STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165285	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corning Specialty Care	1614 Northgate Drive Corning, IA 50841

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47079 Based on observation, resident and staff interviews, clinical record review, and policy review, the facility failed to develop and implement a Comprehensive Care Plan for 7 of 12 residents (Resident #10, #11, #13, #17, #22, #76, and #176) reviewed for care plans. The facility reported a census of 26 residents. Findings include: 1. On [DATE] at 9:49 AM, Resident #76 was observed lying in bed watching television. He stated he had been on oxygen (O2) for about 3 years. The oxygen delivery setting on his concentrator was observed at 4 liters per minute (LPM) or (L) via nasal cannula (NC). The Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of Atrial Fibrillation (abnormal heart beat), Coronary Artery Disease (narrow or hardened heart arteries), and Chronic Obstructive Pulmonary Disease (COPD). It did not include the resident's use of oxygen but was still being completed at the time of the survey. The Electronic Health Record (EHR) Physician Orders dated [DATE] included an order for Oxygen continuously at (3 L), maintain O2 Sat. of 88% and above. The Admission Orders dated [DATE] included oxygen inhale 3 L/min into the lungs continuous. Titrate to O2 saturation of 88%. Do not exceed 4 L/min. On [DATE] at 10:02 AM, the Director of Nursing (DON) stated the Admission Orders were accurate. The Oxygen (O2) saturation summary indicated the resident's blood oxygen level on [DATE] at 9:27 AM was 94%. It did not specify whether the resident was receiving supplemental oxygen at the time. The Care Plan dated [DATE] included OXYGEN SETTINGS: O2 via nasal cannula @ 3 L at rest and 4 L with exertion. The Care Plan failed to match admission orders. 49628 (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The MDS for Resident #10 dated [DATE] identified a BIMS score of 10 out of 15 which indicated moderate cognitive impairment. The MDS included diagnoses of Anxiety Disorder, Depression, and Post Traumatic Stress Disorder (PTSD). It did not identify any lack of pleasure, interest or feeling down/depressed, or potential indicators of psychosis. It also revealed the resident exhibited behavioral symptoms not directed toward others, but indicated the identified symptoms put the resident at significant risk for physical illness or injury, significantly interfered with resident's care, and with the resident's participation in activities or social interactions. It further indicated the resident rejected care and exhibited worsening in behavior, and care rejection compared to prior assessments. The MDS identified Resident #10 took antipsychotic and antidepressant medications during the last 7 days of the assessment period. Review of Resident #10's Physician Orders dated [DATE] identified the resident was prescribed a.) Fluoxetine HCl Capsule 40 mg 1 capsule and 10 mg 1 capsule by mouth for a total of 50 mg daily for depression b.) Olanzapine 5 mg 1 tablet daily for psychotic disorder related to Major Depressive Disorder, Recurrent, Moderate, and Generalized Anxiety Disorder. An Electronic Medical Record (EMR) Progress Note dated [DATE] identified occasional behavioral disturbances as mild. Behavior Symptoms documentation did not identify any behaviors in the past 30 days. Resident #10's Care Plan revised [DATE] included an antidepressant medication focus area related to major depressive disorder. A goal identified decreased symptoms of depression throughout the review period. However, the interventions/tasks did not include the resident s target behaviors of depression. It also included an antipsychotic medication focus area related to anxiety and cognitive function decline with behaviors. A goal of decreased behavioral episodes throughout the review period was noted. However, the interventions/tasks did not identify the resident's target behaviors. 3. The MDS for Resident #11 dated [DATE] identified a BIMS score of 12 out of 15 which indicated moderate cognitive impairment. The MDS included diagnoses of Anxiety Disorder, and Depression. It neither identified any symptoms of lack of please/interest or feeling down/depressed nor potential indicators of psychosis. It revealed the resident exhibited behavioral symptoms not directed toward others, and the identified symptoms did not significantly impact the resident or others in the environment. The document revealed no change in behavior or other symptoms. The MDS identified the resident took antipsychotic and antidepressant medications during the last 7 days of the assessment period. Review of Resident #11's Physician Orders dated [DATE] identified the resident was prescribed a.) Risperdal (Risperidone) Oral Tablet 2 mg 1 tablet twice daily for Major Depression, b.) Sertraline HCl 150 mg once daily for Major Depression, and Clonazepam Tablet .5 mg 1 tablet twice daily for Generalized Anxiety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The EMR Progress Notes identified on [DATE] the resident isolated to his room most times with refusals to get up. An entry on [DATE] indicated the resident was pushing against staff during personal care but was redirectable without further behaviors, and refused to get out of bed. The Behavior Symptoms documentation revealed the resident had behaviors of rejection of care on [DATE] and kicking/hitting on [DATE]. Resident #11's Care Plan revised on [DATE] did not identify focus areas, goals, or interventions related to the antipsychotic and antidepressant medications and their respective target behaviors. 4. The MDS for Resident #13 dated [DATE] identified a BIMS score of 3 out of 15 which indicated severe cognitive impairment. The MDS included diagnoses of Non-Alzheimer's Dementia, and Alzheimer's Disease. It neither identified any symptoms of lack of please/interest or feeling down/depressed nor potential indicators of psychosis. It revealed the resident exhibited behavioral symptoms directed toward others. The MDS identified the resident took antipsychotic medication during the last 7 days of the assessment period. Review of Resident #13's Physician Orders dated [DATE] identified the resident was prescribed a.) Seroquel Oral Tablet 25 mg (Quetiapine Fumarate) give 1 tablet daily for behavioral disturbances b.) Seroquel Oral Tablet 50 mg (Quetiapine Fumarate) give 1 tablet in the evening for Vascular Dementia. The EMR Progress Notes from [DATE] to [DATE] revealed numerous entries with behaviors of yelling at staff and other residents, attempts of hitting staff and residents and delusions regarding deceased family members. The Behavior Symptoms documentation revealed rejection of care on [DATE]. Resident #13's Care Plan revised on [DATE] revealed a psychotropic medication focus area related to vascular dementia for behavioral management. A goal identified decreased symptoms of depression throughout the review period. However, the interventions/tasks did not include the resident's target behaviors of depression. It also included an antipsychotic medication focus area related to anxiety and cognitive function decline with behaviors. A goal of decreased behavioral episodes throughout the review period was noted. However, the interventions/tasks did not identify the resident's target behaviors. 5. The MDS for Resident #17 dated [DATE] identified a BIMS score of 15 out of 15 which indicated normal cognitive impairment. The MDS included diagnoses of Anxiety Disorder and depression. It did not identify any symptoms of lack of please/interest or feeling down/depressed, but did indicate rare instances of social isolation. It neither identified potential indicators of psychosis nor behavioral symptoms towards others, herself or rejection of care. The MDS identified the resident took an antidepressant medication during the last 7 days of the assessment period. Review of Resident #17's Physician Orders dated [DATE] identified the resident was prescribed Fluoxetine HCl Oral Tablet 10 mg 3 tablets for a total of 30 mg daily for depression. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The EMR Progress Notes from [DATE] to [DATE] revealed entries with anxiety behaviors related to ailments, attention, medications, and weight. The Behavior Symptoms documentation revealed no behaviors. Resident #17's Care Plan revised on [DATE] revealed an antidepressant medication focus area related to bipolar. A goal identified freedom from discomfort or adverse reactions related to antidepressant therapy. However, the interventions/tasks did not include the resident's target behaviors of depression. 6. The MDS for Resident #22 dated [DATE] identified a BIMS score of 15 out of 15 which indicated normal cognitive impairment. The MDS included diagnoses of Anxiety Disorder and depression. It identified symptoms of feeling down/depressed for ,d+[DATE] days and sometimes socially isolated. It identified hallucinations, rejection of care for 1 to 3 days, and worsened behaviors and rejection of care. The MDS identified the resident took antipsychotics and antidepressant medications during the last 7 days of the assessment period. Review of Resident #22 Physician Orders dated [DATE] identified the resident was prescribed a.) Seroquel 12.5 mg at bedtime for Hallucinations b.) Namenda (Memantine HCl) 10 mg 1 tablet daily for Major Depressive Disorder c.) Zoloft (Sertraline HCl) Oral Tablet 100 mg 2 tablets for 200 mg daily for depression d.) Wellbutrin XL Oral Tablet Extended Release 24 hour 150 mg (Bupropion HCl) 1 tablet daily for depression. The EMR Progress Notes from [DATE] to [DATE] revealed entries with hallucinations (verbal and audible), isolation, refusal of getting up, and medication refusals. The Behavior Symptoms documentation revealed no behaviors. Resident #22's Care Plan revised on [DATE] revealed a risk for side effects from antipsychotic drug use. A goal identified no injury related to medications and maintenance of normal/therapeutic blood drug range. The Care Plan did not identify target behaviors related to the use of an antipsychotic medication. 7. The MDS for Resident #176 dated [DATE] was an Admission Medicare - 5 day document and did not contain a BIMS, diagnoses, medications, or treatments. The EMR included diagnoses of depression, hypertension, and pain. Review of Resident #22 Physician Orders dated [DATE] identified the resident was ordered to have oxygen continuously at 3 Liters (L) every night shift. The hospital discharge document dated [DATE] revealed oxygen administration 3 L at night. The Order Summary Report dated [DATE] indicated oxygen continuously at 3 L every night shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #176's Care Plan initiated on [DATE] revealed altered respiratory status/difficulty breathing related to COPD and needing oxygen focus area. A goal identified no signs and symptoms of poor oxygen absorption through the review date. The interventions/task revealed oxygen setting of oxygen via nasal cannula with prongs using 3 L/minute continuously and may use 4 liters with exertion. The intervention did not match with physician orders. The facility policy, Goals and Objectives, Care Plans, revised [DATE], revealed objectives should be resident oriented, behaviorally stated and are derived from the information contained in the comprehensive assessment. It indicated goals and objectives were written for all disciplines to have access to information and report whether the desired outcomes are being achieved. On [DATE] at 8:03 AM the Administrator, Director of Nursing (DON), and MDS Coordinator stated the interventions/tasks of a Care Plan should reflect the focus area. The DON stated it should be specific to the focus area. The staff stated the Certified Nursing Aides (CNAs) utilize a Kardex system for reference on a residents needs and abilities which is condensed from the interventions of the Care Plan. The DON acknowledged that if target behaviors for a particular medication were not identified on the interventions/tasks the staff would not be able to report them.

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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** 47079 Based on observation, resident and staff interviews, clinical record review, and policy review, the facility failed to revise a resident's Care Plan to include a newly inserted indwelling catheter. The facility reported a census of 26 residents. Findings include: On 1/21/25 at 10:32 AM, Resident #16 stated he had an indwelling catheter (urinary catheter) for about 6 months per his request. The Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated a completely intact cognition. It included diagnoses of hypertension, Diabetes Mellitus (DM), pneumonia, Chronic Kidney Disease (CKD), hemiplegia (one-sided weakness), and difficulty walking. It indicated the resident was independent with eating, required set-up assistance with oral and personal hygiene, required maximum assistance with toilet transfers, and was dependent with lower body dressing and toileting hygiene. It also revealed the resident was frequently incontinent. The Electronic Health Record (EHR) included a physician order for an indwelling catheter dated 12/03/24. The last Care Plan revision was dated 11/19/24 and did not include an indwelling catheter. On 1/23/25 at 10:02 AM, the Director of Nursing (DON) stated staff should have revised the Care Plan after inserting the resident's indwelling catheter. A policy titled Goals and Objectives, Care Plans revised April 2009 indicated goals and objectives are reviewed and/or revised: a. When there has been a significant change in the resident's condition; b. When the desired outcome has not been achieved; c. When the resident has been readmitted to the facility from a hospital/rehabilitation stay; and d. At least quarterly.

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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. 49628 Based on observations, clinical record review, resident and staff interviews, and policy review the facility failed to provide the needed services in accordance with professional standards by not following physician orders for 1 of 12 residents (Resident #176) reviewed. The facility reported a census of 42 residents. Findings include: The Minimum Data Set (MDS) for Resident #176 dated 1/18/24 was an Admission Medicare - 5 day document and did not contain a Brief Interview of Mental Status score, diagnoses, medications, or treatments. The Electronic Medical Record (EMR) included diagnoses of depression, hypertension, and pain. Review of Resident #22 Physician Orders dated 1/20/25 identified the resident was ordered to have oxygen (O2) continuously at 3 Liters (L) every night shift. The Hospital Discharge document dated 1/18/25 revealed O2 administration 3 L at night (HS). The Order Summary Report dated 1/20/25 indicated O2 continuously at 3 L every night shift. Resident #176's Care Plan initiated on 1/19/25 revealed altered respiratory status/difficulty breathing related to COPD and needing oxygen focus area. A goal identified no signs and symptoms of poor oxygen absorption through the review date. The interventions/task revealed oxygen via nasal cannula with prongs using 3 L/minute continuously and may use 4 liters with exertion. The intervention did not match with physician orders. On 1/21/25 at 9:25 AM observed Resident #176 seated in her recliner awake with oxygen via nasal cannula with the concentrator set at 3 L. The oxygen tubing did not have a date of placement or initials of staff who placed the tubing. On 1/21/25 at 3:46 PM observed the resident to be lying in bed with oxygen via nasal cannula with the concentrator set at 3 L. On 1/22/25 at 11:09 AM observed the resident lying in bed sleeping with oxygen via nasal cannula with the concentrator set at 3 L. On 1/22/25 at 1:06 PM observed the resident lying down with O2 via nasal cannula at 3 L. On 1/22/25 at 2:22 PM Staff B, Licensed Practical Nurse (LPN), stated tubing for oxygen is changed every Sunday night and should be documented in the Treatment Administration Record (TAR). The staff stated if an order indicated 3 L at HS, it would be expected the oxygen would be used at bedtime. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 8:35 AM the Director of Nursing (DON) and MDS Coordinator stated that if an order for a resident indicated HS they would expect oxygen would be used when the resident was sleeping at night. On 1/23/25 at 8:40 AM the DON and the Administrator stated they expected care to be provided to the residents per physician orders. The facility policy, Administering Medications, revised April 2019, revealed medications are administered in accordance with prescriber orders, including any required time frame.

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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. 49628 Based on observation, clinical record review, staff interviews, and facility procedure review the facility failed to protect a resident from a possible accident and injury by pushing the resident in a wheelchair without foot rests for 1 of 12 residents (Resident #11) reviewed. The facility reported a census of 26 residents. Findings include: The Minimum Data Set (MDS) for Resident #11 dated 10/30/24 identified a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderate cognitive impairment. The MDS included diagnoses of Anxiety Disorder, and Depression. It revealed the resident required substantial or maximum assistance for sit to/from stand positions, and transfers to/from bed, wheelchair and toilet. It further indicated the resident utilized a manual wheelchair and could wheel at least 150 feet with setup assistance. Resident #11's Care Plan revealed he required substantial to dependent assistance for transfers to/from the wheelchair. Observation on 1/21/25 at 12:26 PM revealed Staff E, Certified Nursing Assistant (CNA) pushed Resident #11 from the dining room to his bedroom with both of the resident's feet touching the floor with no footrests present. The distance was approximately 50 feet. Observation on 1/22/25 at 11:47 AM revealed Staff F, CNA, use a handheld grasp with Resident #11 while walking to the side and slightly ahead of the resident while in the wheelchair. The resident appeared to be pulling on the staff's hand to move forward. The resident's feet were on the floor and were attempting to move the wheelchair. The resident stopped every 4-5 feet. The last 10 feet the staff pulled the resident to his dining table with no movement of the resident's feet. Observation on 1/22/25 at 12:16 PM revealed Resident #11 self propelled from the dining room to his bedroom independently. On 1/22/25 at 12:45 PM Staff G, CNA, stated residents must have footrests on to be pushed in their wheelchairs. The staff stated they are trained upon hire to use footrests. Staff G stated if a resident does not have footrests they cannot be pushed, and footrests should be kept on the back of the wheelchair. On 1/22/25 at 2:28 PM Staff B, Licensed Practical Nurse (LPN), stated residents must have footrests on their wheelchairs to be pushed. The staff stated training has been provided on the use of footrests on wheelchairs in the past several months. The staff stated she has observed other staff push residents without footrests. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 8:40 AM the Administrator, MDS Coordinator, and Director of Nursing (DON) concurred that the facility had the requirement for residents to be pushed in their wheelchairs and footrests must be in place. The Administrator stated residents should not be pushed without footrests. The DON stated it was part of basic training to be a CNA that footrests were to be in place on wheelchairs to prevent injuries. The facility document, Wheelchair (use of) from Nursing Guidelines and Procedure Manual, dated January 2015 edition, revealed footrests were to be out of the resident ' s way for safety prior to transfer, but not removed from the wheelchair. It further indicated footrests were to be lowered, and the resident's feet placed on the footrests once the resident was seated in the wheelchair.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49628 Based on clinical record review, staff interviews, and policy review, the facility failed to identify target behaviors for psychotropic medication use for 5 of 12 residents reviewed (Resident #10, #11, #13, #17, and #22). The facility reported a census of 26 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #10 dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated moderate cognitive impairment. The MDS included diagnoses of Anxiety Disorder, Depression, and Post Traumatic Stress Disorder (PTSD). It did not identify any lack of pleasure, interest or feeling down/depressed, or potential indicators of psychosis. It also revealed the resident exhibited behavioral symptoms not directed toward others, but indicated the identified symptoms put the resident at significant risk for physical illness or injury, significantly interfered with resident's care, and with the resident's participation in activities or social interactions. It further indicated the resident rejected care and exhibited worsening in behavior, and care rejection compared to prior assessments. The MDS identified Resident #10 took antipsychotic and antidepressant medications during the last 7 days of the assessment period. Review of Resident #10's Physician Orders dated [DATE] identified the resident was prescribed a.) Fluoxetine HCl Capsule 40 mg 1 capsule and 10 mg 1 capsule by mouth for a total of 50 mg daily for depression b.) Olanzapine 5 mg 1 tablet daily for psychotic disorder related to Major Depressive Disorder, Recurrent, Moderate, and Generalized Anxiety Disorder. The Physician Orders failed to include target behaviors for each psychotropic medication order. An Electronic Medical Record (EMR) Progress Note dated [DATE] identified occasional behavioral disturbances as mild, but did not identify specific target behaviors. Behavior Symptoms documentation did not identify any behaviors in the past 30 days. Resident #10's Care Plan revised [DATE] included an antidepressant medication focus area related to major depressive disorder, and an antipsychotic medication focus area related to anxiety and cognitive function decline with behaviors. However target behaviors were not identified in the document. 2. The MDS for Resident #11 dated [DATE] identified a BIMS score of 12 out of 15 which indicated moderate cognitive impairment. The MDS included diagnoses of Anxiety Disorder, and Depression. It neither identified any symptoms of lack of please/interest or feeling down/depressed nor potential indicators of psychosis. It revealed the resident exhibited behavioral symptoms not directed toward others, and the identified symptoms did not significantly impact the resident or others in the environment. The document revealed no change in behavior or other symptoms. The MDS identified the resident took antipsychotic and antidepressant medications during the last 7 days of the assessment period. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #11's Physician Orders dated [DATE] identified the resident was prescribed a.) Risperdal (Risperidone) Oral Tablet 2 mg 1 tablet twice daily for Major Depression b.) Sertraline HCl 150 mg once daily for Major Depression c.) Clonazepam Tablet .5 mg 1 tablet twice daily for Generalized Anxiety. The Physician Orders failed to include target behaviors for each psychotropic medication order. The EMR Progress Notes identified on [DATE] the resident isolated to his room most times with refusals to get up. An entry on [DATE] indicated the resident was pushing against staff during personal care but was redirectable without further behaviors, and refused to get out of bed. The Behavior Symptoms documentation revealed the resident had behaviors of rejection of care on [DATE] and kicking/hitting on [DATE]. Resident #11's Care Plan revised on [DATE] did not identify focus areas, goals, or interventions related to the antipsychotic and antidepressant medications and their respective target behaviors. 3. The MDS for Resident #13 dated [DATE] identified a BIMS score of 3 out of 15 which indicated severe cognitive impairment. The MDS included diagnoses of Non-Alzheimer's Dementia, and Alzheimer's Disease. It neither identified any symptoms of lack of please/interest or feeling down/depressed nor potential indicators of psychosis. It revealed the resident exhibited behavioral symptoms directed toward others. The MDS identified the resident took antipsychotic medication during the last 7 days of the assessment period. Review of Resident #13's Physician Orders dated [DATE] identified the resident was prescribed a.) Seroquel Oral Tablet 25 mg (Quetiapine Fumarate) 1 tablet daily for behavioral disturbances b.) Seroquel Oral Tablet 50 mg (Quetiapine Fumarate) 1 tablet in the evening for Vascular Dementia. The Physician Orders failed to include target behaviors for each psychotropic medication order. The EMR Progress Notes from [DATE] to [DATE] revealed numerous entries with behaviors of yelling at staff and other residents, attempts of hitting staff and residents and delusions regarding deceased family members. The Behavior Symptoms documentation revealed rejection of care on [DATE]. Resident #13's Care Plan revised on [DATE] revealed a psychotropic medication focus area related to vascular dementia for behavioral management, and an antipsychotic medication focus area related to anxiety and cognitive function decline with behaviors. However it did not identify the resident's target behaviors. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The MDS for Resident #17 dated [DATE] identified a BIMS score of 15 out of 15 which indicated normal cognitive impairment. The MDS included diagnoses of Anxiety Disorder and depression. It did not identify any symptoms of lack of please/interest or feeling down/depressed, but did indicate rare instances of social isolation. It neither identified potential indicators of psychosis nor behavioral symptoms towards others, herself or rejection of care. The MDS identified the resident took an antidepressant medication during the last 7 days of the assessment period. Review of Resident #17's Physician Orders dated [DATE] identified the resident was prescribed a.) Fluoxetine HCl Oral Tablet 10 mg 3 tablets for a total of 30 mg daily for depression. The Physician Orders failed to include target behaviors for each psychotropic medication order. The EMR Progress Notes from [DATE] to [DATE] revealed entries with anxiety behaviors related to ailments, attention, medications, and weight, but not target behaviors. Resident #17's Care Plan revised on [DATE] revealed antidepressant medication use, but did not include target behaviors for staff to monitor. 5. The MDS for Resident #22 dated [DATE] identified a BIMS score of 15 out of 15 which indicated normal cognitive impairment. The MDS included diagnoses of Anxiety Disorder and depression. It identified symptoms of feeling down/depressed for ,d+[DATE] days and sometimes socially isolated. It identified hallucinations, rejection of care for 1 to 3 days, and worsened behaviors and rejection of care. The MDS identified the resident took antipsychotics and antidepressant medications during the last 7 days of the assessment period. Review of Resident #22's Physician Orders dated [DATE] identified the resident was prescribed a.) Seroquel 12.5 mg at bedtime for Hallucinations, Namenda (Memantine HCl) 10 mg 1 tablet daily for Major Depressive Disorder b.) Zoloft (Sertraline HCl) Oral Tablet 100 mg 2 tablets for 200 mg daily for depression c.) Wellbutrin XL Oral Tablet Extended Release 24 hour 150 mg (Bupropion HCl) 1 tablet daily for depression. The Physician Orders failed to include target behaviors for each psychotropic medication order. The EMR Progress Notes from [DATE] to [DATE] revealed entries with hallucinations (verbal and audible), isolation, refusal of getting up, and medication refusals. The Behavior Symptoms documentation revealed no behaviors. Resident #22's Care Plan revised on [DATE] revealed a risk for side effects from antipsychotic drug use, but did not identify target behaviors. On [DATE] at 8:03 AM the Administrator, Director of Nursing (DON), and MDS Coordinator acknowledged target behaviors should be identified for each psychotropic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility did not provide a policy related to medications and target behavior identification.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observation, staff interviews, clinical record review and policy review the facility failed to ensure the residents were free of significant medication errors to 1 of 6 residents reviewed (Resident #16). The facility reported a census of 26 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] documented Resident #16 entered the facility on 3/23/22. The MDS documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS documented Resident #16 had a diagnosis of type 2 diabetes mellitus with hyperglycemia. Review of Resident #16's Medication Administration Record (MAR) documented an order for insulin glargine solution (Lantus)100 UNIT/ML inject 50 unit subcutaneously one time a day in the morning. On 1/22/25 at 7:18 AM an observation of Staff B Licensed Practical Nurse (LPN) drawing insulin to administer to Resident #16 revealed Staff B removed Lantus insulin from the medication cart, cleansed the insulin bottle septum with an alcohol wipe, and drew out 46 units from the insulin bottle. Staff B stated her intent was to give Resident #16 Lantus insulin prepared in the syringe. The surveyor then requested Staff B to verify the amount of insulin ordered with the amount of insulin in the syringe. Staff B acknowledged 46 units in the syringe and Resident #16 had an order for 50 units of Lantus insulin. Staff B then drew up 50 units and administered the insulin. On 1/22/25 at 7:42 AM the DON stated the nurse should have followed policy. Stated she should have followed the rights of medication administration and the physicians order. Review of policy revised 4/19 titled, Administering Medications documented The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47673 Based on observations, staff interview, and policy review the facility failed to provide food at an appetizing temperature to 3 of 26 residents reviewed. The facility reported a census of 26 residents. Findings include: On 1/21/25 at 11:45 AM an observation of lunch service revealed Staff A completed hand hygiene and started lunch service. Two mechanical soft roast beef in portions on a plate and a single puree portion of roast beef in a bowl placed on the steam table after being prepared in the food processor. Staff A acknowledged intent to serve mechanical and puree plates. Temperature check requested by surveyor of puree and mechanical soft roast beef. The temperature of the mechanical soft roast beef on the plates were 99 degrees and 97 degrees. The temperature of the puree roast beef was 92 degrees. Staff A heated all 3 dishes in the microwave. Pureed roast beef heated to 152.6 and mechanical soft roast beef heated to 152.7 and 158.2. On 1/22/25 at 8:29 AM Staff A stated a temperature of 155 - 165 would be an acceptable temperature to serve the mechanically altered food. Staff A acknowledged the food was not at an acceptable temperature to serve to the residents. Review of policy revised 4/19 titled, Food Preparation and Service documented Mechanically altered hot foods prepared for a modified consistency diet remain above 135 F during preparation or they are reheated to 165 F for at least 15 seconds. On 1/22/25 at 4:15 PM the Administrator stated the facility's expectation was the cook would have followed the facility's policy. The Administrator stated her expectation was the mechanically altered hot food would remain above 135 degrees or reheated to 165 for at least 15 seconds.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observation, staff interview, and policy review the facility failed to store food in accordance with professional standards by not dating open food items or dispose of expired food items and not appropriately wearing hair restraints (hair nets). The facility reported a census of 26 residents. Findings include: 1. On [DATE] at 8:24 AM an observation revealed a single door freezer had a bag of open undated sausage patties. The double door refrigerator had a container of strawberries that were expired on [DATE], a pitcher of tomato juice that expired on [DATE], a 46 oz box of prune juice that was open and undated and a 46 oz box of cranberry juice cocktail that was open and undated. The dry storage had a 16 oz bag of potato chips that were open and undated and 8 bottles of Worcestershire sauce that was best if used by [DATE]. On [DATE] at 8:51 AM Staff A, Dietary Services Manger stated all drinks in pitchers were good for 3 days. Staff A acknowledged the pitcher of tomato juice and the container of strawberries were expired. Staff stated all food should be dated when the item was opened. Staff A acknowledged the sausage patties, box of prune juice, box of cranberry juice cocktail and the bag of potato chips were undated and all should have been dated. Staff A acknowledged the date of the Worcestershire sauce. Staff A removed all the bottles and stated she would be dumping them. Staff A stated the Worcestershire sauce was not ordered by her but the previous kitchen manager. Staff A stated she worked every Sunday and checked for expired items then and must have missed the Worcestershire sauce. On [DATE] at 1:59 PM Staff A stated there had been people who had walked through the kitchen not wearing a hair net. Staff A stated a hair net was required at all times when in the kitchen where food could be prepared. Staff A stated 2 weeks ago there was a verbal conversation with Staff C about the need for her to wear a hair net in the kitchen. Staff A stated staff had reported Staff C was not wearing a hair net at night while in the kitchen. On [DATE] at 3:12 PM Staff C, Cook, Dietary Aide, House Keeping Aide, and Laundry Aide stated she had worked at the facility since [DATE]st 2024. Staff C stated there had been times when she observed staff in the kitchen without hair nets. Staff C stated Staff A had discussed with her the need for her to wear hair nets while in the kitchen. Staff C stated somebody had reported to Staff A that she was not wearing a hairnet while in the kitchen. Staff C acknowledged she had not been wearing a hair net appropriately while in the kitchen. Staff C stated she did not have any formal disciplinary actions about not wearing a hair net, just a conversation. Review of policy revised ,d+[DATE] titled, Food Receiving and Storage documented all foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). Review of policy revised ,d+[DATE] titled, Preventing Foodborne Illness - Employee Hygiene And Sanitary Practices documented Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 3:09 PM the Administrator stated the facility's expectation was that all items of food opened should have an open date on them and expiration dates would be followed and food would be disposed of. The Administrator stated the facility's expectation was that hair nets would be worn by all staff at all times in the kitchen. 47079 2. On [DATE] at 1:48 pm, Staff A, DM and Staff C, [NAME] were observed in the kitchen area walking toward the exit door without hair nets. At 2:08 pm, Staff A, DM stated staff are to don a hairnet upon entry through the door and remove it at the door upon exit. She stated there was no reason for she or her staff to have not had their hairnets on at that point in the kitchen. She also stated all food was stored and the kitchen was clean but admitted she was not aware of that being an exception to the policy. On [DATE] at 7:55 PM, Staff D, DA was observed in the kitchen without a hair net. She stated she wasn't serving food but was rolling silverware. She stated she thought the facility's policy required hair nets in the kitchen.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49628 Based on resident and staff interview, clinical record review, and policy review, the facility failed to ensure accurate and complete resident records for 1 of 12 residents reviewed. Resident #22 did not have an inventory sheet in her record, and the resident stated she had lost a phone. The facility reported a census of 26 residents. Findings include: The Minimum Data Set (MDS) for Resident #22 dated 12/4/24 identified a BIMS score of 15 out of 15 which indicated normal cognitive impairment. The MDS included diagnoses of Anxiety Disorder and depression. The Electronic Medical Record (EHR) Progress Notes reviewed from 3/1/24 to 1/23/25 revealed the resident had made a report of a missing jacket on 8/16/24, which was found. Other Progress Note entries revealed the resident had a vehicle that was full of belongings, and lived in multiple locations prior to admission to the facility. The notes reflected the resident having stacks of items in her room and does not like assistance with these items or for people to touch her items. The Care Plan dated 12/6/24 did not reveal Resident #22 to have behaviors of making false reports of missing items. The Care Plan lacked behaviors regarding the keeping of excessive items in her room or car, or refusing of assistance for organization of her items. On 1/21/25 at 11:02 AM and on 1/22/25 at 12:10 PM Resident #22 stated she had lost a cell phone towards the end of June 2024 after returning from the hospital. The resident stated she notified the Business Office Manager (BOM). On 1/22/25 at 2:47 PM the BOM stated the resident did not inform her of a missing cell phone in June of 2024. The staff stated the resident had a phone in her room that she knew of. The BOM looked through the resident's room with the resident present and with permission and found a blue phone. The BOM stated the resident told her the blue phone was an old phone and the missing phone was blue. The BOM stated the itemized inventory list was managed by the Social Services Coordinator who also had the same first name and the resident may have told her about the missing phone. On 1/22/25 at 3:26 PM and 3:39 PM the Social Services Coordinator (SSC) stated there may or may not be an itemized inventory list for the resident. The staff stated she was aware of the resident's blue phone, but did not know anything about a missing pink phone. The SSC stated she was unable to locate an inventory sheet for the resident. The staff stated the resident had bags of items located in her closet, as well as her personal vehicle which was parked in a neighboring parking lot. The staff stated the resident had a history of making false claims regarding missing items. The staff stated the inventory list for the resident would likely be inaccurate due to the number of items the resident accumulated. The staff stated the resident was provided with donated items upon admission as she did not have appropriate clothing and personal items due to prior living arrangements of living in hotels. The SSC stated the resident would report if a cell phone was missing. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 3:45 PM the Regional Consultant confirmed there was not an itemized inventory sheet for the resident. The facility policy, Personal Property, revised March 2021, revealed a resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary. On 1/22/25 at 4:00 PM the Administrator acknowledged that without an itemized inventory sheet the facility could not verify a resident's belongings and would not be able to know whether a resident was making a false claim. The Administrator expected there to be itemized inventory sheets for all residents.