STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. Building B. Wing	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Nursing and Rehabilitation Center	5600 E 16th St Indianapolis, IN 46218

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 40287 Based on observation, interview, and record review, the facility failed to timely provide assistance with dressing for 1 of 1 resident reviewed for ADL (Acts of Daily Living) care (Resident 6). Findings include: The clinical record for Resident 6 was reviewed on 4/16/24 at 3:21 p.m. The Resident's diagnosis included, but were not limited to, dementia and heart failure. A care plan, initiated 6/16/2020, indicated Resident 6 required assistance with ADL care related to his dementia, heart failure and muscle weakness. The goal was for him to improve current functional status. The interventions included, but were not limited to, assist with toileting and/or incontinent care, start date 6/16/2020, and assist with dressing, grooming, and hygiene as needed. Encourage him to do as much for self as possible, start date 6/16/2020. A Quarterly MDS (Minimum Data Set) Assessment, completed 3/4/24, indicated he had moderately impaired cognition and needed cues and supervision with dressing. On 4/16/24 at 3:21 p.m., Resident 6 was observed sitting in his wheelchair in his room. He was wearing a brown t-shirt and purplish sweatpants with a binder clip attached to the waist band. The sweatpants were not pulled up to his waist and the back of the waist band was around his thighs. He indicated the sweatpants were too big for him. On 4/17/24 at 9:13 a.m., Resident 6 was observed wearing the same sweatpants and t-shirt. On 4/18/24 at 9:20 a.m., Resident 6 was observed wearing the same purplish pants and brown shirt. A blue sweatshirt and a pair of grey sweatpants were laying on the chair in his room. On 4/19/24 at 9:24 a.m., Resident 6 was observed sitting in his room. He continued to wear the same purplish sweatpants with the waist band at his mid-thigh. During an interview on 4/19/24 at 9:36 a.m., CNA (Certified Nursing Assistant) 2 indicated Resident 6 would change his clothing if approached correctly. He was wearing the same clothing as the day before. She would assist him is changing his clothing. 3.1-38(b)(4)

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

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

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F 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. 34850 Based on interview and record review, the facility failed to assess a resident's skin condition; timely clarify the dosage and administration time of a resident's antipsychotic medication; administer insulin as ordered; and monitor frequency of bowel movements for a resident with constipation for 1 of 1 resident review for constipation, 1 of 5 residents reviewed for unnecessary medications, and 1 of 1 resident reviewed for skin conditions. (Residents B and 27) Findings include: 1a. The clinical record for Resident B was reviewed on 4/17/24 at 9:00 a.m. The diagnoses for Resident B included, but were not limited to, type 2 diabetes mellitus, borderline personality disorder, somatization disorder, post-traumatic stress disorder and bipolar disorder. A care plan dated 4/17/24 indicated .Resident is at risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus .Approach .medications as ordered .Monitor blood sugars as ordered . A physician order dated 4/1/24 indicated Resident B was to receive 10 units of lispro insulin prior to meals three times a day. The April 2024 Medication Administration Record (MAR) for Resident B indicated the following days and times the lispro insulin was not administered: 4/4/24 at 8:00 a.m., 4/5/24 at 12:00 p.m., and 5:00 p.m., 4/11/24 at 8:00 a.m., 5:00 p.m., and 4/12/24 at 8:00 a.m., During an interview with Resident B on 4/17/24 at 9:25 a.m., she indicated she does not receive her insulin as often as she should. There are times she misses dosages and does not receive at all. An interview was conducted with the Director of Nursing Services (DNS) on 4/19/24 at 3:34 p.m. She indicated she was unsure why the resident had not received her lispro insulin on 4/4/24, 4/5/24, 4/11/24, and 4/12/24. 1b. A physician order dated 3/23/24 indicated Resident B was to receive 400 milligrams of seroquel at bedtime. A physician order dated 4/1/24 indicated Resident B was to receive 50 milligrams of seroquel twice a day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A psych visit note dated 4/3/24 for Resident B indicated .Staff has reported that she has made multiple false accusations against the facility staff. This clinician discussed her case with collaborating physician, who believes that her behaviors are due to her borderline personality disorder and somatization disorder . Antipsychotic use .Seroquel dosage/route/: 450 mg [milligrams] po [by mouth] qhs [every night] and 50 mg daily. A medical provider visit note dated 4/4/24 indicated Resident B was to receive 400 milligrams of seroquel at night and 50 milligrams of seroquel in the morning and afternoon. The April 2024 Medication Administration Record (MAR) indicated the resident was to receive 50 milligrams of seroquel at 9:00 a.m., and 1:00 p.m. The resident was to receive 400 milligrams of seroquel at bedtime. An interview was conducted with the DNS on 4/19/23 at 11:46 a.m. She indicated she will contact the pysch provider to clarify the dosage and administration time of Resident B's seroquel medication. 1c. An interview was conducted with Resident B on 4/17/24 at 9:25 a.m. She indicated she has an area on her stomach that was opened, and she needs a dressing applied. The staff are not addressing it. A physician order 4/3/24 indicated staff was to Cleanse area to umbilicus twice a day. Keep area as clean and dry as possible. The April 2024 Treatment Record indicated the staff were cleansing the area twice a day. The resident's clinical record did not include assessments of an area on her umbilicus. The weekly skin assessments dated 4/3/24 and 4/10/24 did not indicate the resident had any skin altercations. A wound management note dated 4/17/24 indicated the resident had an old biopsy site reopen. The location of the skin area was the umbilicus. The measurements 1 centimeter in length and 1 centimeter in width with a depth of 0.5 centimeters. The area had bloody drainage. An interview was conducted with the DNS on 4/19/23 at 11:46 a.m. She indicated she did not know the reason why there was an order placed on 4/3/24, to cleanse Resident B's umbilicus twice a day. She was unable to locate any skin assessments that included the staff assessing the area on her umbilicus prior to 4/17/24. A skin management policy was provided by the Infection Preventionist Float on 4/22/24 at 11:47 a.m. It indicated .Procedure for wound prevention: .6. any skin altercations noted by the direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises, open areas, redness, skin tears, blisters, and rashes. The license nurse is responsible for assessing all skin altercations by the direct caregivers on the shift reported . 40287 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The clinical record for Resident 27 was reviewed on 4/16/24 at 2:02 p.m. The Resident's diagnosis included, but were not limited to, constipation, heart failure and chronic kidney disease. A care plan, initiated 12/8/22, indicated Resident 27 was at risk for constipation due to her medications and mobility deficit. The goal was for her to have a soft formed bowel movement at least every 3 days. The approaches included, but were not limited to, notify physician if no bowel movement after 3rd day, initiated 12/8/22, administer medications as ordered, initiated 12/8/22, monitor bowel function, initiated 12/8/22, and abdominal assessment if no BM x 4 days. Document and notify physician of abnormal findings, initiated 12/8/22. A physician's order, dated 3/13/24, indicated she was to receive Dulcolax 5 mg tablet once every 24 hours as needed for constipation. A physician's order, dated 3/14/24, indicated she was to receive Milk of Magnesia suspension 30 milters once a day as needed for constipation. A Significant Change of Status MDS (Minimum Data Set) Assessment, completed 3/20/24, indicated she was cognitively intact and was dependent on staff for toileting. During an interview on 4/16/24 at 2:02 p.m., Resident 27 indicated she did not feel well. She was constipated and it had been at least 3 days since she had a bowel movement. She did not feel like eating. The April 2024 bowel record for Resident 27 was as follows: 4/1/24 at 1:55 a.m.- no bm (bowel movement), 4/1/24 at 6:43 a.m.- small bm, 4/1/24 at 7:58 p.m.- large bm, 4/2/24 at 9:03 p.m.- no bm, 4/3/24 at 9:09 p.m.- no bm, 4/4/24 at 9:37 p.m.- no bm, 4/5/24 at 10:12 p.m.- no bm, 4/8/24 at 6:17 a.m.- no bm, 4/8/24 at 9:24 p.m.- no bm, 4/9/24 at 8:10 p.m.- no bm, 4/10/24 at 7:43 p.m.- no bm, 4/11/24 at 9:04 p.m.- no bm, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/13/24 at 6:28 a.m.- no bm, 4/14/24 at 10:21 p.m.- small bm, 4/15/24 at 1:52 a.m.- no bm, 4/15/24 at 6:17 a.m.- no bm, 4/16/24 at 4:45 p.m.- large bm, 4/18/24 at 7:33 p.m.- no bm, 4/19/24 at 8:24 p.m.- no bm, 4/20/24 at 6:18 a.m.- no bm, and 4/20/24 at 10:27 p.m.- no bm. The April 2024 MAR (Medication Administration Record) did not indicate that Resident 27 had received any doses of her as needed Dulcolax or Milk of Magnesia during April. During an interview on 4/22/24 at 11:36 a.m., the IPF (Infection Preventionist Float) indicated that normally bowel movement status should be documented each shift. On 4/22/24 at 11:36 a.m., the IPF provided the Bowel Elimination policy, dated 1/2015, which read .It is the policy of . to ensure that each resident maintains a safe and healthy bowel elimination pattern .4. Bowel movements will be recorded on the facility EMR [Electronic Medical Record] and/or record daily by the direct care staff. 5. A resident bowel report will be completed by the assigned charge nurse of resident [s] who have not had a bowel movement for 3 consecutive days. 6. Any resident not having a bowel movement for 3 consecutive days, will be given a laxative or stool softener, as prescribed by the physician, at the end of the 3rd day .8. If by the 4th afternoon, the resident [s] has not had results, the nurse will do an abdominal assessment, chart the results of the assessment, and notify the physician for further order . 3.1-37(a)

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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. 40287 Based on observation, interview, and record review, the facility failed to provide oral care, as ordered by the physician, and to timely obtain a physician's order to provide gastrostomy tube site care for 1 of 1 resident reviewed for tube feeding (Resident 23). Findings include: The clinical record for Resident 23 was reviewed on 4/16/24 at 2:40 p.m. The Resident's diagnosis included, but were not limited to, dysphagia (inability to swallow), aphasia (inability to speak), and gastrostomy (g-tube). A care plan, initiated 11/8/2018, indicated Resident 23 was at risk for complications related to enteral feedings. The goal was for him to be free from complications related to enteral feeding. The approaches included, but were not limited to, cleanse around site as ordered, initiated 11/8/2018, and elevate head of bead, initiated 11/08/2018. A physician's order, dated 1/28/2021, indicated to provide oral care every shift. A Quarterly MDS (Minimum Data Set) Assessment, completed 3/28/24, indicated his long- and short-term memory was intact. He was independent with decision making and was dependent on staff for oral hygiene. On 4/16/24 at 2:40 p.m., Resident 23 was observed laying in his bed with his g-tube visible. There was dried brown drainage present on the base of his g-tube. His mouth had a white film present on his teeth and lips. On 4/18/24 at 12:04 p.m., Resident 23's g-tube site was observed with LPN (Licensed Practical Nurse) 3. LPN 3 removed an undated drainage sponge from Resident 23's g-tube site. LPN 3 indicated the g-tube site was care for on the night shift daily. The ostomy site had a brown dried crust at the base of the tube. Resident 23 indicated he had drainage at his g-tube site often by shaking his head yes and putting his thumb up. He indicated that his g-tube site was not cleansed each night by shaking his head no. Resident 23's mouth had a white film present on his teeth and lips. On 4/18/24 at 2:02 p.m., Resident 23 was observed with LPN 3. LPN 3 indicated that oral care was provided each shift by either the nurse or the certified nursing assistants. The bedside table drawers were observed to have an unopened toothbrush in a plastic wrapper. There were no oral swabs present in the bedside table. LPN 3 indicated that Resident 23 was in need of oral care. Resident 23 indicated that mouth care was not provided each shift by shaking his head no and indicated that he would like to have oral care done each shift by putting his thumb up and shaking his head yes. During an interview on 4/18/24 at 2:17 p.m., the DNS (Director of Nursing Services) indicated that Resident 23's medical record did not contain an order for g-tube site care and that oral care should be done as ordered by the physician. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/24 at 2:19 p.m., the DNS provided the Enteral Tube Skills Competency, last reviewed 9/2019, which read .enteral Tube- Dressing Change and Site Care . Dressing or site care of enteral tube site should be done at least daily. 3.1-44(a)(2)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30344 Based on interview and record review, the facility failed to adequately monitor and document behaviors for 1 of 1 resident reviewed for mood and behaviors and 2 of 5 residents reviewed for unnecessary medications. (Residents 38 and 45) Findings include: 1. The clinical record for Resident 45 was reviewed on 4/17/24 at 1:43 p.m. His diagnoses included, but were not limited to: schizoaffective disorder, bipolar disorder, insomnia, neurocognitive disorder, encephalopathy, and extrapyramidal and movement disorder. He was admitted to the facility on [DATE] from another skilled nursing facility. The 1/14/24 New/Worsening Behavior Communication Event indicated Resident 45 grabbed a female staff's breast/buttocks inappropriately. The intervention attempted in response to the behavior was to explain that it was inappropriate and encouraged not to do it again. The effectiveness of the interventions were somewhat effective, but Resident 45 did it again after the first action. The interventions put into place to prevent another behavior was to redirect as needed. The 1/23/24 behavioral symptoms care plan indicated the goal was for him to be free of incidents of inappropriate behavior in touching female staff. An approach, starting 1/23/24, was to redirect him as needed and remind him when a behavior was inappropriate. The care plan did not reference or address the potential for him to have an inappropriate sexual behavior towards another resident. The 2/24/24 New/Worsening Behavior Communication Event indicated after dinner in the hallway, Resident 45 was allegedly touching females breast. The interventions attempted in response to the behavior was a chair placed in the hallway by nurses station; redirection; and encourage resident to stay separate during meals and activities. The effectiveness of the interventions was indicated as helpful. Another resident was affected by this behavior and Resident 45 was removed from the other residents environment. On 4/22/24 at 9:30 a.m., the ED (Executive Director) provided the investigative file into the above 2/24/24 behavior event. The file included the 2/28/24 follow-up incident report. The report indicated on 2/24/24, Resident B alleged that Resident 45 made contact with her chest during conversation. The residents were immediately separated. The ED, DNS (Director of Nursing Services,) and physician were notified and an investigation was initiated. The 2/28/24 follow up section of the report indicated Resident B went about her daily routine with no signs or symptoms of psychosocial distress. The root cause of Resident 45's behavioral expression was age and cognition. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The file included a documented interview with Resident B conducted on 2/28/24 by the SSD (Social Services Director.) The interview indicated Resident B informed the SSD that Resident 45 tended to come into her room and watch television without asking. When Resident B redirected Resident 45 and asked him to leave, he would leave without incident. One day last week, Resident 45 was walking closely behind Resident B and she was talking with other residents. Resident 45 walked up closely to Resident B and said hello, that she was pretty, and grazed her breast with his open hand. Resident B stated that she screamed and told him to stop and informed nursing staff, who redirected Resident 45 and informed him that was not appropriate to touch peers in that manner. The file included an undated documented interview with RN (Registered Nurse) 6 conducted by the ED. It read, Staff member reported to ED that [name of Resident B] was alleging inappropriate contact by [name of Resident 45.] When asked if she had witnessed this contact, [name of RN 6] stated no. The file included a documented interview with Resident 44 conducted on 2/28/24 by the ED. The interview indicated another resident was sitting in between him and Resident B. He saw Resident 45 approach Resident B and grab her breast. Resident B told Resident 45 he couldn't touch her. Resident 44 just stood there, looking at them. The 4/4/24 Quarterly MDS (Minimum Data Set) assessment indicated Resident 44 had a BIMS (brief interview for mental status) score of 15, indicating he was cognitively intact. He did not have any care plans referencing a history of making false allegations. An interview was conducted with Resident 44 on 4/22/24 at 11:25 a.m. He indicated RN 6 was doing paperwork in the conference room with the door open. He, another resident, and Resident B were in the hallway just outside of the conference room. Resident 45 was walking down the hallway towards them, and once he reached Resident B, he grabbed her breast. Resident 44 saw Resident 45 let go of his walker, stop, and grab Resident B's breast. Resident B jumped back when it happened. Then she went into the conference room and talked to RN 6 about it. Resident 44 saw Resident 45 touch a female staff member inappropriately once too. An interview was conducted with the SSD on 4/22/24 at 11:38 a.m. She indicated Resident 44, who witnessed Resident 45 grab Resident B's breast in the hallway, had no history of false allegations of which she was aware. If he said something, she was likely to believe him. He's not one to make up a story. The 2/24/24, 4:15 p.m. progress note, recorded as a late entry by the SSD on 2/26/24 at 8:53 a.m., read, This writer spoke with resident to see if she was displaying any s/s [signs/symptoms] of psycho-social distress due to inappropriate interaction with peer. This writer listened to resident's thoughts and feelings on situation and validated her perception of what transpired. Resident was calm stated see [sic] felt that she will just [sic] in her room and eat her meals for a couple of days. This writer encouraged her not to self-isolate and that this is her home and she is free to move about. Staff can address any issues or situations that arise. The 2/23/24 Quarterly MDS assessment for Resident 42 indicated she had a BIMS score of 15, indicating she was cognitively intact. She did not have any care plans referencing a history of making false allegations. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Resident 42 on 4/17/24 at 11:07 a.m. She indicated Resident 45 would just walk into other residents' rooms uninvited. Her roommate, Resident 39, woke up one morning and he was standing at the foot of her bed claiming she was in his bed. Resident 45 was fixated on Resident 39. Earlier in the week, Resident 45 put his wheel chair in their doorway and wouldn't leave. She stated, He doesn't know what he's doing. She'd never seen Resident 45 touch anyone, but he would follow Resident 39 around and ask if he could live with her. She stated, Staff cant watch him 24 hours a day We all have to watch him It's not up to us to have to monitor him. The 2/24/24 Quarterly MDS assessment for Resident 39 indicated she had a BIMS score of 15, indicating she was cognitively intact. She did not have any care plans referencing a history of making false allegations. An interview was conducted with Resident 39 on 4/17/24 at 1:51 p.m. She indicated she woke up one night about a month ago at 3:00 a.m. to Resident 45 at the foot of her bed, telling her she was in his bed. She told the SSD about it, who informed her she was working with him on it. Another time, he was at her door and asked if he could live with her. The same day, he followed her down the hallway telling her he loved her. One day, he stood at the door and wouldn't leave. An interview was conducted with the SSD on 4/22/24 at 11:38 a.m. She reviewed Resident 39's and Resident 42's care plans and indicated she knew Resident 39 and Resident 42 had a history of backing each other up, kind of move as one, but to her knowledge, neither Resident 39 nor Resident 42 had a history of making false allegations, and neither had a care plan referencing such. The 2/25/24 New/Worsening Behavior Communication Event indicated on 2/24/24 at 10:30 p.m., Resident 45 asked a female staff member to help him fix his television, and as she reached up to do so. Resident 45 tried to pull down her pants. The physician suggested a neuro-psyche stay. The 2/25/24 Physician Communication Tool Event indicated Resident 45 was transferred to a neuropsychiatric hospital for a psychiatric evaluation. The 2/25/24 psychiatric evaluation from the neuropsychiatric hospital read, This provider reviewed clinical documentation provided by the skilled nursing facility and there is very minimal detail regarding his mood or sexual behaviors There is no documentation that this patient has hit or harmed anyone nor harmed himself. The most documented behavior is the patient is noncompliant with use of his walker. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the SSD on 4/22/24 at 11:38 a.m. She indicated in January, 2024 it was relayed to her that Resident 45 touched a female staff member's breast and buttocks over the weekend. As far as interventions put in place afterwards to address his sexually inappropriate behavior, there was a care plan approach to remind him the behaviors were inappropriate and to redirect him. No other interventions were put in place at that time, and there were no interventions to address a potential for him to be sexually inappropriate with residents too. After the 2/24/24 sexually inappropriate behavior towards staff, they added the intervention of care in pairs, effective 2/26/24. The care in pairs should have gone into place after the 1/14/24 event. Resident 45 was fairly new to the facility when the first incident happened with staff on 1/14/24, and they were still learning his behaviors at that time. Resident 45 wore a wanderguard, because when he first came to the facility, he was going up to doors, trying to get out. He'd gone into quite a few other residents rooms and started watching television, such as Resident 19, Resident 7, and Resident 28. The other residents would tell him to leave and he would just get up and walk out. The SSD had never seen him go in or come out of anyone's room. She knew Resident 45 was a concern for some of the other residents because he was younger. There were no progress notes or events in the electronic health record that referenced the frequent occurrences of Resident 45 going into other residents' rooms uninvited. Resident 45 had a care plan to address his potential for elopement, but none to address his wandering into other residents rooms uninvited. An interview was conducted with the SSD on 4/22/24 at 12:45 p.m. She indicated there was no care plan to address him going into other residents rooms uninvited. 34850 2. The clinical record for Resident 38 was reviewed on 4/17/24 at 10:00 a.m. The diagnosis for Resident 38 included, but was not limited to, schizophrenia. A care plan dated 9/7/23 indicated Resident gets agitated and will yell and cuss .Approach Encourage resident to do an activity such as bingo .Encourage resident to communicate frustration in a positive way Redirect resident to a calmer and quieter space . A physician order dated 2/8/24 indicated resident was to receive 100 milligrams of zoloft daily. The medication was discontinued on 4/17/24. A physician order dated 3/8/24 indicated resident was to receive 50 milligrams of zoloft totaling 150 milligrams daily. The medication was discontinued on 4/17/24. A social services note for Resident 38 dated 3/12/24 indicated resident had became anger when the Executive Director checked for a missing item in his room per his family request. The resident was upset and cussing. The resident's clinical record did not include any other documented behaviors the resident had in March. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Community Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5600 E 16th St Indianapolis, IN 46218	

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavior progress note for Resident 38 dated 4/11/24 indicated Date and Time of behavioral expression: 4/11/24 2:40 p.m. Location of expression: hallway, Describe the specific behavioral expression: cursing and using foul language towards staff, Interventions attempted: attempt to determine root cause, Effectiveness of Interventions: not effective, Suggestions/Other information: bx [behavior monitoring] . The resident's clinical record did not include any other documented behaviors the resident had in April. During a resident council meeting on 4/16/24 at 2:00 p.m., Resident 38 was observed upset and left the meeting angry and cussing loudly down the hallway. The resident's clinical record did not include documentation of the incident on 4/16/24. A psych follow up visit note for Resident 38 dated 4/17/24 indicated .He denies difficulty sleeping or changes in appetite. Per staff reports, resident does have episodes of verbal aggression, irritability, and outbursts due to anger .Plan .increase sertraline [Zoloft] to 200 mg [milligrams] daily due to reports of verbal aggression and irritability . A physician order dated 4/17/24 indicated resident was to receive 200 milligrams of zoloft daily. An interview was conducted with Social Services Director on 4/22/24 at 2:39 p.m. She indicated when direct care staff observe residents having behaviors they need to report the behavior to a nurse. The behavior should be documented in the progress notes. If the behavior was new or worsening the staff would open an event in the resident's record. An interview was conducted with Executive Director (ED) on 4/22/24 at 2:27 p.m. She indicated there are occasions Resident 38 exhibits aggression and irritability. There should be documentation in the progress notes if staff observe the resident's behaviors. The staff are not following the facility's behavior management policy. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavior management policy was provided by the Infection Preventionist Float on 4/22/24 at 2:36 p.m. It indicated .Policy: It is the policy of American Senior Communities to provide behavior interventions for residents with problematic or distressing behaviors. Interventions provided are both individualized and non pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's behavioral expressions .Procedure: 3. When a behavioral expression occurs, the staff communicates to the nurse what behavior occurred. The nurse records the behavior in Matrix. 4. If the behavioral expression is new, worsening, or high risk, the nurse will record the behavior using the New/Worsening Behavior Event. New or Worsening Behaviors include: a. Behaviors that are new for the resident, b. Behaviors that are directed at another resident (Note: follow abuse reporting and prohibition protocols), c. Behaviors that are increasing in either frequency or severity, d. Behaviors that have potential for risk to others including sexual advances, intrusive wandering, exit seeking and chronic combativeness with care. The IDT [Interdisciplinary] team is a discussion with the team as to the behavioral expression, an evaluation of interventions, presentations of new interventions if applicable and an assessment of any underlying causes of the behavior (ie pain,, environmental stressor, medical illnesses, etc.) The root cause and preventative interventions will be included in the resident's care plan. 5. If the behavior expression is not new, worsening or high risk; the nurse will record the behavior in the progress notes using the Behavior Communication Note. The IDT will review progress notes the next business day to determine if immediate follow up action is required for the Behavior Communication. If the behavior requires an interdisciplinary response as described above, the IDT will complete the IDT Behavior Review. If not, the plan of care will be reviewed and updated if needed to include a description of the behavior and effective interventions . 3.1-43(a)(1)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34850 Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5 percent for 1 of 5 residents observed during medication pass. There were 34 opportunities with 2 errors resulting in a 5.88% medications error rate. The errors involved 1 resident (Resident 43) in the sample of 5. Findings include: The clinical record for Resident 43 was reviewed on 4/17/24 at 1:00 p.m. The diagnosis for Resident 43 included, but was not limited to, type 2 diabetes mellitus. A care plan dated 2/27/24 indicated staff was to obtain blood sugars as ordered. The Annual MDS (Minimum Data Set) assessment dated [DATE] indicated Resident 43 was cognitively intact. A physician order dated 1/9/24 indicated the staff was to obtain blood sugars four times a day. The scheduled times were 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. A physician order dated 4/16/24 indicated the resident was to receive 22 units of lantus insulin. A physician order dated 4/17/24 indicated the resident was to receive 12 units of lispro insulin three times a day. An observation was made of breakfast room trays delivered to residents' rooms on 4/18/24 at 9:06 a.m. During medication administrations, an observation was made of Resident 43's blood sugar obtained by License Practical Nurse (LPN) 3 on 4/18/24 at 9:37 a.m. LPN 3 was observed removing a glucometer from the medication cart, and then entered Resident 43's room. At that time, the resident was at the bedside eating her breakfast tray. The resident had consumed half of the meal that was on the tray. LPN 3 obtained Resident 43's blood sugar, and then left the room. After, LPN 3 returned back to the medication cart. LPN 3 was observed pulling Resident 43's lantus flex pen from the medication cart and dialing up 22 units. There was no observation of priming the lantus flex pen at that time. After collecting the lispro from the medication supply room, LPN 3 then was observed administering the 22 units of lantus and 12 units of lispro to Resident 43 in her right arm. An interview was conducted with LPN 3 on 4/18/24 at 9:45 a.m. She indicated she still needed to obtained Resident 3 and Resident 18's blood sugars that morning. An interview was conducted with the Director Nursing Services (DNS) on 4/19/24 at 11:46 a.m. She indicated LPN 3 should obtain blood sugars prior to the reidents eating their meals, and the insulin flex pens should be primed prior to dialing up the insulin dosage. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Resident 43 on 4/22/24 at 3:23 p.m. She indicated the staff frequently check her blood sugar after she eats her meals. How to use your Lantus SoloStar pen manufacture instructions at website www.lantus.com dated 8/2022, was retrieved on 4/22/24. It indicated .Step 3. Perform A Safety Test. Dial a test dose of 2 units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test .Always perform the safety test before each injection . 3.1-48(c)(1)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40287 Based on observation, interview, and record review, the facility failed to serve breakfast at safe and palatable temperatures with the potential to affect 54 of 55 residents residing at the facility. Findings include: During a Resident Council meeting on 4/16/24 at 3:00 p.m., 8 of 10 residents who attended indicated that breakfast was often served cold. During an interview on 4/17/24 at 11:06 a.m., Resident 43 indicated that breakfast was served cold most days. A grievance form, dated 4/10/24, indicated that Resident B had a concern that the food was sometimes cold. On 4/18/24 at 8:25 a.m., breakfast service was observed in the facility kitchen. Three plates of fried eggs and 1 plate of scrambled eggs were observed sitting on the counter in back of the steam table. Seven plates of fried eggs were observed sitting on the shelf above the stove. FC (Facility Cook) 5 was observed taking a plate of fried eggs from the counter behind the steam table and placing them on a tray to be served. The tray was taken from the serving area and served to a resident. At 8:35 a.m., the DM (Dietary Manager) obtained the temperature of the scrambled eggs sitting on the counter behind the steam table at 100 degrees Fahrenheit. The temperature of one plate of fried eggs from the shelf above the stove was obtained at 86 degrees Fahrenheit. The temperature of the sausage patties on the steam table was 109 degrees Fahrenheit. FC 5 indicated that the fried eggs had been cooked about 5 to 7 minutes before serving had started. The DM indicated that the fried eggs should be microwaved prior to being served and the sausage would be reheated prior to serving any more of them. At 9:35 a.m., the IPF (Infection Preventionist Float) provided a breakfast tray containing scrambled eggs, sausage patties, oatmeal, and toast from the hallway food cart. The temperature of the food upon delivery were obtained. The sausage patty was 129.3 degrees Fahrenheit, and the oatmeal was 130.5 degrees Fahrenheit. On 4/18/24 at 2:03 p.m., the Executive Director provided the Food Temperatures Policy, last revised 6/23, which read . The facility will maintain proper food temperature control to prevent food borne illness . Hot foods that are potentially hazardous will be held for service at or above 135 degrees Fahrenheit . All hot and cold food items will be served to the resident at a temperature that is considered palatable at the time the resident receives the food 3.1-21(a)(2)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 40287 Based on observation and interview, the facility failed to maintain the first-floor shower room in good condition and to timely repair a leaking pipe for the pot filler in the kitchen with the potential to affect 55 of 55 residents residing at the facility. Findings include: 1. On 4/16/24 at 12:00 p.m., the facility kitchen was observed with the RD (Registered Dietician) and the (DM) Dietary Manager A pipe located to the side of the stove was observed to have a clear pasty substance present at the joints and rusted joint clamps. The copper pipe had a heavy patinated appearance. There was a puddle of water present under the pipe. The DM indicated the water on the floor was because the pipe of the pot filler was leaking and believed a work order had been done. The RD indicated that due to the appearance of the pipe and the rust present on the pipe clamps, the pipe had been leaking for a while. On 4/18/24 at 2:03 p.m., the Executive Director provided a service request, dated 4/16/24, requesting service to the water leak in the kitchen. 2. During an interview on 4/17/24 at 11:04 a.m., Resident 42 indicated that the shower room on the first floor was often dirty and smelled of urine. On 4/22/24 at 1:35 p.m., the first-floor shower room was observed. The tile floor in the shower room appeared dingy and appeared that it had dirt on the floor. There were 2 bags of soiled linen sitting on the floor. On 4/22/24 at 3:11 p.m., the first-floor shower room was observed with the ED (Executive Director) and MS (Maintenance Supervisor). The shower room tile was dry but appeared stained and dirty. There were dried dark brown tracts present on the floor from the wheels of the shower chair. There were stained tiles that appeared dirty around the shower drain and a dark brown stain against the wall of the shower by the floor. The ED indicated that the shower room floor looked stained. 3.1-19(f)(5)