STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Jacksonville	1021 North Church Street Jacksonville, IL 62650

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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** 50908 Based on interviews, observations, and record reviews the facility failed accommodate a resident's preference to eat in his room for 1 of 5 residents, (R8), reviewed for Resident's Rights in a sample of 35. Findings include: R8 was admitted to the facility on [DATE] with diagnosis of, in part, multiple sclerosis (MS), quadriplegia, type 2 diabetes mellitus, and chronic obstructive pulmonary disease. R8's Care Plan dated 10/18/24, documented he is dependent on staff for Activities of Daily Living (ADL's); he is able to move only neck/head, has a diagnosis (Dx) of end stage MS, has muscle spasms extremities involuntarily jerk, prefers to use safety belts on the electric wheelchair (w/c) to promote positioning and enhance mobility. R8 is unable to stand and has little use or movement in is extremities and per his request, R8 refuses to come to the dining room at times. R8's Care Plan further documented he isolates in his room a majority of the time. R8's Minimum Data Set (MDS) dated [DATE] documented R8 is cognitively intact. R8's MDS also documented that he has impairment to both sides of his upper extremity and is dependent on staff to assist him with all self-care abilities including eating. On 11/18/24 at 9:52 AM, R8 stated he does not eat his meals in the dining room, he prefers to eat in the comfort of his room. On 11/20/24 at 12:15 PM, R8 was out in the dining room for lunch. On 11/21/24 at 7:30 AM, R8 was out in the dining room for breakfast. On 11/21/24 at 9:05 AM, R8 stated he was told by the facility that they were short staffed and that he needed to eat out in the dining room. R8 stated he does not like eating in the dining room because it is noisy, the other residents are hollering and screaming. R8 stated the staff are too lazy to feed him in his room, he would prefer to have soup heated up so he could avoid the dining room. On 11/21/24 at 11:05 AM, V1, Administrator, stated the residents have the right for the facility to accommodate their preference to eat in their room if they choose. (continued on next page)

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	The facility's Statement of Resident Rights, undated, documented residents have the right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect. The statement further documented it is the resident's right to exercise free choice in selecting activities, schedules, and daily routines.

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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** 33112 Based on interviews, observations, and record reviews the facility failed to report changes in condition to the physician for 1 out of 2 residents, (R30), reviewed for notification of changes in a sample of 35. 1. R30's Admission record, print date of 11/21/24, documents that R30 was admitted on [DATE] and has diagnoses of Psychosis, Schizoaffective Disorder, Drug Induce Subacute Dyskinesia, and Schizophrenia. R30's Minimum Data Set, dated dated [DATE], documents that R30 is severely cognitively impaired, requires setup or clean up assistance for eating, supervision or touching assistance for sitting and walking. On 11/18/24 at 3:58 PM, R30 is in the hallway walking. R30 has very spastic jerky movements of the arms, legs, head, tongue, and mouth. R30 has involuntary backward arching of the back, shuffling of the feet sidewise and forward motion. R30 tripped over her feet and fell into surveyor. V9, Licensed Practical Nurse, (LPN) who was steps away came and assisted R30 to regain her footing by grabbing her under her arms. R30 remained unsteady even with assistance of V9 and surveyor. V9 attempted to get R30 to sit in a chair, however R30 proceeded to sit in the area beside the chair causing her to lose balanced and start to fall. V9 had to stop R30 from falling, stood her upright and got her over the chair to sit. On 11/19/24 at 12:18 PM, R30 is sitting in the assisted dining room eating her noon meal which consisted of turkey, mashed potatoes, and gravy. R30 has very spastic jerky movements of the arms, legs, head, tongue, and mouth. R30 has involuntary backward arching of the back, shuffling of the feet sidewise and forward motion. R30 is very unsteady on her feet. R30 is unable to control the spontaneous movements. R30's turkey was not cut up. It was in larger pieces not bite size. R30 took her plastic fork and stabbed the meat then with her hand pulled off a meat and put it in her mouth. R30 began to gag. R30 grabbed her drink and took a drink. R30 continued to gag. R30 leaned forward and spit the drink out toward the table. R30 then leaned to the side and spit her drink and the turkey meat out onto the floor. V15, Certifed Nurse Aide, (CNA) assisted R30 with a towel and removed her tray. V21 CNA assisted in moving R30's tablemates to another table. V15 then brought R30 a cup of soup with a metal spoon. On 11/19/24 at 4:45 PM, V19, Licensed Practical Nurse, (LPN), stated that she was not aware of R30 gagging on her noon meal. On 11/21/24 at 2:09 PM, V15 was asked if she let V19 know about R30 gagging on her lunch, V15 CNA, stated, I went and told (V19). I had her double check her diet too. She was suppose to get a mechanical diet. V15 stated that R30 did receive large pieces of turkey and not mechanical turkey on 11/19/24. V15 stated that R30 has worsened with her movements just recently. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 2:13 PM, V21, CNA was asked if she let V19 know about R30 gagging on her lunch on 11/19/24, V21 CNA, stated, (V19) was told. (V15) went right up to (V19) and told her. She was standing right there at the nurses desk. R30's Nurses Note, dated 11/19/2024 19:00 (7:00pm), documents, (V16, Medical Director) notified of resident vomiting at lunch. Orders received to obtain chest xray per (V16). Resident chart updated and resident aware. (mobile) xray called. On 11/25/24 at 9:10 AM, V3, Assistant Director of Nurses, stated that the Physician should have been notified of R30's fall and gagging incident when it happened. The facility's policy, Physician-Family Notification- Change in Condition, dated 10/2024, documented, The facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse Practitioner; and if known, notify the residents legal representative or an interested family member when there is: A. An accident involving the resident which results in injury and has the potential for requiring physician intervention.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview and record review, the facility failed to prevent abuse for 1 of 3 residents (R52) reviewed for abuse in the sample of 35. Findings include: R52's Admission Profile, print date of 11/19/24, documents that R52 was admitted on [DATE] and has a diagnosis of Schizoaffective Disorder. R52's Minimum Data Set, dated dated [DATE], documents that R52 cognitively intact. R52's General Note, dated 11/7/24, documents, On 11/7/24 @ 3:08 pm Staff reported an allegation of a res (resident) to res physical altercation. Resident has no injuries outside of some redness on the right hand. No complaints of pain. Investigation initiated. Resident/staff interviews initiated. Physician/Resident Representative/Ombudsman notified. Follow up report will be sent. BIMS (Brief Interview of Mental Status): 13/15 Dx (diagnosis): COPD (Chronic Obstructive Pulmonary Disease), Emphysema, Schizoaffective Disorder, Bipolar Type, Bipolar II Disorder, Mild Intellectual Disabilities Investigation initiated. Resident/staff interviews initiated. Physician/Resident Representative/Ombudsman notified. Follow up report will be sent. R52' Final Abuse Investigation Report, dated 11/14/24, documents, Conclusion and Action Taken: Staff were present at the time of the incident were interviewed and indicated they has witnessed (R52) hit R5 on her hand while she was reaching for Bingo chips. On 1/19/24 at 4:00 PM, V1, Adminstrator, stated it did happen and it was an intentional hit and she knows why she is getting a tag for it. The facility's Abuse Prevention and Reporting Policy dated 09/2024, documented this facility affirms the right of our residents to be free of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40650 Based on record review and interview, the facility failed to notify residents and representatives, in writing, prior to being transferred to the hospital, for 6 of 6 (R7, R12, R17, R36, R54, R72) residents reviewed for discharge transfer notice requirements in a sample of 35. Findings include: 1. On 11/20/2024 at 09:14 AM, R17 stated that he didn't know why he was going to the hospital nor was he given a document explaining why he was sent to the hospital on 12/18/2023, 12/31/2024, and 1/1/2024. R17's Progress note, dated 12/18/2023 at 11:27 AM, documented, Resident being sent to (Emergency Department) for evaluation related to altered mental status, resident is unaware of who we are, low BP (blood pressure), not following commands as normal, (Nurse Practitioner) aware and resident agreeable for ambulance to take to hospital, resident also was seeing things in his bed that were not there. R17's Progress noted, dated 12/31/2023 at 5:10 pm documented, (4:50 PM)- labs received from (Regional Hospital). Emailed to (Nurse Practitioner) new orders received to transfer (patient) to hospital with altered mental status AKI (actue kidney injury), and CHF (congestive heart failure). (Patient) was still talking to people that were not in the room. Not making sense of his conversations. Decision made to transfer to hospital. (Local Ambulance) notified. 5:10 PM (local ambulance) here. (Patient) transferred to stretcher without complications. Report and (patient) status given to ambulance personnel. (5:18 PM) transferred per (Local ambulance) to (Local Hospital) with labs from (Regional Hospital) from today 12/31/2023. R17's Progress note, dated 1/1/2024 at 9:33 AM, documented, Resident returned to facility in the night. Now resident is cool and clammy-pale and hallucinating. BP 160/100-Eyes blood shot. Called (Local) Ambulance to take resident back to the hospital. Called report to the ER (local hospital) and again informed them that his BNP (B-type Natriuretic Peptide) was 1538. And that his mental status was worsening and so was his condition. Called his sister and his daughter and informed them of the need to transport back to the hospital for a re-evaluation of his condition. R17's Minimum Data Set (MDS), dated [DATE], documented that his cognition was intact. R17's Physicians order, dated 11/21/2024, documented diagnoses of Morbid severe obesity and COPD (Chronic Obstructive Pulmonary Disease). 2. R54's Progress note, dated 10/23/2024 at 10:48 pm documented, Staff found Resident on bedside mat face down. Resident was placed back on bed and resident was unresponsive. Staff attempted to arouse resident with sternum rubs, no response. Staff called 911. Staff attempted to notify family, no response. (V16, Medical Director) notified. EMS (Emergency Medical Services) here at 10:40pm for transport to (local hospital). Noted by (V18, LPN) (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R54's Progress note, dated 3/31/24 at 7:37 AM, documented, Resident sustained a fall on 03/31/2024 7:00 AM. The incident occurred in the Resident room. Resident is alert and oriented to time, person, place and situation. No changes in range of motion from normal baseline. Physician notified on: 03/31/2024 7:00 AM. Date/time family/responsible party notified: 03/31/2024 7:00 AM. Resident denies pain. The resident's pain is not a new onset. R54's Progress note, dated 3/31/24 11:41 am, After assessing resident after fall resident sent to ER (emergency room) for a x-ray eval after portable unavailable due to holiday. Resident was alert and in agreement with this plan resident emergency contact (family member) was called and voicemail reached and left message for her to (return call) . Resident was sent to ER via (Local ambulance) ambulance and report was called to (Local Hospital). R54's Progress note, dated 1/15/2024 at 11:46 AM, documented, (Patient) (vital signs) BP 154/89 pulse 110 temp 99.1 (Patient) not oriented to person or time altered mental status noted. Transferred to (local hospital) per ambulance. R54's Minimum Data Set, dated dated [DATE], documented that his cognition was moderately impaired. R54's Physicians order sheet, dated 11/21/2024, documented a diagnoses was End Stage Renal Disease. 33112 3. R12's Admission Profile, print date of 11/20/24, documents that R12 was admitted on [DATE] and has a diagnosis of Dementia. R12's Incident Note, 9/10/2024 16:50, documents, Resident sustained a fall on 09/10/2024 4:35 PM. The incident occurred in the outside. Resident is alert and oriented to time, person, place and situation. Change in range of motion from normal baseline noted. Physician notified on: 09/10/2024 2:45 PM. Date/time family/responsible party notified: 09/10/2024 2:50 PM. Resident rates pain 10 out of 10. The resident?s pain is a new onset. A new skin concern or change in skin condition noted. New order/s received: Sent to ER (emergency room) Care plan reviewed. On 11/20/24 at 1:18 PM, R12's Electronic Medical Records (EMR) fails documents a Bed Hold for the hospitalization of 9/10/24. On 11/20/24 at 10:33 AM, V26, Licensed Practical Nurse, (LPN), stated that when a resident goes out to the hospital she makes a copy of the residents medications, their profile, code status, and the medical necessity form which tells the hospital why they are being sent to the hospital. V26 stated that she does not give the resident a written explanation of why they are going to the hospital but does give them a bed hold letter. On 11/20/24 at 10:35 AM, V27, LPN, stated that when a resident goes out to the hospital she makes a copy of the residents medications, their profile, code status, and the medical necessity form which tells the hospital why they are being sent to the hospital. V27 stated that she does not give the resident a written explanation of why they are going to the hospital but does give them a bed hold letter. V27 stated that she does make a copy of the bed hold letter for the facility. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/25/24 at 9:33 AM, V4, Regional Nurse, stated that she was unaware of the need that residents need a letter in simple writing explaining why they are being sent out to the hospital. 50908 4. R72 was admitted to the facility on [DATE] with diagnosis of, in part, fracture of femur. R72's Progress Notes dated 9/7/24, documented, Resident sustained a fall on 09/07/2024 1:30 PM. The incident occurred in the Resident room. Resident is alert and disoriented per usual baseline. Change in range of motion from normal baseline noted. Physician notified on: 09/07/2024 1:45 PM. Date/time family/responsible party notified: 09/07/2024 1:45 PM. Resident rates pain 8 out of 10. The resident's pain is a new onset. No new skin concern or change in skin condition noted. 11/20/24 01:34 PM R72's Electronic Medical Record (EMR) does not have documentation of written notice of the reason for transfer to the hospital on 9/7/24 and a copy of the notice to the ombudsman. 32874 5. R7's Nursing Note dated 8/12/2024 at 09:56AM documents R7 lethargic and non responsive at times this a.m. Notes document R7 continues not to take meds or treatments as prescribed. Notes document R4 gets angry with staff when he is educated or encouraged to take meds. Notes document R7 sitting in wheelchair in dining room slouched over in chair. Very hard to arouse. Notes document R7 being sent to the local hospital emergency room for evaluation. R7's nursing note did not document that reason for transfer was provided to R7 or legal representative at time of transfer. 6. R36's nursing note dated 6/6/2024 at 11:15AM documents R36 sent to the hospital emergency room for evaluation due to a fall. R36's record did not document that R36 or legally responsible person was provided documentation of transfer in writing at the time of transfer. The facility policy notice of transfer and discharge date d revised 10/2022 documents prior to discharge or transfer, the facility will notify the resident and the residents' representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The policy documents reason for transfer or discharge may include emergency transfer to acute care. The policy documents when the facility transfers or discharges a resident the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health institution or provider.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interview and record review the facility failed to provide a discharge summary for 2 out of 2 residents, (R227 and R276), reviewed for discharge summaries in a sample of 35. Findings include: 1. R227 was admitted to the facility on [DATE] with diagnosis of, in part, sepsis, pneumonia, and cerebral infarction. R227's Progress Notes dated 7/30/24 documented, List of medications (meds), discharge papers and meds given to patient (pt.) and daughter. Explained how to take his meds per list. Resident discharged home per wheelchair (w/c) and driven home per daughter and car. R227's Electronic Medical Records (EMR) did not document a discharge summary. 2. R276 was admitted to the facility on [DATE] with diagnosis of, in part, pneumonia, malignant neoplasm of unspecified bronchus or lung, and malignant neoplasm of prostate. R276's Face Sheet documented a discharge date of [DATE]. R276's EMR did not document a discharge summary. On 11/20/24 at 1:55 PM, V20, Social Services Director, stated she did not document a discharge summary for R227 and R276. On 11/2/24 at 2:50 PM, V4, Regional Nurse Consultant, stated the facility does not have a policy on discharge summaries.

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview, observation, and record review, the facility failed to coordinate services for a neurology consult for abnormal movements, falls and a gagging incident for 1 of 16 residents (R30) reviewed for quality of care in the sample of 35. This failure resulted in R30 having increased involuntary movements that resulted in worsening involuntary movements. Findings include: R30's Admission record, print date of 11/21/24, documents that R30 was admitted on [DATE] and has diagnoses of Psychosis, Schizoaffective Disorder, Drug Induce Subacute Dyskinesia, and Schizophrenia. R30's Minimum Data Set, dated dated [DATE], documents that R30 is severely cognitively impaired, requires setup or clean up assistance for eating, supervision or touching assistance for sitting and walking. R30's Care Plan, revision date of 10/04/2022, documents, (R30) is at increased nutritional risk r/t (related to) DX (diagnosis): COPD (Chronic Obstructive Pulmonary Disease), Hypertension, Anxiety, Bipolar. Intervention: I use adaptive equipment to ensure my safety: plastic silverware therapy request her to get plastic do (sic) to resident poking herself so get plastic for a safety Date Initiated: 11/18/2024. Monitor/document/report PRN as needed) any s/sx (signs and symptoms) of dysphagia: coughing, drooling, pocketing food, swallowing attempts, refusing to eat. Date Initiated: 10/04/2022. R30's Care Plan, revision date of 11/18/24 , documents, (R30) has an ADL (Activities of Daily Living) (self-care performance deficit r/t weakness, lack of coordination, dyskinesia, cog impairment and multiple psych (psychiatric) dx. (R30) needs pills whole in pudding at times. Plastic ware for all meals. Intervention: Bed Mobility: One person physical assist Transfer: Supervision One person physical assist at times Walk in room: Supervision One person physical assist with gait belt Walking corridor: Supervision Setup help only, One person physical assist at times Locomotion on unit: Supervision Setup help only, One person physical assist at times Locomotion off unit: Supervision Setup help only, One person physical assist at times Eating: Supervision One person physical assist at times. R30's Care Plan, revision date of 10/13/22, documents, (R16) risk for falls r/t weakness, medications, dyskinesia, abnormal gait and mobility, lack of coordination. I like to stand in the hall and sway side to side. Interventions: Be sure my call light is within reach and encourage me to use it for assistance as needed. Date Initiated: 04/30/2018. Bed height to be placed where my feet are flat on the floor. Date Initiated: 04/30/2018. Ensure resident is wearing shoes or non skid slippers when out of bed Date Initiated: 10/28/2024. Follow facility fall protocol. Date Initiated: 08/14/2019. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R30's Care Plan, revision date of 11/08/2019, I have the potential for adverse side effects related to medication use r/t: antipsychotic use. Diagnosis: Schizophrenia, Schizoaffective disorder, and Psychosis. Interventions: Observe for: ANTI-PSYCHOTIC: COMMON SIDE EFFECTS: Sedation, drowsiness, dry mouth, constipation, blurred vision, extrapyramidal reaction, weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention. UNCOMMON SIDE EFFECTS: Tardive Dyskinesia, seizure disorder, chronic constipation, glaucoma, diabetes, skin pigmentation, jaundice. Date Initiated: 08/14/2019. R30's Speech Therapy Discharge Summary, dated 11/19/24, documents, Patient Progress: Progress & Response to Treatment: Pt (patient) achieved max (maximum) rehab potential for the stated goals with d/c (discharge) complete. Communication: Team Communication / Collaboration: ST (Speech Therapy) instructed pt (patient) on small bites / sips, slowing the rate of consumption, and liquid wash every 1 - 3 bites. Pt requires staff supervision for staff to provide cues and assist during PO (oral) intake when needed. Discharge Recommendations and Status Oral Intake Solids = Mechanical soft / ground textures. Liquid - Thin liquids. Strategies Compensatory Strategies / Positions: with staff supervision. Aspirations precautions. Dining / Swallowing Program Established / Trained: Pt has restorative program / staff education in place for swallowing / dysphagia to ensure safety of the swallow. Outcome Risks Risk Areas that may impact Long Term Outcome (s) = lacks insight into condition and risk factors. Multiple medical conditions / history. Desired Change in Condition of Risk area: Dysphagia. R30's Fall Risk Assessment, dated 10/19/24, documents that R13 is at risk for falls. R30's AIMS - Abnormal Involuntary Movement Scale, dated 11/8/23, documents that R30 has Moderate movements of the muscles of the facial expression, mild movements of the lips and perioral area, jaw, and mild movements of the tongue. R30 has moderate movements of the upper arms, wrists, fingers, hands, legs, knees, ankles, and toes. R30 has moderate neck, shoulder, hips, e.g. (for example) rocking, twisting, squirming, pelvic gyrations. R30 severity of abnormal movements is moderate. Incapacitation due to abnormal movements is mild. R30 scores a 18. The higher the score (0-28), the greater the impact of observed movements on resident. R30's AIMS - Abnormal Involuntary Movement Scale, dated 10/19/24, documents that R30 has Moderate movements of the muscles of the facial expression, lips and perioral area, jaw, and mild movements of the tongue. R30 has severe movements of the upper arms, wrists, fingers, hands, legs, knees, ankles, and toes. R30 has severe neck, shoulder, hips, e.g. (for example) rocking, twisting, squirming, pelvic gyrations. R30 severity of abnormal movements is severe. Incapacitation due to abnormal movements is mild. R30 scores a 23. The higher the score (0-28), the greater the impact of observed movements on resident. R30's Electronic Medical Record fails to document an AIM scale between 11/8/23 and 10/19/24. R30's Physician Order, dated November 2024, documents, REGULAR diet, Mechanical Soft, Ground Meat texture, Thin consistency with staff supervision. Start date of 5/2/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/18/24 at 03:58 PM, R30 is in the hallway walking. R30 has very spastic jerky movements of the arms, legs, head, tongue, and mouth. R30 has involuntary backward arching of the back, shuffling of the feet sidewise and forward motion. R30 tripped over her feet and fell into surveyor. V9, Licensed Practical Nurse, (LPN) who was steps away came and assisted R30 to regain her footing by grabbing her under her arms. R30 remained unsteady even with assistance of V9 and surveyor. V9 attempted to get R30 to sit in a chair, however R30 proceeded to sit in the area beside the chair causing her to lose balanced and start to fall. V9 had to stop R30 from falling, stood her upright and got her over the chair to sit. On 11/18/24 at 4:05 PM, V9, LPN, stated, Thank goodness you were there. I could have never held her up on my own. She would have fallen. I normally don't work this hall. I have heard that they are suppose to be starting her on a medication for Tardive Dyskinesia. I started in August and she has always been this way. She follows her roommate around and she is very unsteady on her feet. On 11/18/24 at 4:07 PM, V10, Certified Nurse Aide, (CNA) stated, She was not this bad last year this is something recent. On 11/19/24 at 12:18 PM, R30 is sitting in the assisted dining room eating her noon meal which consisted of turkey, mashed potatoes, and gravy. R30 has very spastic jerky movements of the arms, legs, head, tongue, and mouth. R30 has involuntary backward arching of the back, shuffling of the feet sidewise and forward motion. R30 is very unsteady on her feet. R30 is unable to control the spontaneous movements. R30's turkey was not cut up. It was in larger pieces not bite size. R30 took her plastic fork and stabbed the meat then with her hand pulled off a meat and put it in her mouth. R30 began to gag. R30 grabbed her drink and took a drink. R30 continued to gag. R30 leaned forward and spit the drink out toward the table. R30 then leaned to the side and spit drink and the turkey meat out onto the floor. V15 CNA assisted R30 with a towel and removed her tray. V21 CNA assisted in moving R30's tablemates to another table. V15 then brought R30 a cup of soup with a metal spoon. On 11/19/24 at 4:45 PM, V19 LPN, stated that she was not aware of R30 gagging on her noon meal. On 11/21/24 at 2:09 PM, V15, CNA was asked if she let V19 know about R30 gagging on her lunch, V15 stated, I went and told (V19). I had her double check her diet too. She was suppose to get a mechanical diet. V15 stated that R30 did receive large pieces of turkey and not mechanical turkey on 11/19/24. V15 stated that R30 has worsened with her movements just recently. On 11/21/24 at 2:13 PM, V21 was asked if she let V19 know about R30 gagging on her lunch on 11/19/24, V21 CNA, stated, (V19) was told. (V15) went right up to (V19) and told her. She was standing right there at the nurses desk. R30's Nurses Note, dated 11/19/2024 19:00 (7:00PM), documents, (V16, Medical Director) notified of resident vomiting at lunch. Orders received to obtain chest xray per (V16). Resident chart updated and resident aware. (mobile) xray called. R30's Nurses Note, dated 11/20/2024 08:10PM, documents, Resident being transported to (local hospital) for STAT (now) chest x-ray r/t (related to) vomiting, resident leaving via facility transports order and face sheet sent with. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/20/24 at 11:50 AM, V34, Psychiatry Nurse Practitioner, stated, I saw her (R30) on 10/23/24. The facility asked me to see her because she was getting worse with her movements. I increased her Austedo from 24 milligrams (mg) to 30 mg. I also ordered for a consult to Neurology because I don't think we are dealing with Tardive Dyskinesia. I was not told that they were unable to get her the Austedo. I would have like to know that. Austedo is a drug that you can stop abruptly with no ill effects. V34's Progress Note for 10/23/24 fails to document an order for a consult for neurology. On 11/25/24 at 9:10 AM, V3, Assistant Director of Nurses, stated that she is not sure as to why R30's insurance company did not approve the Austedo medication. She stated that V2, Director of Nurses handled that and that she believes V2 did notify V16 and V34 of the need to place the order on hold. V2 is unavailable for interview to confirm this. V3 further stated that when V34 came in on 10/23/24 she did not write an order for a neurology consult. I have reached out to several neurologist and sent them R30's information and I am waiting for them to accept her as a patient. The facility's policy, AIMS Side Effect Monitoring, dated 10/2024, documented, The examination will be performed either at the time of resident's admission or when medications are initially prescribed. In addition, for residents taking psychotropic medication, AIMS examination procedures will be repeated at intervals of no less than every six (6) months. The facility's Diet Orders Policy dated 08/2023, documented diet orders are checked for accuracy regularly, at the quarterly care plan meeting, by comparing diet orders on file in Dining Services with the Physician Order Sheet (POS) in the health record. The facility's Fall Prevention Program Policy dated 10/2024, documented the purpose of the policy is to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interviews, observations, and record reviews the facility failed to prevent a pressure injury for 1 out of 2 residents, (R1), reviewed for pressure ulcers in a sample of 35. This failure resulted in R1 acquiring a new pressure ulcer. Findings include: R1 was admitted to the facility on [DATE] with diagnosis of, in part, cerebrovascular disease, facture of femur, mild protein-calorie malnutrition, and joint replacement surgery aftercare. R1's Minimum Data Set (MDS) dated [DATE], documented he is cognitively intact. The MDS further documented R1 is dependent on staff to roll from lying on back to left and right side, and return to lying on back on the bed. R1's current Care Plan dated 9/26/2024, documented R1 is at risk for further skin impairment related to aging/disease process, decreased mobility, fragile skin, impaired mobility, incontinence, non-compliance with turning and repositioning, and terminal illness with interventions to monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, signs/symptoms of infection, maceration et cetera (etc.) and keep skin clean and dry. R1's care plan continued to document he has an actual skin impairment of left heel, right heel, right inner heel with interventions to turn and reposition every 2 hours as he will allow, a low air loss mattress, minimize pressure over boney prominences, and to float bilateral heels while in bed. R1's Braden assessment dated [DATE] documented he was at moderate risk for pressure related injuries to develop. On 11/19/24 at 9:45 AM, V17, Lead Certified Nursing Assistant (CNA), and V8, CNA, provided catheter and peri-care (perineal care) to R1. V17 and V8 turned R1 onto his right side and exposed his buttock region while providing peri care. A large amount of redness to both buttocks and coccyx was seen. R1's left buttock had a scab, darkening color of the skin and skin tears, the right buttock had a small region with skin tears. V8 stated the area has been this way for about a week now. On 11/21/2024 at 2:12 PM, V19, Licensed Practical Nurse (LPN), stated that there was nothing wrong with R1's buttock region she knew, no one has mentioned anything as of now. V19 observed R1's buttock region and stated the skin has break down and needs treatment started. V19 stated this is the first time she has seen the skin breakdown. R1's wound assessment dated [DATE], documented a new facility acquired wound. On 11/21/2024 at 2:20 PM, V3, Assistant Director of Nursing (ADON), measured R1's left buttock and stated the measurements were 4.5cm (centimeters) length by 3cm width. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility's Skin Condition Assessment and Monitoring-Pressure and Non-Pressure Policy dated 06/2018 documented the following guidelines: A skin condition assessment and pressure ulcer risk assessment (Braden) will be completed at the time of admission, quarterly and as necessary. Residents identified will have a weekly skin assessment by a licensed nurse. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the chare nurse who will perform the detailed assessment.

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F 0689 Level of Harm - Minimal harm or potential for 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** 50908 Based on interviews, observations, and record reviews the facility failed to protect a resident while smoking for 1 out of 1 residents, (R8), reviewed for smoking safety and accident prevention in a sample of 35. Findings include: R8 was admitted to the facility on [DATE] with diagnosis of, in part, multiple sclerosis (MS), quadriplegia, type 2 diabetes mellitus, and chronic obstructive pulmonary disease. R8's Minimum Data Set (MDS) dated [DATE] documented R8 is cognitively intact. R8's MDS also documented that he has impairment to both sides of his upper extremity and is dependent on staff to assist him with all self-care abilities including eating and oral hygiene. R8's care plan dated 10/18/24 documented a plan for smoking with interventions for a smoking apron to be worn while smoking. R8 refuses to wear the smoking apron and instruct him about the facility policy on smoking: locations, times, safety concerns. R8's care plan further documented he is dependent on staff for Activities of Daily Living (ADL's), is able to move only neck/head with interventions to use a lap and chest belt while up in electric wheelchair to enable proper positioning and safety in the event of a spasm related to MS. On 11/18/24 at 9:52 AM, R8 had ashes on sweatshirt while seen in his bedroom. On 11/18/24 at 10:39 AM, R8 went outside for a smoke break with no smoke apron on. R8 held the cigarette in his mouth with his lips, his arms remained at his sides and a chest belt was in place around R8 holding him in position while in his wheelchair. Ashes were seen in the same place they were when previously seen in his room at 9:52 AM. More ashes were seen falling on R8's sweatshirt as he smoked. V25, Activity Aid, was supervising and did not intervene or remove the ashes from R8's shirt. R8 was wheeled back inside by V25 and continued to have cigarette ashes left on his shirt after smoking. On 11/19/24 at 1:42 PM, R8 lined up in the hallway to go out for a smoke break. V23, Housekeeping, placed a cigarette in R8's mouth. Once outside, V23 lit R8's cigarette with a lighter and walked away. Twelve residents were outside smoking with the supervision of V23 and V24, Activity Director. R8 was not offered an apron and did not wear one while he smoked his cigarette. Ashes from R8's cigarette were seen falling onto his shirt as he smoked. When R8 was done with his cigarette, V23 removed it from his mouth. V24 stated R8 doesn't like to wear the apron so we enforce more supervision. On 11/19/24 at 2:40 PM, V20, Social Services Director, stated V8 refuses to wear the smoke apron, and he has the right to refuse it but also the right to smoke. V20 stated we monitor V8 and ask him about pain because he has a BIMS (Brief Interview of Mental Status) of 15 so he can tell us if he's in pain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 9:05 AM, R8 stated the does not like to wear the smoking apron because it is uncomfortable especially in the summer it gets too hot and he is left in a puddle of sweat. R8 stated the staff have not tried using anything else besides the apron to prevent his cigarette ashes from falling on him. On 11/21/24 at 11:07, V1, Administrator, stated it is the facility's policy to maintain safe smoking conditions. The facility's Smoking Safety Policy with a last revision date of 10/2022, documented the objective of this policy is to communicate to each resident that they are responsible for following each rule and on-going compliance with this policy. A Smoking Safety Assessment will be completed to determine the level of assistance and supervision needed during smoking and if a smoking apron is indicated. The policy further documented the facility maintains the right to limit and restrict access to smoking products, matches, and lighters for persons deemed unsafe. Smoking privileges will be revoked when there is a pattern of persistent, hazardous behavior.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview, observation, and record review, the facility failed to provide complete incontinent care for 3 of 7 residents (R16, R31, R43) reviewed for incontinent care in the sample of 35. Findings include: 1. R16's Admission Record, print date of 11/21/24, documents that R16 was admitted on [DATE] and has a diagnosis of Multiple Sclerosis. R16's Minimum Data Set, (MDS), dated [DATE], documents that R16 is severely cognitively impaired, is always incontinent of bowel and bladder, and dependent on staff for toileting and personal hygiene. On 11/20/24 at 1:43 PM, V33, Certified Nurse Aide (CNA), entered R16's room to provide incontinent care. V33 removed R16's wet incontinent brief. With soapy wash cloths, V33 cleansed the groin, labia, and meatus. R16 was rolled over and the left buttock and rectal area were cleansed. V33 dried the buttocks and put on a new incontinent brief. V33 failed to rinse or dry R16's peri-area. R16's peri-area was wet and had soap suds left. V33 failed to rinse R16's buttocks. The Body Wash and Shampoo bottle used, documents, Apply to wash cloth or directly to skin. Massage into lather and rinse and towel dry. On 11/21/24 at 4:00 PM, V1, Administrator stated that she expects staff to cleanse, rinse, and dry residents during incontinent care. 40650 2. On 11/19/2024 at 9:27 AM, V13, CNA and V14, CNA provided incontinent care to R31. V14 pulled R31's pants down and unfastened her adult incontinent brief, which were both saturated with urine. V14, CNA performed incontinent care, using non rinse soap and water. These areas were not dried afterwards. R31 was then rolled on to her right side and V14 cleansed R31's left hip and peri rectal area. V14 then placed a clean incontinent brief and R31 was then rolled slightly over, onto her left side for V13, CNA, to pull incontinent brief rest of the way from underneath R31. Incontinent brief then was secured without performing incontinent care to her right hip, buttock and down her right back thigh. R31's Physicians order sheet, documented diagnoses of COPD, Schizo-Affective Disorder and Bipolar Disorder. R31's Minimum Data Set, dated dated , 11/11/2024, documented that her cognition was severely impaired and that she was always incontinent of her bowels and bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R31's Care plan, dated 11/9/2022, documented, Toilet use: Dependent uses incontinent briefs One person physical assist. It continues, Toilet before and after meals, upon rising in the AM and before bed at night. 3. On 11/21/2024 at 09:35 AM, V21, CNA assisted by V28, CNA, performed incontinent care on R43. R43's incontinent brief was saturated with bowel movement. There was no rinse peri wash with water was placed in a basin with wash cloths. V21, cleansed R43's abdominal fold, bilateral groins and labial area. V21 nor did V28 dry the soapy suds from the peri wash from underneath R43's abdominal fold, bilateral groins or labial area. R43 was then turned on to her left side. V21, using cleansing wipes, cleansed R43's right hip, right buttock and peri rectal area. Areas were dried and V21 placed a clean incontinent brief on R43. R43 was then rolled on to her right side and V28, fastened the incontinent brief, without cleansing R43's left hip, her left buttock or the back of her thigh. R43's physician order, dated 11/21/2024, documented diagnoses of COPD and Dementia. R43's MDS, dated [DATE], documented that resident is rarely to never understood and that she is always incontinent of her bladder and her bowels. R43's care plan, dated 9/4/2024, documented, TOILET USE: The resident requires one to two assist with toileting. Resident is incontinent of B&B (bowels and bladder) and wears briefs. Check and change every two hours and prn (as needed). On 11/21/2024 at 11:15 AM, V29, CNA, stated that when she performs incontinent care, she would dry the areas that were washed and she would make sure that all areas were cleansed. On 11/21/2024 at 11:17 AM, V17, CNA, stated that when she performs incontinent care, she would dry all areas that were washed and she would make sure that all areas were cleansed. On 11/21/2024 at 11:20 AM, V10, CNA, stated that when she performs incontinent care, she would dry all areas that were washed and she would make sure that all areas were cleansed. On 11/21/2024 at 11:26 AM, V2, Director of Nurses, stated that it is her expectation that CNA's would dry all areas when washed during incontinent care and that she would expect them to cleanse all areas during incontinent care. The facility's, Incontinence Care policy, dated 10/2024, documented, 4. Soap one cloth at a time to wash genitalia using a clean part of the cloth for each swipe. a. Wash the labia first then groin area. b. Rinse with remaining cloth using clean surfaces for all three surfaces areas (female). Do not place soiled soapy cloths back in clean basin water until procedure completed. It continues, C. Clean/rinse inner/upper thigh areas to remove urine moisture. It continues, 6. Gently pat area dry with a towel from anterior to posterior. 7. Assist resident to turn to side away from you. 8. Using the final rinse cloth, from front washing, wash and rinse the peri-anal area. Pat dry.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview, observation, and record review, the facility failed to recognize a nonfunctioning Gastrostomy tube for 1 of 4 residents (R16) reviewed for Gastrostomy tube in the sample of 35. Findings include: R16's Admission Record, print date of 11/21/24, documents that R16 was admitted on [DATE] and has a diagnosis of Multiple Sclerosis. R16's Minimum Data Set, dated dated [DATE], documents that R16 is severely cognitively impaired and has a feeding tube. On 11/19/24 at 12:55 AM, V19, Licensed Practical Nurse, donned a gown and entered R16's room to do her tube feeding. V19 washed her hands and put on gloves. V16 using a large disposable syringe attempted to aspirate residual liquid from R16's stomach to verify the Gastrostomy tube (G-tube) placement. V19 was unable to pull back the plunger anymore than an approximate 0.25 to 0.5 centimeter (cm). While V19 was attempting to pull back the plunger, the G-tube was visibly closing in on itself at the top and the bottom near the abdomen. V19 stated that sometimes R16's G-tube is difficult to be able to pull residual but that it always flushes well. She stated, You have to play with the tube. It can be tricky. After multiple attempts and manipulations of the G-tube, V19 was still unable to pull the syringe back more than 0.25 to 0.5 cm. V19 stated, I know this happens with her G-tube. I was just in here 5 minutes ago and tested it. I was able to pull back and get residual. I wanted to make sure it would work while you were in here. V19 stated that she has asked many times for her G-tube to be replaced because of this same problem but it was never done. V19 was questioned what does she do if she can not verify placement of G-tube, V19 stated, You don't use it. V19 removed the plunger from syringe and appeared to be getting ready to instill the water flush into R16's G-tube at this point, the surveyor asked V19 to stop and refer to V2, Director of Nurses or the Physician to see what their recommendations are for the usage of R16's G-tube. V19 stated that she had just checked placement 5 minutes before and agreed that she was unable to check placement at this time. R16's Nurses Note, dated 11/19/24, documents, Writer unable to collect residual prior to tube feeding. PCP (Primary Care Provider) orders res (resident) to be sent out for tube placement check and/or new tube installation. R16's Nurses Note, dated 11/19/24, documents, Res taken to (hospital) via (local) EMS (Emergency Medical Service). On 11/20/24 at 11:16 AM, V4, Regional Nurse Consultant, stated that V19 should have stopped and notified V2 Director of Nurses of the problem with R16's G-tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy medication Administration - Gastrostomy or Nasogastric Tube, dated 10/2024, documents, Gastrostomy Tube. Aspirate to visually verify stomach contents. Gastric fluid normal appears clear or yellow with mucus or may appear milky if residual remains from previous feeding. Aspirated contents must be returned to the stomach to maintain pH, fluid and electrolyte balance. It continues, 'If there is a suspicion of feeding tube misplacement, Notify Physician to request an X-ray to confirm feeding tube placement.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 32874 Based on observation, interview and record review the facility failed to provide a Registered Nurse (RN) 8 hours a day, seven days a week for 18 of 18 days reviewed for RN coverage from 11/1/2024-11/18/2024. This failure has the potential to effect all 75 residents at the facility. Findings include: On 11/18/2024 at 9:00AM, an RN was not observed to be on duty. On 11/19/2024 at 10:14 AM, V2 Director of Nurses, stated the facility does not employ any full time RN's at the facility. V2 stated they are unable to provide RN coverage 8 hours a day. V2 stated the facility has 3 RN's who work per diem. The facility daily staffing schedule dated 11/1/2024-11/18/2024 documents no RN for 8 hours a day 7 days a week. On 11/19/2024 at 12:30PM V2, DON stated the facility does not have policy for staffing, V2 stated the facility follows Central Management Services (CMS) guidelines. The CMS 671 Long Term Care Application for Medicare and Medicaid documents a census of 75 residents at the facility.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 33112 Based on interview, observation, and record review, the facility failed to provide medications as the Physician Ordered. There were 37 opportunities with 6 errors resulting in a 16.22% medication error rate. The errors affected 2 residents (R70 and R44). Findings include: 1. On 11/19/24 at 7:54 AM, V26, Licensed Practical Nurse, (LPN) administered R70's morning medications. V26 administered 10 milligrams (mg) of Lexapro. R70's Physician Order, dated 11/20/24, documents, Escitalopram Oxalate 20 MG Tablet Give 1 tablet by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE 2. On 11/19/24 at 8:05 AM, V26 prepared and administered medications to R44. 1. Baclofen 10 mg 1/2 tablet given. 2. Fluconase Nasal Spray 50 microgram (mcg) 1 spray in each nare given 3. Breo Ellipta 100-25 mcg not given by V26. V26 stated that the medication was not available and she would need to order it from the pharmacy. On 11/20/24 at 10:30 AM, V26 stated that R44's Breo Ellipta did not come in from the pharmacy on 11/19/24 so R44 never did receive his dose for 11/19/24. V26 stated, It did come in so I was able to give it to him this morning. V26 failed to give R44 his Aspirin 81 Oral Tablet Chewable (Aspirin) and his Cholecalciferol Oral Tablet 125 MCG during this medication pass. R44's Physician Order, dated 9/10/24, documents, Breo Ellipta 100-25 MCG/ACT Aerosol Powder, breath activated 1 inhalation inhale orally one time a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED () Rinse mouth with water after inhalation and expectorate. R44's Physician Order, dated 4/24/24, documents, Fluticasone Propionate Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) 2 spray in both nostrils one time a day for allergies. R44's Physician Order, dated 4/25/2024, documents, Cholecalciferol Oral Tablet 125 MCG (5000 UT) (Cholecalciferol) Give 1 tablet by mouth one time a day for supplement. R44's Physician Order, dated 4/23/2024, documents, Baclofen Oral Tablet 10 MG (Baclofen) Give 1 tablet by mouth three times a day for muscle spasms. R44's Physician Order, dated 4/20/2024, documents, Aspirin 81 Oral Tablet Chewable (Aspirin) Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION. On 11/21/24 at 4:00 PM, V1, Administrator, stated that medications should be given as ordered by the physician. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy, Medication Administration Policy, dated 10/2024, documented, II. Administration of Medications. Medications must be administered in accordance with physician's order, e.g., the right resident, right medication, right dosage, right route, and right time.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview, observation, and record review, the facility failed to provide diets as ordered by the physician for 1 of 16 residents (R30) reviewed for quality of care in the sample of 35. Findings include: R30's Admission record, print date of 11/21/24, documents that R30 was admitted on [DATE] and has diagnoses of Psychosis, Schizoaffective Disorder, Drug Induce Subacute Dyskinesia, and Schizophrenia. R30's Minimum Data Set, dated dated [DATE], documents that R30 is severely cognitively impaired, requires setup or clean up assistance for eating, supervision or touching assistance for sitting and walking. R30's Care Plan, revision date of 10/04/2022, documents, (R30) is at increased nutritional risk r/t (related to) DX (diagnosis): COPD (Chronic Obstructive Pulmonary Disease), Hypertension, Anxiety, Bipolar. Intervention: I use adaptive equipment to ensure my safety: plastic silverware therapy request her to get plastic do to resident poking herself so get plastic for a safety Date Initiated: 11/18/2024. Monitor/document/report PRN as needed) any s/sx (signs and symptoms) of dysphagia: coughing, drooling, pocketing food, swallowing attempts, refusing to eat. Date Initiated: 10/04/2022. R30's Care Plan, revision date of 11/18/24 , documents, (R30) has an ADL (Activities of Daily Living) (self-care performance deficit r/t weakness, lack of coordination, dyskinesia, cog impairment and multiple psych (psychiatric) dx. (R30) needs pills whole in pudding at times. Plastic ware for all meals. Eating: Supervision One person physical assist at times. R30's Speech Therapy Discharge Summary, dated 11/19/24, documents, Patient Progress: Progress & Response to Treatment: Pt (patient) achieved max (maximum) rehab potential for the stated goals with d/c (discharge) complete. Communication: Team Communication / Collaboration: ST (Speech Therapy) instructed pt (patient) on small bites / sips, slowing the rate of consumption, and liquid wash every 1 - 3 bites. Pt requires staff supervision for staff to provide cues and assist during PO (oral) intake when needed. Discharge Recommendations and Status Oral Intake Solids = Mechanical soft / ground textures. Liquid - Thin liquids. Strategies Compensatory Strategies / Positions: with staff supervision. Aspirations precautions. Dining / Swallowing Program Established / Trained: Pt has restorative program / staff education in place for swallowing / dysphagia to ensure safety of the swallow. Outcome Risks Risk Areas that may impact Long Term Outcome (s) = lacks insight into condition and risk factors. Multiple medical conditions / history. Desired Change in Condition of Risk area: Dysphagia. R30's AIMS - Abnormal Involuntary Movement Scale, dated 11/8/23, documents that R30 has Moderate movements of the muscles of the facial expression, mild movements of the lips and perioral area, jaw, and mild movements of the tongue. R30 has moderate movements of the upper arms, wrists, fingers, hands, legs, knees, ankles, and toes. R30 has moderate neck, shoulder, hips, e.g. (for example) rocking, twisting, squirming, pelvic gyrations. R30 severity of abnormal movements is moderate. Incapacitation due to abnormal movements is mild. R30 scores a 18. The higher the score (0-28), the greater the impact of observed movements on resident. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R30's AIMS - Abnormal Involuntary Movement Scale, dated 10/19/24, documents that R30 has Moderate movements of the muscles of the facial expression, lips and perioral area, jaw, and mild movements of the tongue. R30 has severe movements of the upper arms, wrists, fingers, hands, legs, knees, ankles, and toes. R30 has severe neck, shoulder, hips, e.g. (for example) rocking, twisting, squirming, pelvic gyrations. R30 severity of abnormal movements is severe. Incapacitation due to abnormal movements is mild. R30 scores a 23. The higher the score (0-28), the greater the impact of observed movements on resident. R30's Electronic Medical Record fails to document an AIM scale between 11/8/23 and 10/19/24. R30's Physician Order, dated November 2024, documents, REGULAR diet, Mechanical Soft, Ground Meat texture, Thin consistency with staff supervision. Start date of 5/2/24. On 11/19/24 at 12:18 PM, R30 is sitting in the assisted dining room eating her noon meal which consisted of turkey, mashed potatoes, and gravy. R30 has very spastic jerky movements of the arms, legs, head, tongue, and mouth. R30 has involuntary backward arching of the back, shuffling of the feet sidewise and forward motion. R30 is very unsteady on her feet. R30 is unable to control the spontaneous movements. R30's turkey was not cut up. It was in larger pieces not bite size. R30 took her plastic fork and stabbed the meat then with her hand pulled off a meat and put it in her mouth. R30 began to gag. R30 grabbed her drink and took a drink. R30 continued to gag. R30 leaned forward and spit the drink out toward the table. R30 then leaned to the side and spit drink and the turkey meat out onto the floor. V15 CNA assisted R30 with a towel and removed her tray. V21 CNA assisted in moving R30's tablemates to another table. V15 then brought R30 a cup of soup with a metal spoon. On 11/19/24 at 4:45 PM, V19 LPN (Licensed Practical Nurse), stated that she was not aware of R30 gagging on her noon meal. On 11/21/24 at 2:09 PM, V15 (CNA-Certified Nurse Assistant) was asked if she let V19 know about R30 gagging on her lunch, V15 CNA, stated, I went and told (V19). I had her double check her diet too. She was suppose to get a mechanical diet. V15 stated that R30 did receive large pieces of turkey and not mechanical turkey on 11/19/24. V15 stated that R30 has worsened with her movements just recently. On 11/21/24 at 2:13 PM, V21 (CNA) was asked if she let V19 know about R30 gagging on her lunch on 11/19/24, V21 stated, (V19) was told. (V15) went right up to (V19) and told her. She was standing right there at the nurses desk. R30's Nurses Note, dated 11/19/2024 19:00, documents, (V16, Medical Director) notified of resident vomiting at lunch. Orders received to obtain chest xray per (V16). Resident chart updated and resident aware. (mobile) xray called. R30's Nurses Note, dated 11/20/2024 08:10, documents, Resident being transported to (local hospital) for STAT (now) chest x-ray r/t (related to) vomiting, resident leaving via facility transports order and face sheet sent with. On 11/25/24 at 9:10 AM, V3, Assistant Director of Nurses, stated that the Physician should have been notified of R30's gagging incident when it happened. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy, AIMS Side Effect Monitoring, dated 10/2024, documented, The examination will be performed either at the time of resident's admission or when medications are initially prescribed. In addition, for residents taking psychotropic medication, AIMS examination procedures will be repeated at intervals of no less than every six (6) months. The facility's Diet Orders Policy dated 08/2023, documented diet orders are checked for accuracy regularly, at the quarterly care plan meeting, by comparing diet orders on file in Dining Services with the Physician Order Sheet (POS) in the health record. The facility's Fall Prevention Program Policy dated 10/2024, documented the purpose of the policy is to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview, observation, and record review, the facility failed to perform hand hygiene, change gloves when soiled, wear Personal Protective Equipment, and sanitize a multi-use blood glucose monitor to prevent cross contamination for 10 of 16 residents (R1, R4, R16, R20, R22, R24, R31, R57, R61, R71) reviewed for infection control in the sample of 35. Findings include: 1. On 11/19/24 at 09:11 AM, While toileting R20, V28 Certified Nurses Aide (CNA) and V21 CNA both donned gloves without hand hygiene. 2. On 11/19/24 V26 Licensed Practical Nurse, (LPN) was observed giving morning meds during the medication pass. At 7:33 AM, V26, Licensed Practical Nurse LPN was outside of R22's room with her medication cart. V26 donned gloves without hand hygiene, gathered the blood glucose monitoring machine, and the blood glucose test strip, alcohol pad and entered R22's room to obtain a blood glucose level. V26 wiped R22's finger with alcohol, pricked R22's finger and obtained the needed blood sample. The blood glucose monitor failed to read the sample. V26 removed her gloves, V26 exited the room, obtained another test strip from the medication cart, returned to room, donned gloves, cleansed R22's finger with alcohol and pricked R22's finger for a blood sample. The blood glucose monitor registered a blood glucose level of 226. V26 removed her gloves and returned to her medication cart and sanitized her hands. V26 prepared a 25 unit Lispro insulin subcutaneous injection, entered R22's room, donned gloves with no hand hygiene, and gave the injection in the right lower abdomen. On 11/19/24 at 7:40 AM, V26 returned to her medication cart and placed the blood glucose monitor on top of her cart. On 11/19/24 at 8:20 AM, V26 donned gloves, obtained a micro-kill cloth and using one wipe, wiped the front and back of the blood glucose machine. V26 then placed the blood glucose machine on top of the same micro-kill cloth. The facility provided a list of residents that would of had their blood glucose checked using the 300 Hall medication cart, dated 11/21/24. This list documents R4, R22, R24, R57, R61, and R71. The policy Glucometer Cleaning, dated 10/24, documents, Wipe meter with bleach wipe / towel disinfectant until all surfaces of the glucometer are visibly wet and note kill time of product. The (surface disinfectant cleaner) information, undated, documents (surface disinfectant cleaner) has a kill time of 30 seconds for HBV (Hepatitis B) and HCV (Hepatitis C) and 3 minutes for C Diff (clostridium difficile colitis) spores. 3. R16's Admission Record, print date of 11/21/24, documents that R16 was admitted on [DATE] and has a diagnosis of Multiple Sclerosis. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at 11:21 AM, V27, Licensed Practical Nurse (LPN), entered R16's room to provide tube feeding for R16 through R16's Gastrostomy (G-tube). V27 washed her hands and donned gloves. V27 using a disposable syringe checked for residual through the G-tube. R16 had no residual. V27 gave R16 a 75 milliliter (ml) water flush, 250 ml of Jevity 1.5, and then a 75 ml water flush. V27 removed her gloves and washed her hands. On 11/20/24 at 11:27 AM, V27 was asked why she did not wear a gown while working with R16's G-tube, V27 stated, Oh, I forgot. 40650 4. R31's Physicians order sheet, dated 11/21/2024, documented diagnoses of COPD, Schizo-Affective Disorder and Bipolar Disorder. On 11/19/2024 at 9:27 AM, R31 was placed in to her bed per full mechanical lift. V14 (CNA) pulled R31's pants down and unfastened her adult incontinent brief, which were both saturated with urine. V14 did not perform hand hygiene or changed gloves prior to performing incontinent care. V14, then performed incontinent care on R31. R31 was then rolled on to her right side, V14 removed R31's soiled pants, incontinent brief and full mechanical lift pad from underneath her, placed items in a trash bag and without performing hand hygiene or glove changes, V14 cleansed R31's left hip and peri rectal area. V14 then placed a clean incontinent brief and R31 was then rolled slightly over for V13, CNA, to pull the clean incontinent brief rest of the way from underneath R31. On 11/21/2024 at 11:15 AM, V29, CNA, stated that she would wash her hands and change gloves when she has contaminated her gloves. On 11/21/2024 at 11:17 AM, V17, CNA, stated that she would wash her hands and change gloves when her gloves are dirty. On 11/21/2024 at 11:20 AM, V10, CNA, stated that she would wash her hands and change gloves when her gloves are dirty. On 11/21/2024 at 11:26 AM , V2, Director of Nurses, stated that she would expect the staff to change their gloves and wash their hands when their gloves have been contaminated. 50908 5. R1 was admitted to the facility on [DATE] with diagnosis of, in part, cerebrovascular disease, facture of femur, mild protein-calorie malnutrition, and joint replacement surgery aftercare. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/19/24 at 9:45 AM, V17, Lead CNA, and V8, CNA, provided catheter and peri care to R1. V17 and V8 turned R1 onto his right side, V8 pulled out a container of barrier ointment from his pocket. V8, applied the barrier ointment to R1's buttock then removed his gloves. V8 then applied new gloves without hand hygiene and rolled a new pad out under R1 for him to lie on. V17, cleansed R1's right buttock as he was turned on his left side. V17 then grabbed the barrier container without removing her gloves or performing hand hygiene and applied the ointment to R1's right buttock. V8 removed his/her gown and gloves then tied up the two plastic bags that were used to contain the dirty linen and towels after providing peri-care to R1. V8 grabbed the bags, touched the door handle to open the door and removed the items without hand hygiene. The facility's Use of Disposable Gloves Policy dated 09/2023, documented hands will be washed before putting on disposables gloves. Anytime a contaminated surface is touched, the gloves must be changed. Hands should be washed each time disposable gloves are removed. The facility's Hand Hygiene/Handwashing Policy dated 03/2023, documented hand hygiene should be performed if hands will be moving from a contaminated-body site to a clean-body site during patient care, before glove placement and after glove removal. The facility's Enhanced Barrier Precautions (EBP) Policy dated 03/2024, documented use of EBP to be for residents with chronic wounds or indwelling medical devices during high-contact care activities. The EBP policy documented further that gown and gloves must be worn when providing medical device care.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 32874 Based on interview and record review the facility failed to provide 12 hours of Certified Nursing Assistant (CNA) training on a yearly basis for 3 of 5 CNA's (V13, V31 and V36) reviewed for training. This failure has the potential to affect all 75 residents residing at the facility. Findings include: The Facility's trianing records did not document on V13, V31 and V36 CNA's training record they received 12 hours of annual competency training. On 11/25/2024 at 9:42AM V35, Human resources director stated V36, V31, and V13 did not receive required in-service training of 12 hours for CNA's. V35 stated she provides staff with the training site they are to utilize and the log in . V35 stated she does not provide oversight to ensure the training is completed. V35 stated it is the expectation that staff completed required training. The facility policy, policy on training of Employees and documentation of such training dated 9/2023 documents the facility will train all members of its workforce on its policies and procedures with respect to protected health information, as necessary and appropriate for the the members of the work force to carry out their functions. The policy documents the facility will retrain each new workforce member whose functions are affected either by a material change in its privacy policies and procedures on in the members job function within a reasonable time after the changes. The CMS 671 Long Term Care Application for Medicare and Medicaid documents a census of 75 residents at the facility.