STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165228	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dubuque Specialty Care	2935 Kaufmann Avenue Dubuque, IA 52001

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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** 48452 Based on record review, resident interviews, staff interviews, and policy review the facility failed to treat residents with dignity and respect for 2 of 6 residents reviewed for dignity (Residents #36 and #214). The facility reported a census of 58 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #36, dated 4/5/24 documented a Brief Interview for Mental Status (BIMS) of 15 out of 15, which indicated intact cognition. The MDS reflected diagnoses of diabetes mellitus, morbid obesity, and need for assistance with personal care. The MDS indicated Resident #36 was dependent for toileting and transfers, and required partial to moderate assistance for sitting to lying and lying to sitting. The resident's Care Plan included a focus area dated 10/6/23 related to activities of daily living (ADL), with a goal to continue to participate during ADLs and an intervention required assist of 2 staff with toileting. A focus area dated 10/13/22 indicated the resident experienced incontinence. These focus areas lacked documentation of the urinal as an intervention and the resident's request for staff assistance with it. A document titled Documentation Survey Report v2, dated 07/11/24 at 7:48 AM, revealed the resident had incontinence episodes during the day shift July 4, 5, and 10. On 07/09/24 at 09:19 AM observed the resident lying in bed with the TV on and a urinal next to him. He stated he kept it close most of the time in case he needed it but sometimes forgot to make sure it was there. He indicated he could use it himself, but when he did not feel well it was better to have help. He mentioned about a week ago he put on his call light for help. He waited well over an hour around breakfast time. When he finally went his output was several hundred milliliters and he had been uncomfortable. He stated mornings between 6:00 AM and 8:00 AM were usually the longest wait times, and sometimes after lunch. Resident #36 described another incident where he had urinated on himself when he could not hold it any longer and described urine ending up on his stomach and legs, the bed, and the floor. He said he had put his call light on that morning, and it was 3 hours before anyone came (TV as a time reference). He reported a certified nursing assistant (CNA) told him the call light system must not be working because it was not on in the hallway. The resident recalled another time he had an accident in the morning and it was 5-6 hours and after lunch before his sheets were changed. He revealed it was embarrassing and uncomfortable to have to sit like that and just wait. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/09/24 at 1:40 PM Staff B, Certified Nursing Assistant, stated the resident had reported long call lights and she was aware of at least one incident where he had an accident from staff not getting there fast enough. She stated he could use the urinal alone, but she understood that it might be harder if his blood sugars were low or he did not feel well. Staff B also noted urinal was sometimes hanging on a garbage can out of the resident's reach. A policy titled Answering the Call Light, revised March 2021, documented staff should be sure that call light was plugged in and functioning at all times. It further indicated staff were expected to document any significant requests or complaints made by the resident and how the request or complaint was addressed. An interview with the Administrator on 7/10/24 at 8:05 AM determined audits are conducted every weekend. She was not aware of any documented call light complaints. She also stated Resident #36 could use the urinal himself. An interview with the Director of Nursing 7/10/24 at 8:16 AM revealed residents had spoken to her about call lights. She stated the staff were very busy and the population of the facility was younger with more needs. She was not aware of documented complaints. On 7/10/24 at 2:19 PM the Maintenance Supervisor stated he was in the building once per week, and the last couple of times he was in the building there were issues reported to him about call lights not working that he had to fix. He stated he didn't know how to run a call light report with this system and didn't think they even could. 25855 2. The Minimum Data Set (MDS) dated [DATE] identified Resident #214 with moderate cognitive impairment with a BIMS (Brief Interview for Mental Status) score of 11 and had the following diagnoses: Peripheral Vascular Disease, Diabetes Mellitus and Hip Fracture. The MDS also identified Resident #214 required partial/moderate staff assistance with transfers from bed to chair and required supervision with toilet transfers. On 7/1/24, the Care Plan identified Resident #214 with the problem of a right hip fracture related to fall at home and directed staff to anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Observations on 7/8/24 which began at 4:00 PM revealed the following. 4:00 PM, the [NAME] at the end of C hall showed the call light on for Resident #214's room, surveyor observed during medication pass on C hall. 4:05 PM, assessment unchanged 4:10 PM assessment unchanged 4:14 PM Resident #214 in her room, observed sitting at the edge of her bed. Staff G, CNA exited another resident's room pushed a mechanical lift and walked by Resident #214's room and did not check on Resident #214. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4:15 PM the [NAME] at the end of the A hall showed room Resident #214's call light was still on and had been on for 15 minutes 4:17 PM, the [NAME] now showed the call light to Resident #214's room had been answered. The call light had been on for 16 minutes. In an observation and interview on 7/10/24 at 2:39 PM, Resident #214 had clock in her room that was easily visible from her bed. Resident #214 reported she has had accidents waiting for help to the bathroom which made her feel awful like a child pooping in her pants. Resident #214 reported this usually happens 2 to 3 times a week usually on night shift which she felt was embarrassing and degrading. Resident #214 also reported she was not supposed to get up by herself to go to the bathroom and thought it was ridiculous that she had to wait so long until she ends up soiling herself. In an interview on 7/11/24 at 7:52 AM, the Assistant Director of Nursing (ADON) reported no residents had reported bouts of incontinence waiting for assistance to the bathroom and that she would expect staff to answer call lights within 15 minutes. A review of the facility policy titled: Resident Rights dated as last reviewed September 2016 had documentation that resident shall be treated with respect, kindness and dignity.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on record review, family and staff interview, the facility failed to notify family of changes in the resident's condition for 1 of 3 residents reviewed (Resident #5). The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #5 with moderate cognitive impairment with a BIMS (Brief Interview for Mental Status) of 10 and had the following diagnoses: Renal Insufficiency (a kidney impairment), Diabetes Mellitus, and Urinary Tract Infection. The MDS also identified Resident #5 had been totally dependent on staff for assistance with all transfers and toileting. In an interview on 7/8/24 at 2:01 PM, Resident #5's family member reported the following: a. Family notification has been a chronic problem for years. She had asked the DON (Director of Nursing) about it and she reported she would find out who is not documenting it. b. Someone from the facility had left a message that she had a fractured ankle which happened 6/29/24 which may have been caused by a transfer using a mechanical lift. c. On 7/2/24 they sent her to the hospital for an x-ray and that they would have her see an orthopedic doctor after that. No one ever called after she had the x-rays and saw the Orthopedic doctor. She called the Director of Nursing (DON) the next day and the DON said the x-ray showed an old fracture. d. When the family member asked the DON what date the incident occurred, she checked the records and found that it happened on 6/28/24. The Care Plan dated as last reviewed 5/28/24 did not direct staff to notify family with any changes in the resident's condition or medications, etc. A review of the Progress Notes revealed the following: 6/28/24 at 3:15 PM The Resident complained of right ankle pain and rated at a 8 (on the pain scale). Her right ankle was swollen with two purple bruises. Upper bruise measured 3.3 mm (millimeters) long and 6.6 mm wide. The lower bruise measured 3.5 mm long and 4.3 mm. wide. Resident stated that she was being assisted for a transfer on the EZ-stand when her ankle slipped off the stand. Resident states this happened yesterday 6/27/24. This nurse asked the CNA if this happened on her shift she reported that it did not and resident already had a bruise there yesterday. Administered Tylenol and called the Nurse Practitioner. Orders received for an x-ray of the right ankle, scheduled Tylenol 650 mg (milligrams) QID (four times daily) for 10 days and Voltaren gel 4 Grams QID. Biotech to come today. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/28/2024 15:17 POA (Power of Attorney) aware of right ankle pain and new orders. No comments or concerns at this time. 7/2/2024 14:36 Call placed to the Orthopedic Doctor and said orders received for an appointment for an x-ray of the right ankle and to see the orthopedic doctor. The notes did not show documentation to show the family had been notified of the x-ray results or the visit with the Orthopedic Doctor. A review of the E-interact forms showing family notification revealed the last form completed was dated 5/21/24. A review of the facility policy titled: Change in a Resident's Condition or Status dated as last revised February 2021 had documentation of the following: Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source; b. there is a significant change in the resident's physical, mental, or psychosocial status; c. there is a need to change the resident's room assignment; d. a decision has been made to discharge the resident from the facility; and/or e. it is necessary to transfer the resident to a hospital/treatment center. f. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. In an interview on 7/11/24 at 7:52 AM, the ADON (Assistant Director of Nursing) reported the following: a. She would expect the nurse to notify the family as soon as it occurs with any medication change, falls even without injuries, transfers out to the hospital. b. This should be documented in the Progress Note or E-interact note under Evaluations In an interview on 7/11/24 at 12:15 PM, Staff I, RN reported the following: a. The nurse should notify the family as soon as there is any falls, medication change, change of status, transfer to the hospital. b. This should be documented in the Progress Notes. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/12/24 at 9:32 AM, Staff H, RN reported If there are any changes in condition and changes in medication, etc. this should be called to family, and documented in the electronic record either in the incident report or a Progress Note. Family should be notified as soon as the change occurred.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on observation, facility records, resident interviews, and staff interviews the facility failed to maintain a homelike environment related to musty urine odors in common areas and stains on hallway carpets. The B wing was noted by Resident #27 to have more odor during humid days. The facility reported a census of 58 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #27 dated 4/5/24 documented a Brief Interview for Mental Status (BIMS) of 15 out of 15, which indicated intact cognition. The clinical record documented Resident #27 resided in the B hallway in room [ROOM NUMBER]. On 07/09/24 at 01:09 PM observed this resident seated in the common area at the end of the B hallway watching television. He made a slight grimace and shook his head. When asked if he was okay, the resident described a musty smell, maybe urine, but he wasn't sure. The resident revealed this was not the first time he had smelled the same odor. He said it was worse when it was humid in the building. On 07/09/24 at 01:10 PM observed 6 visible stains on the carpet between the common area and the resident's room from approximately golf ball sized to about 6 inches by 3 inches. The stains were darker than the carpet and involved unknown substances that appeared ground into the fibers. An additional observation of this hallway and hallway A on 07/11/24 at 11:59 AM revealed a milky white stain approximately 8 inches long, matted stained carpet going into 9 different rooms, and a reddish brown 4 inch by 3 inch stain that clumped the carpet fibers together. An interview with the Administrator on 7/10/24 at 8:05 AM determined housekeeping shampooed carpets until a full time maintenance person could be hired. She was not aware of the schedule for cleaning the carpets. During room visits on 7/10/24 at 2:01 PM noted a strong, musty type of odor in the B hallway by the common area TV, pop machine, and snack machines. An interview with the Maintenance Supervisor on 7/11/24 at 11:58 AM revealed carpets were spot cleaned by the facility between deep cleanings twice a year by a contracted provider. He acknowledged they were past due for a deep cleaning. He was not aware of the odor concern in the B hallway.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 49976 Based on record review, policy review, and staff interview the facility failed to notify the ombudsman of resident transfers for 1 of 2 residents reviewed (Resident #6). The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) report dated 6/12/24 for Resident #6 documented a Brief Interview for Mental Status score of 13/15 indicating no cognitive impairment. The MDS documented diagnoses including heart failure, urinary tract infection, and acute and subacute infective endocarditis (infection of the heart valve lining). The eINTERACT Transfer Form V5 dated 5/18/24 indicated Resident #6 transferred to the hospital on 5/6/24 for shortness of breath. The nursing Progress Note dated 5/18/24 documented the resident was again sent to the hospital on that date for evaluation and treatment. Review of the May Notice of Transfer Form to Long Term Care Ombudsman revealed the facility failed to notify the ombudsman of both hospital transfers. In an interview on 7/10/24 at 11:12 AM the Business Office Manager (BOM) explained she had looked at the discharge report for May but Resident #6 was not on that report. From 5/6/24 to 5/16/24 she was on 10 day bed hold and was on an interrupted stay at the end of May. The BOM noted she was not aware the ombudsman needed to be notified if residents were admitted to the hospital even if they were not discharged from the facility. The facility lacked a policy regarding ombudsman notification.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on record review, staff interview and policy review, the facility failed to document that the Bed Hold policy had been reviewed with 1 of 4 residents that were transferred to the hospital (Resident #14). The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #14 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 15 and had the following diagnoses: Heart Failure, Renal Insufficiency and COPD (Chronic Obstructive Pulmonary Disease) The MDS also identified Resident #14 to be dependent on staff assistance with putting on and taking off footwear, transfers from chair to bed, and from sitting to standing. A review of the Progress Notes revealed the following: 9/14/23 at 8:01 AM The resident was unresponsive to tactile stimuli, was foaming out the right side of mouth, difficult to arouse, and pupils dilated 6-7 mm (millimeters), resident unable to respond to questions. Found with vape with unknown substance. Ambulance called to facility. Last known time for patient having normal activity was 5:00 PM on 9/13/23. Transferred to emergency department. 9/14/23 at 8:30 AM Nurse Practitioner called and gave orders to send to the ER (emergency room) 9/14/23 at 11:00 AM Hospital called. Resident admitted with diagnosis of Urosepsis No documentation to show the resident's family had Bed Hold policy reviewed. 9/17/23 at 3:05 PM Resident returned from the hospital with new orders for antibiotic. A review of the Bed Hold policy dated 9/14/23 at 7:49 AM revealed the option to request to reserve a room had been marked, however, written or verbal confirmation had not been marked and the form did not have the signature of the family or date confirmation was obtained. In an interview on 7/11/24 at 7:52 AM, the ADON reported the following: a. When residents are transferred to the hospital, the nurse who is sending the resident out is responsible for reviewing the Bed Hold policy with resident or family. b. This should be documented on a form under the Evaluations tab in the electronic medical record. c. The form should include the name of the family member or resident. d. The form should be reviewed with the resident/family prior to the resident being transferred. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	In an interview on 7/11/24 at 12:15 PM, Staff I, RN reported she had never completed the Bed Hold policy before or reviewed it with any residents and did not know the process to follow when a resident is transferred to the hospital.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, and staff interview, the facility failed to update the Care Plans for 2 of 2 residents reviewed after changes in care occurred (Residents #5 and #14). The facility reported a census of 58 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #5 with moderate cognitive impairment with a BIMS (Brief Interview for Mental Status) of 10 and had the following diagnoses: Renal Insufficiency (a kidney impairment), Diabetes Mellitus and Urinary Tract Infection. The MDS also identified Resident #5 had been totally dependent on staff for assistance with all transfers and toileting. In an interview on 7/8/24 at 2:01 PM, Resident #5's family member reported the facility called on 6/29/24 to inform them that Resident #5 had a fractured ankle. She was later sent to the hospital on 7/2/24 to get another x-ray and see an orthopedic doctor. The doctor said the plastic brace placed on her was to be temporary over the weekend. A review of the Progress Notes revealed the following: 6/28/24 3:15 PM The Resident complained of right ankle pain and rated at a 8 (on the pain scale). Her right ankle was swollen with two purple bruises. Upper bruise measured 3.3 mm x 6.6 mm. Lower bruise 3.5 mm x 4.3 mm. Resident stated that she was being assisted for a transfer on the EZ-stand when her ankle slipped off the stand. Resident states this happened yesterday 6/27/24. This nurse asked the CNA if this happened on her shift she reported that it did not and resident already had a bruise there yesterday. Administered Tylenol and called the nurse practitioner. Orders received for an x-ray of the right ankle, scheduled Tylenol 650 mg (milligrams) QID (four times daily) for 10 days and Voltaren gel 4 Grams QID. A review of the Physician Orders revealed the following: 6/29/24 Non Weight Bearing status every shift. 6/29/24 CAM BOOT right ankle/foot every day and evening shift for right ankle fracture. 7/3/24 Open brace to check skin every shift. 7/3/24 Follow up appointment with orthopedic doctor on July 16, 2024 at 1:45 PM. On 11/01/17, the Care Plan identified Resident #5 with the problem of being at risk for falls and dated as reviewed last 6/30/23 and no new interventions added after the incident occurred 6/28/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The Minimum Data Set (MDS) dated [DATE] identified Resident #14 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 15 and had the following diagnoses: Heart Failure, Renal Insufficiency, and COPD (Chronic Obstructive Pulmonary Disease) The MDS also identified Resident #14 to be dependent on staff assistance with putting on and taking off footwear, transfers from chair to bed, and from sitting to standing. A review of the nurse practitioner Progress Notes dated 3/25/24 had documentation of the following: On 3/22/24, a pressure ulcer noted to the left lateral lower leg which measured 4.6 cm (centimeters) long, 2.2 cm wide and no depth. No signs of infection or drainage noted. On 3/22/24, a pressure ulcer noted to the right lateral lower leg which measured 5.1 cm long, and 3 cm wide and no depth. On the surface of her leg with 1.2 cm long and 1.4 cm wide and no depth area of eschar and surrounding erythema and warmth and inflammation, mild yellow drainage on the bandage. A review of the Treatment Administration Records revealed the following orders: 4/4/24 Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to right, left outer leg topically one time a day for pressure wound clean area with wound cleaners then Santyl border. 4/10/24 Heel protectors on at all times, every shift for protection 5/24/24 Wound care to Left and Right lateral lower legs: clean wounds with soap and water, pat dry with gauze, apply Prisma (cut to fit wound) to wound beds, lightly dampen Prisma with Normal Saline, cover with Mepilex border dressing 3 times a week and PRN (as needed) for dressing dislodgement or soiling. Resident aware of new wound care orders and will tell family. every day shift every Monday, Wednesday, Friday for wound care both legs. 6/21/24 clean the right and the left bilateral leg with Vashe and and apply thin hydrocolloid to the area and change every 3 days and PRN if falls off, one time a day every Monday, Wednesday, Friday for wounds. 6/27/24 To bilateral calves: cleanse wounds well with Vashe, apply calcium alginate AG to open areas. cover with bordered foam dressing. Once lymphedema therapy starts change on lymphedema days, every day shift for wound care 7/11/24 Vashe Cleansing External Solution (Wound Cleansers) Apply to Bilateral calfs topically every day shift for wound care To bilateral calves: cleanse wounds well with Vashe, apply Medihoney to open areas. cover with bordered foam dressing. Once lymphedema therapy starts change on lymphedema days. On 7/30/20, the Care Plan identified Resident #14 with the problem of being at risk for developing pressure ulcers. It did not include the new pressure ulcers identified 3/22/24 or include new interventions ordered. In an interview on 7/11/24 at 7:52 AM, the ADON reported the following: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. If a resident develops a pressure ulcer, she would expect to have that added to the Care Plan. b. The MDS Coordinator is responsible for updating Care Plans, however, any nurse can update the Care Plans. c. She could not explain why Resident #14's Care Plan was not updated when her pressure ulcers developed. A review of the policy titled: Care Plan and Care Plan Conference dated as last revised 4/1/24 had documentation of the following: Resident care plans must be updated immediately when there is: a. Change in ADL status b. Risk Management Incident/Accident/Unusual Occurrence c. Falls d. Adding/removing devices (alarms/wander guards)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on observation, record review, staff interviews, resident interviews, and policy review the facility failed to follow Physician's Orders when administering insulin for 4 of 4 residents reviewed for diabetes mellitus medication administration (Residents #4, #36, #56, and #60). The facility reported a census of 58 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #36, dated 4/5/24 documented a Brief Interview for Mental Status (BIMS) of 15/15, which indicated intact cognition. The MDS reflected diagnoses of diabetes mellitus, morbid obesity, and need for assistance with personal care. The assessment indicated Resident #36 was dependent on staff for toileting and transfers, and required partial to moderate assistance for sitting to lying and lying to sitting. The resident's Care Plan included a focus area dated 1/11/23 which documented the resident had diabetes mellitus with interventions to take diabetes medication as ordered by doctor, and to monitor for and document side effects and effectiveness. On 07/09/24 at 09:19 AM Resident #36 stated his medications were 'messed up' a lot, and that he missed his Ozempic altogether on 7/6/24. He stated they seemed short staffed and that someone told him his medication had been thrown away by mistake. He thought they reordered it but he wasn't sure, and he had not heard anything more about it. The resident stated his insulin was often late, and he sometimes received his breakfast insulin closer to lunch. A document titled Medication Administration Record for July 2024 documented the resident did not receive his scheduled semaglutide (1 mg/dose) by solution pen-injector 4 mg/3 ml (Ozempic) on 7/6/24 as scheduled. The electronic health record entry was not checked and included a number 9, which indicated there was an associated Progress Note. A Progress Note dated 7/6/2024 at 12:58 PM indicated the resident's medication was not available, and staff requested for pharmacy to send the medication. It noted the facility was awaiting delivery. As of 7/10/24 no follow up documentation was in the electronic health record. On 7/11/24 at 8:59 AM Certified Medication Aide, Staff F, confirmed the resident did not receive his semaglutide over the weekend and that some of his medications have been late. She stated the medication was requested 7/6/24 and it had not been received. A document titled Location Administration Report, dated 07/09/24 at 11:19 AM, revealed that between 7/1/24 and 7/9/24 Resident #36 received the following medications outside of the allowed one hour administration window 33 out of 43 times; Insulin Lispro Injection Solution, Insulin Lispro Solution 100 UNIT/ML, and Insulin NPH (Human) (Isophane) Subcutaneous Suspension 100 UNIT/ML. 15 of those injections were over 2 hours late, with the longest gap documented as a 7:00 AM dose of Lispro given at 10:20 AM on 7/8/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nursing on 7/11/24 at 9:32 AM determined she was not aware of the missed and late medications and needed to follow up. At 11:01 AM on 7/11/24 the DON stated the pen used to administer multiple doses of the resident's Ozempic was mistakenly thrown away after just the first dose was administered, so they were down a pen. When staff updated the pharmacy to let them know they needed a refill, they had updated the facility pharmacy instead of the resident's preferred pharmacy. This was corrected by the facility on 7/11/24. A policy titled Administering Medications, revised April 2019, indicated medications were to be administered in a safe and timely manner, and as prescribed. Staffing schedules were arranged to ensure medications were administered without unnecessary interruptions. Medications were administered in accordance with prescriber orders, including any required time frame. 25855 2. The Minimum Data Set (MDS) dated [DATE] identified Resident #4 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 15 and had the following diagnoses: Coronary Artery Disease, Peripheral Vascular Disease, and Diabetes Mellitus. The MDS also identified Resident #4 as independent with most activities of daily living. On 1/23/23 the Care Plan identified Resident #4 with the problem of Diabetes Mellitus and directed staff to administer Diabetes medication as ordered by doctor. Monitor for and document side effects and effectiveness. In an observation on 7/9/24 at 7:28 AM, Staff C prepared the Novolog insulin pen using the correct technique, however, Resident #4 was not in her room. Staff C stated she would give it to her after Resident #4 had her breakfast. In an observation on 7/9/24 at 8:42 AM, Staff C, RN used the correct technique to administer Novolog 12 units subcutaneously. A review of the physician orders revealed the following order: 5/12/24 Novolog (Insulin Aspart) Inject 12 unit subcutaneously two times a day. Give with meals Hold if Blood Glucose is below 100. A review of the facility report titled: Location of Administration Report for July 2024 revealed the following: Insulin Glargine Solution scheduled to be given at 7:00 AM 07/02/24 given at 8:55 AM 07/03/24 given at 8:28 AM 07/03/24 given at 8:28 AM 07/09/24 given at 8:44 AM (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/10/24 given at 8:03 AM 3. The MDS dated [DATE] identified Resident #56 as cognitively intact with a BIMS of 14 and had the following diagnoses: Diabetes, Thyroid Disorder, and Bipolar Disorder. The MDS also identified Resident #56 as independent with most activities of daily living. On 4/26/24, the Care Plan identified Resident #56 with the problem of using insulin/hypoglycemic medications related to diabetes and directed staff to: a. Monitor blood glucose as ordered. b. Monitor for side effects (low blood sugar, headache, weakness, sweating and fainting) and effectiveness. A review of the Physician Orders revealed the following: Basaglar KwikPen Subcutaneous (Insulin Glargine) Inject 14 unit subcutaneously two times a day for diabetes. Admelog SoloStar Subcutaneous (Insulin Lispro) Inject 20 unit subcutaneously three times a day for Diabetes II give w/meals. Hold insulin if blood sugar is less than 90. In an observation on 7/9/24 at 8:52 AM, Staff C prepared Lantus 14 units and Admelog 20 units using the correct technique, however, upon entering Resident #56's room, he was in the bathroom. In an observation on 7/9/24 at 9:02 AM, Staff C used the correct technique to administer Lantus 14 units and Admelog 20 units subcutaneously. A review of the facility report titled: Location of Administration Report for July 2024 revealed the following scheduled to be given at 7:00 AM Basaglar KwikPen Subcutaneous 7/2/24 given at 9:04 AM 7/3/24 given at 9:34 AM 7/5/24 given at 8:18 AM 7/6/24 given at 8:29 AM 7/9/24 given at 9:09 AM 7/10/24 given at 9:45 AM Admelog (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/2/24 given at 9:04 AM 7/3/24 given at 9:34 AM 7/5/24 given at 8:18 AM 7/6/24 given at 8:29 AM 7/9/24 given at 9:10 AM 7/10/24 given at 9:45 AM 4. The MDS dated [DATE] identified Resident #60 as cognitively intact with a BIMS of 15 and had the following diagnoses: Diabetes Mellitus, Osteomyelitis, and Sleep Apnea. The MDS also identified Resident #60 required staff supervision or partial assistance with most activities of daily living. On 6/21/24, the Care Plan identified Resident #60 with the problem of using insulin /hypoglycemic medications related to diabetes and directed staff to: a. Monitor blood glucose as ordered. b. Monitor for side effects (low blood sugar, headache, weakness, sweating and fainting) and effectiveness. A review of the Physician Orders revealed the following: 6/21/24 Insulin Lispro Inject 5 unit subcutaneously three times a day for Diabetes Mellitus with meals. Update physician if blood glucose is less than 60 or greater than 400. In an observation during medication pass task on 7/9/24 at 8:47 AM, Staff C RN administered Lispro 5 units subcutaneously. A review of the facility report titled: Location of Administration Report for July 2024 revealed the following: Insulin Lispro Injection scheduled to be given at 7:00 AM were given at the following dates and times: 7/2/24 given at 9:02 AM 7/3/24 given at 9:32 AM 7/4/24 given at 9:01 AM 7/5/24 given at 8:55 AM 7/7/24 given at 8:41 AM (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/9/24 given at 8:52 AM 7/10/24 given at 9:44 AM In an interview on 7/11/24 at 7:52 AM, the ADON (Assistant Director of Nursing) reported the following: a. When insulin is scheduled to be given in the morning, it is usually given before breakfast or right after breakfast. b. When asked if there would be any reason why insulin was being given 2 hours late, the ADON reported only if it is per resident's choice or doctor order. c. This has not been a problem identified by the QA Committee and she was not aware of any new interventions to correct the problem. In an interview on 7/11/24 at 10:55 AM, Staff J, Nurse Practitioner reported she would expect morning doses of insulin to be given before meals or at least within an hour after breakfast. In an interview on 7/11/24 at 12:15 PM, Staff I, RN reported morning doses of insulin should be given with breakfast and that there should not be any reason for insulin to be given 2 hours late.

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F 0684 Level of Harm - Minimal harm or potential for 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** 25855 Based on observation, record review, resident and staff interview, the facility failed to document an assessment for 1 of 2 residents sent to the hospital (Resident #5). The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #5 with moderate cognitive impairment with a BIMS (Brief Interview for Mental Status) of 10 and had the following diagnoses: Renal Insufficiency (a kidney impairment), Diabetes Mellitus, and Urinary Tract Infection. The MDS also identified Resident #5 had been totally dependent on staff for assistance with all transfers and toileting. In an observation on 7/8/24 at 10:53 AM, Resident #5 sat up in her wheelchair in her room, with an open brace to her right foot and both feet on a foot buddy on the foot pedals of her wheelchair. Resident #5 reported when the staff pushed her in her wheelchair 2 weeks ago, her right foot slid off the foot pedal and got caught underneath the pedal and she fractured her right ankle. In an interview on 7/8/24 at 2:01 PM, Resident 5's family member reported Resident #5 fell on [DATE] and the facility informed her that she had a fractured ankle. When asked how it happened, they said it may have been due to the mechanical lift out of the wheelchair. On 7/2/24 they sent her to the hospital for an x-ray and that they would have her see an Orthopedic Doctor after that. The Director of Nursing (DON) reported the fracture was an old fracture. A review of the Progress Notes revealed the following: 6/28/24 at 3:15 PM, Resident #5 complained of right ankle pain which she rated at a 8 (out of 10) on the pain scale. Her right ankle appeared swollen with two purple bruises. Upper bruise measures 3.3 mm x 6.6 mm. Lower bruise 3.5 mm x 4.3 mm. Resident #5 stated that she was being assisted for a transfer on the EZ-stand when her ankle slipped off the stand. Resident states this happened yesterday 6/27/24. 7/2/24 2:29 PM Call placed to the son who wanted her sent to the Hospital emergency room . 7/2/224 2:36 PM Call placed to Orthopedic Physician and orders received for an x-ray at of the right ankle and bring to the Orthopedic Physician's office . Resident #5 was not hospitalized . However, the Progress Note did not include documentation of an assessment of the right ankle and foot prior to being sent out. In an interview on 7/12/24 at 9:32 AM, Staff H, RN reported before she was sent to the hospital on 7/2/24, the nurse should have documented an assessment of the resident. A review of the facility policy titled: Acute Condition Changes, dated as last revised September 2017 had documentation of the following: Before contacting a physician about someone with an acute change of condition, the nursing (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff will collect pertinent details to report to the physician; for example, the history of present illness and previous and recent test results for comparison. If it is decided, after sufficient review, that care or observation cannot reasonably be provided in the facility, the physician will authorize transfer to an acute hospital, emergency room , or another appropriate setting.

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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** 25855 Based on observation, record review, resident and staff interview, the facility failed to prevent two pressure ulcers from developing for 1 of 2 residents reviewed with pressure ulcers (Resident #14). The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #14 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 15 and had the following diagnoses: Heart Failure, Renal Insufficiency, and COPD (Chronic Obstructive Pulmonary Disease). The MDS also identified Resident #14 to be dependent on staff assistance with putting on and taking off footwear, transfers from chair to bed and from sitting to standing. On 7/30/20, the Care Plan identified Resident #14 with the problem of being at risk for pressure ulcers and had an open areas on her right shin. The Care Plan did not identify Resident #14 developed pressure ulcers to both outer calves. On 3/25/24, the Care Plan directed staff to teach her the risk factors for development of pressure ulcers. A review of the Progress Notes revealed the following: 03/25/24 New wounds which opened up 4 days ago. The nurse called stating she had a new blister on her leg that popped up rather quickly and large, she had these blisters before. She has no feeling on these aspects of her legs, with history of neuropathy. Her blisters seem to be where her wheelchair rubs with the footrest bars. Does have chronic edema issues, this had been slowly worsening with time, but no worse today than last week. The wound to the left outer leg On 3/22/24 the wound was 4.6 cm (centimeters) long, 2.2 cm wide and had no depth. No signs of infection (no odor or purulence, inflammation or surrounding erythema or undue warmth). The wound to the right outer leg On 3/22/2024, the wound was 5.1 cm long, 3.0 cm wide and had no depth. There was surrounding erythema and warmth and inflammation, mild yellow drainage on the bandage. A review of the Treatment Administration Records revealed the following: Santyl External Ointment 250 units per gram - Apply to right, left outer leg topically one time a day for pressure wound clean area with wound cleaners then Santyl border. There was no documentation to show treatments were given on April 12, 26, and May 3, 18, & 22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 7/10/24 at 8:04 AM, Staff R, Nurse Practitioner reported Resident #14 developed pressure ulcers to lateral sides of both calves possibly caused by rubbing against the foot pedals of her wheelchair. They are stage 3. Her edema fluctuates and we have lymphedema wraps to both legs. Currently they are cleaning with Vashe and apply Calcium Alginate AG then bordered foams. These are changed when lymphedema wraps are changed and after she gets her massage for the lymphedema. It will vary from week to week. In an observation of wound care on 7/10/24 8:32 AM Staff H, LPN had donned an isolation gown and gloves, removed the soiled dressing from the wound to Resident #14's left calf area. Staff H cleansed the wound using the correct technique, then picked up the scissors with same gloves and left the scissors in the Calcium Alginate packet which had already been opened. Then Staff H changed gloves and did not disinfect the scissors (after she had picked them up with previous gloves) and cut the Calcium Alginate dressing and placed the dressing on to wound to left calf then covered with Mepilex Border Flex Lite dressing. The wound appeared to have a small necrotic area to the top of the wound, however, no signs of infection noted to the surrounding skin. 7/10/24 at 8:39 AM Staff H then used the correct technique to cleanse the wound to the right outer calf, however, she did not disinfect the scissors before she cut the Calcium Alginate dressing. Staff H placed the dressing onto the wound. The wound to the right calf did not have any necrotic areas or any redness to surrounding skin. In an interview on 7/10/24 at 2:53 PM, the DON (Director of Nursing) reported the following: a. She was not sure if the Primary Care Physician/Medical Director had been notified of Resident #14's pressure ulcers to her calves. b. Actions taken to prevent further wounds or to prevent current wounds from growing were lymphedema wraps that are applied at a clinic. A wound nurse practitioner, Staff R makes rounds every Wednesday on all the residents with pressure ulcers. c. She was not sure how the wounds developed. But when they develop, the facility should complete a root-cause analysis and change what ever could have caused it. She was not sure if a root-cause analysis had been completed yet. In an interview on 7/11/24 at 7:52 AM, the ADON (Assistant Director of Nursing) reported the following: a. The pressure ulcers to Resident #14's calves opened up due to her foot pedals from the wheelchair pushing into her legs. b. She could not recall the exact date the wounds developed, she thought it may have been the beginning of this year c. When asked if she felt the pressure ulcers could have been prevented, she reported she was not sure. d. The Medical Director had been notified and should be documented in the Progress Notes. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 7/11/24 at 11:19 AM, Staff M, CNA reported she was unsure how the wounds developed, but thought it may be from rubbing against the foot pedals. There was nothing to cover the foot pedals. In an interview on 7/11/24 at 12:10 PM, Staff P, CMA reported she was not sure what caused the wounds to her legs. Resident #14 used to have a bigger wheelchair but she had a hard time self propelling in that wheelchair. She uses her feet to self propel. A review of the facility policy titled: Ulcers/Skin Breakdown dated as last revised September 2017 had documentation of the following: Recognition a. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility and medical instability. b. The staff and practitioner will examine the skin of newly admitted residents/patients for evidence of existing pressure ulcers and other skin conditions. c. The physician will help the staff identify the type (for example, arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of wound bed, etc.) of an ulcer. d. The physician will help identify and define any complications related to pressure ulcers.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, family and staff interview, the facility failed to prevent an incident with injury for 1 of 3 residents reviewed (Resident #5). The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #5 with moderate cognitive impairment with a BIMS (Brief Interview for Mental Status) of 10 and had the following diagnoses: Renal Insufficiency (a kidney impairment), Diabetes Mellitus and Urinary Tract Infection. The MDS also identified Resident #5 had been totally dependent on staff for assistance with all transfers and toileting. In an interview on 7/8/24 at 2:01, Resident #5's family member reported that the facility called and said Resident #5 fractured her ankle on 6/29/24. The doctor had been notified and orders for Tramadol (pain medication). When asked how it happened, they said it may have been due to the mechanical lift of the wheelchair. On 7/2/24, they sent her to the hospital for an X-ray and to see an Orthopedic Doctor after that. She called the DON (Director of Nursing) and said the bruise to her ankle was an old fracture. The Doctor had ordered a brace for her right foot. The Care Plan identified Resident #5 as being at risk for falls on 11/1/2017 and directed staff to encourage her to use the call light for assistance and refer her to Physical Therapy for evaluations as needed. A review of the Incident Report dated 6/28/24 at 3:01 PM had documentation of the following: Resident #5 complained of right ankle pain and rated at a 8 on the pain scale. Her right ankle was swollen with two purple bruises. Resident #5 stated on 6/27/24, she was being assisted for a transfer on the EZ stand when her ankle slipped off the stand. A review of the nurse's Progress Notes revealed the following: 6/28/24 3:15 PM Resident #5 Complained of right ankle pain and rated at a 8 on the pain scale. Her right ankle was swollen with two purple bruises. Resident #5 stated on 6/27/24, she was being assisted for a transfer on the EZ stand when her ankle slipped off the stand. 6/30/24 12:11 PM Received a written statement from Staff K, CNA on this day 6/30/24 which documentation of the following: On the 26th or 27th, Resident #5 was being pushed down the hall in her chair and as she was being pushed she took her foot off the pedal and her foot got stuck under her wheelchair. She kept taking her foot off while being pushed even after several reminders to keep feet up if being pushed. A review of the Physician Orders revealed the following: 6/29/24 Non-Weight Bearing status. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/29/24 CAM boot right ankle/foot every day and evening shift for right ankle fracture. 7/3/24 Open brace to check skin every shift. 7/3/24 Follow up appointment with orthopedics on July 16 at 1:45 PM to evaluate right ankle. A review of the emergency room Physician Notes dated 7/2/24 had documentation of the following: [AGE] year-old female presents to the emergency department via EMS for evaluation of leg pain. Patient reports that she has an appointment with Orthopedic Doctor to evaluate ongoing right ankle pain. She reports that she re-injured the ankle and requests repeat x-rays for further evaluation. She denies any right knee pain or right hip pain. X-rays of the right foot showed diffuse severe osteopenia. No evident fracture, dislocation, or other bony abnormality. In an interview on 7/11/24 at 8:27 AM, Staff K, CNA reported the following: a. When asked how she would transport a resident in a wheelchair, she would make sure both feet are up on foot pedals. b. When asked what happened when Resident #5 had the incident with her foot in the wheelchair, she reported another CNA pushed Resident #5 in the wheelchair in the hallway. She could not recall the name of the CNA. Resident #5 somehow got her foot caught under the foot pedal of the wheelchair. c. She could not recall if Resident #5 had any injuries or fractures. She had heard a week later that she had a broken foot or broken ankle. Someone said it happened when she was transferred from the EZ stand. In an interview on 7/11/24 at 10:55 AM, Staff J, Nurse Practitioner reported the following: a. She was notified the Monday after the incident that there was swelling to Resident #5's right ankle. At that time, they did not how it happened. b. She asked Resident #5 what happened and she said when they transferred her from her wheelchair to the toilet using the EZ stand and her foot slipped off the EZ stand platform. c. There was a questionable fracture on the Biotech X-ray. Staff J was not working that day. The nurse notified the on-call Physician who ordered a brace for it and did an orthopedic referral. She went to orthopedics and had repeat X-rays done, Staff J did not know what the results of that X-ray were. In an interview on 7/11/24 at 11:19 AM, Staff M, CNA reported when asked how she would transport a resident in a wheelchair, she reported she should place both feet on the foot pedals. That the foot pedals are on the wheelchair, feet should be on the pedals. She could not recall what happened when Resident #5 had the incident with her right ankle. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/11/24 at 11:30 AM, Staff N, CNA/CMA reported when she transports a resident in the wheelchair, she would make sure both feet are on the foot pedals. She could not recall what happened when Resident #5 had the incident with her right ankle. In an interview on 7/11/24 at 11:45 AM, Staff O, CNA reported she could not recall what happened when Resident #5 had the incident with her right ankle. When asked about the incident Resident #5 had with her right ankle, she reported she was working that hallway when she reported that her foot was hurting her. Resident #5 said it happened when her foot fell off a pedal of the wheelchair. And her right foot folded over and got caught under the foot pedal. She said this had happened two days before and she could not remember what happened. A review of the facility policy titled: Falls - Clinical Protocol dated as last revised March 2018 had documentation of the following: The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable.

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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** 25855 Based on observation, record review, resident and staff interview, the facility failed to answer call lights in a timely manner for 4 of 4 residents observed. (Residents #14, #28, #36 and #214). The facility reported a census of 58 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #14 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 15 and had the following diagnoses: Heart Failure, Renal Insufficiency, and COPD (Chronic Obstructive Pulmonary Disease) The MDS also identified Resident #14 to be dependent on staff assistance with putting on and taking off footwear, transfers from chair to bed and from sitting to standing. An observation of Resident #14's call light on 7/29/24 revealed the following: 6:50 AM [NAME] at end of C hall showed Resident #14's call light was on. Currently no staff in the hallway. 6:56 AM Staff S, CNA entered room C 11 to assist that resident then pushed that resident out to the main dining room without checking on Resident #14. 7:00 AM Staff S, CNA returned to C hall and knocked on door to room C 7. Call light to Resident #14's room had been on for 10 minutes now. No other staff in hallway. Resident #14 sat up in her wheelchair in her room and did not appear to be in any distress. 7:05 AM Resident #14's call light had been on for 15 minutes now. Staff S, CNA entered room C 14, however, did not check on Resident #14. 7:07 AM [NAME] now showing call lights on to Resident #14's room now off. It had been on for 17 minutes. The Care Plan with the last revision date of 5/17/24 did not address the need to answer Resident 14's call light in a timely manner despite requiring staff assistance with transfers. During an observation and interview on 7/10/24 at 2:46 PM , Resident #14 sat up in her wheelchair, properly positioned and appeared comfortable. She had a clock above the bathroom door which was visible from her bed. She also had a cell phone on her tray table that has a clock to show her the time. 2. The MDS dated [DATE] identified Resident #28 as cognitively intact with a BIMS of 15 and had the following diagnoses: Diabetes Mellitus, Bipolar Disorder, and Right Below the Knee Amputation. The MDS also identified Resident #28 was completely dependent on staff for assistance with toileting, showers, putting on and taking off footwear, lower body dressing, and personal hygiene. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/9/24 7:41 AM, Resident #28 reported when asked if staff answer his call light timely, he stated when his call light works. The call light will not work properly and this happened at least once a month. The longest he has had to wait to get his call light answered was 3 hours In an observation of Resident #28 in his room on 7/10/24 at 2:44 PM, he was asleep in bed, had a cell phone on a tray table next to him which shows a clock where he can see the time. There was also a clock above the bathroom door, that can be seen from his bed. The Care Plan identified Resident #28 with requiring assistance with most activities of daily living however, it did not address the need to answer Resident 14's call light in a timely manner. 3. The Minimum Data Set (MDS) dated [DATE] identified Resident #214 with moderate cognitive impairment with a BIMS (Brief Interview for Mental Status) score of 11 and had the following diagnoses: Peripheral Vascular Disease, Diabetes Mellitus, and Hip Fracture. The MDS also identified Resident #214 required partial/moderate staff assistance with transfers from bed to chair and required supervision with toilet transfers. On 7/1/24, the Care Plan identified Resident #214 with the problem of a right hip fracture related to fall at home and directed staff to anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Observations on 7/8/24 which began at 4:00 PM revealed the following. 4:00 PM, the [NAME] at the end of C hall showed the call light on for Resident #214's room which surveyor observed during medication pass on C hall. 4:05 PM, assessment unchanged. 4:10 PM assessment unchanged. 4:14 PM Resident #214 observed sitting at the edge of her bed. Staff G, CNA exited another resident's room pushing a mechanical lift and walked by room A 4 and did not check on the resident. 4:15 PM the [NAME] at the end of the A hall showed Resident #214's call light was still on and had been on for 15 minutes. 4:17 PM, the [NAME] now showed Resident #214's call light had been answered. The call light had been on for 16 minutes. In an observation and interview on 7/10/24 at 2:39 PM, Resident #214 had a clock in her room that was easily visible from her bed. Resident #214 reported she has had accidents waiting for help to the bathroom which made her feel awful like a child pooping in her pants. Resident #214 reported this usually happens 2 to 3 times a week usually on night shift which she felt was embarrassing and degrading. Resident #214 also reported she was not supposed to get up by herself to go to the bathroom and thought it was ridiculous that she had to wait so long until she ends up soiling herself. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/11/24 at 7:52 AM, the ADON reported the following: a. She would expect staff to answer call lights as soon as possible, within 15 minutes at most. b. When asked what did she feel would be the reason why call lights were not being answered timely, she reported because the [NAME] is located at the end of the hall and the aides are not looking up to check the [NAME]. Half of the CNA staff were newer. c. Staff call in at least once a month, shifts varies. In an interview on 7/11/24 at 11:13 AM, Staff L, CNA reported the following: a. When asked when staff should answer a call light, she reported right away. b. When asked if she felt she had enough help to give the residents the care they need, she reported no. On day shift, there should be 2 CNAs and one nurse for each hall. Today, there is only one nurse out on the floor and 2 CMAs covering for the nurses in the other two halls. c. Staff call in sick daily and at least 2 people will call in. In an interview on 7/11/24 at 12:15 PM, Staff I, RN reported the following: a. Staff are expected to answer call lights right away. b. When asked why she felt call lights were not being answered timely, she reported there are a lot of agency staff that aren't familiar with the building and may not know to look up at the [NAME], however, the call lights are audible. In an interview on 7/11/24 at 11:19 AM, Staff M, CNA reported the following: a. Staff are expected to answer call lights as soon as possible. b. Staff call in sick at least two to three times a week on all shifts and more so on the weekends. In an interview on 7/11/24 at 11:30 AM, Staff N, CNA/CMA reported the following: a. Staff are expected to answer call lights within 15 minutes. b. Staff will call in sick at least 3 times a week on the days she is scheduled, however, they try to cover it by asking someone to stay over or have someone come in early. c. Staff should be checking the [NAME] every time they are in the hallway. The call lights are audible. Anyone can answer a call light. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. When call lights aren't answered timely, this usually happens before or after meals when staff are helping residents to and from the dining room to their rooms and when staff are helping residents to bed. In an interview on 7/11/24 at 11:45 AM, Staff O, CNA reported the following: All staff should be able to hear them and see the [NAME] at the end of each hall, except the D hall where there is no [NAME]. 48452 4. The Minimum Data Set (MDS) assessment for Resident #36, dated 4/5/24 documented a Brief Interview for Mental Status (BIMS) of 15/15, which indicated intact cognition. The MDS reflected diagnoses of diabetes mellitus, morbid obesity, and need for assistance with personal care. The assessment indicated Resident #36 was dependent for toileting and transfers, and required partial to moderate assistance for sitting to lying and lying to sitting. The resident's Care Plan included a focus area dated 10/6/23 related to activities of daily living (ADL), with a goal to continue to participate during ADLs and an intervention required assist of 2 staff with toileting. A focus area dated 10/13/22 indicated the resident experienced incontinence. Another section dated 1/11/23 documented the resident had diabetes mellitus with interventions to take diabetes medication as ordered by doctor, and to monitor for and document side effects and effectiveness. On 07/09/24 at 09:19 AM Resident #36 stated his medications were 'messed up' a lot, and that he missed his Ozempic altogether the Saturday before (7/6/24). He stated they seemed short staffed and that someone told him his medication had been thrown away by mistake. He thought they reordered it but he wasn't sure, and he had not heard anything more about it. The resident stated his insulin was often late, and he sometimes received his breakfast insulin closer to lunch. A document titled Hallway Assignments dated 7/6/24 revealed 2 of the 6:00 AM to 2:00 PM staff called off, 2 CNAs on the 2:00 PM -10:00 PM shift did not come in, and another 2nd shift CNA was late. A document titled Medication Administration Record for July 2024 documented the resident did not receive his scheduled semaglutide (1 mg/dose) by solution pen-injector 4 mg/3 ml (Ozempic) on 7/6/24 as scheduled. The box included a number 9, which indicated there was an associated Progress Note. A Progress Note dated 7/6/2024 at 12:58 indicated the resident's medication was not available, and staff requested for pharmacy to send in medication. It noted the facility was awaiting delivery. As of 7/10/24 no follow up documentation was in the electronic health record. A document titled Location Administration Report, dated 07/09/24 at 11:19 AM, revealed that between 7/1/24 and 7/9/24 Resident #36 received the following medications outside of the allowed one hour administration window 33 out of 43 times; Insulin Lispro Injection Solution, Insulin Lispro Solution 100 UNIT/ML, and Insulin NPH (Human) (Isophane) Subcutaneous Suspension 100 UNIT/ML. 15 of those injections were over 2 hours late, with the longest gap documented as a 7:00 AM dose of Lispro given at 10:20 AM on 7/8/24. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/11/24 at 8:59 AM Certified Medication Aide, Staff F, confirmed the resident did not receive his semaglutide over the weekend and that some of his medications have been late. She stated the semaglutide medication was requested 7/6/24 and it had not been received. An interview with the Director of Nursing on 7/11/24 at 9:32 AM determined she was not aware of the missed medication and needed to follow up. A policy titled Administering Medications, revised April 2019, indicated medications were to be administered in a safe and timely manner, and as prescribed. Staffing schedules were arranged to ensure medications were administered without unnecessary interruptions. Medications were administered in accordance with prescriber orders, including any required time frame.

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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. 49976 Based on observation, policy review, and staff interview the facility failed to keep fingers off the drinking surface of glasses during dining service. The facility reported a census of 58 residents. Findings include: During an observation on 7/08/24 at 11:25 AM Staff A, Dietary Aide passed 20 glasses to 14 residents with fingers over the top of the glass or touching the drinking surface on the side of the glass. She served 7 glasses to 2 residents with fingers on the inside surface of the glass. During an interview on 7/10/24 at 8:31 AM Dietary Service Manager explained staff are instructed to have no fingers on the plates, they must wear hair nets, and no gloves are worn unless cleaning. Staff can pour drinks ahead of time but they have to cover, date, and refrigerate them. Diets are right on the ticket to make sure the order matches. She further explained no hands are to be over the top on tumblers, and staff must use handles on the mugs. The facility policy titled Sanitation, updated October 2008 lacked direction for hand placement during dining service.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, and staff interview, the facility failed to utilize the proper infection control techniques during wound care for 1 of 2 residents (Resident #14). The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #14 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 15 and had the following diagnoses: Heart Failure, Renal Insufficiency and COPD (Chronic Obstructive Pulmonary Disease) The MDS also identified Resident #14 to be dependent on staff with assistance with putting on and taking off footwear, transfers from chair to bed and from sitting to standing. On 7/30/20, the Care Plan identified Resident #14 with the problem of being at risk for pressure ulcers and has an open areas on her right shin. The Care Plan did not identify Resident #14 developed pressure ulcers to both outer calves. On 3/25/24, the Care Plan directed staff to teach her the risk factors for development of pressure ulcers. In an observation of wound care on 7/10/24 8:32 AM Staff H, LPN had donned an isolation gown and gloves, removed the soiled dressing from the wound to Resident #14's left calf area. Staff H cleansed the wound using the correct technique, then picked up the scissors with same gloves and left the scissors in the Calcium Alginate packet which had already been opened. Then Staff H changed gloves and did not disinfect the scissors (after she had picked them up with previous gloves) and cut the Calcium Alginate dressing and placed the dressing on to wound to left calf then covered with Mepilex Border Flex Lite dressing. The wound appeared to have a small necrotic area to the top of the wound, however, no signs of infection noted to the surrounding skin. 7/10/24 at 8:39 AM Staff H then used the correct technique to cleanse the wound to the right outer calf, however, she did not disinfect the scissors before she cut the Calcium Alginate dressing. Staff H placed the dressing onto the wound. The wound to the right calf did not have any necrotic areas or any redness to surrounding skin. A review of the Progress Notes revealed the following: 03/25/24 New wounds which opened up 4 days ago. The nurse called stating she has a new blister on her leg that popped up rather quickly and large, she has had these blisters before. She has no feeling on these aspects of her legs, with history of neuropathy. Her blisters seem to be where her wheelchair rubs with the footrest bars. Does have chronic edema issues, this has been slowly worsening with time, but no worse today than last week. The wound to the left outer leg On 3/22/24 the wound was 4.6 cm (centimeters) long, 2.2 cm wide and had no depth. No signs of infection (no odor or purulence, inflammation or surrounding erythema or undue warmth). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The wound to the right outer leg On 3/22/2024, the wound was 5.1 cm long, 3.0 cm long and had no depth. There was surrounding erythema and warmth and inflammation, mild yellow drainage on the bandage. In an interview on 7/10/24 at 10:25 AM, the DON (Director of Nursing) reported that she would expect the nurse during wound cares to change gloves anytime they are going from dirty to clean. For example if they take dirty bandages off, take off gloves and do hand hygiene and then new gloves. And any time they are soiled. Scissors- definitely when they come out of the room. They should sanitize in between if using scissors going from a dirty bandage to a clean bandage. In an interview on 7/11/24 at 7:52 AM, the ADON (Assistant Director of Nursing) reported when providing wound care, she would expect the nurse to change her gloves any time she soils them and disinfect the scissors any time they get soiled or prior to and after using. In an interview on 7/11/24 at 12:15 PM, Staff I, RN reported when providing wound care the nurse should change her gloves any time they get soiled and they should disinfect the scissors after each use.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, resident and staff interview, the facility failed to repair call lights for 2 of 2 residents (Residents #28 and #36). The facility reported a census of 58 residents. Findings include: 1. The MDS dated [DATE] identified Resident #28 as cognitively intact with a BIMS of 15 and had the following diagnoses: Diabetes Mellitus, Bipolar Disorder, and Right Below the Knee Amputation. The MDS also identified Resident #28 was completely dependent on staff for assistance with toileting, showers, putting on and taking off footwear, lower body dressing, and personal hygiene. In an interview on 7/9/24 7:41 AM, Resident #28 reported when asked if staff answer his call light timely, he stated when his call light works. The call light will not work properly and this happens at least once a month. The longest he has had to wait to get his call light answered is 3 hours. When asked if he had reported the problem to anyone, he stated the CNAs knew about it when he told them it didn't work, he assumed they would tell the maintenance supervisor. In an interview on 7/10/24 at 2:13 PM, the Maintenance Supervisor reported the following: a. When asked if he worked full time at the facility, he reported he worked full time at another facility and tries to come to this facility once a week. b. He had trained the last 2 maintenance supervisors, and both were terminated. c. When asked how he is notified of any repairs that need to be completed, he reported there is a book that the staff will write down what repairs need to be done. When it's done it gets crossed off. They're not always good about filling out the form. Sometimes they will verbally tell me when I am here. When I come in, I will check the book first thing in the morning and before I leave. d. When asked if work orders were recorded when completed, he reported the work orders stay in the book and after he completed the orders, he crossed it off as completed and initial it. e. When asked if he had been notified of any problems with call lights not working, he reported he had been notified of some the last few times he was at the facility and repaired them before he left for the day. f. He had not been aware of the call light for Resident #28's room not functioning. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165228	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dubuque Specialty Care	2935 Kaufmann Avenue Dubuque, IA 52001

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 2:31 PM, the Maintenance Supervisor returned and reported he looked at the call light for Resident #28 and it appeared to be working fine. He also reported there was a problem with the wrong room numbers showed up on the [NAME] and he repaired that today. The housekeeper had called the previous Maintenance Supervisor and he told her the transmitter has 2 wires that gets hooked up to where the call light plugs in. There is a wireless transmitter in the wall. The current Maintenance Supervisor reported he took care of that problem today because the housekeeper hooked it up wrong. In an interview on 7/11/24 at 11:19 AM, Staff M, CNA reported if a resident reports their call light isn't working, she would report it to the charge nurse, then to the maintenance supervisor. 48452 2. The Minimum Data Set (MDS) assessment for Resident #36, dated 4/5/24 documented a Brief Interview for Mental Status (BIMS) of 15/15, which indicated intact cognition. The MDS reflected diagnoses of diabetes mellitus, morbid obesity, and need for assistance with personal care. The MDS indicated Resident #36 was dependent for toileting and transfers, and required partial to moderate assistance for sitting to lying and lying to sitting. The resident's Care Plan included a focus area dated 10/6/23 related to activities of daily living (ADL), with a goal to continue to participate during ADLs and an intervention required assist of 2 staff with toileting. A focus area dated 10/13/22 indicated the resident experienced incontinence. These focus areas lacked documentation of the urinal as an intervention and the resident's request for staff assistance with it. A document titled Documentation Survey Report v2, dated 07/11/24 at 7:48 AM, revealed the resident had incontinence episodes during the day shift July 4, 5, and 10. On 07/09/24 at 09:19 AM observed the resident lying in bed with a urinal next to him and the TV on. He stated he kept it close most of the time in case he needed it but sometimes forgot to make sure it was there. He indicated he could use it himself, but when he did not feel well it was better to have help. Resident #36 stated he had urinated on himself in the past when he could not hold it any longer and described urine ending up on his stomach and legs, the bed, and the floor. He said he put his call light on the morning that happened, and it was 3 hours before anyone came (TV as a time reference). He reported a certified nursing assistant (CNA) told him the call light system must not be working because it was not on in the hallway. The resident could not confirm if the light had been repaired. On 07/09/24 at 1:40 PM Staff B, CNA, stated the resident had reported long call lights and she was aware of at least one incident where he 'had an accident' when staff did not get there in time to provide assistance. She stated he could use the urinal alone, but she understood it might be harder if his blood sugars were low or he did not feel well. Staff B added the resident sometimes left the urinal hanging on a garbage can out of his reach and would need help getting it. An interview with the Administrator on 7/10/24 at 8:05 AM determined audits are conducted every weekend. She was not aware of any documented call light complaints. She also stated Resident #36 could use the urinal himself. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing 7/10/24 at 8:16 AM revealed residents had spoken to her about call lights. She stated the staff were very busy and the population of the facility was younger with more needs. She was not aware of documented complaints. On 7/10/24 at 2:19 PM the Maintenance Supervisor stated he was in the building once per week, and the last couple of times he was in the building there were issues with call lights not working. He stated he didn't know how to run a call light report with this system and didn't think they even could. A policy titled Answering the Call Light, revised March 2021, documented staff should be sure that call light was plugged in and functioning at all times.