STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115482	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Lake Arbor	304 Fifth Avenue Decatur, GA 30030

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50524 Based on observations, record review, and staff and resident interviews, the facility failed to ensure two of 45 sampled residents (R) (R51 and R38) call lights were accessible and placed within their reach while in bed. This deficient practice had the potential to cause delayed assistance, medical attention and worsening of the residents' medical conditions. Findings include: 1. Review of the Electronic Medical Record (EMR) for R51 revealed diagnoses that included but not limited to aphasia following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting the left non dominant side, muscle weakness, difficulty walking and need for assistance. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] for Section C (Cognitive Patterns), a Brief Interview of Mental Status (BIMS) revealed, R51 had a memory problem; Section GG (Functional Abilities and Goals) revealed, R51 required substantial /maximum assistance for toileting hygiene, bath, upper body dressing, personal hygiene and dependent on staff for lower body dressing and transfers. Observation on 1/6/2025 at 10:54 am revealed, R51 lying in bed with the call light observed on the floor beside bed. Observation on 1/6/2025 at 12:00 pm revealed, R51 lying in bed with the call light observed on the floor beside bed. Observation on 1/6/2025 at 3:00 pm revealed, R51 lying in bed with the call light observed on the floor beside bed. Interview on 1/6/2025 at 3:13 pm with Registered Nurse (RN) JJ confirmed the call light was on the floor beside R51's bed. She revealed, the call light should not be on the floor and should be on R51's bed and accessible to him. She further stated she should have clamped the call light on R51's pillow or his bedsheets beside him so that he could have access to the call light. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/6/2025 at 3:17 pm with Certified Nursing Assistant (CNA) KK confirmed the call light was on the floor beside R51's bed. She revealed, she attended to R51, and did not see the call light on the floor. She stated it should not be on the floor, and it should have been clamped on R51's pillow or bedsheet so that he could have access to it. Interview on 1/7/2025 at 1:31 pm with the Unit Manager (UM) MM revealed, the call lights should be in place for the residents to use. She stated her expectations were for the CNAs and the nurses to ensure the call lights were in place and accessible to the residents. She stated the CNAs do rounds every two hours and the nurses do rounds continually on the floor. She stated the call lights should be clipped on to the residents' pillows or their bedsheets as close to the residents as possible for them to access it. She further stated the outcome if the call lights were not in place could possibly cause harm to the residents if they did not have access to the call lights and needed help. Interview on 1/7/2025 at 1:39 pm with Director of Nursing (DON) revealed, his expectations were for the call lights to always be accessible to the residents. He stated anyone who goes into the residents' rooms should ensure the call lights were accessible to the residents. The DON further stated that primarily the nurses and CNAs were the ones who should ensure the call lights were always accessible to the residents. He stated the outcome if the call lights were not accessible to the residents would be a delay in care and it may also lead to grievances from the residents or family members. He stated it could also increase the level of dissatisfaction with the level of care provided by the facility. 50170 2. Review of the EMR for R38 revealed diagnoses that included but not limited to Parkinson's disease, dysphagia, contracture of muscle to the left upper arm and contracture of muscle to the right upper arm. Review of the Quarterly MDS dated [DATE] for Section C (Cognitive Patterns) revealed, a BIMS of 10 which indicated the resident was moderately impaired; Section GG (Functional Abilities and Goals) revealed, R38 required substantial /maximum assistance for toileting hygiene, bath, upper body dressing, personal hygiene and dependent on staff for lower body dressing and transfers. Observation on 1/8/2025 at 1:25 pm revealed, there were no staff members present in the hallway or the residents' rooms in the locked dementia unit. Upon entering R38's room, the resident was lying in bed with a substance, appearing to be food, coming from his mouth and onto his clothes and shoulder. The resident began to cry when approached. When asked what was wrong, the resident continued to cry. His call light was lying on the side of his bed near his head, but due to his contracted condition, he was unable to reach it. Observation and interview on 1/8/2025 at 1:30 pm revealed, R38 lying in bed with vomit on his mouth and clothing. When R38 was questioned, if he was, okay? he mumbled a response. R38 was asked if he could press his call light, and he mumbled, Yes. When prompted to demonstrate, the resident was unable to push the call light due to his contracted condition. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/8/2025 at 1:43 pm with CNA CC and CNA DD about R38's ability to call for assistance. CC stated that although R38 is contracted, You may not believe me, but this man can use his arm. CNA CC attempted to demonstrate this by pulling the covers down, but the resident did not move his arm. When asked how R38 typically calls for help, CNA CC responded that he would usually yell for assistance. CNA CC admitted that the call light was not in the proper position for the resident to use it and expressed uncertainty as to why it had been placed in a higher position. CNA DD explained that she was usually stationed near R38's room to monitor him for help as needed. However, when asked why no staff were present in the hallway or rooms at the time of the observation, CNA DD stated that she had been assisting another resident. CNA DD confirmed that R38 does not use the call light but instead typically says hey to get the staff's attention. Further interview, with CNA CC when asked again to demonstrate how R38 could call for help, CNA CC became defensive, stating, I don't know, this isn't usually my patient, but since y'all think I'm lying, I'm just going to leave. CNA DD then reiterated that R38 does not press the call light button and instead uses his voice to alert staff. During an interview on 1/8/2025 at 4:07 pm with the Director of Nursing (DON) revealed, that that R38 was able to press his call light when it was placed on his shirt, but not very often. DON revealed that he had personally answered R38's call light a couple of times. During an interview on 1/9/2025 at 10:32 am with the Restorative Aide, EE regarding R38's call light usage, she mentioned that while he initially did not use the call light, he has adapted to using a flat call device operated with his chin. She expressed confidence that the flat call device currently in place adequately meets his needs. Restorative Aide, EE believes that while R38 has pressed the call light using his contracted hand in the past, it may have been accidental, as he typically yells for assistance when needed. A policy was requested however, the facility's personnel stated there was no policy on call lights.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49396 Based on observations, resident and staff interviews, record review, and review of the facility-provided document titled Your Rights and Protections as a Nursing Home Resident, the facility failed to honor the resident's right to make a choice for one of 45 sampled residents (R) (R8) related to returning to bed for a nap. The deficient practice had the potential to place R8 at risk for unmet care needs and a diminished quality of life. Findings include: A review of the undated facility-provided document titled Your Rights and Protections as a Nursing Home Resident revealed the What are my rights in a nursing home? section included Be Treated with Respect: . You have the right to decide when you go to bed, rise in the morning, and eat your meals. A review of R8's electronic medical record (EMR) revealed diagnoses included a cerebrovascular accident (CVA) with right-sided hemiparesis, hypertension, type 2 diabetes mellitus, depression, anxiety, dementia, insomnia, and muscle weakness. A review of R8's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 14 (indicating little to no cognitive impairment). Section GG (Physical Abilities and Goals) documented the resident was dependent for transfers. A review of R8's Annual MDS assessment dated [DATE] revealed Section F (Preferences for Customary Routine and Activities) documented it was very important for the resident to make his own choices. A review of R8's Physician's Orders revealed no order or intervention for the resident to sit up in a wheelchair for eight hours a day. A review of R8's care plan dated 5/22/2019 revealed a Focus on activities of daily living (ADL) function, including The amount of care may vary from day to day. Interventions included allowing the resident to make choices and offer positive reinforcements when indicated. Observation on 1/6/2025 at 9:27 am revealed that R8 was asleep and leaning forward in a wheelchair in his room. Observation and interview on 1/6/2025 at 10:04 am revealed that R8 was sitting in his chair in his room. He stated he was ready to be put back to bed and pushed his call light for assistance. Observation on 1/6/2025 at 10:10 am revealed Certified Nursing Assistant (CNA) II entered the R8 room and closed the door. Observation on 1/6/2025 at 11:00 am revealed R8 was sitting in his wheelchair in his room. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with R8 on 1/6/2025 at 11:58 a.m., he stated that the facility staff would not assist him back to bed until after lunch. He stated he desired to take a catnap before getting back up for lunch. He further stated that he did not always want to take a nap before lunch, but he would like to from time to time. In an interview on 1/7/2025 at 4:17 pm, CNA II stated she recalled R8 did ask to be put back to bed on 1/6/2025, and later that day, he asked again. She stated she preferred he wait until after he ate his lunch to be put back to bed so she didn't have to keep getting him up and putting him back. She stated she understood his rights. In an interview on 1/8/2025 at 3:13 pm, Registered Nursing (RN) GG stated that if a resident requested to lie down, it was their right to do so. RN GG further stated she did not know why CNA II would refuse to put R8 to bed as much as he would like. In an interview on 1/9/2025 at 4:22 pm, the Director of Nursing (DON) stated that if a resident wanted to lie down, they should be allowed to do so.

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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** 38154 Based on staff interview and record review, the facility failed to accurately code a fall with major injury on the Minimum Data Set (MDS) for one of three residents (R) R14 reviewed for accidents. This failure had the potential to place R14 at risk for additional falls and an adverse effect on her quality of life and quality of care. Findings include: Review of R14's Admission Record revealed, diagnoses that included but were not limited to other fracture of upper end of left tibia, subsequent encounter for closed fracture with routine healing and other fracture of upper and lower end of left fibula, subsequent encounter for closed fracture with routine healing, dated 8/21/2024. Review of the Electronic Medical Record (EMR) revealed, R14 sustained a fall on 8/13/2024 when she attempted to get out of bed without calling for assistance. The x-rays revealed, a proximal fracture to the left tibia. R14 was hospitalized and treated without surgical intervention. R14 returned back to the facility on [DATE]. Review of the quarterly MDS assessments, dated 8/19/2024, 10/23/2024, and 11/25/2024 for Section J (Health Conditions) revealed, the omission of the fall sustained on 8/13/2024. Interview on 1/9/2025 at 3:33 pm with the MDS Coordinator confirmed the fall was not captured during those assessments and should have been. She stated, she would make the corrections immediately.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49396 Based on observations, staff interviews, record review, and review of the facility's policy titled Restorative Nursing Programs, the facility failed to revise the care plan that addressed the refusals of restorative nursing services for one of 45 sampled residents (R) R8. Specifically, the facility failed to revise the care plan that included alternative interventions for splint usage and Range of Motion (ROM) exercises. Findings include: Review of the facility's policy titled Restorative Nursing Programs, dated 2/1/2024 revealed, 10. A resident's Restorative Nursing plan will include: (a.) The problem, need, or strength the restorative tasks are to address. (b.) The type of activities to be performed. (c.) Frequency of activities. (d.) Duration of activities. (e.) Measurable goal and target date. Review of R8's clinical records revealed diagnoses that included cerebrovascular accident (CVA) with right-sided weakness and contractures of the right upper and lower extremities. Review of R8's physician orders dated 9/4/2019 revealed, Resident presents with right knee contracture, and would benefit from a right knee contracture splint to increase ROM and prevent/correct contractures, and deformities of the right knee; Resident presents with right wrist/hand contracture and would benefit from a contracture splint to increase ROM and prevent/correct contractures and deformities of the right wrist/hand. Review of R8's care plan with revision date of 9/26/2023 revealed, ADL function: [Resident Name] is at risk for Alteration in ADL (Activities of Daily Living) care r/t (related to) his h/o (history of) CVA with right sided weakness and vision deficit to right eye. He has contracture to RUE (right upper extremity) and RLE (right lower extremity). He is able to participate in his care minimally. Staff will adjust and assist. Often refuses ADL care and shower even though he is encouraged. Interventions included but not limited to Range of motion as ordered by PMD (date initiated 9/26/2023) and splints as ordered to right hand/right knee (date initiated 9/26/2023 with revision date of 11/3/2024). However, the care plan did not address R8's refusals of restorative care, including splint use, nor did it document any alternative interventions or strategies to encourage participation. Observation on 1/6/2025 at 9:28 am revealed, R8 was observed in his room in a wheelchair, sleeping and not wearing a splint to his right hand/wrist or right knee. Observation on 1/7/2025 at 4:17 pm revealed, R8 was observed in the dining room not wearing a splint to his right hand/wrist or right knee. Observation on 1/8/2025 at 10:35 am, revealed, R8 was observed in the dining room not wearing a splint to his right hand/wrist or right knee. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Registered Nurse (RN) GG on 1/9/2025 at 3:13 pm revealed, she had been at the facility since March 2024 and did not recall R8 having a splint or restorative services documented in his care plan prior to the survey. She later identified a note, revised on 1/9/2025, indicating refusals for splint use. Interview with Restorative Aide FF on 1/9/2025 at 3:15 pm revealed, she did not provide services for R8 unless explicitly documented in the care plan. She revealed, R8 often refused restorative care, which led to the service not being provided consistently. She confirmed that there was no prior documentation of refusals or interventions for refusal of restorative services in R8's records. During an interview on 1/9/2025 at 3:35 pm with the Minimum Data Set (MDS) Coordinator when asked about R8's care plan, regarding the use of a splints for his contractures and any documentation related to his refusals and interventions, the MDS Coordinator confirmed that splint use and resistance had been recently updated in the care plan as of 1/9/2025. The MDS Coordinator also confirmed that when R8's refuses the splint, staff were instructed to encourage him and document his refusals. The MDS Coordinator revealed, alternative interventions such as adjusting the splint or providing additional support, were not previously mentioned in the care plan however, the updated plan included specific language regarding his refusals and strategies for encouraging compliance. The MDS Coordinator emphasized that these updates were made to ensure accurate documentation and alignment with R8's current needs and behaviors. Cross Reference F688, F842

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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** 49396 Based on observations, resident and staff interviews, record review, and review of the facility's policy titled Activities of Daily Living, the facility failed to provide activities of daily living (ADL) care for three of 45 sampled residents (R) (R8, R38, and R16) according to the resident's care needs. Specifically, the facility failed to ensure R8 and R38 received nail care and failed to ensure R16 received a bath or shower. This deficient practice had the potential to place R8, R38, and R16 at risk for unmet needs and a diminished quality of life. Findings Include: A review of the facility's policy titled Activities of Daily Living, dated 2/1/2022, revealed the Policy section included . Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care. The Policy Explanation and Compliance Guidelines section included . 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1. A review of R8's Electronic Medical Record (EMR) revealed diagnoses included a cerebrovascular accident (CVA) with right-sided hemiparesis, type 2 diabetes mellitus with diabetic cataracts, legal blindness, and muscle weakness. A review of R8's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 14 (indicating little to no cognitive impairment). Section GG (Physical Abilities and Goals) documented upper and lower extremity impairment on one side and required substantial/maximal assistance for personal hygiene. A review of the care plan revealed a Focus area initiated on 5/22/2019 and revised on 9/26/2023 of ADL function, indicating the resident was at risk for alteration in ADL care due to CVA and vision deficit. Interventions/Tasks included communication to all staff regarding resident special care needs and goals. Observation on 1/6/2025 at 10:04 am revealed that R8 was sitting in his chair with his right hand contracted and his fingernails dirty and long and digging into the skin. Observation on 1/7/2025 at 4:11 pm revealed R8 was in the dining room, and his fingernails remained long and dirty. In an interview on 1/7/2025 at 4:17 pm, Certified Nursing Assistant (CNA) II confirmed R8's fingernails were long and dirty. She stated she had not noticed his nails being long and dirty. She further stated since R8 was diabetic, she would notify the nurse. Registered Nursing (RN) GG stated she could attempt to cut R8 nails, but due to their thickness, she would need to consult the podiatrist. RN GG confirmed that it was not a good idea to leave R8's nails so thick and long. RN GG asked R8 if he would be okay with getting his nails clipped, and R8 responded, Yes, it's hurting me really bad. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/8/2025 at 12:38 pm, the Director of Nursing (DON) revealed he expected resident shower days to include observations of nails to ensure residents were groomed appropriately. The DON stated if the shower was refused, observation of nails and hair should be documented on the shower sheet. He further stated nails should not grow to the length that they curl unless the resident wants them to, and the outcome included overgrown nails, which can be unsightly, and a buildup of dirt, which could be a health risk. 50170 2. A review of R38's EMR revealed diagnoses included Parkinson's disease, osteoarthritis, diabetes mellitus, muscle weakness, and contracture of muscle right and left upper arm. Review of R38's Quarterly MDS assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a BIMS of 10 (indicating moderate cognitive impairment). Section GG (Functional Abilities) documented R38 was dependent for ADL care, including personal hygiene. Review of the care plan dated 12/9/2024 revealed a Focus area of the resident was dependent with ADLs and care. Interventions/Tasks included ensuring the resident is groomed daily. Observation on 1/8/2025 at 1:33 pm revealed R38's nails appeared long, unclipped, and with dirt and debris built up on the thumb, and his hand was contracted. Observation on 1/8/2025 at 4:06 pm revealed R38's nails appeared to have been cleaned but were still long and unclipped. In an interview on 1/8/2025 at 1:43 pm, CNA DD confirmed they did need to do something about his nails. In an interview on 1/8/2025 at 4:07 pm, the DON acknowledged the resident's nails needed care due to them being unkept. In an interview on 1/9/2025 at 2:49 pm, CNA DD and Licensed Practical Nurse (LPN) NN revealed they provided nail care on R38's shower days on Tuesdays, Thursdays, and Saturdays. They stated R38 refuses to have his nails clipped. They further stated that hospice was responsible for bathing the resident and providing nail care, and it was also the facility's responsibility to provide nail care. LPN NN asked R38 if he would like his nails clipped and if his nails bothered him, and R38 replied, Yes. LPN NN declined to acknowledge the length of R38's nails and stated that they monitor him to ensure his nails aren't digging into his skin. In an interview on 1/9/2025 at 3:07 pm, the DON confirmed R38's nails had dirt and debris on them and declined to confirm how long R38's nails were. 38154 3. Review of R16's EMR revealed diagnoses to include hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side, dementia, hypertensive retinopathy, seborrheic dermatitis, and psoriasis vulgaris. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R16's Quarterly MDS assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a BIMS score of 11 (indicating mild cognitive impairment). Section E (Behavior) documented no behaviors. Section GG (Functional Abilities and Goals) documented R16 required partial to moderate assistance for oral hygiene and substantial to maximal assistance for toileting hygiene, shower/bathe self, lower body dressing, footwear, personal hygiene, and shower/tub transfer. Review of the care plan revealed a Focus area revised on 9/2/2021 of the resident was at risk for alteration in care related to impaired mobility and cognitive deficit. Staff will provide and adjust care as needed. The Goal was for R16 to appear clean, well-groomed, and dressed as per preferences. Interventions/Tasks included communication to all staff regarding the resident's special care needs and goals, encouraging the resident to participate to the fullest extent possible with each interaction, and establishing customary routine for ADLs that is agreeable to the resident. In an observation and interview with R16 on 1/6/2025 at 12:06 pm in his room, he was alert, oriented, and pleasant. Observation revealed the skin on his right arm was dry and scaly, his face was ashen, and debris was noted on his pillow and bedsheets. When asked if he received regular showers, he stated he did not. He stated his shower schedule was Tuesday, Thursday, and Saturday and that he did not get his shower last Saturday (1/4/2025). In an observation and interview with R16 in his room on 1/7/2025 at 11:42 am, he was alert, oriented, and pleasant. Observation revealed his skin was dry and ashen. He stated he did not have a shower today, but he could not recall if he had one yesterday. Review of the CNA Bath and Skin Audit Tool dated October 2024 to date revealed R16 received four showers in October 2024 (10/10, 10/14, 10/22, 10/24), one shower in November 2024 (11/7), seven showers in December 2024 (12/2, 12/4, 12/13, 12/18, 12/20, 12/25, 12/31), and two showers in January 2025 (1/2 and 1/6). In an interview with LPN LL on 1/7/2025 at 11:00 am, she stated the shower schedule was posted at each nurse's station and staff should report any missed or refused showers to the nurse. She stated the nurse would then visit with the resident to confirm the refusal, find out the reason, and try to determine a more suitable time for the resident to shower. She further stated the nurse should notify the charge nurse, the DON, and the Responsible Party (RP). She stated the shower should include shampoo, shave, and nail care. Finally, she stated the nurse had to sign off on all shower sheets. In an interview with CNA FF on 1/07/2025 at 11:15 am, she stated resident showers were scheduled twice a week and always included shampoo, shave, and nail care. She stated she would report missed showers or refusals to the nurse. In an interview with CNA II on 1/07/2025 at 11:30 am, she stated the CNAs offered showers twice weekly and as needed and included shampoo, shave, and nail care. She stated refusals or missed showers should be reported to the attending nurse. In an interview with LPN HH on 1/9/2025 at 1:19 pm, she stated without shower sheets, there was no way to confirm if a resident received his/her shower. She stated the number of documented shower sheets for R16 revealed he did not receive his showers as scheduled. She further stated that R16 had a history of refusing care, which should be documented on the shower sheets. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with RN GG on 1/9/2025 at 1:46 pm, she stated she expected the nursing staff to perform all scheduled showers and report refusals or missed showers to the attending nurse, who will sign off on all shower sheets, speak with the resident about the reason for the refusal, and notify the Unit Manager, Physician, DON, and the RP.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49396 Based on observation, staff and resident interviews, record review and review of the facility's policy titled Restorative Nursing Programs, the facility failed to provide evidence that restorative services for splinting and range of motion (ROM) were consistently provided for one of four residents (R) (R8) reviewed for rehab and restorative nursing services. Findings include: Review of the facility's policy titled Restorative Nursing Programs, dated 2/1/2024 revealed, 6. Residents, as identified during the comprehensive assessment process, will receive services from restorative aides when they are assessed to have a need for restorative nursing services. These services may include passive or active range of motion, splint or brace assistance, bed mobility training and skill practice, and training and skill practice in transfers or walking. Review of R8's Quarterly Minimum Data Set (MDS) dated [DATE] for Section C (Cognition) revealed, a Brief Interview of Mental Status (BIMS) of 5, which indicated moderate cognitive impairment, Section GG (Functional Abilities) revealed, R8 required substantial /maximum assistance for toileting hygiene, bath, upper body dressing, personal hygiene and dependent on staff for lower body dressing and transfers; and Section O (Special Treatments and Programs) revealed, no restorative services documented. Review of R8's physician orders dated 9/4/2019 revealed, orders for a right knee contracture splint to increase ROM and prevent/correct contractures and a contracture splint to increase ROM and prevent/correct contractures and deformities of the right wrist/hand. Record review of R8's Physical Therapy (PT) discharge summary revealed, that R8 received PT from 1/10/2024 to 3/8/2024; Discharge Recommendations: Restorative Program Established/Trained= Restorative Splint and Brace Program. Passive Range of Motion (PROM) right hand wrist all joints 10x2 reps. Right-hand splint application for four to six hours daily and monitor for pressure areas. Further review of R8's medical records revealed, no documentation that R8 received restorative services. Observation on 1/6/2025 at 9:28 am revealed, R8 was observed in his room in a wheelchair, sleeping and not wearing a splint. Observation on 1/7/2025 at 4:17 pm revealed, R8 was observed in the dining room not wearing a splint. Observation on 1/8/2025 at 10:35 am, revealed, R8 was observed in the dining room not wearing a splint. Interview on 1/6/2025 at 10:40 am with R8 stated he would feel more comfortable if they could put something in his hands, and maybe it wouldn't hurt him so much. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/9/2025 at 3:08 pm with R8 revealed, he doesn't recall ever wearing a splint, and he believe if he did, it wouldn't be so bad now. He said he never refused to get any help for his hand, and if possible, he would love to get some help now. Interview on 1/9/2025 at 3:13 pm with Registered Nurse (RN) GG revealed, she had been at the facility since March of last year, and she didn't ever recall R8 having a splint. She was not sure about restorative care if he refused or whether the care plan was being updated, but she would check the electronic medical records (EMR) in the Plan of Care (POC) section. She said that if any restoratives were needed, they would be in the EMR under POC. RN GG stated she was able to find a note that R8 refused splints, saying the word splints with s meant for his lower leg and right hand. RN GG was asked to provide the date. She stated it was revised today, 1/9/2025. Interview on 1/9/2025 at 3:15 pm with Restorative Aide (RA) FF revealed, when asked if she could locate the notes for restorative services for R8, she stated if it's not in the POC, she didn't provide services, and he must have refused. Interview on 1/8/2025 at 4:07 pm with the Director of Nursing (DON) revealed, that R8 was supposed to receive restorative nursing services. He revealed that he was unable to provide any documentation of restorative nursing care, even for the past six months, due to the system acquisition issues. A request was made upon the facility for additional documentation of the restorative nursing program for R8 but was not provided prior to the survey exit. Cross Reference F842, F657

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50524 Based on observations, staff interviews, record review, and review of the facility's policies titled, Medication Storage and Storage of Medications, the facility failed to lock two of four (100-Hall and 200-Hall) medication carts when not in use and failed to remove expired medications from two of four (100-Hall and 500-Hall) medication carts. Findings include: Review of facility's policy titled Medication storage dated 2/14/2024 revealed, Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (ie. Medication carts .). Review of facility's policy titled Storage of Medications dated 8/2024 revealed, 1. General Guidelines: 8. Outdated .medications . are immediately removed from inventory, disposed of according to procedure for medication disposal . 1. Observation on 1/7/2024 at 9:32 am revealed, the medication cart on the 100-Hall was left open and unattended during medication administration after Registered Nurse (RN) JJ removed medications from the medication cart and went into a resident's room without locking the medication cart. Observation on 1/7/2024 at 10:20 am revealed the medication cart on the 200-Hall was left open and unattended during medication administration after RN JJ removed medications from the medication cart and went into a resident's room without locking the medication cart. Interview on 1/7/2025 at 10:52 am with RN JJ revealed, the medication cart was not locked and was left unattended on the 100 and 200 halls. She stated she should not have left the medication cart open and unattended because someone could go in the cart. She stated, if a resident opened the cart, they would have access to the medications, and it could lead to a bad outcome for the resident. Interview on 1/8/2025 at 9:10 am with Director of Nursing (DON) revealed, his expectations was for the medication carts to be locked at all times when not in use. He stated the outcome would be the medication in the medication cart would be accessible to any unauthorized person such as visitors, unlicensed staff or residents. He stated if residents accessed the medications in the medication cart, they could experience adverse medical events. Interview on 1/8/2025 at 11:52 am with Unit Manager (UM) MM revealed, the medication cart should not be left open, and it should be locked by the nurse when not in use. She stated the outcome would be someone could possibly get in the medication cart when it was left open. She stated if a resident takes the medication from the cart because it was left open, the resident could get sick and need to be hospitalized . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Observation on 1/8/2025 at 10:50 am revealed, the 100 Hall cart had four bottles of expired medications. There were two bottles of iron tables which expired on 12/2024, one bottle of aspirin which expired on 12/2024 and one bottle of ferrous sulfate tables which expired on 12/2024. Observation on 1/8/2025 at 12:33 pm revealed, the 500 Hall cart had two bottles of expired medications. There was one bottle of iron tables which expired on 12/2024 and one bottle of pro-stat which expired on 9/2023. Interview on 1/8/2025 at 11:00 am with RN JJ confirmed the expired medications were in the medication cart. She stated that expired medications should not be in the medication cart. She further stated if the residents were administered the expired medications, they could possibly get sick. Interview on 1/8/2025 at 12:35 pm with Licensed Practical Nurse (LPN) LL confirmed the expired medications were in the medication cart. She stated that expired medications should not be in the medication cart. She further stated it was a medication error to administer expired medications to residents and it could cause complications if the residents were administered the expired medications. She also stated there could be adverse reactions to the residents if the residents received the expired medications. Interview on 1/8/2025 at 12:48 pm with UM HH for the 500-Hall revealed, medications should be checked by day and night shift nurses and the expired medications should be removed from the medication cart so that they would not administer them to the residents. She further stated if the residents received expired medication the outcome would be the medications would not work effectively, and the residents could get sick or have adverse effects of the expired medications. Interview on 1/8/2025 at 4:25 pm with UM MM for the 100 and 200 halls revealed, the day and night shifts nurses should check the medications daily and if the medications were expired, they should be disposed of. She further stated there would be no known outcome to the residents if they were given the expired medications. Interview on 1/9 2025 at 2:20 pm with the DON revealed, his expectations were for the expired medications to be promptly removed by the licensed nurses. He stated he was unsure of the outcome if residents received expired medications because he did not have much experience about expired medication and how it would affect the residents if they received it.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49396 Based on staff interviews, record review, and review of the facility's policy titled Restorative Nursing Programs, the facility failed to complete, maintain, and make readily accessible accurate documentation of medical records for one of four residents (R) (R8) reviewed for rehab and restorative nursing services. Findings include: A review of the facility's policy titled, Restorative Nursing Programs, dated 2/1/2024 revealed, 12. Restorative aides will implement the plan for a designated length of time, performing the activities, and documenting on the Restorative Aide Documentation Form. 13. The Restorative Nurse or designated licensed nurse will provide oversight of the restorative aide activities, review the documentation at least weekly, and evaluate the effectiveness of the plan monthly. Review of R8's medical records revealed diagnoses including a cerebrovascular accident (CVA) with right-sided weakness and contractures of the right upper and lower extremities. Review of R8's physician orders dated 9/4/2019 revealed, restorative services, including passive ROM for the right wrist and hand and the application of a splint for 4-6 hours daily to prevent contractures and maintain mobility. Review of R8's physical therapy discharge summary dated 3/8/2024 revealed, recommendations for the restorative program with right hand splint application for 4-6 hours daily and passive ROM (Range of Motions) exercises for the right wrist and hand. Review of R8's Quarterly Minimum Data Set (MDS) dated [DATE] for Section GG (Functional Abilities) revealed, R8 required substantial /maximum assistance for toileting hygiene, bath, upper body dressing, personal hygiene and dependent on staff for lower body dressing and transfers; and Section O (Special Treatments and Programs) revealed, no restorative services documented. Further review of R8's medical records revealed, there was no documentation of restorative nursing services being provided as ordered. Interview on 1/8/2025 at 4:07 pm with the Director of Nursing (DON) revealed, that R8 was supposed to receive restorative nursing services. He revealed that he was unable to provide any documentation of restorative nursing care, even for the past six months, due to the system acquisition issues. Interview on 1/9/2025 at 3:15 pm with Restorative Aide (RA) FF revealed, when asked if she could locate the notes for restorative services for R8, she stated if it's not in the POC. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/9/2025 at 4:45 pm, the Administrator acknowledged the facility's challenges in providing complete and accurate documentation of restorative nursing services for R8. He stated that, as of today, the facility had been working diligently to address the gaps identified during the investigation. The Administrator confirmed that restorative services, including splint application and ROM exercises, should have been documented in R8's medical records per the facility's policy. The Administrator noted that the facility had faced significant challenges related to the system transition from the previous ownership. This transition had caused delays in retrieving historical medical records and other pertinent documentation. He expressed frustration with the slow progress in obtaining necessary access to the electronic medical record (EMR) system and legal documentation, stating that the facility ' s legal team was working with the previous owners to resolve the issue. Cross Reference F688, F657

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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** 50524 Based on observations, staff interviews, record review, and review of the facility's policy titled Hand Hygiene, the facility failed to maintain infection control protocol by not practicing hand hygiene during wound care for one of three residents (R) R64 receiving wound care. The deficient practice had the potential to increase the risk of infection due to cross-contamination and the potential to increase the risk of spread of infection to R64 and other residents. Findings include: Review of the facility's policy titled Hand Hygiene dated 2/1/2024 revealed, Policy: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors . Policy Explanation and Compliance Guidance: 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Review of R64's Annual Minimum Data Set (MDS) dated [DATE] revealed, Section C (Cognitive Pattern), a Brief Interview of Mental Status (BIMS) of 15 which indicated R64 had intact cognition and Section M (Skin conditions) revealed, R64 had a stage 4 pressure ulcer. Review of R64's physician's orders dated 12/10/2024 revealed orders that included but not limited to, 1. Wound care: Cleanse area to sacrum with Dakin's. Apply Dakin's wet to moist dressing. Cover with protective dressing every day shift for skin integrity AND as needed for skin integrity; 2. Collagenase Ointment 250 UNIT/gram (GM), Apply to sacrum topically every day shift for wound healing; 3. Renew Wound Consult: Follow and treat until wound is healed. Observation on 1/8/2025 at 11:27 am revealed, Wound Care Nurse (WCN) HH performing wound care on R64's stage four sacral wound. During observation WCN HH removed her gloves and put on a clean pair of gloves without sanitizing her hands. Interview on 1/8/2025 at11:40 am with WCN HH confirmed she did not sanitize her hands after she removed the used gloves and before putting on a new pair of gloves. She stated she should have sanitized her hands in between glove change to prevent the spread of germs to R64. She stated the resident could get an infection if she did not sanitize her hands after removing her gloves and before putting on a new pair of gloves. Interview on 1/8/2025 at 11:50 am with Unit Manager (UM) MM revealed, that staff should wash their hands or hand sanitize before going into the residents' rooms, rendering care to the residents, after removing gloves and before putting on a new pair of gloves. She stated if hand hygiene was not performed the outcome would be the residents could get infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/9/2025 at 2:16 pm with Director of Nursing (DON) revealed, his expectations were for hand hygiene to be performed during wound care. He stated the nurse should adhere to the standard precautions and precautions related to the wound. He stated it was a clean technique, and the nurse needs to adhere to it. The DON further revealed that hand hygiene should be performed before donning gloves, after removing gloves and before putting on new gloves. He stated if hand hygiene was not performed the outcome could cause delayed healing for the resident.