STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165174	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa DE Paz Health Care Center	2121 West 19th Street Sioux City, IA 51103

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 49628 Based on personnel file reviews, staff interviews, and policy reviews the facility failed to complete the Iowa Criminal History, Iowa Sex Offender Registry, Iowa Central Abuse Registry and Professional License information prior to employment for 3 of 7 employees reviewed (Staff B, C, D). The facility census was 55. Findings include: On 4/10/24 Staff B, Cook's personnel file contained the Iowa Criminal History, Iowa Sex Offender Registry, Iowa Central Abuse Registry and Professional License information dated 1/24/24. Staff B was hired on 1/14/24. On 4/10/24 Staff C, Dietary Aide ' s personnel file contained the Iowa Criminal History, Iowa Sex Offender Registry, Iowa Central Abuse Registry and Professional License information dated 1/25/24. Staff C was re-hired on 1/14/24. On 4/10/24 Staff D, Cook's personnel file contained the Iowa Criminal History, Iowa Sex Offender Registry, Iowa Central Abuse Registry and Professional License information dated 1/25/24. Staff C was re-hired on 1/14/24. On 4/10/24 at 11:11 AM the Administrator stated that Staff B, C, D all began working directly for the facility on 1/14/24 Staff B, C, and D were previously working for the contracted services in the facility ' s kitchen. The facility had requested documentation from the contract services company, but they had refused to supply the requested information. On 4/10/24 at 4:00 PM the Administrator confirmed that Staff B, C. and D did begin work on 1/14/24 prior to the completion of the Iowa Criminal History, Iowa Sex Offender Registry, Iowa Central Abuse Registry and Professional License background check. The Administrator stated the paperwork had been submitted to the facility's corporate Human Resources Department (HR) for the completion of the background checks, but did not receive the results back prior to the employees beginning work. The Administrator confirmed the individuals were working already in the facility's kitchen for a contract company. The contract company did not share paperwork with the facility. On 4/11/24 at 8:03 AM requested the document for Staff D ' s ability to work for the background check completed on 1/25/24. The Administrator stated only Staff D ' s 3/30/24 ability to work document was in the employee file. (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/11/24 at 9:25 AM the Administrator stated HR did not receive anything back from the Department of Health and Human Services (DHS) 1/25/24 background check for Staff D ' s ability to work. HR re-submitted Staff D ' s paperwork on 3/26/24 and received approval for right to work. The facility ' s Onboarding and Status Change Process & Divisions of Responsibilities reveals background checks with Sterling and Iowa Sing were to be completed prior to onboarding packets being sent to the new employees. The facility ' s Abuse Prevention Program & Reporting Policy revealed that the facility screening would consist of, but not limited to abuse, neglect, exploitation, and criminal record for all potential employees prior to hire.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review and staff interviews, the facility failed to notify the ombudsman office of a facility initiated discharges for 3 of 3 residents (Residents #30, #25, #3) reviewed. The facility reported a census of 55 residents. Findings include: 1. Resident #30's Minimum Data Set (MDS) dated [DATE] assessment identified Brief Interview for Mental Status (BIMs) score of 15, indicated intact cognition. The MDS included diagnoses of anemia, coronary artery disease, heart failure (heart doesn't pump blood as it should), end stage renal disease (kidney), diabetes mellitus and respiratory failure. Review of the Clinical Census revealed Resident #30 was on an unpaid hospital leave in January 2024 during the following dates: 1/4/24 to 1/11/24 1/22/24 to 1/29/24 Review of the facility Admission/Discharge report dated 2/1/24 used to track discharges and notify the Ombudsman office revealed Resident #30 was not listed on the report. On 4/10/24 at 12:15 PM, the Administrator acknowledged and verified Resident #30's transfers to the hospital in January 2024 were not reported to the Ombudsman. She stated the facility did not have a policy regarding Ombudsman notifications. She stated the facility followed the rules and regulations. 41785 2) According to the Minimum Data Set (MDS) dated [DATE], Resident #25 did not have a Brief Interview for Mental Status (BIMS) score because he was rarely/never understood. The resident was totally dependent on staff for sit to standing and toileting transfer and he was on a mechanically altered diet. The Care Plan last revised on 7/17/23, showed he had the potential for altered nutrition, he was able to eat independently, staff were directed to serve his diet per doctor order. Had limited range of motion to right arm due to contracture related to stroke, but was able to eat independently. The resident required use of coumadin and had a history of high INR level with certain antibiotic use. He had a history of blood in the urine when INR level was high. His diagnosis include neurogenic bladder, anemia, diabetes mellitus, Cerebrovascular accident, dementia, hemiplegia or hemiparesis. The Census tab in the electronic chart showed Resident #25 went to the hospital on 7/25/23, 9/15/23 and 11/12/23. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Ombudsman notification list provided by the Administrator, lacked information on these three hospitalization s. 26527 3) According to the MDS assessment dated [DATE] Resident #3 scored 10 on the BIMS which indicated moderate cognitive impairment. The resident's diagnoses included pneumonia, septicemia, and diabetes. The Clinical Census showed Resident #3 on unpaid hospital leave 10/16 to 10/23/23, and 11/14 to 11/20/23. The Ombudsman notification for October did not include Resident #3. The facility did not submit an Ombudsman notification for November.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on Electronic Health Record review (EHR) and staff interviews the facility failed to submit a comprehensive Minimum Data Set (MDS) as directed by the Centers for Medicaid and Medicare Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual assessment within the required timeframe for 1 out of 17 residents reviewed (Resident #49). The facility census was 55. Findings include: The review of Resident #49 ' s MDS assessment dated [DATE] lacked a transmission date. On 4/10/24 at 9:21 AM Staff F, MDS Coordinator, acknowledged the 2/6/24 MDS Assessment had not been submitted. Staff F stated a correction would be made with the submission of the 2/6/24 MDS assessment. On 4/10/24 at 10:52 AM the Administrator stated expected the MDS assessments would be completed and submitted within the required timeframes. The Administrator was not aware of other instances where the MDS assessments were not completed according to the required timeframes. On 4/10/24 at 12:45 PM the submission report for the 2/6/24 MDS revealed it had been submitted but was more than 14 days late in submission. On 4/11/24 at 7:46 AM the Administrator stated the facility did not have a policy for the completion of the MDS, but followed the RAI manual.

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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** 41785 Based on interview, record and policy review, the facility failed to ensure that residents received medications as orders for 1 of 3 residents. After a medication change, staff continued to administer the previous order to Resident #38. The facility reported a census of 55 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #38 had a Brief Interview for Mental Status (BIMS) score of 14 (intact cognitive ability.) The resident had frequent pain, and received scheduled, and as needed pain medication. The resident's diagnosis included; diabetes mellitus, Parkinson's Disease, malnutrition and anxiety disorder. The Care Plan updated on 11/12/23, showed that Resident #38 had a communication problem related to Parkinson's Disease, and a mental health diagnosis. He had pain related to Parkinson's, staff were directed to assess pain every shift, and evaluate the effectiveness of pain interventions. The resident was able to call for assistance when he was in pain, On 4/10/24 at 6:25 AM, Director of Nursing (DON) acknowledged that due to a computer entry error, the nurses had an option to give one or two tabs. She developed a plan going forward to ensure it didn't happen again. ask for medication, and could tell staff how much pain he was experiencing. A review of the electronic record Orders tab showed an order, on 11/3/23 at 4:00 PM, for Pregabalin 50 milligrams (mg) (medication used to treat nerve pain), give 1 capsule by mouth 2 times a day. On 2/27/24 at 5:00 PM, the order was changed from one tab to two tabs. In a review of the hand-written, Controlled Drug Administration Record it was discovered that on 3/6, 3/17 and 3/28 the resident received just one tab rather than two. The facility policy titled: Medication Management revised on 1/20/22, showed that medications would be administered in accordance with the resident's plan of care and all efforts were made to prevent medication errors. A wrong does error defined as; when the resident received an amount of medication that was greater than or less than the amount ordered by the prescriber.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview the facility failed to ensure residents received restorative exercises as planned for 4 of 4 resident's reviewed (Resident #3, #16, #20 and #37). The facility reported a census of 55 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #3 scored 11 on the Brief Interview for Mental Status (BIMS) which indicated moderate cognitive impairment. The resident was dependent with toileting hygiene, bathing, dressing, and personal hygiene. The resident demonstrated a functional limitation in range of motion (ROM) of both lower extremities. The resident had diagnoses including age related osteoporosis, and osteoarthritis. The Care Plan revised 11/20/21 identified the resident required assistance with all activities of daily living (ADL's) related to a lack of motivation, impaired cognition, impaired communication, pain, incontinence, limited ROM to lower extremities, and required assist with transfers. The interventions included: a. Per occupational therapy (OT): Bilateral upper extremity (BUE) therapeutic exercises with 2# weight for shoulder extension (ext)/flexion (flex), elbow flexion/extension, wrist flexion/extension, wrist pronation/supination x 15 repetitions (reps). b. Red Thera (T)-band for horizontal abduction (ABD)/adduction (ADD), triceps x 15 reps, 3-5 x/week. c. Per physical therapy (PT): bilateral lower extremely (BLE) therapeutic exercises in seated x 15 reps with 2# and red theraband of marches, knee flex/ext, glute sets, heel/toe raises, hip ABD/ADD, hip extension, 3-5 x/week. The Progress Notes dated 3/8/24 at 11:35 a.m. documented the resident's restorative plan was current in tasks and in the care plan. The resident actively participated. Would continue with current program and re-evaluate next review. The POC Response History documented in the 30 day period 3/12/24 - 4/10/24 the resident only received BUE exercises 1 time. The POC Response History documented in the 30 day period 3/12/24 - 4/10/24 the resident only received BLE exercises 2 times. 2) According to the MDS assessment dated [DATE] Resident #16 scored 14 on the BIMS which indicated no cognitive impairment. The resident was dependent with toileting hygiene, dressing, and personal hygiene. The resident demonstrated a functional limitation in range of motion (ROM) of both lower extremities. The resident had diagnoses including osteoporosis, and arthritis. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan revised 8/21/23 identified the resident had an ADL self care performance deficit related to a mental health diagnosis and impaired balance. The resident had limited ROM to lower extremities and impaired communication. The interventions included: a. Per OT: Red theraband for BUE x 15 reps shoulder flexion/extension, elbow flexion/extension, horizontal adduction/abduction, and triceps 3 times per week. b. Per PT: Bilateral lower extremity exercises with 3 pound weight and green theraband, 3 x/week. The Progress Notes dated 3/8/24 at 7:16 a.m. documented the resident's restorative plan was current in tasks and in the care plan. The resident participated sporadically depending on her mood. The restorative aid continued to document plan completion. Would continue with all modalities. The Documentation Survey Report for January 24, documented 2 resident refusals, and no days of completed restorative exercises. The Documentation Survey Report for February 24, documented 1 resident refusal, and no days of completed restorative exercises. The Documentation Survey Report for March 24, documented 1 resident refusal, and no days of completed restorative exercises. 3) According to the MDS assessment dated [DATE] Resident #20 scored 14 on the BIMS which indicated no cognitive impairment. The resident was dependent with toileting hygiene, bathing, dressing, and personal hygiene. The resident had diagnoses including non-Alzheimer's dementia, chronic obstructive pulmonary (lung) disease, and chronic respiratory failure. The Care Plan revised 11/30/22 identified the resident required assist with cares and had schizophrenia with impaired communication. The interventions included: a. Per OT: BUE therapeutic exercises: 3# weight bilateral shoulder flex/ext, elbow flex/ext, internal rotation (IR)/external rotation (ER), wrist pronation/supination, wrist flex/ext, green T-band horizontal ABD/ADD, triceps, all x 15 reps, 3-5 x/week. b. Per PT: Ambulate with front wheeled walker (FWW) followed with wheelchair in hallway x distance tolerated 1 x/shift-except overnight shift 3-5 x/week. The Progress Notes dated 3/11/24 at 8:24 a.m. documented the resident's restorative plan was current in tasks and in the care plan. The resident actively participated. Would continue with his current program and would re-evaluate at the next review. The POC Response History documented in the 30 day period 3/14/24 - 4/10/24 the resident only received BUE exercises 2 times. The POC Response History included Nustep level 3 x 15 minutes, 3-5 x per week, documented completed 0 times in the 30 day period 3/14/24 to 4/10/24. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The POC Response History included BLE therapeutic exercises seated x 15 reps with green theraband of knee flex/ext, marches, heel/toe raises, hip ABD/ADD completed 1 time the 30 day period 3/14/24 to 4/10/24. 4) According to the MDS assessment dated [DATE] Resident #37 scored 11 on the BIMS which indicated moderate cognitive impairment. The resident depended on staff for lower body dressing, and personal hygiene. The resident demonstrated a functional limitation in ROM of 1 lower extremity. The resident had diagnoses including a fracture (left femur), and non-Alzheimer's dementia. The Care Plan revised 10/11/23 identified the resident required assist with cares related to a recent fall with fracture, mental health diagnosis with psychotropic medication, dementia with impaired cognition/communication, anemia, coronary artery disease (CAD), impaired hearing/vision, complaints of pain, and incontinence. The interventions included: a. Per OT: BUE with 2# weight for shoulder flex/ext, elbow flex/ext, wrist pronation/supination, wrist flexion/extension x 15 reps, red T-Band ABD/ADD, triceps x 15 reps, 3-5 x/wk. b. Per PT: BLE therapeutic exercise in seated x 15 reps with 2# and yellow theraband of marches, hip ext, hip ABD/ADD, knee flex/ext, heel/toe raises, glut sets, hip IR/ER. Nustep x 15 minutes level 3, 3-5 x/wk. The Progress Notes dated 3/8/24 at 8:17 a.m. documented the resident's restorative plan was current in tasks and in the care plan. The resident actively participated. Would continue with current program and would re-evaluate at the next review. The POC Response History documented in the 30 day period 3/12/24 - 4/10/24 the resident only received BUE exercises 2 times. The POC Response History documented in the 30 day period 3/12/24 - 4/10/24 the resident only received BLE exercises or Nustep 2 times. On 4/10/24 at 9:59 a.m. Staff G Restorative Aide (RA) stated she had 36 residents on restorative. When she got called to the floor she couldn't do restorative. She did restorative as often as she could, but other cares came first. On 4/11/24 at 10:23 a.m. the Director of Nursing (DON) stated sometimes they had to pull Staff G to the floor and restorative was not getting done like it should. They were working on that. The facility policy Restorative Nursing dated 05/14 documented the facility strove to enable residents to attain and maintain their highest practicable level of physical, mental, and psychosocial functioning. The interdisciplinary team worked with the resident and family/responsible party to identify measurable restorative goals and practical interventions that could be implemented and achieved with nursing support. A licensed nurse managed the restorative nursing process with assistance of nursing assistants in providing restorative care. The policy included documenting refusals in the resident's medical record.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on observation, record review and staff interview, the facility failed to provide appropriate care to prevent urinary tract infection for 1 resident reviewed (Resident #37). The facility reported a census of 55 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #37 scored 11 on the Brief Interview for Mental Status (BIMS) which indicated moderate cognitive impairment. The resident was dependent with toileting hygiene and had an indwelling suprapubic urinary catheter. The resident had diagnoses including non-Alzheimer's dementia and a (left femur) fracture. The Care Plan revised 3/26/24 identified the resident had an indwelling suprapubic catheter. The goal with a target date of 6/24/24 included minimizing the potential of complications through the next review with the intervention to check the tubing for kinks each shift. The Progress Notes dated 11/14/23 at 10:52 p.m. documented the resident was post antibiotic treatment for urinary tract infection (UTI). On 4/8/24 at 11:30 a.m. the resident sat at the dining room table, with the catheter bag hanging under the wheelchair. The catheter bag hung in a dignity bag. The catheter bag hung through (slits in the bag) and rested on the floor. At 12:20 p.m. staff pushed the resident down the hall with the catheter bag dragging on the floor. On 4/10/24 at 8:24 a.m. Staff G Certified Nursing Assistant (CNA) wheeled the resident to her room, the catheter bag hanging through the dignity bag, touching the floor. The catheter tubing also touched the floor. On 4/10/24 at 2:42 p.m. the Nurse Consultant stated she would expect the catheter bag and tubing to be kept off the floor, but should refer to the Director of Nursing (DON). On 4/11/24 at 10:18 a.m. the resident sat in the TV area near the nurse's station. The catheter bag hung through the dignity bag with a small portion touching the floor. On 4/11/24 at 10:23 a.m. the DON confirmed the bag and tubing should not touch the floor. She said they had a problem with the dignity bags splitting at the bottom. According to the Center for Disease Control (CDC) Guidelines for Prevention of Catheter-Associated Urinary Tract Infection, proper techniques for urinary catheter maintenance included the catheter bag not resting on the floor.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview and record review the facility failed to ensure that residents were free from unnecessary psychotropic medications for 1 of 5 residents reviewed. Resident #43 had an order for Haloperidol as needed (PRN), and a review of the clinical record revealed that the order continued past the 14-day limit for PRN psychotropic medication use. The facility reported a census of 55 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #43 had a Brief Interview for Mental Status (BIMS) score of 0 (severe cognitive deficits). The resident did not have physical behavioral symptoms such as hitting, kicking or grabbing, did not scream at others and did not reject cares. The resident was totally dependent on staff assistance for transfers and with eating. Diagnosis for Resident #43 included non-Alzheimer's Dementia, anxiety disorder and respiratory failure. The Care Plan for Resident #42, last revised on 2/19/24, showed that she used psychotropic medications. Staff were to consult with pharmacy and provider to consider dosage reduction when clinically appropriate, monitor occurrence of target behavior symptoms such as yelling at staff, arguing with other residents, and aggression towards staff. She needed one-person assistance with dining and staff were directed to serve diet as ordered. On 4/9/24 at 2:30 PM, Resident #42 was in bed and often called out for help. Her concerns were disorientated and delusional. A Nursing Note dated 3/6/24 at 3:46 AM, showed that for three consecutive nights, the resident displayed immense emotional distress, increased agitation and was combative with cares. On 3/6/24 at 9:05 AM the facility received a one-time Intramuscular (IM) dose of Haldol 5milligram(mg) /milliliter (ml). They also received an order dated 3/6/24 at 9:15 AM, for Haloperidol Oral tab 5 mg. to be given every 12 hours a needed for anxiety and agitation. The Medication Administration Record (MAR) showed the following administration of PRN Haldol and the chart lacked corresponding description of reason for administration: a. 3/12 IM injection given at 10:48 AM and a 5mg tab given at 7:54 AM. b. 3/13 at 3:03 AM and 7:12 PM, 5 mg tab given. c. 3/20 at 9:20 AM 5mg tab given d. 3/25 at 9:47 AM 5 mg tab given e. 3/26 at 6:57 AM and 6:19 PM 5mg tab given (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. 3/29 at 6:54 PM 5 mg tab given g. 3/30 at 9:41 AM 5 mg tab given h. 4/1 at 7:55 AM 5 mg tab given i. 4/5 at 8:54 AM. 5 mg tab of Haldol given and a 0.5 mg tab of Ativan was given at 8:54 AM. On 4/11/24 at 9:38 AM the Director of Nursing acknowledged that the PRN Haldol order should have been addressed and reassessed after 14 days of use. According to the facility policy titled: Medication Management reviewed on 8/2020, When possible, non-pharmacological interventions were considered before initiating a new medication. As needed order would include an indication for use. If the PRN medication was used to modify behavior, the indications for use are clearly defined in objective terms; what specific symptoms were being addressed. The resident was monitored for the effectiveness of the medication or possible adverse consequence. Results were documented in the resident active record.

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Casa DE Paz Health Care Center	2121 West 19th Street Sioux City, IA 51103

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview the facility failed to ensure residents remained free from significant medication errors for 1 of 17 residents reviewed (Resident #40). The facility reported a census of 55 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #40 scored 9 on the Brief Interview for Mental Status (BIMS) which indicated moderate cognitive impairment. The resident was independent ambulating with a walker. The resident had diagnoses including non-Alzheimer's dementia. The resident took antidepressant and antipsychotic medications. The Care Plan revised 2/7/23 identified the resident used psychotropic medications. The goal to minimize the potential of complications while on psychotropic medication. The interventions included monitoring/recording/reporting to the NP as needed side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. The Medication Administration Record (MAR) for January showed the resident received Olanzapine 5 mg 1 time a day with a start date of 3/17/23. The Progress Notes dated 1/5/24 at 3:15 p.m. documented the resident returned from appointment per facility van with new orders. An MD/Nursing Communications form dated 1/5/24 documented Olanzapine should be 7.5 mg daily. The MAR for January showed the Olanzapine 5 mg discontinued 1/5/24, and Olanzapine 7.5 mg added with a start date of 1/5/24. The Progress Notes dated 1/18/24 at 11:10 a.m. documented a call to the physician to see if the resident's order for Olanzapine could stay at 5 mg instead of 7.5 mg. The resident did well on that dose. Waiting on return call. The Progress Notes dated 1/18/24 at 11:44 a.m. the physician returned the call stating to keep the resident on 5 mg of Olanzapine. The resident's family notified of the new order. A phone order for the resident dated 1/18/24 at 11:48 a.m. read Olanzapine 5 mg 1 time a day. The MAR for January 2024 showed Olanzapine 5 mg daily with a start date of 1/18/24. The MAR showed the Olanzapine 7.5 mg daily continued. A Consultant Pharmacist Recommendation to Physician with a med regimen review date of 1/30/24 documented the resident received 2 drugs with very similar activity: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Olanzapine 7.5 mg daily for behaviors, 2. Olanzapine 5 mg daily for mood disorder. Asked to verify if the drug regimen was required, and if not to adjust therapy as necessary. The physician/prescriber responded the resident should only be taking 7.5 mg daily. On 2/8/24 at 10:14 a.m. the primary care provider responded to the pharmacy recommendation on Olanzapine that the resident should only be taking 7.5 mg daily. On 4/10/24 at 5:15 p.m. the Director of Nursing stated she notified the provider the resident did well on the Olanzapine 5 mg, but she didn't discontinue the 7.5 mg. She acknowledged it was a medication error on their part. Instead of getting a decreased dose she was getting 2 doses. It was caught by the pharmacist during med regimen review. The Medication Management: Medication Error Preventing and Reporting policy revised 1/20/22 documented a medication error was any preventable event that may cause or lead to innappropriate medication use or resident harm while the medication was in control of the health care professional, resident or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication. Categories of medication errors included extra dose error. The administration of duplicate doses to a resident which may include administration of a medication dose after the order was discontinued.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on observation, staff interviews, and policy review the facility failed to prepare and serve pureed food to meet the nutritional needs of 3 of 3 residents reviewed (Residents #5, #25, #43). The facility reported a census of 55 residents. Findings include: A facility form titled Diet Type Report dated 4/8/24 identified three residents (Resident #5, #25 and #43) who received a pureed texture diet. On 4/9/24 at 11:00 AM observed Staff A, Cook took four Rueben sandwiches and placed the sandwiches in the Robo Coupe. She then added chicken broth to the contents. After she was finished pureeing the sandwiches, she poured the contents into a sprayed pan, covered the pan with aluminum foil and placed the pan in the oven. Staff A did not measure the total volume of the food after it was pureed to determine the appropriate portion or scoop sizes. On 4/9/24 during noon meal service, observed Staff A, Cook serve one scoop full of the #6 scoop of pureed [NAME] sandwich to Resident #5, #25 and #43. On 4/9/24 at 12:40 PM after meal service had ended, asked Staff A how many servings were left of the pureed Rueben sandwich. Staff A took the #6 scoop and scooped out three scoops full of the pureed sandwich contents from the pan. Staff A acknowledged and verified there should only be one serving left over. She reported she should have measured the pureed contents after she blended it. She stated she got confused as the menu stated to use a #6 scoop. On 4/9/24 at 3:50 PM, the contracted Certified Dietary Manager (CDM) reported she had reviewed the Pureed Diet Portion Sizes/Scoops chart and acknowledged/verified the pureed food items should have been measured prior to serving to determine the correct portion size. The undated facility policy titled Puree Process documented the following steps: 1. Measure out the desired number of servings into a container for pureeing. 2. Puree the food. 3. Add any necessary thickener or appropriate liquid of nutritive value and flavor to obtain desired consistency. 4. Measure the total volume of the food after it is pureed. 5. Divide the total volume of the pureed food by the original number of portions (see Puree Scoop Chart). 6. Heat or chill the pureed food to safe serving temperature.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview and record review the facility failed to serve residents the therapeutic menus as ordered for 5 of 5 reviewed. Residents #25, #5 and #43 had pureed diet orders and staff served them oatmeal that was not pureed. Residents #36 and #12 had mechanical soft diets, staff served them corn with the mixed vegetables. The facility reported a census of 55 residents. Findings include. 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #25 did not have a Brief Interview for Mental Status (BIMS) score because he was rarely/never understood. The resident was totally dependent on staff for sit to standing and toileting transfer and he was on a mechanically altered diet. The Care Plan last revised on 7/17/23, showed that he had the potential for altered nutrition, he was able to eat independently, staff were directed to serve the diet per doctors order. The resident had limited range of motion to right arm due to contracture related to stroke, but he was able to eat independently. Diagnosis include neurogenic bladder, anemia, diabetes mellitus, Cerebrovascular accident, dementia, hemiplegia or hemiparesis The electronic record showed that Resident #25 had an order dated 2/13/24 at 1:50 AM, for a regular diet, with puree texture. 2) According to the MDS dated [DATE], Resident #43 had a BIMS score of 0 (severe cognitive deficits). The resident was totally dependent on staff assistance for transfers and with eating. The diagnosis for Resident #43 included non-Alzheimer's Dementia, anxiety disorder and respiratory failure. The Care Plan for Resident #42, last revised on 2/19/24, showed that she needed one-person assistance with dining and staff were directed to serve diet as ordered. The electronic record showed an order dated 3/1/24 at 4:34 PM, showed that Resident #42 required a regular diet with pureed texture. 3) According to the MDS dated [DATE], Resident #5 had a BIMS score of 13 (moderate cognitive deficits). She was independent with eating, toileting and dressing and was on a mechanically altered diet. The Care Plan revised on 4/8/24 showed that Resident #5 was at nutritional risk with weight fluctuations. She was served pureed foods with honey thick liquids. Staff were directed to serve the diet as ordered. She had self-care performance deficits related to inattention and confusion. A review of the clinical record showed an order for Resident #5, dated 2/13/24 at 3:35 AM, for regular diet, puree texture. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation of the breakfast meal on 4/09/24 at 8:47 AM, staff had served Residents #5, #25 and #43 servings of oatmeal with their breakfast. The cereal had visible lumps, and was not a pureed consistency. The Menu for Week 4, showed that the puree diet included an option for hot cereal, pureed. On 4/9/24 at 2:10 PM, Staff B, Cook, said that she had been working as a dietary aide, and her status had recently changed to cook without having any training. She said that she helped with breakfast on 4/9/24 and served the oatmeal for puree diets and she said that she thought that it was acceptable to serve the oatmeal without pureeing. On 4/9/24 at 1:48 PM, The Certified Dietary Manager (CDM) said that a resident on pureed diet should have been served a cream of wheat, or the oatmeal should have been pureed. The [NAME] Brothers, Menus Planning Guide dated 3/22, showed the use of puree texture modification was for individuals with moderate to severe dysphagia, and for individuals with poor dentitions. 26527 2) The facility Diet type report dated 4/8/24 at 2:56 p.m. showed Resident #12 and Resident #36 were on a mechanical soft diet. On 4/8/24 at 12:15 p.m. Resident #12, and Resident #36 received mixed vegetables that included corn. The meal served was not the meal on the menu at a glance. The menu for the meal served 4/8/24 included mixed vegetables for the regular diet. The mechanical soft diet included carrots instead of mixed vegetables. On 4/9/24 at 1:38 p.m. the Certified Dietary Manager (CDM) stated residents on a mechanical soft diet should not have received the mixed vegetables with corn. They should have received cooked carrots. Serving residents the incorrect diet put them at risk for choking.

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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. 46875 Based on observations, staff interviews and policy review, the facility failed to ensure food was labeled with dates after opening, staff complete hand hygiene before applying gloves and when removing, supplies and ingredients are stored in a safe and sanitary way, and ensure hair is completely covered with a hair net. The facility identified a census of 55 residents. Findings include: 1. An initial Kitchen tour conduct on 4/8/24 at 10:46 AM, of the kitchen revealed the following: a. Walk in refrigerator had multiple cups of fruit, a chunk of cheese, and more fruit on an upper shelf not dated. b. The inside door of the walk in refrigerator had white spatter on the inside. c. In the dry storage room on the bottom shelf, the large sugar canister had a cup stored in it and the large flour canister had a mug in it. 2. A follow up Kitchen tour conducted on 4/9/24 at 9:50 AM, of the kitchen revealed the following: a. In the dry storage room, the large flour canister had a mug in it. b. In the dry storage room a case of straws was sitting on the floor. c. Walk in refrigerator had a bag of watery lettuce, turning brown that was opened and not dated and a 16 ounce whipped topping container, opened and not dated. On 4/9/24 at 11:00 AM, observed a contracted Certified Dietary Manager (CDM) with hair hanging outside of the hairnet and not fully covered when in the kitchen. On 4/9/24 at 11:30 AM, observed Staff B, Cook put a pair of gloves on per the direction of the CDM without completing hand hygiene and then transferred Rueben sandwiches from one oven pan to another oven pan. On 4/9/24 at 11:45 AM, observed Staff B take a pair of gloves off, placed the used gloves on the counter top where food preparation took place, did not completed hand hygiene, picked up a food thermometer and hand the thermometer to the CDM to check a temperature on a Rueben sandwich in the oven. The used pair of gloves stayed on the counter throughout the meal service. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/9/24 at 1:30 PM, the contracted CDM reported she would expect staff to complete hand hygiene before putting on gloves and when removing them. She stated she was focused on getting the Rueben sandwiches ready for serving when she asked Staff B to put the gloves on. She reported a mug should not be stored in the flour container. She stated she had checked the sugar container but not the flour one. She stated she was aware of the lettuce in the walk in cooler and threw it out. She stated she was only at the facility one time per week. On 4/9/24 at 3:50 PM, observed the contracted CDM's hair hanging outside the hair net and not fully covered when in the kitchen. On 4/11/24 at 9:20 AM, contracted CDM stated she had noticed her hair had not been fully covered when she went to the bathroom on 4/9/24. A facility policy titled Sanitation dated 6/2015 documented to never store scoops in ingredient bins or ice machines and place in a separate container. The policy further documented to store products on shelving. A facility policy titled Personal Hygiene dated 6/2015 documented that all staff involved in handling food to follow proper personal hygiene practices to prevent contamination of food. The policy directed staff to wear a hair restraint at all times and to cover all hair. The policy also directed staff to change gloves when a task had been completed and to remove gloves and wash hands before proceeding to the next task. A policy titled Refrigerator Storage dated 6/2015 documented to label all leftovers with name, date (month, day and year) of storage.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 46875 Based on interview and record review, the facility failed to ensure the binding arbitration agreement provided for the selection of a venue that was convenient to both parties for 3 of 3 residents reviewed for binding arbitration (Residents #107, #52, #44). The facility reported a census of 55 residents. Findings include: Review of the undated facility Voluntary Arbitration Agreement, provided by the Administrator on 4/8/24, revealed no evidence for the selection of a venue that was convenient to both parties. Review of the undated facility Voluntary Arbitration Agreement Program Guide, provided by the Administrator on 4/8/24 and attached to the arbitration agreement, documented the dispute would be decided at an arbitration hearing at a court reporter's or attorney's office, which would occur within 6 months /180 days of the request for arbitration. Review of Resident #107, #52 and #44 ' s electronically signed Voluntary Arbitration Agreements failed to include the selection of a venue that was convenient to both parties. Review of Resident #107, #52 and 44 ' s electronically signed Voluntary Arbitration Agreement Program Guide documented the dispute would be decided at an arbitration hearing at a court reporter's or attorney's office, which would occur within 6 months /180 days of the request for arbitration. On 4/10/24 at 11:15 AM, the Administrator acknowledged and verified the selection of a venue that was convenient to both parties was not included in the binding agreement. She also acknowledged that the arbitration program guide was different from the agreement. She stated she sent the arbitration agreement and program guide to the Corporate Office to have it reviewed and updated.