STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165322	A. Building B. Wing	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottage Grove Place	2115 First Avenue SE Cedar Rapids, IA 52402

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 35434 Based on clinical record review, policy review, and staff and resident interviews, the facility failed to notify a resident's representative of a fall, medication refusals, and a significant weight loss for for 1 of 4 residents reviewed for a change in condition (Resident #48). The facility reported a census of 53 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 11/22/24, listed diagnoses for Resident #48 which included skin changes, diabetes, and non-Alzheimer's dementia. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 4 out of 15, indicating severely impaired cognition. 12/18/23 eMAR Administration Notes stated the resident refused his Med Pass supplement. 12/28/23 eMAR Administration Notes stated the resident refused his donepezil (used to treat dementia), carbidopa-levodopa (used to treat Parkinson's disease, a neurological condition with affected movement), metformin (used to treat diabetes), and vinpocetine (used to treat degenerative diseases of the nervous system). The facility lacked documentation of family notification of the above refusals. 2. A 1/8/24 Health Status Note stated the resident remained on fall follow up. A 1/9/24 Health Status Note stated the resident was on fall follow ups from the previous day shift fall. Subsequent Health Status Notes/Nursing Progress Notes revealed fall follow-up assessments at the following times: 1/9/24 at 4:31 p.m., 1/10/24 at 7:35 a.m., 1/10/24 at 10:08 p.m., and 1/10/24 at 11:01 p.m. On 7/8/24, via email correspondence, the Administrator stated she could not locate a fall incident report around 1/8/24. The facility lacked documentation of family notification of the fall. 3. A 3/8/24 Physician Fax stated the resident had a significant weight loss from 172 lbs in February to 161 lbs. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility lacked documentation of family notification of the weight loss. Care Plan entries, dated 2/9/24, stated the resident was at risk for falls and would not have any significant weight loss. On 7/8/24 at 4:17 p.m., the Director of Nursing (DON) stated the facility should notify the family of falls, medication refusals, and weight loss. The undated facility policy Reporting Resident Change in Condition, directed staff to report resident changes in condition to the physician and the family.

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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** 35434 Based on clinical record review, policy review, and staff and resident interviews, the facility failed to administer medications in accordance with professional standards for 3 of 6 residents reviewed for medications (Residents #33, #203, and #204). The facility reported a census of 53 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 12/12/23, listed diagnoses for Resident #203 which included diabetes, hip fracture, and pain. The MDS listed the Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. On 6/30/24 at 2:58 p.m., Resident #203 stated she received medications which were ordered twice daily 6 hours apart. The December Medication Administration Record (MAR) listed an order for sulfasalazine (used to treat ulcerative colitis, the inflammation of the colon) delayed release 500 milligrams, give 3 tablets by mouth two times per day. The hours for the MAR were listed as Day and Eve. The Medication Admin Audit Report listed an order for sulfasalazine delayed release 500 milligrams, give 3 tablets by mouth two times per day. The report revealed the following: a. On 12/15/23, the resident received her 7:00 a.m. dose at 10:41 a.m. and received her 4:00 p.m. dose at 7:17 p.m. a. On 12/16/23, the resident received her 7:00 a.m. dose at 10:20 a.m. and received her 4:00 p.m. dose at 5:48 p.m. b. On 12/17/23, the resident received her 7:00 a.m. dose at 12:08 p.m. and her 4:00 p.m. dose at 7:48 p.m. The facility Medication Administration schedule stated medications were scheduled at the following times: 5:00 a.m., 6:00 a.m., 8:00 a.m., 7:00 a.m.-10:00 a.m., 11:00 a.m., 12:00 a.m., 11:00 a.m.-1:00 p.m., 2:00 p.m. -4:00 p.m., 5:00 p.m., 6:00 p.m.-8:00 p.m., 7:00 p.m., and 10:00 p.m. The schedule did not have direction for staff on when to give medications if they were scheduled twice daily (bid) and did not give direction that staff could give Day medications anytime between 6:00 a.m. and 2:00 p.m. and Evening medications anytime between 2:00 p.m. and 10:00 p.m. The resident's Care Plan did not address the resident's medications. On 7/9/24 at 8:21 a.m. via email, the Director of Nursing(DON) stated if a medication was every day and evening shift, it would be given between 6:00 a.m. and 2:00 p.m. and 2:00 p.m. and 10:00 p.m. In a follow-up 7/9/24 8:32 a.m. email, she stated in theory, they could receive a morning dose at 1:00 p.m. and an evening dose at 2:00 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/24 at 9:32 a.m. via phone, the DON stated if a medication was ordered bid and on the MAR for day and evening then staff could give the day medication any time between 6:00 a.m. and 2:00 p.m. and the evening medication anytime between 2:00 p.m. and 10:00 p.m. She stated she did not know where this direction came from as it was in place prior to the start of her time at the facility. During an interview on 7/9/24 at 10:34 a.m. Staff F Advanced Registered Nurse Practitioner(ARNP) stated if a medication was ordered bid, she would assume it would be administered around morning and supper. She stated the practice of giving the day medications between 6-2 and the evening medications between 2-10 would not be a practice she would want carried out. The undated facility policy Physician Order Transcription Policy and Procedure, stated all orders must be accurately transcribed into the medical record. The undated facility policy Medication Administration Policy Template Administration Of Oral Medications, directed staff to provide medications safely and effectively. 48003 2. The Minimum Data Set (MDS) dated [DATE] documented Resident #33 had a Brief Interview for Mental Status (BIMS) score of 09 indicating moderate cognitive impairment. The MDS further documented the resident had diagnoses including diabetes, hypertension, depression, and end-stage renal disease. The Care Plan for Resident #33 showed she had insulin dependent Diabetes. Staff were directed to follow orders for diabetes medications as ordered by the doctor. The electronic chart showed an order dated 6/21/24 at 4:44 PM was received by the facility. The order was noted on 6/22/24 at 5:42 AM. The order was to start Novolog 7 units (short acting insulin) with each meal and to notify the physician if the blood sugar was less than 70 or greater than 400. The Medication Administration Record documented the resident did not receive insulin on 6/21/24 for the supper meal. The resident's blood sugar at supper on 6/21/24 was 246 and at breakfast on 6/22/24 was 334. Further review documented the insulin was held the evening of 6/22/24 due to blood sugar of 69. The record lacked documentation of physician being notified. During an interview on 7/01/24 at 4:08 PM, Staff A, License Practical Nurse (LPN) reported she held the insulin for Resident #33 on 6/22/24 because she thought the order read to hold if the blood sugar was less than 70. She reported she should have called the physician for further directions with the low blood sugar During an interview on 7/01/24 at 4:15 PM, the Director of Nursing (DON) reported the nurse should have called to notify the physician of the low blood sugar and then received further instructions from the physician for insulin. The facility policy titled Physician Order Transcription Policy and Procedure undated directed staff that written orders should be transcribed into the electronic medical record system promptly upon receipt. 48888 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The Minimum Data Set (MDS), dated [DATE], revealed Resident #204's diagnoses included metabolic encephalopathy, respiratory failure with hypoxia, asthma, and pneumonia. Resident #204 had shortness of breath at rest and with exertion. Medications included antibiotic, diuretic, and Resident #204 required continuous oxygen therapy. The Care Plan, initiated 03/30/24, revealed Resident #204 required care at the facility due to a fall at home, recent hospitalization , and weakness that required skilled nursing facility cares. The Care Plan instructed nursing staff to administer all medications and treatments unless otherwise ordered by the doctor. The Post Acute Discharge Report, dated 04/18/24, informed that the reports included constitute orders and instructions for immediate care of the resident upon admission to the facility. This Report revealed an order for Prednisone 10 milligram (mg) tablet, to be given as follows: take 4 tablets for 1 day, then 3 tablets daily for 3 days, then 1 tablet daily for 3 days, then stop. The Discharge Report informed facility the next dose of Prednisone would be due on 04/19/24. The Medication Administration Record (MAR), dated April 2024, revealed an order for Prednisone 40 mg one time a day related to Chronic Obstructive Pulmonary Disease with start date of 04/19/24, coded 09 or other/see nurses notes. The MAR, dated April 2024, revealed additional order for Prednisone 30 mg one time a day for three days, with start day of 04/20/24, to be given through 04/22/24, coded 09 or other/see nurses notes. The MAR, dated April 2024, further revealed an order for Prednisone 20 mg one time a day for three days, with a start day of 04/23/24 , to be given through 04/25/24, coded 09 or other/see nurses notes on 4/23/24, a dose given on 04/24/24, and then coded 06 or hospitalized on [DATE]. Review of Nursing Progress Notes revealed the following entries: a. On 04/18/24 at 04:44 PM, Resident #204 returned to facility from Hospital. b. On 04/18/24 at 03:34 PM, Nurse Practitioner acknowledged resident's medication review without any new orders. c. On 04/19/24 at 05:56 PM, Resident #204 had loud wheezes, some relief after as needed medication given. d. On 04/21/24 at 03:40 PM, Resident #204 had scattered faint wheezes throughout the lungs with occasional non-productive cough. Nurse noted Resident #204 moving legs constantly and reported aches improved but unresolved after massage. Resident #204 mumbling. e. On 04/22/24 at 11:34 AM, Nurse called Pharmacy about missing Prednisone and told it would be sent out same day. f. On 04/23/24 at 11:26 AM, Nurse called Primary Care Provider office to report Resident #204 had not received Prednisone taper as Pharmacy had not delivered, order received to discontinue. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. On 04/23/24 at 11:17 PM, Resident #204 had scattered wheezes in the lungs, reported shortness of breath and had been anxious and talkative. h. On 04/25/24 at 06:47 AM, Resident #204 complained of shortness of breath and mid sternum chest pain. Oxygen saturation at 90% while on oxygen, nurse increased oxygen flow to 4 liters and noted Resident #204 had 24 respirations per minute with use of accessory muscles. Lung sounds had been diminished throughout with wheezes in the upper lungs and coarse crackles in the lung bases. Nurse administered an ordered inhaler and Aspirin. Resident #204 transferred to hospital via ambulance. i. On 04/25/24 at 11:18 AM, Nurse received update from hospital that Resident #204 would be admitted to hospital for pneumonia and fluid overload. The facility provided a list of medications kept on site in the emergency medication (E-kit) provided by the Pharmacy, document not dated. The list revealed Prednisone 10 mg tablet kept onsite in facility's E-kit. On 07/08/24 at 04:41 PM, Director of Nursing (DON) revealed that upon admission from Hospital, nursing staff were expected to transcribe and put resident orders into the MAR and fax the Pharmacy for medications to be delivered to facility on the next delivery. DON also revealed the facility kept an E-kit onsite at the nurses station that could be accessed if medication is not available. On 07/09/24 at 01:31 PM, the Facility Administrator revealed via Electronic mail (email), the facility had been unable to produce any evidence of physician notification of missing prednisone between 04/18/24 and 04/22/24. The facility policy titled, Physician Order Transcription Policy and Procedure, not dated, revealed that all transcribed Physician orders must be documented in the electronic medical records system, including the date, time, and identity of the healthcare professional involved and any errors, clarifications, or amendments made to the transcribed orders should be clearly documented and linked to the original order.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on observations, interviews, and chart review the facility failed to offer toileting on a timely basis and failed perform proper hand hygiene and proper personal protective equipment guidelines to prevent the spread of potential infection and germs during incontinence cares for 2 of 3 residents reviewed (Residents #21, #27). In an observation it was discovered that Resident #21 was left in her chair for over 4 hours before offered toileting. Also, the facility failed to provide baths to residents per the resident's desired frequency for 1 of 4 residents reviewed (Resident #48). Facility further failed to put interventions in place to prevent voiding in inappropriate locations for 1 of 2 residents reviewed for wandering behavior (Resident #34). The facility reported a census of 53 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #21 was always incontinent of bowel and bladder. The MDS documents the resident was dependent with toileting, personal hygiene, transfers, and dressing. The MDS further documented the resident had diagnoses including dementia, hypertension, depression, and anxiety. The Care Plan for Resident #21 indicated that she had bladder incontinence due to diagnosis of dementia and needed staff to perform all her toileting cares. The following was an ongoing observation of Resident #21 on 07/02/24: 6:35 AM Resident observed sitting by the nurse's station in a wheelchair 9:25 AM Staff took resident from by the nurse's station to the dining room for breakfast 9:55 AM staff took resident back to sit by the nurse's station in the wheelchair 10:00 AM Staff took resident to the activity room. 10:45 AM Resident took from activity back to her room to be checked and changed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/02/24 at 10:45 AM Staff B and Staff C, Certified Nursing Assistants (CNAs) performed incontinence cares on Resident #21. Staff C put a barrier under supplies. Staff C performed peri cares on the front wiping from front to back using only one area of the washcloth for each wipe. Staff B and Staff C rolled the resident onto her left side to proceed to do cares on the backside. The first wipe with the washcloth noted bowel movement on it and Staff C noted resident was having a bowel movement. Staff C placed the washcloth in the plastic bag. During this time Staff C touched the residents bedding and then went to her recliner and touched the recliner to grab a clean brief then place it under the resident still wearing the same dirty gloves. She then removed the gloves and did hand hygiene. At 10:55 AM resident was done having a bowel movement so Staff B and Staff C proceeded put on new gloves then roll the resident to her left side and proceed to clean the resident. Staff C wiped toward the front and not from front to back during peri care. Staff C then assisted the resident to her right side and Staff B proceeded to clean the right side. Staff B also wiped from back to front on the backside. Once the brief was on Staff B and Staff C removed their gloves and did hand hygiene. During an interview on 7/02/24 at 11:00 AM, the Director of Nursing (DON) reported Staff did not change their gloves from clean to dirty and should have. She further reported residents are to be toileted every two to three hours. During an interview on 7/02/24 at 2:20 PM, The DON verbalized the facility does not have a peri care or toileting policy. 2. The Minimum Data Set (MDS) dated [DATE] documented Resident #27 was always incontinent of bowel and bladder. The MDS documented the resident was dependent with toileting, personal hygiene, transfers, and dressing. The MDS further documented the resident had diagnoses including Alzheimer's disease, stage 3 pressure ulcer to left heel, depression, and anxiety. The Care Plan for Resident #27 indicated that she had bladder incontinence due to diagnosis of dementia and needed to be checked and changed by staff. During an observation on 7/2/24 at 10:15 AM, Staff D and Staff E, CNAs took Resident #27 from the dining room to lay down to be checked and changed. Staff D and Staff E did hand hygiene and applied gloves. Staff D began cleaning the resident from front to back using a new wipe each time she wiped. She put the wipes on the bed with no barrier underneath. Staff D wiped from front to back. Once the front was cleaned both Staff D and Staff E assisted resident to her left side. Staff D then pulled out the dirty brief and set it on the bed with no barrier underneath. Staff D then wiped the back-side wiping front to back with a new wipe each time and placing the dirty wipes on top of the dirty brief on the bed. Staff D without changing her dirty gloves then grabbed the clean brief and put it under the resident. While putting the brief under the resident Staff D touched the bedding with the dirty gloves. Staff D and Staff E secured the brief and pulled up the bedding and Staff D still was wearing the dirty glove. Staff D and Staff E removed the gloves and did hand hygiene. An interview on 7/02/24 at 10:25 AM, the DON reported the Staff D should have changed her gloves between dirty to clean and should not have put the dirty brief and wipes on the bed. 48888 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating severe cognitive impairment. The MDS additionally indicated Resident #34 had continuous inattention and disorganized thinking, as well as frequent wandering behavior. Resident #34 was able to transfer and ambulate independently but required staff supervision for toileting hygiene. Diagnoses included non-Alzheimer's dementia, hypothyroidism, and depression. Resident #34 required antianxiety and antidepressant medications. The Care Plan, initiated 03/13/24, revealed Resident #34 had potential for wandering and had been at risk for falls due to dementia diagnosis and independent transfer status. The Care Plan instructed staff to allow wandering in spaces where Resident #34 can be safely monitored and cannot harm self. The Care Plan additionally instructed staff to assess the cause of wandering and attempt diversional activities. The Care Plan revealed that Resident #34 had been noted to sit onto the floor and get self up in a safe and gentle manner and informed that Resident #34 may suddenly squat down on the floor when needing to use restroom, staff instructed to intercede and offer toilet. In a Behavior Log, dated 06/10/24 through 07/09/24, staff documented Resident #34 had wandering type behavior on 23 of the 30 days recorded. Review of Nursing Progress Notes revealed the following entries: a. On 05/13/24 at 02:29 PM, a family member reported Resident #34 urinating on the floor of her mother's room. Director of Nursing (DON) and Primary Care Provider (PCP) notified. b. On 05/15/24 at 05:37 PM, during dinner Resident #34 pulled pants down in dining room and urinated in front of other residents, redirected to room. c. On 05/20/24 at 03:54 PM, Resident #34 observed removing pants in lounge area, redirected to room and redressed. d. On 05/30/24 at 12:27 PM, Facility attempted to call and left voicemail for family to report Resident #34 behaviors. e. On 06/05/24 at 03:00 PM, Resident #34 wandering, trying to pick up things off floor that aren't there, talking to people whom aren't there and wandering into rooms. f. On 06/11/24 at 12:41 PM, Resident #34 wandering and lying on floor at times with legs in the air, staff continued to monitor. g. On 06/17/24 at 02:40 PM, Resident #34 observed taking objects from Nurse's Station, would not comply with putting them back. Discouraged from entering other resident's rooms and wandered most of shift. h. On 06/28/24 at 03:54 PM, Resident #34 stood outside a room, talked to wall, and bent down as if to help someone at knee level. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/01/24 at 08:55 AM, Resident #34 wandered around the dining room, no staff or other residents present in area. No staff present within a viewing distance of resident due to L shaped layout of hallway. Resident #34 bent down below kitchenette island, looked into cabinets, and nearly missed bumping head on countertop when she stood back up. On 07/01/24 at 09:53 AM, Resident #34 had wandered into another resident's room, male resident began to yell, staff responded and redirected resident out of the room. On 07/01/24 at 10:00 AM, Resident #34 got onto hands and knees in hallway as staff had been in another resident's room. Resident #34 observed crawling on hands and knees attempting to pick up items from floor that had not been there, eventually she stood herself back up and continued to wander down the hallway unsupervised. On 07/01/24 at 10:11 AM, staff found Resident #34 behind nurse's station, able to redirect from area. On 07/01/24 at 01:34 PM, Resident #34 wandered around dining room following lunch, dirty dishes and used clothing protectors remained on tops of tables. No staff or other residents present in area or within visual distance of resident. Certified Nursing Assistants (CNAs) noted to both be in other resident's rooms. Resident #34 moved dining room chairs and touched dirty dishes on table tops. Resident #34 stood between a dining room table and chair, pulled pants down and urinated on the floor, she then grabbed used clothing protectors from the table and wiped self front and back with used clothing protector before she pulled pants back up. Noted urine soaked on left lower pant leg and large puddle of urine on the laminate flooring in dining room. On 07/02/24 at 08:23 AM, Staff G, Licensed Practical Nurse (LPN), stated the lower level, where Resident #34 resides, typically has 1 nurse to float between upper hallway and lower hallway and indicated this was enough supervision of residents in lower level with behaviors. On 07/03/24 at 10:30 AM, Staff I, CNA, reported 2 CNA staff are needed in lower level, that 1 CNA is not enough supervision or assistance with four residents who required 2 staff assistance to transfer. Staff I informed that if a resident wandered in hallway when both CNA staff were occupied, they would ask another staff in area to monitor the wandering behaviors while CNAs were in with other residents. Staff I informed that Resident #34 had not been on a toileting program but staff try to assist with toileting every two hours and watch for cues that resident may need to use restroom. On 07/08/24 at 02:29 PM, Staff K, CNA, reported staff would attempt to assist Resident #34 to the restroom every 2 hours and if resident wandered, staff would check on her and try a distraction activity before going into a room. On 07/08/24 at 04:41 PM, the Director of Nursing (DON), revealed the expectation of staff to ensure safety and attempt to redirect residents whom wander. The DON also expected staff to try and remain in common area when Resident #34 wanders in area or provide Resident #34 with an activity when occupied with other residents. 35434 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The MDS (Minimum Data Set) assessment tool, dated 11/22/23, listed diagnoses for Resident #48 which included diabetes, non-Alzheimer's dementia, and Parkinson's. The MDS stated the resident required substantial assistance for rolling, partial/moderate assistance for showering, and was dependent on staff for transfers. The MDS listed the residents Brief Interview for Mental (BIMS) score as 4 out of 15, indicating severely impaired cognition. The Documentation Survey Report v2 reports for 11/1/23-12/31/23 documented the resident received baths/showers on 11/25/23, 11/29/23, 12/5/23, 12/7/23, 12/9/23, 12/23/23, and 12/28/23. The facility lacked documentation of additional baths provided during 11/1/23-12/31/23. A 2/9/24 Care Plan entry stated the resident required the assistance of 1 staff for showers. On 7/8/24 at 4:17 p.m., the Director of Nursing(DON) stated residents should receive a shower at at minimum of two times per week. The undated facility policy Activities of Daily Living(ADL) Care Policy and Procedure, stated residents would receive appropriate assistance with their ADLs including bathing, toileting, positioning, and transferring. On 7/9/24 at 1:24 p.m. via email correspondence, the Administrator stated she had no additional documentation related to baths provided during this time frame.

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Cottage Grove Place	2115 First Avenue SE Cedar Rapids, IA 52402

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434 Based on clinical record review, policy review, and staff and resident interviews, the facility failed to obtain a treatment order for a new skin area in a timely manner for 1 of 3 residents observed with a non-pressure skin issue(Resident #203), failed to assess and carry out a treatment for a resident with moisture associated skin damage (MASD) for 1 of 3 residents observed with a non-pressure skin concern (Resident #48), failed to assess and intervene after a resident showed signs of altered mental status for 1 of 4 residents reviewed for a change in condition (Resident #48), and failed to assess and intervene when a surgical wound showed signs of infection for 1 of 3 residents revealed with a non-pressure skin concern (Resident #39). The facility reported a census of 53 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 12/12/23, listed diagnoses for Resident #203 which included diabetes, hip fracture, and pain. The MDS stated the resident required partial to moderate assistance for rolling and transfers and listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. The resident's Care Plan did not address any skin concerns. A 12/30/23 Health Status Note stated the resident complained of her coccyx (tailbone) being sore. A 1/1/24 1:43 p.m. Nursing Progress Note stated the resident had a new area to the coccyx. The area was 2 small 0.1 centimeters (cm) round blanchable partially open areas and the facility notified the physician to request a treatment order. A 1/4/24 Physician's Order Note listed an order for Medihoney (a type of wound treatment) plus Mepilex (a foam dressing) to opened area on the coccyx. The January 2024 Medication Administration Record (MAR) listed a 1/5/24 order for Medihoney Wound/Burn Dressing, apply to coccyx topically one time per day for opened area on the coccyx. The MAR documented the dressing started on 1/5/24. The facility lacked documentation of a treatment initiated earlier than 1/5/24. 2. The MDS assessment tool, dated 11/22/24, listed diagnoses for Resident #48 which included skin changes, diabetes, and non-Alzheimer's dementia. The MDS stated the resident had no pressure ulcers and had moisture associated skin damage. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 4 out of 15, indicating severely impaired cognition. a. A 12/26/23 Skilled Evaluation stated the resident had MASD on his buttocks A 12/30/23 Skilled Evaluation stated the resident had moisture associated skin damage (MASD). A 1/1/24 Resident Skin Report stated the resident had red open areas and displayed a diagram with an area on the left buttock circled. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The December 2023 and January 2024 Treatment Administration Records (TARs) lacked documentation a skin treatment implemented for the resident's MASD. The facility lacked skin assessments from 12/30/23 to 1/16/24. A 1/16/24 Communication with Physician note stated the resident transferred to the hospital. A 2/5/24 hospital Progress Note stated the resident had a Stage 2 pressure injury (caused an open area to the top layer of the skin) to the left buttock present on admission. Care Plan entries, dated 2/9/24, stated the resident was at risk for pressure injuries and/or impairment to the skin, would be free from redness, blisters, or discoloration, and directed staff to administer treatments and monitor for effectiveness. The Care Plan did not address the resident's skin concerns prior to 2/9/24. b. A 2/9/24 Care Plan entry stated the resident had a Foley catheter (a tube which was inserted into the urinary tract to drain urine) and staff provided catheter cares. A 3/15/24 Health Status Note stated the family notified the facility that the resident had an altered mental status. The Temperature Summary report listed a 3/15/24 10:50 p.m. temperature of 99.1 degrees Fahrenheit. The facility lacked an assessment completed on 3/16/24. The facility obtained vital signs on 3/17/24 but lacked documentation of further assessments between 3/15/24 and 3/18/24 including assessments of the resident's mental status and appearance/quality of the urine in his catheter. On 3/18/24, the facility obtained an order for a urinalysis (a laboratory test of the urine). On 3/19/24, the resident's oxygen saturation was in the 80's (normal was 90 or above) and the facility transferred him to the ER. The hospital Discharge Summary Note, dated 3/21/24, stated the resident admitted from a care facility with a fever, confusion, and unresponsiveness. The resident had purulent (referring to pus) drainage from his Foley catheter. On 7/8/24 at 4:17 p.m. the Director of Nursing (DON) stated if a resident had MASD, they should carry out assessments every time there was a treatment. She stated if a resident had a skin issue, there should be a treatment in place and she would want full assessments carried out after a change in condition. In email correspondence on 7/9/24, the Administrator stated the facility did not have a specific policy for assessments and interventions. On 7/9/24 at 1:24 p.m. via email correspondence, the Administrator stated she had no additional documentation related to the Resident #48's skin assessments in January 2024 or assessments conducted between 3/15/24 and 3/18/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated facility policy Wound Care stated the prevention, care, and treatment of wounds was carried out for all resident to prevent skin breakdown and stated the facility would utilize a protocol for the assessment and treatment of wounds. The facility would assess residents with compromised skin integrity no less than once per week. 48888 3. The Minimum Data Set (MDS), dated [DATE], revealed Resident #39 had been dependent upon staff for transfers and toilet hygiene and required substantial to maximal assistance with bed mobility. Resident #39 required both scheduled and as needed pain medication and utilized opioid medication. Diagnoses included aftercare following joint replacement surgery, presence of right artificial hip joint, and periprosthetic fracture around internal prosthetic right hip joint. The Care Plan, initiated 05/03/24, revealed Resident #39 had an infection of the right hip incision site with the goal to be free from complications related to infection through the review date. The Care Plan instructed staff to follow facility policy and procedures for line listing, summarizing, and reporting infections. The Care Plan revealed Resident #39 required the antibiotic Keflex for wound infection from 05/03/24 through 05/10/24, then required the antibiotic Levaquin from 05/14/24 through 05/21/24 for possible cellulitis to incision site. The Treatment Administration Record (TAR), dated April 2024, lacked orders for wound care for right hip surgical wound. The Treatment Administration Record (TAR), dated May 2024, revealed a wound care order, initiated 05/18/24, for Calcium Alginate applied to hip wound topically every day shift and cover with foam border. The Skin and Wound Assessment, dated 04/25/24, revealed a right hip surgical wound, incision approximated, measured 12.3 centimeters (cm) by 1.9 cm. Assessment noted a non-removable dressing had been in place. A picture of the wound revealed a foam type dressing, not dated, secured with transparent film in place, the film rolled around edges, and dressing had small amount of dark yellow drainage. The Skin and Wound Assessment, dated 05/01/24, revealed right hip surgical wound, measured 17.9 cm by 2.3 cm. Assessment noted a non-removable dressing remained in place. A picture of wound revealed foam type dressing remained, not dated, secured with transparent film. Film edges rolled and dressing had moderate amount of yellow, green colored drainage. The Skin and Wound Assessment, dated 05/06/24, revealed right hip surgical wound, measured 20.9 cm by 1 cm. Assessment revealed signs of infection included redness, inflammation, and warmth present as well as light amount of purulent drainage. Assessment noted Resident #39 went to the emergency room and had surgical bandage removed. A picture of wound revealed areas of redness on both sides of incision. Review of Nursing Progress Notes revealed the following entries: a. On 04/25/24 at 03:51 PM, Resident #39 admitted to facility with surgical wound to right hip, covered with a bandage and a small area of old drainage noted on dressing. Resident #39 rated right hip pain 10 on a scale of 1 to 10. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 04/29/24 at 11:14 PM, Right lower extremity is warm to touch, non-pitting edema to feet. c. On 05/01/24 at 02:03 PM, weekly skin assessment completed and surgical incision remained covered with a non-removable bandage. d. On 05/02/24 at 04:46 PM, Resident #39 requested to go to Hospital after several days without bowel movement. e. On 05/02/24 at 11:23 PM, Resident #39 returned to facility from emergency room (ER) with communication that resident had superficial infection around surgical site with an order for antibiotics and instruction to follow up with Orthopedic Surgeon, continue to monitor site, and if redness or drainage worsens to return to ER. Assessment of incision site revealed separation at upper incision line, yellow tinged drainage, redness noted at top to midline incision. Noted swelling and wound felt hardened to touch. On 07/08/24 at 03:03 PM, Staff L, Registered Nurse (RN), informed that signs of wound infection would include pink or redness around wound, warmth, more drainage, and pain. Staff L stated the Primary Care Provider or Orthopedic Surgeon would need to be notified the same day or shift for any signs of surgical wound infection. On 07/08/24 at 04:41 PM, Director of Nursing (DON), revealed the expectation of Nursing staff to complete weekly wound assessment and to notify Provider immediately for signs of wound infection. The facility policy, titled Wound Care, not dated, revealed the DON is responsible for implementation of policy. Policy revealed expectation that all residents be assessed for skin breakdown on admission, routinely thereafter, and as needed. The policy instructed staff that skin breakdown would be reported to the Physician and treatment orders to be requested.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on observation, interviews, clinical record review, and facility policy review, the facility failed to monitor and assess skin underneath a wander guard device which resulted in the development of a Stage 3, facility acquired, pressure injury of left inner foot for 1 of 4 residents reviewed for pressure injury (Resident #31). The facility reported a census of 53 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicative of intact cognition. The MDS indicated Resident #31 had one unhealed stage 2 pressure injury and required pressure reducing device for chair, a turning/repositioning program, pressure ulcer care, and application of non-surgical dressing and ointments or medications. Diagnoses included: encounter for removal of internal fixation device, arthritis, osteoporosis, a mechanical complication of left knee prosthesis, and contracture of muscle in left lower leg. The Care Plan, revised 03/09/24, revealed Resident #31 identified at risk for alteration in skin integrity due to limited mobility, required assistance with toileting, incontinent of bladder, self propels in wheelchair, and had chronic pain that limited mobility with the goal to be free of alteration in skin integrity. Interventions included: notify nurse of any skin breakdown, redness, or potential complications, Resident #31 to wear heel boot, float heels when in bed, use pillows for positioning, antibiotic treatment for Methicillin Resistant Staphylococcus Aureus (MRSA) of left foot wound, wound treatments as ordered, weekly skin evaluation, and application of [NAME] Hose daily for edema in lower extremities. The Care Plan additionally revealed focus area, initiated 01/01/24, for potential to wander due to dementia diagnosis with intervention for Wander guard to be worn at all times and staff to check placement and function every shift. The Care Plan lacked identification of pressure injury. The Braden Scale Assessment for predicting pressure sore risk, dated 03/22/24, revealed Resident #31 had been at risk for pressure injury due to chair-fast activity, limited mobility, and a problem with friction or sheering. The Skin and Wound Assessment, dated 03/21/24, revealed a new medical device related pressure injury to left medial foot, acquired in-house, that measured 1.7 centimeters (cm) by 1.4 cm that presented as a scab without drainage. Assessment noted, new pressure area appeared to be from wander guard, which was removed and placed on wrist instead. Resident #31 had non-pitting edema surrounding wound with non-verbal signs of pain that included: occasionally labored breathing, repeated troubled calling out, sad/frightened/frown expression, and rigid body language with fists clenched, knees pulled up, or pulling/pushing away. No dressing or treatment applied, interventions included no foot pedals on wheelchair and heel suspension or protection device to be applied. The Skin and Wound Assessment, dated 03/27/24, revealed an unstageable medical device related pressure injury to left medial foot that measured 2.7 cm by 1.6 cm. Wound continued to present as a scab with non-attached edges with dry/flaky edematous skin surrounding wound. A film/membrane type dressing applied and notification to Provider with request to apply betadine treatment to wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Skin and Wound Assessment, dated 04/03/24, revealed an unstageable medical device related pressure injury to left medial foot that measured 1.6 cm by 1.4 cm and had 70% of wound filled with slough (or yellow, sticky tissue) and light amount of seropurulent drainage. Assessment noted scab had come off wound and new treatment had been requested. The Skin and Wound Assessment, dated 04/24/24, revealed a Stage 2 pressure injury to left foot that measured 1.6 cm by 1.4 cm with moderate amount of purulent drainage, a faint odor, redness and inflammation surrounding wound and rolled wound edges. Treatment included a Silvadene cream to wound covered with gauze dressing. No indication of Provider or responsible party notification with signs of infection. A picture of the wound appeared to have dry yellow tissue within wound bed, rolled wound edges, and redness surrounding outside of wound. The Skin and Wound Assessment, dated 05/01/24, revealed an unstageable medical device related pressure injury to left medial foot, that measured 1.5 cm by 1.3 cm with 100% of wound filled with slough tissue. Assessment noted wound had increased purulent drainage, redness, inflammation, warmth, and pitting edema surrounding wound. Wound progress documented as deteriorating, Provider notified and order received for antibiotic to start. The Skin and Wound Assessment, dated 05/29/24, revealed an unstageable medical device related pressure injury to left medial foot, that measured 1.6 cm by 1.6 cm, with redness, inflammation, and moderate amount of bloody drainage. Surrounding skin noted to have pitting edema extending greater than 4 cm around the wound. Treatment included calcium alginate to wound bed, calmoseptine ointment to surrounding skin, covered with film dressing. The Assessment noted wound remains the same as previous week, Provider saw on this date and started antibiotic for wound infection. The Skin and Wound Assessment, dated 07/02/24, revealed a Stage 3 medical device related pressure injury to left medial foot measured 1.3 cm by 1.1 cm with light serosanguinous drainage. Wound treatment continues with Calcium Alginate to wound bed, Calmoseptine to surrounding skin and covered with film dressing. The Medication Administration Record (MAR), dated May 2024, revealed the following antibiotic orders for wound infection: 1. Cephalexin 500 milligram (mg) four times a day for possible infection, started on 05/01/24 and ended 05/11/24. 2. Doxycycline Hyclate 100 mg given two times a day for wound infection, started on 05/28/24, and ended 06/06/24. 3. Amoxicillin-Potassium Clavulanate 500-125 mg, given two times a day for wound clinic order, started on 05/29/24 without stop date. Review of the Treatment Administration Records (TAR), for the month of March, April, and May 2024 all lacked documentation of assessment for wander guard placement and function checks. On 07/03/24 at 06:45 AM, Staff M, Licensed Practical Nurse (LPN), completed appropriate dressing change and wound care to Resident #31's left medial foot. Resident called out intermittently during procedure. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/03/24 at 06:55 AM, Director of Nursing (DON) revealed that Resident #31 previous had wander guard device kept on his ankle and informed that due to side sleeping and contracted legs, the wander guard began to rub, which started as a red area on the ankle. DON revealed expectation of wander guard monitoring to be documented in Electronic Health Record. The facility policy, titled Wound Care, not dated, revealed the expectation for all residents to be assessed for skin breakdown at admission, routinely thereafter, and as needed. Certified Nursing Assistants to follow skin care guidelines and observe for any changes in resident's skin or feet daily, and if changes are noted or resident reports pain, this will be reported immediately to supervising nurse. Director of Nursing listed as responsible for implementation of Wound Care policy.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on observations, interviews, and clinical record review, the facility failed to ensure adequate supervision of a resident known to wander, which resulted in unsafe actions and voiding in inappropriate locations for 1 of 2 residents reviewed for accidents and hazards (Resident #34). The facility reported a census of 53 residents. Finding include: The Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating severe cognitive impairment. The MDS additionally indicated Resident #34 had continuous inattention and disorganized thinking, as well as frequent wandering behavior. Resident #34 able to transfer and ambulate independently but required staff supervision for toileting hygiene. Diagnoses included non-Alzheimer's dementia, hypothyroidism, and depression. Resident #34 required antianxiety and antidepressant medications. The Care Plan, initiated 03/13/24, revealed Resident #34 had potential for wandering and had been at risk for falls due to dementia diagnosis and independent transfer status. Care Plan instructed staff to allow wandering in spaces where Resident #34 can be safely monitored and cannot harm self. The Care Plan additionally instructed staff to assess the cause of wandering and attempted diversional activities. The Care Plan revealed that Resident #34 had been noted to sit onto the floor and get self up in a safe and gentle manner and informed that Resident #34 may suddenly squat down on the floor when needing to use restroom, staff instructed to intercede and offer toilet. The Care Plan further revealed Resident #34 can become aggressive to staff which required one on one with staff and redirection. In a Behavior Log, dated 06/10/24 through 07/09/24, staff documented Resident #34 had wandering type behavior on 23 of the 30 days recorded. A Fall Risk Evaluation, dated 06/09/24, revealed a score of 12, evaluation indicated a score greater than 10 being at high fall risk. Evaluation additionally revealed, Resident #34 had been disoriented to person, place, and time of day at all times, was ambulatory and incontinent. Resident #34 had poor vision with or without glasses and had 1 to 2 predisposing diseases that put her at risk for falls. Review of Nursing Progress Notes revealed the following entries: a. On 05/13/24 at 02:29 PM, a family member reported Resident #34 urinating on the floor of her mother's room. Director of Nursing (DON) and Primary Care Provider (PCP) notified. b. On 05/15/24 at 05:37 PM, during dinner Resident #34 pulled pants down in dining room and urinated in front of other residents, redirected to room. c. On 05/20/24 at 03:54 PM, Resident #34 observed removing pants in lounge area, redirected to room and redressed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. On 05/30/24 at 12:27 PM, Facility attempted to call and left voicemail for family to report Resident #34 behaviors. e. On 06/05/24 at 03:00 PM, Resident #34 wandering, trying to pick up things off floor that aren't there, talking to people whom aren't there and wandering into rooms. f. On 06/11/24 at 12:41 PM, Resident #34 wandering and lying on floor at times with legs in the air, staff continued to monitor. g. On 06/17/24 at 02:40 PM, Resident #34 observed taking objects from Nurse's Station, would not comply with putting them back. Discouraged from entering other resident's rooms and wandered most of shift. h. On 06/28/24 at 03:54 PM, Resident #34 stood outside a room, talked to wall, and bent down as if to help someone at knee level. Observations on 07/01/24, at 08:55 AM Resident #34 wandered around the dining room, no staff or other residents present in area. No staff present within a viewing distance of resident due to L shaped layout of hallway. Resident #34 bent down below kitchenette island, looked into cabinets, and nearly missed bumping head on countertop when she stood back up. On 07/01/24 at 09:53 AM, Resident #34 had wandered into another resident's room, male resident began to yell, staff responded and redirected resident out of the room. On 07/01/24 at 10:00 AM, Resident #34 got onto hands and knees in hallway as staff had been in another resident's room. Resident #34 observed crawling on hands and knees attempting to pick up items from floor that had not been there, eventually she stood herself back up and continued to wander down the hallway unsupervised. On 07/01/24 at 10:11 AM, staff found Resident #34 behind nurse's station, able to redirect from area. On 07/01/24 at 01:34 PM, Resident #34 wandered around dining room following lunch, dirty dishes and used clothing protectors remained on tops of tables. No staff or other residents present in area or within visual distance of resident. Certified Nursing Staff (CNAs) noted to both be in other resident's rooms. Resident #34 moved dining room chairs and touched dirty dishes on table tops. Resident #34 stood between a dining room table and chair, pulled pants down and urinated on the floor, she then grabbed used clothing protectors from the table and wiped self front and back with used clothing protector before she pulled pants back up. Noted urine soaked on left lower pant leg and large puddle of urine on the laminate flooring in dining room. On 07/01/24 at 01:42 PM, Resident #34 continued to wander in dining room, removed an orange juice container and a tied plastic bag from the trash and placed items on kitchenette island. On 07/01/24 at 01:44 PM, Dietary staff present in dining room picked up dishes, Resident #34 grabbed a used clothing protector from table and wore it draped around her neck. Resident #34 bent down or got onto floor several times to grab at outlets on the floor or objects not there. Dietary staff did not intervene or call CNA staff for notification or assistance with behaviors. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/02/24 at 08:23 AM, Staff G, Licensed Practical Nurse (LPN), stated the lower level, where Resident #34 resides, typically has 1 nurse to float between upper hallway and lower hallway and indicated this was enough supervision of residents in lower level with behaviors. On 07/03/24 at 10:30 AM, Staff I, CNA, reported 2 CNA staff are needed in lower level, that 1 CNA is not enough supervision or assistance with four residents who required 2 staff assistance to transfer. Staff I informed that if a resident wandered in hallway when both CNA staff were occupied, they would ask another staff in area to monitor the wandering behaviors while CNAs were in with other residents. Staff I informed that Resident #34 had not been on a toileting program but staff try to assist with toileting every two hours and watch for cues that resident may need to use restroom. On 07/08/24 at 02:15 PM, Staff J, Medication Aide, reported the lower level did not have enough supervision since more residents have admitted . Staff J informed that 2 CNA staff are required and 1 Nurse or Medication Aide were to float from upper to lower level. Staff J reported currently there are 2 residents whom wander in and out of rooms, one of which had tried to elope on multiple occasions. Staff J stated if 2 CNA staff were occupied in a room, they would try to check on resident before and after assisting other residents. On 07/08/24 at 02:29 PM, Staff K, CNA, reported staff would attempt to assist Resident #34 to restroom every 2 hours and if resident wandered, staff would check on her and try a distraction activity before going into a room. On 07/08/24 at 04:41 PM, the Director of Nursing (DON), revealed the expectation of staff to ensure safety and attempt to redirect residents whom wander. DON also expected staff to try and remain in common area when Resident #34 wanders in the area, or provide Resident #34 with an activity when occupied with other residents.

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	165322	A. Building B. Wing	07/09/2024

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Cottage Grove Place	2115 First Avenue SE Cedar Rapids, IA 52402

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on observation, interviews, clinical record review, and facility policy review, the facility failed to prime tubing prior to administration of enteral tube feeding and further failed to ensure the head of bed had been elevated to an appropriate level throughout administration of enteral feeding for 1 of 1 residents reviewed for feeding tube treatment and services (Resident #248). The facility reported a census of 53 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicative of moderate cognitive impairment. Diagnoses included cancer, malnutrition, and gastrostomy status. Resident #248 had documentation of coughing or choking during meals or when swallowing medications. Resident #248 required 51% or more proportion of total calories through tube feeding and 501 milliliters (mL) or more of average fluid intake per day by tube feeding. The Care Plan, initiated 06/27/24, revealed Resident #248 required tube feeding related to weight loss and cancer with the goal that resident will remain free of side effects or complications related to tube feeding. Staff instructed to check feeding tube placement and record results prior to use of tube and Administer Osmolyte 1.5 given per gravity three times per day. Resident #248 required 1 to 2 staff assistance for bed mobility and repositioning. The Medication Administration Record (MAR), dated July 2024, revealed a current order, initiated 06/27/24, for Osmolyte 1.5 (355.5 mL) enteral feeding three times a day via gastronomy tube (G-tube) by gravity. On 07/02/24 at 08:23 AM, Staff G, Licensed Practical Nurse (LPN) prepared Resident #248 tube feeing and Staff H Registered Nurse (RN) observed procedure. Staff G hung a bag for enteral feeding via pole and added 50 mL of room temperature water, tube unclamped, flush of water administered, and tube re-clamped. The tubing remained connected to Resident #248's G-tube, Staff G then poured Osmolyte nutritional supplement into the bag, unclamped the tubing, and administered 355.5 mL tube feeding. Tubing re-clamped after tube feeding administration, followed by a 50 mL water flush. Throughout administration of tube feeding, Resident #248 laid in bed, the head of bed remained slightly elevated at approximately 15 degrees. On 07/02/24 at 08:45 AM, Staff G reported they thought the head of bed had been elevated between 30 and 45 degrees. On 07/02/24 at 09:00 AM, Resident #248, observed in bed with head of bed elevated to 30 degrees at this time. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/08/24 at 04:41 PM, Director of Nursing (DON) revealed an expectation that tubing is primed with liquid prior to administration of tube feeding to prevent too much air entering the abdomen. The DON additionally revealed the expectation of staff to maintain resident's head of bed between 30 and 45 degrees, dependent upon how much resident can tolerate, throughout and following the administration of tube feeding. The facility policy titled Gastric Tube Feeding via Syringe (Bolus), not dated, instructed staff to elevate the head of bed at least 30 degrees during feeding and for 30 to 60 minutes after feeding unless contraindicated.

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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** 50874 Based on observation, resident, family, and staff interviews the facility failed to respond to call lights in a timely manner for 5 of 5 residents reviewed (Residents #42, #44, #251, #39, #203, #48). Facility reported a census of 53 residents. Findings include: 1. Resident #44's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. The MDS documented Resident #44 required substantial/maximal (the helper does more than half the effort. The helper lifts or holds trunk or limbs and provides more than half the effort) assistance for, toileting, bathing, and lower body dressing. The MDS listed diagnoses include hip fracture, hepatic encephalopathy, other cirrhosis of liver, and obesity. The Care Plan initiated on 5/30/2024 identified Resident #44 as alert and oriented. The Care Plan identified Resident #44 as needing assistance with transferring, toileting, bathing, and repositioning. On 07/01/24 at 1:27 PM, observed Resident #44 call light on. Staff answered the call light at 1:45 PM. 2. Resident #42's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating moderate cognitive impairment. The MDS documented Resident #42 as dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity). The MDS listed diagnoses of osteomyelitis, cancer, heart failure, pneumonia, and septicemia. The Skilled Evaluation dated 07/02/24 documented mental status as alert & oriented x3, communicated verbally, speech is clear, is able to understand and be understood when speaking. The Care Plan initiated on 5/6/24 documented that Resident #42 needed help with activities of daily living and required assist of 1 with bed mobility, transfers, walking, and toileting. During an interview on 6/30/24 at 12:32 PM, Resident #42 reported he sometimes waits between 20-45 minutes for staff to respond to his call light. Observed on 7/2/24 at 6:42 AM, an active call light for Resident #42. Staff answered the call light at 7:00 AM. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The Clinical Admission assessment dated [DATE] for Resident #251 documented Alert & Oriented x3, communicated verbally, speech is clear, is able to understand and be understood when speaking. The Resident #251 Admission Record listed diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, morbid (severe) obesity due to excess calories, and body mass index (BMI) 45-49.9. The Care Plan initiated on 6/26/24 identified cognition as orientated and required assistance of 2 people for toileting, bed mobility, and repositioning. During an interview on 6/30/24 at 12:29 PM with Resident #251, resident reported the facility is short staffed and it takes too long to answer call lights. During an interview on 7/2/24 at 2:09 PM, Director of Nursing (DON) reported staff should answer call lights within 15 minutes. DON reported the facility has no call light audits and their system does not save data. During an interview on 7/03/24 at 9:31 AM, the Administrator reported the facility has not audited call lights in a while and the system does not have reports to show call light times. Administrator reported staff should answer call lights in 15 minutes or less. 35434 4. The Minimum Data Set (MDS) assessment tool, dated 11/22/23, listed diagnoses for Resident #48 which included skin changes, diabetes, and non-Alzheimer's dementia, and listed the resident's Brief Interview for Mental Status (BIMS) score as 4 out of 15, indicating severely impaired cognition. On 7/3/24 at 11:15 a.m., via phone, Resident #48's representative stated staff did not answer call lights in a timely manner when his father was in a room in the basement. He stated staff could not visualize the call light and at times they had to wait 35 minutes to 1 hour. 5. The MDS assessment tool, dated 12/12/23, listed diagnoses for Resident #203 which included diabetes, hip fracture, and pain. The MDS listed the Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. On 7/1/24 at 2:02 p.m., via phone, Resident #203 stated she had to wait 20 minutes for staff to respond to her call light when she had to go to the bathroom.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35434 Based on clinical record review, policy review, and staff interview, the facility failed to ensure the provision of routine medications for 1 of 6 residents reviewed for medications (Resident #203). The facility reported a census of 53 residents. Findings include: The Minimum Data Set (MDS) assessment tool, dated 12/12/23, listed diagnoses for Resident #203 which included diabetes, hip fracture, and pain. The MDS listed the Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. The December 2023 Medication Administration Record (MAR) listed a 12/7/23 order for Rybelsus (a medication used to improve blood sugars) 7 milligrams daily. A Pharmacy Invoice, dated 12/31/23, listed a 12/6/23 order for Rybelsus. On 7/1/24 at 2:02 p.m., Resident #203 stated when she first arrived they had to use one of her own Rybelsus medications because they did not have it available. On 7/2/24 at 2:42 p.m., the pharmacy Director of Operations stated the pharmacy filled the resident's Rybelsus prescription on 12/6/23 but the facility did not sign for it until 12/8/23. He stated the pharmacy called the facility on 12/6/23 in order to get approval for the medication due to its cost. He stated they waited for the Director of Nursing to call them back and then called again on 12/7/23. He stated they received approval on 12/7/23 and the facility signed for the medication on 12/8/23. On 7/8/24 at 4:17 p.m., the Director of Nursing (DON) stated when they had an admission, they would fax the pharmacy and if the medication was expensive and required verification, they would do so. For skilled residents, the facility had to pay for those medications. The facility admission packet contained an undated section Freedom of Choice Pharmacy Services which stated the facility contracted with a pharmacy to provide pharmaceutical services to residents.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 35434 Based on clinical record review, policy review, and staff interviews, the facility failed to ensure the provision of Speech Therapy services for 1 of 1 residents reviewed for therapy services (Resident #48). The facility reported a census of 53 residents. Findings include: The Minimum Data Set (MDS) assessment tool, dated 11/22/23, listed diagnoses for Resident #48 which included skin changes, diabetes, and non-Alzheimer's dementia. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 4 out of 15, indicating severely impaired cognition. a. The Speech Therapy SLP Evaluation, dated 11/24/23, stated the resident's certification period was 11/24/23-12/21/23 for a duration of 6 weeks at a frequency of 12 times. A review of the Speech Therapy Treatment Encounter Notes revealed the resident received therapy on the following days: 11/24/23 11/28/23 12/5/23 12/12/23 12/20/23 12/26/23 The facility lacked documentation the resident received additional Speech Therapy treatments during the above certification period. b. The Speech Therapy SLP Evaluation, dated 2/13/24 , stated the resident's certification period was 2/13/24-3/13/24 for a duration of 30 days at a frequency of 8 times. A 2/25/24 Health Status Note stated the resident discharged to the hospital. A 3/1/24 Discharge Summary stated the resident discharged from therapy due to a discharge to the hospital. The facility lacked documentation of further Speech Therapy treatments completed between 2/13/24 and 2/25/24. A 2/13/24 Care Plan entry stated the resident received Speech Therapy for evaluation and treatment. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An untitled, undated facility policy stated therapists would provide rehabilitation services in accordance with physician orders. On 7/8/24 at 11:59 a.m., the Director of Therapy stated if a resident had an order for 12 visits during the certification period, staff should carry out that number of visits. She stated they had trouble staffing speech therapists. She stated she was not sure why the resident was not seen by therapy between 2/13/24 and 2/25/24. On 7/8/24 at 4:17 p.m., the Director of Nursing (DON) stated therapy should carry out the number of days/visits ordered.