STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Healthcare of New Harmony	251 Highway 66 New Harmony, IN 47631

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758 Based on observation, record review, and interview, the facility failed to ensure that a resident who had medication at bedside had a physician order for the medication to be kept at bedside and self-administer, a completed assessment to self-administer, and a care plan based on 2 of 2 residents reviewed for self-administration of medications. (Resident 14. Resident 36) Findings include: 1. On 9/10/24 at 9:22 A.M., Resident 14 was observed having 1 bottle of eye relief drops and 1 bottle of cooling pain relief medication sitting on the bedside table. On 9/12/24 at 11:23 A.M., Resident was observed having 1 bottle of eye relief drops and 1 bottle of cooling pain relief medication sitting on the bedside table. On 9/16/24 at 10:25 A.M., Resident 14's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, and depression The current Quarterly MDS (Minimum Data Set) assessment dated [DATE] indicated Resident 14 was cognitively intact. Resident 14 needed partial assistance with transfer, dressing, and toileting. The clinical record lacked a physician order, self-administration assessment, and care plan for the self-administration of medication. 2. On 9/12/24 at 11:45 A.M., Resident 36's clinical record was reviewed. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease). The current Admission MDS dated [DATE] indicated Resident 36 was cognitively intact. Resident 36 was independent with toileting and eating but needed supervision with mobility and transfer. The clinical record lacked and order and care plan to self-medicate medications. During an interview on 9/12/24 at 11:35 A.M., the DON (Director of Nursing indicated no medications should be left at bedside unless there was an order and self-medication administration assessment. The DON also indicated there the residents needed an order and care plan when they were able to self-administer medication. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/16/24 at 12:30 P.M., the Regional Clinical Support Nurse provided a current policy Resident Self-Administration of Medication date 5/30/23. The policy indicated . a resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely .When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following: the resident's cognitive status, . comprehension of instructions for the medication taking .the ability to ensure that medication is stored safely and securely .the care plan must reflect resident self-administration and storage arrangements for such medications . 3.1-11

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview and record review, the facility failed to notify a Resident's representative during change in condition for 1 of 2 Residents with severely impaired cognition reviewed for unnecessary medications. (Resident 37) Finding includes: On 9/10/24 at 8:37 A.M., Resident 37's clinical record was reviewed. Resident 37 was admitted on [DATE]. Diagnoses included, but were not limited to, Alzheimer's Disease, anxiety, major depressive disorder, and visual/auditory hallucinations. The most recent Significant Change MDS (Minimum Data Set) assessment, dated 8/14/24, indicated Resident 37's cognition was below measurable, was completely dependent on staff for eating, bathing, toileting, and transfers, and was receiving antipsychotic, antianxiety, antidepressant, hypnotic, and opioid medications during the seven day lookback period. Physician orders included, but were not limited to: Olanzapine Oral Tablet 10 MG Give 10 mg by mouth two times a day for schizophrenia behavior disorder. Start date 7/12/24 Mirtazapine Oral Tablet 15 MG Give 0.5 tablet by mouth in the evening related to major depressive disorder single episode. Start date 2/29/24 Sertraline HCl Tablet 100 MG Give 1 tablet by mouth one time a day for depression. Start date 8/15/24. A hospital provider follow up note, dated 8/9/24 at 12:30 P.M., indicated Resident 37 was seen in office due to nasal bone fracture. The physician indicated he spoke with the Resident's POA (power of attorney) (spouse) and the POA was unaware the Resident was being seen in office for discussion of treatment options of possible closed reduction surgery. The clinical record lacked documentation of notification to Resident 37's POA during psychotropic medication increases of the following medications: 6/14/24 Olanzapine increased from 7.5 mg each day to 10 mg each day. 6/15/24 Sertraline 75 mg started. 7/8/24 Olanzapine increased from 10 mg each day to 20 mg each day. 7/30/24 Sertraline increased from 75 mg daily to 100 mg daily. 7/29/24 Haloperidol 5 mg PRN (as needed) started. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/16/24 at 9:08 A.M., the ADON (assistant director of nursing) indicated staff are expected to notify the resident's representative anytime there is a new event, new change in condition, and order update. On 9/16/24 at 12:30 A.M., the regional consultant provided a policy titled Notification of Change, dated 11/19/23, that indicated The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: Circumstances that require a need to alter treatment. A transfer or discharge from the facility. Residents incapable of making decisions: the representative would need to make any decisions that have to be made. 3.1-5(a)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview and record review, the facility failed to ensure proper clinical documentation was sent with a resident during a transfer for 1 of 4 residents reviewed for hospital transfers. (Resident 37) Findings include: On 9/10/24 at 8:37 A.M., Resident 37's clinical record was reviewed. Resident 37 was admitted on [DATE]. Diagnoses included, but were not limited to, Alzheimer's Disease and abnormalities of gait and mobility. The most recent Significant Change MDS (Minimum Data Set) assessment, dated 8/14/24, indicated Resident 37's cognition was below measurable, was completely dependent on staff for eating, bathing, toileting, and transfers, and was receiving antiphychotic, antianxiety, antidepressant, hypnotic, and opioid medications during the seven day lookback period. A nurses progress note, dated 8/1/24 at 8:00 P.M., indicated Resident 37 was transferred from the facility to the emergency department by ambulance. The clinical record lacked documentation sent with Resident 37 during the transfer. During an interview on 9/13/24 at 1:07 P.M., the ADON (assistant director of nursing) indicated paperwork could not be provided for the transfer that occurred 8/1/24 because the paperwork was not completed and did not exist. On 9/16/24 at 12:30 P.M., the regional consultant provided a policy titled Transfer and Discharge, dated 2/10/24, that indicated Emergency transfers initiated by the facility for medical reasons to an acute care setting such as a hospital The original copies for the transfer form and Advanced Directive accompany the resident. Copies are retained for the medical record. 3.1-50(h)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48057 Based on interview and record review, the facility failed to ensure a notice of transfer was provided during a transfer for 1 of 4 residents reviewed for hospital transfers. (Resident 37) Findings include: On 9/10/24 at 8:37 A.M., Resident 37's clinical record was reviewed. Resident 37 was admitted on [DATE]. Diagnoses included, but were not limited to, Alzheimer's Disease and abnormalities of gait and mobility. The most recent Significant Change MDS (Minimum Data Set) assessment, dated 8/14/24, indicated Resident 37's cognition was below measurable, was completely dependent on staff for eating, bathing, toileting, and transfers, and was receiving antiphychotic, antianxiety, antidepressant, hypnotic, and opioid medications during the seven day lookback period. A nurses progress note, dated 8/1/24 at 8:00 P.M., indicated Resident 37 was transferred from the facility to the emergency department by ambulance. The clinical record lacked documentation provided to Resident 37 or her representative. During an interview on 9/13/24 at 1:07 P.M., the ADON (assistant director of nursing) indicated paperwork could not be provided for the transfer that occurred 8/1/24 because the paperwork was not completed and did not exist, and documentation sent with a resident during transfer should include a face sheet, orders, post form, labs if recent, bed hold and discharge/transfer form. On 9/16/24 at 12:30 P.M., the regional consultant provided a policy titled Transfer and Discharge, dated 2/10/24, that indicated Emergency transfers initiated by the facility for medical reasons to an acute care setting such as a hospital The original copies for the transfer form and Advanced Directive accompany the resident. Copies are retained for the medical record. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated. The social services director will provide copies of notices for emergency transfers to the Ombudsman. 3.1-12(a)(6)(A)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48057 Based on interview and record review, the facility failed to ensure a bed hold was provided upon transfer for 1 of 4 residents reviewed for hospital transfers. (Resident 37) Findings include: On 9/10/24 at 8:37 A.M., Resident 37's clinical record was reviewed. Resident 37 was admitted on [DATE]. Diagnoses included, but were not limited to, Alzheimer's Disease and abnormalities of gait and mobility. The most recent Significant Change MDS (Minimum Data Set) assessment, dated 8/14/24, indicated Resident 37's cognition was below measurable, was completely dependent on staff for eating, bathing, toileting, and transfers, and was receiving antiphychotic, antianxiety, antidepressant, hypnotic, and opioid medications during the seven day lookback period. A nurses progress note, dated 8/1/24 at 8:00 P.M., indicated Resident 37 was transferred from the facility to the emergency department by ambulance. The clinical record lacked documentation provided for Resident 37. During an interview on 9/13/24 at 1:07 P.M., the ADON (assistant director of nursing) indicated paperwork could not be provided for the transfer that occurred 8/1/24 because the paperwork was not completed and did not exist. On 9/16/24 at 12:30 P.M., the regional consultant provided a policy titled Transfer and Discharge, dated 2/10/24, that indicated Emergency transfers initiated by the facility for medical reasons to an acute care setting such as a hospital The original copies for the transfer form and Advanced Directive accompany the resident. Copies are retained for the medical record. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated. The social services director will provide copies of notices for emergency transfers to the Ombudsman. 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 - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758 Based on record review and interview, the facility failed to ensure the MDS (Minimum Data Set) Assessment was completed accurately for 2 of 2 residents reviewed for restraints (Resident 11, Resident 19), 1 of 5 residents reviewed for unnecessary medications(Resident 37) and 1 of 6 residents review for falls(Resident 37). (Resident 11, Resident 19, Resident 37) Findings include: 1. On 9/10/24 at 10:12 A.M., Resident's 11 clinical record was reviewed. Diagnoses included, but not limited to, systemic lupus erythematosus, chronic kidney disease stage 3, and neuromuscular dysfunction of bladder. The Current Quarterly MDS (Minimum Data Set) Assessment date 7/23/24 indicated Resident was cognitively intact and was dependent to transfer and toilet. The assessment indicated that the resident had a restraint of bed rails and used daily Current physician orders included, but were not limited to, Bilateral 1/2 siderails every shift related to weakness. For resident to assist with positioning and turning dated 6/12/24. 2. On 9/10/24 at 12:49 P.M., Resident 19's clinical record was reviewed. Diagnoses included, but were not limited to, unilateral primary osteoarthritis of the left knee and Alzheimer Disease. The current 5-day MDS assessment dated [DATE] indicated Resident 9 was mildly cognitively intact, the resident needed assistance to transfer and was dependent for toileting. The 7 days look back indicated the resident was taking anticoagulant, antiplatelels, but not on opioid. Resident does not take an anticoagulant. The MDS also indicated that the resident had a physical restraint of bed rails and was used daily. The previous MDS Assessment was reviewed dated 7/29/24 indicated the 7 days look back for medications indicated the resident was on antiplatelet, anticoagulant, opioid, diuretic, hypoglycemic, and antidepressant. Current physician orders included, but not limited to, Cloperidal TAB 75 MG (Milligrams) (antiplatelets). Give 1 tablet orally in the morning dated 8/20/21. Aspirin 81 MG (antiplatelets). Give 1 tablet orally at bedtime dated 8/19/24. Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) (pain medication) Give 5 mg by mouth every 4 hours as needed for pain HOLD FOR BP < 110/60 dated 7/21/23. Bilateral 1/2 siderails on bed for bed mobility every shift related to obesity, dated 7/21/24. 48057 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 9/10/24 at 8:37 A.M., Resident 37's clinical record was reviewed. Resident 37 was admitted on [DATE]. Diagnoses included, but were not limited to, Alzheimer's Disease, anxiety, and major depressive disorder. The most recent Significant Change MDS (Minimum Data Set) assessment, dated 8/14/24, indicated Resident 37's cognition was below measurable, was completely dependent on staff for eating, bathing, toileting, and transfers, had not had any falls since the prior MDS assessment, and was receiving antiphychotic, antianxiety, antidepressant, hypnotic, and opioid medications during the seven day lookback period. During an interview on 8/16/24 at 12:40 P.M., the DON (director of nursing) indicated Resident 37 had fallen since the prior MDS assessment and the section marked no for falls was marked in error. During an interview on 09/11/24 at 10:30 A.M., DON, indicated that she left the opioid off for the last MDS and had been coding that the resident was receiving and anticoagulant and antiplatelet. She indicated that Plavix was listed as an anticoagulant in the drug resource she was using. She was unaware in the RAI (Resident Assessment Instruction) Manual that Plavix was antiplatelet. During the same interview, the DON indicated the facility follows the RAI Manual for the MDS Assessment. During an interview on 9/11/24 11:14 A.M., the DON indicated that she had been coding the MDS wrong with regards to the restraints. During an interview on 9/11/24 at 10:30 A.M., the DON indicated that she left the opioid off for the last MDS and had been coding that the resident receiving an anticoagulant and antiplatelet. She indicated the Plavix was listed and anti coagulant in the drug resource she was using. She was unaware in the Resident Assessment Instruction (RAI) Manual that Plavix was antiplatelet. During the same interview, the DON indicated the facility follows the RAI Manual for the MDS assessments. On 9/11/24 at 11:14 A.M. the DON indicated she had been coding the MDS wrong in regards to the restraints.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48147 Based on interview and record review, the facility failed to develop care plans for 1 of 3 residents reviewed for UTIs and 1 of 5 residents reviewed for unnecessary medications. A care plan was not developed for residents with new diagnoses and new medication orders. (Resident 12 and Resident 7) Findings include: 1. On 9/11/24 at 11:26 A.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, urinary tract infection (UTI). The most current Annual Minimum Data Set (MDS) Assessment, dated 6/17/24, indicated Resident 12 had severe cognitive impairment, required setup assistance for toileting, and did not have a UTI. Current physician orders included, but was not limited to: Ciprofloxacin (an antibiotic) 500 milligrams (mg) - Give 1 tablet by mouth every 12 hours for UTI until 09/13/24, dated 9/8/24 A Nursing progress note, dated 9/7/24 at 2:17 P.M., indicated Resident 12 returned from the hospital on that date with antibiotics for a UTI. The clinical record lacked a care plan related to the UTI diagnosis or antibiotic use. On 9/12/24 at 2:02 P.M., the Director of Nursing (DON) indicated care plan were developed for residents with a new infection or antibiotic order. At that time, she indicated Resident 12's new diagnosis and antibiotic order had been overlooked. 46758 2. On 9/12/24 at 10:35 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were limited to, hypertension and deep vein thrombosis, and diabetes mellitus The current annual MDS (Minimum Data Set) assessment dated [DATE] indicated the resident was cognitively intact. The resident needed supervision with toileting and set up with dressing, eating, and transfer. During the 7 days look back period the resident was on the following types of medications antiplatelets, anticoagulant, antidepressant, diuretic, opioid, and hypoglycemic Current physician orders included, but not limited to: Apixaban Oral Tablet 5 MG (Milligrams) (blood thinner), Give 5 mg by mouth two times a day for DVT (Deep Vein Thrombosis) dated 9/20/23 Aspirin Tablet Chewable 81 MG. Give 1 tablet by mouth one time a day dated 8/4/23. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lasix Oral Tablet 20 MG (Furosemide) (Water Pill). Give 20 mg by mouth two times a day dated 9/6/24. The clinical record lacked a care plan for antiplatelets and anticoagulants. During an interview on 9/13/24 at 10:40 A.M., the DON (Director of Nursing) indicated there should be a care plan for antianxiety, anticoagulants, antiplatelets, and antipsychotics. 3. On 9/13/24 at 9:37 A.M., Resident 17's clinical record was reviewed. Diagnoses included, but were not limited to, unspecified dementia, unspecified severity, with other behavioral disturbance and psychotic disorder with delusions due to physiological condition. clinical record review. The current 5-day Medicare MDS dated [DATE] indicated Resident 17 was cognitively intact. Resident 17 was independent with eating and transfer but required set up assistance for dressing and hygiene. The 7 days look back for medications indicated the resident was on antipsychotic, antidepressant, antianxiety, antihypnotic, anticoagulant, and antiplatelets. Current physician orders included, but were not limited to: Lexapro Oral Tablet 10 MG (Escitalopram Oxalate) (Antidepressant) Give 10 mg(milligrams) by mouth at bedtime date 8/30/24. Risperidone Oral Tablet 0.25 MG (antipsychotic). Give 0.25 mg by mouth in the morning dated 8/27/24. Apixaban Oral Tablet 5 MG (anticoagulant). Give 5 mg by mouth two times a day dated 9/23/23 Current care plan indicates that Resident 17 is at risk for side effects of due to taking antipsychotic, antidepressants, anticoagulants, antianxiety, and antihypnotics, these interventions included, but are not limited to, monitoring for adverse effects for all these medication and monitoring for behaviors. The MAR/TAR for September 2024 indicated the following dates lacking documentation and not following care plan interventions: Lacking monitoring for behaviors- 9/7/24 day shift Lacked monitoring for side effects of antidepressant- 9/7/24 day shift Lacked monitoring for sedation/hypnotic -9/7/24 day shift Lacked monitoring for side effects of antianxiety-9/7/24 days Lacked monitoring for side effects for anticoagulant-9/7/24 day shift Lacked monitoring for side effects for antipsychotics -9/7/24 day shift (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MAR/TAR for August 2024 indicated the following dates lacking documentation and not following care plan interventions: Lacked monitoring for side effects of antidepressant- 8/13 and 8/14/24 nigh shift Lacked monitoring for side effects of antianxiety-8/13 and 8/15/24 night shift Lacked monitoring for side effects for anticoagulant-8/13 and 8/25/24 night shift Lacked monitoring for side effects for antipsychotics -8/13 and 8/14/24 night shift Lacked monitoring for behaviors- 8/13 and 8/15/24 night shift On 9/16/24 at 12:20 P.M., the Regional Consultant provided a Comprehensive Care Plans policy, dated 9/19/2023, that indicated The comprehensive care plan will describe, at minimum, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being. 3.1-35(a)

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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** 46758 Based on interview and record review, the facility failed to ensure care plans were revised quarterly in 12 of 13 residents reviewed for care planning and conferences, 1 of 2 residents reviewed for UTI (Urinary Tract Infections) catheters, and 2 of 3 for siderails. (Resident 7, Resident 9, Resident 11, Resident 12, Resident 13, Resident 17, Resident 18, Resident 19, Resident 12, Resident 23, Resident 37, Resident R) Findings include: 1. On 9/12/24 at 10:35 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were limited to, hypertension and Deep Vein Thrombosis. The current annual MDS (Minimum Data Set) assessment dated [DATE] indicated the resident was cognitively intact. The resident needed supervision with toileting and set up with dressing, eating, and transfer. During the 7 days look back period the resident was on the following types of medications antiplatelets, anticoagulant, antidepressant, diuretic, opioid, and hypoglycemic. Care conferences were offered but declined by the POA (Power of Attorney) on 8/6/24, 6/13/24, and 3/16/24. The clinical record lacked documentation of care plan conferences prior to February 2024. 2. On 9/10/24 at 10:12 A.M., Resident's 11 clinical record was reviewed. Diagnoses included, but not limited to, systemic lupus erythematosus, chronic kidney disease stage 3, and neuromuscular dysfunction of bladder. The Current Quarterly MDS (Minimum Data Set) Assessment date 7/23/24 indicated Resident was cognitively intact and was dependent to transfer and toilet. The assessment indicated that the resident had a restraint of bed rails and used daily. The assessment also identified the resident has an indwelling catheter Current physician orders included, but were not limited to, Bilateral 1/2 siderails every shift related to weakness. For resident to assist with positioning and turning dated 6/12/24. Bed in lowest position and perimeter mattress to bed dated 8/1/23. Catheter care to be done each shift dated 3/12/24 The current falls risk care plan, initiated 8/11/21, indicated Resident 11 had falls and would be free from falls through the review date. Interventions included, but were limited to, bed in lowest position when alone, parameter mattress to bed, and to anticipate and meet the resident's needs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The current restraint care, initiated 6/17/24, indicated Resident 11 uses physical restraints of bilateral; 1/2 rails related to weakness, Goals the resident will be free of complications related to siderail use. Interventions included but were not limited to discuss and record with resident and caregiver, the risks and benefits of siderails dated 6/17/24. The current indwelling catheter care plan indicated Resident 11 uses catheter for obstructive uropathy and would remain free from catheter-related trauma through review date. Interventions included, but were not limited to, monitor and document intake and output and monitor for s/sx of discomfort on urination and frequency. Care plan was not implemented for catheter care on the following dates: July 1, 2, 5, 6, 7, 19, 24, 27, and 28, 2024. August 2, 5, 9,16,19, 20, 21, 22, 25, 26, 27, 30, and 31, 2024 September 1, 5, 6, 7, and 10, 2024 During an interview on 9/13/24 at 3:40 P.M., the DON (Director of Nursing) indicated catheter care should be done every shift output should be documented also. Care conference was conducted on 7/16/24 and was offered on 6/5/24 but was declined by wife. There was no other care conferences conducted before February 2024. 3. On 9/13/24 at 9:37 A.M., Resident 17's clinical record was reviewed. Diagnoses included, but were not limited to, unspecified dementia, unspecified severity, with other behavioral disturbance and psychotic disorder with delusions due to physiological condition. The current 5-day Medicare MDS dated [DATE] indicated Resident 17 was cognitively intact. Resident 17 was independent with eating and transfer but required set up assistance for dressing and hygiene. The 7 days look back for medications indicated the resident was on antipsychotic, antidepressant, antianxiety, antihypnotic, anticoagulant, and antiplatelets. Current physician orders included, but were not limited to: Lexapro Oral Tablet 10 MG (Escitalopram Oxalate) (Antidepressant) Give 10 mg(milligrams) by mouth at bedtime date 8/30/24. Risperidone Oral Tablet 0.25 MG (antipsychotic). Give 0.25 mg by mouth in the morning dated 8/27/24. Apixaban Oral Tablet 5 MG (anticoagulant). Give 5 mg by mouth two times a day dated 9/23/23 Current care plan indicates that Resident 17 is at risk for side effects of due to taking antipsychotic, antidepressants, anticoagulants, antianxiety, and antihypnotics, these interventions included, but are not limited to, monitoring for adverse effects for all these medication and monitoring for behaviors. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care conferences was declined by guardian on 8/14/24 but one was conducted on 5/14/24. There was no other care conferences conducted before February 4. On 9/10/24 at 12:49 P.M., Resident 19's clinical record was reviewed. Diagnoses included, but were not limited to, unilateral primary osteoarthritis of the left knee and Alzheimer Disease. The current 5-day MDS assessment dated [DATE] indicated Resident 9 was mildly cognitively intact, the resident needed assistance to transfer and was dependent for toileting. The 7 days look back indicated the resident was taking anticoagulant, antiplatelels, but not on opioid. Resident does not take an anticoagulant. The MDS also indicated that the resident had a physical restraint of bed rails and was used daily. Current orders included, but not limited to, Bilateral 1/2 siderails on bed for bed mobility every shift dated 7/12/24. The current care plan indicated the Resident 19 uses physical restraints has 1/2 side rails on the bed bilateral r/t (related to) Chronic pain, positioning/bed mobility while in bed, transferring and at their request. During an interview on 9/11/24 at 11:14 A.M., the DON (Director of Nursing) indicated she had coded the MDS wrong. She indicated the restraints care plan template states prepopulates with the interventions for physical restraint and that she would go back and edit the care plans. Care conference was conducted on 5/11/24, and clinical record lacked documentation of a care conferences prior to this date 48057 5. On 9/10/24 at 8:37 A.M., Resident 37's clinical record was reviewed. Resident 37 was admitted on [DATE]. Diagnoses included, but were not limited to, Alzheimer's Disease and abnormalities of gait and mobility. The most recent Significant Change MDS (Minimum Data Set) assessment, dated 8/14/24, indicated Resident 37's cognition was below measurable, was completely dependent on staff for eating, bathing, toileting, and transfers, and was receiving antiphychotic, antianxiety, antidepressant, hypnotic, and opioid medications during the seven day lookback period. Care conferences during the last year were held on 3/7/24 and 8/12/24. 6. On 9/10/24 at 10:28 A.M., Resident 18's clinical record was reviewed. Resident 18 was admitted on [DATE]. Diagnoses included, but were not limited to, hemiplegia and hemiparesis. The most recent Quarterly MDS assessment, dated 8/11/24, indicated Resident 18 was cognitively intact and was dependant on staff for toileting, showers, and transferring. The clinical record lacked documentation of any care conferences held during the past year. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. On 9/11/24 at 10:21 A.M., Resident 23's clinical record was reviewed. Resident 23 was admitted on [DATE]. Diagnoses included, but were not limited to, multiple sclerosis. The most recent Quarterly MDS assessment, dated 8/20/24, indicated Resident 23 was cognitively intact and was dependent on staff for toileting, showers, and transferring. The clinical record lacked documentation of any care conferences held during the past year. 48147 8. On 9/11/24 at 10:28 A.M., Resident 9's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and schizoaffective disorder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 9/7/24, indicated Resident 9 was not assessed for cognitive impairment due to being rarely or never understood, and was dependent on staff for toileting and bathing. A care plan conference was documented on 7/16/24. The clinical record lacked documentation of care plan conferences prior to 7/16/24. 9. On 9/22/35 at 11:26 A.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and urinary tract infection. The most current Annual Minimum Data Set (MDS) Assessment, dated 6/17/24, indicated Resident 12 had severe cognitive impairment and required substantial to maximal assistance of staff (staff does more than half) for bathing. A care plan conference was documented on 4/17/24. The clinical record lacked documentation of care plan conferences prior to or after 4/17/24. 10. On 9/11/24 at 8:56 A.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, atrial fibrillation, and generalized anxiety disorder. The most current Annual Minimum Data Set (MDS) Assessment, dated 7/11/24, indicated Resident 13 had severe cognitive impairment and required substantial to maximal assistance of staff (staff does more than half) for toileting. A care plan conference was documented on 9/27/23 and 4/16/24. The clinical record lacked documentation of care plan conferences between 9/27/23 and 4/16/24 or after 4/16/24. 11. On 9/12/24 at 1:28 P.M., Resident R's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure and diabetes mellitus. The resident was admitted to the facility on [DATE]. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 6/30/24, indicated Resident R had severe cognitive impairment, required supervision of staff for eating, and had verbal behaviors directed towards others daily. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record lacked documented care plan conferences in the past year for Resident R. On 9/12/24 at 2:23 P.M., the Social Services Director indicated there were no care plan conferences for Resident R because she refused them. On 9/13/24 at 10:13 A.M., the Director of Nursing (DON) indicated that MDS meetings were held weekly where residents within their window of MDS comprehensive assessment were discussed. These meetings were not documented. On 9/16/24 at 12:20 P.M., the Regional Consultant provided an undated Care Planning- Interdisciplinary Team policy that indicated A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS). The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team . The resident, the resident's family, and/or the resident's legal representative/guardian or surrogate are encourage to participate in the development of and revision to the resident's care plan. Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family. On 9/16/24 at 12:20 P.M., the Regional Consultant provided a Comprehensive Care Plans policy, dated 9/19/2023, that indicated The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 3.1-35(a) 3.1-35(d)(2)(B) 3.1-35(e)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview and record review, the facility failed to ensure practitioner's diagnostic practices met professional standard of care for 1 of 1 Resident reviewed for a schizophrenia diagnosis over [AGE] years of age after admission. (Resident 37) Finding includes: On 9/10/24 at 8:37 A.M., Resident 37's clinical record was reviewed. Resident 37 was admitted on [DATE]. Diagnoses included, but were not limited to, Alzheimer's Disease, anxiety, major depressive disorder, and visual/auditory hallucinations. On 7/12/24 Resident 37 was given a new diagnosis of schizophrenia. The clinical record lacked any documentation related to that diagnosis, why the diagnosis was given, or any assessment that lead to the diagnosis. The most recent Significant Change MDS (Minimum Data Set) assessment, dated 8/14/24, indicated Resident 37's cognition was below measurable, was completely dependent on staff for eating, bathing, toileting, and transfers, and was receiving antipsychotic, antianxiety, antidepressant, hypnotic, and opioid medications during the seven day lookback period. Physician orders included, but were not limited to: Lorazepam Oral Concentrate 2 MG/ML (milligrams/milliliter) Give 0.25 mL by mouth every 2 hours as needed for anxiety/restlessness. Resident on hospice services with less than 6 months life expectancy. Start date 9/2/24 Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.25 ml by mouth every 2 hours as needed for Pain/SOB (shortness of breath). Start date 9/2/24 Olanzapine Oral Tablet 10 MG Give 10 mg by mouth two times a day for schizophrenia behavior disorder. Start date 7/12/24 Mirtazapine Oral Tablet 15 MG Give 0.5 tablet by mouth in the evening related to major depressive disorder single episode. Start date 2/29/24 Sertraline HCl Tablet 100 MG Give 1 tablet by mouth one time a day for depression. Start date 8/15/24 Haloperidol 5 MG Give 5 mg by mouth every 8 hours as needed for psychosis. 7/29/24-8/16/24 Antipsychotic medication monitoring, Start date 4/18/23 Care plans included, but were not limited to: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Resident) uses psychotropic medications. Interventions: Administer psychotropic medications as ordered by physician; monitor for side effects and effectiveness every shift. Consult with pharmacy, physician to consider dosage reduction when clinically appropriate at least quarterly. Monitor/document/report as needed any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking) frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, nausea, vomiting, behavior symptoms not usual to the person. Monitor/record occurrences for target behavior symptoms of auditory and visual hallucination and document per facility protocol. Date initiated: 4/19/23 (Resident) uses antidepressant medication. Interventions: administer antidepressant medication as ordered by physician. Monitor/document side effects and effectiveness every shift. Educate caregivers about risk, benefits and the side effects and/or toxic symptoms of anti-depressant drugs being given. Monitor and report as needed adverse reactions to antidepressant therapy: change in behavior/mood/cognition, hallucinations/delusions, social isolation, suicidal thoughts, withdrawal, decline in activities of daily living ability, continence, no voiding, constipation, fecal impaction, diarrhea, gait changes, rigid muscles, balance problems, tremors, muscle cramps, falls, dizziness/vertigo, fatigue, insomnia, appetite loss, weight loss, nausea/vomiting, dry mouth, dry eyes. Date initiated: 4/19/23. During an interview on 9/16/24 at the ADON (assistant director of nursing) indicated there was no documented rationale available why the diagnosis was given. On 9/16/24 at 11:30 A.M., a policy related to services provided meeting professional standards was requested and unable to be provided. 3.1-35(g)(1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on record review and interview, the facility failed to monitor progression of pressure ulcers and document assessments for 2 of 2 residents reviewed for wound care. (Resident 23 and Resident 18) Findings include: 1. On 9/11/24 at 10:21 A.M., Resident 23's clinical record was reviewed. Resident 23 was admitted on [DATE]. Diagnoses included, but were not limited to, multiple sclerosis and peripheral vascular disease. The most recent Quarterly MDS assessment, dated 8/20/24, indicated Resident 23 was cognitively intact, was dependent on staff for toileting, showers, and transferring, and had two stage four pressure ulcers. Physician orders included, but were not limited to: Right Ischium: Cleanse area with wound cleanser, pat dry, skin prep peri wound, apply Leptospermum Honey and Calcium Alginate to wound bed, cover with bordered dressing every day shift. Start date 8/28/24 Sacral wound: Cleanse with wound cleanser, pat dry, skin prep peri wound, apply Leptospermum honey and Calcium Alginate to slough areas of wound bed, cover with bordered foam dressing every day shift. Start date 8/28/24 Weekly skin assessment. Nurse must go to forms and document skin only assessment. Document any abnormalities, obtain a full set of vital signs at bedtime every Tuesday. Start date 10/17/23 Care plans included, but were not limited to: Alteration in skin integrity: Surgical site/non resolving to right gluteal fold/ischium with history of surgical debridement and closure failure Interventions: air mattress, labs as directed, observe for changes in wounds, notify doctor of changes, observe for pain during, treatment as ordered. (Resident) has a non-healing surgical wound to right gluteal/ischium fold. Assess/record/monitor wound healing every seven days and as needed Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the doctor. The completion of skin assessments for August and September for the following weeks was lacking: 8/5 - 8/11 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/26 - 9/1 9/2 - 9/8 During an interview on 9/13/24 at 1:07 P.M, the ADON indicated a contracted wound physician had started following Resident 23's wound progress at the end of August and staff should still be documenting weekly skin assessments. 2. On 9/10/24 at 10:28 A.M., Resident 18's clinical record was reviewed. Resident 18 was admitted on [DATE]. Diagnoses included, but were not limited to, hemiplegia and hemiparesis. The most recent Quarterly MDS assessment, dated 8/11/24, indicated Resident 18 was cognitively intact and was dependant on staff for toileting, showers, and transferring. Current physician orders included, but were not limited to: Cleanse area to lumbar spine with soap and water. Pat dry. Apply hydrocolloid. every day shift every 5 day(s) 9/5/2024 Cleanse area to thoracic spine with soap and water. Pat dry. Apply hydrocolloid. every day shift every 5 day(s) 9/5/2024 Weekly skin assessment. Nurse must go to forms and document a skin only assessment. Document any abnormalities. Obtain a full set of vital signs at bedtime every Monday. Start date 8/14/23 The clinical record lacked documentation for a wound assessment or rationale why wound treatments were being applied to Resident 18's lumbar and thoracic spine. The clinical record lacked skin only assessments during the following weeks in August and September: 7/29-8/4 8/12-8/18 8/26-9/1 9/2-9/8 During an interview on 9/13/24 at 1:07 P.M., the ADON (assistant director of nursing) indicated no wound documentation for Resident 18 was completed and the dressings were applied for pressure prevention. On 9/16/24 at 11:30 A.M., a policy relating to complete and accurate wound documentation was requested. On 9/16/24 at 1:00 P.M., the regional consultant indicated the facility policy was to follow standard nursing practice and document completely and accurately. 3.1-40(a)(2) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-50(a)(1) 3.1-50(a)(2)

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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** 48057 Based on interview, record review, and observation, the facility failed to provide care, services, and supervision to prevent accidents, lacked thorough and complete assessments post fall, and failed to update interventions after falls for 1 of 6 residents reviewed for falls (Resident 37) and 1 of 1 for unsafe wandering. (Resident 201) Resident 37 experienced an unwitnessed fall and sustained a nose fracture. Findings include: 1. On 9/10/24 at 8:37 A.M., Resident 37's clinical record was reviewed. Resident 37 was admitted on [DATE]. Diagnoses included, but were not limited to, Alzheimer's Disease, anxiety, major depressive disorder, and abnormalities of gait and mobility. A physician order for antipsychotic medication monitoring was started on 4/18/23. A care plan, created on 4/19/23 and last revised on 4/19/23, and indicated (Resident) is risk for falls. Interventions: Be sure (Resident's) call light is within reach and encourage the resident to use it for assistance as needed. Ensure that (Resident) is wearing appropriate footwear non-skid sock or shoes when ambulating or mobilizing in wheelchair. Date initiated: 4/19/23. The care plan did not include documentation to show the care plan was not reviewed or revised after 4/19/23. A care plan, created on 4/19/23, indicated (Resident) uses psychotropic medications. Interventions: Administer psychotropic medications as ordered by physician; monitor for side effects and effectiveness every shift. Consult with pharmacy, physician to consider dosage reduction when clinically appropriate at least quarterly. Monitor/document/report as needed any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking) frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, nausea, vomiting, behavior symptoms not usual to the person. Monitor/record occurrences for target behavior symptoms of auditory and visual hallucination and document per facility protocol. A care plan, created on 4/19/23, indicated (Resident) uses antidepressant medication. Interventions: administer antidepressant medication as ordered by physician. Monitor/document side effects and effectiveness every shift. Educate caregivers about risk, benefits and the side effects and/or toxic symptoms of anti-depressant drugs being given. Monitor and report as needed adverse reactions to antidepressant therapy: change in behavior/mood/cognition, hallucinations/delusions, social isolation, suicidal thoughts, withdrawal, decline in activities of daily living ability, continence, no voiding, constipation, fecal impaction, diarrhea, gait changes, rigid muscles, balance problems, tremors, muscle cramps, falls, dizziness/vertigo, fatigue, insomnia, appetite loss, weight loss, nausea/vomiting, dry mouth, dry eyes. Mirtazapine (an antidepressant medication) Oral Tablet 15 MG Give half a tablet by mouth in the evening related to major depressive disorder single episode was ordered by the physician to start on 2/29/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent Annual MDS (Minimum Data Set) assessment, dated 3/4/24, indicated Resident 37's cognition assessment was not able to be assessed, was completely dependent on staff (staff does all of the effort) for bathing and toileting, and received antipsychotic and antidepressant medications during the assessment period. The eTAR (electronic treatment administration record), dated 5/1/24-5/31/24, indicated Resident 37 experienced no side effects related to antipsychotic medications during the month of May. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 5/29/24, indicated Resident 37 was severely cognitively impaired, was completely dependent on staff (staff does all of the effort) for bathing, toileting, and transfers, and received antipsychotic and antidepressant medications during the assessment period. The eTAR, dated 6/1/24-6/30/24, indicated Resident 37 experienced no side effects related to antipsychotic medications from 6/1/24-6/13/24 (6/14, 6/15, 6/16 day shift were not completed), and had not experienced any side effects from 6/24/24-6/30/24 (6/23, 6/29, 6/30 day shift were not completed). An order note, dated 6/14/24 3:38 P.M., indicated Resident 37's medication olanzapine was increased from 7.5 mg daily to 10 mg daily. Pharmacy relayed drug to drug warning included, but was not limited to: mirtazapine for major depressive disorder. Severity: Moderate Interaction: mirtazapine may enhance the adverse/toxic effect of olanzapine. Specifically, serotonergic agents may enhance dopamine blockade, possibly increasing the risk for neuroleptic malignant syndrome. Olanzapine may enhance the serotonergic effect of Mirtazapine. On 6/15/24, a physician order for sertraline 75 MG Give every day for depression, was started. A nurse's progress note dated 6/16/24 2:44 P.M., indicated Resident was sleeping all day. Attempted to give morning medications, resident was too lethargic to attempt to give and yesterday during day shift resident was pacing the floor and continuously expressing anger and frustration. On 6/16/24, a pharmacist recommendation was made to discontinue medication mirtazapine 15 mg. The discontinuation was declined by the facility. A nurse's progress note, dated 6/24/24 at 3:37 P.M., indicated Resident 37 was pacing in front of nurses station. Fall #1. A nurse's progress note, dated 6/24/24 6:00 P.M., indicated Resident 37 had an unwitnessed fall in the dining room. A document titled Post Fall Evaluation, dated 6/24/24 at 6:09 P.M., indicated Resident 37 was wearing non-skid shoes/socks at the time of the fall. Care plans, post fall evaluation, and progress notes, dated 6/24/24, lacked documentation to indicate a new intervention was put in place immediately post-fall. A fall risk evaluation, dated 6/24/24 at 6:32 P.M., did not include documentation to show staff reviewed the resident's medication, assessed the resident's risk to experience further falls, or implemented immediate interventions to prevent further falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A document titled Neuro Assessment, dated 6/24/24-6/28/24, was missing assessments on 6/25/24 and 6/26/24. The clinical record did not include documentation in progress notes, assessments, or care plans to determine 6/24/24 through 8/1/24 to indicate the fall was discussed by the interdisciplinary team (IDT) to determine cause of the fall, intervention put in place related to the fall, or plan of care updated to prevent further falls. Olanzapine (an antipsychotic medication) Oral Tablet 10 MG Give 10 mg by mouth two times a day for schizophrenia behavior disorder was ordered by the physician to start on 7/12/24. Haloperidol (an antipsychotic medication) five MG Give five mg by mouth every eight hours as needed for psychosis, was ordered by the physician from 7/29/24-8/16/24. Fall #2. A nurses note, dated 8/1/24 at 7:39 P.M., indicated Resident had an unwitnessed fall in the hallway, Resident 37 was wandering and ambulating independently. Resident's nose was bleeding and crooked and had a laceration on the bridge of her nose. Resident 37 was transferred to the hospital. The resident had an unwitnessed fall while ambulating independently in the hallway without the use of a wheelchair. A hospital radiology result, dated 8/1/24 at 9:28 P.M., indicated Resident 37 had acute comminuted (broken in at least two places) and mild to moderate displaced fractures of bilateral nasal bone involving the nasal boney septum. A care plan, initiated on 8/1/24, indicated (Resident) has an actual fall. Interventions: Resident is to have 1:1 monitoring along with referral to PT/OT (physical therapy/occupational therapy) (start on 8/1/24). Offer activities when restless (start on 8/7/24). Staff are to ensure that resident is wearing appropriate footwear when up ambulating (start on 8/10/24). A document titled Post Fall Evaluation, dated 8/2/24 12:25 A.M., indicated Resident 37 was wearing non-skid shoes/socks at the time of the fall. The clinical record lacked an immediate intervention put in place post-fall. A document titled Fall Risk Evaluation, dated 8/2/24 at 12:23 A.M., lacked risk for falls or interventions put in place. Documents titled Resident safety check dated 8/2/24, 8/11/24, 8/12/24, and 8/13/24 were provided by the ADON (assistant director of nursing) on 9/16/24 at 8:46 A.M., were not complete. The clinical record, including care plan, progress notes, and assessments, lacked documentation stating how long Resident 37 should have received one on one monitoring. A hospital provider follow up note, dated 8/9/24 at 12:30 P.M., indicated Resident 37 was seen in office due to nasal bone fracture. The physician indicated he spoke with the Resident's power of attorney (POA), and the POA was unaware Resident 37 was seen in office for discussion of treatment options of possible closed reduction surgery. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fall #3. A post fall evaluation was created on 8/7/24 at 4:45 A.M., that indicated resident was unsupervised and experienced an unwitnessed fall, lacked documentation, related to how the fall occurred, where the fall occurred, if the fall was witnessed, and any interventions put in place post-fall. The progress notes on 8/7/24 did not include documentation to determine how the resident experienced a fall, the specific characteristics of the fall, or to show interventions were immediately implemented to prevent further falls. The most recent Significant Change MDS (Minimum Data Set) assessment, dated 8/14/24, indicated Resident 37's cognition assessment was not able to be assessed, was completely dependent on staff (staff does all of the effort) for eating, bathing, toileting, and transfers, had not had any falls since the prior MDS assessment (5/29/24) and received antipsychotic, antianxiety, antidepressant, hypnotic, and opioid medications during the assessment period. Sertraline (an antidepressant medication) HCl Tablet 100 MG Give one tablet by mouth one time a day for depression was ordered by the physician to start on 8/15/24. Fall #4. A documented titled Neuro Assessment was reviewed on 9/12/24. The clinical record including progress notes and assessments lacked a post fall evaluation, documentation related to how the fall occurred, where the fall occurred, if the fall was witnessed, and an immediate intervention put in place post-fall. The clinical record lacked documentation to indicate the fall was discussed by the interdisciplinary team (IDT) to determine cause of the fall or new fall intervention put in place related to the fall. A nutrition note, dated 8/16/24 at 6:49 P.M., indicated Resident 37 was experiencing significant weight loss and diet was downgraded to mechanical soft/ground per ST (speech therapy) this date during a one-time evaluation review for tolerance of diet consistency related to recent nose fracture. An order on 8/16/24 indicated Resident 37 was admitted to hospice related to Alzheimer's Disease. During an observation on 9/11/24 at 1:13 PM , Resident 37 was laying in bed and the call light was clipped to the privacy curtain, out of reach. On 9/12/24 at 9:48 A.M., the DON indicated a plan of care was not updated after the fall on 6/24/24, and a fall assessment for Resident 37 was not created on 8/10/24. The DON stated that after an unwitnessed fall, an assessment including vitals and a post fall should be completed and neuro checks should be started, and that the interdisciplinary team (IDT) meets every day, and IDT talks about interventions and what needs to be done after a fall, then it should be added to the care plan immediately. The DON indicated that the facility had a falls protocol. During an interview on 9/13/24 at 2:14 P.M., the pharmacist indicated that a resident receiving multiple psychiatric medications should be managed closely by a psychiatrist to review medications often due to the drug to drug interactions, and that Haloperidol would cause drowsiness and can be increased by other antidepressant medications that should be closely monitored for falls. (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 9/16/24 at 9:45 A.M., the ADON provided a document titled Consent to Treat, dated 4/21/23, that indicated Resident 37's POA elected for her to receive psychiatric services, but that Resident 37 had not received any psychiatric services since admission. On 9/16/24 at 12:20 P.M., the Regional Consultant provided a current undated Assessing Falls and Their Causes policy that indicated After a Fall: If a resident has just fallen or is found on the floor without a witness to the event, the nursing staff will record vital signs and evaluate for possible injuries to the head, neck, spine, and extremities . Once an assessment rules out significant injuries, the nursing staff will .document relevant details . Nursing staff will observe for delayed complications of a fall for approximately forty-eight (48) to seventy-two (72) hours after an observed or suspected fall and will document findings in the medical record . An incident report must be completed for resident falls. The incident report form should be completed by the nurse on duty at the time . When a resident falls, the following information should be recorded in the resident's medical record: The condition in which the resident was found . Assessment data, including vital signs and any obvious injuries. Interventions, first aid, or treatment administered. Notification of the physician and family . Completion of a fall risk assessment. Appropriate interventions taken to prevent future falls . 2 . On 9/9/24 at 11:45 A.M., Resident 201 was observed exhibiting exit seeking behaviors by attempting to open the door from the locked unit to the outside. Certified Nursing Aide (CNA) 8 attempted to redirect Resident 201 away from the doors. On 9/9/24 at 11:58 A.M., Resident 201 opened the door between the locked unit and the nurses station. Staff were not present in the hallways of the locked unit or at the nurses station. Resident 201 closed the door and went into the activities room. The door had a keypad on the locked unit side of the door and a manual lock switch on the nurses station side of the door. On 9/9/24 at 12:06 P.M., Resident 201 came out of the activities room and opened the door between the locked unit and the nurses station with the Memory Care Director present. The Memory Care Director texted the Maintenance Director to come fix the lock. On 9/9/24 at 12:18 P.M., the Maintenance Director arrived and turned the manual lock on the nurses station side of the door to lock the door. On 9/9/24 at 12:24 P.M., the Memory Care Director indicated the manual lock had gotten flipped and the door was unlocked from the nurses station side of the door. On 9/11/24 at 10:03 A.M., Resident 201's clinical record was reviewed. Resident 201 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Alzheimer's disease. The Admission Minimum Data Set (MDS) Assessment was still in progress. The Clinical Admission Nursing Assessment, dated 9/3/24, indicated Resident 201 experienced chronic short term memory loss. An Admission Elopement Evaluation, dated 9/3/24, indicated Resident 201 had a low risk of elopement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record lacked care plans relating to wandering and exit seeking behaviors. Nursing progress notes between 9/4/24 at 5:19 A.M. and 9/6/24 at 6:02 A.M., documented four separate occasions that Resident 201 was wandering and had exit seeking behaviors. The resident was described as wandering per usual behavior and becoming agitated, and exit seeking at doors to enter other unit. On 9/12/24 at 2:23 P.M., the Social Services Director (SSD) indicated that a resident would be care planned for wandering and exit seeking behaviors when it became excessive, or it occurred daily. On 9/16/24 at 12:03 P.M., the Maintenance Director indicated the latch to the door could have easily been knocked open with a staff member's thumb. At that time, the latch was observed to be secure, did not easily move, and needed to be fully turned to unlock the door. On 9/16/24 at 12:20 P.M., the Regional Consultant provided a current Elopements and Wandering Residents policy, dated 2/1/2024, that indicated The facility is equipped with door locks/alarms to help avoid elopements . Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to proper staff. Adequate supervision will be provided to help prevent accidents and elopements. On 9/16/24 at 12:20 P.M., the Regional Consultant provided a current undated Dementia Care - Clinical Protocol policy that indicated Care should be provided to the residents to provide quality of life even with dementia. Care includes but is not limited to .managing behavior . 3.1-45(a)(1) 3.1-45(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** 48147 Based on observation, interview, and record review, the facility failed to ensure oxygen equipment was properly labeled and respiratory services were provided according to the care plan for 2 of 3 residents reviewed for respiratory care. (Resident 15 and Resident 11) Findings include: 1. On 9/9/24 at 10:53 A.M., Resident 15 was observed receiving 3 Liters (L) of oxygen via nasal cannula. There was no date on the oxygen tubing or humidification bottle. An oxygen tubing storage bag was not observed in the resident's room. On 9/10/24 at 10:40 A.M., Resident 15 was not in her room. The oxygen concentrator was turned on to 3L and the nasal cannula tubing was lying across the resident's recliner. There was an oxygen tubing bag attached to the concentrator with no date. There was no date on the oxygen tubing. The date on the humidification bottle was 9/8/24. On 9/10/24 at 10:53 A.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, chronic respiratory failure with hypercapnia and chronic obstructive pulmonary disease (COPD). The most current Admission Minimum Data Set (MDS) Assessment, dated 8/25/24, indicated Resident 15 was cognitively intact, required partial to moderate assistance of staff (staff does less than half) for bed mobility, transfers, toileting, and bathing, and received oxygen. A current potential for impaired gas exchanged care plan, dated 8/3/24, included an intervention to administer oxygen as ordered. Current physician orders included, but were not limited to: Oxygen 3L via nasal cannula, dated 8/22/24 The clinical record lacked an order to change the oxygen tubing and humidification bottle. 2. On 9/12/24 at 8:45 A.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease) and systemic lupus The current Quarterly MDS assessment dated [DATE] indicated Resident 11 was cognitively intact. The resident was dependent for transferring, toileting, and dressing. The resident also has an indwelling catheter. Current physician orders lacked an order for pulse oximetry. The current care indicated Resident 11 was at risk for impaired gas exchange and had an intervention for pulse oximetry bid (two times daily). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 9:00 A.M., the vital sign record of pulse oximetry indicated that the pulse ox was not being implemented twice a day review as follows: 9/10/2024 11:29 95.0% Room Air 9/4/2024 16:59 92.0% Room Air 8/28/2024 19:50 95.0% Room Air 8/28/2024 17:25 95.0% Room Air 8/17/2024 13:17 95.0% Room Air 8/4/2024 16:50 95.0% Room Air 7/21/2024 22:39 97.0% Room Air 7/20/2024 22:13 96.0% Room Air 7/19/2024 23:19 94.0% Room Air 7/17/2024 14:04 96.0% Room Air 7/17/2024 14:03 96.0% Room Air 7/3/2024 14:14 95.0% Room Air During an interview on 9/12/24 at 9:40 A.M.,the DON (Director of Nursing) indicated the care plan should be followed. On 9/12/24 at 1:35 P.M., the Assistant Director of Nursing (ADON) indicated that oxygen tubing and humidification bottles got changed out weekly, usually every Monday. The Infection Preventionist or a Certified Nurse Aid (CNA) did it. The facility did not have a system to document it had been done or a place where it was monitored in the TAR (Treatment Administration Record). Staff was supposed to check the dates on the equipment and make sure it got done. On 9/16/24 at 12:20 P.M., the Regional Consultant provided an undated Oxygen Administration policy that indicated Change nasal cannula weekly or PRN (as needed). Change the humidified prefilled bottle once the contents are consumed. For non-prefilled humidifier bottles, change weekly. If the oxygen tubing/facemask or nasal cannula is not being used, properly store it in a clean plastic bag. 3.1-47(a)(6)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 48147 Based on interview and record review, the facility failed to provide ongoing assessment of the resident's condition and monitoring for complications of dialysis by completing Pre Dialysis Assessments, Post Dialysis Assessments, and Dialysis Communication Records for 1 of 1 residents reviewed for dialysis management. (Resident 15) Finding includes: On 9/9/24 at 10:51 A.M., Resident 15 indicated she went to dialysis every Tuesday, Thursday, and Saturday, and sometimes received an extra dialysis session during the week. On 9/10/24 at 10:53 A.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, end stage renal disease. The most current Admission Minimum Data Set (MDS) Assessment, dated 8/25/24, indicated Resident 15 was cognitively intact, required partial to moderate assistance of staff (staff does less than half) for toileting, and received dialysis. A current hemodialysis care plan, dated 8/3/23, indicated Resident 15 received dialysis related to renal failure. Current physician orders included, but were not limited to: Dialysis 3x per week on Tuesday, Thursday and Saturday at 9:30 A.M. for decreased renal function, dated 8/3/24 Nurse to go to N Adv Pre/Post Dialysis Assessment listed under forms tab and complete before and after dialysis two times a day every Tuesday, Thursday, and Saturday for dialysis, dated 8/1/24 The August and September 2024 Medication Administration Record (MAR) indicated the N Adv Pre/Post Dialysis Form had been completed as ordered. The clinical record lacked completed N Adv Pre/Post Dialysis Forms on the following days: 8/8/24 - pre and post 8/20/24 - post 8/22/24 - post 8/24/24 - pre and post 8/27 - post 8/29 - post (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/31 - pre and post 9/3 - pre and post 9/5 - pre and post 9/7 - pre and post 9/10 - pre and post The clinical record lacked completed Dialysis Communication Records forms on the following days: 8/3/24 - facility to complete upon return from dialysis section 8/6/24 - facility to complete upon return from dialysis section 8/8/24 - all sections 8/20/24 - all sections 8/22/24 - facility to complete upon return from dialysis section 8/24/24 - all sections 8/27 - all sections 8/29 - dialysis center to complete for facility and facility to complete upon return from dialysis sections 9/3 - all sections 9/5 - all sections 9/7 - facility to complete upon return from dialysis section 9/9 - facility to complete upon return from dialysis section 9/10 - dialysis center to complete for facility and facility to complete upon return from dialysis sections On 9/11/24 at 11:00 A.M., the Assistant Director of Nursing (ADON) provided all Dialysis Communication Record forms. At that time, she indicated Resident 15 was in the hospital from 8/10/24 to 8/19/24 so there were no forms completed during that time. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 1:35 P.M., the ADON indicated staff were supposed to complete the Pre and Post Dialysis Forms. If they were marking it done on the MAR, then the forms should be documented under the forms tab of the clinical record. If they were not there, staff were marking it complete when they hadn't been done. At that time, she indicated staff should complete all parts of the Dialysis Communication Record. On 9/16/24 at 12:20 P.M., the Regional Consultant provided a current Hemodialysis policy, dated 3/24/2023, that indicated The facility will coordinate and collaborate with the dialysis facility to assure that . documentation requirements are met to assure that treatments are provided as ordered by the nephrologist, attending practitioner, and dialysis team; and There is ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff . The licensed nurse will communicate to the dialysis facility via .written format, such as a dialysis communication form or other form . The nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications . the QAA committee should review the facility's dialysis care and service on an ongoing bases including: the communication, training, supervision and care coordination between the facility and the participating dialysis facility . and Communication and coordination between the facility and the dialysis facility in sharing data about outcomes and processes and reviewing quality indicators and care issues. 3.1-37(a)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview, record review, and observation, the facility failed to ensure medication side effects were properly monitored and pharmacy recommendations were considered for 1 of 5 Residents reviewed for unnecessary medications. (Resident 37) Finding includes: On 9/10/24 at 8:37 A.M., Resident 37's clinical record was reviewed. Resident 37 was admitted on [DATE]. Diagnoses included, but were not limited to, Alzheimer's Disease, anxiety, major depressive disorder, and visual/auditory hallucinations. The most recent Significant Change MDS (Minimum Data Set) assessment, dated 8/14/24, indicated Resident 37's cognition was below measurable, was completely dependent on staff for eating, bathing, toileting, and transfers, and was receiving antipsychotic, antianxiety, antidepressant, hypnotic, and opioid medications during the seven day lookback period. Physician orders included, but were not limited to: Lorazepam Oral Concentrate 2 MG/ML (milligrams/milliliter) Give 0.25 mL by mouth every 2 hours as needed for anxiety/restlessness. Resident on hospice services with less than 6 months life expectancy. Start date 9/2/24 Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.25 ml by mouth every 2 hours as needed for Pain/SOB (shortness of breath). Start date 9/2/24 Olanzapine Oral Tablet 10 MG Give 10 mg by mouth two times a day for schizophrenia behavior disorder. Start date 7/12/24 Mirtazapine Oral Tablet 15 MG Give 0.5 tablet by mouth in the evening related to major depressive disorder single episode. Start date 2/29/24 Sertraline HCl Tablet 100 MG Give 1 tablet by mouth one time a day for depression. Start date 8/15/24 Haloperidol 5 MG Give 5 mg by mouth every 8 hours as needed for psychosis. 7/29/24-8/16/24 Antipsychotic medication monitoring, Start date 4/18/23 Care plans included, but were not limited to: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Resident) uses psychotropic medications. Interventions: Administer psychotropic medications as ordered by physician; monitor for side effects and effectiveness every shift. Consult with pharmacy, physician to consider dosage reduction when clinically appropriate at least quarterly. Monitor/document/report as needed any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking) frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, nausea, vomiting, behavior symptoms not usual to the person. Monitor/record occurrences for target behavior symptoms of auditory and visual hallucination and document per facility protocol. Date initiated: 4/19/23 (Resident) uses antidepressant medication. Interventions: administer antidepressant medication as ordered by physician. Monitor/document side effects and effectiveness every shift. Educate caregivers about risk, benefits and the side effects and/or toxic symptoms of anti-depressant drugs being given. Monitor and report as needed adverse reactions to antidepressant therapy: change in behavior/mood/cognition, hallucinations/delusions, social isolation, suicidal thoughts, withdrawal, decline in activities of daily living ability, continence, no voiding, constipation, fecal impaction, diarrhea, gait changes, rigid muscles, balance problems, tremors, muscle cramps, falls, dizziness/vertigo, fatigue, insomnia, appetite loss, weight loss, nausea/vomiting, dry mouth, dry eyes. Date initiated: 4/19/23 The eTAR (electronic treatment administration record), dated 5/1/24-5/31/24, indicated Resident 37 experienced no side effects related to antipsychotic medications during the month of May. The eTAR, dated 6/1/24-6/30/24, indicated Resident 37 experienced no side effects related to antipsychotic medications from 6/1/24-6/13/24 (6/14, 6/15, 6/16 day shift were not completed). According to documentation in the eTAR, Resident 37 had not experienced side effects related to antipsychotic medication for months prior to dosage increases and adding new antipsychotic medications. An order note, dated 6/14/24 3:38 P.M., indicated Resident 37's medication Olanzapine was increased from 7.5 mg daily to 10 mg daily. Drug to drug warning included, but was not limited to: Mirtazapine Oral Tablet 15 MG for major depressive disorder. Severity: Moderate Interaction: Mirtazapine Oral Tablet 15 MG may enhance the adverse/toxic effect of Olanzapine Oral tablet. Specifically, serotonergic agents may enhance dopamine blockade, possibly increasing the risk for neuroleptic malignant syndrome. Olanzapine Oral Tablet 5 MG may enhance the serotonergic effect of Mirtazapine Oral Tablet 15 MG. This could result in serotonin syndrome. On 6/15/24, a physician order for Sertraline 75 MG Give every day for depression, was started. A nurse's progress note dated 6/16/24 2:44 P.M., indicated Resident was sleeping all day. Attempted to give morning medications, resident was too lethargic to attempt to give. Yesterday during day shift resident was pacing the floor and continuously expressing anger and frustration. On 6/16/24, a pharmacist recommendation was made to discontinue medication mirtazapine 15 mg. The discontinuation was declined by the facility. The facility did not have a physician signed Gradual Dose Reduction (GDR) for that pharmacy recommendation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's progress note, dated 6/24/24 at 3:37 P.M., indicated Resident 37 was pacing in front of nurses station. A nurse's progress note, dated 6/25/24 2:36 P.M., indicated (Resident) sleeping less, continuous pacing, cussing at staff, unusual behavior for this resident. A nurse's progress note, dated 6/26/24 at 10:55 A.M., indicated Resident is crying and restless, she thinks there are people trying to kill her. Wandering throughout facility. A nurse's progress note, dated 7/4/24 1:15 P.M., indicated during lunch Resident was anxious and ate very poorly. A nurse's progress note, dated 7/4/24 at 6:05 P.M., indicated resident continued to have increased tearfulness and continued to wander the halls. An administration note, dated 7/11/24 3:22 P.M., indicated Resident 37 continued to pace the halls anxiously. A physician order note, dated 7/12/24 at 4:07 P.M., indicated Resident 37's medication Olanzapine was increased from 10 mg daily to 20 mg daily. Drug to drug warning from pharmacy included but was not limited to: Mirtazapine 15 MG for major depressive disorder. Severity: Moderate Interaction: Mirtazapine may enhance the adverse/toxic effect of Olanzapine. Specifically, serotonergic agents may enhance dopamine blockade, possibly increasing the risk for neuroleptic malignant syndrome. Olanzapine may enhance the serotonergic effect of Mirtazapine. This could result in serotonin syndrome. Sertraline HCl 75 MG one time a day for depression. Severity: Moderate Interaction: Mirtazapine and Sertraline HCl may enhance the adverse/toxic effect of Olanzapine. Specifically, serotonergic agents may enhance dopamine blockade, possibly increasing the risk for neuroleptic malignant syndrome. Olanzapine may enhance the serotonergic effect of Mirtazapine and Sertraline. This could result in serotonin syndrome. A nurse's progress note, dated 7/16/24 at 12:19 P.M., indicated Resident was resting in bed when it was noted by roommates' family that her cheeks appeared to be red. Upon walking in residents' room, resident was lying in bed eyes closed. Opened upon verbal stimuli, difficulty obtaining O2 (oxygen) saturation, resident was dressed and assisted out of bed. After ambulating halls, vitals were rechecked, O2 at 81% room air. Nurse practitioner saw resident for concerns and ordered STAT labs. Urine sample sent was accidentally sent without identifiers. A nurse's progress note, dated 7/16/24 at 7:25 P.M., indicated Resident intermittently tearful, resident seems paranoid, talking to herself at time. Auditory and visual hallucinations, wandering more than usual today. The clinical lacked any new assessment or progress note related to monitoring side effects from 7/16/24 to 7/25/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's progress note, dated 7/25/24 at 12:56 P.M., indicated throughout the day resident wandered the hallway speaking nonsensical speech. An order administration note, dated 7/25/24 at 10:07 P.M., indicated Resident 37 was constantly pacing in the hall and was restless most of the night shift. The clinical lacked any new assessment or progress note indicating side effects of medications from 7/25/24 to 7/29/24. A nurse's progress note, dated 7/29/24 at 12:21 P.M., indicated physician called for orders related to Resident is crying off and on, drooling, auditory and visual hallucinations. An physician order note, dated 7/29/24 at 12:32 P.M., indicated Resident 37 was to start a new medication Haloperidol Tablet 5 MG, Give 5 mg by mouth every 8 hours as needed for psychosis. Drug to drug warning from pharmacy included but was not limited to: Olanzapine for schizophrenia behavior disorder. Severity: Moderate Sertraline HCl for depression Severity: Moderate Interaction: Plasma concentrations and pharmacologic effects of Haloperidol may be increased by Sertraline. Haloperidol toxicity and other symptoms similar to serotonin syndrome may occur. A progress note, dated 7/29/24 at 1:48 P.M., indicated Resident tearful, drooling frequently, crying at times, auditory and visual hallucinations. A nurse practitioner order note, dated 7/30/24 at 11:14 A.M., indicated Resident 37's medication Sertraline was increased from 75 mg daily to 100 mg daily. Drug to drug warning from pharmacy included but was not limited to: Olanzapine for schizophrenia behavior disorder. Severity: Moderate Mirtazapine and Sertraline may enhance the adverse/toxic effect of Olanzapine. Specifically, serotonergic agents may enhance dopamine blockade, possibly increasing the risk for neuroleptic malignant syndrome. Olanzapine may enhance the serotonergic effect of Mirtazapine and Sertraline. This could result in serotonin syndrome. Haloperidol for psychosis. Severity: Moderate Interaction: Plasma concentrations and pharmacologic effects of Haloperidol may be increased by Sertraline. Haloperidol toxicity and other symptoms similar to serotonin syndrome may occur. Mirtazapine for major depressive disorder. Severity: Severe Interaction: Additive serotonergic effects may occur during co-administration of selective serotonin re-uptake inhibitors (SSRIs) and Mirtazapine and the risk of developing serotonin syndrome may be increased. A nurses note, dated 7/30/24 9:59 P.M., indicated Resident was tearful knocking on window of nurse's station and was anxious; Haloperidol 5 mg was administered. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurses note. dated on 7/31/24 at 7:39 A.M., indicated Resident is continuing to drool and spit, having hallucinations, and is trying to get what is in her mouth out. The eMAR (electronic medical record) indicated Resident 37 was given Haloperidol on 8/1/24 at 8:30 A.M. because she was pacing the halls, hollering nonsensical speech, and was too anxious to sit down and eat. A social service note, dated 8/2/24 at 12:29 P.M., indicated Resident was on 1:1 monitoring due to safety. The eMAR indicated Resident 37 was given Haloperidol on 8/3/24 at 1:08 P.M.; the clinical record lacked indication for medication administration. The eMAR indicated Resident 37 was given Haloperidol on 8/4/24 at 8:20 P.M. due to hallucinations and agitation. Documents titled Resident safety check dated 8/2/24, 8/11/24, 8/12/24, and 8/13/24 were provided by the ADON (assistant director of nursing) on 9/16/24 at 8:46 A.M., were not completed. The eMAR indicated Resident 37 was given Haloperidol on 8/9/24 at 9:46 A.M. due to hallucinations. The eMAR indicated Resident 37 was given Haloperidol on 8/12/24 at 7:18 P.M. due to psychosis but did not specify what symptoms of psychosis. During an interview on 9/13/24 at 2:14 P.M., the pharmacist indicated the medications Resident 37 was receiving could have contributed to the symptoms of serotonin syndrome, that a resident receiving multiple psych medications should be managed closely by a psychiatrist to review medications often due to the drug to drug interactions, and that Haloperidol would cause drowsiness and can be increased by other SSRI medications that should be closely monitored for falls. During an interview on 9/13/24 at 1:07 P.M., the ADON (assistant director of nursing) indicated there were no pharmacy recommendations for GDR (gradual dose reduction) previous to February 2024 available for review because the previous DON (director of nursing) had not been keeping them, and some GDR suggestions were not signed because the physician was refusing to sign GDR's for a period of time. During an interview on 9/16/24 at 9:45 A.M., the ADON provided a document titled Consent to Treat, dated 4/21/23, that indicated Resident 37's POA elected for her to receive psychiatric services, but that Resident 37 had not received any psychiatric services since admission. On 9/16/24 at 12:30 P.M., the regional consultant provided a policy titled Behavior Monitoring that indicated The nursing staff and the physician/nurse practitioner will monitor for side effects and complications related to the psychoactive medications, for example, lethargy, abnormal involuntary movements, anorexia, or recurrent falling. 3.1-48(a)(6)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48147 Based on interview and record review, the facility failed to ensure an intravenous (IV) antibiotic was administered in accordance with physician orders for 1 of 1 resident reviewed for IV therapy. This deficient practice resulted in a resident being re-hospitalized to receive intravenous (IV) antibiotics. (Resident R) Finding includes: On 9/12/24 at 1:28 P.M., Resident R's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus, and bacteremia. The most current Annual Minimum Data Set (MDS) Assessment, dated 5/14/24, indicated Resident R was cognitively intact, required setup assistance of staff to eat, and was not receiving IV therapy. The most current Quarterly MDS Assessment, dated 6/30/24, indicated Resident R had severe cognitive impairment, required supervision of staff to eat, and was not receiving IV therapy. Nursing progress notes from 9/1/24 at 2:28 P.M. to 9/3/24 at 12:22 P.M. indicated R was sent to the hospital on 9/1/24 for evaluation and treatment of pneumonia. Resident R returned to the facility on [DATE] at 11:45 A.M. without any antibiotic orders. A Nursing progress note dated 9/4/24 at 10:03 A.M., the hospital lab notified the facility that Resident R's blood culture results indicated the resident had bacteremia (an infection of bacteria in the blood). Nursing progress notes lacked documentation that staff notified the physician of the blood culture results. A physician's order for ertapenem sodium (an antibiotic) 1 gram one time a day via midline IV was entered on 9/5/24 at 8:10 P.M. with a start date of 9/7/24 at 9:00 A.M. A September 2024 Order Recapitulation lacked orders for IV placement, IV maintenance, IV flushing, and dressing change. A midline IV (a flexible tube inserted into a vein in the upper arm to provide intravenous treatment) insertion record from the outside company who placed the IV, dated 9/5/24, indicated the midline was placed in Resident R's left upper arm on 9/5/24 at 9:40 P.M. Nursing progress notes between 9/5/24 at 10:52 P.M. and 9/7/24 at 12:57 A.M. did not include an assessment of Resident R's midline IV or to show the resident was adequately monitored for signs and symptoms of bacteremia. A Nursing progress note, dated 9/7/24 at 12:57 A.M., indicated Resident R's midline IV flushed easily, had no symptoms of inflammation, and that the dressing was dry and intact. The clinical record did not document what substance was used to flush the IV, or the amount used. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Medication Administration Note, dated 9/7/24 at 9:38 A.M., indicated the ertapenem sodium antibiotic was not delivered to the facility and a nurse would need to contact the pharmacy. Nursing progress notes between 9/7/24 at 9:38 A.M. and 9/7/24 at 6:09 P.M. did not indicate staff notified the physician that the antibiotics did not come, communicated with the pharmacy about the antibiotics, or showed the resident was adequately monitored for signs and symptoms of bacteremia. A Nursing progress note, dated 9/7/24 at 6:09 P.M., indicated the resident was transported to the hospital for evaluation due to blood culture results. The Hospital Physician's Report, dated 9/12/24, indicated Resident R was brought to the emergency roiagnom on [DATE] to receive IV antibiotics ordered while the resident was living at the facility to treat a blood culture that was positive for Klebsiella pneumoniae. The resident's son contacted the physician because the resident had a midline IV placed at the facility, but the antibiotic was never started. The physician contacted the facility to order the resident be sent to the emergency room so the IV antibiotics could be started. The resident had no signs or symptoms of sepsis upon admission to the hospital; however, the resident refused all labs so there was no way to monitor the resident. IV antibiotics were started, but the patient was concerned with discharging back to the facility prior to completion of the IV antibiotic therapy. The resident was discharged back to the facility after the IV antibiotics were completed on 9/12/24 with orders for an oral antibiotic. On 9/13/24 at 10:00 A.M., the ADON indicated she was not sure why the order for IV antibiotics was entered on 9/5/24 with a start dated of 9/7/24 because antibiotics were usually started right away. She indicated the nurse who entered the order probably entered the wrong start date. At that time, she indicated that the pharmacy sent new medications before the start date. She was unsure why Resident R's IV antibiotic was not at the facility before the erroneously transcribed start date of 9/7/24. On 9/13/24 at 10:40 A.M., the Director of Nursing (DON) indicated there were no orders for the IV, to flush the IV, or to change the dressing. On 9/13/24 at 1:05 P.M., Resident R indicated she just got back from the hospital. She was hospitalized because the facility did not give her antibiotics that were ordered for a blood infection. She told her son that he needed to call the Doctor because she felt like she was about to die. She received the antibiotics in the hospital and felt better now. On 9/13/24 at 1:07 P.M., the Assistant Director of Nursing (ADON) indicated there was no documentation indicating staff notified the physician of the blood culture results or orders were received. During a confidential interview on 9/13/24 at 1:16 P.M., it was indicated that Resident R's doctor gave orders for an antibiotic to treat sepsis while the resident was in the facility, and the resident never received the antibiotic. The resident was re-hospitalized to receive the antibiotic. On 9/16/24 at 8:57 A.M., the ADON indicated that antibiotics should be started immediately after the order was given. The pharmacy delivered medications every day and if medications are not received, nursing staff should call the pharmacy and the Doctor. All documentation related to IV therapy monitoring, including but not limited to adverse side effects and vital signs, are documented in Nursing progress notes. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/16/24 at 12:20 P.M., the Regional Consultant provided a current Routine Intravenous Catheter Care and Infusion Site Care policy, dated 3/20, that indicated Peripheral IV site, unless ordered by the physician, the following are recommended but not limited to: If not in use, flush the catheter with 5 ml (milliliters) of normal saline every 12 hours. On 9/16/24 at 12:20 P.M., the Regional Consultant provided a current Notification of Changes policy, dated 11/19/2023, that indicated The facility must .consult with the resident's physician .when there is a change requiring such notification. Circumstances requiring notification include: .Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: Life-threatening conditions or clinical complications. Circumstances that require a need to alter treatment. This may include New treatment . On 9/16/24 at 1:00 P.M., the Regional Consultant indicated the facility did not have a policy for Documentation Requirements. It was the facility's policy that staff follow standard nursing practice and document accurately and completely. On 9/16/24 at 1:01 P.M., the Regional Consultant provided a current Pharmacy Services policy, dated 4/16/2024, that indicated The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice . The pharmacist is responsible for helping the facility obtain and maintain timely and appropriate pharmaceutical services that support resident's' healthcare needs, goals and quality of life that are consistent with current standards of practice and meet state and federal requirements . The pharmacist, in collaborate with the facility and medical director, should include within its services to . Strive to assure that medications are requested, received, and administered in a timely manner as ordered by the authorized prescriber (in accordance with state requirements) . This citation related to complaint IN00443107. 3.1-25(a) 3.1-47(a)(2)

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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. 48147 Based on observation, interview, and record review, the facility failed to ensure proper storage of medications for 3 of 3 medication carts, 1 of 1 treatment cart, and 1 of 1 medication storage room observed. Loose pills were observed in the medication cart drawers, medication was not labeled, and medication room refrigerator temperature logs were not completed. (200-M Hall, 400 Hall, 300 Hall, [NAME] Medication Storage Room) Findings include: 1. On 9/9/24 at 9:18 A.M., the 200-M Hall medication cart was reviewed. The following loose pills were observed in the bottom of the drawers: 1 white circle pill with marking TCL 340 1 white circle pill with marking 44 157 2. On 9/9/24 at 9:23 A.M., the 200-M Hall treatment cart was reviewed. The following items were observed opened, without labels, and not in a resident bag: Triple Antibiotic Ointment Ready Prep Therahoney Gel At that time, Licensed Practical Nurse (LPN) 10 indicated that once house stock items were opened, they were stored in individual resident bags. 3. On 9/9/24 at 9:58 A.M., the 400 Hall medication cart was reviewed. The following items were observed without a label: clinical treatment antifungal powder 4. On 9/9/24 at 10:00 A.M., the 300 Hall medication cart was reviewed. The following loose pills were observed in the bottom of the drawers: 1 white oval pill with marking m10 1 white circle pill with marking 300 .5 red oval pill with marking 252 A bottle of Tylenol was observed in the cart with no resident name or label. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time, LPN 15 indicated that the bottle of Tylenol needed a label, and she would get one printed off for it. 5. On 9/10/24 at 9:13 A.M., the [NAME] medication storage room was reviewed. The September 2024 refrigerator temperature log was observed on the locked refrigerator. Temperatures were not recorded on 9/2, 9/4, 9/5, 9/7, 9/8, and 9/9. At that time LPN 10 indicated the log got filled out by a nurse or whoever remembered to fill it out. On 9/12/24 at 1:35 P.M., the Assistant Director of Nursing (ADON) indicated either the nurses or the Qualified Medication Aides (QMA) would clean out the medication carts. On 9/16/24 at 12:20 P.M., the Regional Consultant provided a current Medication Storage policy, dated 5/30/2023, that indicated It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations . Refrigerated Products: Temperatures are maintained within 36-46 degrees F (Fahrenheit). Charts are kept on each refrigerator and temperature levels are recorded daily by the charge nurse or other designee . The pharmacy and all medication rooms are routinely inspected by the consultant pharmacy for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed . On 9/16/24 at 12:20 P.M., the Regional Consultant provided a current Labeling of Medications and Biologicals policy, dated 4/16/2024, that indicated All medications and biologicals used in the facility will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices . Labels for individual drug containers must include: the resident's name; the prescribing physician's name; the medication name (generic and/or brand name); the prescribed dose, strength, and quantity of the medication; the prescription number (if applicable); the date the drug was dispensed; appropriate instructions and precautions .; the expiration date when applicable; the route of administration . Labels for medications designed for multiple administrations .the label will identify the specific resident for whom it was prescribed. 3.1-25(j) 3.1-25(l) 3.1-25(m)

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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. 48057 Based on observation, interview, and record review, the facility failed to ensure food was stored, labeled, and dated properly in accordance with professional standards for food service and ensure chemical sanitization was monitored for 2 of 2 kitchen observations. Findings include: On 9/9/24 at 8:57 A.M., an initial tour of the kitchen was conducted. The following items were observed: In the dry storage area,1 bottle apple cider vinegar labeled open 1/24/24 use by 4/24/24 In the walk in freezer: 1 bag of spanish rice labeled 5/14/24 use by 6/14/24 2 bags of coffee cake; 1 labeled 7/24/24 use by 8/24/24 and 1 with no dates/label 4 plastic containers labeled jalapeno's 8/16 use by 8/20 1 plastic container with foil covering top labeled tomatoes 8/13 to 8/18 1 unlabeled/undated package of raw meat 1 bag labeled pizza sauce 6/29 use 7/29 1 bag labeled biscuits 7/23/24 use 8/23/24 In the walk in fridge: 2 unlabeled/undated pitcher of brown liquid 2 unlabeled/undated pitchers of orange liquid 2 unlabeled/undated pitchers orange juice 1 box of black bananas with no dates 1 unlabeled/undated ketchup bottle 1 unlabeled/undated mustard bottle 1 bottle labeled ketchup 8/23 use by 8/26 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 bottle ketchup labeled 8/23 During an observation on 9/11/24 at 9:50 A.M., the following was observed: In the walk in freezer: 1 bag of spanish rice labeled 5/14/24 use by 6/14/24 2 bags of coffee cake; 1 labeled 7/24/24 use by 8/24/24 and 1 with no dates/label 4 plastic containers labeled jalapeno's 8/16 use by 8/20 1 plastic container with foil covering top labeled tomatoes 8/13 to 8/18 1 unlabeled/undated package of raw meat 1 bag labeled pizza sauce dated 12/21 1 bag labeled biscuits 7/23/24 use 8/23/24 In the walk in fridge: 1 box of black bananas with no dates 1 unlabeled/undated pitcher of orange juice 2 unlabeled/undated pitchers of red liquid During an interview on 9/9/24 9:35 A.M., the kitchen manager indicated the high temperature dishwasher was used for washing most items, but handwashed items were washed in the three compartment sink. The kitchen manager used a chemical test strip to test the sanitization level and indicated the kitchen staff did not keep a log of test results. On 9/16/24 at 12:45 P.M., the regional consultant provided a document titled Date Marking for Food Safety, dated 4/16/24, that indicated Refrigerated, ready to eat, time/temperature control for safety food shall be held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. On 9/16/24 at 12:45 P.M., the regional consultant provided a document titled Manual Warewashing 3 Compartment Sink, dated 4/9/24, that indicated Sanitization solution shall be tested by a test kit or other device that accurately measures the concentration in MG/L. Testing will occur periodically but not limited to: When the sink is initially filled, at least once per shift, with extended use, and as needed. 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758 Based on record review and interview, the facility failed to ensure the documentation was completed and accurate for 5 of 6 residents reviewed for accuaracy of falls documentation. (Resident 9, Resident 12, Resident 19, Resident 7, Resident 11) Findings include: 1.On 9/11/24 at 10:28 A.M., Resident 9's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 9/7/24, indicated Resident 9 was not assessed for cognitive impairment because the resident was rarely or never understood, required partial to moderate assistance of staff (staff does less than half) for transfers, and had no falls since the prior assessment. A falls risk assessment, dated 9/13/23, indicated the resident was at high risk for falls. A potential for falls and injuries care plan, dated 6/23/21, included the intervention ensure well lit/clutter free area. Fall 1: On 10/7/23 at 6:15 P.M., Resident 9 had a witnessed fall. The resident was standing in the hallway by the nurses station and another resident ran into her with their walker. The resident sustained an abrasion to her back. The clinical record lacked documentation to indicate the fall was discussed by the Interdisciplinary Team (IDT). The care plan was not updated with a new intervention. A falls risk assessment, dated 10/17/23, indicated the resident was at high risk for falls. Fall 2: On 3/18/24 at 5:25 A.M., Resident 9 had an unwitnessed fall while attempting to self-toilet. The clinical record lacked documented neuro checks. The clinical record lacked documentation to indicate the fall was discussed by the IDT. A current Actual Falls care plan, initiated 3/18/24 and revised 8/16/24, indicated the resident had actual falls on 3/18/24, 5/14/24, and 8/16/24. The intervention [Resident 9] is to have a nightlight in her room was added to the care plan on 3/19/24. A falls risk assessment, dated 3/18/24, indicated the resident was at high risk for falls. Fall 3: On 5/14/24 at 2:32 A.M., Resident 9 had an unwitnessed fall while wandering around the hallway in her socks. The clinical record lacked documented neuro checks. The clinical record lacked documentation to indicate the fall was discussed by the IDT. The intervention Staff are to ensure that resident has non-skid socks when not wearing shoes was added to the care plan on 5/15/24. A falls risk assessment, dated 5/14/24, indicated the resident was at high risk for falls. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fall 4: A Nursing progress note, dated 8/9/24 at 6:00 A.M., indicated Resident 9 had a small tear on a finger on her right hand due to a fall that occurred on 8/8/24. The clinical record lacked facility documentation of the fall on 8/8/24. The clinical record lacked a Post Fall Evaluation for the fall that occurred on 8/8/24. The clinical record lacked documented neuro checks. The clinical record lacked documentation to indicate the fall was discussed by the IDT. The intervention Resident is not to be left unattended by staff when toileting was added to the care plan on 8/8/24. On 9/12/24 at 11:33 A.M., the Assistant Director of Nursing (ADON) indicated there was no fall evaluation for the fall that occurred on 8/8/24, and no documented neuro checks for the falls that occurred on 3/18/24, 5/14/24, and 8/8/24. 2. On 9/10/24 at 10:42 A.M., Resident 12 was observed in the activities room on the locked unit sitting in her wheelchair with a purple bruise on the right side of her face covering her temple, eye, and cheekbone. On 9/11/24 at 11:26 A.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most current Annual Minimum Data Set (MDS) Assessment, dated 6/17/24, indicated Resident 12 had severe cognitive impairment, required supervision of staff for transfers, was independent in walking, did not use mobility devices, and had no falls since the prior assessment. A fall risk assessment, dated 9/29/23, indicated the resident was at low risk for falls. A risk for falls, dated 8/3/23, included the interventions anticipate needs, call light in reach, and footwear. A potential for a fall incident care plan, dated 10/17/23, that included the interventions assist with transfers, free of clutter, assist with adl (activities of daily living) care, and nonskid footwear. Fall 1: On 2/5/24 at 8:40 P.M., Resident 12 had an unwitnessed fall while attempting to self-toilet. The resident sustained a right eyelid laceration and a right facial bruise. An Interdisciplinary Team (IDT) note, dated 2/6/24 at 2:51 P.M., indicated the fall was discussed on 2/6/24 and the care plan had been updated. The intervention Motion sensored [sic] night light placed in resident room was added to the care plan on 2/20/24, two weeks after the IDT met. Fall 2: On 3/16/24 at 7:25 P.M., Resident 12 had an unwitnessed fall while adjusting the window blinds in the dining room. The clinical record lacked documented neuro checks. The clinical record lacked documentation to indicate the fall was discussed by the IDT. The intervention Visual reminder to walker was added to an actual fall incident 3/16/24 care plan on 3/18/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fall 3: A Trauma History and Physical from the hospital, dated 8/31/24, indicated [Resident 12] presented to the hospital from nursing facility after an unwitnessed fall . On evaluation, she is extremely lethargic and is minimally responsive. She does respond to pain . Scattered bruising noted throughout forearms and elbows. Hematoma noted to right forehead. Unable to obtain any history . A computed tomography (CT) scan of the head revealed no acute injuries. A urinalysis indicated the resident had a UTI (urinary tract infection). The resident was admitted to the hospital for monitoring. She was discharged back to the facility on [DATE] with an order for oral antibiotics. The clinical record lacked facility documentation of the fall on 8/31/24. The clinical record lacked a Post Fall Evaluation for the fall that occurred on 8/31/24. The clinical record lacked documentation that staff notified the physician of the fall and orders were received to send the resident to the hospital. The clinical record lacked documentation that staff notified the resident's representative of the fall. The clinical record lacked documentation to indicate the fall was discussed by the IDT. The intervention Bathroom light is to be left on in room at night was added to an actual fall incident 8/31/24 care plan on 8/31/24. On 9/12/24 at 11:33 A.M., the Director of Nursing (DON) indicated there was no fall evaluation for the fall that occurred on 8/31/24. On 9/12/24 at 9:50 A.M., the DON indicated that the facility had a fall prevention protocol. After a resident fell , the nurse did an assessment of the resident. If the fall was unwitnessed, neuro checks were initiated. The nurse completed a Post Fall Evaluation form. The physician, resident representative, and DON were notified of the fall. IDT met daily and talked about each new fall to determine the root cause of the fall and appropriate interventions to prevent future falls. A new and relevant intervention was added to the care plan immediately. IDT meetings were documented on an internal form and were not a part of the clinical record. All information in the IDT meetings would be documented as a progress note. 3. On 9/10/24 at 12:49 P.M., Resident 19's clinical record review was reviewed. Diagnoses included, but were not limited to, unilateral primary osteoarthritis of left knee, and pain in left knee. The current Five- Day MDS assessment dated [DATE] indicated Resident 9 was mildly cognitively impaired. The resident needed partial assistance to transfer and dressing and was dependent for toileting. Current physician's orders 7/12/2024 included, but were not limited to, resident is one assist with transfers to BS (Bedside) commode. Not to be left unattended while using BS commode dated 7/20/24. The current falls care plan dated 7/12/24 indicated Resident 19 was a fall risk and will resume usual activities without further incident by the next review. Interventions included, but were not limited to, call light in reach, encourage nonskid footwear, and ensure the room is well lit and clutter free. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/12/2024 at 5:30 A.M., an Alert Note indicated Resident 19 was assisted to the restroom by staff but decided to walk to the bed by their self without using the bathroom call bell. The resident became dizzy, lost their balance by the bed hitting their head and elbow. The nurse did an assessment but failed to complete a post fall evaluation and neuro check and did not use the call bell and decided to walk back to the bed by themself. The resident became dizzy and lost their footing by the bed, hit their head and elbow. The nurse did an assessment, but the incident lacked post fall evaluation and neurochecks. During an interview on 9/11/24 at 11:22 A.M., the ADON indicated there was no paperwork for the post fall evaluation or the neurochecks for the fall from 7/12/24. 4. On 9/12/24 at 10:16 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, unilateral primary osteoarthritis, right hip and unspecified thoracic, thoracolumbar, and lumbosacral intervertebral disc disorder. The current annual MDS (Minimum Data Set) assessment dated [DATE] indicated the resident was cognitively intact. The resident needed supervision with toileting and set up with dressing, eating, and transfer. The resident used a walker and a wheelchair with ambulation. There were no falls indicated at this assessment. The most recent order recapitulation included, but were not limited to, Anticipate the resident's needs dated 4/1/2024. Encourage resident to properly use the assistive devise when ambulating with walker dated 4/1/2024 Non-skid stripes in front of bed dated 1/3/2024 revised on 4/3/24 Staff are to ensure that bed/chair alarms are functioning properly and in place dated 4/26/2024. Staff to ensure that alarming pad to chair is functioning properly (Resident is deaf alarm is alert the staff dated 4/25/2024 and revised on 5/14/2024. Staff are to toilet resident after each meal dated 5/22/2024. Staff are not to leave resident unattended while using the restroom dated 8/1/2024 and revised 8/26/2024. Fall#1 A Fall Risk Evaluation dated 12/31/23 at 3:05 A.M., indicated Resident 7 had an unwitnessed fall of sliding out recliner on slick floor falling on their bottom. Head to Toe assessment, vital signs, and neuro checks were initiated at 3:15 A.M. no injuries, deformities, or pain was noted. Fall Risk Score: 11.0 On 1/3/2024 7:11 A.M, The IDT (Interdisciplinary Team) Alert Note indicated that the root cause of the fall was due to the slick floor because the resident had slick house shoes on, and the intervention add was placing nonskid stripes in front of the recliner. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/16/24 at 11:30 A.M., the ADON provided a document The Neuro Assessment that was initiated on 12/31/23 at 3:15 A.M., the assessments were completed as per the required times but lacked an assessment of verbal responses for the first 15 minutes of the assessment. Fall #2 A Nurses Notes dated 3/30/2024 at 2:41 P.M., indicated that Resident 7 was found by a QMA (Qualified Medicine Aid) sitting on floor in front of bed. Resident indicated they was going from recliner to bed and floor was slick and slid on their bottom. Resident had a head-to-toe assessment with no injuries observed vital signs and neuro checks were initiated. On 9/12/24 at 10:30 A.M., the ADON provided a document Neuro Assessment that was initiated on 3/22/24 at 11:45 P.M., the assessments were completed at the required times but lacked every 4 hours times 3 on 3/23/24 at 11:30 P.M. On 9/16/24 at 11:30 A.M., the ADON provided a document The Neuro Assessment that was initiated on 3/30/24 at 3:00P.M., the assessments were completed as per the required times but lacked an assessment for the last 2 hours times 4 neuro checks at 2:45 A.M. Fall #3 A Nurse's Notes dated 3/30/2024 at 2:41 P.M., indicated that Resident 7 was found by a QMA (Qualified Medicine Aid) sitting on floor in front of bed. Resident indicated they was going from recliner to bed and floor was slick and slid on their bottom. Resident had a head-to-toe assessment with no injuries observed vital signs and neuro checks were initiated. A Post Fall Evaluation dated 3/30/2024 at 2:53 P.M., indicated the fall was unwitnessed and the resident was trying to transfer from chair to bed. Resident was wearing nonskid socks, but the personal alarm was ringing when Resident was found. Fall Risk Score: 13.0 Fall #4 A Nursing Health Status note dated 8/1/2024 at 6:50 A.M., indicated Resident 7 had an unwitnessed fall in bathroom while trying to self-toilet. Assessment, vital signs and neuro checks were initiated, but no documentation of the neuro checks was provided. A post-fall evaluation note done on 8/1/24 at 6:50 A.M., indicated the resident was attempting to self-toilet and the reason for the fall was not evident. The resident had on nonskid socks but did not use the call bell. New interventions were to not leave the resident unattended in the restroom. Fall risk score was. Fall Risk Score: 23.0 On 9/16/24 at 11:30 A.M., the ADON provided a document The Neuro Assessment that was initiated on 12/31/23 at 3:15 A.M., the assessments were completed as per the required times but lacked an assessment of verbal responses for the first 15 minutes assessment. The ADON (Assistant Director of Nursing) indicated they should have been done and documented completely. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 9/10/24 at 10:12 A.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, systemic lupus erythematosus unspecified, chronic kidney disease stage 3 unspecified, neuromuscular dysfunction of bladder. The current Quarterly MDS assessment dated [DATE] indicated Resident 11 was cognitively intact. The resident was totally dependent for transferring, toileting, dressing, and mobility. No falls this assessment. Current physician orders included, but were not limited to, Bed in lowest position and perimeter mattress to bed dated 8/1/23. Revised on 3/27/2024. On 8/1/2024 at 10:52 A.M., from a Fall Risk Evaluation indicated that the fall risk score is 13. The falls risk care plan, initiated 8/11/21, indicated Resident 11 had falls and would be free from falls through the review date. The care plan was revised on 8/16/2024. Interventions included, but were limited to, anticipate and meet resident need, have call bell within reach and encourage the resident to use, bed in lowest position initiated 8/11/202. Parameter mattress to bed initiated 7/14/2023 and revised 1/26/2024. Increased supervision until UTI (Urinary Tract Infection) initiated 3/27/22. PT evaluate and treat as ordered initiated 12/13/2022. Therapy to evaluate and treat as indicated initiated on 5/24/2023. These were all in place prior to fall the newest intervention started staff are to place over bed table on the opposite side of the where the change of plane mattress is not present. A Health Status Note dated 8/1/24 at 9:45 A.M., indicated a CNA (Certified Nurse Aide) heard resident crying out, and found resident laying the left side between bed and mat. Resident had repositioned self after when falling from bed. Had complaint of head pain. Nurse started head to toe assessment was completed but lacked neuro check initiation for 8/1/24. On 9/12/24 at 10:30 A.M., the ADON provided a document Neuro Assessment that was initiated on 3/22/24 at 11:45 P.M., the assessments were completed at the required times but lacked every 4 hours times 3 on 3/23/24 at 11:30 P.M. On 9/16/24 at 12:20 P.M., the Regional Consultant provided a current undated Assessing Falls and Their Causes policy that indicated After a Fall: If a resident has just fallen or is found on the floor without a witness to the event, the nursing staff will record vital signs and evaluate for possible injuries to the head, neck, spine, and extremities . Once an assessment rules out significant injuries, the nursing staff will .document relevant details . Nursing staff will observe for delayed complications of a fall for approximately forty-eight (48) to seventy-two (72) hours after an observed or suspected fall and will document findings in the medical record . An incident report must be completed for resident falls. The incident report form should be completed by the nurse on duty at the time . When a resident falls, the following information should be recorded in the resident's medical record: The condition in which the resident was found . Assessment data, including vital signs and any obvious injuries. Interventions, first aid, or treatment administered. Notification of the physician and family . Completion of a fall risk assessment. Appropriate interventions taken to prevent future falls . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/16/24 at 1:00 P.M., the Regional Consultant indicated the facility did not have a policy for Documentation Requirements. It was the facility's policy that staff follow standard nursing practice and document accurately and completely. 3.1-50(a)(1) 3.1-50(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758 Based on observation, record review, and interview, the facility failed to ensure a resident was on EBP (enhanced barrier precautions) for 1 of 2 residents reviewed for catheters, for 3 of 3 random observations reviewed for hand hygiene during incontinence care and medication administration, and for 2 of 2 random observation for cleaning equipment in between residents (Resident 11, Resident 2, Resident 19, Resident 5, Resident 6 Findings include: 1. On 9/9/24 at 9:30 A.M., there was no Enhanced Barrier Precautions (EBP) Sign observed on a Resident 11's door for indwelling catheter. On 9/10/24 at 10:00 A.M., there was no Enhanced Barrier Sign observed on Resident 11's door for and indwelling catheter. On 9/11 at 12:46 P.M., there was no Enhanced Barrier Sign observed on Resident 11's door for and indwelling catheter. On 9/13/24 at 9:07 A.M., there was no Enhanced Barrier sign observed on Resident 11's door for and indwelling catheter. On 9/10/24 at 10:12 A.M., Resident 11's clinical record was reviewed. Diagnoses included, but not limited to chronic kidney disease stage 3, Benign prostatic hyperplasia without lower urinary tract symptoms, neuromuscular dysfunction of bladder. The currently Quarterly MDS (Minimum Data Set) assessment dated [DATE] indicated Resident 11 was cognitively intact. Resident 11 is totally dependent for transferring, toileting, dressing, and has an indwelling catheter. Current physician orders included, but were not limited to: Insert Coudet French size 18, balloon size 10 ml (milliliters). Change Foley (Indwelling Catheter) and urinary bag q (every) 14 days for system failure and if the urinary bag gets cloudy and with sediment, every day shift 14 days for urinary retention (related to) BPH (Benign Prostatic Hyperplasia) change catheter every 14 days dated 8/30/24. Catheter care to be done each shift dated 3/12/2024. The current EBP (Enhanced Barrier Precautions) for indwelling catheter with a goal to be monitored signs and symptoms of infection. Interventions included, but were not limited to: Place the resident on Enhanced Barrier Precautions and educate or encourage the resident on the importance of complying with enhanced barrier precaution measures to prevent the spread of the infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 9/24 at 9:19 A.M., RN (Registered Nurse) 11 and CNA (Certified Nurse Aide) 20 were observed performing incontinence care for Resident 2. RN 11 and CNA 20 went into room and did not sanitize. Both placed gloves on with CNA 20 turned resident to left side and cleaned buttocks after bowel movement. Prior to cleaning, CNA 20 removed bed pan and placed in a bag. CNA 20 donned new gloves but did not perform hand hygiene prior to placing gloves. Pulled up clean brief. RN 11 fastened new brief and then began touching items in room with the same gloves on before got to get to the air freshener. Removed gloves and washed hands when completed. 3. On 9/11/24 at 1:20 P.M., RN 7 was observed giving Resident 14 medication and did not sanitize hands after leaving room. 4. On 9/12/24 at 7:11 A.M., RN 18 was observed leaving Resident 19's room after medication pass not sanitizing hands. RN 18 proceeded into Resident 5's room to move them up in bed. RN donned gloves but did not perform hand hygiene prior to entering and after leaving Resident 25's Room. 5. On 9/12/24 at 7:40 A.M., RN 18 was observed going into Resident 2's and did not perform hand hygiene prior to entering Resident 2's room. While in Resident 2's, RN 18 performed a blood pressure on BP was 151/85. RN exited Resident 2's room without performing hand hygiene or cleaning the BP (Blood Pressure) cuff. 6. On 9/12/24 at 11:35 A.M., RN 18 was observed performing an Accu-Chek on Resident 11. The test was performed, and the nurse left the room but did not clean machine after using it During an interview on 9/12/24 at 11:40 A.M., RN 17 indicated that each resident has their own machine and should be cleaned after each use. During an interview on 09/16/24 at 8:57 A.M., the ADON (Assistant Director of Nursing) indicated hands needed to be washed before, after, and during if there were glove changes. Equipment should be cleaned before and after the procedure complete such as a blood pressure cuff and glucometers. 48057 7. During a wound treatment observation on 9/12/24 at 2:59 P.M. RN 3 was observed putting on PPE (personal protective equipment) in the hall. RN 3 began by putting on gloves, mask, then gown. RN 3 entered Resident 23's room, removed a dressing from Resident 23's lower right buttock and sacrum, and began cleansing the wounds with wound cleanser and gauze. RN 3 removed gloves and put new gloves on, dried both wounds with gauze. RN 3 applied Leptospermum honey to the wound beds with her gloved finger, applied calcium alginate and dry dressings over sacral wound. RN 3 applied skin prep around the lower wound dressing, performed a glove change, applied the lower dressing, applied Desitin around both dressings, and performed a glove change. RN 3 rolled Resident 23 back over, retrieved linens out of the closet, put new linen on Resident 23's bed, put the soiled linen in a trash bag, assisted Resident with getting dressed. RN 3 removed her gown and gloves in the room, turned down the air conditioner temperature by the window, and adjusted the bed position with the bed remote. RN 3 exited the room, retrieved hand sanitization foam and rubbed hands together for 4 seconds, then walked back to the nurses station. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/16/24 at 9:08 A.M., the ADON indicated if a nurse is applying medication directly to a wound bed, they should be using sterile cotton applicators, and that hand hygiene should be performed before wound care, during wound care if there are glove changes, and after wound care. On 9/16/24 at 12:30 P.M., the Regional Clinical Support Nurse provided a current policy Policy/Guidelines on Enhanced Barrier Precautions dated 9/23/22. The policy indicated .indications for EBP included but not limited to .indwelling medical devices . which includes .urinary catheters. During this same time, the Regional Clinical Support Nurse provided a current policy Hand-Hygiene dated 5/29/24. The policy indicated .indicated all staff will perform proper hand hygiene procedures to prevent the spread of infections to other personnel, residents, and visitors .if task requires gloves, perform hand hygiene prior to donning, and immediately after removing gloves. An additional current policy Cleaning and Disinfection of Resident-Care Equipment dated 5/29/24. The policy indicated .resident-care equipment can be a source of indirect transmissions of pathogens . each staff is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident . 3.1-18(b) 3.1-18(l)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Healthcare of New Harmony	251 Highway 66 New Harmony, IN 47631

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 46758 Based on observation and interview, the facility failed to ensure the safety of resident's by not utilizing an emergency call system for 6 of 6 days during survey. (Public Restroom) Finding includes: During random observations throughout the week of survey from dates September 9 to September 16, 2024. The visitor restroom located in the main hallway across from the beauty shop lacked an emergency call system. During an interview on 9/16/24 at 9:55 A.M., the DON (Director of Nursing) indicated that residents from the beauty shop used that restroom and there was no emergency call light system in the visitor restroom. A current nondated policy was provided by the Regional Clinical Support Nurse at 10:00 A.M. The policy Personal Property-Home Like Environment lacked information concerning call lights. 3.1-19(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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. 46758 Based on observation, record review, and interview, the facility failed to provide a safe and sanitary environment for residents, staff, and the public for 9 random observations on 6 of 6 days. Urine odors in entrance hallway, conference room and [NAME] unit hallways. (Entrance Hallway, Conference Room, [NAME] Unit Hallways) Findings include: 1. On 9/9/24 at 8:50 A.M., the odor of urine was observed in the entrance hallway and the conference room. On 9/10/24 at 8:55 A.M., the odor of urine was observed in the entrance hallway and conference room. On 9/12/24 at 6:55 A.M., the odor of urine was observed in the conference room. On 9/13/24 at 8:20 A.m., the strong smell of urine was observed in the Entrance Hallway and the Conference Room. 2. On 9/10/24 at 12:48 P.M., the odor of urine was observed by the [NAME] Hall Unit Nurses Station. 3. On 9/11/24 at 8:20 A.M., the odor of urine was observed in hallway outside of the conference room. On 9/11/24 at 11:00 A.M., the strong odor of urine with air freshener was observed in the hallway by the conference room 4. On 9/12/24 at 7:04 A.M., the smell of urine was observed in the [NAME] Unit Hallway. 5. On 9/16/24 at 8:15 A.M. the strong of odor was observed in the conference and the hallway leading to patio. During an interview on 9/16/24 at 9:10 A.M., the Administrator indicated the facility should be free of smells and should be clean. On 9/16/24 at 10:00 A.M., the Regional Clinical Support Nurse provided a current, nondated policy Personal Property-Home Like Environment. The policy indicated .to eliminate odors and prevent pest, resident rooms will be cleaned daily . 3.1-19(f)(5)