STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165235	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lenox Care Center	111 East Van Buren Lenox, IA 50851

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on the clinical record review, resident interview, staff interview and policy review the facility failed to provide access to personal funds managed by the facility for 1 of 1 residents reviewed. The facility reported a census of 24 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] documented Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 2/24/25 at 11:55 AM Resident #11 stated she wanted to have some money on the weekend recently to buy soda but it is not available from personal funds at the facility on the weekends or in the evenings. On 2/25/25 at 2:28 PM Staff C, Business Office Manager stated the facility did have money in a lockbox available for the residents. Staff C stated the facility kept $110.00 in the lockbox. Staff C stated she and the Administrator are the only staff that had access to the petty cash. Staff C stated the residents could not have money if she was not in the building unless it was an emergency. Staff C stated she worked at the facility 8:00 AM to 4:30 PM or 5:00 PM. Staff C stated she worked Monday through Friday. Staff C stated the residents at the facility did not have access to their money in the evening or on the weekend. Staff C acknowledged yesterday a resident wanted to break a $10.00 bill for $10.00's in change but she was not at the facility. Staff C stated the resident did not get the $10.00 bill broken. Staff C stated a CNA told her this morning. On 2/25/25 at 2:55 PM Staff B, CNA stated she works the 2-10 PM shift and every other weekend. Staff B stated a resident asked just the other day if she could have money in the evening. Staff B stated residents did not have access to get money from the resident trust in the evening or on the weekends. Staff B stated the only person that has access to resident funds was Staff C. On 2/25/25 at 3:08 PM the Administrator stated the residents could ask the staff to call the Administrator or Staff C to come in and get money for the residents. The Administrator acknowledged she had not been asked to come in on the weekends or in the evening. The Administrator stated she thought Staff C works sometimes on the weekend. The Administrator acknowledged the residents at the facility did not have access to funds on the weekends or in the evening when the Administrator or Staff C had left. (continued on next page)

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

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of policy revised 3/21 titled, Deposit of Residents' Personal Funds documented that if a resident chose for the facility to hold personal funds, the facility would provide the resident access to funds of 100 dollars (fifty dollars for Medicaid residents) or less within twenty-four hours, and access to funds in excess of 100 dollars (fifty dollars for Medicaid residents) within three banking days.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49628 Based on clinical record review, staff interviews, and policy review the facility failed to develop and implement a Comprehensive Care Plan for 2 of 12 residents (Resident #16, and #5) reviewed. The facility reported a census of 24 residents. 1. The Minimum Data Set (MDS) for Resident #16 dated 1/28/25 identified a Brief Interview for Mental Status (BIMS) score of 2/15 indicating a severe cognitive impairment. The MDS included diagnoses of Non-Alzheimer's Dementia, depression, psychotic disorder, and hypertension. The MDS did not identify a diagnosis for use of oxygen. The MDS indicated Resident #16 did not utilize oxygen during the reporting period. The Electronic Medical Record (EMR) Physician Orders dated 2/25/25 revealed Resident #16 was ordered on 11/20/22 oxygen at 2 liters/minute via nasal cannula as needed to keep saturations above 90%. The Physician Orders failed to identify times for monitoring of oxygen saturations. The EMR vitals oyxgen saturation summary revealed saturations were monitored weekly. The Care Plan revised 1/14/25 revealed lack of documentation related to respiratory compromise. The facility failed to develop a Comprehensive Care Plan with goals and interventions related to oxygen. On 2/25/25 at 12:18 PM Staff A, Certified Nursing Assistant (CNA), stated Resident #16 did use oxygen but not all the time. On 2/25/25 at 2:31 PM Staff B, CNA, stated she had not seen Resident #16 out of breath, and did not know when the resident used oxygen. On 2/25/25 at 2:37 PM Staff P, the Assistant Director of Nursing (ADON)/Social Worker/Licensed Practical Nurse (LPN), stated Resident #16 began using oxygen around Thanksgiving when the resident's oxygen would randomly drop for no apparent reason. Staff P stated saturations should be monitored on each shift which would be twice a day to ensure saturations were stable. Staff P stated the Care Plan should identify the use of oxygen as well as the signs/symptoms for use, what to do, who is responsible, and when to do it. Staff P stated Care Plans should be able to provide instructions for anyone new to working with the resident. On 2/25/25 at 2:55 PM the Director of Nursing (DON) stated she was aware that all of the Care Plans may not be completely up to date and there were likely problems. The DON stated the facility was working to correct this and that Care Plans should reflect the needs of the residents. 47673 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS for Resident #5, dated 12/27/2024 did not document a BIMS. The MDS documented Resident #5 was rarely/never understood. The MDS documented Resident #5 required the use of an enteral tube, tracheostomy tube, and a suprapubic catheter. The MDS also documented diagnoses of athetoid cerebral palsy, abnormal posture, contracture of right hand, contracture of left hand, contracture unspecified ankle, contracture unspecified knee, contracture unspecified hip, unspecified quadriplegia, and unspecified dystonia. Review of Resident #5's Electronic Heath Record (EHR) titled, Care Plan documented no focus, goal, or intervention in place for restorative, physical therapy, or occupational therapy (OT). The Care Plan also did not document a focus, goal or intervention for repositioning Resident #5. On 2/25/25 at 1:55 PM Staff Q, CNA stated Resident #5 does not get repositioned. Staff Q stated Resident #5 only had stuffed animals under his arm. Staff Q stated Resident #5 laid only on his back in bed. Staff Q stated Resident #5 would grimace when repositioned. On 2/25/25 at 1:55 PM Staff A, CNA stated Resident #5 does not get repositioned. Staff A stated Resident #5 only stuffed animals under his arm. Staff Q stated Resident #5 laid only on his back in bed. Staff Q stated Resident #5 would grimace when repositioned. On 2/25/25 at 2:10 PM the DON stated Resident #5 did not get repositioned from side to side. The DON stated Resident #5 only laid on his back while in bed. The DON stated the air flow mattress provided enough change in position that Resident #5 did not need repositioning. The DON acknowledged there was no Care Plan focus, goals, or interventions in place related to Resident #5's positioning. The DON acknowledged there should be a Care Plan with focus, goal, or intervention for positioning. On 2/26/25 at 9:37 AM the DON stated a restorative program was on the EHR but fell off in September of 2024. The DON acknowledged there was a system error that led to the restorative program falling off the EHR. The DON stated they would get OT involved to find out if the restorative was appropriate and repositioning was needed. On 2/26/25 at 9:40 AM the Administrator stated it was the facility 's expectation that staff would reposition Resident #5. The Administrator stated Resident #5 was on a restorative program and still should have been. The Administrator acknowledged that the restorative program was on the EHR but fell off in September of 2024. The Administrator acknowledged there was a system error that led to the restorative program falling off the EHR. On 2/26/25 at 5:49 PM the DON stated that Resident #5 was repositioned when care was completed. The DON stated that personal cares were Resident #5's repositioning. On 2/26/25 at 5:51 PM the Administrator stated she would have expected something with therapy would have been completed. The Administrator acknowledged Resident #5 should have a Care Plan in place for positioning and restorative care. The Administrator acknowledged Resident #5 did not have either Care Plan in place. Review of policy revised 7/17 titled, Restorative Nursing Services documented residents will receive restorative nursing care as needed to help promote optimal safety and independence. The document also states the restorative goals and objectives are individualized and resident - centered, and are outlined in the resident's plan of care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy dated 5/13 titled, Repositioning documented the purpose of this procedure was to provide guidelines for the evaluation of the residents repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. Residents who are in bed should be on at least an every 2 hour repositioning schedule. Review of policy dated 3/22/22 titled, Care Plans, Comprehensive Person - Centered documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Care plan interventions are derived from a thorough analysis of the information gathered as part of comprehensive assessment. Review of policy revised 3/18 titled, Activities of Daily Living (ADL), supporting documents that residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's). Residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain food nutrition, grooming and personal and oral hygiene. Appropriate care and services would be provided for residents who are unable to carry out ADLs independently, with the consent of the resident in accordance with the plan of care including appropriate support and assistance with bathing and mobility. Care and services to prevent and or minimize functional decline will include appropriate pain management, as well as treatment for depression and symptoms of depression. The resident's ability to perform ADL's will be measured using clinical tools, including the MDS. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice.

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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** 49628 Based on clinical record review, staff interviews, observations and policy reviews the facility failed to review and revise the Care Plan interventions for 3 of 12 residents reviewed (Resident #12, #19, and #2). The facility failed to revise Care Plan Interventions for a resident who smoked, a resident who utilized a power wheelchair (w/c), and failed to include a family representative in the Care Plan Conference. The facility reported a census of 24 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #12 scored 15/15 on the Brief Interview for Mental Status (BIMS) indicating normal cognition. The resident had diagnoses of hypertension, anxiety disorder, depression, and morbid (severe) obesity. The resident required total staff assistance for toilet hygiene, bathing, footwear and substantial/maximal assistance for lower body dressing. Resident #12 completed bed mobility independently, transferred bed to w/c and toilet independently and walked 10 feet. The document revealed ambulation of 50 feet or greater with 2 turns was not attempted due to medical condition or safety concerns. The document revealed the resident utilized a motorized w/c for 150 feet with independence. The Electronic Medical Record (EMR) Progress Notes revealed the resident refused 19/30 opportunities of walk to dine restorative nursing program. The document revealed on 8/9/24 an order was received for discontinuation of the walk to dine restorative nursing program. Resident #12's Care Plan revised 2/3/25 with a focus area of risk of falling revealed an intervention for walking to meals. The facility failed to update the intervention upon discontinuation of the restorative nursing program on 8/9/24. On 2/25/25 at 2:47 PM Staff P, the Assistant Director of Nursing (ADON)/Social Worker/Licensed Practical Nurse (LPN) stated she did not believe Resident #12 walked to the dining room for meals. The staff stated she was not sure if that was on the Care Plan. 2. According to the MDS dated [DATE] Resident #19 scored 11/15 on the BIMS indicating moderate cognitive impairment. The resident had diagnoses of coronary artery disease, hypertension (high blood pressure), Non-Alzheimer's Disease, anxiety, depression, psychotic disorder, and nicotine dependence. The EMR Smoking Data Collection dated 12/2/24 revealed Resident #19 required smoking interventions of a smoker's apron, and supervised smoking. Resident #19's Care Plan revised 10/31/24 revealed a focus area for risk for injury related to smoking. Interventions for staff to follow included that the resident is not required to wear a smoker's apron at this time. The facility failed to update the Care Plan with the interventions from the Smoking Data Collection dated 12/2/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 2:43 PM Staff P stated she and the Director of Nursing (DON) primarily completed the assessments in the EMR, but sometimes floor nurses may complete an assessment. Staff P stated the smoking assessment was completed upon admission and then quarterly thereafter. Staff P stated the interventions recommended from the smoking assessment should be on the Care Plan. On 2/25/25 at 2:55 PM the DON stated she was aware that the Care Plans may not be completely up to date and there were likely problems. The DON stated the facility was working to correct this and that Care Plans should reflect the needs of the residents. Observed Resident #19 on 2/25/25 at 3:04 PM wearing a smoker's apron while smoking. 47673 3. The MDS for Resident #2 dated 1/7/24 documented a BIMS score of 0 indicating severe cognitive impairment. On 2/24/25 at 3:09 PM Resident #2's Power of Attorney (POA) stated she spoke to Staff P, a couple months ago about when Resident #2's care conferences would be. The POA stated Staff P told her that she was not sure. The POA stated she had not been invited to the care conference held in January 2025. Review of the EHR titled, Progress Notes entry by Staff P on 1/7/2025 at 10:01 AM documented a Care Plan meeting was held with resident, POA, DON, SSD, and charge nurse. No concerns voiced, no request for transfer to another facility, meds reviewed, no change in code status was desired. On 2/25/25 at 10:56 AM Staff P stated Resident #2 usually stated that she did not want to attend the care conferences. Staff P stated she notifies Resident #2 about the care conferences in advance. Staff P stated Resident #2 and Resident #2's POA was not present at the Care Plan meeting that was held 1/7/25. Staff P acknowledged that was inaccurately documented. Staff P stated she did not document when family members were notified of the care conference. Staff P stated she usually calls the resident family or POA. Staff P stated she spoke with Resident #2's POA about the Christmas party being scheduled. Staff P stated she did not remember if she reached out to the POA after that to invite her to the care conference. Staff P acknowledged that care conferences had not been done at all prior to her starting in her position in June of 2024. Staff P acknowledged she did not know what was supposed to be included in the care conference even now. Staff P stated the facility has in-services called lunch and learns and most recently she just found out she was supposed to be documenting who was present at the meetings. On 2/25/25 at 12:16 PM the DON acknowledged Care Plan conferences were not being completed appropriately prior to Staff P starting in her current position in June 2024. The DON stated care conferences should be completed every 3 months with the resident, resident family member, or POA if possible. The DON stated the facility's expectation was that accurate documentation of who was present at the care conferences would be completed. The DON stated the facility's expectation was the resident and/or residents POA would be invited to the care conference. Review of policy dated 3/22 titled, Care Planning - Interdisciplinary Team documented the resident, the resident's family and / or the resident's legal representative / guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan.

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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. 47673 Based on Electronic Health Records (EHR) review, staff interviews, and policy review the facility failed to provide an opportunity for bath or shower and reposition 1 of 12 residents reviewed (Resident #5). The facility reported a census of 24 residents. Finding include: The Minimum Data Set (MDS) for Resident #5, dated 12/27/24 did not document a Brief Interview for Mental Status (BIMS) score. The MDS documented Resident #5 was rarely/never understood. The MDS documented Resident #5 required the use of an enteral tube, tracheostomy tube, and a suprapubic catheter. The MDS also documented diagnoses of athetoid cerebral palsy, abnormal posture, contracture of right hand, contracture of left hand, contracture unspecified ankle, contracture unspecified knee, contracture unspecified hip, unspecified quadriplegia, and unspecified dystonia. Review of Resident #5's Care Plan documented Resident #5 had a self-care deficit and required assistance with Activities of Daily Living (ADLs). Resident #5 required 2 people to assist and encourage bathing 2 x weekly. Resident #5 required 2 person assistance with bed mobility. Resident #5 mobility was described as bed bound. The Care Plan documented Resident #5 was at risk for pain/discomfort and increased risk for injury from decreased function related to dx of cerebral palsy. The Care Plan also documented to attempt and document any of non-pharmacological interventions used as appropriate such as repositioning, heat pack, and massage. Encourage Resident #5 to shift weight, if able, every 2 hours to assist with skin integrity. On 2/25/25 at 1:55 PM Staff Q, Certified Nursing Assistant (CNA) stated Resident #5 does not get repositioned. Staff Q stated Resident #5 only had stuffed animals under his arm. Staff Q stated Resident #5 laid only on his back in bed. Staff Q stated Resident #5 would grimace when repositioned. On 2/25/25 at 1:55 PM Staff A, CNA stated Resident #5 does not get repositioned. Staff A stated Resident #5 only stuffed animals under his arm. Staff Q stated Resident #5 laid only on his back in bed. Staff Q stated Resident #5 would grimace when repositioned. On 2/25/25 at 2:10 PM the Director of Nursing (DON) stated Resident #5 did not get repositioned from side to side. The DON stated Resident #5 only laid on his back while in bed. The DON stated the air flow mattress provided enough change in position that Resident #5 did not need repositioning. On 2/26/25 at 9:40 AM the Administrator stated it was the facility's expectation that staff would reposition Resident #5. On 2/26/25 at 10:06 AM Staff R, Certified Occupational Therapy Assistant (COTA) / Director of Rehab stated he was familiar with Resident #5. Staff R stated the pressure relief mattress would be enough to prevent breakdown. Staff R stated the pressure relief mattress was to offload weight. Staff R stated he did not think repositioning would benefit the resident. Staff R stated there was a current order to evaluate. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 5:49 PM the DON stated that Resident #5 was repositioned when care was completed. The DON stated that personal cares were Resident #5's repositioning. Review of documents titled, Bathing Records for the last 90 days revealed 24 opportunities for baths. The clinical record lacked documentation of baths being given on 12/20, 12/13, and 11/29/24. Bathing records revealed Resident #5 received only one bath a week for 3 out of 4 weeks and was not given a bath on Friday 3 out of 4 of the same weeks. The weeks were 11/24/24 - 12/21/24. On 2/27/25 at 9:06 AM the DON stated the facility's expectation for baths was Resident #5 would have received 2 baths a week on Tuesday and Friday and made up if the bath was missed. The DON acknowledged baths were missed on 12/20, 12/13, and 11/29/24. The DON acknowledged Resident #5 did not get a bath 3 out of 4 weeks on Fridays. Review of policy dated 5/13 titled, Repositioning documented the purpose of this procedure was to provide guidelines for the evaluation of the residents repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. Residents who are in bed should be on at least an every 2 hour repositioning schedule. Review of policy revised 3/18 titled, Activities of Daily Living (ADL), documented that residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's). Residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain food nutrition, grooming and personal and oral hygiene. Appropriate care and services would be provided for residents who are unable to carry out ADLs independently, with the consent of the resident in accordance with the plan of care including appropriate support and assistance with bathing and mobility. Care and services to prevent and or minimize functional decline will include appropriate pain management, as well as treatment for depression and symptoms of depression. The resident's ability to perform ADL's will be measured using clinical tools, including the MDS. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47673 Based on Electronic Health Records (EHR), staff interview, and policy review the facility failed to provide restorative cares to promote range of motion to 1 out of 1 residents reviewed (Residents #5). The facility reported a census of 24 residents. Findings include: The Minimum Data Set (MDS) for Resident #5, dated 12/27/24 did not document a Brief Interview for Mental Status (BIMS) score. The MDS documented Resident #5 was rarely/never understood. The MDS documented Resident #5 required the use of an enteral tube, tracheostomy tube, and a suprapubic catheter. The MDS also documented diagnoses of athetoid cerebral palsy, abnormal posture, contracture of right (R) hand, contracture of left (L) hand, contracture unspecified ankle, contracture unspecified knee, contracture unspecified hip, unspecified quadriplegia, and unspecified dystonia. Review of Resident #5's EHR titled, Care Plan documented no focus, goal, or intervention in place for restorative, physical therapy, or occupational therapy. Review of Resident #5's EHR revealed Resident #5 had no restorative therapy, physical therapy, or occupational therapy. Review of document dated 6/16/24 titled, Occupational Therapy OT Evaluation and Plan of Treatment documented for assessment summary clinical impressions were Resident #5 unable to communicate or actively move upper extremities and lower extremities. Resident #5 dependent for all cares and positioning with good staff support. Review of document dated 6/16/24 titled, Occupational Therapy OT Recert, Progress Report, and Updated Therapy documented continued OT services are necessary in order to assess use of palm protectors for both hands to reduce risk of skin breakdown and ROM to prevent further contracture. The document also documented Resident #5 demonstrated good rehab potential as evidenced by supportive caregivers/staff. Review of document dated, 7/6/24 titled, Occupational Therapy Treatment Encounter Notes documented Resident #5 would benefit from a trial of carrot hand orthosis to improve ROM and reduce contracture. Review of document dated, 7/10/24 titled, Occupational Therapy Treatment Encounter Notes documented Resident #5 would benefit from palm protectors to decrease skin breakdown and prevent contractures from getting worse. Order form given to DON for both R and L. Review of document dated, 7/14/24 titled, Occupational Therapy Treatment Encounter Notes documented palm protectors ordered for both hands to decrease risk of skin breakdown. Recertification completed to continue therapy. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's EHR titled Treatment Administration Record (TAR) documented no splint orders and no carrot hand orthosis orders. Review of the TAR also revealed no orders for restorative therapy. Review of document titled, Occupational Therapy OT Discharge Summary documented the reason for Resident #5's discharge was because Resident #5 discharged to the hospital. The document also revealed Resident #5 progress was there was no progress to report. Resident #5 was unable to tolerate a gentle range of motion to bilateral upper extremities. Ordered palm protectors as the best options to prevent contractures from worsening and reduce risk of skin breakdown. On 2/26/25 at 9:37 AM the DON stated a restorative program was on the EHR but fell off in September of 2024. The DON acknowledged there was a system error that led to the restorative program falling off the EHR. The DON stated the facility would get occupational therapy (OT) involved to find out if the restorative was appropriate. On 2/26/25 at 9:40 AM the Administrator stated Resident #5 was on a restorative program and still should have been. The Administrator acknowledged that the restorative program was on the EHR but fell off in September of 2024. The Administrator acknowledged there was a system error that led to the restorative program falling off the EHR. On 2/26/25 at 10:06 AM Staff R, Certified Occupational Therapy Assistant (COTA) / Director of Rehab stated he was familiar with Resident #5. Staff R stated Resident #5 was on therapy a couple of times to prevent contractures in the past. Staff R stated Resident #5 was on occupational therapy (OT) from 6/24 to 7/24. Staff R stated Resident #5 was on evaluation only for physical therapy (PT) and was referred for contracture management for PT and then OT picked Resident #5 up. Staff R stated Resident #5's short term goal was trial of orthotic splints for the palms of Resident #5's hands. Staff R stated there was an ordered request given to the DON for purchase of palm protectors. Staff R stated Resident #5 was discharged from OT when he was discharged to the hospital. Review of policy revised 7/17 titled, Restorative Nursing Services documented residents will receive restorative nursing care as needed to help promote optimal safety and independence. The document also states the restorative goals and objectives are individualized and resident - centered, and are outlined in the resident's plan of care.

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F 0692 Level of Harm - Minimal harm or potential for 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** 47079 Based on observations, clinical record review, staff interviews and policy review, the facility failed to provide care and services to maintain acceptable parameters of nutritional status for 1 of 1 resident (#1) reviewed for nutrition. This failure resulted in Resident #1 experiencing a weight loss of 11.05% in 6 months. The facility reported a census of 24 residents. Findings include: On 2/24/25 at 11:27 AM, Resident #1 was observed asleep in her bed. At 2:22 PM, Resident #1 got up, walked to the kitchen, knocked on the kitchen door, and got a tray of food the kitchen staff heated up. The Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. It included diagnoses of diabetes mellitus, Alzheimer's Disease, non-Alzheimer's dementia, bipolar disorder, psychotic disorder, schizoaffective disorder, and anxiety. It indicated she required moderate assistance with bathing and was independent with all other Activities of Daily Living (ADLs). It also indicated she had a 10% or more weight loss in the previous 6 months and was not on a physician-prescribed weight-loss regimen. The Care Plan dated 8/21/24 indicated Resident #1 had a potential nutritional problem related to her schizoaffective disorder, Alzheimer's Disease, bipolar disorder, anxiety, and diabetes mellitus. It directed staff to monitor/record/report to the medical doctor (MD) as needed (PRN) signs and symptoms of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3 lbs in 1 week, >5% in 1 month, >7.5% in 3 months, or >10% in 6 months. It also directed staff to provide, serve diet as ordered: Regular diet with thin liquids. Monitor intake and record every meal. A weight change note authored by the Registered Dietitian (RD) dated 2/05/25 at 12:48 PM revealed Resident #1 experienced a significant weight loss of 7.3% in 30 days, 7.5% in 90 days and 11% in 180 days. It indicated with available information, continue same and monitor as needed. On 2/25/25 at 9:05 AM, the resident was observed asleep in her room. At 11:53 AM, Resident #1 got up, walked to the kitchen, knocked on the kitchen door, and got something to drink. She walked back to her room then returned and sat in the dining room. On 2/26/25 at 7:20 AM and 9:14 AM, Resident #1 was observed asleep in her room. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 9:29 AM, the RD stated she generates a Weights and Vitals Exception Report on Wednesdays when she is at the facility and reviews meal intake amounts, labs, and nurses' notes. She also stated she talks to the Certified Nursing Aides (CNAs) and kitchen staff to see if the resident had been asking for meals, and selecting the regular menu and not a bowl of soup, etc. She confirmed she had not been notified that staff had not been waking the resident for breakfast. She stated had she been told staff hadn't been waking the resident for meals, she would've rechecked the resident's weight and directed staff to attempt to awaken the resident for each meal and document resident refusals or ineffective attempts to awaken the resident. She stated with the available information, she didn't feel a nutrition supplement was necessary because the resident remained above Ideal Body Weight Range (IBWR). On 2/26/25 at 10:05 AM, Staff F, Certified Medication Aide (CMA) stated she had not been instructed to not wake the resident up for meals. She also stated she was not aware of the resident's significant weight loss. At 10:40 AM, Resident #1 walked up to the nurses' station and asked about food. Staff G, Activities Supervisor, told her lunch was not for another hour and 20 minutes. Resident #1 walked to the kitchen entrance, knocked on the kitchen door, and asked Staff H, AM cook, for some lunch. Staff H told Resident #1 lunch was in 1 hour and 20 minutes and offered Resident #1 something to drink. Resident #1 went into the dining room and sat down. At 10:42 AM, Resident #1 stated she was hungry but said staff wasn't getting her any food for another hour. Staff H brought Resident #1 some punch. Resident #1 drank it and went back to her room. On 2/26/25 at 10:54 AM, Staff A, Certified Nurse Aide (CNA) did not identify Resident #1 as not wanting to be awakened for meals. At 10:59 AM, Staff J, CNA stated Resident #1 did not like to be awakened for meals. She also indicated she was not aware of Resident #1's significant weight loss. At 11:08 AM, Resident #1 stated she never asked staff to not awaken her for meals and added she would not get mad if they did. At 1:48 PM, Staff H stated she was told the resident refused breakfast Monday (2/24/25), Tuesday (2/25/25), and Wednesday (2/26/25). She stated she prepared a breakfast plate for Resident #1 on those days but threw it away just before lunch time. She confirmed she does not document resident meal refusals and had not been made aware of the resident's significant weight loss. The Electronic Health Record (EHR) Meal Eaten Response History dated 1/28/25 to 2/25/25 did not include any documented breakfast responses. On 2/27/25 at 3:11 PM, the Administrator stated staff should have given the resident a snack and provided an alternative. She added staff should attempt to wake the resident for breakfast and lunch and document if it's refused. A policy titled Assistance with Meals revised March 2022 indicated residents shall receive assistance with meals in a manner that meets the individual needs of each resident.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observations, record review, staff interview, and policy review the facility failed to ensure a medication error rate of less than 5%. During observations of medication administration, the facility had 2 errors out of 28 opportunities for errors resulting in an error rate of 7.14% (Residents #178). The facility identified a census of 24 residents. Findings include: On 2/25/25 beginning at 7:16 AM, Staff F, Certified Medication Aide (CMA) prepared the following medications to administer to Resident #178: a) One (1) Oxycodone/APAP 5/525 milligrams (mg) tablet b) Miralax 17 grams c) gabapentin 2 milliliters (mL) d) One (1) celecoxib 100 mg capsule e) One (1) citalopram 40 mg tablet f) One (1) azathioprine 50 mg tablet g) One (1) Lisinopril 10 mg tablet h) One (1) Omeprazole 40 mg capsule i) One (1) multivitamin (MVI) tablet j) One (1) vitamin C 500 mg tablet k) One (1) Ocuvite gummy Staff F confirmed there were 11 medications, she then administered them to Resident #178. The Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score was not documented. It indicated the resident had memory problems and severely impaired decision-making ability. It included diagnoses of diabetes mellitus, anxiety disorder, immunodeficiency, Alzheimer's Disease, and dementia. The Electronic Health Record (EHR) included a physician's two (2) orders for a) Vitamin C oral tablet 1000 mg; give 1 tablet by mouth one time a day for promote wound healing, and b) Omeprazole oral capsule delayed release 20 mg; give 1 capsule by mouth every morning. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration Record (MAR) revealed staff acknowledged administering one (1) Omeprazole oral capsule delayed release 20 mg by mouth one time a day between 2/01/25 through 2/27/25. The pharmacy supplied Omeprazole 40 mg; take 1 capsule by mouth every morning. The Care Plan dated 1/19/25 indicated the resident had an unstageable pressure ulcer on her left heel and included Vitamin C 1000 mg order obtained to promote wound healing. On 2/27/25 at 9:25 AM, Staff F stated the resident received one (1) 500 mg tablet by mouth Tuesday, 2/25/25 during medication pass observation. She confirmed the stock medication bottle was 500 mg tablets. On 2/27/25 at 11:38 AM, the Assistant Director of Nursing (ADON) stated the Omeprazole order was supposed to be 40 mg and was incorrectly entered into the resident's EHR. At 3:46 PM, the Director of Nursing (DON) stated staff should have been looking at the MAR and should have clarified the order with the physician. A policy titled Medication Therapy revised April 2007 indicated all medication orders will be supported by appropriate care processes and practices.

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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. 47673 Based on observation, document review and staff interview the facility failed to follow the menu and prepare food to meet the nutritional needs of the residents by not serving residents on a mechanical soft diet the appropriate amount of meat according to the menu for 4 of 24 residents reviewed. The facility reported a census of 24 residents. Findings include: On 2/26/25 at 11:50 AM Staff H, AM [NAME] obtained 8 meatballs and placed them in the food processor. Staff H processed the meatballs and removed them from the processor into a plastic container. Staff H then placed the plastic storage container in a pan in the steam table. Lunch was served. Tongs were utilized for serving mechanical soft meatballs. The last plate was for a resident with a mechanical soft diet. Staff H measured 1/3 cup for the remaining mechanical soft meatballs. Review of document titled, Diet Spreadsheets Week 3 Wednesday documented 2 ground meatballs for mechanical soft diets. On 2/26/25 at 1:10 PM Staff I, Certified Dietary Manager (CDM) acknowledged all of the mechanical soft meatballs should have been served. Staff I stated there should not have been 1/3 cup leftover after lunch service. Staff I stated there were 4 servings processed and all of the mechanical soft meatballs should have been served. On 2/26/25 at 3:56 PM Staff E, Contract Registered Dietitian stated all of the mechanical soft meatballs should have been served. Staff E stated there should not have been 1/3 cup leftover after lunch service. Review of the undated policy titled, Portion Control documented food would be served according to standard portion sizes to ensure adequate servings of food and to provide portions that are equal in size for those residents that do not require specialized dietary modifications. Portion control equipment will be used at meal times. Ounce scales will be available to weigh meat portions after they are cooked. Residents on diets that require portion variations will have the required information either stated on their tray card or it could be found on the diet spreadsheet under the diet they are on.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47673 Based on observation, staff interview and policy review the facility failed to provide food at an appetizing temperature when the mechanical soft meatballs temperature was 95 degrees in the steam table. The facility reported a census of 24 residents. Findings include: During continuous observation of lunch service on 2/26/25 at 11:50 AM - 1:00 PM Staff H, AM Cook, completed lunch service with the last plate for a resident on a mechanical soft diet. Staff H obtained a temperature of 95 degrees on the remaining mechanical soft meatballs left in the steam table. On 2/26/25 at 1:00 PM Staff H acknowledged the mechanical meatball temperature of 95 degrees was unacceptable. Staff H stated food in the steam table should have had a holding temperature of 135 degrees or higher. On 2/26/25 at 1:10 PM Staff I, Certified Dietary Manager (CDM) stated the mechanical meatball temperature of 95 degrees was unacceptable. Staff I stated the mechanical soft meatballs in the steam table should have had a holding temperature of 135 degrees or higher. On 2/26/25 at 3:56 PM Staff E, Contract Registered Dietitian stated she would have expected the mechanical meatballs to have a holding temperature of 135 degrees or higher in the steamtable. Review of the undated policy titled, Food Temperatures documented hot food temperatures must read no less than 140 degrees when residents are served.

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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. 47673 Based on observation, staff interview, and policy review the facility failed to store food in accordance with professional standards by not labeling and dating open food items and discarding leftovers. The facility also failed to sanitize a thermometer prior to use. The facility reported a census of 24 residents. Findings include: During a continuous observation on 2/24/25 from 10:00 AM - 10:25 AM revealed a white stand up refrigerator/freezer had containers of cut lettuce dated 2/19, cut tomatoes dated 2/19, cut tomatoes dated 2/18, turkey gravy dated 2/18, bread stuffing (dressing) dated 2/16, cut ham dated 2/19, and cut lettuce dated 2/18. A stand up double door refrigerator had a plastic bag of ham dated 2/4. A double door stand up refrigerator for liquids had a pitcher of lemonade dated 2/14. The same double door stand up refrigerator for liquids also had undated pitchers of grape drink and pitchers of tea. On 2/24/25 at 10:30 AM Staff I, Certified Dietary Manager (CDM) stated the facility's expectation was that open food in containers would be thrown away after 3 days. Staff I acknowledged the containers of tomatoes, lettuce, cut ham, bread stuffing (dressing) and the plastic bag of ham should have been disposed of. Staff I stated the drink pitchers should have been dated and after 3 days should also have been disposed of. A continuous observation on 2/26/25 from 11:50 AM - 1:00 PM revealed Staff I obtained a thermometer and checked the mechanical meatball temperature in the plastic container. A temperature of 109 was revealed for the mechanical soft meatball. The plastic container with mechanical soft meatballs was removed from the table, thermometer placed on the table where the plastic container was, the plastic container with the mechanical meatballs was placed in the microwave, the container was removed from the microwave and taken to the table, the thermometer was picked up, the container was placed where the thermometer was, the mechanical soft meatballs temperature was rechecked. A temperature of 144 was obtained. The process was completed over again until the mechanical soft meatballs in the microwave reached a temperature of 165. On 2/26/25 at 1:10 PM Staff I stated the thermometer should have been cleaned/sanitized prior to rechecking the mechanical meatballs after being microwaved. On 2/26/25 at 3:56 PM Staff E, Contract Registered Dietitian, stated she would expect the food to have been thrown out after 3 days. Staff E stated there should have been dates on items/drinks when they were made. Staff E stated she would have expected the food thermometer would have been sanitized before checking the temperature of foods. Review of policy revised 7/14 titled, Food Receiving and Storage documented all foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).

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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. 47673 Based on observation, Electronic Health Record (EHR) review, policy review, and staff interview the facility failed to provide appropriate infection prevention practices by not completing appropriate hand hygiene when personal care was completed for 1 of 3 residents reviewed (Resident #5). The facility reported a census of 24 residents. Finding include: The Minimum Data Set (MDS) for Resident #5, dated 12/27/2024 did not document a Brief Interview for Mental Status (BIMS) score. The MDS documented Resident #5 was rarely/never understood. The MDS documented Resident #5 required the use of an enteral tube, tracheostomy tube, and a suprapubic catheter. On 2/25/25 at 11:11 AM the Director of Nursing (DON) present during observation of tracheostomy care completed on Resident #5 by Staff M, Licensed Practical Nurse (LPN). Observation revealed Staff M completed hand hygiene, applied gloves, obtained materials for suctioning and tracheostomy cares. Staff M removed Gaze 4x4 around tracheostomy, removed metal trachea appliance. Staff M then removed gloves and applied sterile gloves. Staff M picked up sterile water off the bed, opened the bottle, poured the sterile water into the tracheostomy tray, picked up gauze 4x4, and put gauze in the sterile water in the tray. Staff M removed moistened 4x4, cleansed tracheostomy stoma, applied lube to clean tracheostomy appliance and reinserted. Staff M obtained a gauze 4x4 4 from the night stand and applied it to tracheostomy stoma. Staff M gathered trash and removed it from the bed. Staff M removed gloves, completed hand hygiene, applied gloves, initiated suctioning to clear tracheostomy. Staff M checked oxygen saturation with an oximeter with 94% on 8 L recorded. Staff M removed gloves, completed hand hygiene, applied gloves and completed cleaning of previously inserted tracheostomy appliances. Staff M removed gloves, doffed gown, completed hand hygiene, and exited the room with trash. On 2/25/25 at 11:39 AM the DON acknowledged missed opportunities for hand hygiene during tracheostomy care completed by Staff M. The DON stated the facility's expectation was that hand hygiene would be completed with all glove changes. The DON acknowledged Staff M did not complete hand hygiene with the glove change after initial removal of the tracheal appliance. An observation on 2/26/25 at 4:39 PM revealed Staff O, Certified Nursing Assistant (CNA) and Staff N, CNA knocked on Resident #5 room door, entered the room, completed hand hygiene, applied gloves and donned gowns. Staff O completed peri care to Resident #5's penis with peri wash and wet wipe. Staff O then utilized an alcohol wipe to cleanse catheter tubing and catheter stoma site. Resident #5 was assisted to the right side by Staff N. Staff O then cleansed Resident #5's buttocks and hips. Staff O applied barrier cream to Resident #5's buttocks. Gloves removed by Staff O, hand hygiene completed, gloves applied, assisted Resident #5 to the right side, assisted in helping Staff N apply new brief and completed care. Gloves and gown doffed by both and hand hygiene completed. On 2/26/25 at 5:30 PM the DON acknowledged missed opportunities for hand hygiene when Staff O completed personal cares on Resident #5. The DON stated hand hygiene and glove change should have been completed before moving from peri area to suprapubic catheter stoma, before moving from catheter stoma to buttocks and prior to application of barrier cream. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy revised 8/19 titled, Handwashing/Hand Hygiene documented hand hygiene should have been completed before moving from a contaminated body site to a clean body site during resident care, after contact with blood or bodily fluids, and after removing gloves.