STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135055	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Vista Care Center of Sandpoint	220 South Division Sandpoint, ID 83864

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure to respect and maintain a residents' dignity. This was true for 1 of 1 resident (Resident #12) reviewed for respect and dignity. This deficient practice created the potential for psychosocial harm if Resident #12 experienced embarrassment or lack of self-esteem. Findings include: The facility's Resident Rights policy, dated 12/26/22, stated residents are to be treated with respect, kindness, and dignity. Resident #12 was admitted to the facility on [DATE], with multiple diagnoses including intracranial (brain) injury with loss of consciousness and epilepsy (seizure disorder), and aphasia (an impairment of language due to brain injury, affecting the production or comprehension of speech and the ability to read or write). An annual MDS assessment, dated 9/20/23, documented Resident #12 was rarely/never understood. On 4/29/24 at 1:11 PM and 5/2/24 at 7:36 AM, Resident #12 could be seen from outside his room with no sheet to cover his lower body. He was wearing an adult diaper and his legs were exposed. Resident #12's shirt was rolled up exposing his PEG (percutaneous endoscopic gastrostomy - a surgically placed tube inserted through the abdomen into the stomach to administer liquid feedings) tube. Resident #12's door was all the way open, and he was in full view of anyone passing by his room. On 5/2/24 at 7:47 AM, the DON entered Resident #12's room and stated he would always uncover himself. The DON then took the sheets to cover Resident #12 and stated she would remind the staff to always check on Resident #12 and make sure he had a sheet covering his body.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on record review, policy review, observation, and resident and staff interview, the facility failed to ensure the interdisciplinary team had determined it was appropriate for a resident to self-administer medications for 2 of 6 residents (#39 and #52) reviewed for self-administration of medications. Findings include: The facility's policy Self-Administration of Medications dated December 2016, documented Residents had the right to self-administer medications if the interdisciplinary team clinically determined it was appropriate and safe for the resident to do so. 1. Resident #39 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (COPD - group of diseases that cause airflow blockage and breathing-related problems). A quarterly MDS assessment, dated 3/25/24, documented Resident #39 was cognitively intact. A physician order, dated 4/4/24, documented Resident #39 was to start a Ventolin inhaler, two puffs every 4 hours as needed for bronchospasms and that she may keep the inhaler in her room. On 4/30/24 at 9:56 AM, and 5/1/24 at 4:57 PM, a Ventolin inhaler was observed on Resident #39's overbed table in her room. On 4/30/24 at 9:56 AM, Resident #39 stated, They let me have that [Ventolin inhaler] in case I get short of breath. On 5/1/24 at 5:03 PM, the DON accompanied the surveyor to Resident #39's room and stated there was an albuterol (Ventolin) inhaler with Resident #39's name on it lying on her overbed table. On 5/2/24 at 11:00 AM, the DON stated there was no checklist completed indicating Resident #39 knew and understood how to use the inhaler. On 5/2/24 at 2:30 PM, the RCS was asked if Resident #39 was able to self-administer medications. The RCS stated, I am not aware Resident #39 can. The RCS was notified of the 4/4/24 order which stated Resident #39 could have a Ventolin inhaler at the bedside. The RCS stated, I was not aware of that order. The RCS also confirmed the interdisciplinary team had not determined Resident #39 was appropriate for self-administering medications. 2. Resident #52 was admitted to the facility on [DATE], with multiple diagnoses including type 2 diabetes mellitus, heart disease, and dementia. A quarterly MDS assessment, dated 4/12/24 documented Resident #52 was moderately cognitively impaired. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 9:21 AM, LPN #3 was observed taking a cup containing Resident #52's pills and placed the cup on the dining room table where Resident #52 was sitting. LPN #3 walked out of the dining room to the hallway to obtain a glucometer strip from the medication cart before returning to Resident #52 in the dining room. On 4/30/24 at 9:24 AM, when asked if Resident #52 could self-administer medications, LPN #3 stated, No, I don't believe so. LPN #3 stated she could not visualize the medication cup she left on the table when she left the dining room and went into the hallway. On 5/3/24 at 2:00 PM, the DON stated Resident #52 was not assessed or determined by the interdisciplinary team to be appropriate to self-administer medications.

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F 0580 Level of Harm - Minimal harm or potential for actual harm 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** 36193 Based on record review and staff interview, it was determined the facility failed to ensure the physician was notified of a resident's decision to leave the facility against medical advice. This was true for 1 of 1 resident (Resident #62) reviewed for discharge. This deficient practice placed Resident #62 at risk of harm due to lack of physician input or involvement. Findings include: Resident #62 was admitted to the facility on [DATE], with multiple diagnoses including dementia, weakness, and anxiety. A nurse's progress note, dated 1/31/24 at 1:46 PM, documented Resident #62's representative told the nurse he was taking Resident #62 home. The nurse documented, I attempted to explain that unless we have a discharge order, he would have to take her home AMA [against medical advice]. A Social Services progress note, dated 1/31/24 at 3:37 PM, documented Resident #62's representative stated Resident #62 was unhappy with the placement and he was taking her home. The RSC informed Resident #62 that the facility would not be able to organize a discharge that quickly, and if her representative were to take Resident #62 home it would be AMA. Resident #62's representative was also informed of Resident #62's urinary retention and that she was unable to void (urinate) on her own without assistance. Resident #62's representative stated he was confident Resident #62 would be able to urinate once she was home. The Social Services progress note documented the AMA form was signed by Resident #62's representative at 12:50 PM. The DON was interviewed on 5/2/24 at 3:05 PM. When asked if the staff were expected to notify the physician of a resident's decision to leave the facility AMA, the DON stated, Yes, the physician is usually notified of every resident wanting to go home AMA. The DON then reviewed Resident #62's record and stated she was unable to find documentation the physician was notified. The DON then called the RSC and was told the physician was verbally notified but the RSC failed to document it into Resident #62's record.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48401 Based on record review and staff interview, it was determined the facility failed to ensure residents were provided with an Advance Beneficiary Notice (ABN) when their Medicare Part A benefits ended. This was true for 1 of 3 residents (Resident #19) reviewed for an ABN. This failure created the potential for Resident #19 and his representative to experience financial and psychological distress when they were not informed of their potential financial liability to continue services. Findings include: Resident #19 was admitted to the facility on [DATE] for care related to his dementia diagnosis. Resident #19 had a representative who made healthcare and financial decisions on his behalf. On 4/3/24 Resident #19's Representative was given the Notice of Medicare Non-Coverage CMS 10123 Form (NOMNC). The form documented his Skilled Nursing Service Coverage would end on 4/5/24 as his health had improved and he no longer qualified for coverage. On 5/2/24 at 11:48 AM, the RSC stated Resident #19 continued to stay at the facility after 4/5/24 when his benefits ended. The RSC added the facility did not provide Resident #19 or his representative an ABN to inform them of the financial costs they would be liable to pay if he continued to receive care after 4/5/24 because they thought Resident #19 would be going home.

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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 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** 20243 Based on record review, policy review, review of the State Agency's Long-Term Care Reporting Portal, and resident and staff interview, it was determined the facility failed to protect the residents' right to be free from physical and verbal abuse by staff. This was true for 2 of 3 residents (#3 and #37) who were reviewed for abuse. These deficient practices placed the safety of Resident #3 and Resident #37 and all other residents residing in the facility at risk for immediate jeopardy of serious harm, impairment or death. Findings include: The faclity's Abuse policy, dated December 2023, defined verbal abuse as the use of oral, written, or gestured language that willfully included disparaging derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. The policy stated when an incident of resident abuse was suspected staff were to ensure the resident was safe by stopping the abuse and/or removing the resident from the situation. If the accused individual was an employee, the alleged perpetrator was removed from resident care areas immediately and placed on suspension pending results of the investigation. 1. Resident #37 was admitted to the facility on [DATE], with multiple diagnoses including heart disease, high blood pressure, arthritis, and depression. An admission MDS assessment, dated 3/18/24 documented Resident #37 was cognitively intact. During an interview on 4/30/24 at 12:00 PM, Resident #37 stated LPN #1 on the night shift was confrontational. Resident #37 stated that LPN #1 hollered and screamed at her, leaned her body in toward her and stated she never liked Resident #37 and never would. LPN #1 continued to scream she wanted Resident #37 out of the facility because Resident #37 had turned everyone against her. Resident #37 stated she could not remember the date of the incident approximately two weeks ago, but knew it was around 8:00 or 8:30 PM. During the same interview, Resident #37 stated she was very afraid of LPN #1 and she was afraid when LPN #1 was in the building she may do something to her. Resident #37 stated after LPN #1 left her room she immediately called the Administrator and the Administrator planned to send LPN #2 to come to her room and sit with her. Resident #37 stated LPN #1 came back by herself a second time and they again had a verbal encounter. LPN #2 asked LPN #1 to leave Resident #37's room. Resident #37 stated she had not seen LPN #1 since the incident but knew she was in the building. On 4/30/24 at 1:16 PM, LPN #2 stated while on duty (she worked 2:00 PM to 10:00 PM on 4/7/24) the Administrator called her and instructed her to go to Resident #37's room and sit with her. The Administrator told LPN #2 Resident #37 called him and stated LPN #1 was yelling at her. LPN #2 stated the Administrator gave her no additional instructions regarding Resident #37. LPN #2 stated when she checked on Resident #37 she was upset, tearful, and stated she wanted to leave the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/30/24 at 2:19 PM, the Administrator and the DON were asked if a resident had reported an allegation of verbal abuse in the last month. The DON stated no and the Administrator stated, nothing comes to mind. When asked if Resident #37 had made an allegation of verbal abuse against LPN #1, the DON stated the incident was investigated and unsubstantiated. On 4/30/24 at 3:15 PM, the DON confirmed the incident occurred on the evening shift of 4/7/24. The nursing schedule, provided by the DON, dated 4/7/24, documented LPN #1 was the only licensed nurse on duty on 4/7/24 and 4/8/24 during the night shift from 10:00 PM to 6:00 AM. The DON stated LPN #1 returned to work the following day on the night shift of 4/8/24. During an interview on 5/2/24 at 8:22 AM, LPN #1 stated her shift assignment was night shift from 6:00 PM to 6:00 AM. When asked what type of contact she had with Resident #37 on 4/7/24, LPN #1 stated she provided Resident #37 medication administration but did not answer Resident #37's call light. LPN #1 denied yelling or screaming at Resident #37 on the evening of the alleged incident on 4/7/24. When asked if she had spoken to the Administrator or the DON during her shift on 4/7/24 - 4/8/24 about the incident, LPN #1 stated no. The facility's failure to ensure residents were protected from alleged verbal abuse placed the health and safety of all residents residing in the facility at risk for immediate jeopardy of serious harm, impairment, or death. On 4/30/24 at 5:05 PM, the Administrator and DON were informed verbally and in writing of an Immediate Jeopardy (IJ) determination at F600 related to the facility's failure to protect residents from alleged verbal abuse. This failure resulted in a serious adverse outcome for Resident #37 who verbalized she was fearful LPN #1 would do something to her when LPN #1 continued working in the facility and placed other residents residing in the facility in immediate jeopardy of serious harm, impairment, or death. On 5/1/24 at 5:51 PM, the facility provided a plan to remove the immediacy which was accepted. The facility's IJ removal plan included: - All residents were safe by having the accused leave the building immediately and placed on administrative leave. LPN #1 was placed on administrative leave on 4/30/24. - The facility will re-educate all staff members to Valley Vista Care Corporation Abuse Policy and Procedures and the Federal and State requirements for reporting prior to their next shift following Train the Trainer in-service by 4 PM on 5/1/24. - The CEO, Director of Corporate Compliance, and/or Director of Administrative Services will be alerted of any allegation(s) of abuse immediately to ensure Federal and State law has been followed. - Residents were interviewed on 4/30/24 to ensure they felt safe in the building, if they were abused (verbal, physical, and/or neglect), and if they knew who they could report abuse allegations. On 5/3/24 at 1:00 PM, the Administrator was verbally notified the immediacy was removed based on onsite verification the IJ removal plan was implemented. Following the immediacy, noncompliance remained at actual harm. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	36193 2. Resident #3 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including traumatic brain injury with loss of consciousness, dementia, and epilepsy (seizure). An annual MDS assessment, dated 1/11/24, documented Resident #3 was moderately cognitively intact. An Abuse Investigation report, dated 10/24/23, documented CNA #14 reported to Human Resources (HR) that on 10/20/23, she observed CNA #15 and CNA #16 flick Resident #3's ear and start laughing. CNA #15 and CNA #16 continued to tease Resident #3 which made Resident #3 swear, causing other residents to also swear. CNA #14 asked CNA #15 and CNA #16 to stop, at which time CNA #14 and CNA #15 started to mock her. CNA #14 reported to LPN #5 about the incident, however LPN #5 thought it was funny and did nothing to stop the situation. The report also documented Housekeeper #1 reported to the Human Resources Coordinator that on 10/24/23, she saw a CNA pulling Resident #3's hair as she was pushing him in his wheelchair toward the nurses' station from the Day Room. This caused Resident #3 to yell out cuss words. Another CNA then yelled at Resident #3 for cussing. The same CNA pulled Resident #3's hair again which caused Resident #3 to yell out again. Housekeeper #1 was unable to identify the two CNAs' names. However, on 10/25/23, Housekeeper #1 was able to identify to the Human Resources Coordinator that it was CNA #15 and CNA #16 making fun of Resident #3. The report also included a statement made by CNA #17. CNA #17 reported on 10/24/23, she heard CNA #15 and CNA #16 getting Resident #3 all worked up using bad language. CNA #14 and CNA #15 were laughing at Resident #3 and CNA #17 felt they were antagonizing Resident #3. LPN #5, CNA #15, and CNA #16 all made statements and denied the abuse allegations regarding Resident #3. The Abuse Investigation report substantiated the abuse allegation based on the three separate witness statements, which two were observed and one heard on three separate occasions. LPN #5, CNA #15, and CNA #16 were terminated from employment at the facility. On 10/31/23, the facility provided abuse training titled Abuse - What it is and How to Report it to all staff. On 5/3/24 at 12:39 PM, CNA #17 stated she reported to the Human Resources Coordinator an incident wherein she heard a CNA making fun of a resident. CNA #17 stated the incident was investigated and the CNAs involved were no longer in the facility. On 5/2/24 at 2:49 PM, the DON stated staff involved in Resident #3's abuse allegation were removed from their schedule while it was being investigated. The DON stated the CNAs and the LPN were no longer in the facility.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20243 Based on record review, policy review, and resident and staff interview, it was determined the facility failed to report allegations of potential abuse to the State Survey Agency within 2 hours. This affected 1 of 3 residents (Resident #37) who were reviewed for abuse/neglect. This failure resulted in Resident #37's allegation of verbal abuse not being acted on in a timely manner, investigated, and measures implemented to protect residents during the investigation, which placed all residents in the facility at risk of abuse. Findings include: The facility's Abuse policy, dated December 2023, stated each resident had the right to be free from abuse. Residents must not be subjected to abuse by anyone. The policy defined verbal abuse as the use of oral, written, or gestured language that willfully included disparaging derogatory terms to residents or within their hearing distance, regardless of their age, ability to comprehend, or disability. The policy stated the Initial Report of allegations of abuse, or resulting serious bodily injury, the facility must report the allegation immediately, but no later than 2 hours after the allegation was made. The facility must provide a report with sufficient information to describe the alleged violation. The policy further stated It was important the facility provide as much information as possible at the time of submission of the report, so that State Agency (SA) can initiate action necessary to oversee the protection of nursing home residents. 1. Resident #37 was admitted to the facility on [DATE] with multiple diagnoses including heart disease, high blood pressure, arthritis, and depression. An admission MDS assessment, dated 3/18/24 documented Resident #37 was cognitively intact. During an interview on 4/30/24 at 12:00 PM, Resident #37 stated LPN #1 on the night shift was confrontational. Resident #37 stated that LPN #1 hollered and screamed at her, leaned her body in toward her and stated she never liked Resident #37 and never would. LPN #1 continued to scream she wanted Resident #37 out of the facility because Resident #37 had turned everyone against her. Resident #37 stated she could not remember the date of the incident approximately two weeks ago, but knew it was around 8:00 or 8:30 PM. Resident #37 stated she was very afraid of LPN #1 and she was afraid when LPN #1 was in the building she may do something to her. Resident #37 stated after LPN #1 left her room she immediately called the Administrator and that the Administrator planned to send LPN #2 to come to her room and sit with her. Resident #37 stated LPN #1 came back by herself a second time and they again had a verbal encounter. On 4/30/24 at 2:19 PM, the Administrator and the DON were asked if a resident had reported an allegation of verbal abuse in the last month. The DON stated no and the Administrator stated, nothing comes to mind. When asked if Resident #37 had made an allegation of verbal abuse against LPN #1, the DON stated she reported to the SA, investigated and unsubstantiated the allegation of verbal abuse. The Administrator stated he did not recall Resident #37 calling to report an allegation of verbal abuse to him. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 3:15 PM, the DON stated she could not find the investigation. The DON stated the incident should have been reported to the SA. The DON stated the incident occurred on the evening shift of 4/7/24, and LPN#1 was the only licensed nurse on duty during the evening/night shift on 4/7/24 - 4/8/24. The DON stated she was informed about the incident the next morning on 4/8/24 by the Administrator.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20243 Based on policy review, record review, and resident and staff interview, it was determined the facility failed to ensure an allegation of verbal abuse was thoroughly investigated for 1 of 3 residents (Resident #37) reviewed for abuse. This failure subjected Resident #37 and other residents in the facility to ongoing abuse without detection. Findings include: The facility's Abuse policy, dated December 2023, stated Each resident has the right to be free from abuse. Residents must not be subjected to abuse by anyone. The policy defined verbal abuse as the use of oral, written, or gestured language that willfully includes disparaging derogatory terms to residents regardless of their age, ability to comprehend, or disability. The policy stated that when an incident of resident abuse is suspected staff members are to ensure the resident is safe by stopping the abuse and/or removing the resident from the situation. If the accused individual is an employee, the alleged perpetrator will be removed from resident care areas immediately and placed on suspension pending results of the investigation. 1. Resident #37 was admitted to the facility on [DATE] with multiple diagnoses including heart disease, high blood pressure, arthritis, and depression. An admission MDS assessment, dated 3/18/24 documented Resident #37 was cognitively intact. During an interview on 4/30/24 at 12:00 PM, Resident #37 stated LPN #1 on the night shift was confrontational. Resident #37 stated that LPN #1 hollered and screamed at her, leaned her body in toward her and stated she never liked Resident #37 and never would. LPN #1 continued to scream she wanted Resident #37 out of the facility because Resident #37 had turned everyone against her. Resident #37 stated she could not remember the date of the incident approximately two weeks ago, but knew it was around 8:00 or 8:30 PM. Resident #37 stated she was very afraid of LPN #1 and she was afraid when LPN #1 was in the building she may do something to her. Resident #37 stated after LPN #1 left her room she immediately called the Administrator and that the Administrator planned to send LPN #2 to come to her room and sit with her. Resident #37 stated LPN #1 came back by herself a second time and they again had a verbal encounter. LPN #2 asked LPN #1 to leave Resident #37's room. Resident #37 stated she had not seen LPN #1 since the incident but knew she was in the building. On 4/30/24 at 1:16 PM, LPN #2 stated while on duty (she worked 2:00 PM to 10:00 PM on 4/7/24) the Administrator called her and instructed her to go to Resident #37's room and sit with her. The Administrator told LPN #2 Resident #37 called him and stated LPN #1 was yelling at her. LPN #2 stated the Administrator gave her no additional instructions regarding Resident #37. LPN #2 stated when she checked on Resident #37 the resident was upset, tearful, and stated she wanted to leave the facility. On 4/30/24 at 2:19 PM, the Administrator and the DON were asked if a resident had reported an allegation of verbal abuse in the last month. The DON stated no and the Administrator stated, nothing comes to mind. When asked if Resident #37 had made an allegation of verbal abuse. (continued on next page)

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Valley Vista Care Center of Sandpoint	220 South Division Sandpoint, ID 83864

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/24 at 3:15 PM, the DON presented a phone interview statement dated 4/8/24 for CNA #1. The DON stated these documents were all she could find about the investigation. When asked if LPN #1 was reassigned during the investigation, the DON stated no. When asked about the timeline of the investigation, the DON confirmed the incident occurred on the evening shift of 4/7/24, and that there were three LPNs (LPN #1, LPN #2, and LPN#3) working in the facility. Review of the nursing schedule, provided by the DON, dated 4/7/24, documented LPN #1 was scheduled to work the evening/night shift from 6:00 PM to 6:00 AM, and LPN#2 and LPN#3 were scheduled to work 2:00 PM to 10:00 PM. LPN#1 was the only licensed nurse on duty during the night shift from 10:00 PM to 6:00 AM on from 4/7/24 to 4/8/24. Further review of the nursing schedule documented 7 CNAs worked on 4/7/24 from 2:00 PM to 10:00 PM and 1 CNA worked 6:00 PM to 10:00 PM. The DON stated she was informed about the incident the next morning on 4/8/24 by the Administrator and completed interviews the same day. The DON stated LPN #1 worked the night shift from 4/8/24 to 4/9/24. The DON was unable to provide any documentation other than CAN #1's statement. The DON could not provide LPN #1, LPN #2, or LPN #3's statements or the other CNAs that were working that evening.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review, policy review, and staff and resident interview, it was determined the facility failed to implement a restorative nursing program for 1 of 1 resident (Resident #13) reviewed for restorative nursing services. This deficient practice created the potential for Resident #13 to experience a decline in range of motion (ROM). Findings include: The facility's policy, Restorative Nursing Services, undated, documented residents would receive restorative nursing services care as needed to help promote optimal safety and independence. Resident #13 was admitted to the facility on [DATE], with multiple diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following stroke. Resident #13's care plan, revised 5/19/22, documented Resident #13 was to receive LUE/PROM (left upper extremity/Passive Range of Motion) 1 set/3 reps-Left shoulder flex/ext (extension) adb (abduction)/add (adduction) (up to 90 degrees). L (left) elbow flex/ext, L forearm pronation/sup (supination), L wrist flex/ext, L hand/finger joints PROM, including opposition. On 5/1/24 at 11:35 AM, Resident #13 stated he used to have a restorative program but noticed he was not receiving it lately. Resident #13 stated he did not know why he was not receiving a RNA program. On 5/2/24 at 2:00 PM, when asked about the facility's RNA program, the DON stated currently the facility did not have a restorative nursing program and they were planning to re-institute the RNA program. The DON stated the staff who the facility was going to appoint to do the RNA program had surgery recently.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation and staff interview, it was determined the facility failed to ensure professional standards of practice were followed for 1 of 1 resident (Resident # 12) reviewed for standards of practice. This deficient practice placed Resident #12 at risk of neck and back discomfort when his head was not supported. Findings include: Resident #12 was admitted to the facility on [DATE] with multiple diagnoses including intracranial (brain) injury with loss of consciousness and epilepsy (seizure disorder) and aphasia (loss of ability to understand or express speech). On 4/29/24 at 1:11 PM, Resident #12 was observed in his bed with his eyes closed. Resident #12's head was tilted to his left side almost touching his shoulder. On 4/30/24 at 10:40 AM and 5/2/24 at 2:47 PM, Resident #12 was observed sitting in his wheelchair in the Lodge Unit TV room. Resident #12's head was tilted to his left side and almost touching his shoulder. There was no supporting device for his head or to support his posture. On 5/2/24 at 9:43 AM, the DON and the surveyor went to Resident #12's room. The DON looked at Resident #12 and stated it had been a while since Resident #12 was evaluated by the Physical Therapist. The DON stated she was not sure if Resident #12 was evaluated for his neck positioning. When asked if Resident #12 should be evaluated for his neck positioning, the DON stated Yes, it is reasonable for him to be assessed by the Physical Therapist.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based record review, review of the State Survey Agency's Long-Term Care Reporting Portal, I&A reports, and staff interview, it was determined the facility failed to ensure residents' care plans were followed to prevent falls. This was true for 1 of 5 residents (Resident #16) reviewed for falls. This resulted in harm to Resident #16 when he fell and sustained a calcaneal (heel) fracture while being assisted by one staff during his pericare. Findings include: Resident #16 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including viral infection of the brain, dementia, epilepsy (seizure), and abnormal posture. An annual MDS assessment, dated 9/27/23, documented Resident #16 was rarely/never understood. A care plan, revised 2/18/21, documented Resident #16 had an ADL self-care performance deficit related to his alteration in cognition, behaviors, weakness, and decreased mobility secondary to Human Prion (group of disorders that damage brain and nervous system tissues and function) disease. The care plan directed staff to provide him 2-person total assist in all his ADLs. An I&A report, dated 12/21/23 at 1:45 PM, documented Resident #16 had a witnessed non-injury fall. He was transferred to his bed by CNA #13 and RN #1 using a Hoyer lift. RN #1 left the room and CNA #13 proceeded to perform pericare to Resident #16. CNA #13 pulled Resident #16's pants down, turned him to his right side, and cleaned him. CNA #13 then turned Resident #16 towards her. While CNA #1 was turning Resident #16 towards her, Resident #16 threw his left arm to his right side and rolled off his bed onto the floor. The I&A report documented possible muscle spasm or seizure activity as the root cause of Resident #16's fall and to provide him with 2 staff for all his cares. A nurse's progress note, dated 12/22/23 at 10:10 PM, documented Resident #16 had a bruise to his right heel. A nurse's progress note, dated 12/23/23 at 12:01 PM, documented Resident #16 had no apparent signs of pain or other latent injuries. A nurse's progress note, dated 12/24/23 at 1:42 PM, documented Resident #16's right foot was swollen and bruised. He had no signs and symptoms of pain. A nurse's progress note, dated 12/28/23 at 1:27 PM, documented Resident #16's right foot was yellow and swollen. A physician's progress note, dated 1/4/24 at 10:15 AM, documented It was unclear if there was any injury. I do not appreciate any ecchymosis (bruise) but it is definitely painful to palpate. The physician ordered for Resident #16 to have an x-ray of his foot. An x-ray report, dated 1/5/24, documented Resident #16 had a nondisplaced superior calcaneal fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/2/24 at 2:49 PM, the DON stated there was only one staff assisting Resident #16 during his pericare and he might have a seizure. The DON stated Resident #16's care plan was not followed, he needed two staff assistance during his cares because he could be combative and became rigid during his cares. She stated CNA #13 should have known Resident #16 needed two persons during cares by checking their Kardex (a desktop file system that gives a brief overview of each patient and is updated every shift). The DON stated CNA #13 was in-serviced after Resident #16's fall.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on record review, policy review, observation, and staff interview, the facility failed to ensure the cleanliness of a nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) mouthpiece was maintained when not in use. This was true for 1 of 3 residents (Resident #42) reviewed for respiratory care. This created the potential for respiratory infections due to growth of pathogens (organisms that cause illness) in respiratory treatment equipment. Findings include: The facility's policy, Administering Medications through a Small Volume (Handheld) Nebulizer, dated October 2010, documented when the equipment was completely dry, to store it in a plastic bag with the resident's name and the date on it. 1. Resident #42 was admitted to the facility on [DATE], with multiple diagnoses including high blood pressure, dementia, malnutrition, and dementia. A quarterly MDS assessment, dated 3/26/24, documented Resident #42 was moderately cognitively impaired. On 4/30/24 at 9:34 AM and 5/1/24 at 4:58 PM, Resident #42's nebulizer mouthpiece was lying directly on the overbed table and was not stored in a plastic bag. On 5/1/24 at 4:58 PM, DON accompanied the surveyor to Resident #42's room and stated the nebulizer mask/mouthpiece should be stored in a plastic bag.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review and staff interview, it was determined the failed to ensure professional standards of practice were met for monitoring the effectiveness of residents' medications. This was true for 1 of 17 residents (Resident #49) whose medications were reviewed. This deficient practice created the potential for Resident #49 to experience adverse reactions or side effects due to lack of appropriate monitoring of his medication. Finding include: The State Operation Manual, Appendix PP, documented an unnecessary drug is any drug when used: - in excessive dose, - for excessive duration or - without adequate monitoring or -without adequate indications for its use. Resident #49 was admitted to the facility on [DATE], with multiple diagnoses including senile degeneration of the brain, chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness) and insomnia. Resident #49 physician's order, dated 6/6/22, included Trazodone (anti-depressant, also used to treat insomnia) 50 mg by mouth in the evening for insomnia. Resident #49's April 2023 MAR, documented he received Trazodone 50 mg in the evening. Resident #49's record did not include monitoring of his hours of sleep. On 5/2/24 at 7:55 AM, the DON stated Resident #49's hours of sleep were being monitored by the staff. The DON then reviewed Resident #49's record and stated she was unable to find his sleep monitor. The DON stated Resident #49 should have a sleep monitor.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 36193 Based on record review and staff interview, it was determined the facility failed to meet the regulation requirements for frequency of QA meetings. This has the potential to negatively affect all residents in the facility if quality deficiencies throughout the facility were not identified and responded timely and appropriately. Findings include: The facility's Quality Assurance and Performance Improvement (QAPI) Program, revised February 2020, stated the committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan. On 5/3/24 at 1:02 PM, the Administrator stated the facility held their QAPI meetings monthly. The surveyor then asked for the attendance sheet of QAPI meetings from April 2023 to April 2024. The QAPI attendance sheet was reviewed with the Administrator. Upon review of the sign-in sheets, it was determined there was no QAPI meetings held between April 2023 and June 2023. When asked why there was no meetings held between April 2023 and June 2023, the Administrator stated he could not find the sign-in sheets of QAPI meetings held between April and June 2023.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 28306 Based on record review, policy review, and staff interview, the facility failed to provide a minimum of 12 hours of in-service education per year for 3 of 25 CNAs (CNA #7, CNA #8, and CNA #9) reviewed for sufficient and competent CNA staffing. This failure placed residents at risk of receiving care from staff who are not adequately trained in competencies to meet residents' needs. Findings include: The facility's policy, In-Service Training Program, dated 12/1/23, stated, .All nursing home direct care personnel (CNAs) are required to complete twenty-four (24) hours of in-service per year .Attendance at all mandatory in-service is incorporated as a part of the annual performance evaluation. Lack of completion of mandatory in-service hours or required in-services may impact any pay raise normally given at the time of the annual evaluation and will result in termination if the training is required for the position . An untitled document provided by the Human Resources Coordinator (HRC) documented CNA #7 was hired as a CNA in 2/2022. Review of CNA #7's training log documented 2.75 hours of training between 2/2023 through 2/2024. An untitled document provided by the HRC documented CNA #8 was hired as a CNA in 1/2023. Review of CNA #8's training log documented 6.75 hours of training between 1/2023 through 1/2024. An untitled document provided by the HRC documented CNA #9 was hired as a CNA in 4/2006. Review of CNA #9's training log documented 7.75 hours of training between 4/2023 through 4/2024. During an interview on 5/3/24 at 9:15 AM, the HRC stated the facility used the employee anniversary date for the training hours needed to meet the CNA education requirement. When asked how often the training hours were reviewed, the HRC stated, I review them [training hours] monthly. The HRC stated she was aware the CNAs were short on getting their 12 hours of training annually. During an interview on 5/3/24 at 11:35 AM, HR confirmed the training hours for CNA #7, CNA #8, CNA #9 did not meet the criteria for 12 hours of annual training.