STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155490	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Healthcare	705 E Main St Centerville, IN 47330

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 25054 Based on observation, interview, and record review, the facility failed to provide privacy during care for 2 of 2 random observations (Resident 50 and Resident 36). Findings include: 1. During a medication pass observation on 4/28/25 at 10:10 a.m., Registered Nurse (RN) 11 knocked on Resident 50's door and walked in without waiting for a response. Resident 50 was standing up in front of his wheelchair and Certified Nurse Aide (CNA) 10 was applying an incontinent brief on the resident. The resident had no clothes on, and the privacy curtain was not pulled. Resident 50 was visible to the hallway. Review of the clinical record of Resident 50, on 4/30/25 at 11:10 a.m., indicated the diagnoses included, but were not limited to, schizophrenia, diabetes, depression, and muscle weakness. The Quarterly Minimum Data Set (MDS) assessment, dated 3/3/25, indicated the resident was cognitively intact for daily decision making. The resident was frequently incontinent of bowel and bladder. 2. Review of the clinical record of Resident 36, on 4/28/25 at 10:35 a.m., indicated the diagnoses included, but were not limited to, diabetes, Alzheimer's disease, dementia, major depressive disorder, anxiety, weakness, heart disease and stage three pressure ulcer to the coccyx (wound with full thickness tissue loss). During an observation of a pressure ulcer treatment for Resident 36 on 4/28/25 at 1:44 p.m., CNA 10 held Resident 36 on her right side while RN 11 was providing a pressure ulcer treatment to Resident 36's coccyx. RN 8 walked into Resident 36's room without knocking and the resident's buttocks were visible to the hallway. Resident 36 did not have a privacy curtain in her room. RN 11 and CNA 10 indicated they were unsure why the resident did not have a privacy curtain in her room. During an interview with RN 8 on 4/28/25 at 2:28 p.m., they indicated Resident 36 did not have a privacy curtain in her room because it was a private room. RN 8 indicated she knocked on Resident 36's door lightly before she came in but should have waited for a response before entering the resident's room. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The dignity policy was provided by the Director of Nursing (DON) on 4/29/25 at 10:45 a.m. The policy indicated the residents would be treated with dignity and respect at all times. Staff would promote, maintain and protect resident privacy, including bodily privacy during assistance with person care and treatment procedures. Staff were expected to knock and request permission before entering residents' rooms. 3.1-3(p)(2) 3.1-3(p)(4) 3.1-3(t)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 45291 Based on observation, interview, and record review, the facility failed to ensure call lights were within reach (Resident 67 and 71) and failed to ensure fluids were available at the bedside (Resident 22) for 3 of 3 residents reviewed for accommodations of needs. Findings include: 1. The clinical record for Resident 67 was reviewed on 4/28/2025 at 2:08 p.m. The medical diagnoses included anoxic brain injury and contractures. A Significant Change Minimum Data Set Assessment, dated 2/14/2025, indicated Resident 67 was able to participate in his cognition exam, was severely cognitively impaired, and was dependent on staff for activities of daily living. A care plan, last revised 1/8/2025, indicated to ensure Resident 67's call light was within reach. During an observation on 4/29/2025 at 12:01 p.m., Resident 67's call light was noted to be out of his range. When asked if he could use his call light, he indicated no. During an interview and observation, on 4/29/2025 at 12:10 p.m., Licensed Practical Nurse (LPN) 2 verified the call light was out of Resident 67's reach. She stated the call light should definitely be closer, and moved it down so Resident 67 would be able to press it. 30344 2. The clinical record for Resident 71 was reviewed on 4/24/25 at 11:55 a.m. Her diagnoses included, but were not limited to, rheumatoid arthritis, diabetes mellitus, and stage four pressure ulcer of sacral region. The 1/14/25 Annual MDS (Minimum Data Set) assessment indicated she was cognitively intact. She was totally dependent for toileting hygiene, bathing, lower body dressing, and putting on/taking off footwear. She required substantial/maximal assistance with eating, oral hygiene, upper body dressing, and personal hygiene. An observation and interview were conducted with Resident 71 in her room on 4/24/25 at 11:59 a.m. She was lying in bed with the covers over her. Her call light was clipped to her outer cover but was wedged between her left side enabler bar and mattress. Resident 71 attempted to reach for her call light but was unable to reach it. She indicated, I can't reach it. I need my call light. An observation and interview were conducted with Resident 71 in her room on 4/30/25 at 1:14 p.m. She was lying in bed with the covers over her. Her call light cord was wrapped and tied around her left side enabler bar. There was not enough cord length available for Resident 71 to reach her call button. Resident 71 kept pulling at the cord and requested it be pulled within her reach. LPN 13 entered the room to assist. LPN 13 untied the cord from the enabler bar and pulled the cord to release more of its' length. LPN 13 asked Resident 71 if she'd rather it be clipped onto her cover. Resident 71 answered in the affirmative, so LPN 13 detached it from the enabler bar, and clipped it onto her blanket, within Resident 71's reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy, entitled Call System, Residents, was provided by the Administrator on 4/30/2025 at 9:40 a.m. The policy indicated residents are to be provided a means to call staff for assistance through a communication system that directly calls a staff member or central work location and, .if the resident has a disability that prevents him/her from making use of the call system, an alternative measure of communication that is usable for the resident is provided . 50436 3. During an observation on 4/23/25 at 1:53 p.m., Resident 22 was lying in bed. The resident had no water or any type of fluids in their room. During an observation on 4/28/25 at 10:19 a.m., Resident 22 was sleeping in bed. The resident had no water or any type of fluids in their room. During an observation on 4/28/25 at 1:55 p.m., Resident 22 was lying in bed. The resident had no water or any type of fluids in their room. During an observation on 4/29/25 at 9:38 a.m., Resident 22 had a clear, empty plastic glass sitting on their bedside table. The clinical record for Resident 22 was reviewed on 4/28/25 at 11:00 a.m. The diagnoses included, but were not limited to, anxiety and diabetes mellitus. A physician's order, dated 3/13/25, indicated Resident 22 was on a regular diet with regular texture and nectar (thickened) consistency for fluids. An interview was conducted with Certified Nurse Aide (CNA) 3 on 4/29/25 at 9:41 a.m. CNA 3 indicated Resident 22 was able to drink by herself and did not need assistance if the drink was placed in front of her. During an interview with the Director of Nursing (DON) on 4/29/25 at 10:49 a.m., she indicated residents who have nectar (thickened) liquids ordered were not allowed to have pitchers of water at the bedside, but they can have thickened fluids at the bedside. The Serving Drinking Water policy was provided by the DON on 4/28/25 at 2:30 p.m. It indicated, . the purpose of this procedure are to provide the resident with a fresh supply of drinking water and to provide adequate liquids for the resident . 3.1-3(v)(1)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30344 Based on observation, interview, and record review, the facility failed to maintain comfortable sound levels for 1 of 5 residents reviewed for accidents. (Resident 71) The clinical record for Resident 71 was reviewed on 4/24/25 at 11:55 a.m. Her diagnoses included, but were not limited to, rheumatoid arthritis, diabetes mellitus, and stage four pressure ulcer of sacral region. She was admitted to the facility on [DATE]. The 1/14/25 Annual MDS (Minimum Data Set) assessment indicated she was cognitively intact. She was totally dependent for toileting hygiene, bathing, lower body dressing, and putting on/taking off footwear. She required substantial/maximal assistance with eating, oral hygiene, upper body dressing, and personal hygiene. The physician's orders indicated to check the function and placement of her bed and chair alarm every shift, effective 9/11/23. The 9/11/23 at risk for falls care plan indicated she would climb out of bed and onto the floor mat and unplug her bed alarm. Interventions were bed and chair alarms, initiated on 9/11/23. An observation and interview were conducted with Resident 71 in her room on 4/24/25 at 11:57 a.m. She was lying in bed at this time. A position change alarm was attached to the side of her bed. Resident 71 indicated she had an alarm on her bed that beeped, if she moved around. She didn't' like it. It beeped all the time and was really loud. Interviews were conducted with the DON (Director of Nursing) on 4/29/25 at 1:26 p.m. and 4/30/25 at 10:44 a.m. She indicated the facility was not monitoring for efficacy of residents' alarm use, including Resident 71's, on a routine basis, and they had no documentation or verification that any resident's alarm use was for the purpose of assisting staff to assess for residents' patterns and routines. She understood the alarm use in the facility was a concern and it was next on her list to address. The Bed/Chair Alarm policy was provided by the DON on 4/30/25 at 11:45 a.m. It indicated, 1. Purpose .To reduce fall risks through timely staff interventions. To ensure alarms are used appropriately and not as a restraint. To comply with regulatory and ethical standards 4. Alarm Selection and Placement. Choose the least intrusive and most effective alarm 5. Staff Responsibilities Document alarm triggers and responses 6. Review effectiveness regularly (e.g., weekly or monthly). Remove alarms when they are no longer clinically justified. Document review findings in the care plan. 7. Alternatives and Least Restrictive Interventions. Use other fall prevention methods when possible: Increased supervision. Environmental adjustments. Scheduled toileting. 8. Regulatory and Ethical Considerations Follow CMS (Centers for Medicare & Medicaid Services) and state regulations. Avoid alarms as restraints unless absolutely necessary. Encourage resident independence and dignity. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Homelike Environment policy was provided by the Administrator on 4/30/25 at 9:40 a.m. It indicated, 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .comfortable sound levels. 3. The facility staff and management minimizes, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include: .chair and bed alarms. 3.1-19(f)(5)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25054 Based on observation, interview, and record review, the facility failed to provide nail care and oral care for 3 of 3 residents reviewed for activities of daily living (ADLs). (Resident 9, Resident 66 and Resident 23) Findings include: 1. During an observation on 4/23/25 at 1:05 p.m., Resident 9 had a dark substance underneath her fingernails on both hands. During an observation on 4/28/25 at 9:46 a.m., Resident 9 had a dark substance underneath her fingernails on both hands. During an observation and interview on 4/28/25 at 12:44 p.m., Resident 9 had a dark substance underneath her fingernails on both hands. Resident 9 indicated her fingernails were horrible. During an observation and interview on 4/29/25 at 10:08 a.m., Certified Nurse Aide (CNA) 12 verified Resident 9 had a black substance under her fingernails. CNA 12 indicated that the aides were supposed to clean her fingernails on bed bath days. Resident 9 received her bed bath on evening shift. CNA 12 indicated she was unsure if Resident 9 was a diabetic, but she would not trim her nails at this time but would clean the resident's fingernails. The clinical record for Resident 9 was reviewed on 4/29/25 at 9:55 a.m. The diagnoses included, but were not limited to, dementia, chronic obstructive pulmonary disease, Alzheimer's disease, anxiety, pain, major depressive disorder, and psychosis. The plan of care for Resident 9, dated 7/26/24, indicated the resident required limited assistance with self-care related to poor motivation and dementia. The interventions included, but were not limited to, shower per staff assistance two times a week and to include nail care. The Quarterly Minimum Data Set (MDS) assessment for Resident 9, dated 4/4/25, indicated the resident required substantial/maximal assistance with personal hygiene. The fingernail care policy was provided by the Administrator on 4/30/25 at 9:40 a.m. The policy indicated the purpose was to clean the nail bed to prevent infection. 30344 2. The clinical record for Resident 66 was reviewed on 4/24/25 at 11:20 a.m. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes, Alzheimer's disease, and congestive heart failure. He was admitted to the facility on [DATE]. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of Resident 66 was conducted on 4/24/25 at 12:06 p.m. He was lying in bed and was not wearing any socks. Both of his feet were completely visible. On his left foot, the pinky toenail and toenail next to the big toe were extremely long. On the right foot, the big toe and middle toe were long and curled over the end of the toes. The 3/21/25 Admission MDS assessment indicated he was severely cognitively impaired, required substantial/maximal assistance with bathing, and was totally dependent for putting on/taking off footwear. The 4/28/25 ADL care plan indicated he required maximum assistance with showers twice weekly with hair and nail care included. He was totally dependent on staff with putting on/taking off footwear. The 3/12/25 Request For Service Consent form did not indicate whether Resident 66's representative accepted or refused podiatry services, as both options were left blank on the consent form. The physician's orders indicated he may be seen by the podiatrist, effective 3/13/25. An interview was conducted with LPN (Licensed Practical Nurse) 4 on 4/28/25 at 1:18 p.m. Resident 66 was not available for observation at this time. She indicated she noticed how long his toenails were and how they curled over. They had a podiatrist who came to the facility, but a lot of residents' families didn't approve for them to be seen. Nursing staff usually contacted social services, who would talk with the family about being seen by the podiatrist. She hadn't discussed Resident 66's toenails with social services and was unsure if anyone else had either. An interview was conducted with the Social Services Director (SSD) on 4/28/25 at 1:46 p.m. She indicated no one mentioned anything to her about Resident 66 needing to be seen by the podiatrist. An interview was conducted with the SSD on 4/29/25 at 11:27 a.m. She indicated she had a call out to Resident 66's family member to discuss podiatry services. If they declined, perhaps nursing could address his long toenails. 45291 3. The clinical record for Resident 23 was reviewed on 4/29/2025 at 12:45 p.m. The medical diagnoses included stroke and heart failure. A Quarterly Minimum Data Set Assessment, dated 3/31/2025, indicated Resident 23 was cognitively impaired and did not reject care. A care plan, revised 11/11/2024, indicated Resident 23 needed maximal assistance with oral care twice a day and as needed. During an observation on 4/23/2025 at 1:10 p.m., Resident 23 was observed to have a thick white build up on her teeth as well as a white film over her teeth and lips. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation, on 4/29/2025 at 12:39 p.m., Resident 23 was sitting in the common area by the nurse's station. She was observed to have a blue substance over her lips, around her mouth, and coating her teeth. She was also noted to have dry skin built up on her lips and a thick white substance built up between her teeth. During an interview on 4/30/2025 at 11:30 a.m., the Director of Nursing (DON) indicated nursing staff should provide care to assure residents are clean from food debris after meals. A policy entitled Mouth Care was provided by the Administrator on 4/30/2025 at 9:40 a.m. The policy indicated the purpose of the policy was to keep the resident's mouth and lips moist and provide oral care. 3.1-38(a)(2)(A) 3.1-38(a)(3)(A) 3.1-38(a)(3)(C) 3.1-38(a)(3)(E)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30344 Based on observation, interview, and record review, the facility failed to timely provide optometry services and timely address a resident's missing glasses for 2 of 3 residents reviewed for vision services. (Residents 38 and 91) Findings include: 1. The clinical record for Resident 38 was reviewed on 4/24/25 at 12:10 p.m. Her diagnoses included, but were not limited to, cataracts, history of cerebral infarction, and dementia. The 3/26/25 Quarterly MDS (Minimum Data Set) assessment indicated she was cognitively intact. An interview and observation were conducted with Resident 38 in her room on 4/24/25 at 12:13 p.m. She indicated she had a hard time seeing, needed glasses, and hadn't seen the optometrist lately. She was not wearing glasses at that time. The physician's orders indicated she may be seen by the optometrist, effective 3/22/19. The 3/30/20 facility optometry provider's Request for Services Consultation indicated to please have the optometrist examine Resident 38. The 6/30/23 eye exam indicated new glasses were not recommended at this time, and that she only wore them intermittently. The plan was to monitor and follow up with a comprehensive exam on 6/30/24, and to continue wearing spectacles. The action required by nursing home staff was to encourage part-time use of glasses for reading. There was no information in the clinical record to indicate a follow up comprehensive exam was ever completed after the 6/30/23 exam, as planned. An interview was conducted with the SSD (Social Services Director) on 4/28/25 at 1:28 p.m. She indicated she handled ancillary services for all residents in the facility, including optometry services. No vision services had been provided in the facility since 10/7/24, which was by a previous provider. Resident 38 was not seen at the 10/7/24 visit and hadn't been seen since her 6/30/23 exam. The facility recently obtained a new provider who was scheduled to come to the facility for the first time on 5/1/25. An interview was conducted with the SSD on 4/29/25 at 11:50 a.m. She indicated she was unable to locate any glasses for Resident 38 yesterday. She also spoke with nursing staff and was informed they hadn't seen any glasses for Resident 38 either. The SSD reviewed Resident 38's clinical record and indicated there was no vision or ancillary services care plan for Resident 38, but she would create one now. 2. The clinical record for Resident 91 was reviewed on 4/24/25 at 11:30 a.m. His diagnoses included, but were not limited to, dementia. He was admitted to the facility on [DATE]. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's orders indicated he may be seen by the optometrist, effective 12/17/24. The 12/19/24 care plan indicated he had glasses. Interventions were to clean his glasses daily; ensure his glasses were on daily and removed prior to going to bed; and notify nursing/social services promptly of any lost/broken glasses. The 12/26/24 Admission MDS assessment indicated he had adequate vision with corrective lenses used. The 3/28/25 Quarterly MDS assessment indicated he had adequate vision, but no corrective lenses were used. It indicated he was severely cognitively impaired. An observation of Resident 91 and interview with Family Member 5 was conducted in Resident 91's room on 4/24/25 at 11:39 a.m. Resident 91 was sitting up in his wheelchair next to Family Member 5, and he was not wearing any glasses. Family Member 5 indicated he needed glasses, because he does better with glasses, but she thought he may have thrown them away, as they were unable to be located at this time. Family Member 5 was unsure whether he'd seen the optometrist since he'd been at the facility or if his missing glasses had been addressed. An observation of Resident 91 and interview with Family Member 6 was conducted in Resident 91's room on 4/28/25 at 1:00 p.m. Resident 91 was sitting up in his wheelchair, and he was not wearing any glasses. Family Member 6 indicated she hadn't heard anything about him seeing the eye doctor or getting new glasses. An interview was conducted with the SSD on 4/28/25 at 1:28 p.m. She indicated she handled ancillary services for all residents in the facility, including optometry services. No vision services had been provided in the facility since 10/7/24, which was by a previous provider. The facility recently obtained a new provider, who was scheduled to come to the facility for the first time on 5/1/25. The SSD reviewed the optometry provider's 5/1/25 visit list and indicated Resident 91 was not on the list to be seen as a new patient, but she would add him to the list to be seen today. She was unaware he was currently missing his glasses. The Availability of Ancillary Services: Dental, Vision, Podiatry, Audiology policy was provided by the Administrator on 4/30/25 at 9:40 a.m. It indicated, Oral, visual, podiatry and audiology services will be provided to each resident. Policy Interpretation and Implementation: 1. Oral, visual, podiatry and audiology services are available to all residents requiring routine and emergent care. 2. Social Services will be responsible for making necessary dental, visual, audiology and podiatry arrangements and obtain consents for services. 3. All requests for routine services should be directed to social services to assure that appointments/referral can be made in a timely manner 6. Residents with lost or damaged glasses/contacts will be promptly referred to an optometrist. 3.1-39(a)(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. 45291 Based on observation, interview, and record review, the facility failed to provide pressure wound interventions for a resident at high risk of developing pressure areas for 1 or 2 residents reviewed for pressure wounds. (Resident 67) Findings include: The clinical record for Resident 67 was reviewed on 4/28/2025 at 2:08 p.m. The medical diagnoses included anoxic brain injury and contractures. A Significant Change Minimum Data Set Assessment, dated 2/14/2025, indicated Resident 67 was able to participate in his cognition exam, was severely cognitively impaired, and at risk for developing pressure areas. A skin care plan, last revised 4/7/2025, indicated to provide Resident 67 with wound care as ordered. A physician order, dated 4/24/2025, indicated to apply a foam dressing to the top of Resident 67's right foot as a preventative measure. A wound practitioner note, dated 4/28/2025, indicated for Resident 67 to encourage the use of pressure reducing (prevalon) boots at all times. During an observation on 4/29/2025 at 12:01 p.m., Resident 67 was observed in bed. Resident 67's pressure reducing boot were sitting on the bedside table. During an interview and observation, on 4/29/2025 at 12:10 p.m., Licensed Practical Nurse (LPN) 2 verified pressure reducing boots were off. Observation of Resident 67's right foot indicated the preventative dressing was off. LPN 2 indicated she did not provide that dressing, she was not sure if he had an order for a dressing to the foot, but if he did then he should have one on. The order for the preventative dressing to Resident 67's right foot was verified in the electronic medical record. A policy entitled Prevention of Pressure Injuries was provided by the Administrator on 4/30/2025 at 9:50 a.m. The policy indicated selecting appropriate supportive devices, to apply to devices, and to review the interventions and strategies for effectiveness. 3.1-40(a)(2)

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	155490	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Healthcare	705 E Main St Centerville, IN 47330

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25054 Based on observation, interview, and record review, the facility failed to implement and provide interventions for a resident with bilateral hand contractures for 1 of 2 residents revived for range of motion (ROM). (Resident 98) Findings include: Review of the clinical record of Resident 98, on [DATE] at 10:12 a.m., indicated the diagnoses included, but were not limited to, anoxic brain damage, anxiety, and respiratory arrest. The admission assessment for Resident 98, dated [DATE], indicated both arms were contracted at varying degrees. The Admission Minimum Data Set (MDS) assessment for Resident 98, dated [DATE], indicated the resident was severely cognitively impaired for daily decision making. The resident had impairment on both sides of his upper extremities. The plan of care for Resident 98, revised date of [DATE], indicated the resident was at risk for skin breakdown due to bilateral upper extremity contractures. During an observation on [DATE] at 1:20 p.m., Resident 98 was lying in bed, the resident had bilateral hand contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to restricted joint mobility), and the resident did not have any splint/carrot in place. During an observation on [DATE] at 1:54 p.m., Resident 98 was lying in bed, the resident had bilateral hand contractures, and the resident did not have any splint/carrot in place. During an interview with Registered Nurse (RN) 9 on [DATE] at 1:55 p.m., she indicated she was the nurse caring for Resident 98. RN 9 indicated the resident had bilateral hand contractures since admission to the facility. RN 9 had not seen any splint/carrot utilized for the resident. The contracture prevention policy was provided by the Director of Nursing (DON) on [DATE] at 11:45 a.m. The policy indicated the purpose was to prevent the progression of contractures in residents and ensure timely appropriate management when they occur. Individual care plans would be developed for at risk residents, addressing ROM, splints or supportive devices. 3XXX,d+[DATE](a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 30344 Based on observation, interview, and record review, the facility failed to implement fall interventions, as care planned; transfer a resident utilizing a gait belt, as required; ensure position change alarm use was monitored for efficacy on an on-going basis; and ensure position change alarm use was aimed at assisting staff to assess for patterns and routines of residents for 4 of 5 residents reviewed for accidents. (Residents 23, 31, 41, and 71) Findings include: 1. The clinical record for Resident 71 was reviewed on 4/24/25 at 11:55 a.m. Her diagnoses included, but were not limited to, rheumatoid arthritis, diabetes mellitus, and stage four pressure ulcer of sacral region. She was admitted to the facility on [DATE]. The 1/14/25 Annual MDS (Minimum Data Set) assessment indicated she was cognitively intact. She was totally dependent for toileting hygiene, bathing, lower body dressing, and putting on/taking off footwear. She required substantial/maximal assistance with eating, oral hygiene, upper body dressing, and personal hygiene. An observation and interview were conducted with Resident 71 in her room on 4/24/25 at 11:57 a.m. She was lying in bed at that time. A position change alarm was attached to the side of her bed. Resident 71 indicated she had an alarm on her bed that beeped, if she moved around. She didn't' like it. It beeped all the time and was really loud. The physician's orders indicated to check the function and placement of her bed and chair alarm every shift, effective 9/11/23. The 9/11/23 at risk for falls care plan indicated she would climb out of bed and onto the floor mat and unplug her bed alarm. Interventions were bed and chair alarms, initiated 9/11/23. The clinical record indicated Resident 71's last fall was on 10/31/24, when she slid out of her wheel chair onto the floor after being transferred into her wheel chair with a Hoyer lift. The fall prior to the 10/31/24 fall was on 9/17/23, when she was found face down on the floor by the side of her bed. There was no information in the clinical record to indicate Resident 71's bed alarm was monitored for efficacy on an on-going basis or that it was originally aimed at assisting staff to assess for her patterns and routines. Interviews were conducted with the DON (Director of Nursing) on 4/29/25 at 1:26 p.m. and 4/30/25 at 10:44 a.m. She indicated the facility was not monitoring for efficacy of residents' alarm use, including Resident 71's, on a routine basis, and they had no documentation or verification that any resident's alarm use was for the purpose of assisting staff to assess for residents' patterns and routines. She understood alarm use in the facility was a concern and it was next on her list to address. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The clinical record for Resident 31 was reviewed on 4/24/25 at 11:05 a.m. Her diagnoses included, but were not limited to, Alzheimer's disease, depression, insomnia, anxiety, paranoid personality disorder, and hypertension. The 3/29/25 Annual MDS assessment indicated she was moderately, cognitively impaired. She was totally dependent for bathing and putting on/taking off footwear. She required substantial/maximal assistance with toilet hygiene, lower body dressing, personal hygiene, and transfers. An observation of Resident 31 and interview with LPN (Licensed Practical Nurse) 17 were conducted on 4/24/25 at 11:10 a.m. Resident 31 was sitting outside in her wheel chair in the patio area. There was a chair alarm attached to the back of her wheel chair. LPN 17 indicated Resident 31 had a chair alarm. If she moved forward, like she was about to get up, it would go off. She stated, Oh yea, it's loud. The physician's orders indicated to verify function and location of the pull pin (attached to chair alarm) on her wheel chair every shift, effective 4/21/25. The at risk for falls care plan, last revised 4/16/20, indicated a bed alarm, initiated on 6/28/19, and pull pin placed on wheel chair, initiated on 4/21/25. The clinical record indicated Resident 31's last fall was on 4/21/25, when staff entered her room and she was observed lying on her right side on the floor in the middle of her room. Resident 31 attempted to ambulate to a bedside table to get some candy. Resident 31's pull pin alarm was placed at this time. There was no information in the clinical record to indicate Resident 31's chair alarm was monitored for efficacy on an on-going basis or that it was originally aimed at assisting staff to assess for her patterns and routines. Interviews were conducted with the DON on 4/29/25 at 1:26 p.m. and 4/30/25 at 10:44 a.m. She indicated the facility was not monitoring for efficacy of residents' alarm use, including Resident 31's, on a routine basis, and they had no documentation or verification that any resident's alarm use was for the purpose of assisting staff to assess for residents' patterns and routines. She understood alarm use in the facility was a concern and it was next on her list to address. The Bed/Chair Alarm policy was provided by the DON on 4/30/25 at 11:45 a.m. It indicated, 1. Purpose .To reduce fall risks through timely staff interventions. To ensure alarms are used appropriately and not as a restraint. To comply with regulatory and ethical standards 5. Staff Responsibilities Document alarm triggers and responses 6. Review effectiveness regularly (e.g., weekly or monthly). Remove alarms when they are no longer clinically justified. Document review findings in the care plan. 7. Alternatives and Least Restrictive Interventions. Use other fall prevention methods [NAME] possible: Increased supervision. Environmental adjustments. Scheduled toileting. 8. Regulatory and Ethical Considerations Follow CMS (Centers for Medicare & Medicaid Services) and state regulations. Avoid alarms as restraints unless absolutely necessary. Encourage resident independence and dignity. 45291 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The safe lifting and movement of residents' policy was provided by the DON on 4/29/25 at 10:45 a.m. The policy indicated in order to protect the safety and well-being of staff and residents, and to promote quality of care, the facility would use appropriate techniques and devices to lift and move residents. Staff responsible for direct resident care would be trained in the use of gait/transfer belts. 3.1-45(a)(2)