. The total time from loading the cart until the last tray was served was (5:40 pm - 6:18 pm) 38 minutes, exceeding the Test Tray policy goal of 20 minutes. The DM stated the cart was not served as quickly as he would like to see. The test tray was evaluated at this time by the DM and the surveyor. The temperatures measured by the DM were 95 degrees F for the Philly cheese steak filling. The DM stated, That's low. The DM and surveyor agreed it tasted good but was cool and not hot. The DM stated his goal was for hot foods to be 135 degrees F when residents received their meals. The vegetable soup was 128.3 degrees F and was warm. This was verified by the DM and surveyor. The surveyor's impression was that it was bland and lacking in flavor. The canned peaches were 54 degrees F, and the DM stated the goal was 40 degrees F for cold foods. The peaches were cool but not cold. The tea was 48 degrees F and was cool; it was not sweet, and no sugar or sugar substitute had been offered to residents. During an interview on 3/26/2025 at 9:04 am, the Regional Dietary Manager (DM) stated the facility had minimal food waste. The Regional DM stated they utilized leftover foods to serve to residents on pureed diets and mechanical soft diets on subsequent days. During an interview on 3/29/2025 at 8:59 am, Registered Dietitian (RD)2 stated the dietary staff should not be reusing foods such as scrambled eggs, sausage, and leftovers to serve to residents daily instead of preparing fresh food. RD2 stated she would look into that. RD2 stated dietary staff should throw out pureed foods and scrambled eggs and not reuse them for serving another meal because this was a palatability issue. RD2 also stated the food should be hot when served to residents. RD2 stated staff should offer salt and pepper, and it should be on the food cart taken to the units for meal service. During an interview on 3/29/2025 at 10:56 am, Social Worker (SW) A Hall stated she attended and coordinated the resident council meetings. SW A Hall stated that residents expressed dietary concerns at every meeting. SW A Hall stated that residents routinely complained that the food was cold. During an interview on 3/29/2025 at 2:20 pm, the DM stated the dietary staff had not been providing salt, pepper, sugar, or sugar substitute packets as directed on the menus.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observations, interviews, record review, and a review of the facility's policy titled Menu Planning, the facility failed to ensure there was not more than a 14-hour gap between the evening meal (dinner) and breakfast the following day for 99 out of 101 residents (two residents received nutrition via tube feeding). The planned meal gap between dinner and breakfast the following day was 15 hours. A substantial evening snack was not provided, and the resident group had not approved of the 15-hour gap between dinner and breakfast. This created the potential for residents to experience hunger while waiting for breakfast. Findings included: A review of the undated Menu Planning policy revealed, Menus are written in advance to include at least three meals daily at regular times. The facility did not have a policy more specific to mealtimes and how much time could elapse between dinner and breakfast. A review of the undated Mealtimes document, provided by the facility, revealed breakfast was scheduled to be served at 8:00 am in the Main Dining Room, 8:15 am on A Hall, and 8:30 am on B Hall. Lunch was scheduled to be served at 12:00 pm in the Main Dining Room, at 12:15 pm on A Hall, and at 12:30 pm on B Hall. Dinner was to be served at 5:00 pm in the Main Dining Room, at 5:15 pm on A Hall and at 5:30 pm on B Hall. There was a 15-hour span for each location from dinner until breakfast the following day. A meal observation revealed breakfast on 3/26/2025 in the Main Dining Room was served after the scheduled time of 8:00 am. Observation on 3/26/2025 at 9:10 am revealed the last resident had just been served. Most residents in the dining room were eating their breakfast at this time. A meal observation for breakfast on 3/26/2025 at 9:19 am revealed the cart for A Hall was being served; it was scheduled for meal service to begin at 8:15 am. Breakfast being served late created the potential for a longer delay than the scheduled 15-hour delay between dinner and breakfast. A review of R72's quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/22/2024 revealed R72 was intact in cognition with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. During an interview on 3/25/2025 at 11:51 am, R72 stated she did not always get enough to eat at dinner, and that breakfast the next day was served between 8:00 am and 8:30 am. R72 stated it was a 15-hour gap between dinner and breakfast, and by the time breakfast came, she was hungry. R72 stated there were snacks with chips and cookies at night, but she did not eat that type of snack. A review of R14's quarterly MDS assessment with an ARD of 1/18/2025 revealed R14 was intact in cognition with a BIMS score of 15 out of 15. During an interview on 3/29/2025 at 11:31 am, R14 stated residents had asked about the long period between dinner and breakfast at resident council meetings. R14 stated she was not offered a snack in the evening; she had to go to the nursing station to get one if she wanted one. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/29/2024 at 10:56 am, Social Worker (SW) A Hall stated she coordinated and attended the resident council meetings. SW A Hall stated she did not remember talking about the gap between dinner and breakfast at the meetings, and the group definitely had not approved of the 15-hour period between dinner and breakfast. SW A Hall stated residents frequently complained about not being served timely manner. During an interview on 3/27/2025 at 6:14 pm, the Dietary Manager (DM) stated he got complaints from the resident council about late meals, and getting carts unloaded timely manner was a concern. The DM stated a bedtime snack was offered and consisted of individually packed chips, cookies, drinks, etc., with one cart going to both A and B nursing stations. During an interview on 3/29/2025 at 8:59 am, Registered Dietitian (RD)2 stated no more than a 14-hour gap was allowed between dinner and breakfast, and the mealtimes would need to be adjusted, taking this into account. During an interview on 3/29/2025 at 2:20 pm, the DM stated he was aware of the requirement that no more than 14 hours elapse between dinner and breakfast the next day. The DM stated that mealtimes were set up when he started in his position and had not changed. He stated he did not realize the scheduled gap was more than 15 hours; however, he verified it was a 15-hour gap after counting the hours on the Mealtimes document.

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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. Based on observations, interviews, record review, and a review of the facility's policy titled Policy: Hand Washing, the facility failed to maintain and practice food service principles in the kitchen in a manner to prevent the potential spread of food borne illness for 99 out of 101 total residents (two residents received nutrition via tube feeding). Specifically, staff did not adhere to hand hygiene principles when touching ready-to-eat food on the tray line; there was condensation between stacked plastic cups stored as clean; and labeling was inconsistent, making it difficult to determine when to discard leftover food. Findings included: A review of the facility's undated dietary department policy titled Policy: Hand Washing revealed, When to wash hands. After handling soiled equipment or utensils, during food preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks. Before donning gloves for working with food, after engaging in other activities that contaminate the hands. A review of the facility's undated and untitled food storage and labeling policy revealed, Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 3 days or discarded. All foods should be covered, labeled, and dated. All foods will be checked to ensure that foods (including leftovers) will be consumed by their safe use by dates. During the initial kitchen inspection on 3/25/2025 from 10:05 am through 10:40 am, observations revealed there were stacks of plastic cups (at least 30 cups) stored in a bin, on the clean side of the dishwashing area. There was pooled water/condensation between all the cups that were stored as clean. In addition, during the initial inspection, there were two steamtable pans with leftovers in the reach-in refrigerator with labels indicating the items were pureed eggs and pureed sausage. Both foods were dated 3/25/2025. It was unknown whether the date of 3/25/2025 was the date the food was placed into the reach in refrigerator or was the use-by date. Kitchen observations were made on 3/27/2025 from 4:59 pm through 5:55 pm. The Dietary Manager (DM) accompanied the surveyor to the dish washing room, and there were stacks of cups stored as clean, with pooled water and condensation between each cup. The DM verified the presence of pooled water/condensation between the cups. The DM stated the cups should be air dried and not stacked when they were wet, and this was important to prevent the growth of bacteria. The reach in the refrigerator was observed, and there was a steamtable pan of scrambled eggs and sausage patties, each dated 3/27/2025. The DM stated the staff had three days to use leftovers. The DM stated there should be two dates on the food: the first date when the leftover was placed into the refrigerator, and the second date was the use-by date (three days later). There was also a steamtable pan labeled mashed potatoes with a date of 3/26/2025. The DM verified it was unknown if the date of 3/26/2025 was the date the item was placed in the refrigerator or the date it expired (use by date). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The tray line meal service was observed from 5:22 pm, when it started, until 5:55 pm, at which time the DM and surveyor left the kitchen. More than half of the residents' trays were observed being dished up (Dining Room and A Hall cart). During the tray line observations, two dietary staff who were both wearing gloves, Dietary Aide (DA)1 and DA2, touched ready-to-eat food without adequate hand hygiene being implemented. DA1 placed hoagie buns onto the plates for residents (except those on pureed diets) using gloved hands for every sandwich served. With the same gloved hand, DA1 touched the utensil handles, silverware, tray cards, plates, counter, plastic packages of crackers, and the reach-in refrigerator handle. DA2 placed potato chips from a bulk container onto the plates for residents (except those on pureed diets) using a gloved hand. With the same gloved hand, DA2 touched plates, utensil handles, cups, silverware, the counter, and tray cards. Neither DA1 nor DA2 was observed to wash their hands or change gloves during the procedure. During an interview on 3/27/2025 at 6:05 pm, the DM verified that DA1 and DA2 touched ready-to-eat food (rolls and potato chips) with the same gloved hands that they touched multiple other items with. The DM verified that gloves were intended to be single-use and that they could touch ready-to-eat foods; however, they could not touch anything else with the same gloved hands. During an interview on 3/27/2025 at 6:20 pm, DA1 stated she had not thought about touching the bread and everything else with the same gloved hand. She stated she should not have touched other items with the same gloves she used to serve the roll. During an interview on 3/26/2025 at 9:04 am, the Regional DM stated that everything refrigerated should be labeled with the date it went into the refrigerator and with the discard date. The DM stated, There should be two dates. During an interview on 3/29/2025 at 9:06 am, Registered Dietitian (RD)2 stated that staff wearing gloves were not allowed to touch anything besides the food they were serving. She stated that if they needed to touch something else besides the food, they should change their gloves. The RD stated that labeling for leftovers should document the date the food went into the refrigerator and the use-by date.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations, interviews, and a review of the facility's policy titled Waste Disposal, the facility failed to ensure the dumpster area was maintained in a sanitary manner to prevent harborage of pests. This had the potential to affect 101 of 101 residents who resided at the facility. There was garbage on the ground around the dumpster and strewn along the edge of the parking area for three days of the survey. The dumpster door was open, and a bag, stuck in the lid, hung outside the dumpster. Findings included: A review of the undated Waste Disposal policy revealed, All garbage will be disposed of daily and as needed throughout the day. Trash will be deposited into a sealed container outside the premises. Dietary will maintain the cleanliness of the surrounding area. During an observation on 3/25/2025 at 10:30 am, the garbage dumpster area was noted with two dumpsters, one for garbage and one for cardboard. Garbage was strewn around the dumpsters in the parking lot and along the grass edge of the parking lot for approximately 100 feet. Garbage included numerous cigarette butts, assorted plastic pieces, individually portioned plastic food containers such as ice cream, a variety of lids, cardboard pieces, pieces of paper, a pile of garbage on the edge of the pavement near the dumpster with cardboard, used latex gloves (at least 20), wipes, several surgical masks, two toothbrushes, plastic soda bottles, several plastic straws, cigarette boxes, paper, and plastic medication cups. There was garbage strewn from the dumpster approximately 100 feet along the edge of the parking lot including miscellaneous pieces of paper, numerous gloves, cigarette butts, plastic pieces, and water bottles. There were no staff in the area disposing of garbage. During an observation on 3/27/2025 at 7:45 am, the garbage dumpster area was found in the same condition with garbage around the dumpsters including numerous cigarette butts, assorted plastic pieces, individually portioned plastic food containers, a variety of lids, cardboard pieces, pieces of paper, a pile of garbage on the edge of the pavement near the dumpster with cardboard, used latex gloves (at least 20), wipes, several surgical masks, two tooth brushes, plastic soda bottles, several plastic straws, cigarette boxes, paper, and plastic medication cups. There was garbage strewn along the edge of the parking lot approximately 100 feet. At this time, the side door to the regular garbage dumpster was open, and it was half full of garbage bags. There was also a 55-gallon garbage bag that was stuck in the lid and was hanging on the outside of the dumpster. There were no staff in the area disposing of garbage. During an observation on 3/27/2025 at 4:49 pm with the Dietary Manager, the dumpster area was in the same condition as noted on 3/25/2025 at 10:30 am and 3/27/2025 at 7:45 am. The Dietary Manager (DM) verified that the area needed to be cleaned up and stated it was the responsibility of the maintenance department to do so. At this time, the side door to the regular garbage dumpster continued to be open, and it was half full of garbage bags. The 55-gallon garbage bag that was stuck in the lid and was hanging on the outside of the dumpster continued to be present. The DM stated garbage bags should be inside the dumpster, and the doors closed when the dumpster is not being used. The DM stated this was important to prevent rodents, pests, and contamination from the garbage. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/29/2025 at 9:34 am, the Maintenance Director (MD) stated that departments such as dietary and housekeeping were responsible for maintaining the dumpster area when they dispose of garbage. The MD stated maintenance was responsible for ensuring the area was cleaned up weekly and stated Mondays were the day he usually did that. However, he stated he had missed Monday this week for cleaning the area. The MD stated he was notified by the DM that the area needed to be cleaned up on 3/27/2025, and he came and cleaned it on 3/28/2025. The MD verified the presence of the garbage, including numerous gloves, and all the garbage along the edge of the parking lot. The MD stated he removed the garbage bag that was hanging on the outside of the dumpster on 3/28/2025.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interviews, facility policy review, and job description review, the facility administration failed to use resources to ensure residents attained and maintained their highest physical well-being. The facility's Administrator and the Director of Nursing (DON) failed to identify failures from nursing and other facility staff, which caused the actual harm and/or death of residents. 1. The facility's administration failed to ensure that residents' physicians and/or other medical providers were notified after R159 and R9 had changes in conditions related to the worsening of their skin conditions. Cross Reference F580-J 2. The facility's administration failed to ensure residents were free from neglect and abuse. Nursing staff neglected to identify and/or report the worsening of R159's and R9's skin conditions, which led to actual harm and death. Additionally, the facility failed to protect R360 from being abused by R46, even though the facility documented copious notes where R46 abused multiple other residents. Cross Reference F600-J 3. The facility's administration failed to ensure licensed nurses used their professional standards of nursing practices to identify the worsening of R159's skin condition. The facility's nurses failed to appropriately assess, intervene, and notify the resident's physician on several occasions of changes in the resident's skin condition. Cross Reference F658-J 4. The facility's administration failed to ensure nursing services were provided to prevent the development of a serious pressure ulcer. Cross References F686-J 5. Additionally, Substandard Quality of Care (SQC) was identified at §483.12, Free from Abuse and Neglect F600, and at §483.25 Quality of Care, Treatment/Services to Prevent/Heal Pressure Ulcers. On 3/28/2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator and Regional Director of Clinical Operations (RDCO) were informed of the Immediate Jeopardy (IJ) for F580, F600, F658, F686, and F835 on 3/28/2025 at 6:27 pm. The facility was unable to provide an acceptable IJ Removal Plan before the survey team's exit on 3/30/2025, and the IJ remained ongoing. Findings included: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility-provided job description titled Administrator revealed Summary The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines and regulations that govern long-term care facilities to ensure that the highest degree of quality care can be provided to our residents at all times. A review of the facility-provided position description titled Director of Nursing revealed Overview: Provides leadership and direction for the nursing staff while being responsible for the overall management of the Nursing Department. Ensures nursing staff's compliance with all facility and nursing policies and procedures as well as compliance with regulatory requirements. During an interview on 3/28/2025 at 8:57 am, the DON confirmed she started the position in May 2024 and was responsible for the overall management of the nursing staff. The DON stated the nurses did not follow the change in condition policies, but had received training on the policy during in-services held in 2024. The DON stated the Assistant Director of Nursing (ADON) was responsible for training the agency and full-time staff on the policies during orientation and in-services provided throughout the year. The DON stated she expected the nurses to complete alert charting when a change in condition was identified, to notify the provider, to perform a thorough assessment of the resident, and document a change in condition by completing an SBAR (situation, background, assessment and recommendation) form in the electronic medical record (EMR). During an interview on 3/28/2525 at 9:32 am, the Administrator confirmed he was responsible for the overall management of the facility, and the DON was responsible for the management of the nursing staff, and the ADON for the education of nursing staff. The Administrator stated that the nurses' failure to identify a change in condition and report it to the provider was not per the change in condition policy. During an interview on 3/28/2025 at 10:00 am, the ADON verified that she was responsible for training the nursing staff on nursing policies. ADON stated she trained the nurses on the change in condition policy last year, and she held a skills fair in 2025. The ADON stated there was a change in condition policy at each nurse's station in a binder and posted by the time clock. The ADON stated that the nurses who have been working should also be able to identify a change in conditions because it was not new to them.

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	115020	A. Building B. Wing	03/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bell Minor Home, The	2200 Old Hamilton Place NE Gainesville, GA 30507

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide a neutral and fair arbitration process and agree to arbitrator and venue. Based on interviews, record review, and review of the Arbitration Agreement, the facility failed to ensure that the Arbitration Agreement presented to residents and resident representatives during admission included a clause that a mutually convenient venue for the Arbitration would be selected. This failure had the potential to affect 101 of 101 residents who had signed the Arbitration Agreement and future residents who might sign the agreement. Findings included: A review of the undated Agreement to Resolve Disputes by Binding Arbitration provided by the facility revealed that the agreement did not provide for the selection of a venue that is convenient and agreeable to both parties. A review of The Bell Minor Home Resident List Report dated 3/25/2025 and provided by the facility revealed the facility had 101 residents in-house. During an interview on 3/25/2025 at 10:30 am, the Administrator stated every resident had signed the arbitration agreement in the admission packet upon admission, but no arbitrations had been conducted since 9/16/2019. During an interview on 3/28/2025 at 1:15 pm, the Administrator confirmed he had reviewed the Arbitration Agreement, and it did not include the clause for a mutually convenient venue for the arbitration to be selected by both parties. He also confirmed the agreement did not contain location criteria of any kind. An arbitration agreement policy was requested but not received before the exit of the survey.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interview, and a review of the facility's policies titled Enhanced Barrier Precautions and Isolation - Categories of Transmission-Based Precautions, the facility failed to ensure that infection control practices was followed for two of 40 sampled residents (R) (R51 and R78) related to: (1) utilizing the proper personal protective equipment (PPE) for enhanced barrier precautions (EBP) for R51; and (2) having PPE available outside of a room for staff to don for R78. Findings included: A review of the facility's Enhanced Barrier Precautions policy revised 3/30/2024, revealed that EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO (multi-drug resistant organisms) to staff hands and clothing. EBP is indicated for residents with indwelling medical devices such as feeding tubes. EBP is employed when performing the following high-contact resident care activities: dressing . device care of use: central line, urinary catheter, feeding tube. A review of the facility's Isolation - Categories of Transmission-Based Precautions policy revised September 2022, revealed that When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. Contact precautions are also used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, even before a specific organism has been identified. Staff and visitors wear disposable gowns upon entering the room. 1. A review of the electronic medical record (EMR) revealed R51 was admitted to the facility on [DATE] and had diagnoses that included gastrostomy (an opening into the stomach for feeding) status and dyskinesia (abnormal movement) of the esophagus. A review of R51's Care Plan revealed a nutritional focus area that R51 took nothing by mouth because she had tube feeding, initiated on 7/9/2024. An intervention, dated 3/3/2025, stated, Staff will use enhanced barrier protection (PPE) during peg [gastrostomy] care. A review of R51's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 3/11/2025 revealed R51 was rarely/never understood, and staff reported short-term memory impairment. R51 obtained more than half of her calories by tube feeding. A review of R51's Order Summary Report dated 3/27/2025 revealed an order for enhanced barrier precautions dated 3/25/2025. Medications were ordered to be given by gastrostomy tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/26/2025 at 1:31 pm Licensed Practical Nurse (LPN) 4 applied gloves, checked for tube placement of the feeding tube, and then flushed the tube with water, administered medication, and flushed the tube again. No gown was worn. An EBP sign was inside the room on the wall. The sign said to wear gloves and a gown for the following high-contact care activities: dressing. A separate paper hung by the EBP sign stated to use EBP for bathing/showering, transferring, changing linens, providing hygiene, changing briefs, device care, including tube feedings, and wound care. A contact precautions sign was posted in the hall next to the door to the room, which stated to wear a gown and gloves and see the nurse before entering. No PPE was located outside of the room. Gloves and gowns were placed in holders on the wall inside the room. During an observation on 3/26/2025 at 1:37 pm, R51's visitor pointed to the contact precautions sign and asked if there was something he needed to know. LPN4 stated he could go into the room. The visitor walked in without any PPE. During an interview on 3/26/2025 at 1:38 pm, LPN4 stated she believed the contact precautions sign was for R51's roommate, R78. LPN4 said she did not know how facilities decided who was on EBP. LPN4 stated the facility did not use EBP for catheters or tube feedings. 2. A review of R78's EMR revealed she was admitted to the facility on [DATE] and readmitted from the hospital on 3/3/2025. R78 was diagnosed with enterocolitis due to Clostridium difficile (C-diff) on 3/3/2025. A review of R78's admission MDS with an ARD of 2/26/2025 revealed R78 scored four out of 15 on the BIMS, which indicated severe cognitive impairment. A review of R78's MAR for March 2025 revealed an order for vancomycin HCl oral suspension 50mg/mL (milligram per milliliter) give 2.5mL by mouth four times a day for C. Difficile for nine days, starting 3/3/2025. A review of R78's Prog Note revealed an entry dated 3/25/2025 by a nurse practitioner, The patient was reported to be having multiple loose stools. The patient is not a reliable historian. When asking the patient if she had been having diarrhea, she reported that she thought maybe she had, but it was getting better. She had multiple uncontrolled watery stools with a foul odor per CNA [Certified Nursing Assistant]. She continued to repeat watery stools pouring out when she was standing. Instructed the nurse to give Imodium, but collect a stool sample for culture first. The patient has a diagnosis of IBS-D (irritable bowel syndrome) and C-Diff. During an interview on 3/28/2025 at 10:42 am, LPN3 responded, That's a good question when asked how staff knew which of two residents in a room was on EBP when a sign was posted in the room, which did not identify which resident was on precautions. During an interview on 3/28/2025 at 10:43 am, CNA5 responded that she received a report from the nurses regarding who was on EBP when asked how staff knew which of two residents in a room was on EBP when a sign was posted in the room, which did not identify which resident was on precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/29/2025 at 3:30 pm, CNA3 stated staff were to wear a gown, mask, and gloves for residents who had catheters or tube feedings. Signs were posted on the doors to the rooms or bathrooms, or somewhere in the room for residents on EBPs. If there were two residents in a room and she was unsure which was on EBPs, she asked the nurse. For transmission precautions, she wore a gown and gloves, and a regular or N95 mask depending on the type of precautions. CNA3 stated that, technically, the PPE for transmission-based precautions should be outside the door. During an interview on 3/29/2025 at 3:58 pm, the Assistant Director of Nursing (ADON) stated that staff are educated on EBPs when they start, and the facility just had a skills fair teaching donning and doffing of PPE. ADON stated EBP was used when emptying a Foley catheter, changing a colostomy bag, or doing PEG (tube feeding) site care. ADON reported that staff were expected to wear gowns and gloves during those activities, but the gowns and gloves were not required for transfers of residents with catheters or PEG tubes. ADON said the CDC (Centers for Disease Control) stated EBPs were not needed when flushing or administering medications via a PEG tube. Staff knew which residents the signs referred to because they conveyed the information during huddle and walking rounds. A resident on contact precautions should have a plastic cart with PPE in it outside their room and a sign stating visitors were to see the nurse before entering the room. During an interview on 3/29/2025 at 6:26 pm, the Regional Director of Clinical Operations (RDCO) stated she expected the facility to follow the CDC guidelines for EBPs and transmission-based precautions. Staff should use EBPs and wear a gown and gloves for any contact care, including PEG tube flushes and medication administration. The RDCO stated she typically saw PPE outside of the rooms, but the facility was told during their ICAR (Infection Control Assessment and Response) review that PPE outside of the rooms was a HIPAA violation.