STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165204	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keosauqua Health Care Center	819 Country Lane Road Keosauqua, IA 52565

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observations, staff interview, and clinical record review, the facility failed to ensure a dignified dining experience when a resident was not provided assistance timely during two meal observations and was not assisted timely after the resident spilled water on themselves for one of two residents reviewed for dignity (Resident #12). The facility reported a census of 58 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #12 dated 3/28/24 revealed the resident scored 2 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. The MDS documented the resident independent for eating. The Dietary assessment dated [DATE], noted to be the same day as the resident's MDS, revealed the resident required set up assist and encouragement/cues. The Comments section documented, she is able to feed herself after set-up and utilizes weighted silverware; staff may provide occasional PRN (as needed) assist. Observation of Resident #12 during the lunch meal on 4/30/24 revealed the following: a. 12:22 PM: Resident #12 served the lunch meal. The resident had a built up utensil and observed not eating. The resident had pureed food in a pink divided plate, and also had a small dish with jello. b. 12:25 PM: Resident #12 observed with their eyes closed and arms crossed across their chest. c. 12:30 PM: Resident #12's lunch remained in front of the resident and the resident remained without assistance. d. 12:33 PM: The resident had their arms to chest, and the utensil remained resting in the resident's plate. e. 12:39 PM: Resident #12 observed to be awake. Resident #12's food present in front of her, and the resident did not eat the food served. Staff not observed to offer assistance. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165204	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. 12:44 PM: Resident #12 picked up a utensil, had food on the utensil, and the utensil sat on the lip of the divided plate. g. 12:46 PM: Resident #12 picked up their spoon and had it upside down (curved side facing downwards). The resident ate, and licked the back of the spoon. h. 12:48 PM: The resident ate food in front of them. At the times of observations documented above, other than at the time of delivery of the meal, observations lacked facility staff providing encouragement, cueing, or assistance for Resident #12. On 5/2/24 at 12:58 PM, the Assistant Director of Nursing (ADON) acknowledged during a previous survey a concern had been identified with assisting one resident, then assisting another. The ADON explained she did not know if this was the reason, or if staff just did not do so. 35434 On 5/1/24 at 7:57 a.m., observed Resident #12 sitting at at a dining table alone and had a plate of pureed food in front of her. The resident had a clear liquid spilled on her lap and dripping down to the floor. No staff member assisted the resident and she put a spoon in her food and then into her mouth but no food was on her spoon. Other staff members arrived in the dining room but began to assist other residents. At 8:08 a.m., the resident had liquid dripping out of her mouth and liquid was still visible on her lap. At 8:11 a.m., the resident dipped the handle of her adaptive fork into her pureed food and placed it into her mouth to lick it off. Very little food entered the resident's mouth. The resident remained unassisted until 8:15 a.m.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 35434 Based on observation, clinical record review, policy review, resident interview and staff interview, the facility failed to individualize the physical space of a resident's bathroom in order to ensure the resident maintained independent functioning, dignity, and well-being for 1 of 1 residents reviewed for accommodation of needs (Resident #16). The facility reported a census of 58 residents. Findings: The Minimum Data Set (MDS) assessment tool, dated 2/13/24, listed diagnoses for Resident #16 which included acquired absence of the left leg above the knee, pain in the right shoulder, and chronic obstructive pulmonary disease. The MDS stated the resident required supervision or touching assistance for oral hygiene and listed the resident's Brief Interview for Mental Status (BIMS) score as 14 out of 15 indicating intact cognition. A 4/19/21 Care Plan entry stated the resident able to complete oral hygiene independently and took care of his dentures himself. The resident's Census List stated he moved to his current room on 12/5/23. A 12/7/23 Interdisciplinary Team (IDT) Resident Care Conference note stated the resident had a problem with his new room and the bathroom was too small for him to reach the sink to wash his hands. The note stated the matter would be discussed with the IDT team to find a solution. The facility lacked further documentation of any solutions discussed regarding the resident's bathroom concern. On 4/29/24 at approximately 2:30 p.m., the resident stated he hated his bathroom because he could not get to the sink. The resident wheeled himself into the bathroom and demonstrated his concern. After the resident wheeled into the bathroom, he could not get within 1 foot of the sink and the faucets and sink basin were not within his reach. On 5/1/24 at 3:30 p.m., the Assistant Director of Nursing (ADON) stated the bathrooms were not very large and sometimes the wheelchairs did not fit in the bathrooms. She stated she had not heard of a resident not being able to have access to the sink. She stated she had not heard that Resident #16 was unable to reach his sink. The facility policy Accommodation of Needs dated 12/1/23, stated the facility wound make reasonable accommodations for the individual needs and preferences of a resident.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on resident interview, staff interviews, clinical record review, and the facility policy, the facility failed to supply the resident with a menu that provided him options for the meals for 1 of 3 residents reviewed for choices (Resident #10). The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed resident needed set up and clean up assistance only for eating. The Care Plan revealed a focus area revised on 3/29/24 for a nutritional problem related to his multiple sclerosis, paraplegia, osteoarthritis, diabetes mellitus, vitamin D deficiency, depression, urinary incontinence, hypertension, and obesity. The interventions revised on 11/10/23 revealed a general with ground meat and thin liquid diet and honored food preferences/special requests as able. The Physician Orders revealed a regular/general diet, with regular/ground meat texture, and regular consistency diet. During an interview on 4/29/24 at 1:42 PM, Resident #10 stated they didn't give him choices because he was diabetic. During an interview on 5/1/24 at 1:15 PM, Resident #10 stated why get a menu if you don't get a choice. He stated they never gave him an alternative and no one came in and asked him what he wanted to eat. During an interview on 5/1/24 at 1:43 PM, the Dietary Manager stated Resident #10 didn't get a menu and didn't get options. She stated she never received a menu from Resident #10 and didn't think he wanted a menu. During an interview on 5/2/24 at 3:01 PM, the ADON (Assistant Director of Nursing) queried on Resident #10 received a menu and she stated as long as she worked here he didn't get a menu. She stated at one time he was very sick and didn't pick options and now that he felt better, it never got restarted. She stated the Dietary Manager new to the position and didn't realize he didn't get a menu. She stated not everyone gets a menu, only the residents who can make their own decisions. She stated Resident #10 should get the choice and receive a menu. The Facility Resident Self Determination and Participation dated 12/1/23 revealed the following information: a. According to federal regulations, the resident had the right to make choices about aspects of his or her life in the facility that are significant to the resident.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 45338 Based on facility document review, staff interview and facility policy review, the facility failed to ensure a process in place to allow consistent access to resident funds outside of business hours for five of five residents who participated in the trust fund (Resident #11, #12, #27, #28, and #40). The facility reported a census of 58 residents. Findings include: Review of a document provided by the facility titled Residents who use the trust, undated, revealed the following residents utilized the trust fund: Resident #11, Resident #12, Resident #27, Resident #28, and Resident #40. On 5/1/24 at 3:12 PM, the facility's Business Office Manager (BOM) and Administrator queried as to how residents accessed their personal funds. The BOM responded if residents asked, she would give it to them. The Administrator acknowledged money had not been available 24 hours and would be moving forward. The Administrator further explained the facility had done some weekends, not really consistently, and there had been some access but not consistently. The Facility Policy titled Protection of Resident Funds, undated, revealed, 2. If the facility accepts financial responsibility for the resident's financial affairs the resident or resident's responsible person shall designate, in writing, the transfer of the responsibility. Further, the facility shall establish and maintain policies and procedures that .f. Provide the residents with access to their money in a reasonable time and in the form of cash or check as requested by the resident.

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F 0570 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 45338 Based on facility document review, staff interview and facility policy review, the facility failed to ensure a surety bond in place to cover the total amount of personal funds in the resident trust account for five of five residents who utilized the trust fund (Resident #11, #12, #27, #28, and #40). The facility reported a census of 58 residents. Findings include: Review of a document provided by the facility titled Residents who use the trust, undated, revealed the following residents utilized the trust fund: Resident #11, Resident #12, Resident #27, Resident #28, and Resident #40. Review of a Surety Bond provided by the facility dated 6/23/23 revealed Surety Bond amount of $40,000.00. On 5/02/24 at 2:16 PM the facility's Administrator queried about total amount of resident funds, and responded with an amount which exceeded the facility's Surety Bond. The Facility Policy titled Protection of Resident Funds, undated, revealed, 2. If the facility accepts financial responsibility for the resident's financial affairs the resident or resident's responsible person shall designate, in writing, the transfer of the responsibility. Further, the facility shall establish and maintain policies and procedures that .i. Facility is required to carry a Surety Bond on the cumulative total of all resident trust fund balances.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 35434 Based on clinical record review, staff interview, and policy review, the facility failed to notify 1 of 3 Medicare Part A beneficiaries of coverage ending (Resident#8). The facility reported a census of 58 residents. Findings: The Beneficiary Notice-Residents discharged With the Last Six Months form, collected upon survey entrance, stated Resident #8 discharged from Medicare Part A on 1/19/24. Via email correspondence on 5/2/24 at 8:44 a.m., the Assistant Director of Nursing (ADON) stated the facility could not locate a discharge notice provided to Resident #8. She stated at the time of her discharge, the facility had a different Social Services Director. The facility policy Beneficiary Notices: Skilled Nursing Facility (SNF) Advanced Beneficiaries Notice (ABN) and Notice of Medicare Non-coverage (NOMNOC), effective 4/15/18, stated the facility would notify beneficiaries when their skilled nursing services and/or therapy services would end and their right to request an appeal.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 47336 Based on personnel record review, staff interview, and facility policy review the facility failed to ensure staff's background checks completed prior to hire date for 1 of 5 staff; and failed to ensure the dependent adult abuse mandatory reporter training current for 1 of 5 staff reviewed (Staff C, and Staff D). The facility reported a census of 58 residents. Findings include: According to Staff C, RN (Registered Nurse) personnel file her date of hire was 10/26/23 and the Single Contract Repository (SING) completed on 4/29/24 at 2:57 PM. Staff D, CNA (Certified Nurse Aide), personnel file lacked documentation of the dependent adult abuse mandatory reporter training. Staff D date of hire was 11/8/22. During an interview on 5/2/24 at 2:22 PM, the Administrator queried on the expectations of the dependent adult abuse mandatory reporter being completed and he stated it needed to be current. The Administrator asked the expectations on background checks and he stated they needed done prior to the staff member being hired. The Facility Abuse Policy (no date indicated) revealed the following information: a. The facility conducted employee background checks and will not knowingly employ any individual who had been convicted of abuse, neglect, or mistreatment of individuals. b. Training- Mandated for staff, and others were trained/orientated programs that include such topics as abuse prevention, identification and reporting requirements and to support an environment in which covered individuals report a reasonable suspicion of crime, freedom from retaliation or reprisal, stress management, dealing with violent behavior or catastrophic reactions, etc. Training provided at time of hire, annually, and as needed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434 Based on clinical record review, policy review, and staff interview, the facility failed to ensure accurate Minimum Data Set (MDS) coding for 3 of 7 residents reviewed for medications (Residents #3, #18, #46) and for 1 of 1 residents reviewed with a catheter (Resident#11). The facility reported a census of 58 residents. Findings include: 1. The MDS assessment tool, dated 2/29/24, stated Resident #3 received an anticoagulant (a medication used to prevent blood clots). The February 2024 Medication Administration Record lacked documentation the resident received an anticoagulant. 2. The MDS assessment tool, dated 3/20/24, stated Resident #46 received an anticoagulant. The March 2024 Medication Administration Record lacked documentation the resident received an anticoagulant. On 5/2/24 at 12:37 p.m., the Assistant Director of Nursing (ADON) stated MDS coding should be accurate. She stated her trainer directed her to code medications such as aspirin as an anticoagulant. On 5/2/24 at 4:03 p.m., the ADON stated the facility did not have a policy specific to MDS coding. The facility policy Conducting an Accurate Resident Assessment, implemented 12/1/23, stated residents would receive accurate assessments, reflective of the resident's status at the time of the assessment. 45338 3. Review of the MDS assessment for Resident #11 dated 3/21/24 revealed the resident scored 6 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident always incontinent for urinary continence and did not have an indwelling catheter. Review of hospice documentation for the resident electronically signed on 3/4/24, 3/9/24, and and 4/4/24 revealed the resident had a Foley catheter. On 5/2/24 at approximately 12:50 PM, the Assistant Director of Nursing (ADON) acknowledged the nurses' documentation did not show a Foley, and when the MDS was coded it did not show a Foley. When queried if it should have been coded as a Foley, the ADON acknowledged yes. 4. Review of the MDS assessment dated [DATE] for Resident #18 revealed the resident was rarely to never understood. Per this assessment, the resident did not take an antidepressant. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Order dated 8/26/23 to 4/16/24 revealed Resident #18 ordered Mirtazapine Oral Tablet 45 MG (milligram) with directions to give 1 tablet by mouth one time a day for DX: (diagnosis) Depression. Per the resident's MAR dated February 2024, the resident received the medication every day for the month. On 5/2/24 at 12:52 PM when queried if Mirtazapine should be coded on the MDS as an antidepressant, the ADON responded if classified as one, yes.

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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** 45338 Based on observations, staff interviews, clinical record review, and facility policy review the facility failed to ensure medications were administered per physician order, failed to ensure parameters present for insulin administration for when to hold scheduled insulin dosage, failed to ensure medication dosages consistently included as part of medication orders, and failed to ensure rinse and spit following administration of a steroid inhaler for three of five residents reviewed for professional standards (Resident #11, Resident #18, Resident #50). The facility reported a census of 58 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment for Resident #11 dated 3/21/24 revealed the resident scored 06 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment the resident received insulin injections for 7 of the past 7 days. Review of the Care Plan dated 1/24/21, revised 4/23/24, revealed the following: Resident #11 is at risk for alteration in blood glucose levels r/t (related to) dx (diagnosis) of diabetes mellitus with circulatory complications and CKD (chronic kidney disease) stage 3. Resident #11 routinely receives insulin and oral hypoglycemic medications. The Physician Order dated 3/4/24 revealed, Insulin Aspa Inj 100/ML (milliliter) with directions to inject 5 unit subcutaneous before meals for type 2 diabetes. The order lacked parameters for when to hold the medication. Review of the resident's Medication Administration Record (MAR) dated April 2024 and Progress Notes revealed the resident's insulin given on the following dates with the following corresponding blood sugars: a. 4/3/24 at 8:00 AM: blood sugar 96 b. 4/6/24 at 4:00 PM: blood sugar 86 c. 4/23/24 at 4:00 PM: blood sugar 96 d. 4/24/24 at 8:00 AM: blood sugar 89 Review of the resident's MAR dated April 2024 and Progress Notes revealed the resident's insulin held on the following dates with the the following corresponding blood sugars: a.4/7/24 at 5:51 PM Orders Administration Note: Insulin held, blood glucose check 154, and resident did not eat an adequate amount of supper. b. 4/12/24 at 8:34 AM Orders-Administration Note: Insulin held r/t blood sugar 85. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. 4/14/2024 at 9:10 AM Orders Administration Note: Insulin held r/t blood sugar 89. On 5/2/24 at approximately 11:05 AM, Staff G, Licensed Practical Nurse (LPN) queried about Resident #11's insulin. Staff G explained the resident was so fragile and dropped so easy. When queried at what blood sugar she would hold the insulin, Staff G responded she would hold if under 100 at least. On 5/2/24 at 12:53 PM when queried about when to hold the resident's insulin, the Assistant Director of Nursing (ADON) responded sometimes the resident's blood sugar was high and sometimes really low. The ADON explained she would probably ask around blood sugar of 100 or 120 because the resident could drop really quick, and if it was lower than that she would let the resident eat something before, give the resident a drink, or give something with it if giving it. Per the ADON, the provider did trust their nursing judgement for the most part, still should be notified, and they would probably agree if held the insulin. 2. Review of the MDS assessment dated [DATE] for Resident #18 revealed the resident rarely to never understood. Review of Resident #18's Care Plan did not address use of Levetiracetam, an anticonvulsant medication. The Physician Order dated 8/24/23 documented, Keppra Oral Solution 100 MG/ML (milligram/milliliter) with directions to give 5 ml by mouth two times a day. Review of Resident #18's Medication Administration Record (MAR) dated April 2024 revealed a code of 11, which indicated med not available, marked on the following dates and times: a.4/19/24: HS (hour of sleep) dose b. 4/20/24: AM and HS dose c. 4/21/24: HS dose d. 4/22/24: AM dose The HS dose of medication due on 4/22/24 marked with a code of 9, which indicated other/see progress notes. Review of notes for the corresponding day lacked additional information as to why the dose marked with a code of 9. On 5/2/24 at 12:56 PM, the ADON explained the facility did not have liquid Keppra in back-up and further explained they could get a stat delivery from the pharmacy. Per the ADON, it would take an hour or two to come in, and if staff did not have Keppra they should call the ADON as the ADON could authorize a stat delivery. The facility policy titled Administering Medications dated 2001, revised 12/12, revealed, Medications shall be administered in a safe and timely manner, and as prescribed. 47336 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The MDS assessment dated [DATE] revealed Resident #50 scored a 14 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed a diagnosis of asthma, chronic obstructive lung disease (COPD), or chronic lung disease. The Care Plan revealed a focus area dated 3/7/24 for COPD and at risk for shortness of breath, impaired breathing and respiratory infections. The interventions dated 3/7/24 revealed administration of medications/puffers as ordered. During an observation on 4/30/24 at 8:31 AM, Staff D, CMA (Certified Medication Aide) administered isosorbide mononitrate 30 mg (milligram) tablet and potassium chloride extended release 10 mEq (milliequivalent) to the resident and the resident took a drink of her coffee. No water cup observed in her room. Staff D then administered Dulera inhaler to Resident #50. Resident #50 took 2 puffs and didn't rinse her mouth out with water and spit. The EMR (Electronic Medical Record) revealed a diagnosis for chronic obstructive pulmonary disease with exacerbation. The Physician Orders revealed the following medication orders: a. Dulera aerosol 200-5 mcg (micrograms)- inhale 2 puffs orally two times a day b. Potassium oral tablet (lacked dosage)- give 1 tablet by mouth two times a day c. isosorbide mononitrate oral tablet- give 1 tablet by mouth one time a day During an interview on 4/30/24 at 3:02 PM, Staff H, CMA stated she didn't see a dosage for isosorbide mononitrate on the MAR (medication administration record). During an interview on 5/1/24 at 9:31 AM, Staff D stated she didn't see the dosages on the MAR for the potassium or the isosorbide mononitrate and stated the dosages were on the medication cards. Staff D stated you wouldn't know if the dose correct since the order didn't reveal them. Staff D queried if a resident administered a steroid inhaler if they had any special instructions after inhalation and she stated wait 5 minutes between puffs and swish and swallow. During an interview on 5/1/24 at 9:34 AM, Interim DON (Director of Nursing) stated she didn't see a dose on the isosorbide mononitrate or potassium physician order. She stated the pharmacy puts the orders in and the dosage should be on the order. During an interview on 5/2/24 at 1:29 PM, Staff C, RN (Registered Nurse) queried if Dulera inhaler had special instructions after inhalation and she stated she didn't know if they did anything. Staff C asked if you spit or rinsed and she stated if Resident #50 will, the resident usually just wanted to go out and smoke. Staff C asked if medication orders needed dosages and she stated yes and whoever confirmed the orders needed to call pharmacy and if no dose sent to call the provider for a dose. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/2/24 at 3:23 PM, the ADON (Assistant Director of Nursing) queried about the two medications without dosages for Resident #50 and she stated the staff should have caught the orders and not activated them. The ADON asked about special instructions with steroid inhalers and she stated the resident supposed to drink water, swish, and spit.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observations, staff interviews, resident interviews, clinical record review, and facility policy review the facility failed to ensure activities of daily living (ADL) including eating assistance, nail care, shaving, and showers consistently completed for three of four residents reviewed for ADLs (Resident #12, #28, and #29). The facility reported a census of 58 residents. Findings include: 1. Review of the Quarterly Minimum Data Set (MDS) assessment for Resident #29 dated 2/2/24 revealed the resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Per this assessment, self care for shower/bathing marked not applicable. The Care Plan dated 1/6/22 revised 4/29/24 revealed, Resident #29 has a self-care deficit due to impaired mobility with dx (diagnosis) of quadriplegia, protein calorie malnutrition/severe, anemia, hypotension, polyneuropathy, neurogenic bladder & bowel, vertigo, R) BKA (below knee amputation), insomnia, muscle spasms to back, depression. The Care Plan Intervention dated 1/6/22, revised 4/30/24, documented, Bathing/showering: 1 peson assist/dependent, 2 person assist to get on/of shower chair. Encourage bathing 2x weekly. Inspect skin during showers and alert charge nurse to any skin issues. Check nail length and trim/clean on bath days and as necessary. Report any changes to charge nurse. On 4/29/24 at 11:04 AM, Resident #29 observed in their room. The resident had blue hand splints present to both hands. Observation of the resident's nails on Resident #29's left hand revealed long fingernails, with a long middle fingernail with a jagged edge. Per the resident, the facility forgot to shave the resident. The resident observed with facial hair present. Observations conducted 4/30/24 at 8:22 AM and 1:02 PM revealed Resident #29 present in their room. The resident had not been shaved as facial hair remained present. Observation conducted 5/1/24 at approximately 10:25 AM revealed Resident #29 in their room. The resident observed to have long nails to the left hand with jagged middle finger nail. The resident had not been shaved as facial hair remained present. Review of Task: Bathing/Showering ADL documentation revealed the following: a. 4/20/24: Task marked as completed. b. 4/24/24: Task marked No for task completed (noted to be marked no with refused option not selected). c.4/27/24: Task marked as completed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/24 at 11:14 AM, when queried if they were aware of refusal of showers for Resident #29, Staff G, Licensed Practical Nurse (LPN) responded not that they were aware of. When queried who cut nails at the facility, Staff G responded the shower aide was supposed to try to assist with non-diabetic residents if the resident allowed them to cut them. Staff G explained nurses would cut nails for diabetic residents. Staff G acknowledged shower aide would be responsible for shaving. On 5/2/25 at 1:01 PM when queried who would address fingernails, the Assistant Director of Nursing (ADON) explained probably the CNAs (Certified Nursing Assistants) during showers if the resident allowed it. The ADON explained the resident was very particular about cares and who completed them. Per the ADON, shaving usually occurred on the resident's shower days. Review of the Facility Policy titled Activities of Daily Living (ADLs), Supporting dated 2001, revised 3/18, revealed, 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); b. Mobility (transfer and ambulation, including walking); c. Elimination (toileting); d. Dining (meals and snacks); and e. Communications (speech, language, and any functional communication systems). 2. Review of the MDS assessment for Resident #12 dated 3/28/24 revealed the resident scored 2 out of 15 on a BIMS exam, which indicated severely impaired cogition. Per this assessment, the resident independent for eating. The Dietary assessment dated [DATE], noted to be the same day as the resident's MDS, revealed the resident required set up assist and encouragement/cues. The Comments section documented, she is able to feed herself after set-up and utilizes weighted silverware; staff may provide occasional PRN (as needed) assist. Observation of Resident #12 during the lunch meal on 4/30/24 revealed the following: a.12:22 PM: Resident #12 served the meal. The resident had a built up utensil and observed not to eat. The resident had pureed food in a pink divided plate, and also had a small dish with jello. b.12:25 PM: Resident #12 observed with their eyes closed and arms crossed across their chest. c.12:30 PM: Resident #12's lunch remained in front of the resident and the resident remained without assistance. d. 12:33 PM: The resident had their arms to chest, and the utensil remained resting in the resident's plate. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. 12:39 PM: Resident #12 observed to be awake. Resident #12's food present in front of her, and the resident did not eat the food served. Staff not observed to offer assistance. f. 12:44 PM: Resident #12 picked up a utensil, had food on the utensil, and the utensil sat on the lip of the divided plate. g. 12:46 PM: Resident #12 picked up their spoon and had it upside down (curved side facing downwards). The resident ate, and licked the back of the spoon. h. 12:48 PM: The resident ate the food in front of them. Assistance including cueing not observed to be offered at the times of the above observations. 35434 2. On 5/1/24 at 7:57 a.m., Resident #12 sat at a dining table alone and had a plate of pureed food in front of her. The resident had a clear liquid spilled on her lap and dripping down to the floor. No staff member assisted the resident and she put a spoon in her food and then into her mouth but no food observed on her spoon. Other staff members arrived in the dining room but began to assist other residents. At 8:08 a.m., the resident had liquid dripping out of her mouth and liquid still visible on her lap. At 8:11 a.m., the resident dipped the handle of her adaptive fork into her pureed food and placed it into her mouth to lick it off. Very little food entered the resident's mouth. The resident remained unassisted until 8:15 a.m. 3. The 2/21/24 MDS assessment tool, dated 2/21/24, listed diagnoses for Resident #28 which included depression, diabetes, and non-Alzheimer's dementia. The MDS listed the resident's cognition as 15 out of 15, indicating intact cognition. A 10/4/21 Care Plan entry stated the resident preferred to complete bathing with the assistance of 1 staff. On 4/29/24 at approximately 1:00 p.m., Resident #28 stated he missed 5-6 showers this year and had gone 2 weeks without a shower. The March 2024 Documentation Survey Report V2 documented the resident received a bath on 3/14/24 and refused a bath on 3/21/24. The report lacked documentation the resident received or was offered an additional bath within that time frame. The April 2024 Documentation Survey Report V2 documented the resident received a bath on 4/1/24 and 4/8/24. The report lacked documentation the resident received an additional bath within the time frame. The report documented the resident received a bath on 4/25/24 but did not receive an additional bath in April after this date. On 5/6/24, the facility provided paper Bathing/Skin Observation Sheets for Resident #28 via email. The sheets did not contain documentation of additional bathing assistance provided during the above time frames. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/24 at 12:37 p.m., the Assistant Director of Nursing (ADON) stated residents were scheduled for 2 baths per week. She stated she knew showers did not get done but did not attribute it to a staffing issue. She stated some staff could complete the showers but others could not.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on clinical record review, policy review, resident interview and staff interviews, the facility failed to carry out assessments and interventions for 2 of 5 residents reviewed for a change in condition (Resident #10, and #209). The facility failed to carry out assessments/interventions for a resident with a low blood sugar (#10), and failed to carry out interventions after a resident did not have a bowel movement for multiple days (#209). The facility reported a census of 58 residents. Findings include: 1. The MDS assessment dated [DATE] revealed Resident #10 scored a 14 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed diagnoses for acute and chronic respiratory failure with hypoxia, heart failure, renal insufficiency, neurogenic bladder, and diabetes mellitus. The Care Plan revealed a focus area revised on 4/23/24 for risk for alterations in blood glucose levels related to diabetes diagnosis. The interventions dated 4/19/24 revealed glucagon kit as ordered; observation for signs/symptoms of hypoglycemia and report to nurse/provider as needed such as shakiness, sweating, headache, nausea, fatigue, irritability, dizziness, tingling/numbness of lips, tongue, and cheeks. The Progress Note dated 10/24/23 at 4:40 PM, revealed the nurse called into the resident's room due to Certified Nurse Aide (CNA) stated that he acted funny. When the nurse arrived in the room the resident found lethargic and barely kept his eyes open. Blood glucose checked and read 60 mg/dl (milligrams per deciliter). Two glucagon packets and 3 cups of orange juice with sugar administered due to resident still able to swallow and continued to check blood glucose and only able to get resident up to 75 mg/dl. The provider notified and ordered glucagon 1 mg intramuscular injection. The nurse administered glucagon and continued to monitor the resident. Twenty minutes later residents blood glucose was in the 200s. The provider called and ordered for continued monitoring the resident though out the night. The e-Interact Transfer Form V5 dated 10/25/23 at 3:48 PM revealed resident sent to the local hospital on 10/25/23 at 3:55 PM for hypoglycemia. The blood glucose registered 62 on 10/25/23 at 3:19 PM. The vitals signs revealed 130/60 blood pressure; 70 heart rate per minute; 14 breaths per minute; temperature 96.9 F; and pulse oximetry 90% on oxygen via nasal at 3.5 liters. The resident started antibiotics on 10/20/23 for cellulitis. The Progress Note dated 10/25/23 at 3:45 PM, notified of POA (Power of Attorney) on the condition of resident and notified her of order to transfer resident to local hospital for evaluation and treatment. The Progress Notes lacked documentation of assessments between 10/24/23 at 4:40 PM and 10/25/23 at 3:48 PM. (continued on next page)

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F 0684

Level of Harm - Actual harm

Residents Affected - Few

The Transfer to Hospital Summary dated 10/25/23 at 3:55 PM revealed provider notified of resident's condition and received verbal order to transfer to local hospital for evaluation and treatment. At 5:43 PM, 911 notified; at 3:45 PM the POA notified of resident's condition and transferred to local hospital; and EMS (Emergency Medical Services) arrived at the facility and got the resident stable. At 3:55 PM, EMS transported resident to local hospital ER (emergency room) for evaluation and treatment. This form revealed incorrect documentation and struck out on 2/7/24 at 8:03 PM.

The Blood Sugar Summary revealed the following blood glucose readings:

a. 10/25/23 at 12:32 PM 110.0 mg/dL

b. 10/25/23 at 3:19 PM 62.0 mg/dL

During an interview on 5/2/24 at 10:54 AM, Staff G, LPN (Licensed Practical Nurse) queried about the incident on 10/25/23 and she stated they fill out a transfer form and document in nursing notes. She stated he had a low blood glucose and they got it back up and then ended up shipping him out to the hospital for awhile.

During an interview on 5/2/24 at 3:07 PM, the ADON (Assistant Director of Nursing) queried on the incident with Resident #10 on 10/25/24 and the documentation and she stated she expected a lot more documentation such as what happened, if he was hypoglycemic from the night before. She stated the assessment needed documented.

2. Due to Resident #209 recent admission to the facility, completed MDS assessment not available for review.

The Care Plan dated 4/15/24 revealed a focus area for self-care deficit as evidenced by requiring assistance with ADLs, impaired balance during transitions required assistance and/or walking, and incontinence. The interventions revised on 4/23/24 revealed resident needed a person assist with toileting.

The EMR revealed the following Medical Diagnoses:

a. slow transit constipation

b. fracture of superior rim of left pubis, subsequent encounter for fracture with routine healing.

On 4/29/24 at 11:48 AM the resident stated he hadn't pooped in 5 days. they gave him MOM and that didn't help. He stated if they give him a can of rotel tomatoes, that would open him up.

The Physician Orders revealed the following medications:

a. ordered 4/30/24- Milk of Magnesia Suspension (MOM) 7.75 %- give 30 ml (milliliter) by mouth every 24 hours as needed for constipation

b. ordered 4/30/24- Enema Disposable Rectal Enema- insert 1 application rectally every 24 hours as needed for constipation

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F 0684 Level of Harm - Actual harm Residents Affected - Few	c. ordered 4/30/24- Bisacodyl Suppository 10 mg (milligrams)- insert 1 suppository rectally every 24 hours as needed for constipation Give 10 mg suppository per rectum daily PRN constipation d. ordered 4/14/24- Oxycodone/acetaminophen 5/325 mg- give 1 tablet orally every 6 hours as needed for pain e. ordered 4/14/24- Senna-time tablet 8.6 mg- give 1 tablet orally every 12 hours as needed for slow constipation The April MAR (Medication Administration Record) revealed the resident received MOM on 4/27/24 at 9:21 AM. The April MAR revealed the resident didn't receive Senna-time tab one time during the month. The May MAR revealed the resident received enema disposable rectal enema on 5/1/24 at 7:17 AM The POC Response History for Bowel Elimination revealed Resident #209 did not have a bowel movement from 4/25/24 at 1:59 AM through 5/2/24 at 2:42 AM. During an interview on 5/2/24 at 1:32 PM, Staff C, RN (Registered Nurse) stated the facility had a bowel list and the night shift nurse left a bowel list for the nurses every morning. Staff C stated no one said anything to her about the resident's constipation. She stated the resident had this issue before and his home caregiver came in and brought things that worked for him and they received good results. During an interview on 5/2/24 at 3:25 PM, the ADON queried on Resident #209 constipation and she stated they gave him an enema the day before and MOM the day before that. She stated they used a 3-day bowel protocol and if in 3 days no bowel movement, the resident received MOM and if no results, they received a suppository, and then after that an enema. She stated everyone usually gets an order set when admitted and Resident #209 didn't and they came to her about his constipation and they got the order set ordered. She stated they should have noticed on Day 3 and the staff needed to look at the bowel list every day. The facility policy Conducting an Accurate Resident Assessment, implemented 12/1/23, stated residents would receive accurate assessments, reflective of the resident's status at the time of the assessment. The policy directed staff to document resident medical, functional, and psychosocial problems and address areas of decline.

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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 0686 Level of Harm - 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** 45338 Based on observations, staff interviews, resident interview, provider interview and clinical record review, the facility failed to implement timely interventions for residents identified at high risk for pressure ulcer development and to prevent worsening of wounds, perform thorough and consistent assessment which included wound measurements and wound description, and coordinate which staff from the clinical team staged and measured wounds for two of three residents reviewed for pressure ulcers (Resident #20, Resident #208). Resident #20 developed a deep tissue injury to the right heel and stage two pressure ulcer to the coccyx, and Resident #208 admitted with wounds not thoroughly assessed by the facility on admission, nor consistently monitored, staged, or measured following the resident's admission. The facility reported a census of 58 residents. Findings include: The MDS identified the following descriptions 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. 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 may be present on some parts of the wound bed. Often includes undermining and tunneling. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. 1. Review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #20 revealed the resident was rarely to never understood. Per this assessment, Resident #20 was at risk for pressure ulcers/injuries, and did not have unhealed pressure ulcers. The assessment revealed Resident #20 had a pressure reducing device for chair and bed, and was not on a turning/repositioning program. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Care Plan initiated on 3/20/23, resolved on 4/30/24, documented, Resident #20 has impaired skin integrity. R (right) heel, unstageable (obscured full-thickness skin and tissue loss) wound. The current Care Plan for Resident #20 dated 4/2/24, revised 4/30/24, documented, Resident #20 has issues with skin integrity. Resident #20 has a deep tissue wound to her R (right) heel. Daily treatments are being applied at this time and Q 3 D (every three days). The Intervention dated 4/2/24 revealed, Monitor and document changes in wound. Measure wound weekly and PRN (as needed). Review of the resident's Braden assessment dated [DATE] identified Resident #20 at high risk for pressure ulcers. The Skin assessment dated [DATE] revealed the resident did not have any alterations in skin integrity. The Late Entry Skin/Wound Note dated 3/11/24 at 10:44 AM documented, family notified of suspected DTI (deep tissue injury-persistent, non-blanchable deep red, maroon or purple discoloration) to right heel as well as Nurse Practitioner. The Weekly Nursing Skin assessment dated [DATE] revealed the resident had an area to the right heel, and documented, duoderm in place, heel protectors on and float heels on blue pillow. This assessment documented the wound as not new. The Weekly Pressure Wound assessment dated [DATE], locked 3/15/24, revealed the resident had a deep tissue injury (DTI) to the right heel, which measured 3 cm (centimeters) length (L) by 3 cm width (W) by 0.0 cm depth (D). The stage documented, suspected deep tissue injury. The assessment documented date of onset as 3/11/24. The Physician Order, start date 3/11/24, revealed, heel booties on at all times every shift for skin. Review of the resident's Treatment Administration Record (TAR) dated March 2024 revealed documentation of floating heels/heel booties began 3/11/24. The Progress Note dated 3/12/24 at 3:10 AM revealed, resident received N.O. (new order) to wear heel protectors at all times and float heels while lying in bed. Resident complied with booties all this shift. The Progress Note dated 3/15/24 at 7:20 AM revealed, Daily dressing change done on coccyx area. Review of the resident's Medication Administration Record (MAR) and TAR dated March 2024 lacked documentation of a treatment to the resident's coccyx. The Weekly Nursing Skin assessment dated [DATE] revealed the resident had an area to the right heel. The assessment lacked description of the wound, and lacked measurements of the wound. The skin assessment did not address a wound present to the resident's coccyx. The Provider Progress Note for Resident #20 dated 3/27/24 authored by the facility's Nurse Practitioner (NP) revealed the following Chief Complaint/Nature of Presenting Problem: Wound. Per the Progress Note, Resident #20 had a stage two pressure ulcer to the coccyx which measured 3 cm x 3 cm x 0.25 cm, had mild serous drainage, and a fragile periwound. The resident also had a deep tissue injury to the right heel which measured 3 x 2 cm. The Plan section documented, in part, the following: (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	a. Pressure injury of sacral region, stage 2: Medihoney, and Mepilex to be changed daily and PRN (as needed). b. Pressure-induced deep tissue damage of right heel: Now open, Change to Medihoney and Mepilex to be changed daily. Review of a Physician Order Form for Resident #20 dated in March (date and year unable to be read) revealed, change wound care to R (right) foot (and sign) bottom to Medihoney (and sign) cover with Mepilex to be changed daily (and sign) PRN (as needed). This Physician Order not signed on the nurse signature line and no date present next to nurse signature line. Although date and year unable to be read, it was noted per the resident's MDS assessment the resident admitted to the facility in November 2023. The Physician Order dated 3/27/24 at 7:00 AM started on the resident's MAR on 3/27/24: MEDIHONEY GEL WOUND Apply to right heel topically in the morning for wound healing. A prior treatment order to the right heel which started 3/14/24 remained active as well as the more current treatment order for the resident's heel dated 3/27/24. Both orders remained active on the resident's April 2024 TAR as well. Review of Resident #20's MAR and TAR for the month of March 2024 lacked a Physician Order to address the resident's pressure injury of the sacral region, or charting to indicate completion of treatment. The Nurses Note dated 3/29/24 at 1:25 PM revealed, prostat 30 ml (milliliter) TID (three times per day) and stress tab ordered for wound healing per Nurse Practitioner. The Weekly Nursing Skin assessment dated [DATE] and 4/6/24 revealed the resident had an area to the right heel, and duoderm in place. heel protectors on at all times along with floating heels on pillow. The assessment also revealed, open area to coccyx. Mepilex in place. The assessment lacked wound measurements or additional descriptions of the wounds. Per this assessment, the areas were not new for the resident. The assessment dated [DATE] revealed, treatments done daily. Review of the resident's TAR dated April 2024 revealed treatment to the coccyx began to be documented 4/5/24, although first noted in Progress Notes on 3/15/24. The Orders-Administration Note dated 4/8/24 at 1:09 PM revealed, ACETAMINOPHEN 650MG (milligram) TAB Give 650 mg orally every 8 hours as needed for Pain residents complaining of pain on her coccyx. The Weekly Nursing Skin assessment dated [DATE], locked on 4/30/24, and the assessments done 4/20/24 and 4/27/24 revealed the resident had an area to the right heel, and duoderm in place. heel protectors on at all times along with floating heels on pillow. The Weekly Nursing Skin assessment dated [DATE] also revealed, open area to coccyx. treatment in place. The assessment dated [DATE] and 4/27/24 provided the same description, although the word treatment had been changed to Mepilex on these assessments. The Assessments 4/13/24 4/20/24, and 4/27/24 lacked wound measurements or additional descriptions of the wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Weekly Wound Log dated 4/27/24 provided by the Assistant Director of Nursing (ADON) revealed the resident had a deep tissue injury to the right heel. Per the log, the wound measured 3 by 2 by 0.1 (no unit of measure documented). Per the log, the resident had a moisture associated wound to the buttock which measured 3 x 2 x 0.2 (no unit of measure documented). Observation on 5/1/24 at 1:19 PM revealed Resident #20 present in the common area between the 300/400 unit. The resident had blue soft boots to their lower legs/feet. Observation conducted 5/2/24 at 10:04 AM revealed Staff C, Registered Nurse (RN) performed wound care to the resident's right heel wound. Resident #20 observed in bed with a cushion under the lower legs to elevate the resident's lower legs from the bed. Per Staff C, the wound was facility acquired. Staff C further explained the wound had necrotic eschar (dead or devitalized tissue), and the Medihoney got it off of there. The resident observed to have the wound to the inner right heel, and Staff C explained the wound looked so much better. Per Staff C the area did not have redness present, was not boggy, and dried. On 5/02/24 at 10:12 AM, Staff C explained the resident had an open area near the right inner cheek which was facility acquired. The resident assisted to turn in the bed, and the old dressing removed. The sticky surrounding edges of the dressing pulled when the dressing was removed from the resident's backside, and some bloody drainage present with the old dressing removal. A wound observed to the top of the resident's gluteal cleft. During the observation the resident noted to have yellow substance which appeared to be urine in their brief when the resident's brief was partially removed in order to access the area of the resident's wound. Staff C described the wound bed as white fibrous tissue, maceration, and healing wound bed with red beefy granulation. Per Staff C, the wound had slight clear serosanguineous drainage, and the area surrounding the wound was a little red. Staff C explained it was better than a week ago. Staff C completed the dressing change, and per observation the same brief as previously described was reapplied for Resident #20. On 5/2/24 at 11:10 AM Staff G, Licensed Practical Nurse (LPN) queried about assessment of skin. Staff G explained if she saw anything it would be reported to the ADON (Assistant Director of Nursing) to let them know if there is a pressure sore, or even thought a pressure sore, anything like that. Per Staff G, they would open up a skin sheet so could continue to monitor it at least on a weekly basis. Staff G acknowledged this would occur in the assessment tab. When queried who measured the wounds, Staff G responded she did not as she worked nights (night shift), and responded she was not sure. Staff G further explained she knew the NP was measuring them when she came in, but did not know if she did so any more. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/2/24 at 1:09 PM the ADON explained there was a time where the Nurse Practitioner (NP) monitored wounds every week, the facility did not have an actual full-time person to do the wounds, and the nurses were asked to help keep the measurements up. When queried what nurses were to do weekly, the ADON responded weekly pressure and weekly non-pressure assessments should be opened with all skin issues/skin wounds, and after opened populate weekly unless healed. The ADON explained they needed to be opened first. The ADON explained there was a time she measured weekly, however could not always keep up with it when the facility didn't have a Director of Nursing (DON). Per the ADON, she charted in weekly pressure and non-pressure. When queried about staging of wounds, the ADON responded the NP staged, said we don't stage at all, and further explained the facility did not call a pressure until they said so. The ADON explained the DON (Director of Nursing) was going to take over wounds for the facility. It was noted the facility had a new DON starting during the week of the survey. On 5/2/24 at 1:40 PM during an interview with the NP, the NP explained she was doing measurements, and it then went back to the facility. When queried about the facility measuring wounds, the NP responded she thought it was being done. Per the NP, the facility would stage wounds. The NP explained she measured Resident #20's wound on 3/27/24, and this was the last time took care of wound. The Facility Policy titled Skin and Wound Management System dated 4/17, revised 9/22 revealed, it is the policy of this center's Skin Management System to identify and assess residents with wounds and/or pressure ulcers, as well as those at risk for skin compromise. Such residents are then provided appropriate treatment to encourage healing and/or integrity. Ongoing monitoring and evaluation are then provided to ensure optimal resident outcomes. 47336 2. The MDS assessment dated [DATE] revealed Resident #208 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed impairment on both sides in the upper and lower extremities. The MDS revealed resident needed substantial/maximal assistance with toileting hygiene; shower or bathing self; upper and lower body dressing; rolled from left to right. The MDS revealed resident dependent with toilet transfer and chair/bed to chair transfer. The MDS revealed medical diagnoses of multiple sclerosis and risk for malnutrition. The MDS revealed risk for developing pressure ulcers/injuries. The MDS revealed one Stage 2 pressure ulcer; one Stage 3 pressure ulcer; and one Stage 4 pressure ulcer present on admission. The Care Plan revealed a focus area dated 4/23/24 for Stage 4 pressure ulcer on right hip; Stage 3 pressure ulcer on left heel; and Stage 2 pressure ulcer on the right ankle. The interventions dated 4/23/24 revealed treatments as ordered. The Wound Care Routine dated 3/7/24 at 11:32 AM from a hospital clinic revealed the following special instructions: a. Apply betadine to left heel daily cover with foam border b. Apply a thin layer of Mupirocin along to buttock wounds and red areas daily c. Apply a thin layer of mometasone with Mupirocin to red area along left hip and groin daily The Admission/Readmission Narrative dated 4/12/24 on 1:33 PM revealed the following for the skin: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	a. alterations in skin integrity: multiple b. site 1. right iliac crest- no measurement documented 2. coccyx- no measurement documented 3. right knee- no measurement documented 4. left heel- no measurement documented 5. right buttock- no measurement documented 6. left buttock- no measurement documented 7. left ankle- no measurement documented 8. groin- no measurement documented The Progress Note dated 4/12/24 at 2:00 PM, revealed resident arrived by ambulance and ambulance crew. The resident transferred to bed with max assist of 5 people. Resident fully oriented and alert, unable to walk, stand, had multiple skin integrity issues which have been identified on admission skin assessment. Resident incontinent. The Physician Orders revealed the following medications: a. start date of 4/13/24- Mepilex border- apply to sacrum topically in the morning b. start date of 4/13/24- Mepilex border- apply to left ankle topically in the morning for wound c. start date 4/15/24- Weekly skin assessment (Day of Week)- one time a day every Monday d. start date of 4/16/24- clean wound to right hip with normal saline apply maxorb to wound bed cover with foam dressing daily one time a day for wound healing e. start date of 4/16/24- apply betadine to left heel and ankle apply Mupirocin ointment 2% to ankle then cover ankle and heel with foam dressing in the morning for wound healing f. start date of 4/17/24- liquacel liquid orange- give 30 ml orally two times a day for wound healing g. start date of 4/18/24- apply border gauze to bony prominence on bilateral feet for prevention. change every 3 days in the morning every 3 day(s) for wound healing h. start date of 4/28/24- Mupirocin ointment 2% to wound on left ankle (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Weekly Nursing Skin Assessment/Shower Skin assessment dated [DATE] at 3:59 PM revealed the following: a. Does this resident have any alterations in skin integrity?- yes b. Are any of the above areas new for this resident- yes The Progress Note from the Provider on 4/15/24 revealed the resident had multiple pressure wounds, patient referred to wound care. Patient had wounds to left ankle, sacrum covered with Mepilex, patient had a wound to right hip covered with Maxorb and foam dressing. Wound to left heel covered with foam dressing with Mupirocin being applied daily. The Physical Exam revealed the Integumentary: Dry, warm, normal color multiple pressure wound and wounds covered at this time, and unable to visualize. The Progress Note dated 4/17/24 at 1:49 PM, revealed the nurse received a phone call from [name redacted] infectious disease physician office located in another city and inquired about resident and how his wounds were progressing. An update given as doing treatments as ordered. phone number if questions arose or resident needed to have a follow-up appointment given. They felt the resident did not need to come back to their office if he under our care, but if needed to call them. The Weekly Nursing Skin Assessment/Shower Skin assessment dated [DATE] at 4:12 PM revealed the following: a. this resident have any alterations in skin integrity?- no b. Are any of the above areas new for this resident- no The Weekly Nursing Skin Assessment/Shower Skin assessment dated [DATE] at 7:48 AM revealed the following: a. Does this resident have any alterations in skin integrity?- no b. Are any of the above areas new for this resident- no The Progress Note from the Provider on 4/24/24 revealed the resident reported that on Thursday he was lifted by a Hoyer and hit his left ankle on the Hoyer, he reported his wound came back open. I assessed left ankle, bruising around wound. Resident reported severe pain to left ankle. discussed ordering an x-ray, resident agreeable. reported to ADON. No other new issues reported. Medications reviewed. Wound #1 on the left ankle was a pressure, with no odor; red wound bed, and periwound- bruising. The Weekly Wound Log dated 4/27/24 for Resident #208 revealed the following: a. right hip - date acquired on admit and measured 2 x 2.3 x 0.5 cm b. left foot - date acquired on admit and measured 4.3 x 1.3 x 0 cm c. heel - date acquired on admit and measured on 1.3 x 1.6 cm (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Weekly Nursing Skin Assessment/Shower Skin assessment dated [DATE] at 4:12 PM revealed the following: a. Does this resident have any alterations in skin integrity? no b. Are any of the above areas new for this resident- no The Weekly Nursing Skin Assessment/Shower Skin assessment dated [DATE] at 11:27 AM revealed the following: a. Does this resident have any alterations in skin integrity?- no b. Are any of the above areas new for this resident- no During an interview on 4/29/24 at 11:04 AM, Resident #208 stated he had a pressure ulcer on one of his ankles and one on his hip. He stated the pressure ulcers present prior to admission. He stated the facility did daily dressing changes. During an interview on 5/1/24 at 1:40 PM, Resident #208 stated he thought they only measured his wounds twice and he thought his insurance wanted them measured every week, but he didn't know if they did that here. During an interview on 5/1/24 at 8:18 AM, the ADON queried on where the skin assessment documented and she stated she just audited them this week and they were not completed correctly. The ADON asked if they documented on paper and she stated no. The ADON asked if she documented any skin measurements and she stated she documented one measurement on Resident #208. During an interview on 5/2/24 at 1:25 PM, Staff C, RN (Registered Nurse) queried on where the skin assessments documented and she stated her and the ADON spoke about it this morning and she was doing it wrong. She stated when she clicked off the dressing change, it should go over to the progress note to document. Staff C stated she misinterpreted because the last place she was at, they hired a skin nurse and she thought the skin nurse measured and the floor staff didn't so the measurements were not off. Staff C stated she knew now she needed to measure and document the measurements weekly. During an interview on 5/2/24 at 1:42 PM, the ARNP (Advanced Registered Nurse Practitioner) stated she expected the facility to do measurements on the wounds and she thought they did the measurements. She stated the facility staged the wounds. The ARNP stated she didn't measure the resident's wounds but she looked at them. During an interview on 5/2/24 at 3:14 PM, the ADON queried on Resident #208 pressure wounds and she stated she knew they needed better measurements for sure and wanted the stages of healing with them. She stated measurements needed done weekly.

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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** 35434 Based on observations, clinical record review, policy review, and staff interviews, the facility failed to ensure an environment free of accidents and hazards for 4 of 6 residents reviewed for supervision. The facility failed to provide adequate supervision to prevent falls for Residents #42 and #18, and #19, and failed to utilize both foot pedals during wheelchair locomotion for Resident #211. The facility reported a census of 58 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 10/27/23, listed diagnoses for Resident #42 which included fracture of the right femur (leg bone), non-Alzheimer's dementia, and heart failure. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicating impaired cognition. The MDS stated the resident required partial/moderate assistance for transfers and walking. The MDS stated during the review period, the resident had 1 fall with injury and 2 falls with a non-major injury. The MDS listed the Brief Interview for Mental Status (BIMS) score as 6 out of 15, indicating severely impaired cognition. The Care Plan initiated 7/3/23 documented the resident at risk for falls related to impaired balance and impaired safety awareness. The Care Plan lacked any interventions dated prior to 8/3/23. The Fall Report dated 7/21/23 at 9:00 p.m. stated the resident laid on the floor of his room on the right side. Staff toileted the resident at 8:30 p.m. The resident sustained an abrasion to the right side of his nose and had pain in his right thigh. The Nurse Notes documented the following: On 7/22/23 the resident had an acute fracture of the right hip. On 8/2/23 the resident returned from the hospital with a diagnosis of right hip fracture and had a surgical incision. On 8/4/23 the resident had a surgical repair of the right hip. The Medicare Part B Note dated 8/9/23 stated therapy would work with the resident on strengthening. The Fall Report dated 8/30/23 stated the resident was on the floor lying on his right side. He sustained a skin tear to the right wrist and an abrasion to the right knee. The facility educated the Certified Nursing Assistants (CNA's) to place the bed in a low position. The Fall report dated 9/10/23 stated staff found the resident between the bed and the bathroom door on the floor. The facility carried out additional education to CNA's regarding frequent toileting and toileting immediately following meals. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Nurse Notes documented the following: On 9/10/23 the resident was educated on the use of the call light. On 9/14/23 the family requested to have the resident's diuretic (a medication used to rid the body of fluid) reduced in an effort to reduce his falls due to self-transferring. On 10/12/23 the facility would begin 1-hour checks at bedtime due to the resident's falls. The Fall Report dated 10/12/23 stated staff found the resident sitting on the floor with his legs stretched out in front of him and the resident stated he had to urinate. The resident sustained a skin tear to the right elbow. A 10/12/23 Care Plan entry stated the family was aware that he fell due to him falling at home. The entry stated there were no new intervention ideas from the family. A 10/26/23 Therapy to Facility Communication form stated the resident required the assistance of 1 staff and a 4 wheeled walker for walking and transfers. The Fall report dated 10/27/23 stated the resident laid on his floor in the bathroom on his left side. A 10/27/23 Fall-Initial note stated staff would take him to the bathroom every 2 hours and encourage him to sit for at least 10 minutes. A 10/27/23 Care Plan entry directed staff to utilize a pressure activated call light to the exiting side of the bed. A 10/30/23 Interdisciplinary Team (IDT) Note stated the resident was placed on a fluid restriction as an intervention to the 10/27/23 fall. A 10/30/23 Care Plan entry stated the resident had an evaluation with urology (a medical specialty focused on the urinary tract) on 10/24/23. The Fall Report dated 11/1/23 stated the nurse was called into the front offices where the resident laid on his right side. The resident complained of left hip pain. Staff took the resident into a common area for increased supervision and the resident started yelling that his hip hurt. The facility obtained an order to send the resident to the ER for evaluation. The Fall-Initial note dated 11/1/23 at 7:00 p.m. stated the resident fell in the office of the Business Office Manager and the Activity Supervisor and when found the resident stated he wanted to see what was going on in there. The note stated staff last toileted the resident at 5:30 p.m. The Nurse Notes documented the following: On 11/1/23 at 9:32 p.m. the resident transferred to the hospital. On 11/1/23 at 11:15 p.m. the resident had a left hip fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An 11/9/23 hospital History and Physical stated the resident had a fall on 11/1/23 and sustained a fracture of the left hip. The resident underwent a left hip hemiarthroplasty (surgical repair of the hip). An 11/10/23 Admission Assessment stated the resident returned to the facility. On 5/2/24 at 11:31 a.m., the Activity Supervisor stated the resident fell in her office when it was after office hours and the door was not locked. She stated he got into the room sometime around supper and no staff were in the office at the time. On 5/2/24 at 11:36 a.m., the Business Office Manager stated normally the last person to leave the office would lock the door. On 5/2/24 at 2:08 p.m., the Administrator stated the door to the office the resident fell in was usually kept locked. He stated there were documents and items in the room and the room needed to be locked. The facility policy Falls Management System, revised 2016, stated the facility would provide an environment that remained as free of accident hazards as possible. The policy stated the facility would provide each resident with adequate supervision to prevent accidents and would provide appropriate evaluations and interventions to prevent falls. Resident Care Plans would include interventions which addressed elements determined as probable causal factors which contributed to the fall. 47336 2. The MDS assessment dated [DATE] revealed Resident #19 scored a 11 out of 15 on the BIMS exam, which indicated moderately impaired cognition. The MDS revealed impairment on one side of the upper extremity. The MDS revealed resident needed partial/moderate assistance with toileting hygiene; chair/bed to chair transfer; and toilet transfer. The Care Plan revealed a focus area revised on 1/10/24 for risk for fall due to heart failure, cervicobrachial syndrome, and history of fall with fracture prior to admission with a fall on 1/8/24 with a right hip fracture. The resolved intervention dated 1/8/24 revealed floor alarm in room, and floor alarm removed on 1/18/24 and pull away alarm placed on resident. The EMR (Electronic Medical Record) revealed the following Medical Diagnosis: a. Fracture of superior rim of right pubis, subsequent encounter for fracture with routine healing. The Fall-Initial Note dated 1/8/24 at 8:10 AM, revealed the following: a. Type of Incident: unwitnessed fall b. Date and Time: 1/08/24 at 8:10 AM c. Location of fall: in resident's room d. Description & Potential Root Cause: non-compliant self-transferred (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	e. Injuries: complaining of inner et outer right hip pain f. Pain: 5/10 on pain scale g. Vitals (include ortho's if able to stand): h. Footwear at time of fall: yes, his regular shoes i. Assistive devices and their location at time of fall: he has 4 wheeled walker that was by his bed at the time of fall j. If resident wore glasses, were they on? no k. Was the call light on at time of fall? yes l. Last time toileted: right before fall m. Any Incontinence: no n. ROM (Range of Motion) Impairments: able to move bilateral lower extremities, but is complained of right leg pain o. Care Provided (how assisted up, first aid): assisted to standing position with assist x 2; neuros initiated p. Intervention/prevention to prevent recurrence (Must complete): floor mat put in room q. received order for resident to be taken to local hospital emergency room for x-rays. r. Provider/ Family notifications: provider and POA (Power of Attorney) The Progress Notes for the resident documented the following: On 1/8/24 at 8:28 AM, Resident #19 fell in his room self-transferring to the bathroom. He stated that he was able to transfer himself. The resident unable to use his right hip at this time order obtained from the provider to transfer resident to local hospital emergency room for evaluation. POA notified verbalized understanding. On 1/8/24 at 10:26 AM, resident noted to be laying on back with legs out in front of him in front of his window. Resident noted to have his regular shoes on, walker over by his bed. Call light on for assistance. Resident started complaining of right outer and inner hip pain. Received order per provider to transfer to local hospital emergency room to be evaluated and treated. POA notified. Neuros initiated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/8/24 at 10:33 AM, CNA responded to call light and asked resident to give her a second so she could gown up, at that time another CNA called and stated that other resident climbing out of her wheelchair. They repositioned that resident and the CNA then finished gowning up and then at that point she heard a crash and heard Resident #19 say ouch. She then opened the door and saw resident laying on the floor and called for the nurse. On 1/8/24 at 11:22 AM, Fall Committee Meeting: Resident fell on [DATE] at 8:10 AM. Resident found on the floor. Resident stated that he was getting a pair of socks out of his dresser. Root cause analysis performed showed that resident attempted to self transfer, lost balance/got weak and fell . Based on the root cause analysis the intervention will be to place a floor alarm in residents room and place it in front of him while he is in his room. Care Plan updated with changes. On 1/8/24 at 1:30 PM, the resident returned per facility vehicle with facility staff. Resident weight bearing as tolerated with walker, continue with NSAIDS (non-steroidal anti-inflammatory drugs) for pain, follow-up with hospital. Resident noted to have multiple fractures to right hip. Resident assisted to his room to his recliner, call light within reach. On 1/13/24 at 3:32 PM, resident alert resting in bed at this time with call light within reach continue to encourage to use call light for all assist verbalized a good understanding. Denies any pain at this time, still verbalized pain when he moved, encouraged to let the nurse know if he needed anything for pain. He verbalized an understanding. Stand aid with assist x 2 utilized today for all transfers. The Provider Progress Note dated 1/8/24 revealed resident seen in ER (emergency room) after fall that resulted in fracture to right pelvis and hip. Resident to be referred to Ortho. Patient reports pain about a 5 out of 10. Tramadol 50 mg every 6 hours PRN (as needed) ordered. The Plan indicated closed fracture of right pubis, unspecified portion of pubis, sequela. Repeated falls: Encouraged use of assistive device. Change positions slowly to avoid dizziness that could result in fall. Ask for assistance from staff when ambulating/transferring. The IDT Resident Care Conference dated 1/17/24 at 12:21 PM, documented looked into more local hospitals for an appointment to see if Resident #19 needed to have surgery on his hip. Coming out of isolation on 1/17/24 at midnight due to diagnosis of COVID. The Progress Note dated 1/19/24 by provider revealed the following information: a. [AGE] year-old male resident seen today for follow-up visit related to recent fractures and COVID. b. Resident appeared to be feeling better. Resident's lungs clear throughout. Patient continues to have 2 liters of oxygen nasal cannula as needed. c. Resident waiting on Ortho referral. d. Resident reported continued constant pain to the hip. Patient currently prescribed tramadol 50 mg every 6 hours as needed, will increase to every 4 hours as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165204	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keosauqua Health Care Center	819 Country Lane Road Keosauqua, IA 52565

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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 0689

Level of Harm - Actual harm

Residents Affected - Few

e. Plan: Right hip pain: Waiting on ortho referral tramadol for pain, increased to every 4 hours PRN

During an observation on 4/30/24 at 12:57 PM, the resident sat in his wheelchair and self-propelled down the hallway. The chair alarm hooked to his shirt and attached to the wheelchair.

During an interview on 5/2/24 at 10:45 AM, Staff G, LPN (Licensed Practical Nurse), stated she believed she worked the day Resident #19 fell and fractured his hip. She stated he needed assistance with walking because he wasn't steady on his feet. She stated he self-transferred when he broke his hip, and we always wanted him to ask for assistance.

During an interview on 5/2/24 at 1:57 PM, Staff I, CNA stated Resident #19 supposed to be a one assist but not always compliant.

During an interview on 5/2/24 at 2:05 PM, Staff J, CNA stated Resident #19 a one assist and he would try to self-transfer and we tried to get him, but hard for him to understand to not transfer.

During an interview on 5/2/24 at 3:27 PM, the ADON queried on Resident #19 fall on 1/8/24 and she stated the resident not compliant, and you couldn't convince him to wait and use the call light and he self transferred and fell . He was not compliant, you could not convince him to wait and use his call light, he self transferred and he fell . She stated the situation tricky, you can try and prevent one fall and another one happened. Since the CNA didn't go into the room yet, she went and helped someone else. The ADON stated the situation depended on the other person, if it was Resident #19 neighbor who had dementia, he would need assistance. You weigh your options. Resident #19 oriented. If someone else falling, easier to catch the person who wasn't safe.

3. The MDS assessment dated [DATE] revealed Resident #211 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed resident impaired on side of upper and lower extremity and used a wheelchair. The MDS revealed resident dependent to wheel 50 feet with two turns once seated in wheelchair. The MDS revealed diagnoses of stroke, CVA (cerebral vascular accident), or TIA (transient ischemic attack); hemiplegia or hemiparesis; and seizure disorder.

The Care Plan revealed a focus area dated 5/1/24 for a self-care deficit due to diagnosis of chronic kidney disease, hypotension, gatroesophageal reflux disease, Type II diabetes mellitus, depression. The interventions dated 5/1/24 revealed resident utilized her left foot pedal and didn't use the right foot pedal, if she self-propelled.

During an observation on 4/30/24 at 12:00 PM, the resident pushed in the wheelchair by Staff O, CNA with left foot on the foot pedal and the right foot barely lifted off the floor (no foot pedal on the right side of wheelchair).

During an observation on 4/30/24 at 12:03 PM, the resident pushed by Staff O, CNA out of the shower room with the right foot lifted off the floor (no foot pedal on the right side) and the left foot on a foot pedal.

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NAME OF PROVIDER OR SUPPLIER Keosauqua Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 819 Country Lane Road Keosauqua, IA 52565	

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/2/24 at 9:18 AM, Staff N, CNA queried where a resident's feet needed located when transferred in a wheelchair and she stated on the foot pedals and or if able then could raise their feet. She stated she had the resident raise their feet and she would push slowly and watch them to make sure their feet stayed off the ground. She stated if the resident self-propelled and they had a bag on the back of their wheelchair with foot pedals in them, she would take them out of the bag and put the foot pedals on the wheelchair. During an interview on 5/2/24 at 1:16 PM, Staff C, RN stated if a resident is being pushed, they needed foot pedals. During an interview on 5/2/24 at 2:00 PM, Staff I, CNA stated they shouldn't move the resident in a wheelchair unless their feet are placed on foot pedals. She stated the facility used a policy called no pedal, no push. During an interview on 5/2/24 at 2:15 PM, Staff O, CNA queried where the foot should be when pushing a resident in a wheelchair and she stated on foot pedals, unless they can propel themselves. Staff O asked about Resident #211 and she stated no, you can't push her without foot pedals, she messed up on that. During an interview on 5/2/24 at 2:49 PM, the ADON queried where a resident's feet needed located when pushed in a wheelchair and she stated on the pedals. She stated if a resident didn't use foot pedals, they shouldn't be pushed, they are supposed to be mobile. 45338 4. Review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #18 revealed the resident was rarely to never understood. Per this assessment, Resident #18 had fallen since admit, entry, reentry, or prior assessment, and had two or more falls since admit or prior assessment with no injury. The Care Plan dated 9/27/23, revision date 4/26/24, documented the following: Resident #18 has had an actual fall without injury from a rolling chair in the dining room. She didn't realize this type chair would roll out from underneath her due to her poor communication/comprehension. Falls documented on: 8/30/2023 9/26/2023 12/24/2023-No Injury 12/29/2023- No Injury 2/16/2024-No Injury 2/19/2024-No Injury (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	2/23/2024-No Injury 3/04/2024-No Injury 3/29/2024- No Injury 3/31/2024- No injury 4/15/2024-No Injury 4/18/2024-No Injury 4/23/2024-No Injury Care Plan interventions in 2024 included the following: a. Date initiated 3/31/24: 3/31/2024 Ensure proper footwear while ambulating. b. Date initiated 4/26/24: 4/18/2024 Broda chair was given to resident d/t (due to) weakness at times of walking. c. Date initiated 9/27/24: Be sure the rolling chairs in the dining room are kept out of residents reach. d. Date initiated 2/16/24: 2/16/24 Offer fresh water multiple times a day. (resident is sick at this time) e. Date Initiated 12/26/23, revised 2/19/24: 2/19/24 PCP (Primary Care Physician) review medication. f. Date Initiated 2/26/24, revised 3/4/24: 2/23/24 Funding verification paper work is being filed to see if resident can get PT/OT (physical therapy/occupational therapy) UPDATE: Funding form approved g. Date Initiated 3/4/24, revised 3/6/24: 3/4/24 Request an eye appointment. (Son stated that resident would not wear glasses even if she had them). h. Date Initiated 12/29/23: 12/29/23 give resident a snack when she is agitated. i. Date Initiated 4/1/24: 3/29/24 PCP (Primary Care Provider) see resident on rounds. j. Date Initiated 4/26/24: 4/23/24 Recliners in 300 alcove replaced with a couch for a large circumference to sit on. Review of Resident #18's clinical record revealed the resident had fallen eleven times between 12/24/23 and 4/23/23. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Fall-Initial Note dated 12/24/23 at 9:00 PM revealed the resident fell in the 300 common area. The Description and Potential Root Cause section revealed, resident in the 300 common area and was trying to sit in a chair but missed it landing on her buttocks. The Fall Initial Note dated 12/29/23 at 1:57 PM revealed the resident fell in another resident's room. The Description and Potential Root Cause section revealed, resident was seen sitting on the floor in [room number redacted], feet out in front of her facing the hallway. The Incident Report revealed there were no witnesses to the event. The Progress Notes for the resident documented the following: On 1/9/24 at 10:18 AM assessed left knee noted blue hematoma from fall earlier this week no s/s (signs/symptoms) of pain noted no moaning yelling or facial grimacing noted will continue to monitor. On 2/16/24 at 6:01 PM called to 300 hall per CMA (Certified Medication Aide) [Name Redacted] noted res sitting in high back chair per staff noted res attempt to sit in chair missed hit posterior head on arm of the chair fell on floor neuro's stated and vitals obtained no injury noted. The Fall Initial Note dated 2/19/24 at 8:43 AM documented: the resident had an unwitnessed fall in their room. The Description & Potential Root Cause documented, resident found lying between wall and bed. resident has recently been ill with flu. Due to cognition resident is unaware of safety issues, is unable to communicate verbally and wanders throughout building 24/7. resident does become restless and agitated at times. Resident can be redirected at times. The Incident Report revealed there were no witnesses to the event. The Fall-Initial Note dated 2/23/24 at 10:10 AM revealed the resident had an unwitnessed fall with no injury noted. The Description & Potential Root Cause documented, weakness after having influenza last week. The Progress Notes for the resident documented the following: On 2/26/24 at 2:32 PM Fall committee meeting: Resident had a fall on 2/23/2024 at 1010. Resident was found sitting on the floor between 2 recliners and had bedside table behind her. Resident appears to have been attempting to sit in a chair but missed with and fell to floor. Root cause analysis was performed and showed that resident thought she was in front of chair, but obviously was not. Based on the root cause analysis the intervention will be to have a funding verification paper filed to see if resident would be able to work with PT/OT (physical therapy/occupational therapy). On 3/4/24 at 8:38 AM resident had an un witnessed fall this morning attempting to sit in recliner missed chair sat herself on the floor. Neuros started vitals obtained no injury noted with assessment .Going to move recliners to see if that helps with the falls. The Incident Report revealed there were no witnesses to the event. The Fall-Initial Note dated 3/29/24 at 2:47 PM documented the resident fell in the 300 hallway, with location of fall documented as 300 alcove. The Description & Potential Root Cause: section documented, resident missed the recliner when she went to sit down. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Fall-Initial Note dated 3/31/24 at 1:45 PM documented the resident had a fall with no injury, and fell at the 200 alcove in front of beauty shop. The Description & Potential Root Cause documented, this nurse was called over walkie to the 200 alcove where resident was sitting on the floor next to the recliner in front of the beauty shop with feet out in front of her wearing gripper socks and no shoes. Cna (Certified Nursing Assistant) witnessed fall. Cna stated that resident was attempting to sit in the recliner and slipped. Review of the Incident Report revealed staff was summoned by a family member. The Fall-Initial Note dated 4/15/24 at 11:44 AM documented the resident slid off of recliner and onto floor. Location of fall documented the 3/400 common area, and documented per the Description & Potential Root Cause section, resident has UTI (urinary tract infection) and is on an antibiotic. The Fall-Initial Note dated 4/18/24 at 7:16 AM for a witnessed fall revealed the resident fell in the 300 common area. The Description & Potential Root Cause revealed, went to sit to soon in the chair. The IDT Note dated 4/20/24 at 9:46 AM documented, Fall Committee Meeting: Resident had a fall on 4/18/2024 at 0550. Resident was found sitting on the floor by recliner. Resident appears to have gotten weak and sat before making it to the recliner. Root cause analysis was performed and showed that resident may have gotten weak while walking and wanted to sit down in recliner. Based on the root cause analysis the intervention will be to assist resident to broda chair when resident appears to be getting weak. Care Plan updated with changes. The Fall-Initial Note dated 4/23/24 at 11:15 AM documented the resident had a witnessed fall in the 300/400 alcove sitting common area. The Description & Potential Root Cause section revealed, resident was witnessed sitting self down on floor between two chairs. On 4/30/24 at 12:18 PM observed Resident #18 stand up from a recliner chair in the 300/400 common area, then sit back down. The resident had yellow grip socks to her feet. Observation on 5/1/24 at 9:56 AM revealed Resident #18 in the common area/tv area between the 300 and 400 hallways. Resident #18 had yellow socks to their feet, and staff not observed in the common area or the medication cart area. At 9:57 AM, a staff member walked past the common area, another staff walked near the common area, and one staff went towards 300 hall while the other staff went towards 400 hall (away from the common area). Staff members walked past the common area and went in different directions away from the common area. At 10:04 AM, the resident observed in a recliner chair with yellow grip socks to her feet. Observation on 5/1/24 at 1:28 PM revealed Resident #18 on a couch in the common area. The resident had yellow socks to their feet. On 5/2/24 at 11:03 AM, Staff G, Licensed Practical Nurse (LPN) explained sometimes Resident #19 would sit too soon and would miss the chair. Staff G explained the resident mainly stayed in the 300/400 area. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/2/24 at 1:12 PM when queried about Resident #18's falls, the Assistant Director of Nursing (ADON) explained for almost every one of the falls the resident tried to sit in a chair and did not make it to the chair. The ADON acknowledged this occurred in the 300 alcove for the most part, where the resident spent a lot of time. Per the ADON the resident did wander, and stop signs were present as the resident liked to go into other people's room.

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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 45338

Based on observations, staff interviews, clinical record review and facility policy review the facility failed to ensure catheter tubing remained off the floor, failed to accurately assess a resident for the presence of a catheter, and failed to ensure timely orders for an indwelling catheter for two of two residents reviewed for catheters (Resident #11, Resident #19). The facility reported a census of 58 residents.

Findings include:

1. Review of the Minimum Data Set (MDS) assessment for Resident #11 dated 3/21/24 revealed the resident scored 6 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. The assessment further revealed Resident #11 was always incontinent for urinary continence and did not have an indwelling catheter.

The Admission assessment dated [DATE] revealed per the urinary continence section that Resident #11 always continent. The option for an indwelling catheter was not selected. The Narrative Notes section at the bottom of the assessment revealed, Foley catheter 16 french present draining yellow urine hang to bedside to drain.

Review of the Documentation Survey Report dated March 2024 revealed the following options had been selected for the resident for bladder elimination during the month:

a. Code 1: incontinent

b. Code 3: continence not rated due to indwelling catheter

c. Code 4: continence not rated due to condom catheter

Review of the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated March 2024 lacked any orders related to a catheter for this resident.

Review of hospice documentation for the resident electronically signed on 3/4/24, 3/9/24, and and 4/4/24 revealed the resident had a foley catheter.

The Physician Order dated 4/3/24 revealed, Foley Catheter French: 16 Balloon: 10 Dx (diagnosis): Hospice comfort care.

Observation conducted of Resident #11 on 5/2/24 at 10:24 AM revealed the resident in a recliner, and the resident observed to have a catheter.

On 5/2/24 at approximately 12:50 PM, the Assistant Director of Nursing (ADON) acknowledged the nurses' documentation did not show a foley, and when the MDS was coded did not show a foley.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/24 at 2:19 PM when queried about orders for a catheter, the ADON explained there would be an order to change it, per the ADON completed every 28 to 30 days at facility. The ADON further explained there would be a place to put in what size catheter and what fill the balloon to, as well as to change the bag. The ADON explained the resident's family made a decision to put the resident on hospice and that was when the resident got the foley. The facility policy titled Catheterization of a Female dated 12/1/23 did not address the area of concern. 47336 2. The MDS assessment dated [DATE] revealed Resident #19 scored a 12 out of 15 on the BIMS exam, which indicated moderately impaired cognition. The MDS revealed resident used an indwelling catheter. The Care Plan lacked documentation of an indwelling catheter. The Physician Orders lacked documentation of an order. During an observation on 5/1/24 at 12:04 PM, Resident #19 sat in his wheelchair in the dining room at a table. His catheter tubing touched the ground. During an interview on 5/2/24 at 1:57 PM, Staff I, CNA (Certified Nurse Aide) queried if the urinary catheter tubing could touch the floor and she stated no, it was placed on the hooks under the wheelchair or it could be placed in the dignity catheter bags. During an interview on 5/2/24 at 2:05 PM, Staff J, CNA queried if the urinary catheter bag could touch the floor and she stated no, they moved it up on the bar under the wheelchair and make sure the urine didn't back up. During an interview on 5/2/24 at 3:32 PM, the ADON (Assistant Director of Nursing) queried where the catheter needed to be placed on the wheelchair and if the tubing could touch the ground and she stated the catheter bag needed placed in a privacy back and the tubing tucked in the privacy back. She stated no, the tubing shouldn't touch the floor for infection control reasons.

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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 0692

Level of Harm - Actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 35434

Based on observations, clinical record review, policy review, staff interviews, family interview and resident interviews, the facility failed to develop and implement interventions to prevent/treat weight loss for 2 of 5 residents reviewed for nutrition (Residents #13 and #52) and failed to provide ordered supplements for 2 of 5 residents reviewed for nutrition (Residents #18 and #34). The facility reported a census of 58 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment tool, dated 3/27/24, listed diagnoses for Resident #52 which included dementia, adult failure to thrive, and muscle weakness. The MDS stated the resident required partial/moderate assistance with eating and listed her Brief Interview for Mental Status (BIMS) score as 7 out of 15, indicating severely impaired cognition.

A Dietary Assessment, dated 3/26/24 listed the resident's weight as 97.8 lbs.

The residents Weight Summary report documented the resident weighed 99.8 lbs on 3/22/24 and 93.0 lbs on 4/16/24, which calculated as a 6.81% loss.

Care Plan entries, dated 3/26/24, stated the resident had the potential for altered nutritional status and directed staff to:

a. provide alternate meals if she did not like the meal served;

b. offer milkshakes with meals;

c. provide supervision and assistance at meals as needed;

d. notify the physician of significant weight changes.

The Care Plan did not address the resident's weight loss and did not include additional interventions to assist the resident in gaining weight.

A 4/24/24 Clinic Note did not address the resident's weight loss and stated nursing reported no concerns.

The facility lacked documentation of provider notification of the resident's weight loss and lacked documentation of further interventions attempted from 4/16/24 until the start of the survey week on 4/29/24.

On 4/29/24 at 4:00 p.m., observed the resident sitting in her room and a plate of food untouched in front of her. The utensils clean and had not been used.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 5/1/24 at 3:30 p.m., the Assistant Direct of Nursing (ADON) stated if a resident had a weight loss, they would start supplements and consult with the dietician and the provider. She stated she would look to see if there was any physician communication to the provider. On 5/2/24 at 10:04 a.m., the ADON stated the facility obtained an order for supplements and they implemented that nurses would document the weights. She stated she spoke with staff about providing feeding assistance to the resident. The facility policy Nutrition and Hydration to Maintain Skin Integrity, revised October 2010, stated the procedure would provide guidelines for the assessment of resident nutritional needs to aide in the development of an individualized care plan. The policy directed staff to conduct nutritional assessments for each resident as indicated by a change in condition and to define meaningful interventions for the resident at risk for or with impaired nutrition. 47336 2. The MDS assessment dated [DATE] revealed Resident #13 scored a 6 out of 15 on the BIMS exam, which indicated moderately impaired cognition. The MDS revealed the resident required set up or clean up assistance with eating. The MDS revealed diagnoses of depression, schizophrenia, and non-Alzheimer's dementia. The MDS revealed a loss of 5% in one month or 10% in 6 months without a prescribed weight-loss regimen. The MDS revealed the resident took an antidepressant. The Care Plan revealed a focus area revised on 3/18/24 for dysphagia and a risk for aspiration pneumonia, excessive salivation, airway obstruction and dehydration. The interventions dated 10/19/23 revealed encourage resident to eat slowly and take small bites and small single sips and provide appropriate diet consistency as ordered. The Care Plan revealed a focus area revised on 4/25/24 for a nutritional problem related to her history of dementia, diabetes mellitus hyperlipidemia, GERD (gastroesophageal reflux disease), depressive episodes, constipation and the need for a mechanically altered diet texture. Resident at risk for weight loss related to her history of decreased appetite (significant losses noted March and April 2024). The interventions dated 3/10/24 revealed to honor food preferences and special requests as able. The resident enjoyed drinking chocolate milk, hot chocolate, orange juice, or water, which needed thickened to nectar consistency. The interventions revised on 3/10/24 revealed general/pureed, nectar thick liquid diet with provided assistance as needed. The Weight Summary revealed the following weights: a. 10/2/23 12:26 AM 131.8 Lbs b. 11/25/23 11:07 AM 129.4 Lbs c. 12/5/23 11:16 AM 128.0 Lbs d. 1/1/24 1:02 PM 124.6 Lbs e. 2/2/24 10:42 AM 121.4 Lbs (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	f. 2/22/24 12:06 PM 121.0 Lbs g. 3/11/24 10:01 AM 117.4 Lbs h. 4/4/24 1:59 PM 113.0 Lbs On 10/02/2023, the resident weighed 131.8 lbs. On 02/23/2024, the resident weighed 117.4 pounds which is a -10.93 % Loss. On 10/02/2023, the resident weighed 131.8 lbs. On 04/04/2024, the resident weighed 113 pounds which is a -14.26 % Loss. The Physician Orders revealed the following orders: a. ordered on 3/7/24- regular diet, pureed texture, nectar consistency with small bites and sips liquid to assist for dysphagia b. start date of 3/12/24- House Supplement 60 ml - two times a day The Progress Note dated 3/12/24 at 1:34 PM, revealed the Dietician recommends adding House Supplement 60 ml (milliliter) BID (twice a day) due to weight loss. The resident representative called and notified of new order, and the doctor faxed. The Dietary Note dated 4/25/24 at 8:15 PM, revealed based on April monthly weight of 113 pounds (4/4), Resident #13 experienced significant weight losses of 9.3% x 3 mo. and 14.3% x 6 mo. She triggered for loss last month as well. The diet texture downgraded on 3/7/24. House supplement 60 ml BID between meals ordered on 3/18, and will continue this intervention. Meal intakes averaging 50-60% at meals. Noted GDR for Duloxetine ordered 4/11, which had the potential to impact appetite/intake. Care plan updated. Requested nursing notify provider of weight status. The Provider Note dated 4/11/24 lacked documentation of the resident's significant weight loss. The April MAR revealed the following dates the resident did not received the house supplement due to medication not available: a. 4/13/24 at 10:00 AM b. 4/13/24 at 2:00 PM c. 4/14/24 at 10:00 AM d. 4/14/24 at 2:00 PM e. 4/15/24 at 10:00 AM f. 4/15/24 at 2:00 PM g. 4/16/24 at 10:00 AM (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	h. 4/16/24 at 2:00 PM i. 4/17/24 at 10:00 AM j. 4/17/24 at 2:00 PM k. 4/18/24 at 10:00 AM l. 4/18/24 at 2:00 PM m. 4/19/24 at 10:00 AM n. 4/19/24 at 2:00 PM o. 4/28/24 at 2:00 PM p. 4/29/24 at 10:00 AM q. 4/29/24 at 2:00 PM r. 4/30/24 at 10:00 AM s. 4/30/24 at 2:00 PM During an interview on 4/30/24 at 9:17 AM, the resident representative stated Resident #13 had weight loss and she had a hard time swallowing. She stated the resident didn't like the soft food and it being all mixed up, but the resident representative thought her mom was getting to used to it. During an observation on 4/30/24 at 12:24 PM, the resident served lunch of glass of water and a glass of milk. The meal served in a divided plate with pureed beans and [NAME] in one section, and pureed Italian blend vegetables in another section. During an observation on 4/30/24 at 12:36 PM, staff came over to the resident and pushed her plate gently in front of her, and the resident shook her head sideways. The staff member left and the resident continued to drink her milk. During an observation on 4/30/24 at 12:53 PM, Resident #13 ate less than 25% of her meal, and drank her 8 ounces of milk. She didn't get served her pureed bread. During an interview on 5/1/24 at 1:43 PM, the Dietary Manager queried if the resident received any options at meals and she stated puree diets don't get options. She stated they get whatever is on the menu. The Dietary Manager asked if the resident given choices if she didn't eat what she was served and she stated she never really thought about it. The Dietary Manager asked if anyone prompted Resident #13 to eat and she stated she prompted her once or twice but she didn't think the CNA prompted her. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/2/24 at 1:18 PM, Staff C, RN (Registered Nurse) stated at times it was hard to get Resident #13 to eat. Staff C stated they gave her supplements to help build her weight back up. During an interview on 5/2/24 at 1:44 PM, the ARNP (Advanced Registered Nurse Practitioner) stated she didn't see Resident #13 for weight loss but her and the doctor alternate. During an interview on 5/2/24 at 2:03 PM, Staff J, stated Resident #13 felt like a hit and miss situation, sometimes the resident ate everything and other times wouldn't eat at all. Staff J didn't know if it was because of the texture or something else. She stated when the resident did eat, it took a lot of encouraging and she needed to approach her multiple times to eat. Staff J stated she thought the resident's drink were optional and they could give her cottage cheese or yogurt. During an interview on 5/2/24 at 2:51 PM, the ADON queried on Resident #13 weight loss and she stated she knew they had issues with her weight loss and tried to implement different things. She stated at one time they had issues getting her weights completed, but now they hired someone to do the weights. The ADON stated the nurse needed to put in the weights on the computer otherwise the weight loss wouldn't pop up. She stated she hoped with the nurse putting in the weights, the communication would improve with her and the provider. The ADON stated if the alert came up, the resident needed assessed earlier, and a fax needed sent at the very least. The ADON stated if the residents had a 3 pound weight loss, the doctor needed notified. The ADON asked if the resident received choices or prompted to eat her meals and she stated with Resident #13, it was difficult because they tried to assist her before and the resident wouldn't eat. The ADON stated they should probably give her choices, but if the resident not eating, she not going to eat. She stated the staff needed to least offer the residents options. 45338 3. Review of the MDS assessment dated [DATE] for Resident #18 revealed the resident was rarely to never understood. The Physician Order dated 9/7/23 for Resident #18 revealed, an order for House Supplement three times a day for Dietary Supplement 90 ml (milliliter). Review of the resident's Medication Administration Record (MAR) dated April 2024 revealed 21 instances in the month of April when the resident's supplement was marked with a code of 11, which indicated the medication was not available. 4. The MDS assessment for Resident #34 dated 2/1/24 revealed the resident scored 00 out of 15 on a BIMS assessment, which indicated severely impaired cognition. The Physician Order dated 10/28/22 documented, an order for House Supplement three times a day 120 ml. Review of the resident's Medication Administration Record (MAR) dated April 2024 revealed 26 instances in the month of April when the resident's supplement was marked with a code of 11. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview conducted on 5/2/24 at 12:56 PM, the facility's Assistant Director of Nursing (ADON) queried about trouble getting the house supplement, and responded there was a time when had issues with back ordered and not being available. Per the ADON, it did take a little while to come in, and with the change of corporations and suppliers there were a few times it took longer to come in.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on observations, resident interviews, staff interviews, clinical record review, and the facility policy, the facility failed to provide adequate staffing to prevent a fall with injury; answer call lights in a timely manner; provide feeding and bathing assistance; and provide a bed pan to a resident before an incontinent accident for 6 of 19 residents (Residents #10, #12, #19, #28, #46, #207). The facility census 58 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 scored a 12 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated moderately impaired cognition. The MDS revealed Resident #19 used a wheelchair and dependent with toilet transfer and transfer to the chair/bed to chair. The Care Plan revealed a focus area dated 3/10/22 for required assistance with ADLs (activities of daily living) due to recent right shoulder surgery with need for immobilizer. The interventions revised on 2/15/24 revealed resident utilized an sit to stand lift with assist of 2 staff. The Progress Note dated 1/8/24 at 10:33 AM, revealed the CNA (Certified Nurse Aid) responded to call light and asked resident to give her a second so she could gown up, at that time other CNA called and stated that other resident climbed out of her wheelchair. They repositioned that resident and CNA then finished gowning up and then at that point she heard a crash and heard resident say ouch. She then opened the door and saw resident laying on the floor and called for the nurse. During an interview on 4/29/24 at 2:12 PM, Resident #19 stated at times it could take a couple hours for the staff to answer a call light. He stated he watched the clock to know how long it took them. 2. The MDS assessment dated [DATE] revealed Resident #207 scored a 13 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed resident dependent with toilet transfer and chair/bed to chair transfer. The MDS revealed resident occasionally incontinent of bowel. The Care Plan revealed a focus area revised on 4/29/24 for self-care deficit due to diagnosis of right femur fracture, arthritis in right hip and rib fractures. The interventions revised on 5/1/24 directed staff to encourage use of bed side commode for toileting using 1 assist and front wheeled walker. Respect the resident rights to refuse. During an interview on 4/29/24 at 11:22 AM, Resident #207 stated the other day he asked for a bed pan at 10 am and didn't get one until 3 PM. He stated he turned on the call light but the staff were overly busy. He stated he had an incontinent episode because he couldn't hold it anymore. He stated when they brought his food in for lunch, they didn't ask if he needed to use the restroom, they just brought in his food. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/29/24 11:26 AM, Resident #207 stated they usually emptied his urinal pretty regular but this morning they didn't change it in time before he urinated again and he spilled some of the urine on his incontinent brief and they needed to change him. 3. The MDS assessment dated [DATE] revealed Resident #10 scored a 14 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed the resident used a wheelchair and dependent with chair/bed to chair transfer. The Care Plan revealed a focus area revised on 4/23/24 for assistance with ADLs due to multiple sclerosis, paraplegia, neurogenic bladder with Foley use, chronic pain syndrome, anemia, congestive heart failure with chronic respiratory failure, depression, and anxiety. The interventions revised on 4/29/24 revealed resident used a full sling Hoyer lift with a 2 person assistance for transfers from surface to surface. The wheelchair used for all locomotion's and propelled by staff if requested. Resident preferred to stay in bed. During an interview on 4/29/24 at 1:46 PM, Resident #10 stated he stayed in bed most of the time because if he got up in his wheelchair his legs would fall asleep after an hour and the staff couldn't seem to come back in a timely manner to get him back to bed. They walk by but they don't have enough people to help him back to bed. Resident #10 stated he used the call light, but waited 2 hours and 25 minutes and they said they would come back. He stated he didn't make demands on staff. During an interview on 5/2/24 at 10:45 AM, Staff G, LPN (Licensed Practical Nurse) stated she didn't think the facility staffed enough nurses. She stated when she worked days, they did but there were 3 nurses working. She stated she just went to night shift because the night nurse left and now they only have one nurse per shift. She stated the facility currently didn't have applicants. The Facility Call Lights Accessibility and Timely Response dated 12/1/23 revealed the purpose of the policy was to assure the facility adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. The Facility Call Lights Accessibility and Timely Response dated 12/1/23 revealed the following information: a. All staff members who saw or heard an activated call light were responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. b. Process for responding to call lights: 1. Turn off the signal light in the resident's room. 2. Identified yourself and call the resident by name. 3. Listen to the resident's request and respond accordingly. Informed the resident if you cannot meet the need and assured him/her that you will notify the appropriate personnel. 4. Informed the appropriate personnel of the resident's need. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Do not promise something you cannot deliver. 6. If assistance needed with a procedure, summon help by using the call light. Stay with the resident until help arrives. 45338 3. Review of the MDS assessment for Resident #12 dated 3/28/24 revealed the resident scored 2 out of 15 on a BIMS exam, which indicated severely impaired cognition. Per this assessment, the resident was independent for eating. The Dietary assessment dated [DATE], noted to be the same day as the resident's MDS, revealed the resident required set up assist and encouragement/cues. The Comments section documented, She is able to feed herself after set-up and utilizes weighted silverware; staff may provide occasional PRN (as needed) assist. Observation of Resident #12 during the lunch meal on 4/30/24 revealed the following: a. 12:22 PM: Resident #12 served the meal. The resident had a built up utensil and not observed to eat. The resident had pureed food in a pink divided plate, and also had a small dish with jello. b. 12:25 PM: Resident #12 observed with their eyes closed and arms crossed across their chest. c. 12:30 PM: Resident #12's lunch remained in front of the resident and the resident remained without assistance. d. 12:33 PM: The resident had their arms to chest, and the utensil remained resting in the resident's plate. e. 12:39 PM: Resident #12 observed to be awake. Resident #12's food present in front of her, and the resident did not eat the food served. Staff not observed to offer assistance. f. 12:44 PM: Resident #12 picked up a utensil, had food on the utensil, and the utensil sat on the lip of the divided plate. g. 12:46 PM: Resident #12 picked up their spoon and had upside down (curved side facing downwards). The resident ate, and licked the back of the spoon. h. 12:48 PM: The resident ate food in front of them. At the times of observations documented above, other than at the time of delivery of the meal, observations lacked facility staff providing encouragement, cueing, or assistance for Resident #12, although other residents were provided with dining assistance. 35434 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 5/1/24 at 7:57 a.m., Resident #12 sat at a dining table alone and had a plate of pureed food in front of her. The resident had a clear liquid spilled on her lap and dripping down to the floor. No staff member assisted the resident and she put a spoon in her food and then into her mouth but no food was on her spoon. Other staff members arrived in the dining room but began to assist other residents. At 8:08 a.m., the resident had liquid dripping out of her mouth and liquid was still visible on her lap. At 8:11 a.m., the resident dipped the handle of her adaptive fork into her pureed food and placed it into her mouth to lick it off. Very little food entered the resident's mouth. The resident remained unassisted until 8:15 a.m. 4. The 2/21/24 MDS assessment tool, dated 2/21/24, listed diagnoses for Resident #28 which included depression, diabetes, and non-Alzheimer's dementia. The MDS listed the resident's cognition as 15 out of 15, indicating intact cognition. A 10/4/21 Care Plan entry stated the resident preferred to complete bathing with the assistance of 1 staff. On 4/29/24 at approximately 1:00 p.m., Resident #28 stated he missed 5-6 showers this year and had gone 2 weeks without a shower. He stated he had to wait as long as 30 minutes for staff to answer his call light. The March 2024 Documentation Survey Report documented the resident received a bath on 3/14/24 and refused a bath on 3/21/24. The report lacked documentation the resident received or was offered an additional bath within that time frame. The April 2024 Documentation Survey Report documented the resident received a bath on 4/1/24 and 4/8/24. The report lacked documentation the resident received an additional bath within the time frame. The report documented the resident received a bath on 4/25/24 but did not receive an additional bath in April after this date. On 5/6/24, the facility provided paper Bathing/Skin Observation Sheets via email for Resident #28. The sheets did not contain documentation of additional bathing assistance provided during the above time frames. On 5/2/24 at 12:37 p.m., the Assistant Director of Nursing (ADON) stated residents were scheduled for 2 baths per week. She stated she knew showers did not get done but did not attribute it to a staffing issue. She stated some staff could complete the showers but others could not. 5. The MDS dated [DATE] documented Resident #46 scored 15 out of 15 on the BIMS indicating intact cognition. The MDS documented the resident as dependent on staff for transfers, repositioning and toileting. On 4/30/24 at 8:52 a.m., Resident #46 stated she sometimes had to wait 1-3 hours for staff to answer her call light. She stated she used the clock on her wall to time the call light response time.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on staff interviews, clinical record review, and the facility policy, the facility failed to ensure the resident didn't have two active orders for the same opioid medication for 1 of 1 residents reviewed for pain (Resident #208). The facility reported a census of 58 residents. Finding include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #209 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed diagnosis for multiple sclerosis. The MDS revealed one Stage 2 pressure ulcer, one Stage 3 pressure ulcer, and one Stage 4 pressure ulcer present on admission. The MDS revealed resident took opioids. The Care Plan revealed a focus area dated 4/12/24 for multiple sclerosis and at risk for a decline in current activities of daily living (ADL) self-performance level and injuries due to increased weakness, pain, fatigue, and impaired coordination. The Care Plan revealed a focus area dated 4/23/24 for Stage 4 pressure ulcer to the right hip, Stage 3 pressure ulcer to the left heel, and Stage 2 pressure ulcer to the right ankle. The inventions dated 4/23/24 revealed administration of pain medications as per orders to treatment/turning to ensure the resident's comfort. The Physician Orders revealed the following medication orders: a. ordered 4/14/24- hydrocodone/acetaminophen tablet 5/325 mg (milligram) *Controlled Drug*- give 2 tablet orally every 6 hours as needed for pain b. ordered 4/15/24- hydrocodone/acetaminophen oral tablet 5-325 mg *Controlled Drug*- give 1 tablet orally every 6 hours as needed for pain The April Medication Administration Record (MAR) revealed the following dates the duplicate orders documented as given at the same time or within the 6 hours. a. 4/25/24 at 3:49 PM- 1 tablet of hydrocodone/acetaminophen documented as administered b. 4/25/24 at 3:50 PM- 2 tablets of hydrocodone/acetaminophen documented as administered c. 4/27/24 at 3:13 PM- 1 tablet of hydrocodone/acetaminophen documented as administered d. 4/27/24 at 9:01 PM- 2 tablets of hydrocodone/acetaminophen documented as administered During an interview on 5/2/24 at 1:21 PM, Staff C, RN (Registered Nurse) queried if the resident's record revealed 2 active orders for hydrocodone/acetaminophen and she stated yes, she saw 2 orders and that needed changed. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/2/24 at 3:17 PM, the ADON (Assistant Director of Nursing) queried on the resident's duplicate orders for hydrocodone/acetaminophen and she stated when the resident came in he took 1 tablet for wound changes and 2 tablets for pain. She stated sometimes she saw two orders for residents with severe pain but if they had 2 orders there needed to be 6 hours between doses. The Facility Administration Medications Policy dated December 2012 revealed the following information: a. medications must be administered in accordance with the orders, including any required time frame. b. the individual administering medications verified the resident, right medication, right dosage, right time, and the right method (route) of administration before giving the medication.

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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** 35434 Based on clinical record review, policy review, and staff interviews, the facility failed to carry out gradual dose reductions (GDR's) for 2 of 5 residents reviewed for psychotropic medications (Residents #13 and #28). The facility reported a census of 58 residents. Findings include: 1. The 2/21/24 Minimum Data Set (MDS) assessment tool, dated 2/21/24, listed diagnoses for Resident #28 which included depression, diabetes, and non-Alzheimer's dementia. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. A 10/18/21 Care Plan entry stated the resident received antidepressant medication related to depression and insomnia. An Order Details report listed a 2/6/23 order for Trazadone (an antidepressant) 100 milligrams (mg) at bedtime for insomnia. A 1/8/24 Pharmacist Recommendation to Prescriber report stated the resident received Trazadone 100 mg for depression and was a candidate for a GDR. The report had a mark next to the prescriber response option of agree. A 2/26/24 provider Progress Note stated the resident received Trazadone 100 mg. The May 2024 Medication Administration Record(MAR) documented the resident currently received Trazadone 100 mg. The facility lacked documentation staff carried out the physician guidance to decrease the resident's Trazadone. On 5/1/24 at 3:30 p.m., the Assistant Director of Nursing (ADON) stated it was her understanding the resident's Trazadone was reduced. On 5/2/24 at 10:04 a.m., the ADON stated she was mistaken with regard to the resident's Trazadone as she was thinking of a different medication. She stated the resident's GDR was missed. 47336 2. The MDS assessment dated [DATE] revealed Resident #13 scored a 6 out of 15 on the BIMS exam, which indicated cognition severely impaired. The MDS revealed the resident received an antidepressant. The MDS revealed a diagnosis of depression. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Keosauqua Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 819 Country Lane Road Keosauqua, IA 52565	

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan revealed a focus area revised on 10/27/23 for a diagnosis of depression and resident received medication for the disease process. The interventions dated 2/3/22 revealed administration of an antidepressant medication as ordered by the primary care provider (PCP). The interventions dated 1/22/24 revealed antidepressant medication decreased by PCP/GDR (gradual dose reduction); observe for signs/symptoms of increased depression and notify PCP as needed. The Physician Orders revealed the following orders: a. Duloxetine 20 mg (milligram)- give 2 tablets- ordered on 5/8/23 and discontinued on 1/20/24 b. Duloxetine 30 mg- give 1 tablet- ordered on 1/23/24 The Pharmacist's Recommendation to Prescriber dated 11/2/24 revealed Resident #13 took Duloxetine 40 mg once daily for depression and a candidate for a gradual dose reduction. A safe dose reduction should occur in modest increments over an adequate period of time to minimize withdrawal symptoms and to monitor symptom reoccurrence. The provider agreed to the recommendation on 11/14/23. The Progress Note dated 11/14/23 at 4:31 PM, revealed called daughter and advised of pharmacist recommendations/approved by Advance Registered Nurse Practitioner (ARNP) of suggestion of gradual dose reduction in her Duloxetine to 30 mg once a day. The pharmacy faxed. The Pharmacist Recommendation to Prescriber dated 1/8/24 revealed Prescriber agreed with November's pharmacy recommendation to decrease Duloxetine to 30 mg daily. However, change not implemented, as it is still listed as 40 mg on the Medication Administration Record (MAR). The Progress Note dated 1/20/24 at 5:29 PM, revealed received pharmacy recommendation to decrease Duloxetine to 30 mg daily in November but was not implemented. Duloxetine order updated at this time. During an interview on 5/2/24 at 3:00 PM, the ADON queried on Resident #13 Duloxetine GDR in November and not implemented until January and she stated she didn't know and needed to look and she originally thought the DON (Director of Nursing) took it but she just recently took it over since the interim DON worked the floor. The ADON stated the GDR should of been implemented in November. The Facility Use of Psychotropic Medications dated 12/1/23 revealed the following information: a. Residents were not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). b. Residents who used psychotropic drugs received gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434 Based on observations, menu review, policy review, and staff interviews, the facility failed to ensure 18 of 18 residents receiving a mechanical soft diet received the correct meal portion and failed to ensure 6 of 6 residents receiving a pureed diet received food in accordance to the menu. The facility reported a census of 58 residents. Findings include: The Week 2 Tuesday Menu directed staff to serve residents receiving a mechanical soft diet 1 serving of beans and ground [NAME], soft garlic bread, and 4 ounces of vegetables. The menu directed staff to serve residents receiving a pureed diet 1 serving of pureed beans and [NAME], 1 serving of pureed garlic bread, and 1 serving of pureed vegetables. On 4/30/24 at 9:45 a.m., the Dietary Manager cut 19 hot dogs into chunks and processed them to a ground consistency. She then measured the volume as 8 cups and walked over to a chart on the wall and stated she would use a #10 scoop. She transferred the hot dogs into a pan and added 19 scoops of baked beans. She did not then measure the total volume of the hot dogs and the beans. The noon meal service on 4/30/24 at 12:00 p.m. revealed the following concerns: a. The Dietary Manager served 18 residents a mechanical soft diet. When she was finished serving the residents, she had over 5 servings of food left. The Dietary Manager acknowledged that she had too much left over and she did not measure the hot dogs with the beans. b. The Dietary Manager served 6 residents a pureed diet. She served the residents a portion of pureed mixed vegetables and a portion of pureed hot dogs and beans. She did not serve the residents pureed bread. On 4/30/24 at 2:57 p.m., the Dietary Manager stated the residents should have received pureed bread. The undated facility policy Process for Mechanically Grinding directed staff to measure out the desired number of servings, place food in the grinder and grind to appropriate texture, measure the total volume of food, and divide the total volume of ground by the original number of servings.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 35434 Based on clinical record review, policy review, resident interviews and staff interviews, the facility failed to offer bedtime snacks to 2 of 2 residents who desired bedtime snacks (Residents #28 and #46). The facility reported a census of 58 residents. Findings include: 1. The 2/21/24 Minimum Data Set (MDS) assessment tool, dated 2/21/24, listed diagnoses for Resident #28 which included depression, diabetes, and non-Alzheimer's dementia. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. On 4/29/24 at approximately 1:00 p.m., Resident #28 stated staff did not offer him bedtime snacks. He stated he would like staff to offer him a snack. The Documentation Survey Report for April 2024 listed an entry for Snacks at 7:00 p.m. The following dates were blank or stated NA-Not Applicable and lacked documentation staff offered the resident a snack: 4/7/24, 4/8/24, 4/9/24, 4/11/24, 4/13/24, 4/15/24, 4/16/24, 4/18/24, 4/19/24, 4/20/24, 4/21/24, 4/24/24, 4/25/24, 4/26/24, 4/29/24, 4/30/24. 2. The MDS assessment tool, dated 3/20/24, listed diagnoses for Resident #46 which included anxiety, depression, and muscle weakness. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition. On 4/30/24 at 8:52 a.m., Resident #46 stated that they did not get bedtime snacks currently. She stated they used to get them around 7:30 p.m. but staff stated corporate discontinued the snacks. The Documentation Survey Report for April 2024 listed an entry for Snacks at 7:00 p.m. The following dates were blank or stated NA-Not Applicable and lacked documentation staff offered the resident a snack: 4/7/24, 4/8/24, 4/9/24, 4/10/24, 4/11/24, 4/13/24, 4/14/24, 4/16/24, 4/18/24, 4/19/24, 4/20/24, 4/21/24, 4/22/24, 4/24/24, 4/25/24, 4/26/24, 4/29/24, 4/30/24. On 5/1/24 at 10:03 a.m., via phone, Staff E Certified Nursing Assistant (CNA) stated lately staff had not been able to offer residents snacks. He stated they were busy assisting residents to bed. He stated within the last month and a half, they have been trying to take care of residents and have not had time to offer snacks. On 5/1/24 at 10:11 a.m., via phone, Staff F CNA stated sometimes there were no snacks available to pass at bedtime. He stated the company changed hands and at certain points there were no snacks to provide. He stated staff sometimes went to the store themselves to buy residents snacks. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 1:43 p.m., the Dietary Manager stated the kitchen evening staff prepared the snack cart for bedtime snacks and left it for the nursing staff. She stated they had some trouble getting snacks when the new company took over because they were trying to think about the budget. She stated things were improving though now. On 5/2/24 at 12:37 p.m., the Assistant Director of Nursing (ADON) stated staff should pass snacks to residents. She stated with the new corporation, they did not have all of the snacks available that they used to that residents wanted. The facility policy Snacks, revised 7/2023, stated all residents would be offered a bedtime snack.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35434 Based on observations, facility document review, policy review, and staff interviews, the facility failed to maintain adequate kitchen sanitation and failed to follow infection control measures to prevent cross contamination during food service for 1 of 1 meal observed. The facility reported a census of 58 residents. Findings: The initial kitchen tour on 4/29/24 at 9:30 a.m., revealed the following concerns: a. Staff B Dietary Aide washed dishes using the dish washing machine. Upon request, Staff A [NAME] ran the machine again. The wash temperature gauge on the side of the machine read 108 degrees Fahrenheit. Staff A then ran the machine a second time and the wash temperature gauge read 108 degrees Fahrenheit. A sign on the side of the machine stated the minimum wash temperature should reach 155 degrees Fahrenheit. The Dietary Manager stated the facility did not have any strips to test the functioning of the machine and stated she could not remember the last time they had the strips. b. The water in the hand washing sink cold to the touch. Staff A stated this just started today and they called someone to fix it. c. The dish machine had a heavy buildup of a thick, dry looking white substance in the seams of the machine and on the underside of the door. d. Black stains and debris present on the floors around the dish machine. e. A thick layer of dust on the shelf above the stove burners. f. Red food debris hung down from the underside of the shelf directly above the stove burners. g. Dust particles hung from the spigots of the fire suppression system located directly above the stove burners. h. [NAME] food debris hung down from the ceiling of the microwave with black buildup in the corners and the seams of the microwave walls. Observations during the noon meal service on 4/30/24 at 12:00 p.m. revealed the following concerns: a. The water in the hand washing sink cold to the touch. The Dietary Manager and other staff utilized this sink to wash their hands. b. Red food smears on the outside of the black plastic covering the stand mixer. c. [NAME] food splatters on the inside of the stand mixer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. A layer of gray dust particles on the ceiling vents above the prep table and the 3-compartment sink. e. The Dietary Manager wore gloves during the meal service and touched menu sheets, the pockets of her uniform, her facial mask, plates, and coughed into her gloves. With the same gloves on, she then walked out into the dining room and touched a mug and the coffee spigot and served coffee to a resident. f. The Dietary Manager wore a new pair of gloves but touched her facial mask with her right hand. She then went into the kitchen and picked up a tuna sandwich with her gloved right hand and served it to a resident. On 4/30/24 at 10:11 a.m., Staff K, dish machine company representative, stated to the Dietary Manager that the wash temperature should be at least 155 degrees Fahrenheit and the Dietary Manager stated she had never seen it that high. The dishwashing machine company Equipment Service History, dated 4/30/24, stated the machine took 20 minutes to get to temperature on the wash and the machine had buildup and was cleaned. On 4/30/24 after the noon meal service, the Dietary Manager stated she recently located some additional staff cleaning lists she would implement. On 5/1/24 from 1:08 p.m.-1:10 p.m. the hand washing sink in the kitchen ran cold. On 5/1/24 at 1:43 p.m., the Dietary Manager stated they turned the heat up in the kitchen to get the water temperature in the hand washing sink high enough. She stated staff should not touch ready-to-eat food with gloves on. She stated they would test the dishwasher regularly. The facility policy General Food Preparation and Handling, reviewed 7/2023, stated: -the kitchen was kept neat and orderly. -all food service equipment should be cleaned and sanitized. The facility policy Food Safety Requirements, implemented 12/1/23, stated food would be distributed and served in accordance with professional standards for food service safety. The policy stated staff should exhibit appropriate use of gloves

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F 0865 Level of Harm - Potential for minimal harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 47336 Based on staff interview, review of CMS-2567 reports, and facility QAPI (Quality Assurance and Performance Improvement) Plan, the facility failed to ensure an effective QAPI (Quality Assurance Performance Improvement) process to address previously identified quality deficiencies, resulting in multiple repeat deficiencies identified on the facility's current recertification and complaint survey previously identified during surveys completed in the last 19 months. The facility reported a census of 58 residents. Findings include: a. The CMS-2567 form from a recertification survey dated 8/29/22 to 9/1/22 revealed the facility issued a deficient practice for dignity, professional standards not met, and food procurement, store/prepare/serve and sanitation with no actual harm level citation. b. Review of the facility's CMS-2567 form from a complaint survey which occurred 7/20/23 to 8/2/22 revealed the facility received a harm level for accident hazards/supervision, and a no actual harm level citation for activities of daily living/maintain abilities. c. The CMS-2567 form from a complaint and incident revisit survey which occurred on 10/9/23 to 10/11/23 revealed the facility received a no actual harm level citations for accident hazards/supervision, dignity, and QAPI program/good faith effort. The facility's current recertification survey, entrance date 4/29/24, resulted in a harm level deficient practice for accident hazards/supervision and no actual harm level citations for dignity, QAPI program/good faith effort, activities of daily living/maintain abilities, meeting professional standards, and food procurement, store/prepare/serve and sanitation. During an interview on 5/2/24 at 4:02 PM, the Administrator queried on how long they keep a process in QA (Quality Assurance) and he stated usually about 3 to 4 months. The Administrator asked how he knew the plan sustainable and he stated they looked at the quality measures and if no improvement they know they didn't do their job and go back to the drawing board. The Administrator informed of the multiple repeated citations and he stated the last survey they didn't have fall citations and the citation on the food concerned the food recipes and taste. He stated the falls had some injuries but not compared to the amount of falls they had. He stated he didn't think the QAPI program ineffective and their quality measures went from a 2 to 3 star and on the verse of a 4 star. The Facility QAPI Plan dated 9/12/13 revealed the following guideline principles: a. The facility's expected areas for improvement identified and provided for a non-retaliatory process that prompted input from staff, residents, resident representatives, and family members. b. Information received through our feedback, data systems, and monitoring programs will be used to develop effective plans that promote safety, quality of care, quality of life, and resident satisfaction. (continued on next page)

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F 0865 Level of Harm - Potential for minimal harm Residents Affected - Many	c. The QAPI efforts were system based, focused on the entirety of a system rather than an individual. These efforts were structured and comprehensive, included the use of Root Cause Analysis, to identify problems, causes and the implications of change. The Facility QAPI Plan dated 9/12/13 revealed the performance improvement plans: a. prioritization of performance improvement plans were based on the scope and severity of the identified issue and the potential impact the issue had on resident safety, clinical outcomes and satisfaction. b. performance improvement plans communicated as often as deemed necessary to assure positive outcomes, through postings to relevant employees/departments, submission of plans to regional management team (if requested) and QAPI committee and all other methods as deemed necessary by Performance Improvement Project (PIP) and/or QAPI committee. c. The Systematic Analysis and Action revealed the QAPI committee reviewed all PIP's and outcomes to assure efficacy and sustainability.