STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlantic Specialty Care	1300 East 19th Street Atlantic, IA 50022

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 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** 41785 Based on resident interview, family interview, staff interviews, clinical record review and personnel record review, the facility failed to ensure that all residents were treated with dignity and respect for 2 of 4 residents reviewed. Resident #57 reported that he has been left to sit on the bed pan for over 50 minutes and he felt upset and angry because he had a sore on his bottom. Resident #35 reported that staff scolded her for drinking too much water and urinating in the bed. The facility reported a census of 65 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #57 had a Brief Interview for Mental Status score of 15 (intact cognitive ability). The resident was admitted to the facility on [DATE] after an acute hospital stay. He had moderately impaired vision, not able to see newspaper headlines but could identify objects. He was totally dependent for toileting, transfers and lower body dressing. Resident #57 used a wheelchair for mobility and he was occasionally incontinent of urine and always continent of bowel. Diagnosis for Resident #57 included diabetes mellitus, anxiety, depression, chronic kidney disease, nutritional deficiency, acute pain, gangrene and necrosis of the lung. The resident had Moisture Associated Skin Damage (MASD) and staff were to apply ointments/medications to the area. The Care Plan updated on 5/31/24, documented Resident #57 had the potential for impairment to skin integrity related to poor immobility, staff were to encourage good nutrition and hydration and to educate him on the importance of repositioning. Resident #57 could become verbally aggressive toward staff, they must anticipate his needs, speak in calm manor, and remove him from the situations as needed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165288	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Atlantic Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 East 19th Street Atlantic, IA 50022	

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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	On 6/4/24 at 6:36 AM, Resident #57 was in his bed at the facility. He recalled that on the previous Saturday afternoon he got back from dialysis and asked for a hot lunch because he didn't typically eat before going to dialysis around 10:30 AM. He said that he felt bad because he lost his temper when the cook said that he was too busy to get him anything right then because he was busy getting ready for the supper meal. It was around 4:00 PM and the nurse on duty tried to shove me down in the room. The resident said that oftentimes when he would come back from dialysis, the staff would wheel him back to his room without getting him into bed and I got a sore on my bottom. Resident #57 said that he had been left on the bedpan for over 50 minutes. Staff S, Registered Nurse had come in and said that he would get someone else to take care of that. The resident yelled at him take me off now and Staff S responded sarcastically; la de da and walked out of the room. 2) According to the MDS dated [DATE], Resident #35 had a BIMS score of 15 (intact cognitive ability). The MDS documented independence with personal hygiene and toileting hygiene, sit to standing, toilet transferring, and walking with walker. She was frequently incontinent of urine and occasionally incontinent of bowel. Bowel and bladder toileting programs were not being used. Diagnoses included depression, schizophrenia, and borderline intellectual functioning. The Care Plan revised on 3/15/23 documented Resident #35 was water and food seeking several times a day. The Care Plan lacked interventions. Diagnoses included schizophrenia with behaviors of yelling out to staff, and inappropriate dress attire. Staff were to approach in a calm manner provide a mug of ice water and Styrofoam cup of ice. The resident requires one assist with toileting. On 6/4/24 at 1:23 PM, Staff Q, Certified Medication Aide (CMA) said that when she came into work in the morning and got report from Staff R, Certified Nurse Aide (CNA) the CNA told her that she took the residents water so she wouldn't wet the bed through the night wouldn't give her water through the night. On 6/4/24 at 2:03 PM, an anonymous friend of the resident said that the night staff was extremely rude to her and took her water overnight. The friend would visit the resident at times and found her lying in bed without any bedding. The resident told her that they would strip the bed but no one came back in to make the bed. On 6/5/24 at 4:19 PM, Staff R said that Resident #35 had behaviors and would be incontinent on purpose She said that the resident was independent but she would just pee all over. She denied taking her water away from her so she wouldn't urinate in bed and said that the resident had 5 cups of water in her room and she left one for her. On 6/4/24 at 2:31 PM, Resident #35 was in bed resting and said she remembered when the CNA wouldn't give her water, and didn't change her bedding. The resident was hesitant to give any details. According to a grievance form dated 4/7/24 an Emergency Medical Technician came to the facility on that date to pick up a resident from facility and a male staff member who gave report was extremely rude. The resident was in distress and asked for some items to bring along to the hospital. The staff member said sarcastically you'll be back soon anyway's, that's more stuff to haul back with you. A review of the staff files revealed that on 4/8/24, Staff S, RN was temporarily suspended pending investigation of the allegations from the EMT. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled; Abuse, Neglect, Exploitation, and Misappropriation Prevention Program reviewed April 2021 residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This included to freedom from corporal punishment involuntary seclusion. Verbal, mental, sexual or physical abuse and physical or chemical restraint not required to treat symptoms. The facility would establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on clinical record review, staff interviews and policy review the facility failed to enter accurate assessment information in the Minimum Data Set (MDS) for 2 of 21 residents reviewed (Resident #36 and #33). The facility reported a census of 65 residents. Findings include: 1) According to the MDS dated [DATE], Resident #36 had a BIMS score of 9 (moderate cognitive deficit). The resident was independent with hygiene, dressing, transferring and walking. Diagnoses included hypertension, Alzheimer's Disease, anxiety and muscle weakness. The MDS documented the resident was on an antiplatelet medication. An MDS dated [DATE] showed that he was on an anticoagulant (warfarin, heparin, or low-molecular weight heparin). The Care Plan for Resident #36 revised on 10/25/23 indicated that Resident #36 was on anticoagulant/blood thinning medication related to left anterior fascicular block. The Clinical Physician Orders revealed an order for clopidogrel (Plavix, antiplatelet) 75 milligrams (mg) dated 7/28/23. 48004 2. The MDS for Resident #33 dated 5/16/24 documented a BIMS score of 15 indicating intact cognition. The MDS further documented the use of bed rails daily as a restraint. Review of the Electronic Health Record (EHR), Clinical Physicians Orders, revealed Resident #33 had an order for assist bars to be added to Resident #33's bed to assist with repositioning related to muscle weakness. During an interview on 6/4/24 at 9:49 AM with the Director of Nursing (DON) revealed that she would not have marked the MDS for restraints for Resident #33 as the resident has an order for an assist bar. The DON further revealed her expectation would be for MDS assessments to be documented accurately. During an interview on 6/4/24 at 9:56 AM with Staff A MDS Coordinator revealed that she may have marked the MDS wrong for restraints on accident and that this was an error on her part. Review of a facility provided policy titled, Certifying Accuracy of the Resident Assessment, with a revision date of 11/2019 documented: a. Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47673

Based on electronic record review (EHR), observations, policy review, resident interview, and staff interviews the facility failed to provide a comprehensive care plan that included goals or interventions for activities or activities of interests and documented insulin on a care plan for a resident who was not on insulin for 1 of 5 residents reviewed (Resident #61). The facility reported a census of 65 residents.

Finding include:

The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #61 had a Brief Interview for Mental Status (BIMS) score of 0 indicating severe cognitive impairment.

An observation on 6/3/24 at 2:38 PM of Resident #61 sitting at bingo by herself with no markers on the bingo card. No staff helping with the activity.

On 6/3/24 at 2:39 PM Resident #61 stated she was not interested in playing bingo at that time.

An observation on 6/03/24 at 3:40 PM of Resident #61 sitting in the dayroom with several other residents sleeping.

An observation on 6/4/24 at 2:30 PM revealed activity staff sitting outside with residents. Resident #61 not present at that time.

An observation on 6/5/24 at 11:44 AM revealed Resident #61 sitting in the dining room during exercise activity. Resident #61 sitting with a blanket on, in a wheelchair, at a table, not participating in the activity.

An observation on 6/5/24 at 1:41 PM of Resident #61 sitting in the dayroom sleeping in front of the television.

An observation on 6/5/24 at 2:45 PM revealed activity staff sitting outside with residents. Resident #61 not present at that time.

Review of the Care Plan initiated 4/23/24 documented no focus, goals, or interventions for activities. Further review of EHR titled, Progress Notes / Activity Participation Notes documented 9 out of 18 activities documented as exercise.

On 6/4/24 3:23 PM Staff E stated there is no care plan for activities for Resident #61. Staff E stated Resident #61 does not have any interest besides movies and coffee. Staff E stated she was laying down during the activity today and was not asked to participate. Staff E stated Resident #61 will come down to exercise and watch people do exercise. Staff E stated Resident #61 does not participate in exercise activity.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Policy titled, Goals and Objectives, Care Plans revised 4/09 documented that care plans shall incorporate goals and objectives that lead to the resident's highest attainable level of independence. Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and: are resident oriented, are behaviorally stated, are measurable, and contain timetables to meet the resident's needs in accordance with the comprehensive assessment. On 6/4/24 at 3:58 PM the Director of Nursing (DON) stated the activity Resident #61 liked to drink coffee. The DON stated her expectation was there would have been a care plan for activities. The DON stated there was no care plan for activities or interests for Resident #61. The DON stated all the staff are aware she enjoys coffee. The DON stated Resident #61 was included in the social and liked to go outside. The DON stated she would expect to see more out of activities than attending exercise especially with Resident #61's cognition to help promote her livelihood.

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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** 41785 Based on clinical record review and facility policy review the facility failed to update resident care plans with changes. Resident #57 admitted to the facility on insulin for type 2 diabetes. The order was discontinued on 4/15/24 due to lack of use. Staff failed to update the care plan. Resident #36 was on an antiplatelet medication (Plavix). Staff failed to use the proper classification on the care plan and referred to the medication as an anticoagulant/blood thinner. The facility reported a census of 65 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #57 had a Brief Interview for Mental Status score of 15 (intact cognitive ability). The resident was admitted to the facility on [DATE] after an acute hospital stay. Diagnosis for Resident #57 included diabetes mellitus, anxiety, depression, chronic kidney disease, nutritional deficiency, acute pain, gangrene and necrosis of the lung. He had some coughing or choking during meals or when swallowing medications. Resident #57 had hemodialysis treatments while a resident at the facility. The Care Plan updated on 5/31/24, showed that Resident #57 had an increased nutritional risk related to chronic kidney disease and diabetes. The dietician would evaluate, staff would maintain a listing of food likes and dislikes, and offer food alternatives when appropriate for any meal served. On 4/1/24 a focus area was added that indicated the use of insulin medications related to diabetes. According to the Progress Note dated 4/15/24 at 8:18 PM the insulin was discontinued due to lack of use. 2) According to the MDS assessment dated [DATE], Resident #36 had a BIMS score of 9 (moderate cognitive deficit). The resident was independent with hygiene, dressing, transferring and walking. Diagnosis included hypertension, Alzheimer's Disease, anxiety and muscle weakness. Showed that the resident was on an antiplatelet medication. An MDS dated [DATE] showed that he was on an anticoagulant (warfarin, heparin, or low-molecular weight heparin). The Care Plan for Resident #36 revised on 10/25/23 indicated that Resident #36 was on anticoagulant/blood thinning medication related to left anterior fascicular block. The orders tab showed an order for clopidogrel (Plavix, antiplatelet) 75 milligrams (mg) dated 7/28/23. According to the facility policy titled: Goals and Objectives, Care Plans dated 2009. Goals and objectives were reviewed or revised when there was a change in condition or desired outcome had been achieved.

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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** 41785 Based on observation, staff interviews, resident interview and clinical record review, the facility failed to follow physician's orders for 1 of 21 residents reviewed. Resident #57 had chronic skin damage on his gluteal area related to moisture and positioning. In an observation it was discovered that the ordered barrier cream and treatments were not in place. The facility reported a census of 65 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #57 had a Brief Interview for Mental Status score of 15 (intact cognitive ability). The resident was admitted to the facility on [DATE] after an acute hospital stay. He was totally dependent for toileting, transfers and lower body dressing. Resident #57 used a wheel chair for mobility and he was occasionally incontinent of urine and always continent of bowel. Diagnosis for Resident #57 included diabetes mellitus, anxiety, depression, chronic kidney disease, nutritional deficiency, acute pain, gangrene and necrosis of the lung. The resident had Moisture Associated Skin Damage (MASD) staff were to apply ointments/medications to the area. Resident #57 had hemodialysis treatments while a resident at the facility. The Care Plan updated on 5/31/24, showed that Resident #57 had the potential for impairment to skin integrity related to poor immobility. Staff were to encourage good nutrition and hydration and to educate him on the importance of repositioning. According to the Medication and Treatment Administration Record (MAR and TAR) for the month of May, the resident had an order dated 5/10/24 at 6:00 AM, for Desitin to bilateral buttock and then apply Mepilex for protection on Tuesdays and Fridays. The treatment was not documented as completed on 5/21/24. On 6/4/24 at 6:36 AM, Resident #57 said that staff would often push him in the wheel chair back to his room after dialysis and not put him in bed. He said that he had a sore on his bottom and it felt better if he could be in bed. He said that many times he was left on the bedpan for long periods of time, and that also irritated the tender area. He said that after sitting for so long on dialysis days, he had some pain, the staff hadn't put barrier cream on the sore for a while. On 6/4/24 at 10:24 AM, Staff T, Certified Nurse Aide (CNA) entered the resident's room to get him ready to go to dialysis. When she removed the soiled brief, it revealed that he had a reddened area that looked raw on the right gluteal. The area did not have any cream or Mepilex padding on it. The resident said that it hurt and he asked for the salve. Staff T looked around the room and, in the dresser, but did not find any cream so she went to get the nurse. At 10:35 AM, Staff L, Registered Nurse (RN) cleaned the area, applied the Desitin and Mepilex protection. Once he was moved to the wheel chair, the resident reported that his bottom felt much better with the added treatment applied. According to a Skin and Wound Evaluation dated 4/1/24 at 10:20 PM, Resident #57 had a Moisture Associated Skin Damage (MASD) on his sacrum. The care for the area included a moisture barrier (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Atlantic Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 East 19th Street Atlantic, IA 50022	

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/24 at 1:30 PM the Director of Nursing said that the resident did not have a pressure injury and the sore was caused by moisture and it was healed.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on electronic record review (EHR), resident observation, policy review, resident interviews, and staff interviews the facility failed to implement resident centered activities for 1 of 5 residents reviewed (Resident #61). The facility reported a census of 65 residents. Finding include: The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #61 had a Brief Interview for Mental Status (BIMS) score of 0 indicating severe cognitive impairment. An observation on 6/3/24 at 2:38 PM of Resident #61 sitting at bingo by herself with no markers on the bingo card. No staff helping with the activity. On 6/3/24 at 2:39 PM Resident #61 stated she was not interested in playing bingo at that time. An observation on 6/3/24 at 3:40 PM of Resident #61 sitting in the dayroom with several other residents sleeping. An observation on 6/4/24 at 2:30 PM revealed activity staff sitting outside with residents. Resident #61 not present at that time. An observation on 6/5/24 at 11:44 AM revealed Resident #61 sitting in the dining room during exercise activity. Resident #61 sitting with a blanket on, in a wheelchair, at a table, not participating in the activity. An observation on 6/5/24 at 1:41 PM of Resident #61 sitting in the dayroom sleeping in front of the television. An observation on 6/5/24 at 2:45 PM revealed activity staff sitting outside with residents. Resident #61 not present at that time. On 6/4/24 at 3:31 PM, Stated Staff F, Activities Assistant stated the facility was told by the previous facility that Resident #61 liked coffee and movies with a specific actress. Staff F stated Resident #61 liked to get her hair done and gets it done every other Friday in the beauty shop. Staff F stated Resident #61 liked to sit outside on nice days. Staff F stated yesterday Resident #61 said she did not want to play bingo. On 6/4/24 at 3:23 PM Staff E, stated there is no care plan for activities for Resident #61. Staff E stated Resident #61 does not have any interest besides movies and coffee. Staff E stated she was laying down during the activity today and was not asked to participate. Staff E stated Resident #61 will come down to exercise and watch people do exercise. Staff E stated Resident #61 does not participate in exercise activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan initiated 4/23/24 documented no focus, goals, or interventions for activities. Further review of EHR titled, Progress Notes / Activity Participation Notes documented 9 out of 18 activities documented as exercise. On 6/4/24 at 3:58 PM the Director of Nursing (DON) stated Resident #61 liked to drink coffee. The DON stated her expectation was there would have been a care plan for activities. The DON stated there was no care plan for activities or interests for Resident #61. The DON stated all the staff are aware she enjoys coffee. The DON stated Resident #61 was included in the social and liked to go outside. The DON stated she would expect to see more out of activities than attending exercise especially with Resident #61's cognition to help promote her livelihood. Review of policy titled, Activity Program with revised date of 6/18/24 documented activity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident. Our activity programs consist of individual, small group and large group activities that are designed to meet the needs and interests of each resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41785

Based on clinical record review, facility record review, staff interviews and facility policy review the facility failed to ensure that residents received accurate and timely assessments and interventions for 5 of 6 residents reviewed. Staff failed to intervene when Resident #25 and #57 had significant weight loss. Resident #120 had a change in condition and staff failed to monitor vitals. Resident #59 was at risk for dehydration related to tube feedings and a catheter and staff failed to monitor his urinary output. Staff failed to complete the recommended neurological assessments after Resident #119 had an unwitnessed fall. The facility reported a census of 65 residents.

Findings include:

1) According to the MDS assessment dated [DATE], Resident #120 had a BIMS score of 0 (severe cognitive deficits). She was independent with eating, and totally dependent on staff for toileting, dressing, bed mobility and transfers.

The Care Plan revised on 3/27/23, showed that Resident #120 used a wheelchair for mobility, but she was able to get out of bed unattended. She required 2 staff to assist with a mechanical lift transfers and had impaired cognitive function/dementia related to vascular dementia. Staff directed to monitor and report any change in cognitive function. On 3/15/24 she was diagnosed with influenza A and staff to monitor for increased heart rate and difficulty in breathing. The diagnosis included type 2 diabetes mellitus, heart disease and muscle weakness.

The Progress Notes documented the following:

a. On 3/14/24 at 5:20 AM, Resident #120 had an episode of emesis. Noted to be flush and lethargic and she was sent to the hospital.

b. On 3/14/24 at 8:54 AM, resident admitted to the hospital for influenza A and aspiration pneumonia.

c. On 3/18/24 at 2:17 PM, resident admitted back to the facility.

d. On 3/20/24 at 1:02 AM, in the hot charting, documented that the vital signs competed. The chart lacked any vitals on 3/20/24.

The chart for Resident #120 lacked documentation of any vital signs from 3/20/24-4/7/24.

The chart lacked nursing notes from 4/5/24 - 4/8/24

e. On 4/8/24 at 11:24 AM, the resident found to be lethargic with her head down and drooling. She was sent to the emergency room .

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Atlantic Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 East 19th Street Atlantic, IA 50022	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a statement included in a facility investigation, dated 4/9/24, Staff H, Certified Medication Aide (CMA) reported that on 4/8/24, she completed the morning medication pass and Resident #120 had her eyes open, but when she attempted to give her medications, the resident was unable to swallow, so she notified the nurse. Later that morning, at 11:30 AM, she noticed that Resident #120 was slumped in her wheelchair so she notified the Director of Nursing (DON). On 6/6/24 at 6:30 AM, Staff H said that in the morning, she noticed a change in Resident #120 and around noon the resident was slumped in her wheel chair. She acknowledged that she was the one that administered the resident's medications on 4/8/24 and she reported to the nurse that the resident had trouble swallowing but she didn't remember if the resident had actually swallowed the pills. She stated she did not remember the nurse's response, what time of morning it was when she administered, and did not remember if the medications were crushed. According to the Medication administration Audit Report, on the morning of 4/8/24, Resident #120 had her medications at 7:49 AM. The Emergency Medical Technician (EMT) Report showed the EMT had been notified at 10:44 AM. According to the vital signs tab in the electronic chart, vital signs had not been taken until 11:39 AM on 4/8/24. A Progress Note dated 4/8/24 at 9:08 PM, showed that the facility was notified from the hospital that Resident #120 presented to the ED unresponsive, and the radiology report showed that she had a subdural hematoma and would return to the facility with hospice services. According to the Emergency Department provider note signed on 4/9/24 at 9:45 AM, the radiologist reported she had a right subdural bleed and the family decided on comfort cares only. A Progress Note dated 4/20/24 at 1:13 PM, showed that Resident #120 had passed away at the facility. On 6/5/24 at 11:05 AM, Staff N, CMA, said that after the 3/18/24 hospitalization , the resident was very sick, and fatigued. She was having difficulty swallowing her medication and had shortness of breath. She said that they would elevate the head of the bed up but did not remember if they ever administered oxygen as needed. She did not remember having taken her vital signs during that time. On 6/5/24 at 2:30 PM, Staff M (CNA) said that Resident #120 required a mechanical lift for transfers. After she came back from the hospitalization in March, they had difficulty turning the resident in bed. She was definitely much weaker but the CNA did not remember ever asking the nurse to check her vitals or complete an assessment. On 6/5/24 at 5:10 PM, Staff O, (CNA) said that when she assisted with Resident #120 on 4/7/24 she seemed about the same. She and another CNA stripped the resident's bed the day before but didn't remember any significant change in condition. In a statement dated 4/8/24, Staff O reported that she worked Sunday 4/7/24 and the nurse on duty said that the resident looked sick. She later helped another CNA strip the bedding on Resident #120's bed because the resident had an episode of a large incontinent diarrhea. (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 6/5/24 at 11:47 AM Staff P, CNA said that when the resident came back from the hospital with influenza, she didn't ever get her energy back. She stayed in her room more and didn't want to get out of her bed. They would keep the head of the bed up and she was refusing her medications. He didn't know about vitals or oxygen use.

On 6/6/24 at 8:32 AM, the Director of Nursing (DON) said that hot charting was implemented after a hospitalization to ensure adequate monitoring. These assessments were to be completed for at least 3 days to include a complete set of vital signs.

2) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #57 had a Brief Interview for Mental Status score of 15 (intact cognitive ability). The resident was admitted to the facility on [DATE] after an acute hospital stay. He required setup assistance with eating, was totally dependent for toileting, transfers and lower body dressing. Diagnosis for Resident #57 included diabetes mellitus, anxiety, depression, chronic kidney disease, nutritional deficiency, acute pain, gangrene and necrosis of the lung. He had some coughing or choking during meals or when swallowing medications. Resident #57 had hemodialysis treatments while a resident at the facility.

A Care Plan updated on 5/31/24, showed that Resident #57 had the potential for impairment to skin integrity related to poor immobility, staff were to encourage good nutrition and hydration and to educate him on the importance of repositioning. The resident had no teeth and did not utilize dentures. Resident #57 was at increase nutritional risk related to chronic kidney disease and diabetes. The dietician would evaluate, staff would maintain a listing of food likes and dislikes, and offer food alternatives when appropriate for any meal served. On 4/1/24 a focus area indicated use of insulin medications related to diabetes.

The Progress Notes documented the following:

a. On 4/1/24 at 6:19 PM, at admission, the resident's weight was 218 pounds (lb.)

b. On 4/7/24 at 12:21 AM, his weight was 224 lb.

c. On 4/18/24 at 3:06 PM, a care plan conference note indicated that the resident hadn't had a significant weight change.

d. On 5/6/24 at 12:00 AM, his weight was 207.3 lb.

The Medication Administration Record (MAR) for May showed an order beginning on 5/11/24 at 7:00 AM for a nutrition supplement; Med pass 8 ounces, twice a day. From the 11th through 31st, the resident refused the supplement 38 out of 42 opportunities. In the month of June (1-3), he had refused all three days.

The chart lacked documentation that the physician or the dietician had been notified that the resident was refusing the supplements.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/24 at 6:36 AM, Resident #57 was in his bed at the facility. He recalled that on the previous Saturday afternoon, he had gotten back from dialysis and asked for a hot lunch because he didn't typically eat before going to dialysis around 10:30 AM, and he often returned to the facility very hungry. He said that he felt bad because he lost his temper when the cook said that he was too busy to get him anything right then because he was busy getting ready for the supper meal. It was around 4:00 PM and the nurse on duty tried to shove me down in the room. The resident said that often times when he would come back from dialysis, the staff would wheel him back to his room without getting him into bed and I got a sore on my bottom. Resident #57 said that he was refusing the Med Pass supplement because he didn't like the taste. However, they had a supplement at dialysis that he liked, so he was getting that twice a week. He said that he wrote down the name of it and told the nurses but they hadn't gotten it for him. On 6/4/24 at 8:11 AM, the Dietician said that she was not aware that Resident #57 had been refusing the supplement. She said that she was not sure what else they can offer him. When advised that he'd had a supplement at dialysis that he liked, she said that she would look into getting that for him. 3) According to the MDS assessment dated [DATE], Resident #59 was admitted to the facility on [DATE] with Autism and Intellectual Disability. He did not have a mental status assessment because he was rarely or never understood. He was totally dependent on staff for toileting, showering, and transferring. He had an indwelling urinary catheter and was dependent on tube feedings, able to consume orally. He was on hospice services and diagnoses included: hypertension, gastroesophageal reflux, benign prostatic hyperplasia, neurogenic bladder, Parkinson's disease, esophageal obstruction, and profound intellectual disabilities, The Care Plan dated 3/19/24 with the focus of tube feedings, documented to monitor for signs of aspiration. The focus urinary catheter due to neuropathic bladder documented to monitor and document signs and symptoms of urinary tract infection: cloudiness, no output, and foul smelling urine. A Communication to Nursing: Dietitian Recommendation, dated 5/16/24 at 2:18 PM documented the Dietician recommended that nursing would monitor the resident's hydration status. On 6/4/24 at 5:30 AM the DON said that they monitored output for all the residents that have urinary catheters. According to the Task tab in the electronic record, documentation for bowel and bladder output did not begin before 6/4/24. On 6/6/24 at 1:38 PM, the DON said that when the dietician recommended to monitor for hydration status on a resident with a catheter, she would interpret that to mean that they would monitor the urine color, odor and amount of output. On 6/5/24 at 5:45 AM, Staff I, CNA said that they had just recently started documenting the output for Resident #59 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a facility policy titled: Change in a Resident's Condition or Status, revised in 2021, the nurse would notify the attending physician or physician on call when there was a significant change in the resident's physical/emotional/mental condition, refusal of treatment or medication two or more consecutive times. Prior to notifying the physician or healthcare provider, the nurse would make detailed observations and gather relevant and pertinent information for the provider. 4) According to the MDS assessment dated [DATE], Resident #119 was admitted to the facility on [DATE] and had a BIMS score of 4 (severe cognitive deficits). She required partial assistance with toileting, dressing, hygiene, sit to stand and toilet transfers. She did have 1 fall with minor injury since admission. The Care Plan created on 5/21/24 showed that Resident #119 was at risk for falls, interventions included encouragement to use the call light, and a physical therapy evaluation. She was to ambulate with walker, dependent on one staff member for transfers and toileting. The Incident Report dated 5/24/24 at 10:10 PM showed that the resident was found on the floor in her room in front of her dresser. She was leaning up against the wheelchair and she tried to pull herself up but could not. She had a laceration at the corner of her right eyebrow and a small amount of blood on her face. Action taken; vitals taken and neuro exam completed. The first neurological assessment was completed on 5/24/24 at 9:50 PM. Review of the documents dated below and titled Neurological Eval for the resident revealed the document showed vitals completed but the chart lacked vital signs on the following dates: On 5/24/24 at 10:20, 10:35, 10:50, 11:20, and 11:50 AM. On 5/26/24 at 9:50 AM. On 5/27/24 at 5:50 PM. On 6/4/24 at 8:55 AM the DON and Corporate Nurse said that the vital for neuros are in the vitals tab and staff were expected to obtain a new set of vitals with each assessment. According to the facility policy titled Neurological assessment dated 2010, the purpose of the procedures was to provide guidelines for a neurological assessment when following an unwitnessed fall, subsequent to gall with suspected head injury. Take temperature, pulse, respirations and blood pressure. 47673 4. The Minimum Data Set (MDS) assessment for Resident #25, dated 3/21/2024 documented a Brief Interview for Mental Status score of 1 indicating severe cognitive impairment. Review of the Clinical Physician Orders for Resident #25 related to weights revealed an order for weekly weights ordered to start 3/30/24 and discontinued 4/19/24. Review of current Clinical Physician Orders for Resident #25 documented orders for Lactulose 10 gm / 15 mL give 60 mL three times daily and mix with 4 oz of boost breeze and 2 oz of water. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of electronic health records (EHR) for Resident #25 titled, all weights and vitals documented on 12/4/23, the resident weighed 249 lbs. On 3/1/24, the resident weighed 231 pounds which is a -7.23 % Loss. On 11/3/23, the resident weighed 255 lbs. On 5/17/24, the resident weighed 206.6 pounds which is a -18.98 % Loss. On 9/1/23, the resident weighed 258 lbs. On 3/1/24, the resident weighed 231 pounds which is a -10. 47 % Loss. EHR for Resident #25 titled all weights and vitals also documented no weights obtained for the month of April. Review of EHR titled progress notes for Resident #25 documented a recommendation from the Registered Dietitian to the facility to initiate a 6oz house supplement once daily to assist with meeting nutrient needs. Review of current Clinical Physician Orders for Resident #25 documented no order for 6oz house supplement. On 6/6/24 at 12:09 PM the ARNP (provider) stated tons of education was provided to Resident #25 about refusing breeze with Lactulose. Staff G stated she could not remember if weight loss was brought up by the facility but stated she was aware of the weight loss and refusals of breeze and Lactulose. Staff G stated she did not remember if she signed an order for an increase to 6 oz supplement. Staff G stated if she did not sign the order then the order for 6 oz house supplement was not brought to her attention. Staff G stated even with the order being entered she did not believe it would have helped to prevent the weight loss in Resident #25. Staff G stated even with offering supplemental food she did not believe Resident #25 would have accepted the food. Staff G stated she thought with Resident #25's non-compliance with taking medications and supplements that Resident #25 would have been compliant for a couple days and stopped. Staff G stated medications and supplements were always encouraged but frequently refused. Staff G stated there was too much speculation to assume any other interventions would have made a difference. On 6/5/24 at 4:33 PM the Director of Nursing (DON) stated the provider was well aware of Resident #25's refusals of Lactulose and supplement. The DON stated she was unable to find an order for a 6 oz house supplement. The DON stated the order was not entered into the electronic health records (EHR). The DON stated she expected the order to have been printed off, shared with the physician, and then transcribed to the medication administration record.

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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. 48004 Based on clinical document review, resident interview, staff interview, and policy review the facility failed to provide services to increase range of motion or prevent a decrease in range of motion for 1 of 3 residents (Resident #42) reviewed. The facility reported a census of 65 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #42 dated 4/25/24 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS further documented diagnosis of hemiplegia following cerebral infarction affecting the left non-dominant side. Review of Resident #42's Care Plan revealed a restorative plan for omni cycle or nu step 10-15 minutes 3 times weekly and PRN (As necessary). Review of Resident #42's restorative program documents for the month of 5/2024 revealed no documentation of minutes for the month along with no signatures of completion. During an interview on 6/5/24 at 3:03 PM with Resident #42 revealed his insurance discharged him from therapy at the beginning of May of this year. Resident #42 revealed that the facility doesn't have a restorative person at the moment. Resident #42 did reveal that he does refuse to go sometimes, but for the most part he is going at least weekly. During an interview on 6/5/24 at 3:13 PM with Staff B Physical Therapist (PT) revealed that Resident #42 was discharged from therapy in the beginning of May of this year. Staff B further revealed that Resident #42 had reached his maximum potential. Staff B revealed that the facility would be charting in their system when restorative would be completed. Staff B further revealed that the facility does not currently have a restorative staff. During an interview on 6/5/24 at 4:23 PM with the Director of Nursing (DON) revealed the facility had a full time restorative aide who recently left. The DON further revealed that her expectation would be for restorative therapy to be completed as ordered. Review of a facility provided policy titled, Restorative Nursing Services with a revision date 7/2017 documented: a. Residents will receive restorative nursing care as needed to help promote optimal safety and independence.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 47673 Based on electronic health records review (EHR), staff interviews, policy review, and observations, the facility failed to implement policies and procedures regarding the technical aspect of feeding tubes by not accurately administering supplemental formula according to physician's order and pushing medications with a piston syringe into feeding tube for 1 of 1 residents (Resident #59) reviewed. The facility reported a census of 65 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #59, dated 4/25/24 documented a Brief Interview for Mental Status score indicating the resident is rarely / never understood. The MDS documented a percutaneous endoscopic gastrostomy (PEG) tube for nutrition. Review of Resident #59's Clinical Physician Orders documented PEG Tube feedings: Osmolite 1.5 Cal continuous feed at 60 mL/hr over 12 hours. Osmolite 1.5 provides 1078 kcal. 45 grams protein, and 550 mL of water. Tap water flush q1h at 60ml Start 8pm and off 8am. In an observation on 6/4/24 at 4:00 AM it was discovered that the tube feeding for Resident #59 was set for 70 ml/hr over 12 hours. According to the Clinical Physician Orders in the electronic chart dated 5/29/24 at 8:00 PM the feeding is to be set at 60 ml/hr over 12 hours. On 6/4/24 at 4:02 AM, Staff U, Registered Nurse (RN) said that she had set up the resident's feedings many times. She said they are running it just at night because he's had some emesis. She acknowledged that it was set on 70 ml/hr and then checked the orders with the Director of Nursing. A continuous observation on 6/4/24 of Staff L Registered Nurse (RN) completing medication administration to Resident #59 via PEG tube revealed Staff L crushed all medications, and mixed medications in a glass of 30 mL of water. The nurse, Staff L, knocked on the door, entered the room, and shut the door. Staff L completed hand hygiene, applied a gown, and applied gloves. Staff L pushed with a piston syringe a 60cc flush of water prior and after administration of medication. 60cc with no flush entered in the pump. Full bag of water noted. Staff L auscultated an air Bolus for tube placement. Staff L drew up medications in a 60 mL piston syringe. Staff L pushed medications with a piston syringe. Staff L completed hand hygiene. Review of the feeding pump history with Staff L revealed 70mL of water fed over the course of 24 hours and a total of 414mL of formula fed over 24 hours. Review of the feeding pump setting revealed no hourly flush set for water. Review of policy titled, Administering Medications Through an Enteral Tube with revision date of 11/18 documented medication should be administered by gravity flow. Review of policy titled, Enteral Tube Feeding via Continuous Pump with revision date of 11/18 documented to check the enteral nutrition label against the order before administration and the rate of administration milliliters per hour (mL/hour). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 2:40 PM the DON stated the physician's orders should have been followed for Resident #59's enteral feedings. The DON stated a total of 720mL of formula should have been administered through the enteral pump prior to shutting off the enteral feeding pump, not 414mL. The DON stated a total of 720mL of water should have been administered prior to the enteral feeding pump being shut off. The DON stated medications should have been administered by gravity flow.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on resident interview, staff interview and clinical record review the facility failed to conduct post-dialysis assessments for 1 of 1 resident reviewed (Resident #57). The facility reported a census of 65 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #57 had a Brief Interview for Mental Status score of 15 (intact cognitive ability). The resident was admitted to the facility on [DATE] after an acute hospital stay. Diagnosis for Resident #57 included diabetes mellitus, anxiety, depression, chronic kidney disease, nutritional deficiency, acute pain, gangrene and necrosis of the lung. Resident #57 had hemodialysis treatments while a resident at the facility. The Care Plan updated on 5/31/24, showed that Resident #57 was at increase nutritional risk related to chronic kidney disease and diabetes. The resident to receive hemodialysis related to end stage renal disease. Staff directed to monitor and report any signs or symptoms of renal insufficiency On 6/04/24 at 6:36 AM, Resident #57 was in his bed with supplemental oxygen and said that he went to dialysis on Tuesday, Thursday and Saturdays. According to Dialysis Assessments found in the electronic chart, post dialysis assessments had not been completed on 5/16, 5/23, 5/30/24 and 6/1/24. On 6/04/24 at 8:55 AM, The Assistant Director of Nursing (ADON) looked at the assessments and acknowledged that there should be two assessments on dialysis days; pre and post. He acknowledged that there were a couple of days without the post assessments.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on resident interviews, staff interviews, grievance log review, clinical record review and policy review, the facility failed to ensure that call lights were answered in a timely manner for 11 of 21 residents reviewed. The facility reported a census of 65 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #57 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability). The resident was admitted to the facility on [DATE] after an acute hospital stay. He was totally dependent for toileting, transfers and lower body dressing. Resident #57 used a wheelchair for mobility and he was occasionally incontinent of urine and always continent of bowel. Diagnoses for Resident #57 included diabetes mellitus, anxiety, depression, chronic kidney disease, nutritional deficiency, acute pain, gangrene and necrosis of the lung. The Care Plan updated on 5/31/24, showed that Resident #57 had the potential for impairment to skin integrity related to poor immobility. Staff to encourage good nutrition and hydration and to educate him on the importance of repositioning. On 6/4/24 at 6:36 AM, Resident #57 was in his bed at the facility and said that often times when he would come back from dialysis, the staff would wheel him back to his room without getting him into bed and I got a sore on my bottom. He reported that staff don't answer the call light in a timely manner. He said that he uses a bedpan and was left with the bedpan under him for over 50 minutes. When the call light was finally answered by Staff S Registered Nurse (RN), he asked the resident what he needed, they said that he would get someone to take care of that and left the room. It then took another 15 minutes before anyone came to help. The resident was about to see the clock on the wall and watched how long it took to get help. 2) According to the MDS assessment dated [DATE], Resident #49 was admitted on [DATE] with a BIMS score of 15 (intact cognitive ability). He required partial assistance with toileting and transfers, and was occasionally incontinent of urine and frequently incontinent of bowel. The Care Plan updated on 5/31/24 showed that he was at risk for falls and staff were to encourage the resident to use his call light for assistance. On 6/3/24 at 11:43 AM Resident #49 said that he was admitted to the facility after a fall at home. He said he does get himself up to the bathroom because the call lights would take over 30 minutes. Rather than soil himself, he would transfer himself into the bathroom. 3) According to the MDS assessment dated [DATE], Resident #6 had a BIMS score of 9 (moderate cognitive deficits). She required substantial assistance with sit to standing, transfers and toilet transfers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan updated on 10/24/23 indicated that Resident #6 was at risk for falls and required 2 staff assistance for toileting and for transferring. Staff were to encourage the resident to use her call light for assistance. On 6/3/24 at 12:29 PM Resident #6 said that the call light response was 30-60 minutes, mostly at night. A review of the resident grievances in the previous 6 months revealed the following complaints: a. On 12/8/23 a resident stated that he had to bang on the wall in the bathroom to get staff assistance. b. On 10/20/23 a resident stated that she was left on the toilet for 2 hours after supper. The resident's son had to call the facility. c. On 12/9/23 a residents call light was not being answered, the daughter called the facility. d. On 12/23/23 a resident stated that he was left on the toilet for 45 minutes. 47673 3. The MDS assessment dated [DATE] documented Resident #9 had a BIMS score of 13 indicating no cognitive impairment. On 6/3/24 at 3:44 PM Resident #9 stated she spoke to the Director of Nursing (DON) and everyone at the nurses desk and let them know that her light had been on for 2 hours and she had been incontinent of urine and BM and she was very upset. Resident #9 stated this incident had happened in the last month. 4. The MDS assessment dated [DATE] documented Resident #31 had a BIMS score of 15 indicating no cognitive impairment. On 6/3/24 at 1:39 PM Resident #31 stated at least once it has taken an hour in the last 2 weeks to answer his call light. Resident #31 stated the staff watch their phone all the time. Resident #31 stated the staff are very loud on the overnights at the facility and over nights there were only 2 that worked 3 halls including his. Resident #31 stated the staff state there is only 2 staff and they cant get to all the call lights quickly. Resident #31 stated very often it takes longer than 15 minutes to answer his call light and it had taken longer than 15 minutes to answer his call light numerous times in the last 2 weeks. Resident #31 stated he had 2 clocks in his room and knows exactly how long it takes to answer his call light. Resident #31 stated he also had a watch and clock on his tablet to tell the time. Review of document titled, Resident Council Minutes dated 6/5/24, 5/1/24, 4/3/24, and 3/7/24 documented complaints of call lights taking a long time to answer / longer than 30 minutes. Review of policy titled Answering the Call Light revised 3/21 documented the purpose of that procedure was to ensure timely responses to the resident ' s requests and needs. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlantic Specialty Care	1300 East 19th Street Atlantic, IA 50022

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/6/24 at 11:06 AM the Director of Nursing (DON) stated call light audits had been completed with call light audits since April. The DON stated there was one call light that was noted to be longer than 15 minutes during all the audits. The DON stated no resident had come to the desk and reported incontinent of urine and bowel and call light had been on longer than 1 or 2 hours. The DON stated the facility's expectation was that call lights would be answered in less than 15 minutes. The DON stated the facility had developed a plan of correction as part developed from a mock survey completed by the cooperate. The DON stated if there was a call light that took longer than an hour the facility would have increased the call light audits on that particular resident room light.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48004 Based on observation, resident interview, staff interview, and policy review the facility failed to provide food at an appetizing temperature to 4 of 15 residents (Residents #7, #9, #38, and #60) reviewed. The facility reported a census of 65 residents. Findings include: 1. Review of Resident #7's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 9 indicating moderate cognitive impairment. During an interview on 6/3/24 at 12:11 PM Resident #7 stated the food is cold when it should be hot, and the food is overcooked. 2. Review of Resident #60's MDS assessment dated [DATE] documented a BIMS score of 10 indicating moderate cognitive impairment. During an interview on 6/3/24 at 11:42 AM Resident #60 stated the food is cold when it should be hot. Resident #60 further stated he wouldn't feed the food to his dog. During continuous observation on 6/5/24 at 1:12 PM the room trays and assisted meals were sent out of the kitchen to be delivered to the residents. During an observation on 6/5/24 at 1:30 PM the last room tray was delivered and the requested tray inside the insulated cart had the temperature checked and revealed the breaded shrimp was 113.5 and the carrots were 113 degrees. During an interview on 6/5/24 with Staff C revealed he would have turned up the steam table more, and he would warm up the food before serving it. During an interview on 6/5/24 at 1:42 PM with Staff D revealed that he thinks it might be from the delivery system of how the facility delivers room trays. Staff D further revealed that his expectation would be for food to be served at the appropriate temperatures. 47673 3. The MDS assessment dated [DATE] documented Resident #9 had a BIMS score of 13 indicating no cognitive impairment. On 6/3/24 at 3:46 PM Resident #9 stated hot food has been served cold several times in the last 2 weeks. Resident #9 stated this happens often and she thought the staff would warm it up but she did not ask. 4. The MDS assessment dated [DATE] documented Resident #38 had a BIMS score of 13 indicating no cognitive impairment. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/3/24 at 3:35 PM Resident #38 stated the food is frequently cold when it should be hot. Review of document titled, Resident Council Minutes dated 6/5/24 documented complaints of cold food. Review of policy titled, Food Preparation and Service revised 4/19 documented the longer foods remain in the danger zone the greater the risk for growth of harmful pathogens. Therefore, potentially hazardous food must be maintained below 41 F or above 135 F.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on clinical record review, staff interview and policy review the facility failed to document accurate information in the residents electronic file for 1 of 4 residents reviewed for falls. Resident #119 had an unwitnessed fall and staff began neurological assessments to determine change in status. The neuro assessments included notation that the vital signs had been completed as directed. Further review revealed the chart lacked the vital signs. The facility reported a census of 65 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #119 was admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 4 (severe cognitive deficits). She required partial assistance with toileting, dressing, hygiene, sit to stand and toilet transfers. She did have 1 fall with minor injury since admission. The Care Plan created on 5/21/24, showed that she was at risk for falls, and interventions included encouragement to use the call light, and a physical therapy evaluation. She was to ambulate with walker, and dependent on one staff member for transfers and toileting. An Incident Report dated 5/24/24 at 10:10 PM documented the resident was found on the floor in her room in front of her dresser. She was leaning up against the wheelchair and tried to pull herself up but could not. She had a laceration at the corner of her right eyebrow and a small amount of blood on her face. Action taken; vitals taken and neuro exam completed. The first neurological assessment was completed on 5/24/24 at 9:50 PM. Review of the documents dated below and titled Neurological Eval for the resident revealed the document showed vitals completed but the chart lacked vital signs on the following dates: On 5/24/24 at 10:20, 10:35, 10:50, 11:20, and 11:50 AM. On 5/26/24 at 9:50 AM. On 5/27/24 at 5:50 PM. On 6/4/24 at 8:55 AM, the Director of Nursing (DON) and Corporate Nurse said that the vital for neuros could be found in the vitals tab and staff were expected to obtain a new set of vitals with each assessment. According to the facility policy titled Neurological assessment dated 2010, the purpose of the procedures was to provide guidelines for a neurological assessment when following an unwitnessed fall, subsequent to gall with suspected head injury. Take temperature, pulse, respirations and blood pressure.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47673 Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (October1 - December 31) review, facility staffing reports review, and staff interviews, the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 65 residents. Findings include: The PBJ Staffing Data Report run date 5/31/24 triggered for Excessively Low Weekend Staffing - submitted weekend staffing data is excessively low. Review of Facility Daily Assignment Sheets for each day of the months of October, November and December 2023 staffing revealed staffing for nurses and Certified Nursing Assistants (CNAs) scheduled similarly for weekdays and weekends. The month of December reflected 3 CNA's frequently on the overnight shift during the week and on weekends. On 6/5/24 at 12:06 PM the Administrator confirmed the submission of the data for the PBJ was not submitted correctly. The Administrator stated she spoke with Corporate. The Administrator stated Corporate told him that the report triggers this response because there is no management on the weekends and this has been an issue at their other facilities.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on clinical record review, observations, policy review, and staff interviews the facility failed to provide appropriate infection prevention practices when providing personal care to a resident, during medication administration, and when providing care to a resident on enhanced barrier precautions (EBH) for 5 of 12 residents reviewed for infection control. The facility reported a census of 65 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #31 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. Review of the Clinical Physician Orders for Resident #31 revealed an order for a coude catheter size 18 French to be changed monthly and as needed. On 6/5/24 at 8:01 AM a continuous observation of catheter cares completed on Resident #31 revealed Staff K, Certified Nursing Assistant (CNA) completed hand hygiene, donned a gown, and donned gloves. Staff K completed all catheter cares on Resident #31 with sleeves of the gown pushed up over the elbow of the arms. On 6/5/24 at 8:41 AM the Director of Nursing (DON) stated facility's expectation was Staff K would have appropriately donned the gown with the sleeves covering the arms during catheter care. 2. The MDS assessment dated [DATE] documented Resident #61 had a BIMS score of 0 indicating severe cognitive impairment. The MDS revealed a diagnosis of a neurogenic bladder. Review of the Clinical Physician Orders for Resident #61 revealed an order for a Foley catheter size 16 french to be changed monthly and as needed with a diagnosis of neurogenic bladder. On 6/4/24 at 1:37 PM an observation of catheter cares completed by Staff I and Staff J for Resident #61 with the DON present in the room during catheter care revealed Staff I and Staff J completed hand hygiene, and applied gloves. Indwelling catheter present. Catheter care completed with catheter tubing cleansed about 6 inches from the body. Resident #61's brief was reapplied. Staff I and Staff J removed gloves, hand hygiene completed and new gloves applied. Staff I placed a barrier on the floor. Staff I removed the catheter from the dignity bag, catheter tubing cleansed with alcohol wipe, urine drained from the bag, and alcohol wipe used to cleanse the catheter tubing tip. Staff I measured 525 mL of urine in the graduated cylinder. Staff I and Staff J removed gloves, completed hand hygiene, placed the call light on resident #61's bed near resident's hand. Staff I removed the trash from the room. During the observation neither Staff I or Staff J donned gowns prior to or during catheter cares. On 6/4/24 at 2:40 PM the DON stated during the catheter cares completed on Resident #61 Staff I and Staff J should have donned gowns. The DON stated that an enhanced barrier precaution gown should be donned when completing care of resident's with catheters placed. The DON stated Staff I and Staff J had not donned gowns during catheter cares on Resident #61. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A continuous observation on 6/4/24 from 9:09 AM to 9:20 AM revealed Staff H, Certified Medication Assistant (CMA) removed medication from the medication cart, then took the medication down the hall to a resident's room, and administered medication in the bedroom. Staff H completed no hand hygiene at the medication cart or prior to walking down the hall and no hand hygiene prior to entering the room. Staff H left the resident's room, returned to the medication cart, unlocked the medication cart, returned medication to the drawer, opened the computer, and started removing medications for the next resident. Staff H walked down the hall to the next resident's room, administered medications in applesauce with sips of water, and exited the room. Staff H completed no hand hygiene. Staff H entered the next resident's room, obtained blood pressure, returned to the medication cart, and started the next resident's medication without hand hygiene. Staff H logged into the computer, opened the drawer, and obtained medications. On 6/4/24 at 2:40 PM the DON stated the facility's expectation was that hand hygiene would be completed prior to and after all resident cares including medications administrations to residents. Reviewed of policy titled, Hand Washing / Hand Hygiene revised 8/19 revealed Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water when before and after direct contact with residents and before preparing or handling medications. Review of policy dated 3/28/24 titled, Enhanced Barrier Precautions documented Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. An order for EBP (in accordance with physician-approved standing orders) will be initiated for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. 41785 4. According to the MDS assessment dated [DATE], Resident #57 had a Brief Interview for Mental Status score of 15 (intact cognitive ability). The resident was admitted to the facility on [DATE] after an acute hospital stay. He was occasionally incontinent of urine and always continent of bowel. Diagnosis for Resident #57 included diabetes mellitus, anxiety, depression, chronic kidney disease, nutritional deficiency, acute pain, gangrene and necrosis of the lung. The resident had Moisture Associated Skin Damage (MASD) staff were to apply ointments/medications to the area. Resident #57 had hemodialysis treatments while a resident at the facility. The Care Plan updated on 5/31/24, showed that Resident #57 had the potential for impairment to skin integrity related to poor immobility. Staff were to encourage good nutrition and hydration and to educate him on the importance of repositioning. Resident #57 was at increase nutritional risk related to chronic kidney disease and diabetes. According to a Skin and Wound Evaluation dated 4/1/24 at 10:20 PM, Resident #57 had a Moisture Associated Skin Damage (MASD) on his sacrum. The care for the area included a moisture barrier. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/24 at 6:36 AM, Resident #57 said that staff would often push him in the wheel chair back to his room after dialysis and not put him in bed. He said that he had a sore on his bottom and it felt better if he could be in bed. He said that many times he was left on the bedpan for long periods of time, and that also irritated the tender area. He said that after sitting for so long on dialysis days, he had some pain, the staff hadn't put barrier cream on the sore for a while. On 6/4/24 at 10:24 AM, Staff T, Certified Nurse Aide (CNA) entered the resident's room to get him ready to go to dialysis. She removed the soiled brief with gloved hands and grabbed his right buttock to move him to his side. The resident said that it hurt and he asked for the salve. Staff T looked around the room, without changing her gloves or performing hand hygiene, she touched surfaces on the nightstand and opened a dresser drawer looking for the cream.