STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165191	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Red Oak	201 Alix Avenue Red Oak, IA 51566

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48004 Based on clinical record review, observation, staff interview, and policy review the facility failed to develop a comprehensive care plan that included problems, goals, or interventions for a resident (Resident #6) with suicidal ideations. The facility further failed to implement interventions for a smoking resident (Resident #18) listed on the care plan. The facility reported a census of 43 residents. Findings include: 1. Review of Resident #18's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition. Review of Resident #18's Care Plan with a print date of 4/16/25 revealed Resident #18 is a smoker. The Care Plan further revealed interventions to store cigarettes and lighter at the nurse's station. On 4/16/25 at 9:01 AM observed Resident #18 smoking. It was then observed when Resident #18 came back into the facility Resident #18 kept the lighter in a pocket and did not place it at the nurse's station. Interview 4/16/25 at 9:18 AM with Resident #18 revealed that she keeps her lighter with her, but her cigarettes are kept at the nursing station. Interview 4/16/25 at 9:30 AM with Staff B Licensed Practical Nurse (LPN) revealed that they do not keep any of the cigarettes or lighters at the nurses station. Staff B then revealed that all rooms have a lock box, and that is where the residents who smoke should be keeping their items. Staff B further revealed that Resident #18 should be keeping her cigarettes in a lockbox. Interview 4/16/25 at 9:34 AM with the Director of Nursing (DON) revealed she would expect Resident #18 to place her lighter at the nurses station for safe keeping. During a follow up interview 4/17/25 at 8:06 AM with the DON revealed her expectation would be for staff to follow the care plan as implemented. 41783 (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS assessment dated [DATE] for Resident #6 documented she scored 12 on the BIMS indicating she has moderately impaired cognition. The MDS documented over the last two weeks she had little interest or pleasure in doing things 12-14 days, felt down, depressed or hopeless 7-11 days, and felt tired or had little energy 12-14 days. The MDS documented she had diagnoses to include dementia, anxiety disorder and depression. The Care Plan with the revised date of 1/13/25 documented Resident #6 is on an antidepressant related to depression. The Care Plan directed staff to monitor the resident condition based on clinical practice guidelines or clinical standards or practice. The Care Plan lacked any documentation of suicidal ideation. The Progress Notes for the resident documented the following: On 1/16/25 at 11:47 AM the Nurse Practitioner for Mental Health was here to see the resident for rounds. Resident stated to provider she wants to kill herself. The NP gave an order for the resident to be evaluated and treated in the emergency room (ER) for delirium and suicidal ideation. The fire department called for transport. Report given to the hospital ER and son present and aware. On 1/16/25 at 11:57 AM the resident transferred to the hospital. On 1/16/25 at 6:30 PM the resident returned from the hospital at 6:30 PM. Her son transported her via private vehicle. She had new orders for Sertraline increase for depression. Her other order was for Lorazepam 1 mg IM every 6 hours PRN agitation. Her son is aware of the new orders. The written orders were faxed to the pharmacy. When she arrived, she told her son and myself that we needed to leave her alone, that she was going to bed. She took all of her scheduled (hour of sleep) HS meds without complaint. On 4/16/25 at 11:50 AM the Director of Nursing stated the NP for mental health continued to follow the resident for her psyche concerns but the Care Plan was not implemented for interventions done for the suicidal ideation.

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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. 47673 Based on Electronic Health Record (EHR) review, staff interview, policy, and Medication Administration Records - Treatment Administration Records (MAR-TAR) review the facility failed to provide needed services in accordance with professional standards by leaving medications in the residents room for self administration without visualization by the nurse for 1 of 8 residents (Resident #3). The facility reported a census of 43 residents. Findings include: The Minimum Data Set (MDS) for Resident #3, dated 3/11/2025 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS documented utilization of an enteral feeding tube for medication administration. On 4/16/25 at 9:18 AM an observation revealed Staff N, Registered Nurse (RN) entered Resident #3's room with medications. Staff N completed administration of enteral medications. Staff N left Nystatin at Residents #3's chair side table to self administer later. Staff N left the room and shut the door. Review of Resident #3's MAR-TAR documented a physician's order for Nystatin mouth and throat suspension 100000 unit/mL. The order documented to give 5mL by mouth 2 times a day for sore mouth may give PRN also. Review or Resident #3 EHR titled, Care Plan documented no plan for self administration of medications. On 4/16/25 at 10:05 AM Staff N stated Resident #3 does the Nystatin treatment after breakfast. Staff N acknowledged that usually the medication was administered when she entered the room but at times when the meal had not been eaten she would leave the medication for Resident #3 to administer on her own. Staff N stated she did not think Resident #3 had an assessment for self administration of medications. Staff N acknowledged that day was one of the very few times that she had left the medication for Resident #3 to administer herself. On 4/16/25 at 10:11 AM the Director of Nursing (DON) acknowledged that Resident #3 did not have a self administration assessment completed and did not have a care plan that reflected she could keep the medication at the bedside. The DON stated since Resident #3 did not have a self administration assessment completed or an order from the doctor for self administration her expectation was that the nurse would remain in the room to monitor the administration of the medication. Review of the policy revised 4/8/25 titled, Medication Administration documented the resident had the right to self-administer medications if the interdisciplinary team determined that this practice was safe for the individual resident and was documented in the care plan. An order from the provider was required for that activity. Nursing employees would be aware of medications kept in the room and responsible for recording self-administration doses in the resident's medication record.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observations, resident interview, staff interview and physician interview, record review, and facility policy review the facility failed to provide adequate pressure ulcer care for 2 of 3 residents reviewed (Resident #39, #28). Resident #39 had a Stage IV pressure on his coccyx and staff failed to complete the treatments as ordered. He was found to have 3 areas of skin breakdown that staff failed to document and measure. Resident #28 had a Stage II pressure on his buttocks and was found to be without the ordered dressing. The facility reported a census of 43 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. 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #28 had a Brief Interview for Mental Status (BIMS) score of 7 (moderate cognitive deficit). He was totally dependent on staff for showering, dressing, personal hygiene and toileting. He had one, stage 2 pressure, and one stage 2 pressure that was present upon readmission. The MDS dated [DATE], showed that the resident had one, Stage I pressure injury at that time. The Care Plan updated on 12/16/24, for Resident #28 showed that he had impaired cognitive functioning related to dementia and he was non-ambulatory. He had a suprapubic urinary catheter. Staff were to monitor for cloudiness, output, foul smelling urine. He had the potential for pressure ulcer development and on 3/11/25 he had a stage 2 pressure to coccyx and a pressure on his heel they were noted to be present upon hospital return on 3/7/25. A Wound Data Collection (WDC) document dated 4/9/25 at 7:02 AM, showed that Resident #28 had an unstageable ulcer on the left heel that measured 2 centimeters (cm) x 3 cm. The wound was being treated with Betadine. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The WDC dated 4/9/25 at 7:04 AM, showed that Resident #28 had a Stage II wound on the right buttocks measuring 2 cm. x 2.3 cm. and a depth of 0.2 cm. There was no dressing present at the time of the assessment and the resident did not voice complaints of pain related to the wound. Dressing description; Mepilex. According to the Clinical Physician Orders, Resident #28 had an order dated 3/10/25 at 11:00 AM, to apply Mepilex dressing to open area right buttocks, change every 3 days and as needed when soiled. During an observation on 4/15/25 at 12:48 PM, Staff E, Certified Nurse Aide (CNA) and Staff F CNA, prepared to provide incontinence cares for Resident #28. The resident was laying in bed and was wearing gripper socks. Staff E removed his socks and revealed a large red spot on the bottom of his left heel. It looked to have Betadine on, and around the spot. When the CNA's removed the residents brief and rolled him onto his right side, to clean him, the resident flinched and said ouch as they wiped an open area on the right buttock bottom. Staff F questioned if the resident should have some cream applied to the area and Staff E said that he should have a dressing on it and she would inform the nurse that he needed the treatment completed. The Medication Administration Record and Treatment Administration Record (MAR/TAR), printed on 4/15/25 at 12:52 PM, showed that the treatment order for Mepilex dressing to the open area of the right buttocks had been completed at 10:26 AM that morning. A review of the history of skin breakdown for Resident #28 revealed a Skin Observation document dated 2/24/25 at 10:00 AM, showed that a skin check had been completed that day with no skin conditions observed/skin conditions resolved. The nursing notes on 3/2/25 at 9:24 AM, showed that Resident #28 was transferred to the emergency room at 7:13 AM that morning. The History and Physical report from the hospital, dated 3/2/25 at 3:32 PM, showed that Resident #28 presented from the emergency room with pneumonia, urinary tract infection, suspected deep tissue injury of unknown depth of heel and a sacral wound. Once the resident arrived on the floor of the hospital, his brief was removed, and he was found to have small open skin areas in the groin and scrotum, a possible Stage II wound in the sacral area, and a large deep tissue injury to the left heel. The Wound Care Progress Note, final report from the hospital, recorded on 3/6/25, showed that Resident #28 was found to have an unstageable suspected deep tissue injury of the left heel and a pressure ulcer Stage II of the right buttocks. Both present upon admission to the hospital. On 4/17/25 at 6:50 AM, the Director of Nursing (DON) maintained that Resident #28 had no skin issues when he went into the hospital on 3/2/25. She said the skin nurse did an assessment on the resident the day that he went out to the emergency room , and there was nothing in the notes about the heel or open area on his buttocks. The DON said that the resident was in the emergency room all day and these issues developed during that time before he was admitted to the hospital. On 4/17/25 at 9:05 AM the DON said that the patch probably fell off after the treatment nurse put it on earlier that day. She said she would expect that a new spot would be noted and measured. Measurements are expected once a week. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/25 at 10:09 AM the Physician for Resident #28 said that without having seen the wounds that were described in the ED at first thought, one would think there would be something the staff would have seen on his heel or stage II on his buttocks. Without having seen them, he just couldn't say for sure. He added that overall he is happy with their wound care here. 2. The MDS dated [DATE], for Resident #39, showed that he was admitted to the facility on [DATE] and he had a BIMS score of 13 (moderate cognitive deficit). The resident was always incontinent of urine and frequently incontinent of bowel. His diagnoses include: malnutrition, Chronic Obstructive Pulmonary Disease (COPD) and a Stage 4 pressure ulcer of the sacral region. The Care Plan dated 3/3/25, showed that Resident #39 had self-care performance deficits related to malnutrition and weakness. He was bedfast most of the time and non-ambulatory. Resident #39 was dependent for all bed mobility, dependent for toilet use and hygiene. He was incontinent of bowel and bladder and he required 2 staff assistance for transfers with a mechanical lift. He had the potential for pressure ulcer development. Staff were to notify the nurse immediately of any new areas of skin breakdown: redness, blisters or discoloration. Assess and monitor wound healing and report improvements and/or decline. The resident required Enhanced Barrier Precautions (EBP) related to stage 4 pressure injury to sacrum. The WDC dated 4/8/25 at 12:06 PM for Resident #39 showed that he had a Stage IV wound on sacrum measuring 2 cm. x 1.7 cm. with a depth of 0.5 cm. The wound had minimum drainage, serosanguinous in color with no odor. Undermining or Tunneling Depth was 0.8 cm. at 6:00 and 12:00. On 4/16/25 at 10:14 AM, Staff C Certified Nurse Aide (CNA) and Staff D, CNA, prepared to transfer Resident #39 to the shower chair for a shower. The resident was in bed on his back, his legs supported with a pillow at the knees and he was wearing heel protectors. The resident had a scabbed wound on the back of his left calf and the right calf had a dark spot in the area of where the legs had been resting on the pillow. Further up on the left thigh here were two separate open areas. When asked if those skin issues were documented, Staff D responded that those were old spots that had been there for a while. Staff C and Staff D turned the resident onto his left side. He had a dressing patch on his coccyx that was not dated and was soiled. With gloved hands, Staff C (aide) peeled the dressing off and pulled the packing out of the wound and threw it away. The wound had a large opening that immediately started to bleed and dripped down his side onto the bed. On 4/16/25 at 10:52 AM, Staff D pushed the resident back to his room after his shower. The wound was left open through the shower and the lift sling was still soiled with blood on the back. The resident was transferred back to the bed for the wound treatment. Staff G, Treatment Nurse, provided the wound treatment including measurements and packing. Staff G was not sure if the other skin issues had been documented. She later said that a skin observation had been completed on 4/12/25 and included the other skin breakdown. A Skin Observation document dated 4/12/25 at 12:48 PM, showed an area on outer aspect of the left knee scabbed and right knee outer aspect of right knee scabbed. The chart lacked measurements, description, or reference to the two open areas on the left leg. The Assessments tab lacked follow up documentation of the three areas observed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MAR/TAR for March and April for Resident #39 showed an order for Wound care dated 3/6/25 at 7:00 PM to cleanse with wound cleanser, pack wound/undermining with normal saline soaked gauze, cover with foam dressing twice a day (BID) and as needed (PRN) every morning and at bedtime. The TAR showed that on March 6th, 14th, 17th and 19th the evening treatment was not completed. The charting for the evening treatment was left blank on the 7th, 8th, 9th, 12th, 15th, 18th, 21st, 22nd, 23rd, 26th, 28th, 29th, 30th, 31st, and April 12th and 13th. On 4/17/25 at 10:11 AM the Physician said he would be more concerned with the wound having been exposed to the Hoyer sling then being open in the shower. He stated it is probably not best practice to have put him on the sling. A facility policy titled: Pressure Ulcer/Wound Care Resource Packet, dated 6/5/24 showed that a Wound Data Collection UDA was required for documenting daily monitoring, was required at least weekly when skin integrity was impaired or an open area was present, and was required to be used daily and with every treatment for documenting observations. The facility must ensure that a resident having pressure sores received necessary treatment and series to promote healing, prevent infection and prevent new sores from developing.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observations, staff interviews, record review and facility policy review the facility failed to establish and implement interventions to prevent falls and injuries for 2 of 3 residents reviewed. Resident #20 had a history of confusion and many falls. She tripped on the pedals of the wheel chair on 3/1/25 and staff failed to follow through with an intervention to remove those pedals from the wheelchair when not in use. On 4/2/15 the resident again tripped on the wheel chair pedals, fell and sustained head trauma. Resident #6 had many falls and the facility failed to evaluate for risks and hazards and failed to implement interventions for every fall. The facility reported a census of 43 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #20 had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive deficit). She required supervision with eating, dressing and hygiene and toilet transfers. The resident had two or more falls with injury since admission. She was admitted to the facility on [DATE]. The Care Plan (CP) updated on 4/17/25, showed that Resident #20 was at risk for falls related to confusion, incontinence, osteoporosis, syncope and medication use. The CP listed 11 falls from 1/1/25 through 4/2/25. The resident had self-care performance deficit related to dementia, she was able to ambulate with seated walked, gait belt and assistance of one and she was able to transfer with the assistance of one staff. The resident had behavior symptoms related to dementia, a history of exit seeking and verbal aggression. On 4/7/25 Resident #20 was admitted to Hospice Services after an alteration in neurological status related to head injury with traumatic cerebral hemorrhage. On 4/15/25 at 10:03 AM, observed Resident #20 sitting in her wheelchair with Hospice staff in the dayroom. She had a tall back wheelchair; her feet were on the pedals and it was slightly tilted. There was an open sore on the right side of her face, her forehead and cheek had bruising in various stages of healing. The resident was very calm and the Hospice staff person said that she was just getting to know the resident and she had been told that Resident #20 had days of agitation. The Care Plan (CP) and Fall Scene Huddle Worksheet (FSHW) contained the following information related to falls since January: a. Fall on 1/9/25 the CP included an intervention to check frequently during shifts. The FSHW lacked a root cause or intervention. b. Fall on 1/25/25 unwitnessed in her room no intervention on the CP. FSHW intervention included wearing gripper socks 24 hours a day. c. Falls on 1/26 and 1/27/25 unwitnessed in her room, no interventions listed on the CP. FSHW included a medication change. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	d. Fall on 2/28/25 intervention on the CP not to leave the resident in the room unattended with foot rest on recliner up. FSHW included a root cause of trying to transfer out of the recliner. e. Fall on 3/1/25 the CP included an intervention to keep in view of staff. The FSHW included the root cause to be that she tripped on the foot pedals of the wheel chair, fall with abrasion to head. The corrective actions taken to prevent recurrence of this incident was to remove the pedals when not in use and all staff would complete the corrective action. f. Falls on 3/6 and 3/7/25 CP intervention was to check often (repeat intervention from 1/9) frequently leave door open. 3/7/25 fall in room when up independently with contusion to head. CP intervention to leave door to room open and check often. No FSHW document. g. Fall on 3/16/25 no intervention added on CP. FSHW documentation; found on floor in another resident's room. Confusion, intervention to keep light on in the bathroom. h. Fall on 4/2/25 in the morning, slid from wheel chair no injury no team meeting i. Fall on 4/2/25 late afternoon. CP included; the resident got up out of wheel chair independently, intervention to remove pedals from the WC unless staff pushing resident in chair. FSHW root cause resident attempting to stand up and tripped over wheel chair pedal. She had been fidgeting with pedals on WC all day, talking to people not there The Nursing Progress Notes for the resident included the following: a. On 3/1/25 at 10:38 AM the resident was sitting at the nurse's station, the Certified Nurse Aide (CNA) saw the resident attempt to get up from wheel chair, became unbalanced, swayed backward, unable to clear foot pedals on the wheel chair falling to the floor and obtained a 5-centimeter (cm) x 3 cm. laceration. b. On 4/2/25 at 1:03 PM, the resident was sitting in common area in wheelchair looking at a magazine, she tore a page out and was taking to someone, and slid to the edge of the wheelchair seat and then slow motion went to the floor, did not hit her head. The pedals were on the wheelchair. She was assessed and sat back it the wheelchair then taken to the front nurse's station. c. On 4/2/25 at 5:54 PM, the resident was sitting in chapel in her wheelchair attempting to get up and she tripped over the pedal on the wheelchair and fell and hit her head. Large amount of blood. Emergency service called and sent to the emergency room . d. On 4/2/25 at 8:50 PM, call to the hospital and told that she had a brain bleed and was being transferred to a larger hospital. e. On 4/5/25 at 1:36 PM, returned to facility from hospital. Scattered bruising on bilateral upper extremities abrasion on right forehead measuring 3 cm. x 1.5 cm. The Incident Reports included the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a. 4/2/25 at 10:37 AM the resident was in her wheelchair by the nurses station. She had been messing with the pedals on the wheelchair and talking to someone. She had a picture from a magazine in her hand and scooted to the edge of the wheelchair seat and slid to the floor. b. 4/2/25 at 4:30 PM the resident was getting up out of the wheelchair. The nurse tried to get to her but the resident tripped over the pedals before she could get to her. She fell and hit her head. On 4/16/25 at 1:36 PM, Staff K, CNA, said that she was working on 4/2/25 when Resident #20 fell in the chapel. She and another CNA were taking the residents to the chapel to wait for the dining room to open. There was a nurse in the area and it was about 4:00 PM. Resident #20 said that she was cold so they got her a blanket. Staff K said that she had been more agitated and the night before they found her walking down the hallway on her own. She said there had been a time when they used chair alarms but they were no longer able to use them. The resident would also climb out of bed and it helped to have a bed pad that would alarm but they don't have that any more either. Staff K said they usually have two staff in the dining room to monitor residents. On 4/16/25 at 1:44 PM, Staff H, CNA said that she was working on 4/2/25 when Resident #20 fell . That evening, there was a nurse and about 6-7 residents' in the chapel waiting to be taken into the dining room. She said that she was talking to another resident and next thing she knew, Resident #20 was on the floor. Foot pedals on the wheel chair were down and she was covered with a blanket. On 4/16/25 at 2:15 PM, Staff B Licensed Practical Nurse (LPN) said that she was the only one in the chapel that afternoon and she was passing pills. When she saw the resident getting up, she had some pills in her hands and couldn't get to her fast enough to prevent her from falling. She said the resident had been messing around the pedals earlier in the day. On 4/16/25 at 3:03 PM, the Director of Nursing (DON) said that having just one person in the chapel when the residents were waiting to go into the dining room was enough because the CNAs were in and out as they assisted the other residents. She said that after falls, they had a stand-up meeting with the team and come up with ideas on what they can do differently and add those interventions to the care plan. 41783 2. The MDS assessment dated [DATE] for Resident #6 documented she scored 12 on the BIMS indicating she has moderately impaired cognition. The MDS documented she was independent with transfers and walking 10 feet. The MDS documented she required supervision or touching assistance for walking 50 feet with two turns. The MDS documented she had diagnoses to include arthritis, dementia, multiple fractures of ribs and syncope and collapse. The Care Plan dated 1/2/24 documented the following fall focus for Resident #6: The resident has had an actual fall (prior to admit) with fracture to right arm R/T Poor balance, Dementia. 10/3/24 fall in room without injury. 10/5/24 fall in room when carrying items while pushing walker. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	10/15/24 fall in room with 3 left rib fractures. 12/28/24 fall from obstacle in room. 2/3/25 fall in room when lost balance. 4/11/25 fall in dining room when slipped on floor. Date Initiated: 1/2/2024 Revision on: 4/14/2025 The Care Plan lacked documentation of the fall that occurred on 1/2/25 and any new interventions. The Progress Notes for the resident documented the following: On 1/2/25 at 7:05 PM Late Entry: As leaving room across the hall from resident room (her door was open) heard her yell at her radio, which was on the floor and watched her walk up to it and kick it. She went to kick it again and fell to her buttocks. She did not hit her head. Asked her to wait a minute while got someone to help get her up, she kicked at me, said it was all my fault and I wasn't to touch her. When CNA arrived, we attempted to help her up and she fought us scratching, pulling our clothes and refused to stand. On 1/2/25 at 7:05 PM Late Entry: She refused vitals (VS). When we thought she might be calmer (720pm) we were able to help her to bed, she continued to yell at us both and told us to take her to the huskow (slang for jail?). As we were leaving she put her hands above her head in the air and purposely slid easily to her floor, yelling leave me alone for good, I don't need any help from you and your people. Eventually we were able to get her up in the Hoyer without difficulty and transferred her to bed. No VS were able to be obtained. The Progress Notes lacked any other documentation regarding the fall on 1/2/25. On 4/16/25 at 11:50 AM the DON stated the facility does not have an incident report for the fall on 1/2/25. She stated the nurse at the time missed it. She stated it was crazy at the time of the fall, the resident was uncooperative and that affected their ability to assess her. Review of the clinical record and the chart lacked a Falls Tool assessment for the fall on 1/2/25. During an interview on 4/16/25 at 12:09 PM the DON stated they don't do a drill down to find the root cause at the time of the fall. She stated they discuss them the next morning at daily huddle with all staff and if there are reasons for the fall with recommendations that come out of that meeting then the MDS Coordinator will update the care plan and put those interventions in place. Upon asking, the DON provided the Falls Scene Huddle Worksheet for all of Resident #6's falls except she did not provide one for the fall that occurred on 1/2/25. The facility policy with the revised date 4/8/25 titled Fall Prevention and Management documented the following: Purpose: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-To promote resident well-being by developing and implementing a fall prevention and management program. -To identify risk factors and implement interventions before a fall occurs. -To give prompt treatment after a fall occurs. -To provide guidance for documentation. Policy for fallen resident: 6. A nurse must observe the resident and perform a full body exam to determine if there may be suspected injury and direct whether to move the resident. f. Complete Fall Scene Huddle Worksheet. 8. If the resident is stable, call available employees to the scene of the fall and begin the investigation using the Fall Scene Huddle Worksheet. 9. After the initial documentation of the incident in the SAFE Event Reporting application (Incident Report), if there is a need for additional documentation, this will be done in the Progress Notes. 11. Complete the Falls Tool if not done in the post fall huddle. 16. Review and update the Care Plan with any changes/new interventions. 18. Continue to monitor condition and the effectiveness of the interventions.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on Electronic Health Records (EHR), staff interview, observation and policy review the facility failed to implement policies and procedures regarding the technical aspect of feeding tubes by pushing enteral medication with a piston syringe into enteral tube for 1 of 1 residents (Resident #3). The facility reported a census of 43 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #3 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS documented utilization of an enteral feeding tube for medication administration. The Care Plan with initiation date of 9/21/23 documented the resident requires tube feeding and has a PEG tube. On 4/16/25 at 9:18 AM an observation revealed Staff N, Registered Nurse (RN) completed hand hygiene and crushed medication. Staff N entered Resident #3's room and applied gown and gloves. Staff N flushed enteral tube with 30cc of water and pushed it very slowly. Staff N drew up medications in a piston syringe and slowly pushed medication into Resident #3's enteral tube. Staff N then flushed the enteral tube with 30cc water and pushed slowly. Staff N removed gloves and rinsed the graduate and syringe. Staff N removed the gown and completed hand hygiene. On 4/16/25 at 10:05 AM Staff N, stated Resident #3 was not administered medications via gravity because her tube had resistance and would not flow well via gravity. On 4/16/25 at 10:11 AM the Director of Nursing (DON) stated light pushing would be acceptable when administering medications with a piston syringe. The DON acknowledged the policy did not state pushing was acceptable practice. The DON explained Resident #3 preferred the nurses to give a light push with medication administration with her enteral tube and that should have been on the care plan. The DON acknowledged pushing medications was not on Resident #3's care plan. Review of policy revised 3/4/25 titled, Medication: Tube Administration documented medications were administered with syringe slowly and steadily. Extent of the elevation of the syringe would determine the flow rate.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 48004 Based on observation, staff interviews, and policy review the facility failed to provide a well balanced diet that meets nutritional and special dietary needs by use of incorrect serving size portions for meals. The facility reported a census of 43 residents. Findings include: Continuous observation on 4/16/25 at 11:19 AM to 11:40 AM revealed the following: Staff A placed 10 brownies into the blender and added milk to be pureed. Staff A then added thickener to the puree. Staff then poured the pureed brownies into serving bowls without measuring the puree. Staff A then prepared 4 servings of green beans in the blender to puree. Staff A added thickener to the green beans. Staff A then placed the green bean puree into a pan and placed this onto the steam table without measuring the amount made. Staff A then prepared 10 servings of ham and beans in the blender and again placed the puree mixture into a pan and placed into the steam table without measuring the amount of puree mixture. Staff A then obtained scoops for service and placed them on the steam table. Staff A revealed that he had made extra servings for service. Interview on 4/16/25 at 12:17 PM with the Food and Nutrition Supervisor revealed Staff A didn't measure the puree items prior to service. The Food and Nutrition Supervisor further revealed her expectation would be for puree to be measured after being pureed to obtain the correct scoop size. Interview on 4/16/25 at 12:24 PM with the Administrator revealed that proper portion sizes as well as the pureeing process should be followed. Review of a facility provided policy titled, Textured-Modified Diets with a revision date of 4/23/24 revealed: a. Measure the total volume of the food after it is pureed. b. Divide the total volume of the pureed food by the original number of portions.

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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. 48004 Based on observation, staff interview, and policy review the facility failed to prepare, serve and distribute food in accordance with safe food handling practices. The facility reported a census of 43 residents. Findings include: During continuous observation on 4/16/25 from 11:45 AM to 12:08 PM Staff A [NAME] was observed to have touched plate warmer lids, menus, handles on scoops, and the jeans Staff A was wearing. Staff A was observed to take the lids off of the food items bare handed in the warmers and then scoop out the food and place the food onto a plate. Staff A was then observed to place the lids back on the food in the steam stable and place the scoop on top of the lids on the steam table. Staff A was observed touching multiple items between serving the food from the steam table. Interview on 4/16/25 at 12:17 PM with the Food and Nutrition Supervisor revealed that Staff A should have not placed the scoop on top of the lids of the warmer pans after use. Interview on 4/16/25 at 12:24 PM with the Administrator revealed an expectation that proper hand sanitizing should be completed at the appropriate times in the kitchen while serving. Review of a facility provided policy titled, Hand Hygiene with a revision date of 3/29/22 revealed: a. All employees are responsible for maintaining adequate hand hygiene by adhering to specific infection control practices.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Base on observations, staff interviews and record review the facility failed to use infection control practices for 3 of 13 records reviewed. Resident #39 had an open pressure ulcer on his coccyx that was exposed to pathogens as it came into contact with the mechanical lift sling. Staff failed to use adequate hand hygiene while caring for Resident #3, and Resident #33 was found to have his catheter bag resting on the floor. The facility reported a census of 43 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE], for Resident #39, showed that he was admitted to the facility on [DATE] and he had a Brief Interview of Mental Status (BIMS) score of 13 (moderate cognitive deficit.) The resident was always incontinent of urine and frequently incontinent of bowel. His diagnoses include: malnutrition, Chronic Obstructive Pulmonary Disease (COPD) and a Stage 4 pressure ulcer of the sacral region. The Care Plan dated 3/3/25, showed that Resident #39 had self-care performance deficits related to malnutrition and weakness. He was bedfast most of the time and non-ambulatory. Resident #39 was dependent for all bed mobility, dependent for toilet use and hygiene. He was incontinent of bowel and bladder and he required 2 staff assistance for transfers with a mechanical lift. He had the potential for pressure ulcer development. Staff were to notify the nurse immediately of any new areas of skin breakdown: redness, blisters or discoloration. Assess and monitor wound healing and report improvements and/or decline. The resident required Enhanced Barrier Precautions (EBP) related to stage 4 pressure injury to sacrum. On 4/16/25 at 10:14 AM, Staff C Certified Nurse Aide (CNA) and Staff D, CNA, prepared to transfer Resident #39 to the shower chair for a shower. The resident was in bed on his back, his legs supported with a pillow at the knees and he was wearing heel protectors. The resident had a scabbed wound on the back of his left calf and the right calf had a dark spot in the area of where the legs had been resting on the pillow. Further up on the left thigh here were two separate open areas. When asked if those skin issues were documented, Staff D responded that those were old spots that had been there for a while. Staff C and Staff D turned the resident onto his left side. He had a dressing patch on his coccyx that was not dated and was soiled. With gloved hands, Staff C pealed the dressing off and pulled the packing out of the wound and threw it away. The wound had a large opening that immediately started to bleed and dripped down his side onto the bed. Staff D then got a netted shower sling for the mechanical lift and laid it on the bed. The CNA's assisted him to roll back to his right side, then Staff D tucked the rolled-up sling under his right side. The CNA's told the resident that there would be a bump that he needed to roll over, and they assisted him to roll over the rolled-up sling, back onto his left side, pulled the sling under him and got him into position to transfer him with the mechanical lift. The wound continued to bleed throughout the process and when they transferred him to the shower chair, the netted sling was soiled with blood from the wound and Staff D pushed him to the shower room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/16/25 at 10:52 AM, Staff D pushed that resident back to his room after his shower. The wound was left open through the shower and the lift sling was still soiled with blood on the back. The resident was transferred back to the bed for the wound treatment. Staff G, Treatment Nurse, provided the wound treatment including measurements and packing. Staff G removed her gloves before leaving the room but failed to wash her hands or use sanitizer before walking down the hallway. On 4/17/25 at 7:04 AM, the Director of Nursing (DON) expressed concern that the CNA removed the resident's dressing and packing. She agreed that having the open ulcer in contact with the sling and open throughout the shower was an infection control issue. On 4/17/25 at 10:11 AM the Physician said he would be more concerned with the wound having been exposed to the Hoyer sling then being open in the shower. He stated it is probably not best practice to have put him on the sling. 47673 2. The MDS for Resident #3, dated 3/11/2025 documented a BIMS of 15 indicating no cognitive impairment. The MDS documented utilization of an enteral feeding tube for medication administration. On 4/16/25 at 9:18 AM Staff N, Registered Nurse (RN) completed hand hygiene, applied a gown and applied gloves. Staff N administered medication and water via an enteral tube. Staff N removed the old split sponge, applied a new split sponge, removed gloves and applied tape to the split sponge without gloves on. Staff N removed the gown, and completed hand hygiene. Staff N left the room and shut the door. On 4/16/25 at 10:11 AM the Director of Nursing (DON) acknowledged gloves should be utilized during any cares performed with any interaction with Resident #3's enteral tube. 3. The MDS for Resident #33, dated 1/28/2025 documented a BIMS of 14 indicating no cognitive impairment. The MDS documented placement of a suprapubic catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/16/25 at 6:52 AM Staff O, Certified Nursing Assistant (CNA) and Staff P, CNA applied gowns and gloves. Staff O separated catheter tubing, catheter cleansed with an alcohol wipe. Staff P opened the tip of the catheter tubing, emptied the bed catheter bag into the toilet and replaced the tip of the catheter tubing. The catheter tip was not cleansed prior to replacement. The catheter bag was placed in a plastic bag. Staff O applied Resident #33's catheter leg bag. Staff P changed gloves, completed hand hygiene and applied new gloves. Resident #33 shoes were applied by Staff P. Staff O obtained peri wipes and laid the peri wipes on the bed. Staff O cleansed supra pubic stoma site with wet wipe and tubing down about 6 inches. Staff O then took Resident #33's shoes, took pant leg off, applied brief, put pant leg back on and shoe back on, pulled up pants, tore the sides of brief, obtained wipes, cleansed groin on left and right side, and cleansed the outside of Resident #33's penis. Staff O did not retract Resident #33's foreskin. Staff O asked Resident #33 to turn over. Staff O cleansed buttocks, removed gloves and reapplied gloves without hand hygiene. Staff O pulled Resident #33's brief and pants the rest of the way up. Staff O then removed gloves, completed hand hygiene and applied new gloves. Staff P assisted Resident #33 to apply a shirt, applied a gait belt, utilized the gait belt for transfer. Staff O turned water on and moistened a wash cloth. Staff P removed his gloves, gathered bedding and put them in a plastic bag. Staff O gave the warm cloth to Resident #33 to clean his face. Staff P removed his gown. Staff O removed her gloves and gown. Staff P left the room and did not complete hand hygiene. Staff O removed the gown and completed hand hygiene. Staff P went to the next resident's room and started care. On 4/16/25 at 2:26 PM the DON stated the facility's expectation was that hand hygiene would be completed between all glove changes and when moving from one area of the body to another. Review of the policy revised 3/29/22 titled, Infection Prevention Hand Hygiene documented all employees in patient care areas will adhere to the 4 moments of hand hygiene and 2 zones of hand hygiene: entering room, before clean task, after bodily fluid/glove removal, exiting room, and 2 zones patient zone and health-care zone. Hand sanitizer or soap will be utilized after removing gloves regardless of the task, application of dressings, when exiting the patient room, and when moving from contaminated body site to a clean body site during patient care.