STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165245	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Health Care Center	2121 Avenue L Hawarden, IA 51023

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 44474 Based on clinical record review and staff interview, the facility failed to obtain physical signatures or record attempts to obtain physical signatures on notification of the Notice of Medicare Non-Coverage (NOMNC) Centers of Medicare & Medicaid (CMS)-10123 and CMS form CMS-10055 for 1 of 3 sampled residents (Residents #204). The facility reported a census of 50 residents. Findings Include: Record review for Resident #204 revealed form CMS 10123-NOMNC with a services end date of 9/4/24. Resident #204's representative gave verbal consent for signature on 9/4/24 however lacked a signature of resident or resident representative. Review of Resident #204's Progress Notes lacked any documentation on any attempts to obtain physical signatures on CMS 10123-NOMNC and CMS-10055. Review of the Centers (CMS) Medicare Claims Processing Manual Chapter 30 with a revision date of 1/21/22 revealed the following information under ABN options for Delivery other than in-person revealed ABNs should be delivered in-person and prior to the delivery of medical care which is presumed to be non-covered. In circumstances when in-person delivery is not possible, notifiers may deliver an ABN using another method. Examples include: Direct telephone contact, Mail, Secure fax machine or Internet e-mail. All methods of delivery require adherence to all statutory privacy requirements under HIPAA. The notifier must receive a response from the beneficiary or his/her representative in order to validate delivery. When delivery is not in-person, the notifier must verify that contact was made in his/her records. In order to be considered effective, the beneficiary should not dispute such contact. Telephone contacts should be followed immediately by either a hand-delivered, mailed, emailed, or a faxed notice. The beneficiary should sign and retain the notice and send a copy of this signed notice to the notifier for retention in the patient's record. The notifier must keep a copy of the unsigned notice on file while awaiting receipt of the signed notice. If the beneficiary does not return a signed copy, the notifier should document the initial contact and subsequent attempts to obtain a signature in appropriate records or on the notice itself. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the CMS NOMNC form instructions for the NOMNC CMS-10123 revealed the signature line: beneficiary/enrollee or the representative must sign this line and the date line: The beneficiary/enrollee or the representative must fill in the date that he or she signs the document. If the document is delivered, but the enrollee or the representative refuses to sign on the delivery date, then annotate the case file to indicate the date that the form was delivered. CMS requires that notification of changes in coverage for an institutionalized beneficiary/enrollee who is not competent be made to a representative. Notification to the representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification. Providers are required to develop procedures to use when the beneficiary/enrollee is incapable or incompetent, and the provider cannot obtain the signature of the enrollee ' s representative through direct personal contact. If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee ' s services are no longer covered. The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative ' s address signs (or refuses to sign) the receipt is the date of receipt. Place a dated copy of the notice in the enrollee ' s medical file. When notices are returned by the post office with no indication of a refusal date, then the enrollee ' s liability starts on the second working day after the provider ' s mailing date. Interview on 2/25/25 at 02:47 p.m., with the Administrator revealed she was unaware the forms needed a physical signature as Social Services did the forms.

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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** 48004 Based on resident interview, family interview, staff interview, and policy review the facility failed to ensure 1 of 1 resident's personal property was protected from loss or theft, (Resident #48). The facility reported a census of 50 residents. Findings include: Review of Resident #48's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. Interview on 2/25/25 at 1:17 PM with Resident # 48 revealed that she had a quilt that went missing from the laundry. Resident #48 revealed she had let the facility know, but it had not been replaced. Review of an untitled and undated document for inventory with Resident #48's name revealed nothing marked for personal inventory. Interview on 3/6/25 at 10:32 AM Staff D Social Services revealed that he was not the Social Worker at the time when Resident #48 was admitted to the facility. Staff D then revealed that he did not complete the form but the previous social service personnel should have filled the form out. Staff D revealed that forms should be updated while the residents are here. Staff D further confirmed that the inventory sheet was not filled out but signed by the residents representative. Interview on 3/6/25 at 10:47 AM with Resident #48's representative confirmed she did sign a sheet at admission, but could not recall an inventory sheet. This representative could not recall all the items that Resident #48 came to the facility with. Interview on 3/6/25 at 11:17 AM with the Administrator revealed every time things are brought in they should be added to the inventory list. The Administrator further revealed the inventory list should be updated. Review of a facility provided policy titled, Inventory of Personal Property with a revision date of 7/2015 revealed: a. When a resident is admitted to the facility, an inventory of the resident ' s personal effects shall be done by a staff member of the facility. The inventory should include the recording of all personal clothing, valuable articles, etc. which are brought into the facility with the resident and retained by the resident. These personal effects shall be recorded on the Inventory of Personal Effects form.

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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 0625 Level of Harm - Minimal harm or potential for actual 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** 44474 Based on clinical record review, interviews, and facility policy, the facility failed to ensure bed hold notice was signed by residents and or the resident's responsible person when residents transferred out of the facility and failed to provide written notice of bed hold for 4 of 4 residents reviewed (Residents #4, #11, #40 and #45). The facility reported a census of 50 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #4 documented diagnoses of diabetes mellitus, depression and seizure disorder. The MDS showed the Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Review of Resident #4's census tab revealed the following information: 3/9/24- hospital no charge, 3/21/24- active. Review of Progress Notes revealed the following: On 3/9/24 at 7:46 p.m., resident being assessed at local hospital. On 3/10/24 at 3:17 a.m., resident being transferred via helicopter to a larger hospital. On 3/21/24 at 11:44 p.m., resident readmitted to the facility today. Review of the bed hold dated 3/9/24 revealed verbal authorization from Resident #4's representative but lacked a resident or representative signature. 2. The MDS assessment dated [DATE] for Resident #11 documented heart failure, hypertension and coronary artery disease. The MDS showed the BIMS score of 6, indicating severe cognitive impairment. Review of Resident #11's Census tab revealed the following information: 10/16/24- hospital no charge, 10/18/24- active. Review of Progress Notes revealed the following: On 10/16/24 at 2:54 a.m., resident admitted to local hospital with pneumonia. On 1/18/24 at 2:00 p.m., resident returned with new orders. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48004 3. Review of Resident #40's Electronic Health Record (EHR) page titled Progress Notes revealed Resident #40 was hospitalized [DATE] through 12/10/24. Review of a document titled Bed Hold Notification with date of 12/9/24 revealed that a bed hold notification was verbally informed to Resident #40. This document further revealed that Resident #40 did not sign the form. 4. Review of Resident #45's MDS with a date of 1/8/25 revealed an admitted [DATE] from short-term general hospital stay. Review of a document titled Bed Hold Notification with a date of 12/9/24 revealed a bed hold agreement with the representative of Resident #45 via telephone agreement. This document further revealed no wet signature from the representative of Resident #45. Interview on 2/27/25 at 9:46 AM with the Director of Nursing (DON) revealed that bed holds are usually obtained by the nurse and that the facility should be obtaining them. The DON further revealed that his expectation would be for bed holds to be completed and obtained correctly. Interview on 2/27/25 at 9:53 AM with the Administrator revealed that her expectation would be for bed holds to be obtained correctly. Review of a facility provided policy titled, Bed Hold with a revision date of 5/21/21 revealed: a. The resident, or the resident's representative, shall be informed, in writing, of their right to exercise the bed hold provision in the event of a transfer from the facility to a general acute care hospital or for a therapeutic leave.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review and staff interview the facility failed to revise and update care plans to include and address high risk medications and side effects to watch for 1 out of 22 sampled residents reviewed for comprehensive care plans (Resident #13). The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #13 documented diagnoses of coronary artery disease, fibromyalgia and respiratory failure. The MDS showed the Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. Review of Order Summary Report dated 3/6/25 revealed an order for oxycodone-actaminophen (opioid medication) tablet with an order date of 1/30/25. Review of the undated current Care Plan lacked usage of opioid medication and side effects to watch for with opioid medication usage. Review of the facility provided policy titled Comprehensive Person Centered Care Planning with a revision date of 03/2022 revealed this facility shall develop a comprehensive person-centered care plan for each resident. Interview on 3/10/25 at 2:24 p.m., with the Administrator revealed the medication and side effects should be on the care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48004 Based on clinical record review, resident interview, staff interview, observation, and policy review the facility failed to provide an opportunity for bath or shower to 4 of 6 residents reviewed (Residents #2, #37, #46, and #202). The facility reported a census of 50 residents. Findings include: 1. Review of Resident #46's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. The MDS revealed an admitted [DATE] from a short-term general hospital stay. The MDS revealed Resident #46 required substantial assistance with bathing. Interview on 2/26/25 at 11:48 AM with Resident #46 revealed that he is only getting a shower maybe once a week, and would like to have showers more frequently. Interview on 2/26/25 at 11:51 AM Staff E Certified Nursing Assistant (CNA) revealed residents are supposed to get bathed twice a week. Staff E then revealed that staff will document in the Electronic Healthcare Record (EHR). Staff E Further revealed if a shower is refused the staff would document that as well in the computer. Review of Resident #46's EHR page titled, Tasks with a print date of 2/26/25 revealed a 30 day look back period for showers revealed Resident #46 had a shower on 2/16/25. This document further revealed that Resident #46 was marked as unavailable on 2/24/25. 2. Review of Resident #202's MDS dated [DATE] revealed an admitted [DATE] from a short-term general hospital stay. The MDS further revealed a BIMS score of 15 indicating intact cognition. The MDS revealed that Resident #202 requires supervision during bathing. Interview on 2/25/25 at 10:09 AM with Resident #202 revealed he has only been getting showers once a week, and knows residents are supposed to get them at least twice a week. Observation on 2/25/25 at 10:09 AM noted Resident #202's hair was observed to be greasy in texture and unclean. Review of Resident #202's EHR page titled, Tasks with print date of 2/26/25 revealed a 30 day look back period for showers revealed Resident #202 had a shower 2/13/25, and 2/16/25. This document further marked that Resident #202 was marked as not applicable on 2/24/25. 44474 3. The MDS assessment dated [DATE] for Resident #2 documented depression, anxiety disorder and chronic pain. The MDS showed the BIMS score of 14 indicating no cognitive impairment. Observation on 2/25/25 at 10:46 a.m., showed Resident #2 was sitting in a recliner in the room and noted his hair to be disheveled and greasy. Resident #2 revealed it had been awhile since his bath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's Care Plan with a revision date of 12/31/24 revealed resident requires 1 assistance with bathing/showering and 2 staff for transfers twice weekly and as necessary. Review of report titled POC Response History provided by the facility revealed the following information: February 11, 2025- resident refused February 25, 2025- not applicable February 28, 2025- resident refused March 4, 2025- not applicable March 7, 2025- resident refused 4. The MDS assessment dated [DATE] for Resident #37 documented diabetes mellitus, hypertension and depression. The MDS showed the BIMS score of 14 indicating no cognitive impairment. Observation on 2/25/25 at 1:17 p.m., Resident #37 was laying in his bed noted his hair to be disheveled and greasy in appearance. Review of Resident #37's Care Plan with a revision date of 3/20/24 revealed resident required 2 staff assistance with transfer to tub and 1 assist with bathing showering twice weekly and as necessary. Review of report titled POC Response History provided by the facility revealed the following information: February 11, 2025- full body bath completed February 25, 2025- resident refused February 28, 2025 at 1:59 p.m., resident refused February 28, 2025 at 9:27 p.m., resident refused March 4, 2025- resident refused March 7, 2025 full body bath completed Review of the facility provided policy titled Bath, Shower with a revision date of 5/2007 revealed it is the policy of this facility to promote cleanliness, stimulate circulation and assist in relaxation. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 3/4/25 at 12:00 p.m., with the Director of Nursing revealed if someone refuses a shower or bath they are to let the nurse know and they need to talk to the resident. The nurse then is to talk to the resident and if they continue to refuse to attempt again later in the shift and or the next day until they take their bath.

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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 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** 44474 Based on record review, resident and staff interviews and facility policy review the facility failed to provide physician ordered daily weights 1 of 1 residents reviewed (Resident #11) and failed to provide pressure ulcer dressing changes as ordered by the physician for 1 of 1 residents reviewed (Resident #44). The facility reported a census of 50 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #11 documented heart failure, hypertension and coronary artery disease. The MDS showed the Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. Review of signed Physician Order dated 9/5/24 revealed an order for daily weights, call clinic for a weight gain of 2-3 pounds overnight or 5 pounds in 1 week. Review of signed Order Summary Report dated 2/5/25 revealed an order for daily weights with an order date of 10/18/24 with a start date of 10/19/24. Review of the Progress Notes revealed the following: 11/4/24 at 2:10 p.m., daily weight, scale out for repair 11/5/24 at 1:21 p.m., daily weight, scale broke 11/7/24 at 7:07 a.m., daily weight, scale broke 11/7/24 at 10:12 a.m., daily weight, scale is broken 11/8/24 at 6:49 a.m., daily weight, scale broke 11/11/24 at 7:04 a.m., daily weight, scale broke 12/21/24 at 7:21 a.m., daily weight, scale getting fixed 12/22/24 at 6:48 a.m., daily weight, scale broke 12/23/24 at 11:12 a.m., daily weight, scale inoperable 12/24/24 at 10:46 a.m., daily weight, scale inoperable 12/25/24 at 10:20 a.m., daily weight, scale inoperable 12/26/24 at 7:25 a.m., daily weight, scale inoperable 12/27/24 at 6:13 p.m., daily weight, not gotten, scale broken (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/28/24 at 8:37 a.m., daily weight, scale broke 12/29/24 at 7:54 a.m., daily weight, scale broke 12/30/24 at 8:32 a.m., daily weight, scale broke 12/31/24 at 10:15 a.m., daily weight, scale malfunction 1/1/25 at 12:43 p.m., daily weight, scale broke 1/2/25 at 8:46 a.m., daily weight, scale unavailable 1/3/25 at 11:31 a.m., daily weight, scale broke Review of the clinical record lacked any documentation the physician had been notified daily weights were not being completed and monitored as ordered. Review of the facility provided policy tiled Physician Orders reviewed 8/2023 revealed it is the policy of this facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the order of a person duly licensed and authorized to do so in accordance with the resident's plan of care. 2. The MDS assessment dated [DATE] for Resident #44 documented hypertension, anxiety disorder and edema. The MDS showed the BIMS score of 13, indicating no cognitive impairment. Interview on 2/25/25 at 9:34 a.m., with Resident #44 revealed she had a sore on her bottom. It has been getting better and does not hurt like it did when she first came to the facility. Resident #44 revealed the facility is to change the dressing twice a day. Review of the signed Order Summary Report dated 2/7/25 revealed an order to change dressing to sacral wound every shift with a start date of 11/30/24. Review of the December 2024 Treatment Administration Record (TAR) lacked documentation of the dressing change being completed on the following days during day shift: December 12, 14, 16, 20, 23, 24, and 30th. Review of the January 2025 TAR lacked documentation of the dressing change being completed on the following days during day shift: January 3, 7, 10-12, 16, 17, 21-24 and 28-31st. Review of the February 2025 TAR lacked documentation of the dressing change being completed on the following days during day shift: February 7, 11, 12, 14 and 18th. The clinical record lacked documentation of the physician being notified of the missed dressing changes. Review of the facility provided policy titled Wound Management reviewed 7/2022 revealed a resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable sores from developing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/27/25 at 1:16 p.m., with the Director of Nursing revealed all dressing changes and physician orders should be followed and documented if they are not completed as to why and the physician should be notified.

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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** 48004 Based on clinical document review, staff interview, and policy review the facility failed to provide adequate nursing supervision for 2 of 3 residents reviewed (Residents #22, and #48). The facility reported a census of 50. Findings include: 1. Review of Resident #22's Minimum Data Set (MDS) dated [DATE] revealed Resident #22 had problems with short and long term memory problems. The MDS further revealed diagnosis of non-traumatic brain dysfunction, and Alzheimer's disease. Review of the Electronic Healthcare Records (EHR) page titled, Progress Notes revealed an entry dated 10/18/24 at 4:01 PM. This entry revealed Resident #22 was noted outside of the facility in the parking lot by a staff member and brought back inside. Further review of the Progress Notes revealed Resident #22 had eloped from the facility on 9/26/24 per an entry made on 9/27/24 at 4:35 PM. This entry revealed Resident #22 had exited through a hallway into the assisted living portion of the building. Review of a document titled Elopement/Wandering Risk assessment dated [DATE] revealed a high risk wandering score of 17. Review of another elopement/wandering risk assessment dated [DATE] revealed a high risk score of 13. 2. Review of Resident #48's MDS dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS further revealed diagnosis of non-traumatic brain dysfunction, bipolar disorder, and non-Alzheimer's dementia. Review of the EHR page titled, Progress Notes revealed an entry dated 12/29/24 at 7:26 PM. This entry revealed that Resident #48 was seen walking in through the front doors of the facility with multiple items of clothing on. This entry further revealed that the door alarms had gone off around 7:20 PM. Review of the EHR page titled Elopement/Wandering risk assessment revealed assessments were completed on 12/5/24 and 12/30/24 with high risk scores of 22 and 17. Interview on 3/3/25 at 10:45 AM with Staff F Certified Nursing Assistant (CNA) revealed she was not working at the building during the elopements. Staff F further revealed that doors alarms weren't working well around November. Staff F indicated that the doors would go off without anyone setting them off. Staff F then indicated that the door alarm system was fixed, but could not recall when. Interview on 3/3/25 at 10:50 AM with Staff G revealed that door alarms had been going off without anyone setting them off, and could not recall when this got fixed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Health Care Center	2121 Avenue L Hawarden, IA 51023

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview 3/3/25 at 10:58 AM with the Assistant Director of Nursing (ADON) revealed that she didn't hear about the elopements until the day after they occurred. The ADON further revealed there were no issues with the wander guards. The ADON revealed the front entry door alarm was always alarming every time someone came or left the facility. The ADON then revealed the door issues were during the elopements. Interview on 3/3/25 at 11:09 AM with Staff H MDS Coordinator revealed that Resident #22 had eloped from the facility. Staff H stated when Resident #48 eloped in December was when the wander guard was placed on this resident. Staff H further revealed that she thought the rear door going to assisted living was the only door with an alarm not working and not the front door. Interview on 3/3/25 at 11:17 AM with Staff B CNA revealed she was working the night of 9/26/24. Staff B revealed she could not recall what was happening but does know she was dealing with alarms. Staff B stated that she did see Resident #22 on 10/17/24 in the parking lot by herself. Staff B stated she was aware that the previous Administrator knew the doors were not working correctly, and did not get them fixed. Staff B further revealed the doors were not fixed until the interim administrator came to the facility. Staff B stated that when the doors were not working all the time correctly, she felt that staff didn't respond to alarms as quickly related to the alarms going off. Interview on 3/3/25 at 11:50 AM with Staff I CNA revealed she was working 1 on 1 with another resident in their room and was mid transfer during the elopement for Resident #48. Staff I stated the door alarms did sound, but were off when she came out of the room. Staff I then revealed that the nurse that evening stated Resident #48 had eloped out of the facility through the hallway four door, but Staff I did not know how long she was out. Staff I stated the doors were not working, and would randomly alarm. Staff I stated the prior Administrator knew there was an issue with the doors going off randomly and Staff I revealed that the doors were fixed shortly before the previous Administrator was let go. Interview on 3/3/25 at 12:20 PM with Staff J Licensed Practical Nurse (LPN) revealed that the therapist met her at the front door with Resident #22, and let the other nurse know that Resident # 22 was outside on 10/18/24. Interview on 3/3/25 at 12:39 PM with Staff K Physical Therapist (PT) revealed that she found Resident #22 outside of the facility in the guest parking lot on 10/18/24. Staff K stated that she walked Resident #22 up to the sidewalk of the facility. Staff K stated she doesn't really hear the alarms in the therapy room. Staff K then revealed that Resident #22 was saying that she walked out the assisted living side of the building, and was heading toward the front of the building. Interview on 3/3/25 at 12:49 PM with Staff L Occupational Therapist (OT) revealed when the outside company came in to work on the wanderguard doors, the doors were alarming more frequently. Interview on 3/4/25 at 11:26 AM with Staff M Maintenance Supervisor revealed he could not recall the dates of when the alarm doors were fixed. Staff M revealed there was an issue with the doors, but couldn't recall when and that this company came in and set the alarms to go off anytime someone came in through the door or out of the door. Staff M stated he felt the staff got desensitized to the alarms going off all the time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/4/25 at 11:49 AM with the previous Administrator revealed that she had worked at the facility until 1/6/25. She stated that the door alarms always worked, but they would just go off constantly. She revealed the facility assumed Resident #22 had gotten through the hallway 1 doors into the assisted living area, and then outside of the building during the elopements on 9/26/24 and 10/17/24. The previous Administrator then revealed that Resident #48 had eloped out of hallway 4 door and that staff assumed it was another resident sitting by the door with a wander guard on that set off the alarm. She stated that Resident #48 came back in through the front doors and that is when the staff knew that resident eloped. Interview on 3/4/25 at 12:15 PM with the Administrator revealed that her expectation is for staff to follow policy and procedure and to ensure resident safety. Interview on 3/4/25 at 12:26 PM with the Director of Nursing (DON) revealed that his expectation is for staff to follow policy and procedure and to ensure resident safety. Review of a facility provided policy titled, Elopement/Unsafe Wandering with a revision date of 12/30/24 documented: a. It is the policy of this facility to provide a safe environment, as free of accidents as possible, for all residents through appropriate assessment, interventions, and adequate supervision to prevent accidents related to unsafe wandering or elopement while maintaining the least restrictive manner for those at risk for elopement.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review and staff interview the facility failed to identify side effects, non-pharmalogical interventions to try prior to medication, specific targeted behaviors related to high risk medications in 2 out of 5 sampled residents reviewed (Resident #4 and #13). The facility reported a census of 50 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #4 documented diagnoses of chronic obstructive pulmonary disease (COPD), respiratory failure and dependence on supplemental oxygen. The MDS showed the Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. Review of Resident #4's signed Order Summary report dated 2/7/25 revealed the following order: a. Zyprexa (antipsychotic medication) oral tablet with a start date of 1/29/25. Review of Resident #4's Care Plan with a revision date of 10/30/24 revealed a focus of resident uses anti-anxiety medications with a created date of 9/5/21. It lacked specific targeted behaviors the anti-antianxiety medication is being used for and non-pharmological interventions to be tried. 2. The MDS assessment dated [DATE] for Resident #13 documented diagnoses of coronary artery disease, fibromyalgia and respiratory failure. The MDS showed the BIMS score of 8, indicating moderate cognitive impairment. Review of Resident #13's signed Order Summary report dated 3/6/25 revealed the following orders: a. Oxycodone (opioid medication) with a start date of 1/30/25, b. Risperdone (antipsychotic medication) with a start date of 1/16/25, c. Sertraline (antidepressant medication) with a start date of 1/22/25. Review of Resident #13's Care Plan with a revision date of 2/6/25 lacked information regarding the usage, side effects and non-pharmalogical interventions to use prior to opioid medication usage, lacked the targeted behaviors the antipsychotic and antidepressant medications were being used for and non-pharmalogical interventions to use prior or with the medications. Review of the facility provided policy titled Unnecessary Drugs with a revision date of 11/2022 revealed; a. Each resident's entire drug/medication regimen be managed and monitored to promote or maintain the resident's highest practicable mental, psychical, and psychosocial well-being. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Non-pharmacological interventions are considered and used when indicated, instead of, or in addition to, medication. c. Incorporate appropriate medication related goals and parameters for monitoring the resident's condition into the comprehensive care plan Interview on 3/10/25 at 2:24 p.m., with the Administrator revealed she expected the care plan to have the side effects, targeted behaviors and non-pharmacological interventions listed.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 48004 Based on document review and staff interview the facility failed to employ a clinically qualified nutrition professional by not having a Certified Dietary Manager (CDM). The facility reported a census of 50 residents. Findings include: Interview on 2/24/25 at 11:03 AM with the Administrator revealed that the facility does not have a CDM, and that the facility does have an interim manager working on his CDM. Interview on 2/27/25 at 9:50 AM with the Administrator revealed that the facility does have a person with a CDM certification that is training starting this week, and acknowledged that the facility did not have a CDM prior to this. The Administrator then revealed her expectation would be for a Certified Dietary Manager to be in charge of the kitchen. Interview on 3/6/25 at 12:30 PM with Staff C Facility consultant revealed her expectation would be to have a certified dietary manager in charge of the kitchen. Staff C further revealed that the facility does not have a policy for certified dietary managers.

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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** 48004 Based on observation, staff interview, and infection control policy the facility failed to use universal infection control measures and Enhanced Barrier Precautions (EBP) during incontinence cares for 1 of 3 residents reviewed for infection control (Resident #45). The facility reported a census of 50 residents. Findings include: Review of Resident #45's Minimum Data Set (MDS) dated [DATE] revealed Resident #45 utilized an indwelling catheter. The MDS further revealed diagnosis of neurogenic bladder, and hemiplegia following a cerebral infarction. Review of a document titled Order Summary Report dated 2/3/25 revealed an order to change Resident #45's indwelling catheter monthly and as necessary. Observation on 2/27/25 at 11:17 AM Staff A Certified Nursing Assistant (CNA), and Staff B CNA completed hand hygiene and donned gloves. Staff A and Staff B then proceed to reposition Resident #45 and complete peri cares. No gown was donned by either staff while repositioning or completing peri cares for Resident #45. Interview on 2/27/25 at 11:50 AM with the Director of Nursing (DON) revealed that his expectation would be for staff to follow Enhanced Barrier Precautions (EBP) when taking care of residents with catheters. Review of a facility provided policy titled, Standard and Transmission-Based Precautions with a revision date of 3/2024 revealed: a. Enhanced Barrier Protection (EBP): used in conjunction with standard precautions and expand the use of through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of Multi-Drug Resistant Organisms (MDROs) to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs).