STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165271	A. Building B. Wing	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Specialty Care	4201 Fieldcrest Drive Sioux City, IA 51104

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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** 44420 Based on observation, clinical record review, resident, and staff interviews, the facility failed to respect each resident's dignity throughout all cares provided and talk to residents with dignity and respect for 3 of 3 residents reviewed (Resident #2). The facility failed to provide privacy during cares (Resident #14.) The facility also failed to allow a resident to bathe three times a week as requested (Resident #15). Findings included: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS indicated the Resident #2 required maximal assistance for transfers and toilet hygiene. The MDS included diagnoses of muscle wasting and atrophy, need for assistance with personal cares, and unsteadiness on feet. The Care Plan revised [DATE] identified Resident #2 suffered from a history of physical or emotional trauma, and acute/chronic pain related to Arthritis. The Care Plan instructed staff to anticipate the need for pain relief, respond immediately to any complaint of pain. In an interview on [DATE] at 1:52 PM, Staff Q, Certified Nursing Assistant (CNA), reported while at the nurse's station she overheard Staff T, Licensed Practical Nurse (LPN), yelling at Resident #2. When asked what Staff Q overheard, she replied, I couldn't understand what Staff T said because of her accent, but I could hear her yelling. After observing Staff T exit Resident #2's room, Staff Q and Staff S, CNA, entered her room. Staff Q stated, Resident #2 didn't tell them very much then, just that she was trying to get comfortable, but the nurse was yelling and being rude. Staff Q felt that Staff T became upset because Resident #2 required additional time to get comfortable. In an interview on [DATE] at 2:25 PM, Staff R, CNA, stated Resident #2 didn't act like her normal self. As Staff R walked by, she laid in bed. Which wasn't not normal, so I stopped in and talked to her and her daughter. Staff R explained Resident #2 and her daughter reported the prior night shift a nurse yelled at Resident #2 that she needed to go back to the hospital. (continued on next page)

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	In an interview on [DATE] at 12:01 PM, Staff F, CNA, said she didn't see anything but she did hear the nurse yelling at Resident #2. When asked if she could hear what the nurse said, Staff F replied, no because of her accent it is sometimes difficult to understand her. When asked where she was located when she heard yelling, Staff F replied, at the nurses' station, you could hear it from there. When asked if she checked on Resident #2, Staff F replied, yes, Staff Q and her went to check on Resident #2. The resident told them she felt bad for needing so much help, and thought the nurse was tired of her, and made it seem like her fault. The Dignity policy revised February 2021 directed each resident should be cared for in a manner that promotes and enhances their sense of well-being, level of satisfaction with their life, and feelings of self-worth or self-esteem. Residents are treated with dignity and respect at all times. The policy instructed staff to speak respectfully to residents at all times. On [DATE] at 8:34 AM the Director of Nursing (DON) reported he expected staff to speak and treat the residents in a dignified manner. 44474 2. On [DATE] at 11:51 AM, observed Staff I, Certified Nursing Assistant (CNA), and Staff J, Certified Medication Assistant (CMA), assist Resident #14 with perineal care. At the start of the observation noted the curtain open approximately 15 inches. The curtain remained open during the entire observation. Interview on [DATE] at 1:19 PM, Resident #14 revealed she didn't even notice the curtain open. Resident #14 revealed it happened all the time and she has gotten used to it. The Resident Rights policy revised [DATE] instructed employees to treat all residents with kindness, respect and dignity. The policy continues federal and state laws guarantee certain basic rights to all residents of the facility. The rights include the resident's rights to privacy. 3. Interview on [DATE] at 3:46 PM, Resident #15 said she would like to have 3 baths a week. Resident #15 reported she has asked the facility several times to have 3 baths a week and the facility told her she couldn't have 3 baths a week without a doctor's order. Resident #15 explained she had filed a grievance with the facility in October. She added she got a doctor's order to have 3 baths a week but still didn't get them. She reported she wanted 3 baths a week but the staff recently told her the order expired and she needed a new one. She told her physician, who explained orders like that don't expire. The facilities Grievance binder included a grievance dated [DATE] signed by facility staff on [DATE] documented Resident #15 was upset she didn't get her third bath. Under the action and follow-up indicated they educated Resident #15 of the residents right at that point the facility is only doing 2 baths a week and she needed doctor orders for more. Review of Resident #15's medical chart revealed a physician order dated [DATE] that directed to please bathe patient 3 times a week with a note behind its resident is offered and scheduled 2 times a week plus a as needed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #15's Care Plan revised [DATE] indicated she needed bathing assistance assist of 1 person on Monday, Wednesday and Friday. The Resident Rights policy revised [DATE] instructed federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the resident's rights to exercise his or her rights without interference, coercion, discrimination or reprisal from the facility and be informed of, and participate in, his or her Care Planning and treatment. Interview on [DATE] at 3:27 PM, the DON reported Resident #15 had a as needed bath and if she asked she could have another bath anytime.

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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** 44474 Based on record review and staff interview, the facility failed to notify the physician the resident continued to refuse supplements, resulting in a continued to lose weight for 1 of the 3 residents reviewed (Residents #5). Findings include: The Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating no cognitive impairment. The MDS included diagnoses of cancer, anemia, need for assistance with personal care. The SPN - Dietary Note dated 5/3/23 at 10:28 AM, indicated Resident #5 had a significant weight loss of 5.8% since admission, but weight remains appropriate. Resident #5 didn't take supplements at that time. The facility notified the primary care provider (PCP) on Resident #5's weight loss and recommended to start 206 juice 180 cubic centimeters (cc) daily. The Encounter Note dated 5/10/23 indicated the PCP saw Resident #5. She had a low body mass index (BMI) of 29.6, with a reduction of 5.8% of her weight. Start on 180 cc of a juice supplement once a day. Resident #5's May 2023 Medication Administration Record (MAR) included an order dated 5/11/23 for 206 juice 180 cc one time a day for supplement. The documentation on the MAR indicated Resident #5 refused the supplement 8 times and lacked documentation that Resident #5 received the supplement on May 29. The SPN - Dietary Note dated 6/8/23 at 3:17 PM indicated Resident #5 had a weight of 151 pounds (lbs.). She received a low residue diet and cut meat. Resident #5 continued to lose weight with a weight loss of 6.2% at 30 days (significant weight change is greater than 5% in 30 days) and 11.7% over 90 days (significant weight change is greater than 7% in 90 days). She frequently refused her juice supplement. With the weight loss not desired, the facility recommended to start as house supplement of 120 cc every day to prevent further weight loss. The Nurses Note dated 6/14/23 at 3:53 PM reflected the facility received a signed weight change notification of Resident #5 frequently refused her 206 juice every day and recommended to start house supplement 120 cc every day to prevent continued weight loss. Resident #5's June 2023 MAR included the following orders: a. 5/11/23: 206 juice 180 cc one time a day for supplement. - Resident #5 refused the supplement 13 times in the month. b. 6/15/23: House supplement 120 cc one time a day. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident #5 refused the supplement 6 times 6/15/23 - 6/30/23. The Communication - with Physician Note dated 7/10/23 at 7:04 PM, indicated the physician returned the weight change notification with new order to add ice cream daily. Resident #5's July 2023 MAR included the following orders: a. 5/11/23: 206 juice 180 cc one time a day for supplement. - Refused 7/11/23 - 7/14/23 b. 6/15/23: House supplement 120 cc one time a day. - Refused 7/5/23 - 7/7/23, 7/10/23, 7/11/23, 7/14/23, 7/21/23, 7/27/23. The SPN - Dietary Note dated 8/2/23 at 8:48 PM identified a weight of 150.8 lbs., indicating a 0.1% loss over 30 days and a significant loss of 12% over approximately 90 days. She continued to receive 120 cc of the house supplement from 6/15/23 order, ice cream daily ordered 7/10/23, and 206 juice remains in place. The note directed to see the notification from 7/10/23. Mini Nutritional Assessment (MNA) score of 7, indicated malnutrition related to weight loss, recent stress/acute disease and mobility. The author documented the would notify the PCP about Resident #5's MNA score and recommend discontinuing the low residue diet. In addition, the author recommended to feed Resident #5 nutrient dense meals over 50% and offer a meal/snack alternative as needed to promote intakes. Resident #5's August 2023 MAR included the following orders: a. 5/11/23: 206 juice 180 cc one time a day for supplement. - Refused 8/10/23, 8/13/23, 8/17/23. - Discontinued 8/21/23 b. 6/15/23: House supplement 120 cc one time a day. - Refused 8/13/23, 8/14/23, and 8/22/23. The clinical record lacked physician notification that Resident #5 refused her supplements. The Care Plan lacked information regarding usage of nutrition supplements. The facility did not provide a policy on notification of physician with changes. Interview on 2/28/24 at 12:31 PM the Director of Nursing (DON) reported if a supplement didn't work for a resident, then the nurse should notify the physician.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 44474 Based on facility record review, family and staff interviews and policy review the facility failed to ensure people could file a grievance form without fear. In addition, the facility failed to follow-up on all grievances. Findings include: During a confidential interview on 2/20/24 at 3:04 PM, a former resident's family member (FM) explained she had a concern that her mother didn't get a bath. The FM reported she told the facility staff her family member didn't receive her bath and the facility staff told her they didn't have enough staff to give her the bath. The family member added she filled out a grievance form in November 2023 while visiting the facility. She voiced concerns about being afraid if the staff saw her put the grievance form in the box, they would take it out of the box. She explained that during that time she watched to make sure no staff watched her when she placed the grievance into the box. She explained the facility never called her or followed up with her on that grievance. She explained that during her family members time there she had filed other grievances, the facility followed up on them. However, the grievance about baths, one no one ever addressed. She explained she put her family member's name on the grievance form prior to placing it in the box. The facilities Grievance binder lacked a grievance form regarding the family members' concern over her loved not receiving their scheduled bath. The Grievances, Complaints, and Filing policy revised April 2017 directed residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. The Policy Interpretation and Implementation instructed the following: a. Any resident, family member, or appointed resident representative may file a grievance or complaint concerning care, treatment, behavior of other residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility. Grievances also may be voiced or filed regarding care that has not been furnished. b. Residents, family and resident representatives have the right to voice or file grievances without discrimination or reprisal in any form, and without fear of discrimination or reprisal. c. The results of all grievances files, investigated, and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision. Interview on 2/17/24 at 3:27 PM, Staff O, Regional Director of Clinical Services, questioned why the family member didn't call the office to follow up on the grievance she filed.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review and staff interview, the facility failed to refer 1 resident with a negative Level I result for the Preadmission Screening and Resident Review (PASRR), later identified with newly evident or possible serious mental disorder, intellectual disability, or other related condition, to the appropriate state-designated authority for Level II PASRR evaluation and determination for 1 out of 1 resident (Resident #1) reviewed for PASRR requirements. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 2 indicating severe cognitive impairment. The MDS included diagnoses of Parkinson's Disease, repeated falls, need for assistance with personal care. The MDS lacked psychiatric or mood disorders. Resident #1's PASRR Level 1 dated 11/16/22 listed a Notice of no PASRR Level II required. The PASRR Level I screen remains valid for their stay at the nursing facility and should be transferred with them if they relocate. No further Level 1 Screening is required unless they have or are suspected of having a serious mental illness or an intellectual or developmental disability and exhibit a significant change in treatment needs. Review of Resident #1's Behavior Notes a. 1/10/23 at 5:15 PM, Resident #1 continued to walk in hallway. Resident became more agitated when asked to return to his room because of being COVID positive. b. 1/10/23 at 9:44 PM, Resident #1 continued to go into hallway without assistance, a walker, or a wheelchair. Resident #1 refused to go back to room. c. 3/7/23 at 11:38 AM, Resident #1 attempted to self-transfer. When the staff attempted to redirect him, he became combative and tried to swing at the staff. The staff contacted the Nurse Practitioner who gave a verbal order for intramuscular (IM) Haldol shot and an order for a UA to rule out a UTI. The Clinical Physician Orders reviewed 2/14/24 included the following orders: a. Haldol Injection Solution 5 MG per milliliters (ML). i. Started 1/1/23 - Discontinued 1/15/23. ii. Started 3/7/23 - Discontinued 3/13/23 (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	iii. Started 3/13/23 - Discontinued 3/21/23 iiii. Started 3/25/23 - Discontinued 4/8/23 b. Zyprexa 5 milligrams (MG) Tablet - Give 1 tablet in the morning by mouth. Discontinued 4/6/23. i. Started 3/27/23 - Discontinued 3/30/23 (For repeated falls) ii. Started 4/5/23 - Discontinued 4/6/23. (For psych) c. Seroquel 25 MG i. Started 3/31/23 - Discontinued 4/3/23. Give 1 tablet by mouth on ii. Started 4/3/23 - Discontinued 4/4/23. Give 1 tablet by mouth on iii. Started 4/5/23 - Discontinued 4/5/23. Give 25 tablet by mouth at d. Latuda 20 MG. Give one tablet by mouth i. Started 4/4/23 - Discontinued 4/5/23. The Care Plan lacked information related to specific behaviors or how to address the behaviors. The medical chart lacked an updated PASRR. The facility did not provide a policy on PASRR submissions. Interview on 2/28/24 at 1:11PM, with Director of Nursing (DON) reported someone should have completed a new PASRR for Resident #1.

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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** 44420 Based on clinical record review, policy review and staff interview the facility failed to revise a resident's Care Plan to include appropriate interventions for a cognitively impaired resident to prevent repeated falls and injuries for 1 out of 3 residents reviewed (Resident #6). Findings included: 1. The Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6's cognitive skills for daily decision making as moderately impaired. The MDS included diagnoses of Parkinson's Disease, dysphagia (difficulty swallowing), altered mental status, and repeated falls. Resident #6's Incident Reports from a look back period starting 8/20/23 reflected she fell 38 times. Resident #6's Incident Reports reflected the following predisposing factors for falls: a. 9/16/23 at 10:15 PM: gait imbalance, weakness, ambulating without assist b. 9/18/23 at 8:15 PM: confused, impaired memory c. 9/18/23 at 9:21 PM: confused, impaired memory d. 9/18/23 at 9:35 PM: confused, impaired memory e. 9/25/23 at 11:00 PM: confused f. 9/26/23 at 7:55 PM: impaired memory g. 10/8/23 at 2:00 PM: impaired memory h. 10/2/23 at 1:49 PM: confused i. 10/25/23 at 4:30 PM: confused j. 10/26/23 at 4:10 PM: confused k. 10/29/23 at 1:35 PM: confused, memory impaired l. 11/6/23 at 7:30 PM: confused m. 11/12/23 at 9:45 PM: confused, impaired memory n. 11/16/23 at 11:36 AM: confused, impaired memory (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o. 11/17/23 at 1:55 PM: confused p. 11/24/23 at 11:16 PM: confused, impaired memory q. 11/24/23 at 2:45 PM: confused, impaired memory Resident #6's Care Plan revised 12/13/23 included the following fall interventions of education: a. 10/8/23: Educate Resident #6 to tell the staff if she would like to sit on the floor. If she sits on the floor, provide a cushion, and check on her frequently. b. 10/23/23: Resident #6 educated on the risk of continuing to not asking for assistance and the risk for injury with her falls. c. 10/26/23: Resident #6 reeducated on the importance of using her call light and requesting assistance. d. 11/12/23: Educated on the importance of waiting for assistance. e. 11/20/23: Educate Resident #6 on the importance of not standing during vehicle transfer. f. 11/21/23: Resident #6 educated to ask for assistance in returning to her room. g. 11/22/23: Resident #6 reeducated on the importance of using her call light and waiting for assistance. h. 11/24/23: Resident #6 educated to tell staff when she is ready to go to bed. i. 11/25/23: Resident #6 reeducated to call for assistance and use her call light. j. 11/25/23: Resident #6 educated to ask staff for assistance with needs. On 2/27/23 at 1:57 PM, Staff CC, Certified Nursing Assistant (CNA), stated Resident #6 had a decline while at the facility and got confused towards the end of her stay. On 2/27/23 at 1:59 PM Staff DD, CNA, described Resident #6 as confused and unable to follow directions at times. The Care Planning policy revised September 2013 identified the facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive Care Plan for each resident. Policy Interpretation and Implementation instructed to develop a comprehensive Care Plan for each resident within seven (7) days of completion of the resident assessment (MDS). The Care Plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team which includes, but is not necessarily limited to the following personnel: a. The resident's Attending Physician; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The Registered Nurse who has responsibility for the resident; c. The Dietary Manager/Dietician; d. The Social Services Worker responsible for the resident; e. The Activity Director/Coordinator; f. Therapists (speech, occupational, recreational, etc.), as applicable; g. Consultants (as appropriate); h. The Director of Nursing (as applicable); i. The Charge Nurse responsible for resident care; j. Nursing Assistants responsible for the resident's care; and k. Others as appropriate or necessary to meet the needs of the resident. 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. Every effort will be made to schedule Care Plan meetings at the best time of the day for the resident and family. The mechanics of how the Interdisciplinary Team meets its responsibilities in the development of the interdisciplinary Care Plan (e.g., face-to-face, teleconference, written communication, etc.) is at the discretion of the Care Planning Committee. In an interview on 2/28/23 at 8:36 AM, when asked about if Resident #6's Care Plan included interventions related to confusion, the Director of Nursing reported Resident #6 wasn't confused. When asked if education should be used for interventions for confused residents, the DON replied, Resident #6 wasn't confused. She knew she shouldn't get up but got up anyway.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on record review and staff interviews the facility failed to pass medications as ordered by the physician for 2 of 21 residents reviewed (Resident #5 and #11). Findings include: 1. Resident #5's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating no cognitive impairment. The MDS included diagnoses of cancer, anemia (low blood iron), need for assistance with personal care. The Incident, Accident, Unusual Occurrence Note dated 11/6/23 at 6:34 AM, indicated that Resident #5 didn't receive her night dose of tramadol. While completing the morning narcotic count, the staff saw the scheduled tramadol signed off but not punched out of the medication card for bedtime. Resident #5 rested quietly and denied complaints. Resident #5's November 2023 Medication Administration Record (MAR) include an order dated 5/22/23 for tramadol 50 milligrams (MG) tablet. Give 0.5 tablet by mouth 2 times a day for pain. - The MAR included documentation indicating Resident #5 received the evening dose of tramadol on 11/5/23. 2. Resident #11's MDS assessment dated [DATE] identified a BIMS score of 11, indicating moderate memory loss. The MDS included diagnoses of heart failure, hypertension and coronary artery disease. The Care Plan Focus revised 1/3/24 reflected Resident #11 used insulin and/or hypoglycemic medications related to diabetes. The Order Summary Report signed 1/5/24 listed an order dated 1/3/24 for empagliflozin (diabetes medication) 10 milligrams (mg). Give 0.5 a tablet in the morning for diabetes. Resident #11's January 2024 MAR listed the empagliflozin with documentation of a 5 on 1/18/24 and 1/23/24, indicating hold/see progress notes. The documentation listed a 9 on 1/20/24 and 1/21/24, indicating other/see progress notes. Interview on 2/14/24 at 2:01 PM, Staff G, Pharmacist, reported the facility only received 14 days of medication due to the cost of the medication and Medicare restrictions. Staff G explained the facility ordered the medication on January 3, 2024 and again on January 24, 2024. Staff G expressed the facility needed to reorder the medication prior to running out. The Documentation of Medication Administration policy revised April 2007 directed the facility to maintain a medication administration record to document all medications administered. Interview on 2/27/24 at 3:27 PM, the Director of Nursing (DON) explained the facility needed to order medications when they are needed.

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Westwood Specialty Care	4201 Fieldcrest Drive Sioux City, IA 51104

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, resident interview, staff interview, and facility policy review the facility failed to give a bath twice a week and/or per the resident's preference for 3 of 3 residents reviewed for bathing (Resident #3, #7 and #9). Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score not completed. Resident #3 required supervision or touching assistance for tub or shower transfer and substantial assistance with showering or bathing self. The MDS included diagnoses of hypertension (high blood pressure), morbid obesity due to excess calories (extremely overweight), and chronic kidney disease. Interview on 2/27/24 at 12:27 PM, Resident #3 reported he didn't get his 3 baths a week and he missed baths consistently. Resident #3's Care Plan included an Intervention dated 8/7/23 to give him a bath 3 times a week. Resident #3's Task List indicated he received a shower and bathed himself on Tuesdays and Fridays. Resident #3's Documentation Survey Report v2 provided by the facility revealed the following information: a. December 2023: Bathing scheduled on Tuesdays and Fridays - 12/8/23 - Received a bath. - 12/12/23 - bathing documented as refused and not given. - 12/15/23 - Received a bath Resident #3 went 9 days without a bath. b. January 2024: Bathing scheduled on Tuesdays and Fridays c. February 2024: Bathing scheduled on Tuesdays and Fridays - 1/30/24 - Received a bath - 2/2/24 - Documented as not applicable. - 2/6/24 - Received a bath Resident went 7 days without a bath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score not completed. Resident #7 is dependent on staff for tub or shower transfers and is dependent on staff for showering or bathing self. The MDS included diagnoses of Alzheimer's Disease, aphasia (loss of ability to understand or express speech), and need for assistance with personal care. Review of Resident #7's Care Plan revealed bathing requires 1 assist with ear plugs. With a date initiated of 12/18/23 and a revision date of 12/18/23. The Task List revealed Resident #7 received a shower or bathe themselves on Monday and Thursday. The Documentation Survey Report v2 indicated the following information: a. December 2023: - 12/11/23: Resident #7 received a bath - 12/14/23 and 12/15/23: Documented as not applicable. - 12/18/23: Resident #7 received a bath. Resident #7 went 7 days without a bath. b. January 2024: - 12/29/23 - Resident #7 received a bath - 1/1/24 - Lacked documentation to indicate Resident #7 received a bath. - 1/4/24 - Resident #7 received a bath. Resident #7 went 6 days without a bath. 3. Resident #9's MDS assessment dated [DATE] for identified a Brief Interview for Mental Status (BIMS) score not completed. Resident #9 required supervision or touching assistance for tub or shower transfer and supervision or touching assistance with showering or bathing self. The MDS included diagnoses of non-Alzheimer's Dementia, malnutrition, and need for assistance with personal care. Resident #9's Care Plan revised 12/18/23 indicated they required assistance from one person with bathing. Resident #9's Task List indicated they received a shower or bath on Tuesday and Friday. Review of report titled Documentation Survey Report v2 provided by the facility revealed the following information: a. January 2024 - 12/28/23 - Received a bath (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 1/1/24 - Bathing not attempted due to environmental limitations. - 1/4/24 - Received a bath. Resident #9 went 7 days without a bath. The Bath, Shower, or Tub policy revised February 2018 described the purpose of the procedure is to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin. The policy directed to document the following: a. The date and time the staff performed the shower/tub bath. b. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. c. Reporting: i. Notify the supervisor if the resident refuses the shower/tub bath. ii. Report other information in accordance with facility policy and professional standards of practice. Interview on 2/17/24 at 3:27PM, the Director of Nursing (DON) said if a resident refused to take a bath, he expected the staff to continue to offer that day and every day until the resident takes a bath. Interview on 2/17/24 at 3:27 PM, Staff O, Regional Director of Clinical Services, reported the staff know they must not chart not applicable. The staff are to chart the reason if the bath is not completed, and not use not applicable.

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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** 44420 Based on clinical record review, staff interviews, and policy the facility failed to complete assessment and interventions for the necessary care and services, to maintain the residents' highest practical physical well-being. Clinical record review revealed the nursing staff failed to complete vital signs and neurological assessments for 1 out 3 residents reviewed for falls (Resident#6). Findings included: The Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6's cognitive skills for daily decision making as moderately impaired. The MDS included diagnoses of Parkinson's Disease, dysphagia (difficulty swallowing), altered mental status, and repeated falls. Resident #6's Incident Reports from a look back period starting 8/20/23 reflected she fell 38 times. The review of Resident #6's clinical record and Incident Reports reflected the facility failed to complete vital sign assessments for the following falls: a. 9/7/23 at 10:42 AM b. 9/13/23 at 3:49 PM c. 9/18/23 at 9:20 PM d. 9/18/23 at 9:35 PM e. 9/18/23 at 11:40 AM Record review of neurological assessments and Incident Reports showed the facility failed to complete neurological assessments for the following falls: a. 8/20/23 at 7:35 AM b. 9/6/23 at 7:45 AM c. 9/7/23 at 1:05 AM d. 9/7/23 at 10:42 AM e. 9/13/23 at 3:49 PM f. 9/26/23 at 7:55 PM g. 10/9/23 at 4:04 AM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Assessments and the Care Delivery Process policy revised December 2016 identified comprehensive assessments will be conducted to assist in developing person-centered Care Plans. Comprehensive assessments, Care Planning, and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions. Assessment and information collection include (WHAT, WHERE and WHEN?). The objective of the information collection (assessment) phase is to obtain, organize, and subsequently analyze information about a patient. a. Assess the individual. (1) Gather relevant information from multiple sources, including: - Observation; - Physical assessment; - Symptom or condition-related assessments (Braden, AIMs, falls, etc.); In an interview on 2/28/23 at 8:36 AM, when asked if the DON expected staff to complete neurological assessments and vital signs when a fall occurred, the DON replied, yes, if it is an unwitnessed fall.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on interviews and record review, the facility failed to provide a restorative program to a resident with mobility concerns for 1 of 3 residents reviewed (Residents #7). Findings include: The Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score not completed. Resident #7 is dependent on staff for tub or shower transfers and is dependent on staff for showering or bathing self. The MDS included diagnoses of Alzheimer's Disease, aphasia (loss of ability to understand or express speech), and need for assistance with personal care. Review of Resident #7's Care Plan lacked information regarding range of motion. The Follow Up Question Report for the dates of 12/1/23 - 12/31/23 directed staff to provide Resident #7 restorative of passive range of motion (PROM) to her bilateral upper extremities (BUE) and bilateral lower extremities (BLE) exercises 7 times a week. - The form listed the response on 12/6/23 and 12/14/23 as not applicable - The form lacked documentation for 12/23/23 - 12/26/23, 12/28/23, and 12/30/23. The Follow Up Question Report for the dates of 1/1/24 - 1/31/24 directed staff to provide Resident #7 restorative of PROM to her BUE and BLE exercises 7 times a week. - The form listed the response on 1/1/24, 1/3/24, 1/4/24, 1/8/24 - 1/11/24, 1/15/24 - 1/18/24, 1/22/24, 1/23/24, 1/25/24, 1/26/24, 1/29/24, and 1/31/24. - The form lacked documentation on 1/2/24, 1/12/24, 1/20/24, and 1/27/24. The Follow Up Question Report for the dates of 2/1/24 - 2/22/24 instructed the staff to preform restorative of PROM to her BUE and BLE exercises 7 times a week. - The form listed the response on 2/1/24, 2/5/24, 2/6/24, 2/8/24, 2/12/24, 2/14/24, 2/15/24, and 2/17/24 as not applicable. - The form lacked documentation on 2/9/24, - The form listed a response on 2/18/24 as response not required. Interview on 2/28/234 at 12:31 PM, the Director of Nursing (DON) reported the staff complete PROM every day when the staff get residents dressed.

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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** 44420 Based on clinical record review and facility policy review the facility failed to implement new interventions and adequate interventions, including adequate supervision, consistent with the resident's needs and cognitive status to mitigate the risk of falls and injuries for 1 out 3 residents reviewed (Resident #6). Findings included: The Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6's cognitive skills for daily decision making as moderately impaired. The MDS included diagnoses of Parkinson's Disease, dysphagia (difficulty swallowing), altered mental status, and repeated falls. Resident #6's Incident Reports from a look back period starting 8/20/23 reflected she fell 38 times. The Incident Report dated 9/25/23 at 11:00 PM identified the nurse found Resident #6 sitting on her buttocks in front of her husband's closet. Observed with jerky movements, barefoot with the wheelchair in front of her. She had active range of motion to all of her extremities. Resident #6 could only state she fell and not what happened. She complained of pain of 8 out of 10 on the pain scale, indicating moderately severe pain. The report indicated Resident #6 didn't have injuries observed at the time of the incident. Predisposing Physiological Factors listed confusion and gait imbalance. The Progress Note dated 9/26/23 at 11:06 AM listed Resident #6 complained of pain to her left rib area, left hip area, and head. Staff Z, Medical Doctor (MD), gave an orders to send Resident #6 to the emergency room (ER) for x-rays. Resident #6 transported to the ER per facility van. The Incident Report dated 9/26/23 at 4:13 PM reflected Resident #6 noted to have bruises to the left knee, right knee, left hand and forehead. Resident #6 fell many times that past week. The emergency room documentation dated 9/26/23 indicated Resident #6 had a diagnosis of a fracture of the posterior 8th rib. The Progress Note dated 10/29/23 at 1:50 PM indicated the Certified Nursing Assistant (CNA) assisted Resident #6 to use her walker to ambulate to the bathroom. During the transfer Resident #6's went limp, and couldn't stand. Resident #6 grabbed the rail located by the toilet, and wouldn't let go. When the CNA could not reach the toilet with the resident, she sat the resident down on the ground. The Incident Report dated 10/29/23 at 1:35 PM documented Resident #6 as alert and oriented with periods of forgetfulness and confusion per her usual. Resident unable to state current location, date, or time. The report also indicated fall predisposing factors included confusion and impaired memory impaired. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	The emergency room documentation dated 10/30/23 showed Resident #6's physical exam significant for a small hematoma to the volar aspect of the right forearm with tenderness on palpation. No open wounds appreciated. Extremity vascular intact. Patient chronically aphasic (not able to talk). The differential diagnoses included a wrist fracture, forearm fracture, wrist sprain, and hematoma (a collection of blood under the skin). The Progress Note dated 11/25/23 at 10:15 PM for Resident #6 indicated Resident #6's roommate approached the desk to report her on the floor. Resident #6 found in the supine upward sitting position with the ability to move all extremities. Resident #6 pulled her brief off to attempt a bowel movement. The Intervention listed the nurse educated Resident #6 to use the call light. The Incident Report dated 11/25/23 at 2:45 PM indicated the staff witnessed Resident #6 while at the nurses' station move forward out of the wheelchair, to the floor, landing on her knees. The predisposing factors listed confusion and memory impaired. The Incident Report dated 11/25/23 at 10:15 PM reflected Resident #6's husband went to the nurses' station to tell the nurse Resident #6 was on the floor. The author described Resident #6 as in a supine upward sitting position and moved all extremities. She pulled off her brief to attempt to have a bowel movement (BM). Resident #6's neurological assessment determined within normal limits for her. Resident #6 started melatonin (vitamin that assists with sleep). The author described her as sleepy but easily arousable without injuries. The author encouraged the staff to anticipate her needs as she didn't use the call light. The report indicated Resident #6 didn't go to the hospital and had no pain. The injuries report post incident listed a facture to the right hip. The Communication - with Hospice dated 11/26/23 at 2:46 PM reflected Resident #6 complained of right sided hip pain. Resident #6 sent to the emergency room (ER) for further assessment. The History and Physical dated 11/26/23 at 5:44 PM indicated Resident #6 presented to the ER via an ambulance. Resident #6 fell 4 times that day and complained of right hip pain. Typically, Resident #6 is ambulatory but acutely required help with ambulation and getting out of wheelchair. The Problem List listed the principal problem as a closed right hip fracture. The provider discussed Resident #6's case with the hospice nurse who advised they would admit her because of her acute fracture. The History and Physical dated 11/26/23 at 10:52 AM reflected Resident #6 went to the ER a few times in the previous weeks with a right wrist fracture 3 weeks before. The provider described her as a poor historian due to dementia and they didn't know if she had head trauma loss of consciousness. The plan directed to keep her on bedrest, pain control, and a urinary catheter. The Palliative Care Consult Note dated 11/26/24 indicated Resident#6 had recurrent falls and went to theER on [DATE] with a right wrist fracture after a fall. Resident #6 still had a cast in place. She presented to theER on this occasion after experiencing another fall that resulted in a comminuted and displaced right intertrochanteric hip fracture. The family and medical staff had a discussion regarding surgical intervention versus comfort focused care with continued Hospice support and discharge back to the nursing home. The family unsure how to proceed and requested time to discuss the options. Resident #6's Incident Reports reflected the following predisposing factors for falls: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	a. 9/16/23 at 10:15 PM: gait imbalance, weakness, ambulating without assist b. 9/18/23 at 8:15 PM: confused, impaired memory c. 9/18/23 at 9:21 PM: confused, impaired memory d. 9/18/23 at 9:35 PM: confused, impaired memory e. 9/25/23 at 11:00 PM: confused f. 9/26/23 at 7:55 PM: impaired memory g. 10/8/23 at 2:00 PM: impaired memory h. 10/2/23 at 1:49 PM: confused i. 10/25/23 at 4:30 PM: confused j. 10/26/23 at 4:10 PM: confused k. 10/29/23 at 1:35 PM: confused, memory impaired l. 11/6/23 at 7:30 PM: confused m. 11/12/23 at 9:45 PM: confused, impaired memory n. 11/16/23 at 11:36 AM: confused, impaired memory o. 11/17/23 at 1:55 PM: confused p. 11/24/23 at 11:16 PM: confused, impaired memory q. 11/24/23 at 2:45 PM: confused, impaired memory Resident #6's Care Plan revised 12/13/23 included the following fall interventions of education: a. 10/8/23: Educate Resident #6 to tell the staff if she would like to sit on the floor. If she sits on the floor, provide a cushion, and check on her frequently. b. 10/23/23: Resident #6 educated on the risk of continuing to not asking for assistance and the risk for injury with her falls. c. 10/26/23: Resident #6 reeducated on the importance of using her call light and requesting assistance. d. 11/12/23: Educated on the importance of waiting for assistance. e. 11/20/23: Educate Resident #6 on the importance of not standing during vehicle transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	f. 11/21/23: Resident #6 educated to ask for assistance in returning to her room. g. 11/22/23: Resident #6 reeducated on the importance of using her call light and waiting for assistance. h. 11/24/23: Resident #6 educated to tell staff when she is ready to go to bed. i. 11/25/23: Resident #6 reeducated to call for assistance and use her call light. j. 11/25/23: Resident #6 educated to ask staff for assistance with needs. The Falls and Fall Risk, Managing policy revised March 2018 instructed the staff to identify interventions, based on previous evaluations and current data, related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The policy defined a fall according to the MDS, as unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g., a resident pushes another resident). An episode where a resident lost his/her balance and they would have fell , if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. Challenging a resident's balance and training him/her to recover from loss of balance is an intentional therapeutic intervention. The losses of balance that occur during supervised therapeutic interventions are not considered a fall. The policy included a list of fall risk factors as listed below: 1. Environmental factors that contribute to the risk of falls include: wet floors; poor lighting; incorrect bed height or width; obstacles in the footpath; improperly fitted or maintained wheelchairs; and footwear that is unsafe or absent. 2. Resident conditions that may contribute to the risk of falls include: fever; infection; delirium and other cognitive impairment; pain; lower extremity weakness; poor grip strength; medication side effects; orthostatic hypotension; functional impairments; visual deficits; and incontinence. 3. Medical factors that contribute to the risk of falls include: Arthritis; heart failure; anemia; neurological disorders; and balance and gait disorders; etc. The policy included the following Resident-Centered Approaches to Managing Falls and Fall Risk: a. The staff, with the input of the attending physician, if appropriate, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. b. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once). c. Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	d. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling, or indicate why those medications could not be tapered or stopped, even for a trial period. e. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. f. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. g. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. h. Position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. Included in the policy directed the following about Monitoring Subsequent Falls and Fall Risk a. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. b. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. c. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. d. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls. On 2/27/23 at 1:57 PM, Staff CC, Certified Nursing Assistant (CNA), stated Resident #6 declined during her stay at the facility and became very confused towards the end of her stay. On 2/27/23 at 1:59 PM Staff DD, CNA, described Resident #6 as confused and unable to follow directions at times. In an interview on 2/28/23 at 8:36 AM, when asked if Resident #6 had Care Plan interventions related to confusion, the DON responded Resident #6 wasn't confused. When asked if education should be used for interventions for confused residents, the DON replied, Resident #6 wasn't confused. She knew she shouldn't get up but got up anyway.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on resident observations, resident record reviews and interviews the facility failed to prevent pain during medical procedures for 1 out of 1 resident (Resident #13) reviewed. Findings include: Resident #13's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score not completed. The MDS included diagnoses of coronary artery disease (decreased blood flow due to the heart caused by a buildup in the arteries), heart failure, diabetes mellitus, and depression. Interview on 2/21/24 at 10:37 AM, Resident #13 explained someone changed his catheter recently, but didn't remember the exact date. Resident #13 described Staff EE, Licensed Practical Nurse (LPN) as horrible. He explained during the procedure he had the worst pain he ever had in his entire life. Resident #13 explained Staff EE inserted the catheter and when they started to inflate the balloon he started having pain. Resident #13 told Staff EE to stop, but they continued to inflate the balloon with the full amount in the syringe. Resident #13 added the pain didn't stop and the catheter fell out. He explained that he had a catheter for a long time and that never happened to him before. He knew something was wrong right away when he experienced the pain. Resident #13 said he reported Staff EE to the office but couldn't remember who and told them he never wanted Staff EE back in his room again and he stated Staff EE has never seen him again since the incident. Resident #13 stated he knew after he saw blood in the catheter, something got damaged. He went to the emergency room after the incident due to the amount of blood. Resident #13 reported he needs further testing with urology to see if he had internal damage done with the catheter insertion as he bled for several days after Staff EE inserted the catheter. Interview on 2/26/24 at 1:52 PM, Resident #13's family member revealed Resident #13 saw the urologist, who felt he continued bleeding after the catheter insertion and scheduled a scope (camera visualization of a specific internal body part) to be sure. Resident #13's family member revealed Resident #13 explained he had terrible pain like he never had before when the nurse inserted the catheter. Resident #13's family member added the night Resident #13 had his catheter attempted insertion, he went to the emergency room because they couldn't insert the catheter. The Orders Note dated 2/7/24 at 6:37 PM Resident #13's provider sent orders to reinsert his urinary catheter. The Nurses' Note dated 2/7/24 at 10:35 PM Resident had an order to insert a urinary catheter, while in the middle of inserting he asked for the urinal stating he couldn't hold it. It just comes pushing back the catheter and he started bleeding. The nurse called the provider who gave orders to monitor. The Nurses' Note dated 2/8/24 at 1:00 AM, the nurse called the on-call provider over Resident #13 complained of feeling chills and complaints of frontal headache while still actively bleeding. The provider gave an okay to send Resident #13 to emergency room for evaluation. Resident left the facility via ambulance at 12:55 AM. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/27/24 at 3:27 PM, the Director of Nursing (DON) reported Staff EE worked as the nurse the night Resident #13 had his catheter reinserted. Interview on 2/28/24 at 1:21 PM, Staff EE explained he hadn't worked at the facility in over a year. The Pain Assessment and Management policy revised March 2020 directed to report to the physician or practitioner significant changes in the level of pain the resident's pain. Interview with the DON on 2/28/24 at 11:23 AM, revealed he talked to Resident #13 and he stated the pain started when Staff EE inflated the balloon of the catheter.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 44420 Based on facility personnel record review, resident, and staff interviews, the facility failed to consistently answer call lights within a reasonable amount of time (defined as 15 minutes or less). Residents reported they had to wait over 15 minutes for someone to answer their call light for 6 out 6 residents reviewed (Residents #17, #18, #19, #20, #21, #22). Findings included: The Grievance/Investigation Form dated 12/6/23 completed for Resident #20 by a staff member documented the following: On 11/29/23 Resident #20 turned on the call light at 6:15 PM. At 7:00 PM Resident #20's daughter went to the nurses' station to ask for help. The nurse told her they were in the middle of report, they didn't have time. The Grievance/Investigation Form dated 12/10/23 completed by Resident #21 reported the staff left her on the toilet from 5:00 AM to 9:30 AM. Resident #21 explained the staff told her, he needed assistance from another person to get her up. The Grievance/Investigation Form dated 1/16/24 completed for Resident #18 by a staff member indicated he had a concern with call light times. The Grievance/Investigation Form dated 2/1/24 showed Staff AA reported another staff member failed to assist a resident after the call light had been on for 20 minutes. Staff AA reported the staff member told her that she was leaving, failed to give a report and left. The Grievance/Investigation Form dated 2/8/24 signed by Resident #17 documented she turned her call light on at 6:00 AM. No one came to help her until 8:00 AM. She called the facility at 7:18 AM, 7:30 AM, and 7:41 AM, the last time. No one came in till 8:00 AM. In an interview on 2/27/24 at 2:21 PM, Resident #22 stated, I wait 30 minutes at least one time each evening. The night before she waited 1.5 hours and the nurse had to get her up. In an interview on 2/27/24 at 2:17 PM, Resident #22 reported staff took 30 minutes or longer to answer the call light. When asked how often this happened, Resident #22 reported, once a day and more in the evenings or nights. In an interview on 2/27/24 at 3:35 PM, Staff BB, Licensed Practical Nurse (LPN), reported call lights do not get answered within 15 minutes during weekend shifts, due to being short staffed on the weekends. Staff BB reported it could take up to 45 minutes to 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 - Many	The Answering the Call Light revised 2021 identified the purpose of this procedure is to ensure timely responses to the resident's requests and needs. The General Guidelines directed to document any significant requests or complaints made by the resident and how the request or complaint was addressed. In an interview on 2/28/24 at 8:34 AM, the Director of Nursing (DON), reported he expected the staff to answer call lights within 15 minutes.

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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** 44420 Based on clinical record and staff interview, the facility failed to ensure a resident had an adequate diagnosis for psychotropic medications for 1 of 3 resident's reviewed (Resident #1). Findings included: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 2, indicating severe cognitive impairment. The MDS included diagnoses of cancer, Parkinson's Disease and repeated falls. Resident #1's Medical Diagnosis list, listed the principal diagnosis of Parkinson's Disease. The list lacked diagnoses related to mental health disorders. The untitled physician notification dated 3/26/23 indicated someone from the facility notified Staff W, Nurse Practitioner, Certified (NP-C), they found Resident #1 on the floor in his room. The situation appeared as Resident #1 slid out of his recliner. He suffered a 0.5-centimeter (cm) laceration to the top of his head. Staff W responded with an order for Zyprexa (olanzapine) 5 milligrams (mg) 1 tab by mouth. Resident #1's Clinical Physician Orders dated 3/27/23 included an order for Zyprexa 5 1 tab for repeated falls. A fax from the pharmacy dated 3/28/23 asked for the following clarifications related to the Zyprexa ordered on 3/27/243: a. Is this a new order? b. How often will this be taken? c. Just wanted to double check the order since the situation noted he slid out of chair and Zyprexa can cause increased sedation. Staff W wrote back Zyprexa 5 mg ordered daily. Resident #1's Hospice Communication Notes reflected the following: a. On 3/31/23 at 11:51 AM, Staff Y, Registered Nurse (RN) discussed the Zyprexa order with the consulting pharmacist regarding Resident #1's behaviors and frequent falls. Per the note the pharmacist recommended to discontinue the Zyprexa as it may be contraindicated in his disease with how it works on the dopamine receptors. The pharmacist recommended Seroquel 25 mg daily. b. On 3/31/23 at 2:52 PM, Staff Y obtained a new order from Staff X to discontinue Zyprexa 5mg and begin Seroquel 25 mg. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's Physician Orders dated 3/31/23 indicated Staff X, DO, discontinued Zyprexa 5 mg and started Seroquel 25 mg daily for behaviors. Resident #1's March 2023 Medication Administration Record (MAR) included the following orders a. Zyprexa 5 mg daily for repeated falls - Administered on 3/27/23 - 3/29/23 and 3/31/23. b. Seroquel 25 mg daily for behaviors - Administered on 3/31/23. Resident #1's Physician Orders on 4/4/23 reflected Staff Z, Medical Doctor (MD), discontinued Seroquel 25 mg and started Latuda 20 mg for restlessness. Resident #1's Interdisciplinary Group Meeting Notes dated 4/19/23 included an entry on 4/4/23 from Staff Y indicated Staff Z rounded on him that morning. Staff Z discontinued the Seroquel and ordered Latuda 20 mg at bedtime. Staff Y attempted to clarify the new order with Staff W, but she failed to return the call. Staff X ordered to hold that evening's dose of Latuda. Resident #1's Physician Order dated 4/5/23 listed an order from Staff Z of Zyprexa 5 mg every morning for psych. Resident #1's Physician Orders dated 4/15/23 reflected Staff W revised the Zyprexa 5 mg to give every bedtime for psych. Resident #1's April 2023 MAR included the following orders: a. Seroquel 25 mg ordered daily for behaviors - Administered on 4/1/23, 4/2/23 and 4/4/23. b. Latuda 20 mg ordered every evening for restlessness - Administered on 4/4/23. c. Zyprexa 5 mg every morning for psych - Administered from 4/6/23 - 4/15/23. d. Zyprexa 5 mg every bedtime for psych - Administered from 4/16/23 - 4/30/23. The May 2023 MAR included an order for Zyprexa 5 mg every bedtime for psych. The documentation indicated Resident #1 received the medication from 5/1/23 - 5/7/23. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Consultant Report labeled 3/1/23 - 5/31/23 identified the pharmacist recommended the following: a. 4/5/23: Resident #1 received an antipsychotic, Latuda, without documentation of a diagnosis or adequate indication for use in the medical record. Current indication is listed as restlessness. The recommendation indicated if they choose to continue with Latuda, they needed to update the medical record to include: i. The specific diagnosis/indication requiring the treatment that is based upon an assessment of the resident's condition and therapeutic goals. ii. A list of the symptoms or target behaviors (e.g., hallucinations) including their impact on the resident (e.g., increases distress, presents a danger to the resident or others, interferes with his/her ability to eat) AND iii. Documentation that other causes (e.g., environmental) and medications have been considered, that individualized nonpharmacological interventions are in place, and that ongoing monitoring has been ordered. Rationale for Recommendation: CMS requires the resident's medical record include documentation of adequate indications for medication use and the diagnosed condition for which a medication is prescribed. b. 5/2/23: Resident #1 received an antipsychotic, olanzapine, without documentation of a diagnosis or adequate indication for use in the medical record. Current indication is listed as restlessness. The recommendation indicated if they choose to continue with olanzapine, they needed to update the medical record to include: i. The specific diagnosis/indication requiring the treatment that is based upon an assessment of the resident's condition and therapeutic goals. ii. A list of the symptoms or target behaviors (e.g., hallucinations) including their impact on the resident (e.g., increases distress, presents a danger to the resident or others, interferes with his/her ability to eat) AND iii. Documentation that other causes (e.g., environmental) and medications have been considered, that individualized nonpharmacological interventions are in place, and that ongoing monitoring has been ordered. Rationale for Recommendation: CMS requires the resident's medical record include documentation of adequate indications for medication use and the diagnosed condition for which a medication is prescribed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Therapy policy revised April 2007 instructed each resident's medication regimen should only include medications necessary to treat existing conditions and address significant risks. Medication use shall be consistent with an individual's condition, prognosis, values, wishes, and responses to such treatments. Appropriate care processes and practices will support all medication orders. In an interview on 2/28/23 at 8:36 AM, when asked if Zyprexa should be ordered for repeated falls, the Director of Nursing (DON) stated, I would need to know more about the situation. When asked if a resident, without a history of mental illness, should have an indication of psych used for a Zyprexa order, the DON replied he would need to know more about the situation. When asked what is expected from the nurses when the medical indication is not appropriate for the order, the DON, replied, they should clarify any questions regarding the order with the doctor.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 44475 Based on observation, clinical record, facility policy, Medline Plus, and staff interview, the facility failed to administer medications in the correct form and 1 hour or more before a meal for 1 of 7 residents reviewed (Resident #16). Findings include: During an observation on 2/22/24 at 9:30 AM, Staff A, Licensed Practical Nurse (LPN), reported Resident #16 had an order to crush medications. Staff A crushed the medications and administered them to Resident #16 with chocolate pudding as he sat in the dining room eating breakfast. Resident #16 received the following medications: a. Bumex (treats excess fluid in the body) 1 milligram (mg). b. Ferrous Sulfate (iron supplement) 325 mg. c. Levothyroxine (treats underactive thyroid) 225 mg. The Clinical Record lacked an order to crush Resident #16's medications or he could receive his levothyroxine 1 hour or less before his meal. The Federal government web site, https://medlineplus.gov/druginfo/meds/a682461.html, revised 2/15/19 and accessed 2/22/24 included the following instructions for the use of levothyroxine: a. Take levothyroxine once a day on an empty stomach, 30 minutes to 1 hour before breakfast. b. If you give levothyroxine to an infant, child, or adult who cannot swallow the tablet, crush and mix it in 1 to 2 teaspoons (5 to 10 mL (milliliters)) of water. Only mix the crushed tablets with water; do not mix it with food or soybean infant formula. The Medication Therapy policy dated April 2007 directed all medication orders will support the appropriate care processes and practices. In an interview on 2/22/24 at 11:10 AM, when asked if it was acceptable practice to administer crushed medication without an order or that levothyroxine may be administered during a meal, the Director of Nursing (DON) reported that it was not standard practice.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44475 Based on observation, facility record, pharmacy record, and staff interviews, the facility failed to keep narcotic medication secure to prevent diversion. The facility reported 78 residents. Findings include: 1. In a concurrent interview and observation on 2/22/24 at 11:10 AM, the medication cart contained a drawer containing glucometer (blood sugar testing) equipment with 3 orange medication tablets lying next to an empty clear disposable medication cup. Staff A, Licensed Practical Nurse (LPN), reported that she will dispose of the 3 orange medication tablets immediately and placed them in the sharp's container on the medication cart. The Storage of Medications Policy dated November 2020 directed the following: a. Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. b. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. In an interview on 2/22/24 at 11:10 AM, when asked if it was acceptable that loose medication tablets be stored in a medication cart, the Director of Nursing (DON) reported that it was not acceptable. 2. The Incident Summary Investigation dated 10/30/23 revealed that Staff F, LPN, discovered Resident #3 had a medication card containing 60 tablets of morphine sulfate, 30 mg per tablet, missing. The investigation determined Staff B, LPN, signed the receipt of delivery for those medications on 10/25/23. The Packing Slip dated 10/25/23 listed 60 tablets of morphine sulfate 30 mg tablets delivered to the facility with a receipt signed by Staff B. The packing slip didn't contain the delivery person's signature. In an interview on 2/21/24 at 10:35 AM, Staff G, Pharmacist, reported the facility received the medication with a receipt of the delivery signed by Staff B on 10/25/23. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/21/24 at 12:37 PM, Staff B described the evening shift on 10/25/23 as exceptionally busy as they were short staff and she was assisting a resident on hospice care more often as the resident's condition declined that shift. She reported that the pharmacy delivery person rushed her during the process of taking receipt of the medication delivery. Staff B sorted the medication per the medication cart and called Staff C, Registered Nurse (RN), Staff D, Certified Medication Assistant (CMA), and Staff E, CMA, to the nurse's station to retrieve the medication for their assigned medication carts. Staff B reported being the nurse assigned to oversee the work of Staff D and that as far as she knew, Staff D placed the medication card containing 60 tablets of morphine sulfate into the locked narcotic medication compartment of her medication cart. In an interview on 2/21/24 at 1:05 PM, Staff D reported that Staff B directly handed her the medication cards, but she didn't remember if it happened at the nurse's station or at the medication cart she was assigned to. Staff D reported she didn't receive any narcotics in the medication cards she took receipt of from Staff B. Staff D reported that at that time, the facility just started working with a new pharmacy and they had a rude delivery person. In an interview on 2/21/24 at 8:39 PM, Staff C reported being at her assigned medication cart when Staff B gave her the medication cards to place in her medication cart, and that none of the cards contained narcotics. Staff C reported she observed the pharmacy delivery person put a medication delivery in a location on the nurse's station that is accessible to all staff, residents, and visitors and then leave the medications unattended to use the restroom. In an interview on 2/21/24 at 1:35 PM, Staff E reported that Staff C, not Staff B, handed her the medication cards to place in her assigned medication cart. Staff E reported that the pharmacy delivery person is impatient with the nurses when they are taking receipt of a medication delivery. The Controlled Substances Policy dated April 2019 directed the nurse receiving the medication and the individual delivering the medication verify the name, dose and quantity of each controlled substance being delivered. Both individuals sign the controlled substance record of receipt. An individual resident-controlled substance record is made for each resident who is receiving a controlled substance. In an interview on 2/22/24 at 11:10 AM, the Regional Nurse Consultant (RNC) reported that she knew the incident would be a concern that could cause a deficiency for the facility because the facility couldn't account for the 60 tablets medication card morphine.

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on record reviews, facility policy review, resident, staff, and medical facility interviews, the facility failed to ensure 2 out of 2 residents reviewed (Resident #3 and Resident #13) received transportation to their appointments, causing them to have to be rescheduled. Findings included: 1. The Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score not completed. The MDS included diagnoses of hypertension (high blood pressure), morbid obesity due to excess calories and chronic kidney disease. Interview on 2/17/24 at 12:27 PM, Resident #3 explained he had an appointment scheduled for that day, but it got rescheduled until next week. Resident #3 explained he didn't know they changed his appointment time, but it frustrated him as he had things that he liked to get done but it seemed he had issues with his ride a lot. There are a lot of times when they have to reschedule his appointment due to rides. The facility told him the Veterans Administration (VA) is responsible for taking him to his appointments. Interview on 2/27/24 at 12:37 PM, with Staff U, VA Transportation Services verified Resident #3 didn't have a ride scheduled for his 2/27/24 appointment. Interview on 2/27/24 at 12:41 PM, with Staff V, VA Scheduler, explained Resident #3 had an appointment scheduled with the VA for 2/27/24 but the appointment got canceled on 2/26/24 around 4:00 PM, due to travel difficulties. 2. Resident #13's MDS assessment dated [DATE] identified a BIMS score of 15 indicating no cognitive impairment. The MDS included coronary artery disease (decrease blood flow to the heart), heart failure, diabetes mellitus, and depression. Interview on 2/26/24 at 1:52 PM, Resident #13's family member revealed the facility seems to fight with the VA on who is going to take him to his appointments. Resident #13's family member explained they took off work and waited for Resident #13 to show up at the doctor's office. Then either Resident #13 doesn't show up or is late and then the family member has to talk to the doctor's office and try to still get the doctor to see him. Resident #13's family member tried to set up rides for Resident #13 to ensure he made his appointments. Resident #13's family member is tired of Resident #13 missing important appointments. Observation on 2/27/24 at 8:48 AM, VA transportation arrived at the facility to pick up Resident #13 for an appointment. The facility already rescheduled the appointment but did not notify the VA transportation of the change. Interview on 2/27/24 at 10:23 AM, Resident #13 reported he always had an issue with transportation at the facility. Resident #13 explained he sees a lot of others coming and going with rides but felt he didn't get rides like the others since he has VA benefits. (continued on next page)

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	165271	A. Building B. Wing	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Specialty Care	4201 Fieldcrest Drive Sioux City, IA 51104

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/27/24 at 11:39 AM, Staff U verified Resident #13 had a ride set up on 2/17/24 for an appointment in Sioux Falls. Staff U revealed the facility called him on 2/26/24 but couldn't say for sure if he gave the facility the time the van would pick Resident #13 up or if they told the facility they hadn't confirmed the ride yet. Staff U revealed he didn't tell the facility Resident #13 didn't have a ride. They entered Resident #13's request for a ride into the system on 2/21/24. Staff U describe that ride as a harder ride to arrange as he couldn't get a contract van and had to reschedule the vans in Sioux Falls to meet Resident #13's ride request. Staff U explained the VA struggled working with the facility and arranging rides. Staff U added it got a little better since many of the veterans have passed away. The Transportation, Social Services policy revised December 2008 instructed the facility to help arrange transportation for residents as needed. The policy further revealed that except in emergencies, arrangement of transportation is the responsibility of the resident or his or her representative (sponsor). Social services will help the resident as needed to obtain transportation. The resident shall assume full responsibility for paying for any transportation to or from the facility. The facility will not act as a billing agent for transportation charges. Inquiries concerning transportation should be referred to social services. Interview on 2/17/24 at 3:27 PM, Staff O, Regional Director of Clinical Services revealed it is the facilities policy to assist residents with transportation but the facility is not required to provide the transportation.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 44420 Based on facility record review, the facility failed to sustain an effective quality assurance and performance improvement plan (QAPI) program in place to assist in the provision of quality care for residents. The facility identified a census of 78 residents. Findings included: Per the Iowa Department of Inspections, Appeals, and Licensing (IDIAL) website reflect survey results for 3/30/23. The facility received the following violations on their recertification visits: a. F550 Resident Rights/Exercise of Rights b. F658 Services Provided Meet Professional Standards c. F677 ADL Care Provided for Dependent Residents d. F684 Quality of Care e. F689 Free of Accident Hazards/Supervision/Devices f. F695 Respiratory /Tracheostomy Care and Suctioning g. F725 Sufficient Nursing Staff h. F804 Nutritive Value/Appear, Palatable/Prefer Temp i. F809 Frequency of Meals/Snacks at Bedtime j. F812 Food Procurement, Store/Prepare/Serve-Sanitary k. F842 Resident Records - Identifiable Information Per the IDIAL website the survey results dated 10/24/23 listed the repeated violations that occurred on the 3/30/23 visit and/or on the following visit on 2/12/23: a. F550 Resident Rights/Exercise of Rights b. F658 Services Provided Meet Professional Standards c. F677 ADL Care Provided for Dependent Residents d. F684 Quality of Care e. F689 Free of Accident Hazards/Supervision/Devices (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	f. F695 Respiratory /Tracheostomy Care and Suctioning g. F697 Pain Management h. F725 Sufficient Nursing Staff i. F760 Residents are Free of Significant Med Errors j. F804 Nutritive Value/Appear, Palatable/Prefer Temp k. F809 Frequency of Meals/Snacks at Bedtime l. F812 Food Procurement, Store/Prepare/Serve-Sanitary m. F842 Resident Records - Identifiable Information The Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership policy revised March 2020 identified the Quality Assurance and Performance Improvement Program is overseen and implemented by the QAPI Committee, which reports its findings, actions and results to the Administrator and governing body. The Policy Interpretation and Implementation indicated the Administrator, whether a member of the QAPI Committee or not, is ultimately responsible for the QAPI Program, and for interpreting its results and findings to the governing body. The governing body is responsible for ensuring that the QAPI program: Is implemented and maintained to address identified priorities; Is sustained through transitions of leadership and staffing; Is adequately resourced and funded, including the provision of money, time, equipment, training and staff coverage sufficient to conduct the activities of the program; Is based on data, resident and staff input, and other information that measures performance; and Focuses on problems and opportunities that reflect processes, functions and services provided to the residents. The QAPI Coordinator coordinates the activities of the QAPI Committee. The responsibilities of the QAPI Committee are to: Collect and analyze performance indicator data and other information; Identify, evaluate, monitor and improve facility systems and processes that support the delivery of care and services; Identify and help to resolve negative outcomes and/or care quality problems identified during the QAPI process; Utilize root cause analysis to help identify where identified problems point to underlying systematic problems; Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care; Establish benchmarks and goals by which to measure performance improvement; Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals; and Communicate all phases of the QAPI process to the Administrator and governing body through sharing meeting minutes, committee activities and results of QAPI activities. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The committee has the full authority to oversee the implementation of the QAPI Program, including, but not limited to, the following: Establishing performance and outcome indicators for quality of care and services delivered in the facility; Choosing and implementing tools that best capture and measure data about the chosen indicators; Appropriately interpreting data within the context of standards of care, benchmarks, targets and the strengths and challenges of the facility; and Communicating the information gathered and their interpretation to the owner/governing board (body). The following individuals serve on the committee: Administrator, or a designee who is in a leadership role; Director of Nursing Services; Medical Director; Infection Preventionist; Representatives of the following departments, as requested by the Administrator: Pharmacy; Social Services; Activity Services; Environmental Services;(5) Human Resources; and (6) Medical Records. The committee meets at least quarterly (or more often as necessary). Committee members are reminded of meeting day, time and location via e-mail at least two business days prior to the meeting. The Administrator may call special meetings as needed to present issues that need to be addressed before the next regularly scheduled meeting. On 2/28/23 at 8:36 AM, When asked about Quality Assurance and Performance Improvement (QAPI) related to repeated violations the Director of Nursing (DON) reported a plan of correction (POC) is followed and completed weekly. Audits are done either daily or weekly. The DON reported the POC is followed and monitored through the QAPI team. The DON reported if a plan didn't work, the team either reassessed the plan and changed it or created a new intervention if needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 44474 Based on observation, infection control policy, clinical record review and staff interview, the facility failed to complete hand hygiene while providing incontinence care for 2 of 3 residents observed. In addition, the facility failed to pass food in a sanitary manner. The facility reported a total census of 78 residents. Findings include: 1. Observation on 2/21/24 at 11:51 AM, of Staff I, Certified Nursing Assistant (CNA), and Staff J, Certified Medication Assistant (CMA), assisted Resident #14 with perineal care. Staff J performed hand hygiene and applied clean gloves. Staff J with gloves on took out a package of wipes and laid them on the bed, while they wore the same gloves, she moved the bed out to be able to get behind to assist Staff I. Without hand hygiene or applying new gloves, Staff J removed Resident #14's the pillow from under her legs, then opened the closet, removed a clean pair of shorts, and then closed the closet doors. Without hand hygiene or changing their gloves, Staff J rolled Resident #14 to her side by putting one hand on her shoulder and on her right hip area. With the same soiled gloves, Staff J, opened the wipes container and pulled out clean wipes to hand them to Staff I to use to perform perineal care. Staff J repeated the task until Staff I completed the perineal care. Staff J continued to wear the soiled gloves, removed the soiled brief, pad, and discarded into the trash. Staff J removed the soiled gloves and performed hand hygiene, then removed clean gloves out of her scrub pockets. Staff J applied the gloves to assist Staff I with repositioning and dressing of Resident #14. 2. Observation on 2/21/24 at 1:59 PM, Staff L, CNA, and Staff M, CNA, assisted Resident #12 with perineal care. Staff L and Staff M applied gloves without performing hand hygiene. With their gloves on Staff L took out a package of wipes and laid them directly on the bed. Staff L removed clean wipes, took 2 wipes, and laid the rest of the wipes from the package directly onto the bed behind Resident #12. Staff L picked up the wipes off the bed directly behind Resident #12 and removed another 2 wipes before laying the extra back directly on the bed. Staff L repeated the routine until Resident #13 was clean. Staff L removed gloves and performed hand hygiene prior to reapplying gloves. Interview on 2/17/24 at 3:27 PM, the Director of Nursing (DON) revealed staff shouldn't wear soiled gloves prior to assisting residents with care. The Handwashing and Hand Hygiene policy revised August 2019 directed all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The use of gloves didn't replace hand washing/hand hygiene. The integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water before and after direct contact with residents. The section labeled Applying Gloves instructed to remove one glove from the dispensing box at a time, touching only the top of the cuff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 2/12/24 at 12:22 PM, observed the staff pass the lunch meal service in the dining room. Staff H, Cook, picked up a piece of bread with their bare hands, placed it on the plate, and served the meal to a resident. Staff H repeated this 3 times until they noticed the surveyors watching the meal service. At that time Staff H picked up a set of tongs and continued to serve the bread with the tongs. On 2/12/24 at 12:26 PM, watched Staff H pick up a sandwich wrapped in plastic wrap out of the bag with her bare hands, placed it on a plate, and served it to the resident. On 2/21/24 at 12:07 PM, watched Staff K, CNA, pick up a packet of margarine with her bare hands, placed it directly on top of a piece of bread, and then served it to a resident. Staff K picked up another plate to serve, grabbed 2 packets of margarine, and placed them directly on top of a slice of bread. One of the packets slid into the potatoes and the staff continued to serve the plate to the resident. The facility did not provide a policy on dietary sanitation services. Interview on 2/22/24 at 8:54 am with Staff P, Corporate Dietitian, reported the staff knew better than to touch ready to serve items with their bare hands. The staff should have used tongs or another utensil to serve the bread and sandwiches. The staff also know margarine packets shouldn't be on the food and shouldn't sit on the food that is ready to eat.