STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155282	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Spring Senior Living at Northwood	2515 Newton St Jasper, IN 47547

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 38770 Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity for 2 of 2 random observations. A staff member was observed standing while assisting to feed a resident, and a staff member walked away from a resident with visible urine under her chair. (Resident 27, Resident 48) Findings include: 1. On 5/13/24 at 12:02 P.M., Certified Nurse Aide (CNA) 5 was observed standing next to Resident 27 while assisting to feed the resident. 45933 2. During an observation on 5/13/24 at 11:19 A.M., Resident 48 was observed eating in the dining room with a large wet spot under her wheelchair. On 5/13/24 at 11:28 A.M., Licensed Practical Nurse (LPN) 14 sat Resident 48's meal tray in front of her and walked away. During an interview on 5/13/24 at 11:34 A.M., LPN 14 indicated the wet spot was urine. During an interview on 5/16/24 at 4:14 P.M., the Director of Nursing (DON) indicated if a resident was observed with a wet spot under their wheelchair that she would expect staff to bring the resident back to their room and provide care, and then the wet spot and the chair should be cleaned. On 5/16/24 at 2:49 P.M., the Kitchen Manager indicated staff was supposed to sit next to residents while assisting to feed them. On 5/17/24 at 10:30 A.M., a current Assistance with Meals policy, dated 3/2022, was provided and indicated Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. not standing over residents while assisting them with meals (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 1:35 P.M., the Administrator provided an undated Dignity policy that indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .5. When assisting with care, residents are supported in exercising their rights. For example, residents are: e. provided with a dignified dining experience. 3.1-3(t)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46882 Based on observation and interview the facility failed to provide services based on resident preferences for 1 of 5 residents reviewed. The facility failed to provide ice water to one resident when requested. (Resident 45) Findings include: During an interview on 5/14/24 at 9:39 A.M., Resident 45 indicated she didn't get water unless she asked. During an observation on 5/15/24 at 1:37 P.M., CNA (Certified Nurse Aide) 38 assisted Resident 45 from the commode to her recliner. CNA 38 put the bedside table in front of Resident 45 explaining where her cup of lemonade and box of Kleenex were located. She told Resident 45 her water cup only had a small amount of water in it and asked if she would like the cup filled up. Resident 45 told her yes. During an observation on 5/15/24 at 3:16 P.M., Resident 45's water cup had not been filled up. On 5/14/24 at 1:54 P.M., Resident 45's clinical records were reviewed. Diagnosis included, but were not limited to macular degeneration, chronic combined systolic and diastolic heart failure, Sjogren's Syndrome. The most current Quarterly, State Optional MDS (Minimum Data Set) Assessment, dated 4/17/2024, indicated Resident 45 was cognitively intact and required extensive assistance of two for bed mobility, transfers and toilet use, used oxygen and was on hospice. During an interview on 5/17/24 at 1:27 P.M., LPN 19 indicated ice water was not routinely passed, the residents have to ask for it. When she went into a resident's room and saw an empty cup, she would fill it up. On 5/20/24 at 8:57 A.M., the DON (Director of Nursing) provided a current Resident Hydration and Prevention of Dehydration policy, revised October 2017, which indicated This facility will strive to provide adequate hydration and to prevent and treat dehydration . On 5/20/24 at 8:57 A.M., the DON provided a current Accommodation of Needs policy, revised March 2021, which indicated .1. The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered . 3.1-3(v)(1) 3.1-46(b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45933 Based on observation, interview, and record review, the facility failed to clarify a Resident's code status for 1 of 1 residents reviewed for Advanced Directives. A Resident's current Physician Orders did not match the signed DO NOT RESUSCITATE DECLARATION AND ORDER form. A Resident had a care plan for DNR (Do Not Resuscitate) and CPR (Cardiopulmonary Resuscitation). (Resident 18) Finding includes: On [DATE] at 10:00 A.M., Resident 18's clinical record was reviewed. Current diagnoses included, but was not limited to, end stage renal disease, dependence on renal dialysis and diabetes mellitus. The most recent Admission Minimum Data Set (MDS) Assessment, dated [DATE], indicated Resident 18 was cognitively intact. Current Physician's orders included, but was not limited to, ADVANCE DIRECTIVE: Resuscitate (CPR), start date [DATE]. A STATE OF INDIANA OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION ORDER, dated [DATE], indicated Resident 18 requested to be a DNR and the form was signed by the Physician on [DATE]. Current care plans included, but were not limited to: 1. The resident has impaired cognitive function or impaired thought processes R/T [related to] multiple medical diagnosis .Memory is usually intact .CPR code status in place . revised [DATE]. 2.DNR code status is currently in place . revised [DATE]. During an interview on [DATE] at 1:36 P.M., Licensed Practical Nurse (LPN) 16 indicated if a resident stopped breathing, she would check the computer to verify the resident's code status. At that time, Resident 18's code status was CPR. During an interview on [DATE] at 4:16 P.M., the Director of Nursing (DON) indicated that Resident 18 had a CPR code status, but she should have been a DNR. On [DATE] at 1:35 P.M., the Administrator provided a current Advance Directives policy, revised [DATE] that indicated, 10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive .Do Not Resuscitate-- indicates that, in case of respiratory or cardiac failure, the resident .has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used . 3XXX,d+[DATE](l)(8)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 45933 Based on observation, interview, and record review, the facility failed to ensure the resident right to be free of a physical restraint for 1 of 1 residents reviewed for physical restraints. A bed rail was used as a physical restraint. (Resident 12) Findings include: During an observation on 5/13/24 at 1:54 P.M., Resident 12 was observed in bed with 2 black bed rails that were attached at the top of the mattress 1/3 of the length of the bed. During an interview on 5/13/24 at 2:41 P.M., Resident 12's family member indicated the bed rails were put into place to keep her in bed since she had multiple falls. During an observation on 5/16/24 9:31 A.M., Resident 12 was observed in bed with bed rails up. At that time, she indicated the bed rails are there to keep her from falling out of bed. On 5/15/24 at 2:28 P.M., Resident 12's clinical record was reviewed. Current diagnoses included, but were not limited to hypertension, diabetes mellitus, anxiety, and depression. The most recent Quarterly and State Optional Minimum Data Set (MDS) Assessment, dated 4/30/24 indicated Resident 12 had moderate cognitive impairment and used bed rail's daily. Resident 12's clinical record lacked an order related to the bed rails. Current care plans included, but were not limited to, The resident uses physical devices bilateral assist bars R/T [related to] weakness, created 10/3/23 with current interventions, Monitor/document/report to health care provider PRN [as needed] any changes regarding use of assist bars. Educate and discuss with resident and family the risks of benefits of the assist bars regarding its use, dated 10/3/23. A Physical Devise and/or Restraint Evaluation and review, dated 1/25/24 indicated, Definition of Restraint .A device is considered a restraint if it restricts the resident's freedom of movement, or normal access to one's body, AND the resident is not able to remove the device in the same manner as the staff. NOTE. If it does restrict the resident's freedom of movement, or normal access to one's body, AND the resident is not able to remove the device, you must obtain (1) provider order with justification for medical necessity (2) signed permission from POA [power of attorney] or responsible party if required by state .Restraints must be removed at least every 2 hours to allow for repositioning . The clinical record lacked a restraint evaluation after 1/25/24. The clinical record lacked documentation of informed consent for the bed rails. The clinical record lacked documentation on removal of the restraint at least every 2 hours. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record lacked documentation that Resident 12 could remove the restraint herself. During an interview on 5/16/24 at 9:34 A.M., Licensed Practical Nurse (LPN) 18 indicated the bed rails are used for mobility and she thought the bed rails were assessed under assessments. During an interview on 5/16/24 at 9:41 A.M., Certified Nurse Aide (CNA) 10 indicated the bed rails are used, because she likes to climb out of bed. During an interview on 5/16/24 at 9:51 A.M., the Director of Nursing (DON) indicated the evaluations should be completed quarterly and the bed rails keep Resident 12 in bed. During an interview on 5/16/24 at 10:35 A.M., LPN 18 indicated restraints are assessed every quarter. On 5/17/24 at 9:52 A.M., the Dementia Care Director provided a current Use of Restraints policy, revised April 2017 that indicated, Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented .1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts the freedom of movement or restricts normal access to one's body .4. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: a. using bedrails to keep a resident from voluntarily getting out of bed .6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints .9. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative .The order shall include the following: a. The specific reason for the restraint .b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint .16. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction . 3.1-26(g) 3.1-26(h)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45933 Based on observation, interview, and record review, the facility failed to report an allegation of abuse for 1 of 1 residents reviewed for abuse. A Certified Nurse Aide (CNA) physically removed the resident's fingers and hand from the stand aide lift. (Resident 4) Finding includes: During an interview on 5/13/24 at 2:00 P.M., Resident 4 indicated on 5/4/24 CNA 53 ordered her to do things in an abusive tone and the CNA pulled her fingers one by one off of the sit to stand lift. On 5/13/24 at 2:30 P.M., Resident 4's clinical record was reviewed. Current diagnoses included, but were not limited to, anxiety and depression. The most recent Annual (Minimum Data Set Assessment), dated 12/28/23, indicated Resident 4 was cognitively intact and required assistance with transfers. Current Physician's Orders included, but was not limited to, Activity level: up with assist, dated 10/4/13. Current care plans included, but were not limited to, The resident has an ADL [activities of daily living] self care performance deficit R/T [related to] .decreased mobility, stress incontinence, Cerebellar Ataxia, diplopia, spinal stenosis E/B [evidenced by] requires extensive assist of staff with ADL care. revised 5/6/21. Current interventions included, but were not limited to, TRANSFER: Transfers with 1 x assist with sit to stand aide. revised 4/4/24. The record lacked documentation of the allegation, assessment of the resident's hand/fingers and any follow up to the allegation. On 5/22/24 at 1:45 P.M., Licensed Practical Nurse (LPN) 9 provided a copy of CNA 53's criminal background check that indicated a battery charge in which the staff member was found guilty. CNA 53 was arrested on 8/15/21. During an interview on 5/14/24 at 8:35 A.M., the Administrator indicated the Director of Nursing (DON) was aware of the situation, but she was not told about it when it happened. At that time, she indicated she was going to report the allegation. During an interview on 5/16/24 at 9:54 A.M., the DON indicated it was reported to her that CNA 53 was rude to Resident 4 and she did not like the way CNA 53 talked to her. During an interview on 5/20/24 at 10:31 A.M., the Administrator indicated the allegation should have been reported as soon as they found out about it. On 5/20/24 at 1:35 P.M., the Administrator provided a current Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating policy, revised September 2022, that indicated, If a resident abuse .is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law .Immediately is defined as: .b. within 24 hours of an allegation . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-28(c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 45933 Based on observation, interview, and record review, the facility failed to properly investigate an allegation of abuse for 1 of 1 residents reviewed for abuse. A Certified Nurse Aide (CNA) physically removed the resident's fingers and hand from the stand aide lift. (Resident 4) Finding includes: During an interview on 5/13/24 at 2:00 P.M., Resident 4 indicated on 5/4/24 CNA 53 ordered her to do things in an abusive tone and CNA 53 pulled her fingers one by one off of the sit to stand lift. On 5/13/24 at 2:30 P.M., Resident 4's clinical record was reviewed. Current diagnoses included, but were not limited to, anxiety and depression. The most recent Annual (Minimum Data Set) Assessment, dated 12/28/23, indicated Resident 4 was cognitively intact and required assistance with transfers. Current Physician's Orders included, but was not limited to, Activity level: up with assist, dated 10/4/13. Current care plans included, but were not limited to, The resident has an ADL [activities of daily living] self care performance deficit R/T [related to] .decreased mobility, stress incontinence, Cerebellar Ataxia, diplopia, spinal stenosis E/B [evidenced by] requires extensive assist of staff with ADL care. revised 5/6/21. Current interventions included, but were not limited to, TRANSFER: Transfers with 1 x assist with sit to stand aide. revised 4/4/24. The clinical record lacked any documentation of the allegation, assessment of the resident's hand/fingers and any follow up to the allegation. On 5/22/24 at 1:45 P.M., Licensed Practical Nurse (LPN) 9 provided a copy of CNA 53's criminal background check that indicated a battery charge in which the staff member was found guilty. CNA 53 was arrested on 8/15/21. During an interview on 5/14/24 at 8:35 A.M., the Administrator indicated the Director of Nursing (DON) was aware of the situation, but she was not told about it when it happened. At that time, she indicated she was going to suspend CNA 53 and investigate the allegation. During an interview on 5/16/24 at 9:54 A.M., the DON indicated it was reported to her that CNA 53 was rude to Resident 4 and she did not like the way CNA 53 talked to her. During an interview on 5/20/24 at 10:31 A.M., the Administrator indicated the allegation should have been properly investigated as soon as they found out about it and CNA 53 should have been suspended. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 1:35 P.M., the Administrator provided a current Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating policy, revised September 2022, that indicated, If a resident abuse .is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law .Investigating Allegations 1. All allegations are thoroughly investigated. The administrator initiates investigations . 3.1-28(d)

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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** 46416 Based on interview and record review, the facility failed to ensure a notice of transfer or discharge was given to residents or resident representatives for 5 of 5 residents reviewed for hospitalization s. The transfer or discharge notice was not completed and clinical records lacked documentation of residents/representatives receiving a notice of transfer or discharge at the time of the hospitalization s. (Resident 38, Resident 52, Resident 46, Resident 43, Resident 15) Findings include: 1. On 5/14/24 at 2:49 P.M., Resident 38's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most recent Annual MDS (Minimum Data Set) Assessment, dated 4/23/24, indicated Resident 38's cognition was severely impaired and she was an extensive assist of 1 staff for bed mobility, transfers, and toileting. Progress notes included, but were not limited to, the following: On 1/30/24 at 3:31 A.M., Nurse's Note: At 0300 [3:00 A.M.] this nurse and CNA [certified nurse aide] heard a thump and got up to check what sound was and found res. [resident] setting [sic] on floor in front of bedroom door. Res. was setting [sic] on bottom with legs straight out in front of her, walker was behind resident facing the bedroom room . sending to ER [emergency room] for further eval [evaluation] at this time per MD [Medical Doctor] . The clinical record lacked documentation of the representative receiving a notice of transfer or discharge due to residents severe cognitive impairment at the time of hospitalization . During an interview on 5/16/24 at 9:55 A.M., the Administrator indicated she thinks staff are filling out transfer or discharge forms, sending them with the residents, but are not making copies to keep in the residents clinical record. 2. On 5/14/24 at 3:21 P.M., Resident 52's clinical record was reviewed. Diagnoses included, but were not limited to unspecified intellectual disabilities and senile degeneration of brain. The most recent Admission MDS Assessment, dated 2/28/24, indicated Resident 52's cognition was unable to be assessed and was an extensive assist of 2 staff for bed mobility, transfers, and toileting. Progress notes included, but were not limited to, the following: On 4/25/24 at 1:40 A.M., Nurse's Note: CNA witnessed resident up et [and] walking in lounge, as CNA was walking toward resident to help resident back to W/C [wheelchair], resident fell hitting his head . Per NP [Nurse Practitioner] order to send resident to [name of hospital] for eval & treat . (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record lacked documentation of the representative receiving a notice of transfer and discharge due to residents intellectual disability at the time of hospitalization . 45933 3. On 5/14/24 at 1:54 P.M., Resident 43's clinical record was reviewed. Current diagnosis included, but was not limited to, diabetes mellitus. The most recent Quarterly and State Optional MDS, dated [DATE], indicated Resident 43 was cognitively intact, and he was an extensive assist of 2 for bed mobility, transfers, and toileting. Progress notes included, but were not limited to, the following: 1/13/2024 13:14 [1:14 P.M] .Resident continues to throw up and states he does not feel well. This nurse contacted NP [Nurse Practitioner] who noted order to send res [resident] to ER [emergency room] for eval [evaluation] and treat. Daughter notified . The clinical record lacked documentation of the resident and representative receiving a notice of transfer or discharge at the time of hospitalization . During an interview on 5/16/24 at 9:55 A.M., the Administrator indicated she thinks staff are filling out transfer or discharge forms, sending them with the residents, but are not making copies to keep in the residents clinical record. 38770 4. On 5/17/24 at 1:25 P.M., Resident 15's clinical record was reviewed. Resident 15 had moderate cognitive impairment and was discharged to the hospital due to hypotension (low blood pressure) and lethargy on 5/11/24 and returned to the facility 5/15/24. Resident 15's clinical record lacked a notice of transfer or discharge, and lacked documentation that it was sent with the resident or given to the resident's representative. On 5/20/24 at 8:57 A.M., a copy of a transfer form, dated 5/11/24, was provided. The form lacked a reason for the discharge, ombudsman information, and appeal rights. 5. On 5/13/24 at 2:36 P.M., Resident 46's clinical record was reviewed. Resident 46 was discharged to the hospital on 1/28/24 and returned to the facility 1/29/24. Resident 46's clinical record lacked a notice of transfer or discharge, and lacked documentation that it was sent with the resident or given to the resident's representative. On 5/16/24 at 9:55 A.M., the Administrator indicated the transfer forms that were provided were what was sent with the residents at the time of discharge. She further indicated the ombudsman was notified of the discharge if he/she was already involved with that resident, but not otherwise. On 5/16/24 at 4:10 P.M., a current Transfer Form policy, dated 3/2017 was provided and indicated This facility provides a completed and accurate Transfer Form to a resident transferred or discharged from our facility (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-12(a)(6)(A)

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	155282	A. Building B. Wing	05/22/2024

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46416 Based on interview and record review, the facility failed to ensure a bed hold form and policy was given to residents or resident representatives for 5 of 5 residents reviewed for hospitalization s. The bed hold form was not completed and clinical records lacked documentation of residents/representatives receiving a bed hold form and policy at the time of the hospitalization s. (Resident 38, Resident 52, Resident 46, Resident 43) Findings include: 1. On 5/14/24 at 2:49 P.M., Resident 38's clinical record was reviewed. Diagnoses included, but were not limited to dementia. The most recent Annual MDS (Minimum Data Set) Assessment, dated 4/23/24, indicated Resident 38's cognition was severely impaired and she was an extensive assist of 1 staff for bed mobility, transfers, and toileting. Progress notes included, but were not limited to, the following: On 1/30/24, Nurse's Note: At 0300 [3:00 A.M.] this nurse and CNA [certified nurse aide] heard a thump and got up to check what sound was and found res. [resident] setting [sic] on floor in front of bedroom door. Res. was setting [sic] on bottom with legs straight out in front of her, walker was behind resident facing the bedroom room . sending to ER [emergency room] for further eval [evaluation] at this time per MD [Medical Doctor] . On 2/5/24, Nurse's Notes: resident very lethargic, arms flaccid, will not open eyes, will not respond to nail bed press or sternal rub . Primary Care Provider responded with the following feedback: A. Recommendations: send to ER . The clinical record lacked documentation of the representative receiving a bed hold form and policy at the time of hospitalization due to severe cognitive impairment. 2. On 5/14/24 at 3:21 P.M., Resident 52's clinical record was reviewed. Diagnoses included, but were not limited to unspecified intellectual disabilities and senile degeneration of brain. The most recent Admission MDS Assessment, dated 2/28/24, indicated Resident 52's cognition was unable to be assessed and was an extensive assist of 2 staff for bed mobility, transfers, and toileting. Progress notes included, but were not limited to, the following: On 4/25/24, Nurse's Note: CNA witnessed resident up et [and] walking in lounge, as CNA was walking toward resident to help resident back to W/C [wheelchair], resident fell hitting his head . Per NP [Nurse Practitioner] order to send resident to [name of hospital] for eval [evaluation] & treat . (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/24, Nurse's Note: Resident was found on floor next to his chair in the 200 hall lounge . MD notified and gave order to send out to [name of hospital] ER to eval [evaluation] and treat . The clinical record lacked documentation of the representative receiving a bed hold form and policy at the time of hospitalization due to severe intellectual disability. 45933 3. On 5/14/24 at 1:54 P.M., Resident 43's clinical record was reviewed. Current diagnosis included, but was not limited to, diabetes mellitus. The most recent Quarterly and State Optional MDS, dated [DATE], indicated Resident 43 was cognitively intact, and he was an extensive assist of 2 for bed mobility, transfers, and toileting. Progress notes included, but were not limited to, the following: 1/13/2024 13:14 [1:14 P.M] .Resident continues to throw up and states he does not feel well. This nurse contacted NP [Nurse Practitioner] who noted order to send res [resident] to ER [emergency room] for eval [evaluation] and treat. Daughter notified . The clinical record lacked documentation of the resident and representative receiving a bed hold form and policy at the time of hospitalization . 38770 4. On 5/13/24 at 2:36 P.M., Resident 46's clinical record was reviewed. Resident 46 was discharged to the hospital on 1/28/24 and returned to the facility 1/29/24. Resident 46's clinical record lacked documentation that bed hold information was sent with the resident or given to the resident's representative. During an interview on 5/16/24 at 9:55 A.M., the Administrator indicated she thinks staff are filling out bed hold forms and giving it with the policy to the residents, but were not making copies to keep in the resident's clinical record. On 5/16/24 at 4:10 P.M., the DON provided a current Bed-Holds and Returns policy, dated 3/2022, that indicated All residents/representatives are provided written information regarding the facility bed-hold policies, which address holding or reserving a resident's bed during periods of absence . Residents are provided written information about these policies at least twice . well in advance of any transfer . at the time of transfer 3.1-12(a)(25) 3.1-12(a)26

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38770 Based on observation, interview, and record review, the facility failed to ensure accuracy of assessments for 14 of 26 resident records reviewed during the survey. MDS (Minimum Data Set) Assessments did not accurately reflect resident status. (Resident 52, Resident 38, Resident 12, Resident 35, Resident 36, Resident 41, Resident 19, Resident 17, Resident 19, Resident 43, Resident 48, Resident 5, Resident 53) Findings include: 1. On 5/14/24 at 10:49 A.M., Resident 36's room was observed. The bed was observed equipped with small grab bars. On 5/16/24 at 1:52 P.M., Resident 36's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's Disease. The most recent Annual MDS Assessment, dated 3/14/24, indicated use of physical restraints in the form of bed rails. Resident 36's clinical record lacked a current physician order for bed rails. Resident 36's clinical record lacked a current care plan related to bed rails. A Physical Device and/or Restraint Evaluation and Review form, dated 3/7/24, indicated assist/grab bars were being reviewed for the resident, and were not being used as a restraint. 2. On 5/16/24 at 1:59 P.M. Resident 14's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, and psychotic disorder. The most recent Quarterly MDS Assessment, dated 5/7/24, indicated Resident 14 had taken an anticoagulant medication. The MDS also indicated the Resident did not take an antiplatelet medication. Current physician orders included, but were not limited to: Clopidogrel Bisulfate (an antiplatelet medication) Oral Tablet 75 mg (milligrams) by mouth one time a day, dated 12/27/23. Aspirin (an antiplatelet medication) 81 mg by mouth one time a day, dated 12/27/23. Resident 14's clinical record lacked a current physician's order for an anticoagulant medication. 45933 3. During an observation on 5/14/24 at 10:39 A.M., Resident 48's bed was observed with small grab bars. On 5/15/24 at 8:59 A.M., Resident 48's clinical record was reviewed. Current diagnoses included, but were not limited to, dysphagia and muscle weakness. The most recent Quarterly and State Optional Minimum Data Set (MDS) Assessment, dated 3/26/24, indicated resident 48 used bed rails daily. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No other assessment for use of bed rails was documented. Resident 48's clinical record lacked an order related to a bed rails. Resident 48's clinical record lacked a care plan related to a bed rails. 4. On 5/14/24 at 1:54 P.M., Resident 43's clinical record was reviewed. Current diagnosis included, but was not limited to, diabetes mellitus. The most recent Quarterly and State Optional MDS, dated [DATE], indicated Resident 43 was cognitively intact and received an anticoagulant. Resident 43's record lacked an order for an anticoagulant during the look back period. Current care plans included, but were not limited to, The resident is on anticoagulant therapy, revised 2/19/24 and interventions included, but were not limited to, .Monitor resident condition based on clinical practice guidelines or clinical standards of practice r/t [related to] use of Plavix [antiplatelet] . revised 2/19/24. 46416 5. On 5/14/24 at 9:58 A.M., Resident 19's bed was observed without bed rails. On 5/14/24 at 1:41 P.M., Resident 19's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety and atherosclerotic heart disease The most recent Quarterly MDS Assessment, dated 4/10/24, indicated resident was cognitively intact, an extensive assist of 1 staff for bed mobility, transfers, toileting, had pneumonia, and used a restraint (bed rail) daily. During an interview on 5/17/24 at 11:00 A.M., the MDS Coordinator indicated pneumonia was marked in error and should have been taken off the MDS Assessment, dated 4/10/24. 6. On 5/14/24 at 9:50 A.M., Resident 17 was observed asleep in her bed without bed rails. On 5/16/24 at 2:47 P.M., Resident 17's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and bipolar. The most recent Annual MDS Assessment, dated 4/23/24, indicated Resident 17's cognition was mildly impaired, supervised with set up from staff for bed mobility, transfers, toileting, and used a restraint (bed rail) daily. 7. On 5/13/24 at 10:32 A.M., Resident 52's bed was observed pushed up to the wall on the left side and without bed rails. On 5/14/24 at 3:21 P.M. Resident Resident 52's clinical record was reviewed. Diagnoses included, but were not limited to unspecified intellectual disabilities and senile degeneration of brain. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent Admission MDS Assessment, dated 2/28/24, indicated Resident 52's cognition was unable to be assessed, was an extensive assist of 2 staff for bed mobility, transfers, toileting, and used a restraint (bed rail) daily. 8. On 5/13/24 at 10:00 A.M., Resident 38's bed was observed without bed rails. On 5/14/24 at 2:49 P.M., Resident 38's clinical record was reviewed. Diagnoses included, but were not limited to dementia. The most recent Annual MDS Assessment, dated 4/23/24, indicated Resident 38's cognition was severely impaired and she was an extensive assist of 1 staff for bed mobility, transfers, toileting, and used a restraint (bed rail) daily. 9. On 5/14/24 at 9:54 A.M., Resident 41's bed was observed without bed rails. On 5/16/24 at 3:22 P.M., Resident 41's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most recent Quarterly MDS Assessment, dated 4/24/24, indicated Resident 41's cognition was unable to be assessed, she was an extensive assist of 2 staff for bed mobility and transfers, totally dependent on 2 staff for transfers, and used a restraint (bed rail) daily. 46882 10. On 5/14/24 at 1:54 P.M., Resident 45's clinical records were reviewed. Diagnosis included, but were not limited to, macular degeneration, chronic combined systolic and diastolic heart failure, Sjogren syndrome. The most current Quarterly MDS (Minimum Data Set) Assessment and State Optional MDS, dated [DATE], indicated Resident 45 was cognitively intact and required extensive assistance of two for bed mobility, transfers and toilet use, used oxygen and was on hospice, and had physical restraints, bed rails used daily. Review of the Physical Device and/or Restraint Evaluation and Review, dated 5/1/24, indicated: Which device(s) are you recommending and/or reviewing for this resident? (check all that apply) a. Assist/Grab bar(s) Assist bars increase resident independence with bed mobility. Assist bars increase resident's independence with bed mobility, such as turning side to side in bed, from lying to sitting position on side of bed with transfers. Care planning for use of physical devices (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus: The resident uses physical devices assist bars to bed R/T (related to) increases resident's independence with bed mobility, turning side to side and from lying to sitting on side of bed for transfers. Goal: Resident will demonstrate the appropriate use of assist bars to bed to increase her independence with bed mobility. Intervention: Monitor/document/report to health care provider PRN any changes regarding use of assist bars to bed. 11. On 5/14/24 at 3:18 P.M., Resident 3's clinical records were reviewed. Diagnosis included but was not limited to, cerebral ischemia, depression, cerebral infarction, occlusion and stenosis of bilateral carotid arteries. The most current Quarterly MDS (Minimum Data Set) Assessment and State Optional MDS, dated [DATE], indicated Resident 3 was mildly impaired cognitively, required extensive assistance of two for bed mobility, transfers, and toilet use, had physical restraints, bedrail used daily. Review of Physical Device and/or Restraint Evaluation and Review, dated 4/28/24, indicated: Which device(s) are you recommending and/or reviewing for this resident? (check all that apply) a. Assist/Grab bar(s) Potential resident safety risks have been evaluated for this device/restraint (e.g., potential entrapment, accident hazards, potential negative outcome, physical restraint, potential negative psychosocial outcome, etc.). How will the assist/grab bar(s) benefit and/or allow the resident to reach their highest level of independence? grab bars helps res.(resident), help staff in positioning Would the assist/grab bar(s) be a restraint for this resident? (Refer to Definition of Restraint above.) no Care planning for use of physical devices Focus: The resident uses physical devices bilateral assist bars R/T weakness Goal: Resident will demonstrate the appropriate use of physical device(s) by review date Device assist bars Intervention: Monitor/document/report to health care provider PRN any changes regarding use of assist bars Intervention: Educate and discuss with resident & family the risks and benefits of the assist bars regarding its use. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. On 5/16/24 at 3:19 P.M., Resident 53's clinical records were reviewed. Diagnosis included, but were not limited to, Type II diabetes mellitus with hyperglycemia, amputation at level between knee and ankle of left lower leg, and difficulty in walking. The most current Admission MDS assessment, dated 3/13/24, indicated Resident 53 was cognitively intact, required partial assistance with bed mobility, substantial maximal assistance for transfer and toilet use, and had physical restraints, bed rails used daily. Resident 53's clinical record lacked a Physical Device and/or Restraint Evaluation and Review. Current care plan for The resident uses physical devices bilateral assist bars related to weakness, dated 3/9/24 indicated the following interventions: Monitor/document/report to health care provider PRN (as needed) any changes regarding use of bilateral assist bars, dated 3/9/24. Educate and discuss with resident the risks and benefits of the bilateral assist bars regarding its use, dated 3/9/24. Resident 53's clinical record did contain a signed Consent for bed rail use, dated 3/9/24. During an interview on 5/17/24 at 11:00 A.M., the MDS Coordinator indicated bedrails were not restraints and when she was trained she was told to mark that. She indicated that was an error in coding and training and no one in the building was on physical restraints. 13. On 5/14/24 at 2:44 P.M., Resident 35's clinical records were reviewed. Diagnosis included, but were not limited to, Type II diabetes mellitus with diabetic polyneuropathy, non-pressure chronic ulcer of right foot, acute osteomyelitis of right ankle and foot. The most current Quarterly MDS (Minimum Data Set) Assessment and State Optional MDS, dated [DATE], indicated Resident 35 was cognitively intact, required supervision of one for bed mobility, transfers and toilet use, had no pressure ulcers, no venous ulcers, no diabetic foot ulcers and no other open lesions of the foot. Wound notes dated 5/15/24 indicated: Date wound 1st noted 4/1/24 Diabetic ulcer left heel 1 cm (centimeter) x 1 cm x 0.2 cm 100% granulation No drainage Seen by wound specialist (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Debridement on 5/15/24 Right heel drsg (dressing) present yes Drsg intact yes Resident goes to WCC (Wound Care Clinic) During an interview on 5/17/24 at 11:00 A.M., the MDS Coordinator indicated diabetic foot ulcers should have been marked yes on Resident 35's MDS. On 5/17/24 at 9:35 A.M., a current non dated Physical Device and/or Restraint Evaluation and Review Form was provided by the Director of Nursing (DON) and indicated . Definition of Restraint: A device is considered a restraint if it restricts the resident's freedom of movement, or normal access to one's body . If it does restrict the resident's freedom of movement . you must obtain (1) provider order with justification for medical necessity (2) signed permission from Power of Attorney (POA) or responsible party if required . Restraints must be removed at least every 2 hours to allow for repositioning and checking for areas of skin irritation . During an interview on 5/17/24 at 11:00 A.M., the MDS Coordinator indicated bed rails were not used as physical restraints and that most residents only use the mobility bars, which do not restrict movement, and not bed rails. The MDS Assessments were marked as use of restraints in error she believed because that's how she was taught in training. No one in the building uses a physical restraint. At that time, she indicated there was not a policy for MDS Assessments but it was their policy to use the RAI (Resident Assessment Instrument) Manual. 3.1-31(c)(13)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46416 Based on observation, interview, and record review, the facility failed to develop a comprehensive person-centered care plan with resident specific needs for 4 of 22 residents reviewed for care plan development and implementation. Resident on hospice did not have a care plan for hospice, resident did not have a care plan for eating meals at a bedside table in the main dining room, residents that were taking an antianxiety, diuretic, and antidepressant did not have care plans for use. (Resident 19, Resident 5, Resident 48, Resident 45) Findings include: 1. On 5/14/24 at 1:41 P.M., Resident 19's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety and atherosclerotic heart disease The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/10/24, indicated Resident 19 was cognitively intact, an extensive assist of 1 staff for bed mobility, transfers, toileting, and was on hospice. Current Physician's Orders included, but were not limited to, the following: Admit to [name of hospice company] with diagnosis of atherosclerotic heart disease (ASHD), ordered 4/4/24 Progress notes included, but were not limited to, the following: On 4/4/24 at 2:00 P.M., Note Text: Resident admitted to [name of hospice company] with diagnosis of ASHD. Comfort meds [medications] ordered. Resident 19's clinical record lacked a care plan related to hospice. During an interview on 5/17/24 at 11:00 A.M., the MDS (Minimum Data Set) Coordinator indicated residents on hospice should have a hospice care plan in their clinical record and nurses on the floor should be putting it in when they get the order for hospice. During an interview on 5/20/24 at 3:15 P.M., the Director of Nursing (DON) indicated Resident 19 was on hospice he should have a hospice care plan. 45933 2. On 5/15/24 at 8:59 A.M., Resident 48's clinical record was reviewed. Current diagnoses included, but were not limited to, dysphagia and muscle weakness. The most recent Quarterly and State Optional Minimum Data Set (MDS) Assessment, dated 3/26/24, indicated resident 48 received an antianxiety and antidepressant medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Current Physician Order's included, but were not limited to, Ativan 0.5MG [milligrams] . by mouth three times a day for anxiety/agitation, start date 2/3/24 and traZODone .[sic]50MG .Give q tablet by mouth at bedtime, start date 1/3/24. The clinical record lacked a care plan related to Resident 48 receiving an antianxiety medication (Ativan). The clinical record lacked a care plan related to Resident 48 receiving an antidepressant medication (Trazodone). During an interview on 5/16/24 at 4:16 P.M., the DON indicated the MDS Coordinator should have developed a care plan specific to the antianxiety medication and antidepressant medication. 46882 3. On 5/14/24 at 3:55 P.M., Resident 5's clinical records were reviewed. Diagnosis included, but were not limited to, Alzheimer's disease, bipolar disorder, atherosclerosis of native arteries of bilateral legs, and fracture of shaft of humerus. The most current Quarterly MDS (Minimum Data Set) and State Optional MDS Assessment, dated 5/8/24 indicated Resident 5 was mildly impaired cognitively, required supervision of one for bed mobility and transfers and extensive assist of one for toilet use. She had the following medications: antipsychotic, antianxiety, hypnotic, anticoagulant, antibiotic and diuretic. Current physician orders included, but were not limited to the following: olanzapine oral tablet 20 MG (milligrams) Give 1 tablet by mouth one time a day for bipolar disorder, dated 2/7/2024 lorazepam oral tablet 0.5 MG Give 0.5 mg by mouth three times a day for anxiety, dated 2/6/2024 Lasix oral tablet 40 MG Give 40 mg by mouth one time a day for edema, dated 2/21/2024 apixaban oral tablet 5 MG Give 5 mg by mouth two times a day for pulmonary embolism, dated 2/6/2024 amoxicillin-pot (potassium) clavulanate oral tablet 875-125 MG Give 1 tablet by mouth two times a day for bone/joint infection until 05/20/2024, dated 11/20/2023 doxycycline hyclate oral tablet 100 MG Give 100 mg by mouth two times a day for infection until 05/20/2024, dated 11/20/2023 Belsomra oral tablet 5 MG Give 5 mg by mouth one time a day related to insomnia, dated 2/29/2024 Resident 5's clinical records lacked a care plan for diuretic and anticoagulant use. During an interview on 5/17/24 at 11:00 A.M., the MDS Coordinator indicated she started the care plans and there should be one in the records for medications, especially black box warnings like anticoagulants. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 5/13/24 at 11:27 A.M., Resident 45 was observed in the dining room seated off to the side by self eating off bedside table. On 5/14/24 at 11:09 A.M., Resident 45 was observed with a bedside table sitting in front of her in the dining room during lunch. On 5/14/24 at 1:54 P.M., Resident 45's clinical records were reviewed. Diagnosis included, but were not limited to, macular degeneration, chronic combined systolic and diastolic heart failure, Sjogren syndrome. The most current Quarterly MDS (Minimum Data Set) and State Optional MDS Assessment, dated 4/17/2024, indicated Resident 45 was cognitively intact and required extensive assistance of two for bed mobility, transfers and toilet use, used oxygen and was on hospice, and had physical restraints, bed rails used daily. Current physician orders included, but were not limited to the following: (Name of Hospice Company) to eval. (evaluate), dated 2/29/2024 Resident 45's clinical records lacked a care plan for hospice and use of a bedside table in the dining room. During an interview on 5/15/24 at 11:00 A.M., Resident 45 indicated she had no idea why they have her sitting in the dining room at a bedside table. During an interview on 5/16/24 at 11:06 A.M., CNA 33 indicated Resident 45 used a bedside table in the dining room because she preferred to sit alone, did not see well, and the tables were not low enough for her to reach her plate. During an interview on 5/17/24 at 11:00 A.M., the MDS Coordinator indicated residents on hospice should have hospice care plans. Nurses on the floor should put a care plan in when they get an order for hospice. On 5/17/24 at 9:52 A.M., the Dementia Care Coordinator provided a current Care Plans, Comprehensive Person-Centered policy, revised March 2022, which indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. On 5/17/24 at 10:00 A.M., the DON (Director of Nursing) indicated it was the policy of the facility to follow the physician's orders and care plan interventions. 3.1-35(a)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Spring Senior Living at Northwood	2515 Newton St Jasper, IN 47547

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46416 Based on observation, interview, and record review, the facility failed to ensure residents had care plan conferences and care plans were revised for 1 of 2 residents reviewed for accidents and 3 of 5 residents reviewed for unnecessary medications. A resident moved out of the locked dementia unit and a resident's sleep medication was changed but the care plans were not revised. Residents did not have care plan conferences timely. (Resident 38, Resident 12, Resident 5, Resident 48) Findings include: 1. On 5/13/24 at 11:27 A.M., Resident 38 was observed waiting for lunch in the main dining room. On 5/14/24 at 2:49 P.M., Resident 38's clinical record was reviewed. Diagnoses included, but were not limited to, dementia without behaviors. The most recent Annual MDS (Minimum Data Set) Assessment, dated 4/23/24 indicated Resident 38's cognition was severely impaired and she was an extensive assist of 1 staff for bed mobility, transfers, and toileting. A current Dementia Care Plan, revised 10/13/23, included, but was not limited to, the following interventions: Resident resides on the locked dementia unit and is participating in dementia care activities, initiated 1/28/24 Progress notes indicated Resident 38 was moved from the locked dementia unit onto the 300 Hall 2/22/24. During an interview on 5/17/24 at 1:48 P.M., the Director of Nursing (DON) indicated the care plan intervention that she was on the locked dementia unit should have been revised because she was no longer on the locked dementia unit. 45933 2. On 5/15/24 at 2:28 P.M., Resident 12's clinical record was reviewed. Current diagnoses included, but were not limited to hypertension, diabetes mellitus, anxiety, and depression. The most recent Quarterly and State Optional Minimum Data Set (MDS) Assessment, dated 4/30/24 indicated Resident 12 had moderate cognitive impairment. Resident 12 failed to receive a care plan conference after 12/1/23. 3. On 5/15/24 at 8:59 A.M., Resident 48's clinical record was reviewed. Current diagnoses included, but were not limited to, dysphagia and muscle weakness. The most recent Quarterly and State Option Minimum Data Set (MDS) Assessment, dated 3/26/24, indicated Resident 48's cognition was unable to be assessed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 48 failed to receive a care plan conference after 1/15/24. During an interview on 5/16/24 at 9:10 A.M., the SSD indicated care plan conferences should be completed every 90 days. During an interview on 5/20/24 at 10:30 A.M., the SSD indicated it is the facility's policy to complete care plan conferences every quarter. 46882 4. On 5/14/24 at 3:55 P.M., Resident 5's clinical records were reviewed. Diagnosis included, but were not limited to, Alzheimer's disease, bipolar disorder, atherosclerosis of native arteries of bilateral legs, and fracture of shaft of humerus. The most current Quarterly MDS (Minimum Data Set) Assessment and State Optional MDS, dated [DATE] indicated Resident 5 was mildly impaired cognitively, required supervision of one for bed mobility and transfers and extensive assist of one for toilet use. She had the following medications: antipsychotic, antianxiety, hypnotic, anticoagulant, antibiotic and diuretic. Current physician orders included, but were not limited to the following: Belsomra oral tablet 5 MG Give 5 mg by mouth one time a day related to insomnia, dated 2/29/2024 A current care plan for The resident has sleep disturbance and utilizes Ambien for insomnia, dated 2/6/2024. The care plan was not revised when the Ambien was discontinued and Belsomra was ordered. Progress Notes included, but was not limited to the following: 2/29/2024 10:47 A.M. Psychopharmacological Med/Physical Restraint Note Text: Pharmacy rec [recommends] at this time to d/c [discontinue] ambien [sic] and start belsomra [sic] 5 mg PO [by mouth] QHS [every bedtime] for insomnia. Psych [Psychiatric] NP [Nurse Practitioner] accepted this change, orders updated at this time. During an interview on 5/17/24 at 1:48 P.M., the Director of Nursing (DON) indicated floor nurses and/or the DON should be revising care plans immediately after a change occurs. On 5/17/24 at 9:52 A.M., The Dementia Care Coordinator provided a Care Plans, Comprehensive Person-Centered policy, revised March 2022, which indicated, .11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change . 3.1-35(a) 3.1-35(c)(2)(C) 3.1-35(d)(2)(B) 3.1-35(e)

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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** 46416 Based on observation, interview, and record review, the facility failed to ensure adequate supervision to prevent accidents for 2 of 2 residents reviewed for falls. Neurological checks were not completed after a fall, new interventions were not put into place after falls, and interventions on care plans were not followed for residents at risk for falls resulting in multiple falls. (Resident 38, Resident 52) Findings include: 1. On 5/14/24 at 9:00 A.M., non-skid strips were not observed on the floor in front of the toilet in Resident 38's bathroom. On 5/14/24 at 2:49 P.M., Resident 38's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most recent Annual MDS (Minimum Data Set) Assessment, dated 4/23/24 indicated Resident 38's cognition was severely impaired, she was an extensive assist of 1 staff for bed mobility, transfers, and toileting, and had 1 fall since the last MDS Assessment which was a Quarterly Assessment completed on 1/25/24. A current Risk for Falls Care Plan, revised 5/4/22, included, but was not limited to, the following interventions: Keep Dycem in chair to help prevent resident from sliding out, initiated 8/3/22 Resident to wear appropriate footwear when ambulating or mobilizing in wheelchair, initiated 2/1/22 A current Fall Care Plan, revised on 12/1/23, included, but was not limited to, the following interventions: Non skid strips in front of toilet, initiated 2/7/24 Resident to wear appropriate footwear when ambulating or mobilizing in wheelchair, 2/20/23 All Fall risk assessments from 1/1/24 through 5/17/24 were reviewed and indicated the following: 1/30/24 8.0 (Low risk) 2/7/24 17.0 (High risk) Falls were reviewed from 1/1/24 through 5/17/24. Resident 38 had the following 3 falls: Fall #1 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/30/24 3:00 A.M. Unwitnessed fall. Found resident sitting on floor in front of bedroom door. Resident indicated she was attempting to go to restroom. Resident was not using walker. Resident did not ring for assistance before getting up. A Nurse's note, dated 1/30/24, indicated . foot wear was not on feet properly . Knot on top R [right] frontal lobe [forehead] approx [approximately] 4 centimeters (cm) X 3 cm present. Red mark on res [resident] left upper back approx 7 cm X 5 cm. Res c/o [complained of] pain to head . Sending to ER [emergency room] . Nurse's note, dated 1/30/24, indicated Resident back from ER . will continue with neuro [neurological] checks until completed. The following neuro checks were completed: 3:00 A.M., 3:30 A. M., (resident to ER at 4:17 A.M. and returned at 7:45 A.M.), 9:49 A.M., and 4:09 P.M.; 1/31/24 5:29 A.M., 1:53 P.M.; 2/1/24 3:30 A.M., 9:49 A.M., 1:43 P.M.; 2/2/24 5:45 A.M. New interventions from fall IDT (interdisciplinary team) meeting note, dated 2/1/24, included: therapy to evaluate for safety, remind resident to use walker, keep non slip socks on resident when in bed or when shoes are off. Care plan for resident was not updated with a new intervention. Fall #2 2/6/2024 1:10 P.M. Unwitnessed fall. Resident found on floor sitting against wall in bathroom. A 4 inch diameter red area noted on back. Neuro checks were completed on 2/6/24 at 3:49 P.M.; 2/7/24 at 2:00 A.M., and 10:21 A.M. Intervention: Non skid strips placed in front of toilet and therapy referral made. Care plan was updated with new intervention, but non-skid strips were not placed in front of toilet. Fall #3 2/7/24 11:08 A.M. Unwitnessed fall. Resident found on floor leaning against wall next to the toilet. Neuro checks were completed at 11:14 A.M., 6:15 P.M.; 2/8/24 AT 2:00 A.M., 10:00 A.M., 6:11 P.M.; 2/9/24 2:11 A. M., and 10:00 A.M. Intervention from fall IDT meeting, dated 2/7/24, included: resident currently working with therapy, continue antibiotic for UTI (urinary tract infection). No new interventions were put into place and the care plan was not updated. During an interview on 5/17/24 at 11:45 A.M., the MDS Coordinator indicated Resident 38's Annual MDS Assessment, dated 4/23/24, indicating only 1 fall was an error and after reviewing her clinical record, it should say she had 3 falls. On 5/20/24 at 3:40 P.M., the DON indicated it was Resident 38's room, it should have non skid strips in front of the toilet in her bathroom, and she did use that bathroom. The DON indicated she had moved from the locked dementia unit to the 300 Hall (on 2/22/24) and the non skid strips must not have been put down for her. At that time, she indicated there should be a Dycem in her wheelchair and sometimes they would move it to the recliner when she would sit in it, but the dycem was not observed in the recliner seat or the room. On 5/17/24 at 11:00 A.M., non-skid strips were not observed on the floor in front of the toilet in Resident 38's bathroom. On 5/20/24 at 3:40 P.M., the Director of Nursing (DON) observed that non-skid strips were not on the floor in front of the toilet in Resident 38's bathroom. At that time, she observed there was not a Dycem in Resident 38's wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 5/13/24 at 11:28 A.M., Resident 52 was in the main dining room sitting in a Broda chair that was not locked. On 5/13/24 at 11:33 A.M., Resident 52 was sitting in the main dining room in a Broda chair that wasn't locked and trying to scoot out of it making the chair start rolling backwards. On 5/14/24 at 9:44 A.M., Resident 52 was by the nurse's station at the crosswalk, covered up with his eyes closed and sitting in a Broda chair without staff present. The Broda chair was not locked. On 5/14/24 at 3:21 P.M. Resident Resident 52's clinical record was reviewed. Diagnoses included, but were not limited to unspecified intellectual disabilities, senile degeneration of brain, and displaced fracture of upper end of right humerus (upper arm). Resident 52 was admitted on [DATE]. The most recent Admission MDS Assessment, dated 2/28/24, indicated Resident 52's cognition was unable to be assessed, was an extensive assist of 2 staff for bed mobility, transfers, toileting, and he had no falls or fractures within last 6 months prior to admission. A current Fall Care Plan, revised on 4/12/24, included, but was not limited to, the following interventions: Soft mat to be placed on wall side of bed to prevent injury, initiated 4/11/24 Resident likes to put self on floor, initiated 4/11/24 Resident is non-compliant with safety, initiated 4/12/24 Soft mat to bedside while in bed every shift, initiated 3/11/24 A current Behavior Care Plan, revised on 4/25/24, included, but was not limited to, the following intervention: Resident prefers the following diversional activities: picture books, magazines, and TV, initiated 4/25/24 All Fall Risk Assessments completed from 2/24/24 through 5/17/24 were reviewed and indicated the following: 2/24/24 15.0 (High risk) 3/9/24 10 (Low risk) 3/25/24 17.0 (High risk) 4/12/24 17.0 (High risk) Progress notes were reviewed and included, but were not limited to, the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/10/24 3:28 A.M., Behavior note: Resident threw head back while staff putting him to bed, hitting his head against the wall. Resident has a 3 centimeter (cm) x 3 cm red mark that is blanchable to back of the head. No neuro checks were completed. Care plan was updated with the following intervention: Soft mat to be placed on wall side of bed to prevent injury, initiated 4/11/24 4/29/24 2:38 P.M., Physician's note: This patient is being seen today regarding recent falls as well as increased insomnia and continued behavioral problems. The patient is not sleeping at night, nor during the day really either. He is a major fall risk and keeps having recurrent falls due to not listening and non compliance . He has been sent out for falls as well, some with injuries . 5/3/24 2:10 P.M., Progress note: At 12:15 P.M., Resident was on the floor in his room and he hit his head on the trash can. There is a 'gash' above his right eye. He had already been placed on the floor by staff d/t [due to] he wouldn't stay in his chair. This was the safest measure . No neuro checks were performed. Falls were reviewed from admission on 2/24/24 through 5/17/24. Resident 52 had the following 5 falls: Fall #1 3/9/24 at 1:45 A.M. Unwitnessed fall. Resident found laying in hallway outside his room on the floor. Progress note indicated . will notify family in the morning . , but no documentation of notification was found. The following neuro checks were completed: 3/9/24 1:45 A.M., 2:10 A.M., 2:45 A.M., 3:15 A.M., 3:45 A.M., 1:56 P.M. and 9:33 P.M.; 3/10/24 4:57 A.M., and 9:50 P.M.; 3/11/24 5:01 A.M., 1:25 P.M., and 9:22 P.M.; 3/12/24 5:19 A.M., and 11:22 A.M. IDT meeting note, dated 3/11/24 (late entry), indicated new intervention: floor mat beside bed while in bed will be placed. Care plan updated. Fall #2 3/25/24 3:00 P.M. Witnessed fall. A visitor to the facility witnessed the resident scoot his bottom to sit on Broda chair foot rest, then he scooted himself to the floor while sitting in the 200 Hall Lounge Room. Neuro checks were not completed. Visitor indicated he did not hit his head. IDT meeting note, dated 4/5/24, indicated new intervention: Resident continues to lower himself on the floor. Care plan updated. Fall #3 4/12/24 7:13 A.M. Witnessed fall. As staff entered dining room, Resident 52 was in the dining room, had taken off his pants and incontinence pad, stood up, and fell hitting his head on the AC (air conditioner) unit. The following neuro checks were completed: 4/12/24 at 6:45 A.M., 7:15 A.M., 7:42 A.M.; 4/13/24 12:45 A.M., 4:45 P.M.; 4/14/24 12:01 A.M. and 9:58 P.M.; 4/15/24 4:56 P.M.; 4/16/24 2:44 A.M.; 4/17/24 5:13 P.M. IDT meeting note, dated 4/12/24 (late entry), indicated new intervention: Resident is high fall risk, resident is non compliant with safety and transfers self, and resident is unable to complete BIMS (Brief Interview for Mental Status) Assessment. Care plan updated. Fall #4 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/25/24 1:40 P.M. Witnessed fall. Staff witnessed resident up and walking in 200 Hall Lounge Room. As staff was walking toward resident, resident fell hitting his head. Laceration to back of the head. Order obtained from Nurse Practitioner (NP) to send Resident 52 to ER for evaluation. A progress note, dated 4/25/24 at 4:32 P.M., indicated EMS [Emergency Medical Services] on scene to transport resident to ER. A progress note, dated 4/25/24 at 6:13 P.M., indicated Resident returned to [facility name] with no new orders. Hospital records indicated . Patient had an abrasion to the posterior occipital region of his head nothing requiring suturing, no active bleeding . The clinical record lacked documentation of an IDT meeting note, post fall risk evaluation, or new interventions put into place after fall. Care plan was not updated. Fall #5 4/29/24 3:59 P.M. Unwitnessed fall. Resident found on floor next to his chair in the 200 Hall lounge room. Hematoma [bruise] present to back of head and small amount of blood on wall where resident hit his head. Order obtained from Medical Doctor (MD) to send to ER for evaluation. An ER summary, dated 4/29/24, indicated resident had a Computed Tomography (CT) scan of the head which showed Right parietal and right parieto-occipital [top and back of head] scalp hematoma. A progress note, dated 4/29/24 at 8:38 P.M., indicated resident returned to facility with no new orders. Hospital records indicated that the resident had history of a subdural hematoma (blood between the brain and it's outermost covering) on 2/25/22 and the physical exam indicated Hematoma to the time [sic] of his head with abrasion left of the whole hematoma no palpable skull fracture and abrasion lateral to the left eye not requiring suturing, no active bleeding. IDT meeting note, dated 5/3/24, indicated resident has a history of falls, BIMS Assessment unable to be completed. Resident has history of getting on to the floor and crawling. Care plan updated. Neuro checks were not performed On 5/16/24 at 11:03 A.M., Resident 52 was by the nurse's station at the crosswalk, sitting in a Broda chair lifting his legs and using them in an attempt to scoot himself down in the chair, without staff present. The Broda chair was not locked and started rolling forward. On 5/16/24 at 11:13 A.M., Resident 52 sitting in the unlocked Broda chair in the crosswalk. Certified Nurse Aide (CNA) 4 pushed him in the Broda chair from the crosswalk to the main dining room, pushed him up to the table, did not lock the Broda chair, and left resident at the table. Resident 52 started lifting his butt and legs to scoot out of chair rocking the chair. On 5/20/24 at 3:40 P.M., the DON observed Resident 52's bed had been moved and the left side was against the wall now. There was not a soft mat on the wall. During an interview on 5/17/24 at 11:00 A.M., the MDS Coordinator indicated Resident 52 did come to the facility with a fracture from a fall so the Admission MDS Assessment should have been marked as having at least one fall and fracture in the 6 months prior to admission. During an interview on 5/20/24 at 9:36 A.M., the Activities Director indicated there was not a lot Resident 52 could do with activities but he liked magazines and listening to music. She indicated she tried to talk to him once a day and staff would try to talk to him too. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/24 at 3:15 P.M., the DON indicated she wouldn't expect staff to lock his Broda chair if he was in it because she taught staff that would be a restraint, but after reviewing falls, it may not be a bad idea to at least lock one wheel. She indicated she did not believe his restlessness was from lack of activities. She indicated he was restless because he was hurting before and with medication changes, he was not as restless and having less falls. She indicated he was not aware and could not make decisions about his safety. During an interview on 5/20/24 at 3:40 P.M., the DON indicated his Fall Care Plan should have been revised because of the bed being moved and there was not a soft mat on the wall. During an interview on 5/20/24 at 3:15 P.M., the DON indicated she would consider Resident 38 and Resident 52 a high risk to fall. There should be an IDT meeting, a new intervention placed, revision of the care plan with the new intervention, and a fall risk evaluation should be completed after each fall as part of risk management. It should all be done during the IDT meeting shortly after fall. At that time, she indicated that she was unsure what the protocol was for neuro checks but they should be done after unwitnessed falls and if the resident would hit their head. She thought the neuro checks were to be done every 15 minutes for an hour, then every 30 minutes for 2 hours, then hourly for 2 hours, then every 8 hours. It should equal out to about 2 days of monitoring and if the resident went to ER and returned to the facility before neuro checks should be complete, then she would expect nurse to continue to do neuro checks as long as needed to finish and as needed. A current Neurological Check Protocol for the facility was requested at that time, but was not provided during the survey period. During an interview on 5/17/24 at 10:23 A.M., the DON indicated she would expect staff to follow orders and interventions on care plans and revise the care plans as needed. The facility didn't have a policy about following orders and interventions, but that would be their policy. During an interview on 5/17/24 at 11:00 A.M., The MDS Coordinator indicated there was not a policy for the MDS Assessment, but they use the RAI (Resident Assessment Instrument) Manual. On 5/17/24 at 11:47 A.M., a current Falls Policy, revised March 2018, was provided by the DON and indicated . While many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause . the staff and physician will identify pertinent interventions to try to prevent subsequent falls . staff will try various relevant interventions based on assessment of the nature of falling . the staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling . risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented . If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed . If the individual continues to fall, the staff and physician will re-evaluate the situation . On 5/17/24 at 11:47 A.M., a current Neurological Assessment Policy, revised October 2010, was provided by the DON and indicated . Neurological assessments are indicated: . b. following an unwitnessed fall c. Following a fall or other accident/injury involving head trauma . Perform neurological checks with the frequency as ordered or per falls protocol . 3.1-45(a)

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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. 38770 Based on observation, interview, and record review, the facility failed to ensure a resident received services and assistance to prevent and treat urinary tract infections (UTI) for 1 of 1 residents reviewed for UTIs. A resident with recurrent UTIs was not treated appropriately, and incontinence care provided lacked appropriate infection control practices to prevent infection. (Resident 36) Finding includes: On 5/14/24 at 2:38 P.M., Resident 36's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's Disease and dementia. The most recent Annual MDS (Minimum Data Set) Assessment, dated 3/14/24, indicated no cognitive impairment, no toileting program, and a UTI in the previous 30 days. Resident 36 was frequently incontinent of bladder, and required extensive assistance of one staff with toileting. Current physician orders included, but were not limited to, the following: UTI-Stat Oral Liquid 30ml (milliliters) one time a day for urinary health, dated 5/21/23. Allergies included, but were not limited to, ciprofloxacin (an antibiotic). A current urinary tract infection care plan, dated 1/25/24, indicated to monitor/document/report to health care provider as needed for signs and symptoms of UTI including altered mental status and/or behavioral changes, dated 1/26/24. A progress note on 1/5/24 at 4:04 P.M. indicated Physician was notified via fax regarding behaviors observed yesterday by physical therapy . Awaiting reply from [physician] The clinical record lacked a documented reply from the physician. A care plan review note on 1/10/24 at 10:56 A.M. indicated . Resident is progressing with care and is stable at this time . Resident 36 experienced a fall on 1/20/24 and again on 1/22/24. An IDT (Interdisciplinary team) note on 1/23/24 at 9:30 A.M. indicated . Resident is having cognitive changes as well as a fall. In past reviews resident was found to have a UTI when multiple falls occur. Nursing staff to notify physician for evaluation of UTI . A physician communication note on 1/23/24 at 10:15 A.M. indicated [Physician] called at this time in r/t [related to] fall yesterday, function decline, and brain fog that has been occurring. Order given for UA [urinalysis] with CS [culture and sensitivity] if indicated at this time A urinalysis was obtained on 1/24/24 at 2:35 A.M., 16 hours and 20 minutes after the order from the physician was obtained. The lab was then sent to the hospital on 1/25/24 at 12:35 A.M., 22 hours after it was obtained, and 38 hours and 20 minutes after the order was obtained. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/25/24 at 6:40 A.M., the urinalysis results were faxed to the physician and a new order for Keflex 500mg TID [three times a day] x10 days was placed. A culture and sensitivity, resulted on 1/28/24, indicated the presence of Providencia rettgeri (a bacteria), resistant to Ampicillin, Cefazolin, and Nitrofurantoin. The urinalysis also indicated the presence of Aerococcus urinae (a bacteria), resistant to Erythromycin. On 1/29/24, the Keflex was discontinued and a new order for Cefdinir (an antibiotic) 300mg twice a day for 7 days was placed. A progress note dated 2/26/24 at 4:42 P.M. indicated resident seems to be slightly confused. States she doesn't want to be late for work, resident knows where her bathroom is located but is asking staff where it is, also stated someone was in her bathroom and she had to go use another bathroom , which neveroccurred [sic]. Will continue to monitor On 2/27/24 at 9:37 A.M., a new order was received for Vesicare (a medication used for overactive bladder) 5mg twice a day instead of once daily. A progress note on 2/28/24 at 12:55 P.M. indicated fax sent to [physician] regarding res [resident] increased confusion On 2/29/24, an order was placed for a UA with C&S if indicated, and collected 3/4/24. An incident note from 3/3/24 at 12:14 P.M. indicated Son was called to let him know of resident's slip and he laughed and said shes hard headed and knows she isn't supposed to get up . A medication note dated 3/4/24 at 11:42 A.M. indicated The system has identified a possible drug allergy for the following order: Cipro [an antibiotic] Oral Tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet by mouth two times a day for UTI On 3/4/24 at 4:30 P.M., the order for Ciprofloxacin was discontinued due to allergy, and a new order given for Keflex 500mg TID x 5 days for UTI while awaiting the culture results. The urine culture was resulted on 3/6/24, and indicated the presence of Escherichia coli and Aerococcus urinae. A progress note on 3/6/24 at 2:44 P.M. indicated New order received from [physician] office to extend Keflex 5 more days. Order updated and faxed to pharmacy Resident 36 experienced a fall on 3/9/24 and again on 3/10/24 with increased confusion. A fax was sent to the physician 3/10/24 at 7:20 P.M. regarding falls and continued confusion. On 3/11/24 at 2:30 P.M. a Urine specimen was collected for UA with C&S. A urine culture result, dated 3/13/24, indicated the presence of Citrobacter freundii (a bacteria associated with urinary tract infections). A note from the physician on the report indicated Urine culture grew contamination. I do feel the recent Keflex she took cleared up her UTI. I do not know the reason for her current confusion . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 3/13/24 at 2:34 P.M. indicated Spoke with [physician]'s nurse, states UA was clear. No UTI. To schedule appt w/ [hospital] Neurology for increased confusion. Appt scheduled on Friday 3-15-24 at 10:45AM . A communication note on 3/14/24 at 3:53 P.M. indicated . Called son to see if he would agree to have psych see his mom. He agreed that is would be beneficial . Resident 36 experienced a fall on 3/14/24, 3/21/24, and 3/23/24. A progress note on 3/23/24 at 12:55 A.M. indicated Resident found on floor, laying in front of her recliner with her head pointed towards her door . Resident is confused and states I was chasing butterflies then had to get food off the floor and fell . An IDT note on 3/25/24 at 9:25 A.M. indicated . Psych consult obtained. Neurology notified of hallucinations Medication changes have been made Continue to monitor A progress note on 3/25/24 at 1:12 P.M. indicated Resident has had multiple falls this month. Resident has had a major change. She is hallucinating and very forgetful. Resident gets very upset when she realizes that she is hallucinating or forgetful. Resident has Neurology followingher [sic] and med changes have been made with no change. Psych consult was made . On 3/25/24, a new order was placed for a UA with C&S if indicated d/t increase confusion. A urine culture result, dated 3/28/24, indicated the presence of urogenital flora and mixed enteric organisms. A new order was placed for Keflex 500mg three times a day for 5 days. A progress note dated 4/15/24 at 3:56 A.M. indicated Res. having delusions tonight stating she is picking up golf balls, and putting them in a bucket that she holds up (which nothing is in her hand), then tells me she is going to get in her care [sic], pointing outside her window. Res. also stated she fell and got self up, but the way she describes would not be possible. Notified MD of behavior to see if we can obtain a UA. Urine has strong malodorous smell to it A progress note dated 4/17/24 at 11:18 A.M. indicated New order received [for] UA with C&S if indicated . d/t increased confusion . Order was received 55 hours after physician was notified. A urinalysis result, dated 4/17/24 indicated the presence of dark, yellow, and turbid urine, a white blood cell count of 5-10 (high), and many bacteria. A physician note on the urinalysis result, dated 4/18/24, indicated Urinalysis is clear; she does have a few red cells and she has an appointment with Urology. Please cancel urine culture A progress note dated 4/18/24 at 4:12 P.M. indicated Resident pushing on exit doors in dining room and then pulled fire alarm out of frustration because the door wouldn't open. Resident continues to be non-compliant and aggressive towards staff when trying to assist. Will continue to monitor behaviors Resident 36 experienced a fall on 4/19/24. On 4/19/24, Resident 36 was moved to the secured unit, and diagnosed with dementia on 4/26/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 4/30/24 at 2:22 A.M. indicated During routine check and change res. [resident] was noted to have yellow/white chunky vaginal discharge . A urinalysis was obtained on 5/1/24, and the culture resulted on 5/4/24. The urine culture indicated the presence of Providencia rettgeri and Kocuria rosea. An order was placed on 5/7/24 for Cefdinir (an antibiotic) 300mg twice a day related to cramp and spasm; incontinence, until 5/8/24. A CT of abdomen and pelvis result, dated 5/10/24, indicated a mildly obstructing calculus (stone) within the distal right ureter measuring up to 4-5 mm (millimeter) in size, and development of a moderate size right-sided staghorn calculus with additional left-sided nethrolithiasis as well. 5/12/24 5:52 A.M. Res. [resident] cont. [continues] on ATB [antibiotic] for UTI. Res. is having mucous in urine at this time. Res. [resident] just recently had a CT scan of bladder and kidneys and we are awaiting results at thit [sic] time. Urine remains dark and malodorous . 5/12/24 8:50 P.M. correction-noted to 5-12 charting, res. just completed ATB therapy for UTI On 5/17/24 at 10:23 A.M., the Director of Nursing (DON) indicated nothing had been done related to Resident 36's behaviors in January because the resident wasn't having behaviors before that time. She indicated she was unsure of why the urinalysis ordered on 1/23/24 was not sent until 1/25/24, and did not know why the UA completed on 3/11/24 was indicated as clear, when bacteria were present. She indicated she was unsure why an antibiotic was given on 3/28/24 since the UA was clear. She indicated Resident 36 was moved to the locked unit after she became increasingly aggressive, confused, and delusional. She indicated Resident 36's recent decline in status with behaviors had progressed quickly, and was part of the reason for her recent dementia diagnosis. The DON indicated staff could have called to follow up with the urologist when the CT was resulted showing kidney stones. On 5/20/24 at 8:34 A.M., Certified Nurse Aide (CNA) 5 and CNA 7 were observed assisting Resident 36 with toileting. CNA 7 washed her hands with a 3 second lather and put on gloves. CNA 5 put gloves on while in the doorway entering the bathroom. CNA 5 then touched the door, the resident's wheelchair, a walker, and the hand rail by the toilet. CNA 5 then obtained a gait belt from the other side of the room, and applied it around the resident. Both CNAs assisted the resident to a standing position, and both assisted to pull down her pants and brief. Resident 36 sat on the toilet, and CNA 5 touched the inside of the used brief, then removed it. The brief was visibly wet. Without removing or changing gloves, CNA 5 obtained a clean brief, and opened it touching the inside of it while applying it to the resident. When the resident indicated she was finished, CNA 7 obtained a disposable wipe, and wiped the inside of the resident's thighs, then the creases at the top of the legs, then the groin area. With the same wipe, CNA 7 then wiped down the middle of the resident's peri area. CNA 7 then removed her gloves and put a new pair on without sanitizing in between. Both CNAs assisted the resident to stand and pulled up the new brief and pants. CNA 5 removed her gloves, left the room for 5 seconds, then returned and applied hand sanitizer in the doorway. CNA 7 removed her gloves, and washed her hands with a 2 second lather. On 5/20/24 at 9:17 A.M., a current Handwashing/Hand Hygiene policy, dated 8/2019, was provided and indicated Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 9:17 A.M., a current Urinary Tract Infections/Bacteriuria policy, dated 4/2018, was provided and indicated The physician and nursing staff will review the status of individuals who are being treated for a UTI and adjust treatment accordingly . When a resident has a persistent or recurrent urinary tract infection after treatment with antibiotics, the physician will review the situation carefully with the nursing staff and consider other or additional issues . before prescribing additional courses of antibiotics 3.1-41(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38770 Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided consistent with the resident's orders and care plans for 1 of 1 residents reviewed for respiratory care, and 2 of 2 random observations. Oxygen concentrators were caked with dust, and oxygen orders were not being followed. (Resident 14, Resident 28, Resident 45) Findings include: 1. On 5/14/24 at 10:53 A.M., Resident 14 was observed sitting in the dining room with oxygen on via nasal cannula. The oxygen concentrator was set at 2.5lpm (liters per minute). On 5/14/24 at 2:49 P.M., Resident 14's clinical record was reviewed. Diagnosis included but were not limited to, acute respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/7/24, indicated a severe cognitive impairment, no behaviors, extensive assistance of 1 staff with bathing, transfers, and toileting, and used oxygen. Current physician orders included, but were not limited to: 02 (oxygen) at 3 liters per nasal cannula, dated 12/28/23. Change 02 tubing and humidity , clean 02 concentrator filter one time a day every Sunday, dated 12/31/23. A current oxygen therapy care plan, dated 12/29/23, indicated to provide oxygen therapy as ordered, dated 12/29/23. On 5/15/24 at 9:22 A.M., Resident 14 was observed in a wheelchair in the hall with no oxygen on, and no tubing visible. A portable oxygen tank was observed covered on the back of the wheelchair. On 5/15/24 at 1:43 P.M , Resident 14 was observed sitting in the dining area with oxygen on via nasal cannula between 3.5 and 4lpm. The filter on the back of the concentrator was observed to be too large for the opening with no backing. The filter was caked with dust. The machine indicated it was last serviced 8/16/23. At that time, Qualified Medication Aide (QMA) 3 indicated the oxygen was supposed to be set at 3lpm, and was unsure who cleaned the filters. On 5/16/24 at 3:00 P.M., the Director of Nursing (DON) indicated the order to change the oxygen concentrator filter was put in as a nursing order and therefore did not cross over to the system to be able to check off that it had been done. 46882 2. On 5/15/24 at 1:58 P.M., Resident 28's oxygen filter on the side of the oxygen machine was observed to be caked with dust. Resident 28 was sitting in his recliner wearing O2 per nasal cannula at 2 lpm with gauze on the tubing to protect his ears. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24 at 9:11 A.M., Resident 28 was observed sitting in his recliner with O2 on at 2 lpm per nasal cannula. The filter on the side of the oxygen machine remains dusty. On 5/15/24 at 2:49 P.M., Resident 28's clinical records were reviewed. Diagnosis included, but were not limited to chronic respiratory failure with hypoxia. The most current Annual MDS (Minimum Data Set) Assessment and State Optional MDS, dated [DATE], indicated Resident 28 was cognitively intact, required, extensive assistance of one for bed mobility and toilet use, limited assistance of one for transfers, and used oxygen. Current physician orders included, but were not limited to the following: Change out O2 tubing every Sunday night (Label with initials and date). Clean filter on the back of the concentrator (wash with soap and water, rinse, squeeze out excess water and replace) one time a day every Sunday, dated 1/28/2024 Oxygen 2L (liters) via NC (nasal cannula) as desires as needed for SOA (shortness of air), dated 3/24/2023 Monitor placement of foam cannula tubing protectors to oxygen tubing and ensure it is in correct place behind pt (patient's) ears every shift for protection, dated 2/20/2023 Oxygen at 2 LPM (liters per minute) per nasal cannula via O2 concentrator and/or tank at bed time for SOA related to chronic respiratory failure with hypoxia, dated 3/23/2022 The current care plan for The resident has oxygen therapy R/T (related to) Ineffective gas exchange, dated 3/24/2022, included, but was not limited to the following intervention, Oxygen therapy as ordered. Resident puts oxygen on ad lib during the day. 3. On 5/15/24 at 8:45 A.M., Resident 45 was observed sitting in her recliner wearing O2 at 3.5 lpm per nasal cannula. On 5/15/24 at 1:56 P.M., the filter on back of Resident 45's oxygen machine was observed to be caked with dust, humidification bottle dated 4/29/24. On 5/14/24 at 1:54 P.M., Resident 45's clinical records were reviewed. Diagnosis included, but were not limited to, macular degeneration, chronic combined systolic and diastolic heart failure, Sjogren's Syndrome. The most current Quarterly MDS (Minimum Data Set) Assessment and State Optional MDS, dated [DATE], indicated Resident 45 was cognitively intact and required extensive assistance of two for bed mobility, transfers and toilet use, used oxygen and was on hospice, and had physical restraints, bed rails used daily. Current physician orders include, but were not limited to the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oxygen via nasal cannula 1-4 liters per minute as needed for dyspnea, hypoxia, O2 saturation less than 88% or acute angina. Call provider/practitioner with nursing report two times a day for hypoxia related to chronic combined systolic (congestive) and diastolic (congestive) heart failure, dated 1/19/2024 Resident 45's clinical records lacked orders to change oxygen tubing or humidification bottle and clean filter. Resident 45's clinical records lacked documentation in TAR (Treatment Administration Record) about changing O2 tubing or humidification bottle. During an interview on 5/16/24 at 8:59 A.M., LPN (Licensed Practical Nurse) 18 indicated she thought (name of company) serviced the oxygen machines, and they come on Tuesday and Thursdays. She was not sure who cleaned the filters, but the nurses changed the tubing and water bottles on night shift. During an interview on 5/16/24 at 9:32 A.M., the DON indicated (name of company) serviced the oxygen machines and came weekly. They had shown staff how to clean the filters so they should be clean. On 5/17/24 at 11:47 A.M., the DON provided a current Respiratory Therapy-Prevention of Infection policy, revised November of 2011, which indicated .9. Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry . 3.1-47(a)(6)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 45933 Based on observation, interview, and record review, the facility failed to ensure posted nurse staffing sheets were posted daily during the survey for 2 of 9 days reviewed during the survey process. Post nurse staffing was not updated over the weekend. (May 18, May 19) Finding includes: On 5/20/24 at 6:06 A.M., the posted nurse staffing sheet in the main lobby was dated 5/17/24. Staffing sheets were not completed for May 18, May 19. During an interview on 5/20/24 at 8:58 A.M., the Director of Nursing (DON) indicated night shift is in charge of placing the posted nurse staffing sheet in the lobby, and it should be posted each day including Saturday's and Sunday's. On 5/16/24 at 3:17 P.M., the Dementia Care Director provided the Posting Direct Care Daily Staffing Numbers policy, revised July 2016 that indicated, Our facility will post, on a daily basis for each shift

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45933 Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications for 5 of 6 residents reviewed for unnecessary medications. Resident's as needed anti-anxiety medication was ordered for greater than 14 days. A resident had a Physician's Order for an antipsychotic with an unacceptable diagnosis. (Resident 45, Resident 3, Resident 14, Resident 19, Resident 48) Findings include: 1. On 5/15/24 at 8:59 A.M., Resident 48's clinical record was reviewed. Current diagnoses included, but were not limited to, dysphagia and muscle weakness. The most recent Quarterly and State Option Minimum Data Set (MDS) Assessment, dated 3/26/24, indicated Resident 48's cognition was unable to be assessed, and she received an antipsychotic. Current Physician Order's included, but were not limited to, SEROquel [antipsychotic] Oral Tablet 25 MG [milligrams] .Give 25 mg by mouth one time a day related to DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY. Current care plans included, but were not limited to, The resident is on antipsychotic medication therapy R/T [related to] trouble sleeping and dementia. During an interview on 5/16/24 at 10:31 A.M., the Director of Nursing (DON) indicated dementia is not an acceptable diagnosis for an antipsychotic. 2. On 5/15/24 at 2:28 P.M., Resident 12's clinical record was reviewed. Current diagnoses included, but were not limited to hypertension, diabetes mellitus, anxiety, and depression. The most recent Quarterly and State Optional Minimum Data Set (MDS) Assessment, dated 4/30/24 indicated Resident 12 had moderate cognitive impairment and received an antianxiety medication. Current Physician Orders included, but were not limited to, LORazepam [sic] [antianxiety] Tablet 0.5 MG. Give 1 tablet by mouth every 4 hours as needed for Restlessness . start date, 11/29/22. A review of the April and May Medication Administration Record (MAR) indicated Resident 12 received Lorazepam on 4/21/24 and 5/5/24. 38770 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 5/14/24 at 2:49 P.M., Resident 14's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, and psychotic disorder. The most recent Quarterly MDS Assessment, dated 5/7/24, indicated a severe cognitive impairment, and resident was taking an antianxiety medication. Current physician orders included, but were not limited to: Ativan Oral Tablet 0.5 MG (milligrams) Give 0.5 mg by mouth every 12 hours as needed for increased anxiety, dated 3/25/24. No stop date was documented for the medication. 46882 4. On 5/14/24 at 3:18 P.M., Resident 3's clinical records were reviewed. Diagnosis included, but were not limited to cerebral ischemia, depression, cerebral infarction, and occlusion and stenosis of bilateral carotid arteries. The most current Quarterly MDS (Minimum Data Set) Assessment and State Optional MDS, dated [DATE], indicated Resident 3 was cognitively moderately impaired, and required extensive assistance of two for bed mobility, transfers, and toilet use. Current physician's orders included, but were not limited to the following: lorazepam oral tablet 0.5 MG (milligram) Give 0.5 mg by mouth every 2 hours as needed for anxiety, dated 2/7/2024 Admit to [name of company] hospice with Dx (diagnosis) of I67.82 (cerebral ischemia), dated 2/7/2024 5. On 5/14/24 at 1:54 P.M., Resident 45's clinical records were reviewed. Diagnosis included, but were not limited to, macular degeneration, chronic combined systolic and diastolic heart failure, Sjogren's Syndrome. The most current Quarterly MDS (Minimum Data Set) Assessment and State Optional MDS, dated [DATE], indicated Resident 45 was cognitively intact and required extensive assistance of two for bed mobility, transfers and toilet use, used oxygen and was on hospice, and had physical restraints, bed rails used daily. Current physician orders included, but were not limited to the following: [name of company] hospice to eval. (evaluate), dated 2/29/2024 lorazepam oral tablet 0.5 MG Give 0.5 mg by mouth every 30 minutes as needed for pain/restlessness, dated 3/1/2024 46416 6. On 5/14/24 at 1:41 P.M., Resident 19's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety and atherosclerotic heart disease. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent Quarterly MDS Assessment, dated 4/10/24, indicated resident was cognitively intact, an extensive assist of 1 staff for bed mobility, transfers, toileting, and taking an antianxiety medication. Current Physician's Orders included, but were not limited to, the following: lorazepam (antianxiety) 0.5 mg (milligram), Give 1 tablet by mouth every 2 hours as needed for anxiety , ordered 4/4/24 A current Black Box Warning (the highest safety- related warning that medications can have assigned by the Food and Drug Administration) Care Plan, dated 1/13/24, included, but was not limited to, the following intervention: Black box warning: Lorazepam, initiated 1/13/24 The MAR for April 2024 was reviewed and indicated Resident 19 was administered lorazepam from the as needed order on 4/11/24, 4/17/24, and 4/24/24. The May 2024 MAR was reviewed and indicated Resident 19 was administered lorazepam from the as needed order on 5/15/24. During an interview on 5/16/24 9:52 A.M., the DON indicated PRN (as needed anti-anxieties should only be scheduled for 14 days. On 5/17/24 at 1:27 P.M., a current Psychotropic Medication Use Policy, revised July 2022, was provided by the Administrator and indicated . 12. Psychotropic medications are not prescribed or given on a PRN [as needed] basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days . If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order . 3.1-48(a)(2) 3.1-48(a)(4)(6)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46882 Based on observation, interview and record review, the facility failed to maintain safe and secure storage of medications for 3 of 4 medication carts observed and 1 of 3 medication storage rooms observed. Loose pills were observed in the medication carts, and refrigerator temperature logs were not filled out completely in the medication room. Findings include: 1. On 5/17/24 at 8:44 A.M., the medication cart on the PARF (Therapy to Home) Hall was reviewed. The medication cart was observed with the following loose pills in the drawers: 1 small oval white pill At that time, LPN (Licensed Practical Nurse) 19 indicated nurses on nights were supposed to go through the medication cart to make sure it was clean. She indicated she did it when she was here also. Pharmacy came once a month to review the carts. On 5/17/24 at 9:50 A.M., 300 Hall medication cart was reviewed. The medication cart was observed with the following loose pills in the drawers: 1 oblong white pill with L484 on one side 1 small oval white pill with 15 on one side 1 small oval white pill with 316g on one side At that time, LPN 37 indicated she only worked weekends and was not sure when medication carts were cleaned. She indicated she did clean paper out of the medication cart. On 5/17/24 at 9:59 A.M., the 200 Hall medication cart was reviewed. The medication cart was observed with the following loose pills in the drawers: 1 round red pill with ph32 on one side 1 rectangular white pill with 10 on one side CTN on other side At that time, LPN 18 indicated pharmacy came at least once a month and checked medication carts. She indicated she checked the carts when she worked. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 5/17/24 at 10:15 A.M., the Med room [ROOM NUMBER]-300 Hall on Crossroads was reviewed. The temperature log for the supplement fridge was missing a temperature for 5/14/24 P.M., 5/15/24, 5/16/24, and 5/17/24. The temperature log for the medication fridge was missing a temperature for 5/15/24 P.M., 5/16/24, and 5/17/24 A.M. At that time, LPN 18 indicated night shift usually checked temperatures. The following medications were observed sitting on the counter in the medication room: 2 bottles of Miralax and 2 bottles of geri-tussin DM (dextromethorphan and guaifenesin) for a resident discharged on [DATE]. At that time, LPN 18 indicated she was not sure why the medications were sitting there. She indicated they could not be sent back to pharmacy and had to be destroyed. On 5/17/24 at 11:47 A.M., the DON (Director of Nursing) provided at Storage of Medications policy, revised November 2020, that indicated .2. Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner . On 5/20/24 at 9:29 A.M., the Clinical Care Leader provided a Refrigerator and Freezer policy, revised December 2014, which indicated . 2. Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures . 3.1-25(m) 3.1-25(r)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38770 Based on observation, interview, and record review, the facility failed to ensure distribution and food service was provided in accordance with professional standards for food service safety for 2 of 2 meals observed, and 1 of 1 meal services observed in the kitchen. (Main Kitchen, Locked Unit Dining Room) Findings include: During a lunch observation on 5/13/24 from 11:56 A.M. through 12:02 P.M., Qualified Medication Aide (QMA) 3 was observed taking cookies out of the packaging with bare hands, and placing on the food trays to serve to the residents. Certified Nurse Aide (CNA) 5 was observed to also touch cookies with bare hands before serving to residents. On 5/16/24 at 10:36 A.M., a meal service was being observed in the kitchen. While preparing the cups and utensils, Dietary Aide 21 was observed transferring coffee mugs with bare hands to the trays touching the insides of the mugs. Dietary Aide 21 was also observed touching the inside lids of the handled cups with bare hands before filling them with drinks. On 5/16/24 at 2:49 P.M., the Kitchen Manager indicated staff was not supposed to handle cups by the inside or underside of lids, and should not have been handling food with bare hands during meal service. During a breakfast observation on 5/20/24 at 7:50 A.M., QMA 3 was observed to touch toast with bare hands while applying jelly to them before serving to the residents. On 5/17/24 at 10:30 A.M., a current Food Preparation and Service policy, dated 4/2019, was provided and indicated Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of food-borne illness . Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks 3.1-21(i)(2) 3.1-21(i)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45933 Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed for 2 of 4 residents during observation of incontinence care and 1 of 3 observations of obtaining a blood sugar with a glucometer. Gloves were not changed between dirty and clean tasks during peri care and staff cleaned a glucometer for an unmeasurable amount of time. (Resident 7, Resident 11, Resident 43). Findings include: 1. On 5/16/24 at 10:35 A.M., Qualified Medication Aide (QMA) 59 obtained a blood glucose level on Resident 43. After obtaining the blood glucose level, QMA 59 wiped the glucometer for an unmeasureable amount of time (less than 2 seconds) and placed the glucometer in the medication cart drawer. At that time, he indicated he typically lets the machine dry a minute. 2. On 5/20/24 at 10:04 A.M., incontinence care was performed on Resident 11 by Certified Nurse Aide (CNA) 10 and CNA 12. CNA 12 removed the soiled brief and applied cream to Resident 11's bottom, removed gloves, and placed new gloves on. CNA 12 failed to perform hand hygiene from dirty to clean tasks. 46416 3. On 5/20/24 at 9:20 A.M., CNA 10 and CNA 12 were observed providing incontinence care to Resident 7. Both CNAs used Alcohol-based hand rub (ABHR) and put on gloves. CNA 12 pulled down the residents covers. CNA 10 unfastened incontinence pad and pulled it down and they rolled Resident 7 on her left side while CNA 12 held her there. CNA 10 wiped the resident from front to back once with a wipe, rolled the wet incontinence pad and dirty bed pads under the resident. Then CNA 12 slid a clean bed pad and clean incontinence pad under the dirty bed pad. CNA 12 removed her gloves, did not sanitize her hands, and put gloves back on. Resident 7 was then rolled to her right side. CNA 12 grabbed the wet incontinence pad and dirty bed pads out from under the resident and put them into a trash bag while CNA 10 held the resident and pulled the clean incontinence pad and bed pad out from under Resident 7. CNA 12 took off his gloves, did not sanitize his hands, and put on new gloves. CNA 10 and CNA 12 pulled up and fastened the resident's clean brief, then grabbed the bed pad and moved the resident up in bed before taking off their gloves and covering up the resident before leaving the room. During an interview on 5/20/24 at 2:49 P.M., the Infection Preventionist (IP) indicated she would expect staff to sanitize their hands between glove changes while performing incontinence care. During an interview on 5/16/24 at 12:02 P.M., Licensed Practical Nurse (LPN) 61 indicated she cleaned the glucometer before and after each resident since the glucometer is used on multiple residents. She indicated to use one wipe to clean thoroughly and one wipe to wrap around the glucometer and let it dry for 2 minutes with the wipe around it. During an interview on 5/16/24 at 4:31 P.M., QMA 59 indicated the glucometer should air dry for at least 2 minutes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 9:17 A.M., a Handwashing/Hand Hygiene Policy, revised August 2019, was provided by the IP and indicated . 7. Use an alcohol-based hand rub . m. after removing gloves . On 5/20/24 at 1:35 P.M., a current Blood Sampling- Capillary (Finger Sticks) policy, revised September 2014 indicated, Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses .8. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use. 3.1-18(b)(2) 3.1-18(l)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46416 Based on interview, and record review, the facility failed to properly document influenza and pneumococcal vaccines being offered to residents for 3 of 5 residents reviewed for influenza and pneumococcal vaccination. Clinical records lacked the vaccine consent/refusal date, the reason why it was refused, and a date education was provided to the resident and/or resident representative. (Resident 19, Resident 4, Resident 36) Findings include: 1. On 5/14/24 at 1:41 P.M., Resident 19's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety and atherosclerotic heart disease. The most recent Quarterly MDS Assessment, dated 4/10/24, indicated resident was cognitively intact. Resident 19 was [AGE] years old and was admitted to the facility on [DATE]. Resident 19's immunization history was reviewed for his influenza and pneumonia vaccination status. The following vaccination lacked documentation of a refusal date, the reason why it was refused, and a date education was provided to the resident and/or resident representative: Influenza 2. On 5/13/24 at 2:30 P.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety and depression. The most recent Quarterly MDS Assessment, dated 2/14/24, indicated Resident 4 was cognitively intact. Resident 4 was [AGE] years old and was admitted to the facility on [DATE]. Resident 4's immunization history was reviewed for her influenza and pneumonia vaccination status. The following vaccinations lacked documentation of a consent/refusal date, the reason why it was refused, and a date education was provided to the resident and/or resident representative: Pneumococcal Polysaccharide (PPSV23)-Refused Pneumococcal Conjugated (PCV13)-no record of consent to administer or refusal 3. On 5/14/24 at 2:38 P.M., Resident 36's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease. The most recent Annual MDS Assessment, dated 3/14/24 indicated Resident 36 was cognitively intact. Resident 36 was [AGE] years old and admitted to the facility on [DATE]. Resident 36's immunization history was reviewed for her influenza and pneumonia vaccination status. The following vaccinations lacked documentation of a consent/refusal date, the reason why it was refused, and a date education was provided to the resident and/or resident representative: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Influenza-no record of consent to administer or refusal Pneumococcal Conjugated (PCV13)-no record of consent to administer or refusal During an interview on 5/20/24 at 2:49 P.M., the Infection Preventionist (IP) indicated that newly admitted residents should have the influenza and pneumococcal vaccines offered to them at admission and the other residents were usually offered prior to the influenza season annually. The pharmacy they use, would usually tell her if a resident was due for a pneumococcal vaccine and they would even come into the facility and give the vaccine if needed. During an interview on 5/21/24 at 9:30 A.M., the IP indicated all 4 of the residents refused vaccines but the reason and education given was not clearly documented. She indicated the consent/refusal forms should have been completed and scanned into the clinical record. On 5/13/24 at 11:50 A.M., a current Resident Immunizations Policy, revised 3/8/22, was provided by the Administrator and indicated . Purpose [is] to provide residents and clients the opportunity to receive immunizations as they fit into their healthcare goals [and] to provide guidance for the location's immunization program including recommended vaccinations. Upon admission, each client, resident and/or resident representative will receive the Vaccination Information Statements (VIS) for influenza and pneumococcal vaccines . review current vaccinations and provide and document education on the benefits and potential side effects of the vaccinations for which the client/resident is eligible . If the client, resident and/or resident representative consent to vaccination, obtain written consent if required by state regulation or if written consent is not required, obtain and document verbal consent .complete screening questions prior to administering vaccination . administer vaccination or refer to Provider or Pharmacy for vaccine administration . if the resident and/or resident representative chooses not to be vaccinated after discussion of benefits, document declination . residents will be reviewed for vaccine eligibility annually or when the Adult Immunization Schedule changes . education, consent, and screening are required prior to administration of each dose of any vaccine given . 3.1-13(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38770 Based on observation, interview, and record review, the facility failed to ensure a safe, functional, sanitary, and comfortable environment for residents for 2 of 5 halls observed, and 1 of 1 common area observed. (Locked Unit, room [ROOM NUMBER]) Findings include: 1. On 5/14/24 at 11:02 A.M., the bathroom vent in room [ROOM NUMBER] was observed caked with dust. On 5/20/24 at 8:07 A.M., the same was observed. 2. On 5/14/24 at 11:12 A.M., the bathroom vent in room [ROOM NUMBER] was observed caked with dust, and an unlabeled tube of zinc oxide was observed on the back of the toilet. The back of the room door was observed with a metal strip coming away from the door. On 5/20/24 at 8:15 A.M., the same was observed. 3. On 5/14/24 at 11:06 A.M., the bathroom door of room [ROOM NUMBER] was observed with scuff marks, chipping away at the door, and the room floor was sticky. On 5/20/24 at 8:14 A.M., the bathroom in room [ROOM NUMBER] was the same. The floor was not sticky. 4. On 5/14/24 at 10:49 A.M., the grab bar behind the toilet in room [ROOM NUMBER] was observed with a loose fastener on the right side not attached to the wall. The vent in the bathroom was caked with dust. On 5/20/24 at 8:12 A.M., the same was observed in room [ROOM NUMBER]. A stack of uncovered briefs was observed sitting on the back of the toilet. 5. On 5/14/24 at 10:57 A.M., two unlabeled and uncovered toothbrushes were observed on the shared bathroom sink in room [ROOM NUMBER] in a cup. A denture cream tube and two tubes of toothpaste were observed on the sink unlabeled. Scuff marks were observed on the bottom of the bathroom door. On 5/20/24 at 8:11 A.M., the same was observed, but the denture cream tube and toothpaste had been put up in the cabinet. 6. On 5/14/24 at 11:08 A.M., room [ROOM NUMBER] was observed to be shared by two residents. The call light box had one call light attached to it, and the cord was observed wrapped on one of the beds. No call light was observed for the other side of the room. The bathroom was observed with clean briefs on the back of the toilet, uncovered. On 5/20/24 at 8:13 A.M., the same was observed. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. On 5/13/24 at 11:30 A.M., the common area in the locked unit was observed with a register under the window that was missing the cover on the bottom with exposed wires. On 5/20/24 at 8:23 A.M., the same was observed. 8. On 5/20/24 at 8:23 A.M., a chair seat in the common are of the locked unit was observed not attached to the legs. 45933 9. During an observation on 5/13/24 at 2:06 P.M., room [ROOM NUMBER] had paint chipped off in multiple areas around the door frame to the bathroom, and the inside of the bathroom door had a large chipped area on the bottom. On 5/20/24 at 11:50 A.M., the same was observer in room [ROOM NUMBER]. During an interview on 5/20/24 at 2:22 P.M., the Maintenance Director indicated staff should tell him when there is an issue with the environment or put in a work order. On 5/20/24 at 1:35 P.M., the Administrator provided a current Homelike Environment policy, revised February 2021 that indicated, Residents are provided with a safe, clean, comfortable environment .2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting . 3.1-19(f)(5)