STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Evansville	601 N Boeke Rd Evansville, IN 47711

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48147 Based on interview and record review, the facility failed to ensure SNF-ABN (Skilled Nursing Facility-Advanced Beneficiary Notice) Forms were provided following the end of Medicare skilled services for 1 of 2 residents who discharged from Medicare services and remained in the facility. (Resident Z) Finding includes: On 1/17/25 at 9:45 A.M., the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review Forms were reviewed. The form indicated Resident Z received Medicare Part A Skilled Services starting 12/4/24. The form indicated the last covered day of Part A services was 1/14/25 and the resident remained in the facility. The form indicated Resident Z did not receive a SNF-ABN (Skilled Nursing Facility-Advanced Beneficiary Notice) Form because she was scheduled to be discharged home on 1/15/25 following the last covered day, but family failed to pick up the resident who remained in the facility. At that time, the Administrator indicated a SNF-ABN had not been issued to the resident. During an interview on 1/21/25 at 12:41 P.M., the Administrator indicated Resident Z was still in the facility and would be responsible for the fees associated with room and board for her stay in the facility between 1/14/25 and whenever she was discharged . On 1/23/25 at 9:30 A.M., Resident Z's clinical record was reviewed. The census indicated Resident Z was admitted on [DATE] with Medicare as the payer source. On 1/15/25 the payer source was changed to private pay. On 1/22/25 the resident was discharged from the facility. On 1/27/25 at 12:31 P.M., the Administrator provided a Notice of Medicare Non-Coverage (NOMNC) policy, revised 10/1/23, that did not address the SNF-ABN form requirements. During an interview on 1/27/25 at 2:47 P.M., the Administrator indicated that the facility did not have a policy that addressed SNF-ABN forms and expected the facility to follow federal regulations for form requirements and distribution. 3.1-4(f)(2)

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

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

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F 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 a resident's discharge was documented in the clinical record for 1 of 3 residents reviewed for discharge. (Resident 60) Finding includes: On 1/23/25 at 12:24 P.M., Resident 60's clinical record was reviewed. Resident 60 was admitted on [DATE]. Diagnoses included, but were not limited to, Parkinson's Disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/5/24, indicated Resident 60 was moderately cognitively impaired, required substantial assistance from staff (staff does more than half of the work) for toileting and transfers, and was dependent on staff for bathing. A nutrition note created on 1/17/25 at 2:09 P.M., indicated Resident 60 was discharged with return not anticipated. The clinical record, including progress notes, assessments, and documents, lacked information regarding planning of a discharge, documents sent during discharge, where Resident 60 was discharged to, or when discharge occurred. During an interview on 1/23/25 at 2:58 P.M., the Admissions Director indicated Resident 60 left the faciity on [DATE] after a planned discharge and went to another long term care facility, but was unable to find any documentation of discharge planning. On 1/23/25 at 2:35 P.M., the Administrator provided a document titled Summary of Episode Note, created on 1/17/25, and indicated nursing staff should make a progress note when a resident leaves the facility stating when they left, where they went, and what was sent with the resident. On 1/27/25 at 12:31 P.M., the Administrator provided a policy titled Discharge Summary and Plan, dated 8/2024, that indicated When a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed to assist the resident with discharge. Every resident is evaluated for his or her discharge needs and has an individualized post-discharge plan. A member of the interdisciplinary team reviews the final post-discharge plan with the resident and family at least 24 hours before discharge takes place. A copy of the following is provided to the resident and receiving facility and a copy will be filed in the resident's medical records: an evaluation of the resident's discharge needs, the post-discharge plan, and the discharge summary. 3.1-12(a)(6)(A) 3.1-12(a)(6)(B)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50827 Based on interview and record review, the facility failed to ensure social services were provided to meet a resident's mental and psychosocial needs for 1 of 1 residents reviewed for Preadmission Screening and Resident Review (PASARR). (Resident 61) Finding includes: On 1/22/25 at 2:14 P.M., Resident 61's clinical record was reviewed. Diagnoses included, but were not limited to, Wernicke's encephalopathy, alcohol use disorder, non-Alzheimer's dementia, seizures, anxiety, depression, and an unspecified psychiatric disorder. The resident was admitted to the facility on [DATE]. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/20/24, indicated the resident was cognitively intact, required supervision for all mobility tasks, and received antipsychotics, antianxiety medication, antidepressants, and anticonvulsants during the 7-day look back period. Physician orders included, but were not limited to: olanzapine (an antipsychotic medication) oral tablet 10 milligrams (mg) - 1 tablet at bedtime, dated 11/21/23. Valium (an antianxiety medication) oral tablet 2 mg - 1 tablet by mouth twice daily, dated 6/3/24. Wellbutrin XL (an antidepressant) oral tablet Extended Release 24 Hour - give 150 mg by mouth one time a day, dated 1/21/24. thiamine (vitamin given to alcoholics to prevent Wernecke's encephalopathy) HCl oral tablet - give 100 mg by mouth one time a day, dated 1/21/24. Target behaviors: psychosis, delusions, hallucinations- to be monitored and charted on at the end of each shift, dated 10/13/24. Observe closely for significant side effects from antipsychotic medication use such as sedation, drowsiness, dry mouth, constipation, blurred vision, abnormal tremors/facial/tongue movements, weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention. Notify provider if observed and document in progress notes, dated 10/13/24. May utilize (name of mental health facility) for counseling services, dated 9/29/24. Target behaviors: depression- tearfulness, withdrawn, agitation, excessive crying, or social isolation. To be monitored and documented at the end of each shift, dated 8/9/24. Target behaviors: anxiety- self-reported nervousness, restlessness, sleeplessness, etc. To be monitored and documented at the end of each shift, dated 6/24/24. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident may reside on secured memory care unit, dated 6/6/24. Antianxiety medication- monitor for drowsiness, slurred speech, dizziness, nausea, aggressive/impulse behavior. Monitor and document at the end of each shift, dated 6/4/24. Current care plans included, but were not limited to: Resident resides on secured memory care unit. She has a diagnoses of dementia, Wernicke's Encephalopathy, alcohol induced persisting amnestic disorder, and other signs involving cognitive function and awareness. She has a history of exit seeking and wanting to leave to go home. Date Initiated: 1/24/24 Resident is at risk for ineffective coping due to unexpected loss of loved one (sister and spouse). Date Initiated: 2/1/24. Interventions included: Psych services as needed. Date Initiated: 2/1/24. On 1/23/25 at 9:00 A.M., the Administrator provided a copy of a PASARR completed for Resident 61 in April 2023, 8 months prior to the resident's admission to the facility. During an interview on 1/27/25 at 9:52 A.M., the Administrator indicated that Resident 61's diagnoses were updated after the previous PASARR was completed and the Admissions Director should have reviewed the PASARR on admission to make sure it was current and updated. On 1/27/25 at 12:31 P.M., the Administrator provided an Admissions Criteria policy, dated 8/2024, that indicated All new admissions and readmissions are screened for mental disorders (MD), intellectual disorders (ID), or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review process. 3.1-34(a)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758 Based on interview and record review, the facility failed to ensure the development and completion of a baseline care plan within forty-eight (48) hours of admission for use of respiratory equipment, tracheostomy, and Enhanced Barrier Precautions (EBP) for 1 of 1 residents reviewed for respiratory care. (Resident 277) Finding includes: On 1/21/25 at 11:21 A.M., Resident 277's clinical record was reviewed. Resident 277 was admitted on [DATE]. Diagnoses included, but were not limited to, chronic respiratory failure with hypoxia and tracheostomy. The Admission Minimum Data Set (MDS) Assessment was in progress. Current physician orders included, but were not limited to, the following: Change oxygen tubing monthly and as needed (PRN), one time a day every four weeks on Sunday for Oxygen (O2) use and as needed for soiled or compromised, dated 1/15/25. Change humidifier/bubbler monthly and as needed (PRN), as needed for empty/compromised and change one time a day every four weeks on Sunday for routine oxygen, dated 1/15/25. Resident requires the use of Enhanced Barrier Precautions (EBP) related to the medical device (Tracheostomy & Peg Tube) to reduce the risk of transmission of Multiple Drug-Resistant Organisms (MDROs) every shift for Isolation Precautions. Use Personal Protective Equipment (PPE) precautions when providing prolonged direct resident care, dated 1/14/25. The clinical record lacked a base line care plan for the tracheostomy, oxygen use, and EBP protocol. During an interview on 1/23/25 at 11:35 A.M., the Assistant Director of Nursing (ADON) indicated that a baseline care plan was based on the initial assessment that the admitting nurse completed. The initial assessment included, but was not limited to, physical assessment of the resident and oxygen use with a baseline care plan initiated within 48 hours of admission. On 1/27/25 at 12:31 P.M., the Administrator provided a current Care Plans, Baseline policy, revised 8/2024, that indicated A baseline care plan to meet the resident's immediate health and safety needs is developed within forty-eight (48) hours of admission. The baseline care plan includes instructions to provide effective, person-center care for the resident to meet professional standards of practice and must include the minimum healthcare information to properly care for the resident . 3.1-30(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review and interview, the facility failed to ensure care plans were updated after a fall for 1 of 6 residents reviewed for falls. (Resident 8) Finding includes: On 1/21/25 at 3:19 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, chronic pain syndrome, spinal stenosis lumbosacral region, and age-related physical disability. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 12/13/24, indicated the resident was mildly cognitively impaired, required substantial to maximal help (staff does more than half) with dressing, required partial to moderate assistance of staff (staff does less than half) with transferring, and had one fall with injury since the prior assessment. Current physician orders included, but were not limited to: 1/4 side rails for mobility positioning every day and night shift to aide with bed mobility related to morbid (severe) obesity, dated 11/20/20. A current falls care plan, dated 12/12/17, indicated that Resident 8 was at risk for falls related to potential side effects of medications (cardiac, opioid, psychological etc.). Interventions included, but were not limited to, the following: Medication review, labs, and orthostatic blood pressures, initiated on 1/20/25. Pain management, initiated 12/2/24. There should be a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Side rails as ordered, handrails on walls, personal items within reach initiated on 12/17/17 and revised on 8/2/23. An Interdisciplinary Team (IDT) note, dated 12/2/24 at 9:50 A.M., indicated that Resident 8 had an unwitnessed fall with injury on 11/27/24 at 9:45 P.M. The intervention for that fall was to provide an environmental assessment. The clinical record lacked documentation to indicate the new intervention was added to the plan of care. During an interview on 1/23/25 at 3:15 P.M., the Administrator indicated there should be a new intervention after each fall and the care plan was not updated with a new intervention after the resident fell on [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/25 at 12:31 P.M., the Administrator provided a current Comprehensive Care plans policy, revised 8/2024, that indicated comprehensive assessments are utilized in developing person-centered care plans .a significant change is a major decline or improvement in a resident's status that will not normally resolve itself without intervention by staff . 3.1-35(d)(2)

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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 observation, record review, and interview, the facility failed to ensure physician orders were followed for 2 of 5 residents reviewed for nutrition. (Resident 35 and Resident L) Findings include: 1. During an observation on 1/21/25 at 10:15 A.M., Resident 35's lower extremities were swollen. Resident 35 indicated she was supposed to wear compression stockings to reduce edema but staff had not put them on for her. On 1/21/25 at 1:37 P.M., Resident 35's clinical record was reviewed. Resident 35 was admitted on [DATE]. Diagnoses included, but were not limited to, renal failure and diabetes mellitus. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/16/25, indicated Resident 35 was cognitively intact and required substantial assistance from staff (staff does more than half of the work) for toileting, bathing, and transfers. Current physician orders included, but were not limited to: Patient to wear stockings on bilateral lower extremities (Tubigrips size G) for edema reduction and management. Nursing to assist patient in donning compression stockings in the AM (morning), doffing at HS (bedtime); Start date 11/21/24. 2. On 1/21/25 at 12:34 P.M., Resident L's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most recent Annual Minimum Data Set (MDS) Assessment, dated 12/23/24, indicated Resident L was moderately cognitively impaired and required substantial assistance from staff (staff does more than half of the work) for toileting, bathing, and mobility. Physician orders included, but were not limited to: Obtain weight one time only for monitoring for three days; Start date: 1/14/25 The clinical record, including progress notes, vitals, and medication and treatment administration records, lacked documentation of a weight recorded since 1/1/25. During an interview on 1/24/25 at 1:25 P.M., the Director of Nursing (DON) indicated the weights ordered on 1/14/25 were not obtained and left blank in the order administration record. During an interview on 1/27/25 at 12:31 P.M., the Administrator indicated the facility did not have a written policy for following physician orders, but it was the facility's policy to follow the physician orders as written. 3.1-35(g)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 48057 Based on observation, record review, and interview, the facility failed to ensure assistance at meals or assistance with bathing was provided for 7 of 8 residents reviewed for Activities of Daily Living (ADL) tasks. (Resident L, Resident S, Resident G, Resident U, Resident R, Resident N, and Resident T) Findings include: 1. During a continuous observation on 1/16/25 beginning at 12:08 P.M., a kitchen staff member was observed delivering trays to the dining room. Staff removed trays from the cart and placed them at the dining tables. Resident L was observed sitting in a recliner facing the dining area. Staff served all the residents at the dining tables, then collected trays as residents were done eating. At 12:41 P.M., Resident L called out to staff for help out of the recliner. At 12:47 P.M., staff transferred Resident L out of the recliner into a wheelchair and wheeled him to the dining table where Resident L ate alone. On 1/21/25 at 12:34 P.M., Resident L's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most recent Annual Minimum Data Set (MDS) Assessment, dated 12/23/24, indicated Resident L was moderately cognitively impaired and required substantial assistance from staff (staff does more than half of the work) for toileting, bathing, and mobility. Meal intake for Resident L was not documented for lunch or dinner on 1/16/24. 2. During an interview on 1/21/25 at 10:54 A.M., Resident S indicated showers were not being given according to the plan of care. On 1/22/25 at 9:15 A.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, chronic ulcers and congestive heart failure. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/9/25, indicated Resident S required substantial assistance (staff does more than half of the work) from staff for bathing. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated that bathing/showers were to be given on Monday and Thursday dayshift, before breakfast, Offer full or partial bed bath on non-shower days. Resident S's clinical record lacked showers provided on the following preferred days in December 2024 and January 2025: 12/2/24 12/12/24 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/13/25 1/20/25 On 12/19/24 at 12:03 P.M. and 1/9/25 at 5:51 P.M., shower refusals were documented but did not follow resident preference of time of day offered. 3. On 1/22/25 at 1:55 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/24/24, indicated Resident G was severely cognitively impaired and required substantial assistance (staff does more than half of the work) for bathing and transferring. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering task indicated that Bathing (prefers showers) schedule: Tuesday and Friday night shift. Resident G's clinical record lacked showers provided on the following preferred days in December 2024 and January 2025: 1/3/25 1/10/25 1/17/25 1/21/25 48147 4. On 1/21/25 at 2:04 P.M., Resident U indicated she did not receive showers twice a week. On 1/22/25 at 2:03 P.M., Resident U's clinical record was reviewed. Diagnoses included, but were not limited to, atrial fibrillation. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 12/27/24, indicated Resident U was cognitively intact, required supervision of staff for bathing, and had no rejection of care during the 7-day look back period. A preferences care plan, dated 6/20/23, indicated the resident preferred showers every other day at night time. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated Resident U received showers on Wednesdays and Saturdays on night shift. Resident U did not receive or refuse a shower on the following days in December 2024 and January 2025: 12/4/24 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/7/24 12/14/24 12/25/24 1/11/25 5. On 1/21/25 at 2:04 P.M., Resident R indicated he did not receive showers twice a week. On 1/22/25 at 2:10 P.M., Resident R's clinical record was reviewed. Diagnoses included, but were not limited to, pulmonary fibrosis. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 1/11/25, indicated Resident R was cognitively intact, required substantial to maximal assistance of staff (staff does more than half) for bathing, and had no rejection of care during the 7-day look back period. A choices care plan, revised 1/4/24, indicated the resident preferred showers on Tuesdays and Fridays during the day. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated Resident R received showers on Tuesdays and Fridays before bed. Resident R did not receive or refuse a shower on the following days in December 2024 and January 2025: 12/6/24 12/13/24 12/17/24 12/20/24 12/27/24 12/31/24 1/3/25 1/7/25 1/10/25 1/14/25 1/17/25 6. On 1/21/25 at 2:04 P.M., Resident N indicated she did not receive showers twice a week. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/22/25 at 2:18 P.M., Resident N's clinical record was reviewed. Diagnoses included, but were not limited to, chronic pain syndrome. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 12/19/24, indicated Resident N was cognitively intact, required substantial to maximal assistance of staff (staff does more than half) for bathing, and had no rejection of care during the 7-day look back period. An Activities of Daily Living (ADL) care plan, dated 8/6/23, indicated the resident required physical assistance of one with bathing due to chronic pain. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated Resident N received showers on Mondays and Fridays on day shift. Resident N did not receive or refuse a shower on the following days in December 2024 and January 2025: 12/6/24 12/13/24 12/20/24 12/23/24 1/6/25 50827 7. In an anonymous interview, it was indicated that Resident T had not been getting his showers and smelled like he hadn't showered and was living on the streets. Staff had indicated they didn't brush Resident T's teeth because he was care planned to brush his own teeth even though Resident T was right-arm dominant and that arm had been broken and was in a sling. On 1/21/25 at 1:39 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease with late onset, fracture of distal end of femur, fracture of fibula, and tibial plateau fracture (right side). The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 7/29/24, indicated Resident T had mild to moderate cognitive impairment, exhibited behaviors that included other behaviors not directed towards anyone that had worsened since the previous assessment, and required substantial to maximal assistance (staff does more than half) with oral hygiene and showering. A current Activities of Daily Living (ALD) care plan, dated 2/25/22, included the following interventions: The resident requires extensive assist by one staff with bathing/showering. The resident can be independent but occasionally does require extensive assist by one staff for personal hygiene and oral care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated Resident T received showers on Tuesdays and Fridays. Resident T did not receive or refuse a shower on the following days in June and July 2024: 6/11/24 7/12/24 7/19/24 A nursing progress note, dated 7/24/24 at 6:45 P.M., indicated the Registered Nurse (RN) noted Resident T to have poor oral hygiene, could not change his clothing on his own, and that he was in need of someone to help in doing hygiene such as brushing teeth, bathing, and changing clothes. On 1/22/25 at 2:39 P.M., the Director of Nursing (DON) indicated that all showers were charted in POC Tasks. Shower sheets were used but were not part of the clinical record. During an interview with the Administrator on 1/27/25 at 12:31 P.M., she indicated there was no written policy related to the timing of showers, but residents were expected to receive showers twice weekly. On 1/27/25 at 12:31 P.M., the Administrator provided a policy titled Assistance with Meals, dated 8/2024, that indicated Facility staff will serve resident trays and will help residents who require assistance with eating. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity. This citation relates to Complaint IN00448749. 3.1-38(a)(2)(A) 3.1-38(a)(2)(D) 3.1-38(a)(3) 3.1-38(b)(1) 3.1-38(b)(2)

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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 interview, observation, and record review, the facility failed to promote the prevention of pressure ulcer development through evaluation of clinical risk factors and implementation of interventions consistent with resident needs for 1 of 2 residents reviewed for facility acquired pressure injuries. (Resident G) Finding includes: During an anonymous interview, it was indicated Resident G had a decline in mobility since admission and was being left in the same position for long periods of time resulting in skin breakdown. During an observation on 1/23/25 at 8:57 A.M., Resident G was sitting in a recliner in the common area. The chair did not have a pressure reducing cushion for skin breakdown prevention. On 1/22/25 at 1:55 P.M., Resident G's clinical record was reviewed. Resident G was admitted on [DATE]. Diagnoses included, but were not limited to, dementia. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/24/24, indicated Resident G was severely cognitively impaired, required substantial assistance (staff do more than half of the work) for bathing and transferring, and was at risk for pressure ulcers. Current physician orders included, but were not limited to: Pressure reducing cushion to chair/wheelchair every shift, Start date 12/9/24. The care plan included, but was not limited to: I am at risk for impaired skin integrity related to bowel and bladder incontinence, Date Initiated: 12/10/24. The care plan did not include an individualized repositioning schedule. A progress note, dated 1/23/25 at 6:08 A.M., indicated Resident G had an open area on his coccyx. The clinical record lacked notification to family or physician of open wound. A progress note, dated 1/23/25 at 4:29 P.M., indicated Resident G had open areas on bilateral buttocks. The wound nurse was notified. A skin/wound note dated 1/23/25 at 4:39 P.M., indicated Resident G had five open wounds on his bilateral buttocks, including two stage two wounds (partial thickness skin loss). The following dates and times were documented as no skin issues in the skin observation task: 1/21/25 12:57 P.M. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/22/25 7:42 P.M. 1/23/25 6:16 P.M. 1/24/25 8:40 A.M. On 1/27/25 at 12:31 P.M., the Administrator provided a policy titled Prevention of Pressure Injuries, dated 8/2024, that indicated Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. Evaluate, report, and document potential changes in the skin. 3.1-40(a)(1) 3.1-40(a)(3)

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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** 48147 Based on interview and record review, the facility failed to ensure post fall assessments were completed, care plans were updated, and interventions were in place to prevent falls for 3 of 6 residents reviewed for falls. (Resident W, Resident P, and Resident G) Findings include: 1. On 1/22/25 at 8:59 A.M., Resident W's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease. The most current Annual Minimum Data Set (MDS) Assessment, dated 12/3/24, indicated Resident W had moderate cognitive impairment, required substantial to maximal assistance of staff (staff does more than half) for bed mobility, toileting, and bathing, and had no falls since the prior assessment on 9/3/24. A current fall risk assessment, dated 1/5/25, indicated Resident W was at high risk for falls. A current falls care plan, revised 9/12/22, indicated Resident W had a potential for falls related to impaired balance. A current Activities of Daily Living (ADL) care plan, revised 9/7/22, indicated Resident W required assistance of two staff for bed mobility, transfers, toileting, and bathing. Physician orders included, but were not limited to: Nursing must chart using hot charting progress note for every shift. Monitor vital signs every shift post fall for 72 hours to rule out any abnormal results or fluctuations every shift for three days, dated 1/7/25 A change in condition note, dated 1/5/25 at 6:48 P.M., indicated Resident W had a fall due to altered mental status and was sent to the emergency room (ER) for evaluation and treatment. A health status note, dated 1/6/25 at 2:18 P.M., indicated Resident W returned from the hospital with a diagnosis of Urinary Tract Infection (UTI). Imaging done at the hospital was normal. An Interdisciplinary Team (IDT) note, dated 1/7/25 at 10:09 A.M., indicated Resident W's fall was reviewed and a new intervention to monitor vital signs over 72 hours for any fluctuations or abnormal results post fall was added to the care plan. A Nurse Practitioner (NP) note, dated 1/8/25 at 11:59 P.M., indicated the resident was seen due to increased pain and altered mental status following a recent fall and hospitalization , where she was diagnosed with a UTI and received various diagnostic tests. Her vital signs show erratic blood pressure and an elevated pulse, raising concerns for potential sepsis . Continue close monitoring of vital signs, particularly blood pressure and heart rate. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An alert note, dated 1/13/25 at 4:04 P.M., indicated after continued complaints of pain, the Nurse Practitioner (NP) ordered a repeat x-ray that showed an acute fracture of the distal femur, and the resident was sent to the ER for evaluation and treatment. Hospital discharge papers, dated 1/13/25 at 5:55 P.M., indicated the resident was being discharged with a primary diagnosis of fracture of distal end of femur, fracture of fibula, and tibial plateau fracture (right side). A nursing progress note, dated 1/13/25 at 7:22 P.M., indicated the resident returned to the facility with an immobilizer in place on her right leg. The clinical record lacked documentation that the intervention monitor vital signs x 72 hours was reviewed for effectiveness or that the care plan was updated after the resident returned from the hospital on 1/13/25 with a new diagnosis of femur fracture and an immobilizer in place. In an interview on 1/22/25 at 9:56 A.M., the Director of Nursing (DON) indicated that the terminology hot charting was to remind the nurse they had something specific to chart. Vital sign hot charting would be documented in the vital signs tab. On 1/23/25 at 9:45 A.M., the Regional Support provided a weights and vitals summary for Resident W from 1/7/24 to 1/9/24. The following vital signs were not charted once per shift during that time: Blood pressure - 1/8/25 night shift, 1/9/25 night shift Pulse - 1/8/25 night shift Temperature - 1/8/25 day shift and night shift Pain level - 1/7/25 night shift, 1/9/25 day shift and night shift Respiration - 1/8/25 day shift and night shift, 1/9/25 day shift and night shift Oxygen Saturation - 1/8/25 day shift and night shift, 1/9/25 day shift and night shift. 48057 2. On 1/22/25 at 1:55 P.M., Resident G's clinical record was reviewed. Resident G was admitted on [DATE]. Diagnoses included, but were not limited to, dementia. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/24/24, indicated Resident G was severely cognitively impaired and required substantial assistance (staff do more than half the work) for bathing and transferring. A fall risk assessment, dated 1/15/25, indicated Resident G was a high risk for falls and had fallen multiple times in the past in the past three months. The care plan included, but was not limited to: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I am at risk for falls/injury due to: impaired cognition related to dementia, history of falls, initiated 12/10/24, Interventions included: Assess for pain, Date Initiated: 12/13/24 call light is within reach, Date Initiated: 12/13/24 Ensure pathways are free of clutter, Date Initiated: 12/13/24 Keep personal items within reach, Date Initiated: 12/13/24 Physical therapy to eval (evaluate) and treat as indicated, Date Initiated: 1/9/25 Staff education regarding ambulation of resident to assist with restlessness, Date Initiated: 1/17/25 Nonskid mat at bedside, Date Initiated: 1/17/25 Fall 1: On 12/21/24 at 6:37 A.M., an incident note indicated Resident attempted to get out of the recliner without assistance and slid to bottom of the recliner with legs on floor. Resident G was encouraged to use call light when needing assistance to avoid unsafe transfers. On 12/23/24 at 9:03 A.M., an Interdisciplinary Team (IDT) note indicated the IDT team agreed that the intervention for the fall on 12/21/24 was to offer toileting prior to getting up. The care plan was not updated with the new fall intervention for fall one. Fall 2: On 1/9/25 at 9:21 A.M., an IDT note indicated IDT reviewed a witnessed fall that occurred on 1/8/25. Resident G was reaching for his walker and fell forward. An immediate intervention of 72 hour hot charting was implemented and a new order was entered for physical therapy to evaluate and treat. Fall 3: On 1/15/25 at 11:30 P.M., Resident G was found sitting on the floor near his bed scooting using his hands and feet. Resident G was attempting to self-transfer unassisted and had impaired memory and unsteady gait. The care plan was updated with nonskid mat at bedside. Fall 4: On 1/21/25 6:07 A.M., a nursing progress note indicated Resident G slid onto the floor. The resident experienced minor pain and was transferred back to the chair. The clinical record lacked a post-fall assessment, notification to the physician or family, an intervention following the fall, and an update to the plan of care for fall four. Fall 5: On 1/26/25 at 4:05 P.M., a nursing progress note indicated a nurse and Certified Nurse Aide (CNA) attempted to transfer Resident G. Resident G slid to the floor. The clinical record lacked a post-fall assessment, notification to the physician or family, an intervention following the fall, and an update to the plan of care for fall five. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fall 6: On 1/26/25 at 10:24 P.M., a nursing progress note indicated Resident G slid out of bed onto the floor. The clinical record lacked a post-fall assessment, notification to the physician or family, an intervention following the fall, and an update to the plan of care for fall six. During an interview on 1/23/25 at 11:39 A.M., the Therapy Manager indicated Resident G was not receiving therapy because insurance had not approved services, and was not receiving daily restorative therapy. During an interview on 1/27/25 at 2:50 P.M., the Administrator and Director of Nursing (DON) indicated they could not find fall assessments for Resident G on 1/21/25 and 1/26/25 and were unaware Resident G had fallen either dates. 50827 3. On 1/22/25 at 2:47 P.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and a right intertrochanteric femur fracture. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 11/11/24, indicated the resident was not cognitively intact, required substantial to maximum assistance (staff does more than half) with transfers, and had no falls since the prior assessment. The most current fall risk assessment, dated 12/25/24, indicated Resident P was at high risk for falls. A current risk for falls care plan, initiated 5/2/24, indicated the resident was at risk for injury from a fall due to impaired cognition and dementia. A Communication with the Family note, dated 12/30/24 at 8:00 P.M., indicated the resident's family member was notified of a witnessed fall in the hallway with no injury. A Skilled Charting Note, dated 12/30/24 at 11:00 P.M., included vital signs and a skin/wound assessment. The note lacked documentation regarding the resident's witnessed fall. A Nurse Practitioner (NP) note, dated 12/30/24 at 11:59 P.M., indicated that the resident was seen per staff/resident request for a fall. An Interdisciplinary Team (IDT) note, dated 12/31/24 at 9:26 A.M., indicated the fall that occurred on 12/30/24 at 11:00 A.M. was reviewed. Resident P was witnessed attempting to stand from her wheelchair without the wheels locked and slid to floor. The care plan was updated with the new intervention to apply anti-rollbacks to the wheelchair. The clinical record lacked documentation to indicate Resident P was assessed immediately after falling on 12/30/24. (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 1/27/25 at 9:52 A.M. the Administrator indicated an initial assessment was not charted after the fall that occurred at 11:00 A.M. until the skilled assessment at 11:00 P.M that night. During an interview on 1/23/25 at 11:15 A.M., the Administrator indicated care plans were revised with a new intervention after each fall. The clinical team would meet the next day after a fall, discuss what the most appropriate intervention would be, and look for an intervention that would prevent the next fall or a fall of the same nature. If the intervention was to monitor vital signs, obtain labs, or review medications, the clinical team would meet to follow up on that intervention to determine if it were the cause of the fall, in which case orders were requested from the physician. If it was determined it was not the cause of the fall, another new intervention would be decided upon and placed in the plan of care. On 1/23/25 at 12:15 P.M., the DON provided a current Assessing Falls and Their Causes policy, effective 8/2024, that indicated 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 date, including vital signs and any obvious injuries . Notification of the physician and family . Appropriate interventions taken to prevent future falls . Notify the following individuals when a resident falls: The resident's family; The Attending Physician . Report other information in accordance with facility policy and professional standards of practice. On 1/27/25 at 12:31 P.M., the Administrator provided a current Falls and Fall Risk, Managing policy, effective 8/2024, that indicated If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions . If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling . This citation relates to Complaint IN00448749. 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. 46758 Based on observation, record review, and interview, the facility failed to ensure residents received respiratory care services in accordance with professional standards of practice for 1 of 1 residents reviewed for respiratory care. The facility failed to date oxygen tubing, oxygen concentrator, and suction tubing, and place signs that indicated oxygen was in use. (Resident 277) Finding includes: On 1/21/25 at 9:17 A.M., Resident 277's oxygen tubing, suction tubing, and oxygen concentrator were observed without a label and date. There were no oxygen signs observed that indicated the resident received oxygen. Resident was observed to have a tracheostomy. During the observation of Resident 277's tracheostomy care on 1/22/25 at 8:34 A.M., the obturator for emergency tracheostomy use was not identified in the room. On 1/22/25 at 8:53 A.M., Resident 277's oxygen tubing, suction tubing, and oxygen concentrator were observed without a label and date. There were no oxygen signs observed that indicated the resident received oxygen. On 1/21/25 at 11:21 A.M., Resident 277's clinical record was reviewed. Diagnoses included, but were not limited to, chronic respiratory failure with hypoxia and tracheostomy. The Admission Minimum Data Set (MDS) Assessment was in progress. Current physician orders included the following: Oxygen (O2) - six liters per tracheostomy mask. Titrate to keep O2 saturation greater than 92% at bedtime, dated 1/15/25. Change oxygen tubing monthly and as needed (PRN), one time a day every 4 weeks on Sunday for oxygen use and as needed for soiled or compromised, dated 1/15/25. Change humidifier/bubbler [sic] (container) monthly and PRN for empty/compromised, and change one time a day every 4 weeks on Sunday for routine oxygen, dated 1/15/25. The clinical record lacked a base line care plan for the tracheostomy and oxygen use. During an interview on 1/22/25 at 2:35 P.M., the Director of Nursing (DON) indicated the oxygen tubing, suction tubing, and concentrator should be labeled. There should be a sign on the outside of the door indicating oxygen use. On 1/22/25 at 9:56 A.M., the DON provided a current Oxygen Administration policy, revised 8/2024, that indicated the purpose of this procedure was to provide safe guidelines for safe oxygen administration . equipment needed .no smoking/Oxygen in use sign on the outside of the room entrance door . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-47(a)(4) 3.1-47(a)(5) 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview and record review, the facility failed to follow physician orders and provide ongoing assessment of the resident's condition and monitoring for complications by completing pre-dialysis evaluations assessments for 1 of 1 residents reviewed for dialysis management. (Resident 35) Finding includes: On 1/21/25 at 1:37 P.M., Resident 35's clinical record was reviewed. Resident 35 was admitted on [DATE]. Diagnoses included, but were not limited to, renal failure and peripheral vascular disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/16/25, indicated Resident 35 was cognitively intact and required substantial assistance from staff (staff does more than half of the work) for toileting, bathing, and transfers. Current physician orders included, but were not limited to: Do not obtain blood pressure in the left arm, Start date 10/8/24. Pre-Dialysis assessment to be completed prior to dialysis one time a day every Monday, Wednesday, Friday for pre-dialysis assessment; Start date 10/9/24 Post-Dialysis assessment to be completed after each dialysis appointment one time a day every Monday, Wednesday, Friday for baseline post-dialysis assessment, Start date 10/9/2024 The following dates and times included blood pressures documented obtained from the left arm: 12/1/24 2:11 P.M. 12/4/24 2:54 P.M. 12/5/24 10:03 A.M. 12/11/24 9:34 A.M. 1/7/25 11:20 A.M. 1/8/25 7:56 A.M. 1/15/25 11:33 A.M. 1/15/25 5:47 P.M. 1/22/25 8:00 A.M. 1/22/25 3:22 P.M. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A pre-dialysis assessment on 12/31/24 contained vitals including blood pressure, from a previous date (12/27/24). A pre-dialysis assessment on 1/10/25 contained vitals, including blood pressure, from a previous date (1/8/25). A pre-dialysis assessment on 1/24/25 contained vitals, including blood pressure, from a previous date (1/22/25). During an interview on 1/24/25 at 1:32 P.M., the Director of Nursing (DON) indicated Resident 35's blood pressure should not be taken in the left arm. During an interview on 1/27/25 at 12:31 P.M., the Administrator indicated the facility did not have a written policy for following physician orders, but it was the facility's policy to follow the physician orders as written. A policy related to assessment of dialysis patients was requested and not provided. 3.1-37(a)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview and record review, the facility failed to ensure a resident was assessed by a physician since admission for 1 of 1 residents reviewed for dialysis. (Resident 35) Finding includes: During an interview on 1/23/25 at 3:00 P.M., Resident 35 indicated she had not been assessed by a physician in the facility since admission. On 1/21/25 at 1:37 P.M., Resident 35's clinical record was reviewed. Resident 35 was admitted on [DATE]. Diagnoses included, but were not limited to, renal failure and peripheral vascular disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/16/25, indicated Resident 35 was cognitively intact and required substantial assistance from staff (staff does more than half of the work) for toileting, bathing, and transfers. The clinical record, including assessments, progress notes, and documents, lacked assessment of Resident 35 by a physician in the facility since admission. During an interview on 1/24/25 at 11:39 A.M., the Administrator indicated she was unable to find any physician assessments since admission for Resident 35. On 1/27/25 at 12:31 P.M., the Administrator provided a policy titled Choice of Attending Physician, dated 8/24, that indicated The attending physician requirements and responsibilities include: participating in the resident assessments and care planning; Physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current OBRA regulations and facility policy. 3.1-22(d)(1)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50827 Based on observation, interview, and record review, the facility failed to ensure meals were served at a palatable temperature for 1 of 1 trays tested for temperature. (North Hall) Finding includes: On 1/17/25 at 10:46 A.M., Resident 118 indicated the food tasted bad and was cold. On 1/21/25 at 10:13 A.M., Resident 35 indicated the food temperature was never what it was supposed to be. Her hot foods were not hot and her cold foods were not cold. On 1/21/25 at 10:53 A.M., Resident S indicated the food was cold when she got it and hot plates were sometimes not used to keep it warm while delivering it to residents. On 1/23/24 at 12:45 P.M. a test tray was obtained. Food temperatures from that meal were: Cheeseburger 100.6 F (Fahrenheit) Sweet potato fries 87 F The food tasted lukewarm and the cheeseburger was observed to be pink in the middle of the meat. On 1/23/24 at 12:50 P.M., the Dietary Supervisor indicated that the burgers used were precooked. On 1/27/25 at 12:31 P.M., the Administrator provided a Food Temperatures policy, dated 2021, that indicated foods sent to the units for distribution (such as meals, snacks, nourishments, oral supplements) will be transported and delivered to unit storage areas to maintain temperatures at or below 41 degrees F for cold foods and at or above 135 degrees F for hot foods. 3.1-21(a)(2)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48147 Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 1 of 3 residents reviewed for discharge from Medicare Part A and 1 of 6 residents reviewed for falls. (Resident Z and Resident T) Attempts to contact the family were not documented and details of an injury from a fall were not documented accurately. Findings include: 1. During an interview on 1/17/25 at 9:45 A.M., the Administrator indicated Resident Z was scheduled to be discharged home on 1/15/25, but family failed to pick up the resident. The facility had attempted to call the resident's family, but they had not answered the phone. During an interview on 1/17/25 at 9:58 A.M., Resident Z'a family member indicated that Resident Z was at the facility short term for rehab and was due to be discharged soon. They were waiting on a phone call from the Social Services Director (SSD) to set a date for discharge but had not yet heard anything. On 1/17/25 at 10:45 A.M., Resident Z's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure. The most current Admission Minimum Data Set (MDS) Assessment, dated 12/11/24, indicated Resident Z was cognitively intact and received physical and occupational therapy. Current care plans, dated 12/11/24, indicated the resident anticipated a short-term stay. Physician orders included, but were not limited to: Resident may discharge with Home Health of choice, dated 1/7/25 A late entry social services note, dated 1/13/25 at 8:54 A.M., indicated the resident was to discharge home on 1/15/24 and a family member would pick her up that day. A late entry social services note, dated 1/15/25 at 8:58 A.M., indicated the SSD left a voicemail for the family member asking when the resident would be picked up. The clinical record lacked documentation to indicate the facility attempted to call the family member between 1/15/25 at 8:58 A.M. and 1/17/25 at 12:47 P.M. A Social Service note, dated 1/17/25 at 12:47 P.M., indicated the SSD spoke with the family member and arrangements were made for discharge from the facility on 1/22/25. During an interview on 1/24/25 at 3:20 P.M., the Administrator indicated the Social Services Director was no longer employed by the facility and documentation of attempts to contact Resident Z's family between 1/15/25 and 1/17/25 could not be found. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50827 2. On 1/21/25 at 1:39 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, a Alzheimer's disease with late onset, nondisplaced fracture of greater tuberosity of right humerus, and other displaced fracture of upper end of right humerus. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 7/29/24, indicated the resident was not cognitively intact, required substantial to maximum assistance (staff does more than half) with toileting, showering/bathing, bed mobility, and transfers, and had two or more falls with major injury since the last assessment. An incident note, dated 7/19/24 at 10:44 A.M., indicated Resident T fell in his room. The resident complained of hip and neck pain. Resident T was assessed and had no injury, with the exception of, his previous injury in his left upper and lower arm with bruises visible to almost all of left arm. The Social Service Director (SSD) then decided to put a sling on resident provided by facility due to the sling the resident had currently, was not stable and did not elevate their left arm. A nursing progress note, dated 7/19/24 at 10:50 A.M., indicated Resident T had bruising and discoloration on his right arm from his neck to his wrist. During an interview on 1/27/25 at 9:52 A.M., the Administrator indicated she was unsure of which arm the resident hurt during the fall that occurred on 7/19/24 but it was most likely his right arm. At that time, she indicated it was not typical for the SSD to make the determination to put a sling on a resident, and the progress note was documented inaccurately. On 1/27/25 at 12:31 P.M., the Administrator provided a current Charting and Documentation policy, effective 8/2024, that indicated The following information is to be documented in the resident medical record: . progress towards or changes in the care plan goals and objectives . Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. This citation relates to Complaint IN00448749. 3.1-50(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46758 Based on observation, record review, and interview, the facility failed to ensure the proper use of Enhanced Barrier Protocol (EBP), Personal Protective Equipment (PPE), and hand washing for 2 of 2 residents reviewed for wound care and 1 of 1 residents reviewed for tracheostomy care. (Resident 13, Resident 18, Resident 277) Findings include: 1. On 1/21/25 at 11:21 A.M., Resident 277's clinical record was reviewed. Diagnoses included, but were not limited to, chronic respiratory failure with hypoxia and tracheostomy. Physician orders included, but were not limited to: Resident requires the use of Enhanced Barrier Precautions (EBP) related to the medical device (Tracheostomy & Peg Tube) to reduce the risk of transmission of multidrug-resistant organisms (MDROs) every shift for Isolation Precautions. Use Personal Protective Equipment (PPE) precautions when providing prolonged direct resident care, dated 1/14/25. On 1/22/25 at 8:34 A.M., Resident 227 was observed with a tracheostomy. There was not an Enhanced Barrier Precaution (EBP) sign observed in the resident's room. On 1/22/25 at 8:58 A.M., Licensed Practical Nurse (LPN) 23 was observed performing tracheostomy care for Resident 227. LPN 23 did not wear a gown during care. LPN 23 did not wash her hands prior to putting on gloves and opening items for a sterile field. The items were placed onto the sterile field and LPN 23 removed her gloves. LPN 23 washed her hands for 15 seconds with soap and water prior to putting on sterile gloves. LPN 23 proceeded to place a sterile suction catheter into right hand while using left hand to remove speaking valve. LPN 23 then suctioned Resident 227 three times to clean out the tracheostomy tube. After the suctioning was complete, LPN 23 removed the old trach dressing, removed her gloves, and did not perform hand hygiene. LPN 23 donned new sterile gloves, kept her right hand sterile, and utilized her left hand to remove the inner cannula. LPN 23 removed the dirty gloves, but did not perform hand hygiene before donning another pair of sterile gloves to place the sterile new inner cannula into the tracheostomy. LPN 23 placed a clean dressing under the cannula. LPN 23 did not perform hand hygiene after completing the care. During an interview on 1/22/25 at 9:18 A.M., LPN 23 indicated Resident 277 should be on EBP due to the tracheostomy. During an interview on 1/22/25 at 9:36 A.M., the Infection Preventionist indicated gloves should be changed each time when going from dirty to clean tasks and hands should be washed in between glove changes. 2. On 1/23/25 at 2:30 P.M., Licensed Practical Nurse (LPN) 23 and LPN 3 were observed performing wound care for Resident 18. An EBP sign was present on the door indicating the precautions and the PPE necessary when providing direct care. LPN 23 and LPN 3 did not wear wear a gown while providing wound care to five areas on the resident's lower legs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/24/25 at 3:00 P.M., Resident 18's clinical record was reviewed. Diagnoses included, but were not limited to, peripheral vascular disease, varicose veins with ulcer to left leg, and varicose veins with ulcer to right leg. The clinical record lacked orders and a care plan for Enhanced Barrier Precautions. 48147 3. On 1/22/25 at 10:27 A.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, stage three pressure ulcer. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 12/7/24, indicated Resident 13 had moderate cognitive impairment, was dependent on staff for all Activities of Daily Living (ADLs), and had two stage three pressure injuries. Physician orders included, but were not limited to: Resident requires the use of Enhanced Barrier Precautions related to chronic wound to reduce the risk of transmission of multidrug-resistant organisms (MDROs). Use personal protective equipment (PPE) precautions when providing prolonged direct resident care, dated 11/14/24. A stage three pressure ulcer to right posterior lateral calf care plan, dated 7/2/24, included an intervention for enhanced barrier precautions. A stage three pressure ulcer to left lateral lower leg care plan, dated 7/2/24, included an intervention for enhanced barrier precautions. A diabetic ulcer to left second toe care plan, dated 12/27/24, included an intervention for enhanced barrier precautions. On 1/23/25 at 10:41 A.M., Licensed Practical Nurse (LPN) 3 and LPN 19 were observed performing a dressing change for Resident 13's wounds. A sign indicating the resident was on Enhanced Barrier Precautions (EBP) was observed in the room. LPN 3 and LPN 19 did not wear a gown during the dressing change procedure. During an interview on 1/23/25 at 12:58 P.M., the Director of Nursing (DON) indicated staff should wear all the proper PPE, including gown and gloves, when contacting residents on EBP. There should be a sign on the door indicating EBP protocol. On 1/22/25 at 9:56 A.M., the DON provided a current Enhanced Barrier Precautions policy, revised 8/2024, that indicated .EBP employs targeted gown and glove use during high contact resident care activities . Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include device care .tracheostomy .wound care (any skin opening requiring dressing) . Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE provided . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/25 at 12:31 P.M., the Administrator provided a current Handwashing and Hand Hygiene policy, revised 8/2024, that indicated .the facility considers hand hygiene the primary means to prevent the spread of .infections . Indications for hand hygiene include: . before moving from work on a soiled body site to a clean body site on the same resident and immediately after glove removal . 3.1-18(b)(2) 3.1-18(l)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48147 Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment during 7 random observations. Odor was present in the facility and puddles of fluid and debris were on the floor. (West Hall, East Hall, 500-hall, Pavilion Dining Room) Findings include: 1. On 1/16/25 at 9:23 A.M., an unattended rolling cart of trash sitting in front of East Hall nurses station had an odor consistent with bowel movement. 2. On 1/16/25 at 9:32 A.M., the 500-hall had a strong putrid smell. 3. On 1/16/25 at 9:35 A.M., the [NAME] Hall was noted to have an odor consistent with bowel movement. 4. On 1/16/25 at 12:37 P.M., the Pavilion dining room floor had a large puddle of fluid and dirty debris observed along the dining room floors. 48057 5. On 1/21/25 at 8:00 A.M., the East Hall was noted to have an odor consistent with urine. 6. On 1/23/25 at 8:10 A.M., the East Hall was noted to have an odor consistent with urine. 7. On 1/23/25 at 10:41 A.M., the [NAME] Hall was noted to have an odor consistent with bowel movement. During an interview on 1/24/25 at 9:19 A.M., the Housekeeping Supervisor indicated that managing odors was a part of the housekeeping staff's daily cleaning tasks. All housekeepers have odor eliminating supplies on their cart and odors were taken care of as soon as they were noticed. On 1/27/25 at 12:31 P.M., the Administrator provided a current Homelike Environment policy, effective 8/2024, that indicated The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include . pleasant, neutral scents. 3.1-19(f)