Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165030	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaknoll Retirement Residence	1 Oaknoll CT Iowa City, IA 52240

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 48452 Based on observation, record review, and interviews the facility failed to complete a baseline Care Plan within the first 48 hours of admission that addressed resident goals and services for 1 of 5 residents reviewed (Resident #48). The facility reported a census of 57. Findings include: The Quarterly Minimum Data Set (MDS) for Resident #48 dated 1/31/24 revealed a Brief Interview for Mental Status (BIMS) could not be administered due to short term and long-term memory problems, disorganized thinking, and inattention. The MDS included diagnoses of hypertension, non-Alzheimer's dementia, and depressive episode. The MDS documented that the resident's most recent admit was 6/27/23. A Care Plan printed 4/3/24 at 2:35 PM included the revision history and documented an admitted [DATE]. A focus area for advance directives was initiated 6/27/23. Focus areas which addressed dependence on staff, and impaired cognitive function and impaired thought process, were added 7/6/23. Focus areas for dehydration and altered nutrition were added 7/10/23. Additional focus areas covered incontinence and impaired skin integrity, falls, and self-care deficit and impaired mobility which were added 8/10/23. Progress notes failed to document development of the Plan of Care or that one was discussed with or offered/provided to the resident's power of attorney within 48 hours of admission. On 4/4/24 at 9:13 AM observation revealed facility paper charts for this resident's home were located in an office on the second floor. The resident resided on the 3rd floor. Resident #48's chart did not contain a baseline care plan. On 4/4/24 at 8:39 AM Staff D, Social Worker, indicated there were two Care Plan Coordinators, and each department provided them with information for completion. On 4/4/24 at 11:44 AM the Director of Nursing confirmed nursing was not responsible for care plans. The MDS Coordinator and ADON (Assistant Director of Nursing) both completed them with assistance from her as needed. On 4/4/24 at 1:06 PM Staff B, Licensed Practical Nurse stated she spoke to the ADON about care plans. She did not know why Resident #48's baseline Care Plan was not completed.

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 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** 48452 Based on record review, observation, and interviews the facility failed to ensure the Care Plan was comprehensively reviewed, revised, or followed for 1 of 3 residents (Resident #35) reviewed for nutrition and for 1 of 3 residents (Resident #42) reviewed for behavioral health. The facility reported a census of 57 residents. Findings include: 1. The Annual Minimum Data Set (MDS) assessment dated [DATE] for Resident #35 listed diagnoses of coronary artery disease, gastroesophageal reflux disease, and hypokalemia (low potassium). The MDS documented 3/2/23 as the residents most recent admitted . The MDS indicated the resident needed set up or clean up assistance with eating. The resident was unable to complete the Brief Interview for Mental Status (BIMS) exam due to short term and long term memory problems, inattention, and disorganized thinking. The resident's Care Plan printed at 12:43 PM on 4/2/24 with an admitted [DATE] included focus areas for altered nutrition (revised 3/20/23), Potential for Dehydration (initiated 5/10/21), and self-care deficits (3/16/23). Interventions for nutrition included: a. Labs as ordered (5/10/21) b. Assistance with and encourage intake as needed (5/10/21) c. Cater to food preferences as able (5/10/21) d. Quarterly and PRN dietician consults (5/10/21) e. Documentation of meal intake (5/10/21) f. Educate/encourage healthy food choices (5/10/21) g. Offer snacks between meals (5/10/21) h. Offer substitutions (5/10/21) i. Provide assistive devices as needed (5/10/21) j. Provide diet as ordered (5/10/21) k. Provide banana at breakfast (11/15/23) l. Provide favorite food to encourage intake (5/10/21) m. Provide juice supplement at med pass BID (twice per day)(created 11/15/23) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	n. Provide meal/tray set up (5/10/21) o. Provide meal in room per resident preference (3/20/23) p. Provide supplement at meals (4/17/23) q. Family provided snacks in her room (3/20/23) r. Weight monthly or as registered dietician recommended (5/10/21) A Dietician Note in the paper chart, (without time documentation) and dated 2/7/24, documented a 2 pound weight loss in one month, 8 pounds since the last assessment, and 12 pounds in 6 months. The note documented the resident met and continued care plan goal related to maintaining weight. The weight loss was unplanned. A Communication with Physician (Progress Note) dated 2/7/24 at 1:52 PM indicated the facility communicated with the physician regarding weight loss and documented the resident was unable to understand the importance of nutrition. The Care Plan lacked additional interventions or intervention modifications. A Plan of Care Note dated 2/9/24 at 11:53 AM indicated the note was from 1/30/24 and lacked documentation regarding nutrition. A Order Note dated 2/9/24 at 4:43 PM indicated an order was received to change the supplement. The Care Plan lacked additional interventions or intervention modifications. On 4/1/24 at 12:18 PM observation revealed the resident guided from her room by staff to eat her meal in the dining area. Her shirt was loose on her torso and her pants appeared baggy. She remained at the table for the full meal. On 4/2/24 at 8:18 AM observation revealed a staff enter resident's room and ask if she wanted breakfast. The resident declined. At 9:01 AM staff provided her with a tray. Staff left her room immediately. With continued observation until 10:15 AM staff did not enter the room to assist or encourage the resident to eat or drink, per direction on the Care Plan for nursing staff. On 4/4/24 at 12:38 PM the Dietary Manager stated the resident's weight on 3/18/24 was incorrect due to issues with the scale and resident compliance requiring an updated weight. He reported the new weight for 4/2/24 as 112.8. Weight was reassessed as follows: a. 1 month - 109.4 on 3/5/24 to 112.8 on 4/2/24, up 3.11% b. 3 months - 114.6 on 1/1/24 to 112.8 on 4/2/24, down 1.57% c. 6 months - 126.6 on 10/4/23 to 112.8 on 4/2/24, weight down 10.9% 13 of the 18 nutrition care plan interventions were created during a prior admission. The Care Plan lacked triggers, behaviors, and/or resident specific interventions that addressed the resident's 10.9% weight loss over 6 months. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/24 at 2:43 PM Staff G, Certified Nurses Assistant (CNA) reported the resident's weight fluctuated, the family used to bring snacks but not as much now. On 4/3/24 at 2:48 PM Staff H, [NAME] Coordinator stated the resident had an irregular sleep pattern, some days she slept more during the day and was up at night. Staff H did not know what she ate then, but reported sometimes the kitchen premade sandwiches. On 4/4/24 at 1:06 PM Staff B, Licensed Practical Nurse, reported she was aware of the weight loss. She confirmed the increase in nutritional drinks and stated they tried finger foods. The resident did not have a meal routine and where she ate varied. 2. The Quarterly Minimum Data Set (MDS) assessment for Resident #42 dated 1/31/24 revealed the resident was unable to complete the Brief Interview for Mental Status (BIMS) exam due to short term and long term memory problems, inattention, and disorganized thinking. The MDS documented the resident had the diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The resident's Care Plan, documented a focus area with initiated date 10/26/22 as follows; psychotropic drug use to include Sertraline, Trazadone, and Mirtazapine. The Care Plan Interventions included the following; a. monitor for side effects, provide distractions, and to administer medication as ordered. The Care Plan identified the following focus area dated 11/3/22; the potential to develop a psychosocial well-being problem related to dementia process, [NAME] admission, and worry. The Care Plan interventions dated 11/3/22 included the following; a. give the resident time to answer questions and verbalize feelings b. consult with pastoral care, social services, and psych services as needed c. encourage participation from resident who depends on others to make own decisions d. facilitate connections with friends e. provide opportunities to participate in care. A Progress Note dated 2/26/24 at 9:47 AM documented social services assisted with a referral to a behavioral health provider due to increased anxiety, restlessness, and fearfulness. The Care Plan lacked documentation of triggers, new diagnoses, and resident specific behaviors with associated interventions. A Progress Note titled Order Note dated 3/11/24 at 1:49 PM documented a Telehealth visit with social services and the [NAME] Coordinator present, with new order to increase Mirtazapine (medication for depression). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A document titled Psychiatry Intake Note dated 3/11/24 from 8:00 AM - 9:00 AM documented a new diagnoses of generalized anxiety disorder and dementia, unspecified type, severe, with anxiety. Suggested interventions included encourage participation in activities that promote brain engagement and socialization, warm washcloths, and lavender essential oil for comfort. (These were not added to the resident's Care Plan or included in a progress note.) Resident #42's diagnosis report lacked documentation of resident's new mental health diagnoses as of 4/2/24 at 2:29 PM. The Medication Administration Record documented the resident started Risperidone 3/28/24. The associated diagnosis did not match the diagnosis in the Psychiatry Intake Note. The progress notes lacked documentation of this order. The resident's Care Plan lacked documentation of triggers, new diagnoses, and resident specific behaviors with associated interventions. An interview on 4/3/24 at 2:48 PM with the [NAME] Coordinator confirmed the resident participated in the Telehealth appointment. She stated the resident was very anxious, they worked on his medication, and they tried music, headphones, and 1:1 reading as interventions. On 4/4/24 at 1:06 PM Staff B, Licensed Practical Nurse (LPN) reported the Assistant Director of Nursing addressed their Care Plan updates. Staff B, LPN stated changes and updates for Care Plans were communicated at meetings, by email, or in person. On 4/4/24 at 11:44 AM the Director of Nursing stated that Care Plans were updated in up to 7 days.

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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** 48452 Based on observation, interview, policy review, and record review the facility failed to ensure neurological assessments were completed for residents with a known history of falls, and failed to ensure residents were safely transported via wheelchair for 6 of 21 residents reviewed for accidents (Residents #4, #8, #16, #21, #48, and #49). The facility reported a census of 57 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident#49 was unable to complete the Brief Interview for Mental Status (BIMS) exam due to short term and long term memory problems, inattention, and an altered level of consciousness. Section J of the MDS, Health Conditions, documented the resident had 2 falls since the prior assessment. The MDS documented the most recent admit to the facility occurred on 10/18/2023. A Care Plan with an admitted [DATE] included the following focus areas: a. Dependence on staff for physical needs related to physical limitations and cognitive challenges (2/23/24), b. Communication problems related to hearing and dementia (10/19/23), i. Intervention: Anticipate and meet needs ii. Intervention: Provide a safe environment c. Potential for falls (10/18/23). i. Intervention: Assist with scheduled check and change ii. Intervention: Assist to common areas when restless iii. Intervention: For no apparent acute injury, determine and address causative factors of the fall iv. Intervention: Monitor and report signs/symptoms of or complaints of discomfort A Health Status Note dated 3/27/24 at 11:37 AM documented Resident #49 was found on the gray mat in front of his bed at 7:30 AM with his legs spread. The resident was incontinent of bowel. A Health Status Note dated 4/3/24 at 3:46 PM documented the resident was found by the nurse sitting on the floor with his legs in front of him, leaning against the closet. The resident denied pain and hitting his head, was assisted to stand, and transferred to his wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The electronic health record revealed vitals were taken at 11:11 AM on 3/27/24, 11:33 AM on 3/27/24, and 3:50 PM on 4/3/24 by Staff C, Registered Nurse. An Incident Report dated 4/3/24 at 3:30 PM documented the resident had an unwitnessed fall. The resident description indicated he walked towards his walker, lost his balance near the closet, leaned, and slowly went down. Resident #49's mental status was documented as oriented to person, place, and situation. The report listed no environmental, physiological, or predisposing factors. Documentation in the resident's electronic and paper records lacked documentation of neurological monitoring for unwitnessed falls on 3/27/24 or 4/3/24. The most recent neurological assessment sheet in the resident's paper chart was initiated 1/14/24. During an interview on 4/4/24 at 8:30 AM the resident was unable to answer questions from the surveyor regarding his fall 4/3/24. Staff A, Licensed Practical Nurse, on 4/4/24 at 9:04 AM specified the protocol for an unwitnessed fall for a resident with cognitive impairment or a potential injury was to assess for neurological concerns for 24 hours post fall according to a flow sheet. Staff A stated the assessment started with 15-minute checks, progressed to half hour checks, moved to hourly monitoring, and then 4-hour monitoring. She stated no residents were currently being assessed according to this protocol. On 4/4/24 at 11:44 AM the Director of Nursing reported she was not aware of Resident #49's fall on 4/3/24. She stated if there was a question of a head injury neurological checks should be initiated. On 4/4/24 at 11:50 AM the Administrator stated the decision to evaluate after a fall should be more cautious than less. A policy titled Fall Prevention and Investigation Policy, reviewed 1/25/24, documented each resident received care and services in accordance with their individualized level of risk. A fall was defined as an event where an individual unintentionally moved from a higher plane to a lower plane and came to rest on the ground, floor, or other lower level. It could be witnessed, reported, or presumed and could occur anywhere. Number 5(f) indicated general fall protocol was to monitor vital signs according to facility policy. It lacked documentation regarding the extent of assessments required for residents with cognitive impairment or an unwitnessed fall. 2. The Quarterly Minimum Data Set (MDS) for Resident #48 dated 1/31/24 revealed a Brief Interview for Mental Status (BIMS) could not be administered due to short term and long-term memory problems, disorganized thinking, and inattention. The MDS included diagnoses of hypertension and non-Alzheimer's dementia. The MDS documented that a wheelchair was normally used in the last seven days by the resident. The MDS documented that the resident was dependent on staff for putting on and taking off footwear, and lower body dressing. The MDS documented that the resident was dependent on staff to operate the manual wheelchair for the resident. A Care Plan with an admitted [DATE] addressed dependence on staff (7/6/23), impaired cognitive function and impaired thought process (7/6/23), falls (8/10/23), and self-care deficit and impaired mobility (8/10/23). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/01/24 at 11:10 AM revealed the following; Staff G, CNA pushed the resident in her wheelchair down the hallway from her room to the dining area without pedals, with the resident holding her feet up off of the ground. Staff G reached the table, then looked down and realized the resident did not have wheelchair pedals. She returned to the resident's room to get them and placed them on the chair. 3. The Annual Minimum Data Set (MDS) assessment for Resident #21 dated 1/10/24 revealed the resident was unable to complete the Brief Interview for Mental Status (BIMS) exam due to short term and long term memory problems, inattention, and disorganized thinking. It included a diagnosis of dementia. The MDS documented that a wheelchair was normally used in the last seven days by the resident. The MDS documented that the resident was dependent on staff for putting on and taking off footwear, and lower body dressing. The MDS documented that the resident was dependent on staff to operate the manual wheelchair for the resident. A Care Plan with an admitted [DATE] included focus areas related to impaired mobility (initiated date 4/13/21), dependence on staff for physical needs related to dementia and physical limitations (initiated date 5/4/21), communication deficits related to difficulty with expressing herself (initiated date 4/15/21), and a potential for falls due to poor balance and unsteady gait (initiated date 8/29/22). The Care Plan included the following interventions; a. included scheduled check and change, proper footwear, and monitoring for anxiety related to not being able to propel her wheelchair where she chose. b. The resident needs assistance/escort to activity functions c. The resident can self propel in wheelchair without foot pedals On 4/1/24 at 10:40 AM observed Resident #21 in the common area of the 3rd floor. There was a bag for pedals on the back of her wheelchair. The pedals of her chair were on, and her feet were trapped underneath. She tried to lift her tennis shoes between the pedals without success. The left pedal was at about 80 degrees and the right about 45 degrees from the floor. As she attempted to move, she could not get the momentum in that small foot space to turn the chair without hitting her feet and shins on the pedals. The resident came to a rest with her back to the table she had been sitting at and was unable to move any further. On 4/3/24 at 2:43 PM Staff G, Certified Nursing Assistant (CNA), stated most residents who use wheelchairs have pedals available in their rooms. This resident sometimes needed assistance and sometimes wanted to move on her own. She indicated the resident had a bag on the back of her wheelchair for pedals. She stated some residents need them off so they didn't hit their shins. Staff G stated they are trained by working with other CNAs and they get transfer training. On 4/3/24 at 2:48 PM Staff H, [NAME] Coordinator, stated they educated activity staff about basic wheelchair safety, and CNA staff should know when to use the pedals or leave them off as part of their training with the staff trainer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A document titled CNA Relias Hours Assigned dated 4/1/24 indicated a training called Transferring Safely was assigned 8/14/23. 48888 4. The Quarterly Minimum Data Set (MDS), dated [DATE], documented Resident#4 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated intact cognition. The MDS revealed Resident #4 had impairment to both sides of upper extremities and utilized a wheelchair for mobility. Resident #4 required substantial to maximal amount of staff assistance with transfers and was non ambulatory. The MDS document the resident had diagnoses which included acute osteomyelitis of left ankle and foot, acute lymphangitis of left lower extremity, and osteoarthritis. The MDS documented that the resident normally used a wheelchair for the seven day look back period. The MDS revealed that the resident dependent on a helper to put on and take off footwear, and dress the lower body. The Care Plan, documented a focused care area for impaired mobility with initiated date of 1/25/18. The Care Plan instructed staff to encourage Resident #4 to propel her wheelchair on her own with her feet and to provide assistance as needed. Observation on 04/03/24 at 12:54 PM, revealed Resident#4 pushed by Staff I, Certified Nursing Assistant (CNA), in a wheelchair with no foot pedals in place. Resident #4 held her legs out straight in front of her during transportation from the dining room back to the resident's room. 5. The Quarterly Minimum Data Set (MDS), dated [DATE], documented Resident#8 scored a 4 out 15 for the Brief Interview for Mental Status (BIMS) assessment which indicated severe cognitive impairment. Resident #8 utilized a wheelchair for mobility and required dependence on staff for transfers. The MDS documented that the resident had diagnoses which included the following; thyrotoxicosis with thyrotoxic crisis or storm and mild cognitive impairment. The Care Plan, revised 03/25/24, revealed the focused area for impaired mobility with the goal that Resident #8 will not have a decline in self-care ability or ability to transfer and instructed staff to assist/escort Resident #8 to activity functions. On 04/03/24 at 01:18 PM, observed Resident #8 pushed in a wheelchair by staff from the South hall lounge to her room, foot pedals in place, however, feet had not been placed on foot pedals prior to transport. Resident #8's feet pointed downwards and toes skimmed across the floor during transportation. 6. The Quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Resident #16 utilized a wheelchair for mobility and required partial to moderate amount of staff assistance with transfers and ambulation. Diagnoses included anxiety disorder and restless legs syndrome. The MDS documented that the reside required total assistance with putting on and/or taking off footwear. The Care Plan, revised 02/27/24, revealed a focused area for self care deficit related to impaired mobility with a goal that Resident #16 will continue to be mobile within the facility with an assist of one staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/03/24 at 10:59 AM, observed Resident #16 in wheelchair without foot pedals, pushed by a shower aide, from the South hall shower room to the South hall medication cart, where staff requested hearing aides from the nurse. A nursing student assisted resident with hearing aides, then pushed Resident #16 from the medication cart to resident's room, Resident #16's feet skimmed just over top of the floor while transported in wheelchair. On 04/03/24 at 11:20 AM, Resident #16 self propelled in wheelchair from room to hallway, Staff I, Certified Nursing Aide (CNA), visited with resident in hallway, latched Resident #16's seatbelt across lap, then assisted Resident #16 back to her room, no foot pedals placed on the wheelchair. 7. The Quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicative of severe cognitive impairment. Diagnoses included: dysphagia (difficulty swallowing) and thyrotoxicosis. The MDS revealed Resident #8 had coughing or choking during meals or when swallowing medication and required a change in the texture of food or liquids during the assessment period. The Care Plan, revised on 03/20/24, revealed a focused care area for impaired swallowing related to dysphagia diagnosis and informed that Resident #8 required fluids thickened to pudding consistency. The Care Plan instructed staff to provide direct supervision of intake and monitor Resident #8's respiratory status. The Speech Therapy Note, dated 02/09/24, revealed the recommendation of Speech Therapist to trial pudding thick liquids between the dates of 02/09/24 and 02/15/24. Nursing staff noted the recommendation on 02/13/24. The Speech Therapy Note, dated 02/12/24, revealed a recommendation to discontinue the free water protocol and instructed for no thin liquids between meals at this time. Recommendation lacked nursing notation. The Nursing Progress Note, dated 03/19/24, revealed Resident #8 had episode of coughing during evening meal that resulted in small emesis and informed that Resident #8 continued to have cough but lung sounds had been clear after episode. The Plan of Care Progress Note, dated 03/27/24, revealed Resident #8 had worked with Speech Therapy due to coughing with meals and had an order for a swallow study to be completed due to dysphagia. The Dietary Department provided a residents diet list, revised on 04/01/24, which informed that Resident #8 required pureed diet with pudding thickened liquids and instructed to serve Resident #8 only with staff present. On 04/01/24 at 12:30 PM, Resident #8 received staff assistance with the lunch meal. Staff provided pureed texture food and pudding thickened liquids. Resident #8 frequently coughed and cleared throat during the meal. On 04/02/24 at 11:28 AM, Staff E, Certified Nursing Assistant (CNA), informed that CNA staff would view diet information kept on a care sheet within each resident's wardrobe. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaknoll Retirement Residence	1 Oaknoll CT Iowa City, IA 52240

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/02/24 at 11:58 AM, observation of two care sheets posted inside Resident #8's wardrobe. The first sheet, titled Resident Information, undated, indicated that Resident #8 required thickened liquids, however lacked information on the thickness required. The second sheet, titled Therapy Recommendation, dated 11/11/22, indicated Resident #8 required minced and moist diet and mildly (nectar) thick liquids with an addendum that informed staff to implement the Frazier Water Protocol, which allowed for thin liquids, between meals. On 04/02/24 at 12:00 PM, Resident #8 had water pitcher located on bedside table with a lid and straw, water inside the pitcher had been of nectar thickness consistency, noted the viscosity of liquid too thin to be given via spoon, as required for pudding thick liquids. On 04/02/24 at 02:00 PM, Staff F, CNA, indicated water pitchers are filled towards the end of each shift and thought Resident #8 had been on nectar thickened liquids, after Staff F checked with Staff A, Licensed Practical Nurse (LPN), informed that Resident #8 had required pudding thickened liquids. On 04/03/24 at 10:00 AM, Staff C, Registered Nurse (RN), reported that Resident #8 had been on honey thickened liquids and stated the medication pass liquids for Resident #8 would be thickened to a honey consistency. Staff C informed that that thickened liquids would be kept in the clean utility refrigerator. Staff C checked the refrigerator, which contained only a bottle of pre-thickened nectar thick water, and informed that if liquids needed to be thicker than nectar consistency, they would add thickening powder to achieve the correct thickness. Staff C, unable to locate thickening powder in the clean utility room or within the medication cart. On 04/03/24 at 10:18 AM, water pitcher located in Resident #8's room again contained water with a thickness less than the required pudding thickness for liquids. On 04/03/24 at 04:25 PM, Dietary Manager informed that the Speech Therapists would send recommendations through the facility's electronic system to nursing and dietary departments and that dietary would update the diet list with new recommendations. The Director of Nursing (DON) informed that when nursing received therapy recommendations, nursing would update the resident's orders. DON notified that therapy recommendations are kept in resident's wardrobes for CNA staff to review and indicated that Restorative Aides are responsible for updating Care Sheets in the wardrobe. The Facility Assessment, titled Oaknoll Retirement Residence Community Assessment Tool 2024, reviewed with leadership on 02/14/24, revealed under Part 2: Services and Care Offered Based on Resident's Needs, the facility would provide nutritional service for individualized dietary requirements.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48374 Based on observation, interview, and record review the facility lacked documentation regarding behavioral triggers related to the use of psychotropic medication. The facility failed to implement a comprehensive Care Plan that included documentation identifying behavioral triggers to meet the resident's medical, mental and psychosocial needs prior to the administration of unnecessary medications for two of four residents reviewed for unnecessary medications (Resident #33) and (Resident #36). The facility reported a census of 57 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #33 dated 3/6/24 revealed the resident had severely impaired cognitive skills for daily decision making. Per the MDS, Resident #33 diagnosis included Alzheimer's disease and depression. The Care Plan revised 3/6/2024 documented a focus area of Psychotropic Drug Use: Zoloft as ordered every day, Trazadone as ordered, Risperidone. Interventions included: Alter environmental meet needs, document behaviors as noted et monitoring, Monitor Aims every quarter and as needed, monitor for et report SE of medication as noted, provide distractions per resident needs et preferences. The Care Plan did not document specific behaviors or triggers associated with behaviors. The Physician Order dated 4/3/2024 documented Risperidone TAB 0.5MG 1 TAB PO every morning related to Dementia is other diseases classified elsewhere, unspecified severity The Physician Order dated 12/13/2023 documented Trazadone Tab 50MG 1/2 Tablet (25MG) 1/2 Tablet (25MG) PO every morning and bedtime related to Alzheimer's disease, Unspecified The Physician Order dated 11/30/2022 documented Sertraline Tab 100MG one tab PO every morning related to Depression, Unspecified Review of Resident #33's Medication Administration Record (MAR) documented the resident received Trazadone Tab 50MG 1/2 Tablet (25MG) every morning and bedtime and Sertraline Tab 100MG I tab PO every morning during the review period of April 1, 2024 through April 8, 2024 as prescribed. The resident received Risperidone TAB 0.5MG every morning during the period of April 4, 2024 through April 8, 2024. The Behavior Monitoring document dated 3/10/2024 to 4/8/2024 documented the resident displayed the following behavioral symptoms; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wandering on 3/27,3/29, 4/2,4/3,4/7 Kicking/Hitting on 4/3 Grabbing on 3/29, 4/3 Abusive language and threatening behavior on 4/3 The care plan lacked potential interventions for these behaviors or potential triggers. Review of Progress Notes dated 3/13/24 at 9:03 documented the resident remains alert and oriented to self and familiar people, but with challenges related to expressing self and needs due to dementia disease progression. Resident at times appears agitated and becomes frustrated when unable to express himself. Staff continue to find ways to support resident and anticipate needs. Resident's dementia related behaviors continue to be managed with assistance from geri-psych provider and primary care provider (PCP). The care plan lacked documentation of these or other behavioral triggers. 2. The Minimum Data Set (MDS) assessment dated [DATE], for Resident #36 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS documented the resident received antidepressant medication on 7 out of 7 days of the assessment reference period. Resident #36 is diagnosed with congestive heart failure, type 2 diabetes and unspecified mood disorder. The MDS did not document any behavior concerns. The Care Plan dated 6/23/2023 and revised on 2/19/2024 documented a focus area of Psychotropic Drug Use related to the diagnosis of Depression with the following interventions: a. Administer Wellbutrin, Cymbalta as ordered every day. Monitor et report side effects (SE's) as noted. Symptoms of anxiety. b. Alter environment to meet needs c. Monitor and (et) document behavior et mood changes as noted et monitoring d. Monitor et report complaints of (c/o) or s/sx of nerve pain of lower extremities as noted e. Monitor for et report SE of medication as noted f. Provide distractions per resident needs et preferences g. Provide pharmacy eval every month, Medical Doctor (MD) every 2 months for continued drug use The Care Plan lacked documentation of specific triggers and associated behaviors to support the need for psychotropic drug use. The Physician Order dated 6/30/2023 documented, Bupropion Hydrochloride (HCL) Extra Long (XL) (antidepressant) 300MG TAB 1 TAB PO every morning, related to depression, unspecified (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Order dated 6/30/2023 documented, Duloxetine Delayed Release (DR) (antidepressant) 30MG 1 CAP PO every (Q)AM **Take with 60MG to equal 90MG related to major depressive disorder The Physician Order dated 6/30/2023 documented, Duloxetine HCL DR 60MG 1 CAP PO QAM **Take with 30MG to equal 90MG related to major depressive disorder Review of Resident #36's Medication Administration Record (MAR) documented the resident received Duloxetine DR 30MG, Duloxetine HCL DR 60MG and Bupropion HCL XL 300MG TAB each morning during the review period of April 1, 2024 through April 8, 2024 as prescribed. The Behavior Monitoring document dated 3/23/2024 to 4/4/2024 documented the resident did not display any behavior symptoms. 4/4/2024 at approximately 12:30 PM, the Administrator reported for Psychotropic medications the whole team is involved. The facility focus is on medication reviews and gradual dose reductions (GDR) completed timely. The facility charts by exception so they would not chart unless there was some sort of behavior. Staff members are provided with a lot of education regarding documentation of behaviors and interventions. The facility utilizes non-pharmacological interventions such as music therapy, massage, redirection and distraction. Staff members know resident triggers because they know their residents. Staff members are assigned to designated areas so they are familiar with their residents. Resident #36 has not displayed behaviors. The facility policy titled Medication Regimen Review, dated 11/7/2017 and revised 6/1/2023, included each residents' drug regimen remains free of unnecessary drugs. An unnecessary drug is any drug when used: In excessive doses, including duplicate therapy. For excessive duration. Without adequate monitoring. Without adequate indications for its use. In the presence of adverse consequences which indicate the dose should be reduced or discontinued.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on observation, interview, and facility policy review, the facility failed to maintain secure medication storage when 1 of 3 medication carts remained unlocked without staff supervision and further failed to keep schedule 4 medication (lorazepam concentrate solution) under double lock for 2 of 3 medication storage rooms observed. The facility reported a census of 57 residents. Findings include: On 04/01/24 at 02:14 PM, observation of the medication cart, located on South hallway, with the lock out in an unlocked position and keys hanging from the lock. The medication cart left unattended with four visitors and three residents sitting in the area, various ancillary staff also passed through the hallway. One ambulatory resident wandered in the hallway and attempted to open a locked room near the medication cart. Two Certified Nursing Aides (CNAs) sat around the corner, out of eyesight of the medication cart. At 02:23 PM, after nine minutes of continuous observation, Staff A, Licensed Practical Nurse (LPN), exited room [ROOM NUMBER], returned to South hall medication cart, removed the keys from the cart and pushed the lock in a locked position. On 04/02/24 at 12:04 PM, continuous observation of the South hall medication cart left unlocked and unattended. Four South hallway residents remained in their rooms during this time and various staff passed through the area. At 12:09 PM, Staff A, LPN returned to medication cart, grabbed trash, and again failed to lock the medication cart before leaving it unattended to go to clean utility room. At 12:11 PM, Staff A, returned to medication cart, locked cart, and went into chart room. On 04/03/24 at 10:05 AM, Staff B, LPN, provided a tour of North hall medication storage room. A medication refrigerator, kept inside this medication room, contained an open bottle of liquid lorazepam concentrate medication, classified as a Schedule 4 controlled substance due to potential for abuse and addition. The medication refrigerator lacked an additional locking system to limit access to the schedule 4 medication. Staff B, explained that there had not been a lock on the medication refrigerator as the medication storage room itself is kept locked. On 04/03/24 at 10:20 AM, Staff C, Registered Nurse (RN), provided a tour of South hall mediation storage room. An additional medication refrigerator, kept inside this medication room, contained an open bottle of liquid lorazepam concentrate medication. Staff C informed that this medication would be destroyed due to resident's recent passing and confirmed that no additional locking system had been kept on this medication refrigerator. On 04/03/24 at 04:25 PM, the Director of Nursing (DON), confirmed that medication storage rooms lacked an additional locking system on refrigerators containing Schedule 4 controlled substance (lorazepam concentrate solution) and would check into this requirement. In an E-mail sent from DON, dated 04/03/24 at 06:49 PM, revealed that the facility now had all liquid lorazepam under double lock system. This medication stored in a lock box inside the medication refrigerator within the medication storage room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, titled Medication Storage, revised 02/09/24, revealed the expectation that all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) and instructed that medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. The Medication Storage policy additionally informed that Schedule 2 drugs and back up stock of Schedule 3, 4, and 5 medications are stored under double-lock and key.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 48374 Based on interview, clinical record review, and facility policy review the facility failed to document an agreement and collaboration between the facility and hospice. The facility failed to document a plan to coordinate hospice care and ensure the Care Plan documents, a description of care and services provided by the hospice provider and the facility for two of two residents reviewed for Hospice (Resident #12, #107). The facility reported a census of 57 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment for Resident # 12 dated 3/20/2024 revealed the resident had moderately impaired cognitive skills for daily decision making. The MDS documented Resident #12 had diagnoses which include Parkinson's Disease and Progressive Neurological Conditions. The MDS lacked documentation regarding the resident was on Hospice Care. The Care Plan dated 6/12/2019 and revised on 3/20/24 failed to document Hospice Certification and Plan of Care for Resident #12. A Pharmacist Note dated 12/27/2023 at 9:22 a.m. documented Resident #12 is now enrolled in Hospice. 2. The Admission Minimum Data Set (MDS) assessment for Resident #107 dated 3/25/2024 revealed the resident had mildly impaired cognitive skills for daily decision making. The MDS documented Resident #107 had diagnoses which includes Medically Complex Conditions including Atrial Fibrillation or Other Dysrhythmias and Adult Failure to Thrive. The MDS documented the resident was on Hospice Care. Admission Summary 3/14/2024 at 3:23 p.m. documented as follows; Res brought via wheel chair to health center with assist. Stand by assist transfer to recliner which resident sleeps in, bedside commode. Does not use bed. Hospice Care, DNA, Do not hospitalize, comfort foods. No known allergies, alert and oriented times three, occasional hallucinates, hospice to provide comfort meds. Resident deemed nondesional, Durable Power of Attorney sister enacted. Strong urine odor, resident refused, blood pressure, labs or urinalysis. During an interview on 4/4/2024 at approximately 12:30 PM the facility Administrator was queried regarding a physician orders for residents. The Administrator advised it is her expectation that a medical order for hospice would be in the resident's file. When asked specially about orders for the two identified residents the Administrator advised with both of the identified residents the facility did not initiate hospice and therefore would not have anything to do with the doctor. If a resident's family initiates hospice or the resident is admitted on hospice I think it would be weird to insert ourselves. Upon request, the Administrator was able to obtain a copy of the Hospice Certification and Plan of Care from the hospice provider for resident #12 and resident #107. 4/4/2024 Upon request, Administrative staff provided Interdisciplinary Communication for both residents which they advised is only accessible by the DON and Social Worker. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 4/4/2024 at 2:10 PM The facility Administrator and the Director of Nursing (DON), advised if there were new orders for medication, treatment or symptom management that would be documented. When queried both administrative staff members advised that information would be documented in the hospice notes entered by the agency hospice provider via Interdisciplinary Communication entered by the hospice worker. When further queried, the Administrator and the DON advised they believe the only facility staff to have access to the Interdisciplinary Communication is the DON and the facility Social Worker. The Facility Policy dated 2/26/2024 titled, Agreement For Hospice Care For Skilled Nursing Facility and Nursing Facility Residents documented, Article 1 Responsibilities of Hospice Section 1.2 (a) Hospice Provider will furnish Facility with a copy of the Hospice Provider Plan of Care after the Resident's admission to Hospice Provider and will identity the services to be furnished by Facility and the services to be provided by Hospice Provider.