STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165171	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Oak Nursing and Rehabilitation Center LLC	455 31st Street Marion, IA 52302

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on observation, record review, resident interviews, staff interviews, and policy review the facility failed to treat 3 of 7 residents reviewed with dignity and respect while providing care and services (Residents #30, #49, and #51). The facility reported a census of 74 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #30 dated 3/21/25 documented diagnoses of heart failure, weakness, seizure disorder, and anxiety. The MDS included a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated intact cognition. It reported the resident needed assistance with set up for oral care and was dependent for toileting hygiene, sit to stand, and chair/bed transfers. The resident was marked as touch assistance for toileting transfers with the MDS further documenting tub/shower transfers and bathing were not attempted in the look back period due to medical condition or safety concerns. The Care Plan for Resident #30 included interventions dated 7/10/24 to transfer the resident to her wheelchair at night for toileting, as well as to encourage participation in activities that promote exercise and physical activity for strengthening and improved mobility. An intervention dated 10/12/24 indicated the resident used XXL disposable briefs and directed staff to change or offer toileting every 2 hours and PRN (as needed). On 3/31/25 at 11:16 AM the resident was noted to be asleep in her recliner wearing a red plaid nightgown. From the door of her room, her hair appeared oily and there was an odor outside of her room. On 04/01/25 at 07:49 AM the resident was observed in her room, asleep in nearly the same position as the day before. She was wearing the same plaid nightgown as the day before. Her hair remained oily and tight to the side of her head. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/01/25 at 07:54, when asked about staff treating her with dignity and respect, the resident reported certified nursing assistants (CNAs) had told her she had to go (urinate and defecate) in her brief due to 'spells' she had quite a while ago in the bathroom. She said she felt 'nasty' going in her brief, which caused trouble getting it out and constipation. They told her to finish going and call them when she was done. She stated it had happened more than once in the past week, mostly at night. The resident reported an instance when she sat with poop half in and half out all night. She also reported staff did not regularly comb her hair, change her clothes, help her brush her teeth, or bathe her. She reported she had been wearing the current clothing for 3 days. A Progress Note dated 7/12/24 at 8:19 PM documented the resident became upset waiting to use the restroom. She told the nurse she would need to use the toilet versus 'going in the brief' that night. Documentation indicated that would be passed on to the night shift. It did not include that it was passed on to the Director of Nursing or the Administrator to discuss why she thought she had to go in her brief. On 04/01/25 at 07:25 PM observed Staff E, CNA walk into Resident #30's room without knocking or announcing herself. Between 7:25 PM and 8:11 PM Staff E entered and exited resident rooms 7 times without knocking or announcing herself. 3 of the rooms were dark with residents sleeping and the noise Staff E made could be heard in the hallway. During a follow up interview with Resident #30 on 04/01/25 at 08:16 PM she reported she'd had a shower after dinner. The resident stated the briefs they put her in afterwards were too tight. The surveyor observed the open package of briefs on the bed were XL. The resident stated she needed XXL and staff told her they didn't have any. She reported they were 'cutting' in to her front and back. She further stated the evening shift CNAs changed her brief but would not take her to the bathroom. She confirmed using the bathroom was her preference. On 04/03/25 at 02:50 PM Staff I, Licensed Practical Nurse (LPN), stated she was aware of staff refusing to take the resident to the bathroom at night. She thought the CNA was disciplined and didn't think that person worked there anymore. An interview with Staff G, LPN on 04/07/25 at 11:08 AM revealed the resident needed the wheelchair and 2 CNAs to take her to the bathroom and to change her brief. She stated the resident had told her about concerns with 2nd shift staff not taking her to the bathroom. She did not know if that had been reported to anyone. While interviewing Staff H, CMA/CNA on 04/07/25 at 10:46 AM she stated Resident #30 required pretty much full care. She reported the resident had been upset some mornings when she arrived because the resident said staff at night made her go to the bathroom in her brief. She stated the resident did have 'little episodes' but if staff stayed with her in the bathroom it was fine. 2. The MDS for Resident #49 dated 3/16/25 included diagnoses of atrial fibrillation, neurogenic bladder, and fibromyalgia. It documented a BIMS of 15/15 indicating intact cognition. Section GG revealed the resident required substantial to maximal assistance with transfers, toileting, bathing, dressing, and personal hygiene. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's Care Plan with an admitted [DATE] indicated the resident used an electronic tablet to assist with communication due to hearing deficit. Interventions included anticipating and meeting needs and monitoring for non-verbal signs of distress and frustration. Focus areas included risk for developing pressure ulcers, bowel and bladder incontinence, risk for falls, and fragile skin. On 03/31/25 at 01:19 PM observed the resident's roommate and a guest who opened and closed the curtain dividing the room. Resident #49 asked to speak with the surveyor somewhere private because she felt her roommate listened to everything. At 01:40 PM the resident was transferred to her wheelchair to move to a private area. She reported she was only getting one bath a week, she had to ask repeatedly to get up in the morning, her medications were often late and her pain cream was missed some days. She stated that on 3/4/25 at 11:50 AM a CNA came in and turned off her call light without helping her leading to a 2.5 hour wait to get changed. When asked if she felt staff were respectful she stated she didn't think having to ask the CNAs to make sure she was clean after going to the bathroom, missing showers, or making residents wait so long for care was respectful at all. Resident #49 also reported staff did not provide appropriate daily care for false teeth and it was sometimes hard to get her clothes changed in the morning unless her significant other helped and shut the door. On 04/03/25 at 2:50 PM Staff I, Licensed Practical Nurse (LPN) stated the resident probably had missed showers due to staffing issues. She was not aware of missing denture cleaning. Staff H, Certified Nursing Aide (CNA), during an interview 04/07/25 at 10:46 AM, indicated residents often complained about missing baths, mostly second shift. Staff H stated oral cares should be provided at least every morning. She stated this resident had spoken to her about her care before. On 04/07/25 at 11:08 AM Staff G, LPN reported Resident #49 had expressed concerns about showers, medications, and staff who have told her to wait and then not returned. She addressed it the times she was there but that was only part time. She thought the facility was short staffed for the care residents needed in the building. 3. The MDS for Resident #51, dated 2/9/25, included diagnoses of multiple sclerosis, neurogenic bladder, anxiety, and depression. The resident scored 15/15 on the BIMS indicating intact cognition. He was dependent on staff for oral hygiene, toileting hygiene, and chair/bed transfers. He required substantial/maximal assistance for toilet transfers and dressing. The Care Plan for Resident #51 with an admitted [DATE] included focus areas, goals, and interventions related to multiple sclerosis care, depression, anxiety, mood, and medication monitoring. On 03/31/25 at 11:30 AM the resident reported he was generally happy with his care. During a follow up interview with the resident on 04/08/25 at 9:05 AM he revealed that sometimes he was confused and embarrassed about some of the things he heard. When asked to explain that, he reported he had heard staff in the building talking about about him and a former employee. He stated he did feel safe but also felt 'under duress.' On 4/7/25 at 11:08 AM Staff G, LPN reported staff had talked about the resident and former employee when they still worked at the facility. On 4/9/25 at 9:47 AM Staff H, CNA confirmed that she had talked about the resident, employee, and possible medication issues with other staff. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/9/25 at 9:18 AM Staff F, CNA confirmed that she had talked about possible incidents with other staff and heard rumors among staff about a potential relationship. On 4/7/25 at 9:22 AM the Director of Nursing was asked about resident dignity concerns and stated she expected nurses to check in with residents daily to make sure dressing, toileting, bathing, overall care was being completed and that every resident contact was an opportunity to ensure good care. She stated residents had complained to her about issues related to dignity such as bathing, timeliness, and staffing. She expected staff to knock before entering a room and that CNA's would help with oral care twice a day. On 4/7/25 at 5:06 PM the Administrator reported the facility was continuing their investigation into Resident #51 concerns. She expected staff to remember this was a resident's home and didn't know staff had been talking about this incident. A policy titled Resident Rights revised 3/4/25 revealed the resident had the right to a dignified existence. The resident had the right to be treated with respect and dignity. The resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. The resident had a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care. The resident had a right to personal privacy and confidentiality of his or her personal and medical records.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434 Based on clinical record review, policy review, and staff interviews, the facility failed to ensure resident records included advance directive wishes for 2 of 24 residents reviewed for code status (Residents #2 and #10). The facility reported a census of 74 residents. Findings: 1. The Minimum Data Set (MDS) assessment tool, dated [DATE], listed diagnoses for Resident #2 which included heart failure, bipolar disorder, and depression. The MDS listed her Brief Interview for Mental Status (BIMS) status score as 15 out of 15, indicating intact cognition. A Care Plan entry, dated [DATE], stated the resident wished to be a Full Code. On [DATE] at 8:45 a.m., the resident's face sheet on her electronic health record (EHR) did not include any information under the heading Code Status. The binder at the nurse's station also did not include her Iowa Physician Orders for Scope of Treatment (IPOST). On [DATE] at 8:46 a.m., the Director of Nursing (DON) confirmed that Resident #2's IPOST was not in the binder nor the EHR. She stated she would correct this today. A [DATE] 9:32 a.m. Order Details report listed the resident as a Full Code. 2. The MDS assessment tool, dated [DATE], listed diagnoses for Resident #10 which included non-Alzheimer's dementia, seizure disorder, and mild intellectual disabilities. The MDS listed the resident's BIMS score as 7 out of 15, indicating severely impaired cognition. A [DATE] Care Plan entry stated the resident requested to be a Do Not Resuscitate (DNR) code status. On [DATE] at 8:19 a.m., Staff B Licensed Practical Nurse (LPN) stated aside from the EHR, resident code status information was located in a binder. She provided the binder which had a tab entitled IPOST. On [DATE] at 8:19 a.m., the binder under the tab entitled IPOST did not include an IPOST for Resident #10. On [DATE] at 8:46 a.m., the DON stated if the IPOST was not in the binder and there was no access to the computer, she would need to check with social work or get a copy from the doctor if it was an immediate situation. She stated if they could not locate a code status, they would work under the assumption the resident was a Full Code. The State Agency (SA) informed the DON that Resident #10's IPOST was not in the binder. Staff B was present and located the IPOST in the binder under a different tab after approximately 2 minutes, at 8:48 a.m. The resident's IPOST, dated [DATE], stated the resident resident's code status was a DNR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Cardiopulmonary Resuscitation(CPR), dated [DATE], stated the facility would carry out CPR in accordance with the resident's advance directives or in the absence of advance directives. On [DATE] at 2:38 p.m., the DON stated code statuses should be up to date and in the binder.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on observation, clinical record review, pharmacy record review, resident interview, police narrative, staff interviews, and policy review the facility failed to protect 1 of 3 residents reviewed for abuse from misappropriation of property and exploitation (Resident #51). The facility reported a census of 74 residents. Findings include: The MDS (Minimum Data Set) for Resident #51, dated 2/9/25, included diagnoses of multiple sclerosis, neurogenic bladder, anxiety, and depression. The resident scored 15/15 on the BIMS (Brief Interview for Mental Status assessment) which indicated intact cognition. The Care Plan for Resident #51 with an admitted [DATE] included focus areas, goals, and interventions related to multiple sclerosis care, depression, anxiety, mood, and medication monitoring. Three documents titled Shipment Details indicated the following medication deliveries for the resident from the resident's pharmacy: Sildenafil Citrate 50 mg tablet, quantity 15, filled 8/30/24 (treat erectile dysfunction) Sildenafil Citrate 50 mg tablet, quantity 15, filled 9/8/24 Sildenafil Citrate 50 mg tablet, quantity 15, filled 9/21/24 On 04/08/25 at 9:05 AM the resident revealed he was very close to Staff M, RN (Registered Nurse). He stated he tipped her with 5 or 10 bucks for her birthday. When asked, the resident reported she kept the money and must have really needed it. When asked about a medication order from his urologist, Sildenafil Citrate, Resident #51 stated he knew on a personal level that Staff M had access to it. He thought she was the last one, maybe the only one, to give it to him. Resident #51's Medication Administration Record (MAR) for August 2025 documented the resident received Sildenafil Citrate 50 mg from Staff M 8/31/24 at 6:14 PM. The record did not include documentation that 1 or 2 pills were distributed. The medication was discontinued on 9/7/24. Progress Notes did not include documentation of what happened to the remaining 13 or 14 tablets at that time. No additional documentation was provided by the facility regarding this medication card. The resident's MAR for September 2025 documented an order for Sildenafil Citrate 50 mg tablet. Give 100 mg by mouth as needed for vasculogenic dysfunction of corpus cavernosum, take 1-2 tablets as needed once daily. The resident received this medication from Staff M on the following dates: 9/8 - 9:40 AM 9/11 - 8:56 AM (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/13 - 6:04 PM 9/17 - 5:55 PM 9/21 - 4:57 PM The resident's electronic health record did not document if the resident received 1 or 2 tablets for each administration. Progress Notes did not include documentation of what happened to the other 5-10 tablets. The facility did not have additional information regarding this card. The resident's MAR for October 2025 documented an order for Sildenafil citrate 50 mg tablet. Give 2 tablets by mouth as needed for vasculogenic dysfunction of corpus cavernosum, take 1-2 tablets as needed once daily. The resident received this medication from Staff M on the following dates: 10/4 - 6:17 PM 10/5 - 6:08 PM 10/6 - 6:27 PM 10/15 - 5:16 PM 10/19 - 6:01 PM 10/20 - 5:21 PM The resident's electronic health record did not document if the resident received 1 or 2 tablets for each administration. The facility did not have additional information regarding this card. Progress Notes did not include documentation of what happened to the other 3-9 tablets at that time. No additional administration of this medication was documented in the resident's MAR. In total between 21 and 33 tablets of Sildenafil Citrate were unaccounted for. On 4/1/25 at 8:01 PM the Administrator notified the surveyor they received a call from the local police department requesting information about Staff M and Resident #51. The Administrator stated Staff M was terminated in November (2024) for performance issues. She stated there were two incidents prior to that termination where staff in the facility reported Resident #51 and Staff M hugged and kissed. She stated they investigated and the facility was not able to confirm they occurred because the resident had a BIMS of 15 and denied them when questioned. She stated the denial was why they did not report it to the state. On 4/2/25 at 2:40 PM the surveyor observed Staff N, Licensed Practical Nurse look through the contents of the medication cart. The cart did not contain any of the 3 missing medication cards. Staff N accompanied the surveyor to the medication storage room. The cards were not in the storage room or the pharmacy bin. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/6/25 at 1:43 PM a county deputy emailed the surveyor a narrative of an investigation he was conducting. It noted that a backpack owned by Staff M contained a label from an unknown container, identified as a prescription for Sildenafil Citrate 50 mg to Resident #51 by his provider. The deputy provided a picture of the card top that included Resident #51's name. The narrative further documented Resident #51 resided at a care facility where Staff M was previously employed. Staff M refused to answer the deputy's questions regarding having a sexual and/or inappropriate relationship with Resident #51. On 4/7/25 at 5:06 PM the Administrator stated she assumed Staff M took the medication because it wasn't in the medication cart or the storage room. She reported she contacted the pharmacy and none of the medication was returned. Staff M was the only person to give Resident #51 this medication. On 4/9/25 at 9:18 AM Staff F, CNA (Certified Nurses Aide) stated that while she didn't see physical contact personally, Staff M and Resident #51 had a relationship she observed that was not professional and other staff did witness inappropriate things. She reported hearing Staff M took medications that belonged to residents and mentioned insulin because Staff M said she was 'allergic to cake', an anxiety medication when she had a panic attack at work, and the Sildenafil Citrate. Staff F indicated Resident #51 could be inappropriate with female staff, so staff provided cares in pairs. She reported Staff M and Resident #51 had private time together and she was in his room with the door closed when there was not a reason to be. She stated Resident #51 told other staff that Staff M gave him 'hand jobs,' made out with him, gave her money for her birthday, and gave her money for a phone he never got. She stated rumors increased after the two reports by her co-workers. A facility policy titled Abuse, Neglect and Exploitation reviewed/revised October 2022 documented it was the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing policies and procedures that prohibit and prevent abuse, exploitation, and misappropriation of resident property. The facility would provide ongoing oversight and supervision of staff to ensure policies were implemented as written. Section III. Prevention of Abuse, Neglect, and Exploitation documented the following: B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur; H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. Section V. Investigations of Alleged Abuse, Neglect, and Exploitation included: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on observation, clinical record review, pharmacy record review, resident interview, staff interviews, and policy review the facility failed to report potential misappropriation and exploitation for 1 of 3 residents reviewed (Resident #51). Facility staff indicated they were aware of potential incidents as early as July 2024. The facility reported a census of 74 residents. Findings include: The MDS (Minimum Data Set) for Resident #51, dated 2/9/25, included diagnoses of multiple sclerosis, neurogenic bladder, anxiety, and depression. The resident scored 15/15 on the BIMS (Brief Interview for Mental Status assessment) which indicated intact cognition. The Care Plan for Resident #51 with an admitted [DATE] included focus areas, goals, and interventions related to multiple sclerosis care, depression, anxiety, mood, and medication monitoring. According to pharmacy records, the facility received the following medication cards for Resident #51: Sildenafil Citrate 50 mg tablet, quantity 15, filled 8/30/24 (treat erectile dysfunction) Sildenafil Citrate 50 mg tablet, quantity 15, filled 9/8/24 Sildenafil Citrate 50 mg tablet, quantity 15, filled 9/21/24 Resident #51's Medication Administration Records (MAR) for August, September, and October 2025 documented an order for Sildenafil Citrate 50 mg tablet, 100 mg or two tablets by mouth as needed for vasculogenic dysfunction of corpus cavernosum, take 1-2 tablets as needed once daily. He received doses from Staff M (RN) 12 times. No other staff administered the medication. The electronic health record did not include documentation whether 1 or 2 pills were distributed at each administration. In total between 21 and 33 tablets were unaccounted for. The facility was unable to provide documentation regarding the location of the missing cards or audits of the medication carts or storage that would indicate when the medications went missing. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/08/25 at 9:05 AM the resident revealed he was very close to Staff M, RN (Registered Nurse). He stated he tipped her with 5 or 10 bucks for her birthday. When asked, the resident reported she kept the money and must have really needed it. When asked about a medication order from his urologist, Sildenafil Citrate, Resident #51 stated he knew on a personal level that Staff M had access to it. He thought she was the last one, maybe the only one, to give it to him. He stated he kissed Staff M, and believed that was a romantic thing to do. He confirmed she was an employee of the facility at the time. He stated they had agreed to 'take it slow.' He told the surveyor Staff M talked about her ex with him and that he was really bothered by the fact that Staff M might have been married at that time because he didn't want to be responsible for her cheating. At the end of the interview the resident was tearful, unable to speak for a moment and covered his mouth with his hand. He said he just missed her and this was hard. He thought he was in love with her, she never came back to see him, and he was confused about all of this. On 4/1/25 at 8:01 PM the Administrator notified the surveyor they received a call from the local police department requesting information about Staff M and Resident #51. The Administrator stated Staff M was terminated in November (2024) for performance issues. She stated there were two incidents prior to that termination where staff in the facility reported Resident #51 and Staff M hugged and kissed. She stated they investigated and the facility was not able to confirm the incidents occurred because the resident had a BIMS of 15 and denied them when questioned. She stated the denial was why they did not report it. On 4/7/25 at 5:06 PM the Administrator added that she assumed Staff M took the medication because it wasn't in the medication cart or the storage room. She reported she contacted the pharmacy and none of the medication was returned. Staff M was the only person to give Resident #51 this medication. On 4/2/25 at 2:40 PM the surveyor observed Staff N, Licensed Practical Nurse (LPN) look through the contents of the medication cart. The cart did not contain the 3 missing medication cards. Staff N accompanied the surveyor to the medication storage room. The cards were not in the storage room or the pharmacy bin. On 4/7/25 at 10:46 AM Staff H, CMA (Certified Medication Aide) stated there was a lot going around when Staff M was still at the facility about an inappropriate relationship. There were comments that she stuck her tongue down his throat, and that he gave her money for a phone. She stated the relationship was different from nurse and patient, and that there was some weird stuff going on. On 4/9/25 at 9:47 AM Staff H added she also heard about Staff M taking medication. She believed it was reported to the Director of Nursing at the time or the Administrator. On 4/7/25 at 11:08 AM Staff G, LPN stated she heard about 'tongue swapping' between Staff M and Resident #51, and money changing hands. She reported seeing Staff M in the building late, between 10 and 11, and Staff M would follow him. Staff G stated Staff M gave Resident #51 special treatment, and that the resident was madly in love with her. She stated he still wasn't over it. She indicated staff 'all' knew about it and Staff M pushed to get the Sildenafil Citrate on board. (continued on next page)

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	165171	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/25 at 9:18 AM Staff F, CNA stated that while she didn't see physical contact personally, Staff M and Resident #51 had a relationship she did observe that was not professional and other staff did witness inappropriate things. She reported hearing Staff M took medications that belonged to residents and mentioned insulin because Staff M said she was 'allergic to cake', an anxiety medication when she had a panic attack at work, and the Sildenafil Citrate. Staff F indicated Resident #51 could be inappropriate with female staff, so staff provided cares in pairs. She reported Staff M and Resident #51 had private time together and she was in his room with the door closed when there was not a reason to be. She stated Resident #51 told other staff that Staff M gave him 'hand jobs,' made out with him, gave her money for her birthday, and gave her money for a phone he never got. She stated rumors increased after the two reports by her co-workers. A facility policy titled Abuse, Neglect and Exploitation reviewed/revised October 2022 documented it was the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing policies and procedures that prohibit and prevent abuse, exploitation, and misappropriation of resident property. The facility would provide ongoing oversight and supervision of staff to ensure policies were implemented as written. Section V. Investigations of Alleged Abuse, Neglect, and Exploitation included: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on a police narrative, clinical record review, resident interview, staff interviews, and facility policy review the facility failed to prevent further potential misappropriation of property and exploitation and failed to conduct thorough investigations into two incidents for 1 of 3 residents reviewed (Resident #51). The facility reported a census of 74 residents. Findings include: The MDS (Minimum Data Set) for Resident #51, dated 2/9/25, included diagnoses of multiple sclerosis, neurogenic bladder, anxiety, and depression. The resident scored 15/15 on the BIMS (Brief Interview for Mental Status assessment) which indicated intact cognition. The Care Plan for Resident #51 with an admitted [DATE] included focus areas, goals, and interventions related to multiple sclerosis care, depression, anxiety, mood, and medication monitoring. On 4/1/25 at 8:01 PM the Administrator notified the surveyor they received a call from the local police department requesting information about Staff M (RN) and Resident #51. The Administrator stated Staff M, Registered Nurse (RN) was terminated in November (2024) for performance issues. She stated there were two incidents prior to that termination where staff in the facility reported Resident #51 and Staff M hugged and kissed. She stated they investigated and the facility was not able to confirm either incident occurred because the resident had a BIMS of 15 and denied them when questioned. She stated the denial was why the alleged abuse was not reported to the state. On 4/6/25 at 1:43 PM a county deputy emailed the surveyor a narrative of an investigation he was conducting. It noted that a backpack owned by Staff M contained a label from an unknown container, identified as a prescription for Sildenafil Citrate 50 mg to Resident #51 by his provider. The deputy provided a picture of the card top that included Resident #51's name. Staff M refused to answer questions regarding a sexual or inappropriate relationship with the resident. On 4/7/25 at 5:06 PM the Administrator stated she assumed Staff M took the medication because it wasn't in the medication cart or the storage room. She reported she contacted the pharmacy and none of the medication was returned. Staff M was the only person to give Resident #51 this medication. The facility was unable to provide documentation that cart or storage room audits had been conducted prior to the report from the deputy that would have investigated for the missing Sildenafil Citrate cards. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/08/25 at 9:05 AM the resident revealed he was very close to Staff M, RN (Registered Nurse). He stated he tipped her with 5 or 10 bucks for her birthday. When asked, the resident reported she kept the money and must have really needed it. When asked about a medication order from his urologist, Sildenafil Citrate, Resident #51 stated he knew on a personal level that Staff M had access to it. He thought she was the last one, maybe the only one, to give it to him. He stated he kissed Staff M, and believed that was a romantic thing to do. He confirmed she was an employee of the facility at the time. He stated they had agreed to 'take it slow.' He told the surveyor Staff M talked about her ex with him and that he was really bothered by the fact that Staff M might have been married at that time because he didn't want to be responsible for her cheating. At the end of the interview the resident was tearful, unable to speak for a moment and covered his mouth with his hand. He said he just missed her and this was hard. He thought he was in love with her, she never came back to see him, and he was confused about all of this. The facility did not have documentation that Staff M reported a kiss by or with the resident. There was no indication the resident was separated from Resident #51 while either of the two reported staff reports were investigated. No information was provided that documented dates of the staff reports, written statements, interviews with the resident, the staff who reported the incidents, or other facility staff interviews to verify a thorough investigation was conducted. A facility policy titled Abuse, Neglect and Exploitation reviewed/revised October 2022 documented it was the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing policies and procedures that prohibit and prevent abuse, exploitation, and misappropriation of resident property. The facility would provide ongoing oversight and supervision of staff to ensure policies were implemented as written. Section V. Investigations of Alleged Abuse, Neglect, and Exploitation included: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.

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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** 48452 Based on clinical record review, interview, and facility policy review the facility failed to provide services according to physician orders for 1 of 4 residents reviewed (Residents #49). The facility reported a census of 74 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #49 dated 3/16/25 included diagnoses of chronic pain syndrome, arthritis, osteoporosis, and fibromyalgia. It documented a Brief Interview for Mental Status (BIMS) of 15/15 indicating intact cognition. The resident's Care Plan with an admitted [DATE] indicated staff should anticipate pain and respond immediately to complaints of pain, evaluate the effectiveness of pain interventions including review for compliance, dosing schedules, and resident satisfaction with results, and monitor/record/report signs and symptoms of non-verbal pain. On 03/31/25 at 01:40 PM Resident #49 reported her medications were often late and her pain cream was missed some days. She stated she had discussed this with nurses, the Director of Nursing, and the Administrator. The resident's Medication Administration Record and Treatment Administration Record (MAR/TAR) revealed the resident's orders included Diclofenac Sodium External Gel 1% (Diclofenac Sodium (Topical)) Apply to Bilateral knees topically three times a day for pain 4 grams. Treatments were missed during the evening medication pass (labeled 'supper') between 3/1/25 and 4/8/25: 3/2, 3/4, 3/5, 3/7, 3/8, 3/9, 3/10, 3/11, 3/13, 3/18, 3/22, 3/23, 3/24, 3/25, 3/27, 3/31, & 4/5. During the same time frame, in addition to scheduled pain medication, Resident #49 required the following PRN (as needed) pain medications: 3/23/25 - Acetaminophen Oral Tablet 325 MG 3/27/25 - Acetaminophen Oral Tablet 325 MG 4/5/25 - Acetaminophen Oral Tablet 325 On 04/03/25 at 2:50 PM Staff I, Licensed Practical Nurse (LPN) acknowledged that medications had been missed or given outside of the scheduled time range. On 04/07/25 at 11:08 AM Staff G, LPN reported Resident #49 had expressed concerns about showers, medications, and staff who had told her to wait and then not returned. She addressed it the times she was there and stated that she was only part time. When asked about staffing, Staff G stated she thought the facility was short staffed for the care residents needed in the building. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled Medication Administration - General reviewed/revised 9/19/23 indicated medications were administered by licensed nurses, or other staff legally authorized to do so, as ordered by the physician and in accordance with professional standards of practice. Medications were to be administered within 60 minutes prior to or after scheduled times.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434 Based on observation, clinical record review, facility policy review, and staff and resident interviews, the facility failed to provide bathing and/or grooming assistance for 8 of 13 residents reviewed for activities of daily living assistance (Residents #2, #10, #13, #30, #46, #49, #71, #231). The facility reported a census of 74 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 2/18/25, listed diagnoses for Resident #2 which included heart failure, bipolar disorder, and depression. The MDS stated the resident required substantial/maximal assistance with bathing and listed her Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. The facility policy Activities of Daily Living, dated 12/4/24, stated staff would assist residents with baths, dressing, and oral care. A 2/19/25 Care Plan entry stated the resident usually required assistance to provide supervision, verbal cues, and touching/steadying or contact assistance with bathing. The entry stated the resident required assistance with washing her back and hair. On 3/31/25 at 10:36 a.m., Resident #2 stated she only received one bath per week because the facility was short-staffed. Review of the resident's Documentation Survey Report V2 and paper bath sheets revealed the resident received the following baths or showers between her admission on 2/11/25 and 4/2/25: 2/22/25 shower documented on paper Resident Bath/Shower Sheet 3/1/25 shower documented on paper Resident Bath/Shower Sheet 3/8/25 shower documented on March 2025 Documentation Survey Report V2 3/12/25 shower documented on March 2025 Documentation Survey Report V2 3/15/25 Resident Bath/Shower Sheet was blank 3/19/25 Resident Bath/Shower Sheet stated the resident did not want to shower and requested if she could shower tomorrow 3/22/25 shower documented on paper Resident Bath/Shower Sheet 3/29/25 shower documented on paper Resident Bath/Shower Sheet (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility lacked documentation of additional tub baths or showers received during the above time period including between 2/12/25 and 2/22/25, a span of 9 days, between 2/22/25 and 3/1/25, a span of 7 days, between 3/1/25 and 3/8/25, a span of 7 days, and between 3/22/25 and 3/29/25, a span of 7 days. The facility lacked documentation staff re-approached the resident on a different day after a refusal. 2. The MDS assessment tool, dated 1/5/25, listed diagnoses for Resident #10 which included non-Alzheimer's dementia, seizure disorder, and mild intellectual disabilities. The MDS stated the resident was dependent of staff for personal hygiene including combing hair. The MDS listed the resident's BIMS score as 7 out of 15, indicating severely impaired cognition. A 10/18/23 Care Plan entry stated the resident was depended on staff for combing hair. On 3/31/25 at approximately 1:00 p.m., Resident #10 walked down the East hall and her hair was disheveled and sticking up in the back. On 4/2/25 at 9:00 a.m., the resident ate breakfast in the dining room. The resident's hair was in a head band but her hair was sticking up on both sides and was matted at the crown of her head. 3. The MDS assessment tool, dated 1/20/25, listed diagnoses for Resident #13 which included severe obesity, anxiety, and depression and listed the resident's BIMS score as 15 out of 15, indicating intact cognition. A 10/12/23 Care Plan entry stated the resident required partial to moderate assistance for bathing. On 3/31/25 at 1:11 p.m., Resident #13 stated she was supposed to receive a bath twice per week but that did not happen. Review of the resident's February and March 2025 Documentation Survey Report V2 and paper bath sheets revealed the resident received the following baths or showers during the period of 2/1/25 and 4/2/25: 2/17/25 partial bed bath or wash up at sink documented on February Documentation Survey Report V2 2/20/25 shower documented on paper Resident Bath/Shower Sheet 2/22/25 shower documented on paper Resident Bath/Shower Sheet 3/3/25 shower documented on March 2025 Documentation Survey Report V2 3/13/25 The paper Resident Bath/Shower sheet was blank. 3/27/25 shower documented on March 2025 Documentation Survey Report V2 3/31/25 The resident refused according to the March Documentation Survey Report V2. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility lacked documentation of additional tub bath or showers received or offered during the above time period including between 2/1/25 and 2/17/25, a span of 15 days, between 2/22/25 and 3/3/25, a span of 8 days, between 3/3/25 and 3/10/25, a span of 6 days, and between 3/17/25 and 3/27/25, a span of 9 days. The facility lacked documentation staff re-approached the resident on a different day after a refusal. 4. The MDS assessment tool, dated 1/20/25, listed diagnoses for Resident #46 which included heart failure, non-Alzheimer's dementia, and depression and listed the resident's BIMS score as 11 out of 15, indicating moderately impaired cognition. A 10/12/23 Care Plan entry stated the resident required assistance of staff for washing her back and hair and to provide assistance transferring into the tub or shower. On 03/31/25 at 11:12 a.m., Resident #46 stated she went three weeks with no bath. Review of the resident's February and March 2025 Documentation Survey Report V2 and paper bath sheets revealed the resident received the following baths or showers during the period of 2/1/25 and 4/2/25: 2/7/25 shower documented on February Documentation Survey Report V2. 2/25/25 shower documented on February Documentation Survey Report V2. 2/28/25 shower documented on February Documentation Survey Report V2. 3/21/25 documentation of resident refusal of shower on March 2025 Documentation Survey Report V2 3/28/25 shower documented on February Documentation Survey Report V2. The facility lacked documentation of additional tub baths or showers received or offered during the above time period including between 2/1/25 and 2/7/25, a span of 6 days, between 2/7/25 and 2/25/25, a span of 18 days, between 2/28/25 and 3/21/25, a span of 20 days, and between 3/21/25 and 3/28/25, a span of 6 days. The facility lacked documentation staff re-approached the resident on a different day after a refusal. 5. The MDS assessment tool, dated 3/14/25, listed diagnoses for Resident #71 which included cellulitis (infection of the tissue) of the left lower limb, heart failure, and obesity and listed the resident's BIMS score as 15 out of 15, indicating intact cognition. Review of the resident's Documentation Survey Report V2 and paper bath sheets revealed the resident received the following baths or showers between her admission on 3/7/25 and her discharge on 3/25/25: 3/12/25 shower documented on March 2025 Documentation Survey Report V2 3/13/25 shower documented on March 2025 Documentation Survey Report V2 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/15/25 bed bath documented on paper Resident/Bath/Shower Sheet and stated the resident did not want shower due to her leg dressings 3/24/25 shower documented on Resident Bath/Shower Sheet. The facility lacked documentation of additional tub baths or showers received during the above time period including between 3/7/25 and 3/12/25, a span of 4 days and between 3/15/25 and 3/24/25, a span of 8 days. The facility lacked documentation staff re-approached the resident on a different day after a refusal. On 4/7/25 at 10:31 a.m., Staff C Certified Nursing Assistant(CNA) stated Resident #71 needed a shower and she felt like the facility needed to pay attention to how they sent residents out to appointments. She stated she remembered the resident going to dialysis and her hair was matted. On 4/8/25 at 2:38 p.m., the Director of Nursing (DON) stated residents should receive at minimum two baths per week and she had a plan to remedy the concern moving forward. She stated staff should comb a resident's hair before leaving the room. 48452 6. The MDS assessment for Resident #231 dated 2/15/25 listed diagnoses of heart failure, renal failure, and non-Alzheimer's dementia and indicated the resident was unable to complete the BIMS assessment due to short and long term memory problems. The resident's Care Plan with an admitted [DATE] recorded actual skin impairment, risk of pressure ulcer development, nutritional problems, incontinence, and the need for the assistance of two helpers with bathing due to impaired cognition and weakness. On 03/31/25 at 1:40 PM Resident #231's former roommate reported the resident went weeks without a bath, and she thought that was because Resident #231 couldn't speak up for herself like she could. Facility documentation titled South Hall shower schedule listed Resident #231 was scheduled to receive a bath/shower on Mondays and Thursdays. No shower sheets with skin assessments were completed for the resident between 2/1/25 and 3/14/25. Review of the resident's February and March 2025 Documentation Survey Report V2 revealed the resident received the following baths or showers from 2/1/25 through 3/14/25: 2/10/25 #1 documented, which indicated the resident had a partial bed bath. 2/17/25 shower documented. 2/27/25 shower documented. 3/03/25 #1 documented. The facility did not have documentation that staff communicated missed baths/showers or approached the resident on a different day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. The MDS for Resident #49 dated 3/16/25 included diagnoses of atrial fibrillation, neurogenic bladder, and fibromyalgia and a BIMS of 15/15 indicating intact cognition. Section GG revealed the resident required substantial to maximal assistance with transfers, toileting, bathing, dressing, and personal hygiene. The resident's Care Plan with an admitted [DATE] included focus areas for risk of developing pressure ulcers, bowel and bladder incontinence, risk for falls, and fragile skin. During an interview on 03/31/25 at 01:40 PM Resident #49 reported receiving 1 bath per week and she didn't want a bed bath to replace her showers. She wanted staff to take the time to dry her well after bathing so she didn't get sores under her breasts. She stated it was hard to get a CNA to find the Administrator or Director of Nursing (DON) when she wanted to talk about her concerns. She added regular bathing was important because 3 CNA's didn't get her completely clean, and sometimes she had to use wipes to clean herself. A document titled Monthly Grievance log contained an entry dated 10/21/24 from Resident #49 that she was not receiving showers. It documented the issue was resolved the same day. Review of the resident's Documentation Survey Report V2 and bathing/skin sheets for March 2025 documented: 3/3/25 #1 which meant washed up, sink bath, or partial bed bath. No shower/skin sheet. 3/5/25 #1. No shower/skin sheet. 3/7/25 shower documented. No shower/skin sheet. 3/10/25 blank. No shower/skin sheet. 3/12/25 #1. No shower/skin sheet. 3/14/25 blank, skin sheet documented a shower 3/17/25 #1. No shower/skin sheet. 3/19/25 blank. No shower/skin sheet. 3/21/25 shower documented, bathing sheet confirmed 3/24/25 not applicable documented. No shower/skin sheet. 3/26/25 #1. No shower/skin sheet. 3/28/25 shower documented. No shower/skin sheet. Facility documentation in Progress Notes and bathing sheets did not include documentation that the resident refused any baths/showers. (continued on next page)

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Silver Oak Nursing and Rehabilitation Center LLC	455 31st Street Marion, IA 52302

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. The MDS for Resident #30 dated 3/21/25 documented diagnoses of heart failure, weakness, seizure disorder, and anxiety. The MDS included a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated intact cognition. It reported the resident needed assistance with set up for oral care and was dependent for toileting hygiene, sit to stand, and chair/bed transfers. The MDS further documented tub/shower transfers and bathing were not attempted in the look back period. The Care Plan for Resident #30 included interventions dated 7/10/24 to transfer the resident to her wheelchair at night for toileting. An intervention dated 10/12/24 directed staff to change or offer toileting every 2 hours and PRN (as needed). On 3/31/25 at 11:16 AM observed the resident asleep in her recliner. From the door of her room, her hair appeared oily and there was a musty urine odor outside of her room. On 04/01/25 at 07:49 AM the resident was observed in her room, asleep in nearly same position as the day before and wore the same plaid nightgown. Her hair remained oily and tight to the side of her head. During an interview on 04/01/25 at 07:54 the resident reported certified nursing assistants (CNAs) told her she had to go (urinate and defecate) in her brief due to 'spells' she had in the bathroom. She said she felt 'nasty' going in her brief, which caused trouble getting it out and constipation. The resident reported an instance when she sat with poop half in and half out all night. She also reported staff did not regularly comb her hair, change her clothes, help her brush her teeth, or bathe her. She reported she had been wearing her current clothing for 3 days. Review of the resident's March 2025 Documentation Survey Report V2 indicated the resident received 1 bath in March on 3/11/25 and refused a bath on 3/7/25. The facility was unable to provide bath/skin sheets to supplement missing days or document additional efforts to offer the resident a bath. Progress Notes for Resident #30 did not document additional baths given, alternate attempts after refusals, or offers of alternate interventions. Additional documentation in the V2 report for March 2025 indicated the resident was not assisted with oral hygiene, hair care, shaving, or washing hands and face the following mornings: 3/4, 3/10, 3/11, 3/13, 3/14, 3/15, 3/16, 3/18, 3/19, 3/22, 3/23, 3/30, and 3/31. During an interview with the DON on 4/7/25 at 9:22 AM she stated the nurses should be checking daily to ensure dressing and toileting were done, and that every contact with the resident was an opportunity to ensure cares were done, including oral care morning and night. She indicated residents had complained to her about bathing and linen changes. She did not think there was currently enough staff for all of the needs residents had. The DON confirmed staff had refused to take the resident to the bathroom at night. Staff had been re-educated 3 weeks before. She was not aware it was still happening. On 4/7/25 at 11:08 AM Staff G, LPN reported acuity impacted completion of tasks, and that call ins affected how much could get done in a day. She stated every resident could have better teeth care here. She expected staff to help with oral cares and other activities of daily living, and there was a [NAME] effect when there was not enough staff.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434 Based on clinical record review, facility policy review, and staff interviews, the facility failed to carry out wound assessments and/or wound treatments for 3 of 6 residents reviewed for non-pressure wounds (Residents #63, #71, and #232). The facility reported a census of 74 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 11/5/24, listed diagnoses for Resident #63 which included left foot drop, muscle weakness, and abnormal posture. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicating intact cognition. A 7/30/24 Care Plan entry stated the resident had actual impairment to skin integrity related to a left foot surgical wound. An 8/1/24 surgical note stated the resident had a left fourth toe amputation and had a diagnosis of osteomyelitis(infection of the bone). A 12/20/24 Order Note requested the discontinuation of a betadine (an iodine solution used to treat wounds) treatment to the left foot due to the area long since healed. A 12/28/24 Order Note stated the facility received a verbal order for betadine to the left second and third digits. The facility lacked documentation of an assessment of the left foot and a reason for the betadine order. A 1/3/25 Weekly Skin Observation lacked documentation of a current wound. A 1/10/25 Weekly Skin Observation stated the resident had a left foot mark and scar but lacked any further assessment of the foot. A 1/14/25 surgical note stated the resident had a wound on the left second and third toes which he stated began a couple of weeks prior. The facility lacked further documentation of left foot assessments including a description of the wound and wound measurements from the date of the order on 12/28/24 until the 1/14/25 surgical appointment. 2. The MDS assessment tool, dated 3/14/25, listed diagnoses for Resident #71 which included cellulitis (an infection of the tissues) of the left lower limb, heart failure, and obesity. The MDS stated the resident had two venous or arterial ulcers and listed the resident's BIMS score as 15 out of 15, indicating intact cognition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 3/3/25 hospital note stated the resident had non-healing bilateral lower extremity wounds and had lower left extremity black eschar (a thick, dry, leathery, and often dark-colored (black, brown, or tan) tissue that formed on a wound, typically after a burn or other severe injury) and erythema (redness) with purulent (referring to pus) drainage. A 3/7/25 hospital Summary of Care report listed current medications including silver sulfadiazine 1% cream (used to treat and prevent infections) and [NAME] oxide (used to protect skin) to bilateral lower legs and feet twice daily. A 3/7/25 Health Status Note stated the resident arrived at the facility from the hospital. A 3/7/25 Nursing Admission/Readmission Assessment, documented the resident had vascular wounds to the right and left lower legs. A 3/7/25 Weekly Skin Observation documented the resident had left and right lower leg necrosis (referring to dead tissue), a right foot ulcer measuring 3 centimeters (cm) x 2 cm, and a left upper leg ulcer measuring 3 cm x 5 cm. Care Plan entries, dated 3/8/25, stated the resident had potential/actual impairment to the skin integrity of the right and left legs and directed staff to carry out weekly documentation including measurements, tissue type, and other notable changes or observations. The March 2025 Treatment Administration Record (TAR) included the following orders: a. Silver Sulfadiazine Cream 1%, apply to bilateral lower extremities and feet topically every shift, cleanse wound with soap and water, apply zinc oxide paste to peri-wound skin, apply thick layer like frosting of sulfadiazine on 4x4 gauze and apply to wound, cover with abdominal pads, wrap with kerlix (a type of gauze bandage) and secure with 2 inch paper tape. b. Silver Sulfadiazine Cream 1%, apply to left medial (referring to the middle portion) lower leg topically every shift, cleanse wound with saline and gauze, loosely fill wound with sulfadiazine moistened packing strip, cover with an abdominal pad, wrap with Kerlix, and secure with paper tape. c. Zinc Oxide External Paste 40%, apply to legs and feet per orders. The following entries were blank and lacked staff initials to indicated the completion of the above treatments: 3/8/25 6:00 a.m. dose, 3/11/25 night dose, 3/12/25 morning dose, 3/22/25 night dose. The 3/9/25 morning dose documented a 9 which directed to Progress Notes. 3/9/25 eMAR Administration Notes stated the facility waited for the resident's Silver Sulfadiazine Cream 1% and zinc oxide from the pharmacy. A 3/14/25 Nurse Practitioner note stated the resident had cellulitis of the lower extremities with non-healing ulcers and stated the dressings were intact and per nursing, the wounds were stable with no acute signs of infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 3/14/25 Weekly Skin Observation sheet stated the resident had vascular wounds to the bilateral lower legs. The document contained no other assessments or measurements of the wounds. A 3/21/25 Health Status Note stated the resident's wounds to the left lower extremity were worsening and the redness extended to mid-thigh bilaterally. A 3/21/25 Weekly Skin Observation stated the resident had pressure ulcers to the right and left heels. The sheet lacked documentation of an assessment to the legs. A 3/21/25 Order Note stated the resident's bilateral lower legs weeped with a moderate amount of serosanguinous(bloody, watery) drainage. The wound beds vary with slough (a yellow, white, or tan, stringy, or thick substance, that overlayed a wound bed and hindered healing) and necrotic areas with surrounding redness noted. The facility lacked further assessments of the residents legs during the time of her admission until her 3/25/25 discharge. A 3/25/25 Progress Note stated the resident received orders to discharge. The facility policy Nurse Services and Sufficient Staff revised 2/5/25, listed nursing duties to include: assessing, evaluating, planning, and implementing resident care plans and responding to resident needs. The facility policy Notification of Changes, revised 10/21/24, stated the facility would promptly consult the resident's physician when there was a change requiring notification. On 4/7/25 at 9:22 a.m., the Director of Nursing (DON) stated staff should carry out treatments and should complete skin assessments weekly. On 4/8/25 at 2:38 p.m., the DON stated they did not locate anything additional for Resident #71 but were still working on it.

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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. 35434 Based on clinical record review, facility policy review, and staff interview, the facility failed to complete regular assessments and treatments to treat a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident #71). The facility reported a census of 74 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The MDS assessment tool, dated 3/14/25, listed diagnoses for Resident #71 which included cellulitis (an infection of the tissues) of the left lower limb, heart failure, and obesity. The MDS stated the resident was at risk for pressure ulcers but had no unhealed pressure ulcers. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. A 3/7/25 hospital note stated the resident had wounds to the left and right heel. A 3/7/25 Health Status Note stated the resident arrived at the facility from the hospital. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 3/7/25 Nursing Admission/Readmission Assessment, documented the resident had vascular wounds to the right and left lower legs. A 3/7/25 Weekly Skin Observation documented the resident had left and right lower leg necrosis (referring to dead tissue), a right foot ulcer measuring 3 centimeters x 2 cm, and a left upper leg ulcer measuring 3 cm x 5 cm. The assessment lacked documentation the resident had heel wounds. A 3/8/25 Care Plan entry stated the resident was at risk for developing a pressure ulcer. The March 2025 Treatment Administration Record (TAR) listed an order for skin prep to the bilateral heels every shift and as needed and listed a discontinue date of 3/7/25. The TAR lacked documentation of a heel treatment from the resident's admission on 3/7/25 until her discharge on 3/25/25. The resident's clinical record contained no documentation of wounds on the resident's heels from her admitted on 3/7/25 until 3/21/25. A 3/21/25 Weekly Skin Observation assessment stated the resident had a Stage 3 pressure ulcer to the right heel and a Stage 4 pressure ulcer to the left heel. The document contained no further description or measurements of the wound. A 3/21/25 Care Plan entry stated the resident had a Stage 3 pressure ulcer to the right heel and a Stage 4 pressure ulcer to the left heel. A 3/21/25 Health Status Note stated the resident had a Stage 4 (pressure ulcer) to the left heel and the facility notified the physician. A 3/21/25 Order Note stated the provider visited and observed the resident complete her dressing change. The note did not mention the resident's heel pressure ulcers. The facility lacked documentation of bilateral heel treatments completed from 3/21/25 to the resident's discharge on 3/25/25. A 3/25/25 Progress Note stated the resident received orders to discharge. On 4/7/25 at 9:22 a.m., the Director of Nursing (DON) stated staff should carry out treatments and should complete skin assessments weekly. The facility policy Pressure Injury Prevention and Management, revised December 2024, stated the facility would review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document a summary of findings in the medical record.

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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. 35434 Based on observation, clinical record review, and staff interview, the facility failed to ensure safe wheelchair movement for 1 of 1 residents reviewed for wheelchair safety (Resident #41). The facility reported a census of 74 residents. Findings include: The Minimum Data Set (MDS) assessment tool, dated 1/21/25, listed diagnoses for Resident #41 which included heart failure, non-Alzheimer's dementia, and anxiety. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 3 out of 15, indicating severely impaired cognition. A 10/28/23 Care Plan entry stated the resident was dependent on staff to move the wheelchair. On 3/31/25 at 12:53 p.m., Staff A, Certified Nursing Assistant (CNA) pushed Resident #41 down the hall in her wheelchair and her left foot drug on the ground during the transfer. Staff A pushed the resident approximately 50 feet down the hall. On 4/7/25 at 9:22 a.m., the Director of Nursing (DON) stated staff should utilize foot pedals when pushing residents in a wheelchair. On 4/9/25 at approximately 2:00 p.m., the Administrator stated the facility did not have a policy pertaining to the use of wheelchair foot pedals.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434 Based on observation, clinical record review, facility policy review, and staff and resident interviews, the facility failed to ensure sufficient staff in order to provide bathing and/or grooming assistance for 8 of 13 residents reviewed for activities of daily living assistance (Residents #2, #10, #13, #30, #46, #49, #71, & #231). The facility reported a census of 74 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 2/18/25, listed diagnoses for Resident #2 which included heart failure, bipolar disorder, and depression. The MDS stated the resident required substantial/maximal assistance with bathing and listed her Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. The facility policy Nursing Services and Sufficient Staff, revised 2/5/25, stated the facility would provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility policy Activities of Daily Living, dated 12/4/24, stated staff would assist residents with baths, dressing, and oral care. A 2/19/25 Care Plan entry stated Resident #2 usually required assistance to provide supervision, verbal cues, and touching/steadying or contact assistance with bathing. The entry stated the resident required assistance with washing her back and hair. On 3/31/25 at 10:36 a.m., Resident #2 stated she only received one bath per week because the facility was short-staffed. Review of the resident's Documentation Survey Report V2 and paper bath sheets revealed the resident received the following baths or showers between her admission on 2/11/25 and 4/2/25: 2/22/25 shower documented on paper Resident Bath/Shower Sheet 3/1/25 shower documented on paper Resident Bath/Shower Sheet 3/8/25 shower documented on March 2025 Documentation Survey Report V2 3/12/25 shower documented on March 2025 Documentation Survey Report V2 3/15/25 Resident Bath/Shower Sheet was blank 3/19/25 Resident Bath/Shower Sheet stated the resident did not want to shower and requested if she could shower tomorrow (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3/22/25 shower documented on paper Resident Bath/Shower Sheet 3/29/25 shower documented on paper Resident Bath/Shower Sheet The facility lacked documentation of additional tub baths or showers received during the above time period including between 2/12/25 and 2/22/25, a span of 9 days, between 2/22/25 and 3/1/25, a span of 7 days, between 3/1/25 and 3/8/25, a span of 7 days, and between 3/22/25 and 3/29/25, a span of 7 days. The facility lacked documentation staff re-approached the resident on a different day after a refusal. 2. The MDS assessment tool, dated 1/5/25, listed diagnoses for Resident #10 which included non-Alzheimer's dementia, seizure disorder, and mild intellectual disabilities. The MDS stated the resident was dependent of staff for personal hygiene including combing hair. The MDS listed the resident's BIMS score as 7 out of 15, indicating severely impaired cognition. A 10/18/23 Care Plan entry stated the resident was depended on staff for combing hair. On 3/31/25 at approximately 1:00 p.m., Resident #10 walked down the East hall and her hair was disheveled and sticking up in the back. On 4/2/25 at 9:00 a.m., the resident ate breakfast in the dining room. The resident's hair was in a head band but her hair was sticking up on both sides and was matted at the crown of her head. 3. The MDS assessment tool, dated 1/20/25, listed diagnoses for Resident #13 which included severe obesity, anxiety, and depression and listed the resident's BIMS score as 15 out of 15, indicating intact cognition. A 10/12/23 Care Plan entry stated the resident required partial to moderate assistance for bathing. On 3/31/25 at 1:11 p.m., Resident #13 stated she was supposed to receive a bath twice per week but that did not happen. Review of the resident's February and March 2025 Documentation Survey Report V2 and paper bath sheets revealed the resident received the following baths or showers during the period of 2/1/25 and 4/2/25: 2/17/25 partial bed bath or wash up at sink documented on February Documentation Survey Report V2 2/20/25 shower documented on paper Resident Bath/Shower Sheet 2/22/25 shower documented on paper Resident Bath/Shower Sheet 3/3/25 shower documented on March 2025 Documentation Survey Report V2 3/13/25 The paper Resident Bath/Shower sheet was blank. 3/27/25 shower documented on March 2025 Documentation Survey Report V2 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3/31/25 The resident refused according to the March Documentation Survey Report V2. The facility lacked documentation of additional tub bath or showers received or offered during the above time period including between 2/1/25 and 2/17/25, a span of 15 days, between 2/22/25 and 3/3/25, a span of 8 days, between 3/3/25 and 3/10/25, a span of 6 days, and between 3/17/25 and 3/27/25, a span of 9 days. The facility lacked documentation staff re-approached the resident on a different day after a refusal. 4. The MDS assessment tool, dated 1/20/25, listed diagnoses for Resident #46 which included heart failure, non-Alzheimer's dementia, and depression and listed the resident's BIMS score as 11 out of 15, indicating moderately impaired cognition. A 10/12/23 Care Plan entry stated the resident required assistance of staff for washing her back and hair and to provide assistance transferring into the tub or shower. On 03/31/25 at 11:12 a.m., Resident #46 stated she went three weeks with no bath. Review of the resident's February and March 2025 Documentation Survey Report V2 and paper bath sheets revealed the resident received the following baths or showers during the period of 2/1/25 and 4/2/25: 2/7/25 shower documented on February Documentation Survey Report V2. 2/25/25 shower documented on February Documentation Survey Report V2. 2/28/25 shower documented on February Documentation Survey Report V2. 3/21/25 documentation of resident refusal of shower on March 2025 Documentation Survey Report V2 3/28/25 shower documented on February Documentation Survey Report V2. The facility lacked documentation of additional tub baths or showers received or offered during the above time period including between 2/1/25 and 2/7/25, a span of 6 days, between 2/7/25 and 2/25/25, a span of 18 days, between 2/28/25 and 3/21/25, a span of 20 days, and between 3/21/25 and 3/28/25, a span of 6 days. The facility lacked documentation staff re-approached the resident on a different day after a refusal. 5. The MDS assessment tool, dated 3/14/25, listed diagnoses for Resident #71 which included cellulitis (infection of the tissue) of the left lower limb, heart failure, and obesity and listed the resident's BIMS score as 15 out of 15, indicating intact cognition. Review of the resident's Documentation Survey Report V2 and paper bath sheets revealed the resident received the following baths or showers between her admission on 3/7/25 and her discharge on 3/25/25: 3/12/25 shower documented on March 2025 Documentation Survey Report V2 3/13/25 shower documented on March 2025 Documentation Survey Report V2 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3/15/25 bed bath documented on paper Resident/Bath/Shower Sheet and stated the resident did not want shower due to her leg dressings 3/24/25 shower documented on Resident Bath/Shower Sheet. The facility lacked documentation of additional tub baths or showers received during the above time period including between 3/7/25 and 3/12/25, a span of 4 days and between 3/15/25 and 3/24/25, a span of 8 days. The facility lacked documentation staff re-approached the resident on a different day after a refusal. On 4/7/25 at 10:31 a.m., Staff C Certified Nursing Assistant (CNA) stated Resident #71 needed a shower and she felt like the facility needed to pay attention to how they sent residents out to appointments. She stated she remembered the resident going to dialysis and her hair was matted. On 4/8/25 at 2:38 p.m., the Director of Nursing (DON) stated residents should receive at minimum two baths per week and she had a plan to remedy the concern moving forward. She stated staff should comb a resident's hair before leaving the room. 6. The MDS for Resident #30 dated 3/21/25 documented diagnoses of heart failure, weakness, seizure disorder, and anxiety. The MDS included a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated intact cognition. It reported the resident needed assistance with set up for oral care and was dependent for toileting hygiene, sit to stand, and chair/bed transfers. The MDS further documented tub/shower transfers and bathing were not attempted in the look back period. On 3/31/25 at 11:16 AM observed the resident asleep in her recliner. From the door of her room, her hair appeared oily and there was a musty urine odor outside of her room. On 04/01/25 at 07:49 AM the resident was observed in her room, asleep in nearly same position as the day before and wore the same plaid nightgown. Her hair remained oily and tight to the side of her head. During an interview on 04/01/25 at 07:54 the resident reported certified nursing assistants (CNAs) told her she had to go (urinate and defecate) in her brief due to 'spells' she had in the bathroom. The resident reported an instance when she sat with poop half in and half out all night. She also reported staff did not regularly comb her hair, change her clothes, help her brush her teeth, or bathe her. She did not think the facility had enough staff to take care of the residents. Review of the resident's March 2025 Documentation Survey Report V2 indicated the resident received 1 bath in March on 3/11/25 and refused a bath on 3/7/25. The facility was unable to provide bath/skin sheets to supplement missing days or document additional efforts to offer the resident a bath. Additional documentation in the V2 report for March 2025 indicated the resident was not assisted with oral hygiene, hair care, shaving, or washing hands and face the following mornings: 3/4, 3/10, 3/11, 3/13, 3/14, 3/15, 3/16, 3/18, 3/19, 3/22, 3/23, 3/30, and 3/31. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. The MDS for Resident #49 dated 3/16/25 included diagnoses of atrial fibrillation, neurogenic bladder, and fibromyalgia and a BIMS of 15/15 indicating intact cognition. Section GG revealed the resident required substantial to maximal assistance with transfers, toileting, bathing, dressing, and personal hygiene. During an interview on 03/31/25 at 01:40 PM the resident reported she received 1 bath per week and she didn't want a bed bath to replace her showers. She wanted staff to take the time to dry her well after bathing so she didn't get sores under her breasts. She stated it was hard to get a CNA to find the Administrator or Director of Nursing (DON) when she wanted to talk about her concerns. A document titled Monthly Grievance log contained an entry dated 10/21/24 from Resident #49 that she was not receiving showers. It documented the issue was resolved the same day. Review of the resident's Documentation Survey Report V2 and bathing/skin sheets for March 2025 revealed the resident received a shower on 3/7/25, 3/21/25, and 3/28/25. Facility documentation in Progress Notes and bathing sheets did not include documentation that the resident refused any baths/showers. 8. The MDS assessment for Resident #231 dated 2/15/25 listed diagnoses of heart failure, renal failure, and non-Alzheimer's dementia and indicated the resident was unable to complete the BIMS assessment due to short and long term memory problems. The resident's Care Plan with an admitted [DATE] recorded the need for the assistance of two helpers with bathing due to impaired cognition and weakness. On 03/31/25 at 1:40 PM Resident #231's former roommate reported the resident went weeks without a bath, and she thought that was because Resident #231 couldn't speak up for herself like she could. Facility documentation titled South Hall shower schedule listed Resident #231 was scheduled to receive a bath/shower on Mondays and Thursdays. No shower sheets with skin assessments were completed for the resident between 2/1/25 and 3/14/25. Review of the resident's February and March 2025 Documentation Survey Report V2 revealed the resident received 2 showers from 2/1/25 through 3/14/25, on 2/17 and 2/27. The facility did not have documentation that staff communicated missed baths/showers or approached the resident on a different day. During an interview with the DON on 4/7/25 at 9:22 AM she stated the nurses should be checking daily to ensure dressing and toileting were done, and that every contact with the resident was an opportunity to ensure cares were done, including oral care morning and night. She indicated residents had complained to her about bathing and linen changes. She did not think there was currently enough staff for all of the needs residents had. On 4/7/25 at 11:08 AM Staff G, LPN reported acuity impacted completion of tasks, and that call ins affected how much they could get done in a day. She stated every resident could have better oral care. She expected staff to help with oral cares and other activities of daily living, and stated there was a [NAME] effect when there were not enough staff.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 48452 Based on personnel file review, the Health Facility Database (HFD), and interviews the facility failed to ensure 1 of 4 Certified Nursing Aides (CNAs) was certified prior to employment. The facility reported a census of 74 residents. Findings include: A review of staff personnel files on 4/8/25 determined that Staff J did not have an active CNA certification. A note in the file dated 11/6/23 written by Staff K documented that the facility was waiting on his CNA application. A criminal background check documented that on 11/13/23 there was not a record found for a CNA with Staff J's name and date of birth. An additional undated document in the file from the HFD confirmed there was not a certification date for Staff J. On 4/10/25 at 3:27 PM the HFD page titled DCW Details (Direct Care Worker) did not include a certification date for Staff J and documented that he was not currently employed. An interview with the Administrator on 4/8/25 at 3:37 PM confirmed Staff J was not certified. She stated he had told the facility he was certified in another state. She reported there was an Administrator in training responsible for the building the previous summer who must have realized the error and sent him to take the skills test. As soon as the current Administrator and the facility scheduler confirmed Staff J was not a CNA he was asked to clock out and leave the facility. At 3:38 PM on 4/8/25 Staff L, Scheduling, stated she called the DCW hotline and learned that Staff J failed the CNA test 7/25/24. She thought Staff J was aware he had been caught working without certification because of the 'vibe' she got when they called him in to the office to ask him about it.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 48452 Based on personnel file review, staff training records, and interviews the facility failed to ensure 1 of 4 Certified Nursing Aides (CNAs) received a performance evaluation, competency evaluation, or training based on performance reviews. The facility reported a census of 74 residents. Findings include: A review of staff personnel files on 4/8/25 determined that Staff J was not evaluated for performance between his hire date of 12/5/23 and 4/8/25. The personnel file did not include orientation training or competency evaluations. Training records documented a single training on 3/19/24 for 15 minutes of education regarding communicating effectively. During an interview with the Administrator on 4/8/25 at 3:37 PM she confirmed she was not able to locate evaluations or training based on CNA evaluations.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35434 Based on clinical record review, facility policy review, and staff and resident interviews, the facility failed to ensure the availability of routine medications for 2 of 7 residents reviewed for medications (Resident #17 and #13) The facility reported a census of 74 residents. Findings include: 1. The Minimum Data Set(MDS) assessment tool, dated 1/17/25, listed diagnoses for Resident #17 which included heart failure, diabetes, and anxiety. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. A 9/25/23 Care Plan entry directed staff to administer medications as ordered. On 3/31/25 at approximately 1:00 p.m., the resident stated she missed some pills today. The March 2025 Medication Administration Record (MAR) listed an order for Methocarbamol (a muscle relaxant) 750 milligrams(mgs) three times per day. The following entries lacked a check to indicate staff administered the medication: 3/30/25 supper dose, 3/31/25 lunch and supper doses. eMAR Administration Notes on 3/30/25 at 4:35 p.m., 3/31/25 at 1:08 p.m., and 3/31/25 at 5:02 p.m. stated the resident's medication was not available. 2. The MDS assessment tool, dated 1/20/25, listed diagnoses for Resident #13 which included severe obesity, anxiety, and depression and listed the resident's BIMS score as 15 out of 15, indicating intact cognition. On 3/31/25 at 1:11 p.m., Resident #13 stated she missed some medications today because the facility did not have them. The March 2025 MAR listed the following orders: a. Fesoterodine Fumarate 8 mg one time a day for overactive bladder. b. Lexapro 20 mg one time a day for major depressive disorder. c. Metolazone 2.5 mg once time a day for edema(swelling) d. Spironolactone 100 mg one time a day for hypertension. e. Naproxen 500 mg twice daily for pain. f. Hydroxyzine Pamoate 25 mg three times daily for anxiety. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The entries for the morning dose on 3/31/25 lacked a checkmark to indicate staff administered the above medications. The facility policy Medication Administration-General, revised 9/19/23, stated staff administered medications as ordered by the physician and in accordance with professional standards of practice.On 4/8/25 at 2:38 p.m. , the Director of Nursing (DON) stated there were issues with medication availability and there was a problem with this last medication changeover (from March to April 2025). She stated routine medications should be available.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 35434 Based on observation, facility menus, facility policy review, and staff interview, the facility failed to follow the menu for 2 out of 2 residents on a pureed diet to ensure nutritional needs were met. The facility reported a census of 74 residents. Findings include: On 4/1/25 at 11:01 a.m., Staff D, Cook, pureed meatballs. Staff D did not puree any bread with the meatballs. On 4/1/25 at 12:03 p.m., a resident on a pureed diet received the following lunch: pureed meatballs, mashed potatoes, and pureed cake. The tray contained no bread. The Week 2 Therapeutic Spread Report stated resident on a regular diet should receive 1 slice of bread and residents on a pureed diet should receive 1/2 cup of pureed orzo (a type of pasta). On 4/2/25 at 3:56 p.m., the Administrator stated they would order pureed bread mix and add it to the meat during preparation. The facility policy Food Preparation Guidelines, dated 4/9/24, directed staff to follow written menus during food preparation in the form that met individual resident needs.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 35434 Based on observation, facility policy review, and resident and staff interviews, the facility failed to ensure staff served food at palatable hot holding temperatures for 1 of 1 meal observed. The facility reported a census of 74 residents. Findings include: 1. The facility policy Food Preparation Guidelines, dated 4/9/24, directed staff to serve food at a safe and appetizing temperature. On 3/31/25 at 1:11 p.m., Resident #13 stated that the food in the East dining room was cold so she preferred to eat in the main dining room. On 4/1/25, the Dietary Manager obtained the following temperatures: Carrots 163 degrees Fahrenheit at 11:32 a.m. Mashed Potatoes 163 degrees Fahrenheit at 11:33 a.m. Meatballs 189 degrees Fahrenheit at 11:33 a.m. On 4/1/25 at 11:35 a.m., Staff D, Cook, began to plate meals for the East hall cart. The State Agency (SA) requested a test tray with a thermometer to be placed on the cart. Staff D placed a test tray on the cart and began plating the rest of the resident meals for the East cart. The plates that Staff D utilized did not come from a plate warmer. At 11:47 a.m., Staff D completed the East cart meals and the Dietary Manager (DM) paged staff to inform them the cart was ready. The DM rolled the cart to the East hall at 11:48 a.m. At 11:50 a.m., staff members including the Activity Director began to serve the trays to residents in their rooms. At 11:57 a.m., staff finished passing the last room tray and took the cart into the East dining room. Staff passed the last dining tray at 11:58 a.m. and the SA immediately obtained the following temperatures from the test tray: Carrots 104 degrees Fahrenheit Mashed Potatoes 113 degrees Fahrenheit Meatballs 107 degrees Fahrenheit The SA tasted the food and it was barely warm. On 4/2/25 at 12:57 p.m. the DM stated she expected hot holding temperatures to be over 140-145 degrees Fahrenheit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35434 Based on observation, facility cleaning schedules, and staff interview, the facility failed to maintain adequate kitchen sanitation for 2 of 2 kitchen observations. The facility reported a census of 74 residents. Findings include: The initial kitchen tour, conducted on 3/31/25 at 9:33 a.m., revealed the following concerns: a. a thick layer of dust buildup on the back of the ice machine b. dust particles suspended from the 3 spigots of the fire suppression system located above the stove burners. A follow-up kitchen tour, conducted on 4/1/25 at 10:23 a.m., revealed the following concerns: a. dust particles remained suspended from the 3 spigots of the fire suppression system located above the stove burners. b. a shelf to the right of the three compartment sink covered with a film of dust and hairs, located directly over steam table lids. c. the ceiling above a prep area where staff wrapped silverware had strings of dust hanging down approximately 3 inches in length. d. a thick layer of dust hung from the sprinkler above the prep sink. e. dust particles suspended from the ceiling panels above the steam table and covering a vent above the right hand side of the steam table. The undated facility Weekly Cleaning List directed staff to clean ceiling vents biweekly and clean shelves weekly. On 4/2/25 at 12:57 p.m., the Dietary Manager stated she expected kitchen vents and the ceiling to be clean and stated some of the ceiling panels needed replaced.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 35434 Based on facility policy and staff interview, the facility failed to carry out a system of surveillance to track and address infections and potential infections in the facility. The facility reported a census of 74 residents. Findings include: On 4/8/25 at 11:41 a.m., the Regional Director of Nursing (DON) stated infection control had not been completed well at the facility but they had a new person starting soon. She stated it was her expectation they carry out such activities such as mapping out infections and completing skills fairs. The facility lacked documentation of an infection control surveillance system designed to identify possible communicable diseases or infections before they could spread to other persons in the facility such as: a. systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases of residents, staff, and visitors. b. an ongoing system of surveillance designed to identify possible communicable diseases c. a system for surveillance based upon national standards of practice and the facility assessment, including the resident population and the services and care provided. d. routine, ongoing, and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections. The facility policy Infection Surveillance, revised 6/2024, stated a system of infection surveillance served as a core activity of the facility's infection prevention and control program. The purpose was to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections. Data to be collected, including how often and the type of data to be documented, included: a. the infection site, pathogen (type of bacteria or virus) (if available), signs and symptoms, and resident location. b. summary and analysis of the number of residents (and staff, if applicable) who developed infections. c. observations of staff including the identification of ineffective practices, if any. d. the identification of unusual or unexpected outcomes, infection trends and patterns. e. how the data would be used and shared and with appropriate individuals to ensure that staff minimize the spread of the infection or disease.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 35434 Based on clinical record review, facility policy review, and staff interview, the facility failed to offer influenza vaccines to 4 of 5 residents reviewed for immunizations (Residents #2, #8, #10, and #63). The facility reported a census of 74 residents. Findings include: The facility policy Influenza Vaccination, dated 6/14/23, stated the facility would offer residents annual immunizations against influenza. 1. The Minimum Data Set (MDS) assessment tool, dated 2/18/25, listed diagnoses for Resident #2 which included heart failure, bipolar disorder, and depression. The MDS stated the resident required substantial/maximal assistance with bathing and listed her Brief Interview for Mental Status (BIMS) status as 15 out of 15, indicating intact cognition. 2. The MDS assessment tool, dated 4/1/25, listed diagnoses for Resident #8 which included diabetes, seizure disorder, and low back pain and listed her BIMS score as 9 out of 15, indicating moderately impaired cognition. 3. The MDS assessment tool, dated 1/5/25, listed diagnoses for Resident #10 which included non-Alzheimer's dementia, seizure disorder, and mild intellectual disabilities. The MDS listed the resident's BIMS score as 7 out of 15, indicating severely impaired cognition. 4. The MDS assessment tool, dated 11/5/24, listed diagnoses for Resident #63 which included left foot drop, muscle weakness, and abnormal posture. The MDS listed the resident's BIMS score as 14 out of 15, indicating intact cognition. The facility lacked documentation they offered influenza vaccines to the above residents during the 2024-2025 influenza season. On 4/8/25 at 2:38 p.m., the Director of Nursing (DON) stated residents should be up to date with their vaccinations. On 4/9/25 at 8:10 a.m., the Regional DON stated she could locate no additional influenza vaccine documentation.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 35434 Based on clinical record review, facility policy review, and staff interview, the facility failed to offer a Covid-19 vaccine for 1 of 5 residents reviewed for vaccinations (Resident #2). The facility reported a census of 74 residents. Findings include: The facility policy Covid-19 Vaccination reviewed 11/4/24, stated the facility would offer residents the Covid-19 vaccine. 1. The Minimum Data Set (MDS) assessment tool, dated 2/18/25, listed diagnoses for Resident #2 which included heart failure, bipolar disorder, and depression. The MDS listed her Brief Interview for Mental Status (BIMS) status as 15 out of 15, indicating intact cognition. The resident's clinical record lacked documentation the facility offered the resident a Covid-19 vaccination. On 4/8/25 at 2:38 p.m., the Director of Nursing (DON) stated residents should be up to date with their vaccinations. On 4/9/25 at 8:10 a.m., the Regional DON stated she could locate no additional Covid-19 vaccine documentation.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 48452 Based on personnel file review, staff training records, and interviews the facility failed to ensure 1 of 4 Certified Nursing Aides (CNAs) completed 12 hours of in-services per year that included abuse and dementia training. The facility reported a census of 74 residents. Findings include: A review of staff personnel files on 4/8/25 determined that Staff J did not complete orientation training, competency evaluations, or annual CNA training between his hire date of 12/5/23 and 4/8/25. The orientation checklist in the file was blank. Training records for this CNA documented one training on 3/19/24 for 15 minutes of education regarding communicating effectively. Staff J's files did not include a record of Dependent Adult Abuse training, abuse prevention, or dementia training for residents with cognitive impairments. During an interview with the Administrator 4/7/25 at 5:06 PM she stated she had to own that the facility was not caught up on training. They had staff meetings but their online training platform was switched and they were not caught up. On 4/8/25 at 3:37 PM the Administrator further confirmed she was not able to locate orientation documentation or additional training information for Staff J. She reported the only reason Staff J completed the training on communication was because another staff person sat with him to make sure it was done. She was not able to provide verification of required Dependent Adult Abuse training or facility directed online training completed by Staff J.