STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165443	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Ji Vante	502 Butler Street Ackley, IA 50601

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interviews, and policy review the facility failed to notify the physician and family for a significant change in condition for 2 of 4 residents reviewed (Residents #1 and #4). The facility reported a census of 32 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS listed Resident #1 as independent with bed mobility. Resident #1 required partial/moderate assistance of one staff member with transfers and toilet use. The MDS described Resident #1 as ambulatory walking 10 feet and required a wheelchair for locomotion. The MDS documented Resident #1 had frequent incontinence of bowel and bladder. Resident #1's MDS included diagnoses of hypertension (high blood pressure), non - Alzheimer's dementia, depression, parkinsonism, paroxysmal atrial fibrillation (irregular heartbeat), and fibromyalgia (disorder that causes musculoskeletal pain/tenderness). The Facility Event Report dated 6/17/24 at 8:00 AM identified an unwitnessed fall in Resident #1's room. Someone observed Resident #1 lying on the floor next to her bed in a low position. Resident #1 had her feet under her bed with her head facing the door laying on her left side. Resident #1 reported she had pain but couldn't advise the location. The assessment revealed visible, old, healing bruises, yellow/green in color to ankle from a previous fall with no new skin areas noted. The note documented the staff would notify Resident #1's husband of her fall when he arrived at the facility. A Progress Note dated 6/18/24 at 10:45 PM documented a certified nurse aide (CNA) notified the nurse during report around 10:45 PM that Resident #1 had discoloration to the posterior (back) aspect of the right chin. Upon inspection, the area measured 3 x 5 not measurable in cm (centimeters), the area looked red and purple. Resident #1 denied pain. A Progress Note dated 6/19/24 at 10:58 PM documented the nurse spoke to the family regarding the Resident #1's recent fall. A Progress Note dated 6/21/24 at 9:00 AM reflected Resident #1 awake to take morning medications. She took them with applesauce and then coughed on the drink of water after. Resident #1 acted very confused with slurred speech, minimal urine output, inability to transfer, or even sit up unassisted. (continued on next page)

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	A Progress Note dated 6/21/24 at 9:01 AM indicated Resident #1's primary care provider (PCP) called. The nurse notified them regarding Resident #1's change in condition and new order received to send to emergency room (ER) for evaluation and treatment. Daughter informed about the new order and her condition. A Progress Note dated 6/21/24 at 10:51 AM documented Resident #1 left facility via ambulance for the ER with papers given to the Emergency Medical Technicians (EMTs). A Progress Note dated 6/21/24 at 1:30 PM identified the facility received a phone call from ER. Resident #1's labs and scans came back normal. The caller described Resident #1 as in and out of it while at the ER. The hospital would return Resident #1 to the facility via ambulance with no definitive diagnosis. A Progress Note dated 6/22/24 at 10:55 AM indicated Resident #1 had garbled speech and had difficultly making others understand. Resident #1 had difficulty swallowing medications and water that morning. She received her medications crushed and taken to the dining room for breakfast to monitor due to her difficulty swallowing. A Progress Note dated 6/22/24 at 1:47 PM reflected Resident #1's husband came to the facility at lunch time and sat with Resident #1 in her room for lunch. Resident #1 took her medications whole and swallowed quite a few times before getting them down but didn't need them crushed. Her speech remained garble but had some improvement. Resident #1's husband knew of her swallowing issues that morning. A Progress Note dated 6/22/24 at 9:38 PM documented Resident #1 required maximum assistance of two with activities of daily living (ADLs). Resident #1 had difficulty swallowing her bedtime medications but eventually got the medications down. Resident #1 had a dry oral cavity and cracked lips. She received oral cares and encouragement to drink. According to the note, it took several attempts for Resident #1 to figure out how to drink. Resident #1 blew air into the straw before she eventually started sucking water through the straw. A Progress Note dated 6/23/24 at 2:39 AM documented Resident #1 received crushed Tylenol in applesauce for complaints of mouth pain. Resident #1 had cracked lips with blood, staff cleaned her lips with a washcloth. Resident #1 couldn't drink water by herself and needed staff assistance. Resident #1 unable to suck properly from the straw. A Progress Note dated 6/23/24 at 11:09 AM documented Resident #1 wouldn't open her eyes but did communicate with the nurse. Resident #1's mouth and lips remained dry. Resident #1 received 2 smaller medications and sips of water. Resident #1 struggled to get the medications down and gargled on the water. The nurse crushed the rest of her medications in applesauce and then she could get the medications down. A Progress Note dated 6/23/24 at 8:04 PM documented Resident #1 had poor intake at supper, only eating strawberries and bananas. Resident #1 acted confused and had difficulty following instructions. A Progress Note dated 6/25/24 at 9:55 PM identified Resident #1's husband told the nurse Resident #1 didn't eat much of her dinner. The note indicated someone would offer her snack, if Resident #1 seemed to be hungry throughout the night. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility form titled Nursing Memo Form dated 6/28/24 at 3:20 AM documented the facility notified Resident #1's Physician of her difficulty swallowing thin liquids, dry/chapped lips, and she didn't have a BM since 6/20/24. She received a suppository on 6/27/24 with no results. A Progress Note dated 6/28/24 at 3:30 AM reflected Resident #1 received a small amount of thin liquids and immediately started coughing. Resident #1 didn't have bowel movement. A Progress Note dated 6/28/24 at 11:01 AM indicated the facility received a fax regarding Resident #1's current condition. The fax included new orders to send her medication list, speech therapy (ST) to evaluate and treat. In addition, apply Vaseline to upper and lower lips. A Progress Note dated 6/28/24 at 11:17 PM indicated the facility faxed Resident #1's Medication Administration Record (MAR) to Resident #1's PCP. The staff notified therapy and her husband of her new orders for ST. A Progress Note dated 6/28/24 at 6:56 PM documented Resident #1 had a 9.1% weight loss in 30 days, 11. 8% weight loss in 90 days and 10.4 % weight loss in 180 days. Weights as follows: a. 12/26 was 128.8 pounds (#) b. 1/30 was 134# c. 2/27 was 132.8# d. 3/26 was 130.8# e. 4/10 was 133.2# f. 5/28 was 127# g. 6/12 was 119.6# The progress note documented current weight 115.4# and a body mass index (BMI) 22.5. The note described Resident #1 as independent at meals and with a stable weight until 5/28/24 - 6/12/24. PO (by mouth) intakes have noted to have decreased since fall on 6/8/24; general decline potentially occurring. Resident #1 had an order for speech therapy and was coughing on small sips of thin liquid. Estimated needs include 1300 - 1560 kcals, 42 - 52 grams of protein, and 1500+ ml (milliliters) fluids per day. The dietician recommended a house supplement 4 ounces twice a day between meals. The clinical record lacked documented Resident #1's PCP or family wasn'tified regarding the weight loss. The clinical record reflected no one notified Resident #1 s Physician of her poor meal intakes, poor fluid intakes, and recent weight loss. Resident #1 started having difficulty swallowing on 6/20/24, went to the ER (emergency room) on 6/21/24 and returned to the facility. Resident #1 continued to have difficulty with swallowing with decreased oral intakes after returning from ER. The facility didn't notify Resident #1's Physician of the continued decline until 6/28/24, the day she received a new order for Speech therapy. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress Note dated 6/30/24 at 9:28 PM documented the staff encouraged Resident #1 to drink water throughout the shift. Resident #1 had difficulty swallowing medications with each medication pass, as she pocketed medications and held water under her tongue. Resident #1 didn't eat much dinner that evening. Family at bedside and encouraged fluids. The facility report titled Intake: Breakfast, Lunch, and Dinner from 6/1/24 to 7/1/24 listed meal intakes documented only on the following dates: 6/4/24 = Dinner - 76 - 100% 6/7/24 = Dinner 76 - 100% 6/8/24 = Dinner 26 - 50% 6/9/24 = Breakfast 76 - 100% 6/9/24 = Dinner 26 - 50% 6/12/24 = Dinner 26 - 50% 6/15/24 = Dinner 26 - 50% 6/16/24 = Dinner 26 - 50% 6/19/24 = Dinner 51 - 75% 6/21/24 = Dinner 26 - 50% 6/24/24 = Dinner 51 - 75% 6/25/24 = Dinner 26 - 50% 6/26/24 = Dinner - none 6/28/24 = Dinner - 26 - 50% 6/30/24 = Breakfast 26 - 50% The facility report titled Intakes: Fluids from 6/1/24 to 7/1/24 documented fluid intakes only on the following dates: 6/1/24 - 60 ml 6/2/24 - 450 ml 6/3/24 - 500 ml 6/4/24 - 150 ml (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/5/24 - 400 ml 6/6/24 - 300 ml 6/7/24 - 1400 ml 6/8/24 - 240 ml 6/9/24 - 50 ml 6/10/24 - 200 ml 6/11/24 - 500 ml 6/13/24 - 950 ml 6/14/24 - 500 ml 6/15/24 - 550 ml 6/16/24 - 50 ml 6/17/24 - 50 ml 6/19/24 - 1000 ml 6/21/24 - 450 ml 6/22/24 - 100 ml 6/24/24 - 590 ml 6/25/24 - 240 ml 6/26/24 - 400 ml 6/27/24 - 50 ml 6/28/24 - 100ml 6/29/24 - 50 ml 6/30/24 - 50 ml 7/1/24 - 50 ml (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/24 at 4:00 PM, Staff B, Registered Nurse (RN), reported on 6/19/24 Resident #1's daughter spoke to her regarding concerns about a bruise on her mom's chin. Staff B stated she looked into the concerns and told the daughter the clinical record documentation. Staff B stated Resident #1's daughter reported no one notified the family of her fall on 6/17 that resulted in the bruise on the Resident #1's chin. Staff B stated she apologized to the daughter and spoke to the Director of Nursing (DON) and Assistant Director of Nursing (ADON) about the family's concern. She stated she passed it on in report to notify the family or leave a message. On 7/10/24 at 9:30 AM, the DON reported she would expect the staff to notify the family within 48 hours of a condition change or identification of the change. The DON acknowledged the family learned of the fall from 6/17/24 on 6/19/24 when they questioned how Resident #1 received a bruise on her chin. On 7/10/24 at 9:30 AM, the DON knew about Resident #1's weight loss. The DON stated the Nurse Manager received the information on Friday, 6/28/24 and she re-sent the information via email to the Nurse Manager on Monday, 7/1/24 to address. The DON reported with swallowing difficulties she would expect the nurses to assess the situation, notify the provider right away and follow what they advise. She stated she expected someone to notify the provider prior to 6/28/24 regarding Resident #1's swallowing difficulties. 2. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #4 required supervision/touching assistance with bed mobility. Resident #4 required partial/moderate assistance of one staff member with transfers and toilet use. The MDS indicated Resident #4 was ambulatory walking 50 feet and required a wheelchair for locomotion. Resident #4's MDS included diagnoses of pneumonia, diabetes mellitus, COPD (chronic obstructive pulmonary disease), dementia, and intellectual disabilities. A Progress Note dated 7/2/24 at 1:04 PM documented Resident #4 had an unwitnessed fall in her room. The note reflected when found Resident #4 sat on her bottom in front of her table. The assessment found her skin free of injury. A Progress Note date 7/2/24 at 9:56 PM documented Resident #4 had a bruise to her right flank. Resident #4 stated, I knew I was going to get a bruise from my fall. The clinical record lacked documentation that the facility notified Resident #4's Physician or family/resident representative of her bruise to the right flank identified after the fall. On 7/11/24 at 2:52 PM, Staff C, Regional Nurse Consultant (RNC), confirmed she couldn't locate the physician or family notification for Resident #4's bruise to her right flank. Staff C reported they expected the facility notify the family and physician of a bruise that occurred related to a fall. A facility policy titled Resident Representative and PCP Notification dated 11/16/23 directed to notify the Resident representative in person or by phone as soon as possible of the following: a. Changes in physician's orders occurring between approximately 8 AM - 10 PM. b. Serious injury or significant change of condition unless otherwise specified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. ED visits or hospitalization d. Incident that occur after 10 PM, notify on the following day i. Fall without injury ii. Routine changes in PCP orders e. The facility will notify the PCP in person or by phone as soon as possible (ASAP) of the following: i. Serious injury or significant change of condition ii. Falls resulting in head injury of resident on anticoagulants iii. ED visits or hospitalization iv. Critical labs/x - rays v. Death f. Requests for immediate changes in treatment. i. An accident - causing injury and has the potential for needing physician intervention. ii. A deterioration in health, mental or psycho - social status in either life-threatening conditions or clinical complications. g. The facility may notify the PCP by fax for the following: i. Falls without injury ii. Requests for routine changes in physician's orders h. The facility will call about Issues falling outside of these parameters to the PCP and resident representative. i. The facility should review the resident's wishes with the resident/representative and physician prior to decision being made for hospital transfers.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on observations, staff, and family interviews the facility failed to provide a safe, clean, comfortable environment for 1 of 4 residents reviewed (Resident #1) for a homelike environment. The facility reported a census of 32 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #1 was independent with bed mobility. Resident #1 required partial/moderate assistance of one staff member with transfers and toilet use. The MDS indicated Resident #1 was ambulatory walking 10 feet and required a wheelchair for locomotion. The MDS documented Resident #1 had frequent incontinence of bowel and bladder. Resident #1's MDS included diagnoses of hypertension (high blood pressure), non-Alzheimer's dementia, depression, parkinsonism, paroxysmal atrial fibrillation (irregular heartbeat), and fibromyalgia (disorder that causes musculoskeletal pain/tenderness). The Resident Census tab reflected Resident #1's admitted [DATE] to room [ROOM NUMBER] - 1. Resident #1 discharged from the facility on 7/1/24. On 7/11/24 at 9:14 AM, Resident #1's daughter reported when they picked up her mom's belongings on July 4th, it was the first time she saw a cleaning cart the entire time her mom lived at the facility, she described her mom's room as dirty. She reported when she visited her mom, her son like to take off his shoes and by the time they left her son's feet were black. On 7/11/24 at 11:10 AM observation of room [ROOM NUMBER] - 1 revealed the room not cleaned after Resident #1 discharged from the facility on 7/1/24. Observed personal hygiene items, washcloths, towels, bedpans and a full-body mechanical lift in the bathroom. On the wall and light fixture on the left side of the room behind the bedside table, observed dried splattered substance that ran down the wall. The base of the toilet in the bathroom appeared dirty with dust particles and a dried brown substance. The corner wall behind the toilet had a spider web with a small spider in it. The floor in the bathroom and main living area was dirty with dust and debris particles. The base boards in the bathroom looked scratched up and dirty. The window seal and window shelf had a large amount of dust. Observed between the glass window and window screen spider webs with two large spiders. On 7/11/24 at 11:20 AM, Staff J, Housekeeping Supervisor, acknowledged the room wasn't clean. She reported she waited to make sure the family picked up all the belongings. She acknowledged the dry substance on the light fixture/wall, spiders, and dust build up. Observed a large amount of dust particles on Staff J's hand after she ran her hand along what window ledge/shelf. She acknowledged having challenges with housekeeping staff in June. She reported a week and half ago she started to have a housekeeper daily 7 days a week. She stated prior to that it was whoever was available to do it. She stated she did some of the housekeeping herself. She reported her normal housekeeper needed off for a period of time due to an injury. Staff J brought a housekeeper in the room and showed her the areas that needed cleaned and asked her to suck out the spiders from the windows and back of the toilet. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/24 at 12:20 PM, Staff J agreed the room [ROOM NUMBER] - 1 condition and cleanliness wasn't acceptable. She reported when she runs her hand along the window edge she shouldn't get dust on her hand. Staff J stated Room Cleaning Policy needed changes. The facility provided a To - Do List for daily cleaning to clean resident's rooms directed the following: - Resident bathrooms and trash daily - Room dust, sweep and mop 1 to 2 times a week The Environmental Service policy dated April 2024 instructed the facility to ensure cleanliness in all areas of the nursing center. In addition, the policy directed to thoroughly clean the resident rooms with the following procedure: - Empty wastebaskets, replace liner - Wipe down all bathroom fixtures with correct cleaning solution including sink, counter areas, resident provided fixtures, furniture, handrails, or equipment - Clean stool with correct cleaning solution - put cleaning solution in stool, brush to clean, flush - wipe off rim, seat, and entire outer shell of stool - Clean mirror - Wipe and clean light fixtures - Wash window as needed - Clean fill soap dispenser - Clean and fill towel dispenser - Wipe down wall walls of bathroom as needed - Wipe down shelves, end table, nightstand, bed, ect. Including legs - Wet mop restroom - Wet mop living area/vacuum

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F 0689 Level of Harm - 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** 46875 Based on clinical record review, staff interviews, and policy review the facility failed to provide adequate nursing supervision to prevent accidents and injuries for 1 of 4 residents reviewed (Resident #1) for falls. Resident #1 had four falls in the month of June. Resident #1 experienced a right ankle injury and a skin tear/bruise to right elbow when a fall resulted from the facility not providing the appropriate level of assistance per therapy recommendations. The facility reported a census of 32 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #1 was independent with bed mobility. Resident #1 required partial/moderate assistance of one staff member with transfers and toilet use. The MDS indicated Resident #1 was ambulatory walking 10 feet and required a wheelchair for locomotion. The MDS documented Resident #1 had frequent incontinence of bowel and bladder. Resident #1's MDS included diagnoses of hypertension (high blood pressure), non-Alzheimer's dementia, depression, parkinsonism, paroxysmal atrial fibrillation (irregular heartbeat), and fibromyalgia (disorder that causes musculoskeletal pain/tenderness. The Facility Event Reports and observation notes documented June 2024 reflected Resident #1 fell on the following dates: a. 6/8/24 b. 6/17/24 c. 6/21/24 d. 6/27/24 Resident #1's Fall Risk assessment dated [DATE] identified a score of 17, indicating Resident #1 had a risk for falls related to impaired mobility, required used of an assisted device, required staff assistance, had a history of falls, the use of high risk medications, unsteady gait/balance, and diagnosis of Parkinson's, atrial fibrillation (irregular heart rate), dementia, hallucinations (hearing or seeing things not there), restless leg syndrome, insomnia, hypertension (high blood pressure), fibromyalgia (undetermined cause of pain), disorders of bone density/structures, retentions of urine and weakness. The clinical record lacked a fall risk evaluation after 1/14/24 until 6/27/24. The fall risk score on 6/27/24 identified a score of 19, indicating Resident #1 had a risk for falls. According to the evaluation a score of 10 or higher represented a high risk for falls. A Physician Order dated 5/21/24 directed for Physical Therapy, Occupational Therapy, and Speech Therapy complete an evaluation and treatment for Resident #1 due to Parkinson's and falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Physical Therapy Note dated 6/6/24 documented Resident #1 required maximum assistance of one with a sitting to standing. Resident #1 had a retro lean and needed assistance to stay on her feet and keep hands on the walker. Resident #1 needed assistance with cross over steps and stutter steps to manage her walker. When in the bathroom, Resident #1 required dependent guided sitting motion to sit. Once sitting, Resident #1 had 6 episodes of spasms resulting in becoming stiff and twitching. Resident #1 required maximum assistance of one staff member to sit to stand post toilet use and a second staff member to complete cares. Resident #1 needed moderate assistance of two staff members to ambulate to recliner, one to manage Resident #1, one to manage the walker, and leg movement. The Physical Therapist called the nursing staff to Resident #1's room to attempt to observe spasms/tone episodes. The Physical Therapy Assistant (PTA) and Certified Nurse Aide (CNA) reported incident as the worst they seen. The PTA recommended two staff members assist Resident #1 and not left alone in bathroom due to fear Resident #1 would have an episode and thrust herself off the toilet as the PTA had to stop her from doing that twice. A Facility Therapy Communication Form dated 6/6/24 recommended 2 staff assist Resident #1 and not leave Resident #1 alone in the bathroom during toilet use. A Progress Note dated 6/6/24 at 1:57 PM documented per therapy, reflected Resident #1 needed assistance of 2 staff and if she used the toilet, don't leave her unattended in her bathroom. Resident #1 had tremors that could cause her to fall off the toilet. A Progress Note dated 6/7/24 at 10:52 AM documented they received therapy communication to use 2 assist and don't leave alone in the bathroom. Care plan updated. The Facility Event Report dated 6/8/24 at 1:20 PM identified a witnessed fall in Resident #1's room. The report documented the CNA and Resident #1's husband walked her to the restroom when her legs spasmed, buckled, and they had to lower her to the ground. Resident #1 didn't hit her head and the staff assisted her into the recliner. The nurse noted a small skin tear to her right elbow. The nurse called Resident #1's Primary Care Provider (PCP) and received a new order to send Resident #1 to the emergency room (ER) for evaluation and treatment. The report lacked any further fall interventions except for the ER transfer. A Progress Note dated 6/8/24 at 6:45 PM reflected Resident #1 returned via ambulance at 5:50 PM with her husband. She had new orders start cephalexin (antibiotic) 500 mg (milligrams) four times a day for a urinary tract infection (UTI). A written statement dated 6/8/24 completed and signed by Staff A indicated she answered Resident #1's call light at 1:15 PM. When she arrived, she saw Resident #1's husband present and requested Resident #1 go back to the recliner. Staff A documented she positioned Resident #1 close to her recliner so she could do a pivot transfer and put a gait belt on her. Staff A documented when she transferred Resident #1 she didn't cooperate very well and she had to lower Resident #1 down on the floor as safely as she could. Staff A noted in her statement, Resident #1's Care Plan indicated Resident #1 required assistance of one staff member with a walker or wheelchair. A Progress Note dated 6/9/24 at 2:00 AM documented the CNA called nurse into Resident #1's room. The CNA seen Resident #1 left ankle black and blue, swollen with increased warmth. The nurse gave Resident #1 Tylenol (pain medication) for her pain. (continued on next page)

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Grand Ji Vante	502 Butler Street Ackley, IA 50601

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Progress Note dated 6/9/24 at 9:53 AM documented mild swelling and slight bruising observed on Resident #1's right outer ankle. Resident #1 denied pain with palpation and range of motion. The nurse sent a fax to the PCP to advise on swelling and bruising. A Facility Nursing Memo Form dated 6/9/24 at 9:30 AM documented Resident #1's husband and a staff member lowered her to the floor when she fell on [DATE]. The fax documented the fall assessment revealed only an injury as a skin tear to the right elbow with some mild bruising. The overnight nurse observed swelling and mild bruising to Resident #1's outer right ankle. Resident #1's had range of motion within normal limits and no pain reported with palpation or movement. Resident #1 denied pain when asked. Resident #1 remained assist of two with transfers. The PCP responded to the fax on 6/10/24. The PCP documented urine culture positive, awaiting final results for UTI treatment, discontinue melatonin (sleep aid), and to monitor. The Clinical record lacked documentation regarding an x-ray or diagnosis for the right ankle injury. The Facility Pocket Care Plan dated 6/11/24 directed one staff member with a walker or wheelchair help with transfers and ambulation. The pocket care plan lacked the therapy recommendations from 6/6/24. The Facility Event Report dated 6/17/24 at 8:00 AM identified an unwitnessed fall in Resident #1's room. Someone observed Resident #1 lying on the floor next to her bed in a low position. Resident #1 had her feet under her bed with her head facing the door laying on her left side. Resident #1 reported she had pain but couldn't advise the location. The assessment revealed visible, old, healing bruises, yellow/green in color to ankle from a previous fall with no new skin areas noted. The note documented the staff would notify Resident #1's husband of her fall when he arrived at the facility. A Progress Note dated 6/18/24 documented Resident #1 continued to decline to transfer. Resident #1 downgraded to use full - body mechanical lift for transfer as needed per nursing judgment. A Progress Note dated 6/18/24 at 10:45 PM documented a certified nurse aide (CNA) notified the nurse during report around 10:45 PM that Resident #1 had discoloration to the posterior (back) aspect of the right chin. Upon inspection, the area measured 3 x 5 not measurable in cm (centimeters), the area looked red and purple. Resident #1 denied pain. A Progress Note dated 6/19/24 at 10:58 PM documented the nurse spoke to the family regarding the Resident #1's recent fall. The Facility Event Report dated 6/21/24 at 4:00 PM identified Resident #1 had an unwitnessed fall. The report lacked documentation regarding the event detail, subjective data obtained from the resident, environment details, pain observation, body observation, mental status, possible contributing factors and immediate intervention taken. The Progress Note dated 6/21/24 at 4:00 PM documented the CNA notified the nurse that Resident #1 fell . The nurse discovered Resident #1 laying on the floor beside her bed on her left side facing her nightstand. Resident #1 reported she tried to get from there to go to the bookcase. Neurological checks within normal limits. Resident #1 had two new open injuries, a small skin tear to her left anterior (front) forearm and to her right toe. The progress note lacked a fall intervention. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Observation Detail List report dated 6/27/24 at 1:45 PM identified Resident #1 slid out of her wheelchair due to restless legs and she didn't receive any injuries. The Progress Note dated 6/27/24 at 1:59 PM documented someone called the nurse Resident #1's room due to her being on the floor. Resident #1's husband was present with the fall and reported she had one of her restless leg episodes and slid out of her wheelchair. Resident #1 denied pain or discomfort. Resident #1 required assistance of three staff members with a gait belt to assist the recliner. The new intervention directed to apply a Dycem (nonslip mat) in the wheelchair. The Care Plan revised 5/29/24 lacked documented fall interventions from 6/21/24 and 6/27/24. On 7/9/24 at 11:45 AM, Staff A, CNA, described Resident #1 as very hard to take care of due to her flopping around. She stated she didn't know if she had seizures or anxiety. She stated they tried to calm Resident #1 down so they could transfer her. She stated when she first started working at the facility in June, Resident #1 required assistance of 1 with a gait belt and a walker. Staff A reported she had to lower Resident #1 to the floor during a transfer. Staff A stated she did everything according to the care plan. She reported the husband in the room at the time of the fall. Staff A reported she called for a nurse after lowering Resident #1 to the floor. Staff A reported after Resident #1's first fall in June, they changed her to an assist of 2 with transfers. On 7/9/24 at 4:00 PM, Staff B, Registered Nurse (RN), reported on 6/19/24 Resident #1's daughter spoke to her regarding concerns about a bruise on her mom's chin. Staff B stated she looked into the concerns and told the daughter the clinical record documentation. Staff B stated Resident #1's daughter reported no one notified the family of her fall on 6/17 that resulted in the bruise on the Resident #1's chin. Staff B stated she apologized to the daughter and spoke to the Director of Nursing (DON) and Assistant Director of Nursing (ADON) about the family's concern. She stated she passed it on in report to notify the family or leave a message. On 7/10/24 at 9:30 AM, Staff C, Regional Nurse Consultant (RNC), reported she expected the pocket Care Plan to reflect the therapy recommendation. She stated she expected the Nurse Managers to update the Care Plan and expected the CNAs to follow the pocket Care Plan. On 7/10/24 at 9:30 AM, the DON reported she would expect the staff to notify the family within 48 hours of a condition change or identification of the change. The DON acknowledged the family learned of the fall from 6/17/24 on 6/19/24 when they questioned how Resident #1 received a bruise on her chin. On 7/10/24 at 12:31 PM, Staff C confirmed Resident #1's husband wouldn't count as a second person for a transfer. Staff C reported the facility discussed falls in the morning meeting daily. She stated the team looked to see if interventions are in place. The nurse managers had the responsibility for adding the interventions to the Care Plan. Staff C reported the interventions reflected the root cause analysis and discussed verbally. Staff C reported the fall on 6/27/24, the nurse filled out an observation report instead of the event report which is what the facility uses for an incident report. Staff C confirmed Care Plan didn't include the fall intervention of a Dycem. On 7/11/24 at 2:07, Staff C reported she couldn't locate any additional fall risk assessments for Resident #1 since January 2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Incident/Accident Prevention policy dated April 2024 described the purpose of the policy to ensure that the resident's environment remained as free of accidents as possible, the resident received adequate supervision, and assistance devices to prevent accidents. The procedure consisted of the following: 1. Upon admission, the nurse completed a fall risk assessment and updates it quarterly with the MDS/Care Plan review thereafter. The facility should consider Interventions upon admission. 2. The DON and Administrator would review fall incidents 3 - 5 times per week and evaluate the Interventions appropriateness. 3. The staff will monitor the residents visually per the Care Plan. 4. When restless, assess the resident's need to reposition, assistance to the bathroom, assist with ambulation, provide a diversionary activity, 1:1 attention, snacks, drinks, or any verbal expressed needs from the residents. 5. The Care Plan will include fall interventions, available to caregivers. 6. The facility will review and modify fall interventions after each fall.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on staff interviews, clinical record review, hospital record review, family interviews, and policy review the facility failed to conduct appropriate assessments, interventions and timely Physician notification for 1 of 4 resident reviewed (Resident #1). Resident #1 experienced difficulty swallowing, poor oral intake, and mouth pain that resulted in weight loss and a hospitalization from [DATE] to [DATE] for acute kidney injury, dehydration (inadequate fluid intakes) and pharyngitis/MRSA (Methicillin - resistant Staphylococcus Aureus - staph infection resistant to several antibiotic to the throat). Resident #1 started having difficulty swallowing on [DATE], went to the ER (emergency room) on [DATE] and returned to the facility. Resident #1 continued to have difficulty with swallowing with decreased oral intakes after returning from ER. The facility didn't notify Resident #1's primary care provider (PCP) of her continued decline until [DATE] when the gave an order for Speech therapy. The facility reported a census of 32 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #1 required set up or clean up assistance with eating and oral hygiene. Resident #1 required partial/moderate assistance of one staff member with transfers and toilet use. The MDS indicated Resident #1 was ambulatory walking 10 feet and required a wheelchair for locomotion. The MDS coded Resident #1 didn't have a 5% weight loss in the last month or 10 % weight loss in the last 6 months. Resident #1's MDS included diagnoses of hypertension (high blood pressure), non-Alzheimer's dementia, depression, parkinsonism, paroxysmal atrial fibrillation (irregular heartbeat), and fibromyalgia (disorder that causes musculoskeletal pain/tenderness). Resident #1's Iowa Physician Orders for Scope Treatment (IPOST) dated [DATE], signed by Resident #1 and her PCP reflected she requested CPR (cardiopulmonary resuscitation) and full treatment, including the use of intubation, advanced airway intervention, mechanical ventilation, and cardioversion (machine-initiated restart of the heart) as indicated. In addition, she wished to transfer to the hospital if indicated, including critical care. Review of Physician Order dated [DATE] documented Resident #1 received a regular diet, regular texture with thin liquids, and crush medications unless contraindicated. Review of General Nursing POC (Point of Care) - Tasks dated [DATE] directed the staff to document breakfast, lunch and dinner intakes daily along with offering then documenting a bedtime snack. The Hydration Special Instructions directed the staff to document liquids in cc (cubic centimeter) consumed with meals. Resident #1's Nutritional status Care Plan revised/reviewed [DATE] documented her long-term goal as to maintain her current weight within 5 pounds (#). The Care Plan directed the following nutritional approaches/interventions all dated [DATE]: 1. Acknowledge to Resident #1 that her needs are unique. Convey a willingness to provide acceptable foods. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	2. Assist with meal set up and feeding if needed. Monitor for choking or swallowing problems. 3. Monitor bowel sounds as needed (PRN) and document bowel movements. Report nausea to the nurse. 4. Monitor food and fluid intakes with meals and offer snacks. 5. Provide adaptive equipment as needed. 6. Provide diet as ordered and foods of preference. 7. Provide the resident with as much control as possible in routines, food preferences, etc. 8. Record weight and reported changes if greater than 5# to Physician. A Physician Order dated [DATE] directed for Physical Therapy, Occupational Therapy, and Speech Therapy complete an evaluation and treatment for Resident #1 due to Parkinson's and falls. A Progress Note dated [DATE] at 1:46 AM documented Resident #1 returned from her appointment with new orders for PT, OT, ST for Parkinson's disease and falls. A Progress Noted dated [DATE] at 1:39 PM documented the Physical Therapy Assistant (PTA) at the facility. The staff informed her in person regarding Resident #1's new orders for PT, OT and ST therapy. The Clinical Record lacked documentation Resident #1 received a Speech Therapy evaluation and treatment per the Physician order. A Progress Note dated [DATE] at 4:00 AM documented Resident #1 didn't want to drink water. Resident #1's lips and mouth appeared very dry. When the staff attempted to apply mouth/lip moisturizer, Resident #1 became upset. A Progress Note dated [DATE] at 9:40 PM documented the Certified Nurse Aide (CNA) notified the nurse that Resident #1 had discoloration to bilateral lower extremities. The nurse assessed Resident #1 and discovered discoloration of yellow/brown in color. Resident #1 denied complaints of pain or discomfort. Resident #1's husband updated and the nurse notified the PCP by fax. A Progress Note dated [DATE] at 7:26 AM documented Resident #1 in bed resting, mumbling incoherently, unable to hold a conversation, and unable to answer questions. The note documented the night staff reported that during the night shift, Resident #1 couldn't swallow fluids and the fluids ran out the side of her mouth. The dayshift reported the previous day during the day, Resident #1 didn't void. The note included vital signs of blood pressure ,d+[DATE], pulse 74 beats per minute, respirations 18 breaths per minute, temperature 97.3 degrees Fahrenheit (F), and pulse ox (oxygen in blood) 98% on room air. New order received to obtain a urinalysis with culture and sensitivity (UA with cs), and they could obtain the urine via straight catheter if needed. The staff notified Resident #1's husband. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A Progress Note dated [DATE] at 9:00 AM reflected Resident #1 awake to take morning medications. She took them with applesauce and then coughed on the drink of water after. Resident #1 acted very confused with slurred speech, minimal urine output, inability to transfer, or even sit up unassisted. A Progress Note dated [DATE] at 9:01 AM indicated Resident #1's primary care provider (PCP) called. The nurse notified them regarding Resident #1's change in condition and new order received to send to emergency room (ER) for evaluation and treatment. Daughter informed about the new order and her condition. A Progress Note dated [DATE] at 10:51 AM documented Resident #1 left facility via ambulance for the ER with papers given to the Emergency Medical Technicians (EMTs). A Progress Note dated [DATE] at 1:30 PM identified the facility received a phone call from ER. Resident #1's labs and scans came back normal. The caller described Resident #1 as in and out of it while at the ER. The hospital would return Resident #1 to the facility via ambulance with no definitive diagnosis. A Progress Note dated [DATE] at 10:55 AM indicated Resident #1 had garbled speech and had difficulty making others understand. Resident #1 had difficulty swallowing medications and water that morning. She received her medications crushed and taken to the dining room for breakfast to monitor due to her difficulty swallowing. A Progress Note dated [DATE] at 1:47 PM reflected Resident #1's husband came to the facility at lunch time and sat with Resident #1 in her room for lunch. Resident #1 took her medications whole and swallowed quite a few times before getting them down but didn't need them crushed. Her speech remained garble but had some improvement. Resident #1's husband knew of her swallowing issues that morning. A Progress Note dated [DATE] at 9:38 PM documented Resident #1 required maximum assistance of two with activities of daily living (ADLs). Resident #1 had difficulty swallowing her bedtime medications but eventually got the medications down. Resident #1 had a dry oral cavity and cracked lips. She received oral cares and encouragement to drink. According to the note, it took several attempts for Resident #1 to figure out how to drink. Resident #1 blew air into the straw before she eventually started sucking water through the straw. A Progress Note dated [DATE] at 2:39 AM documented Resident #1 received crushed Tylenol in applesauce for complaints of mouth pain. Resident #1 had cracked lips with blood, staff cleaned her lips with a washcloth. Resident #1 couldn't drink water by herself and needed staff assistance. Resident #1 unable to suck properly from the straw. A Progress Note dated [DATE] at 11:09 AM documented Resident #1 wouldn't open her eyes but did communicate with the nurse. Resident #1's mouth and lips remained dry. Resident #1 received 2 smaller medications and sips of water. Resident #1 struggled to get the medications down and gargled on the water. The nurse crushed the rest of her medications in applesauce and then she could get the medications down. A Progress Note dated [DATE] at 8:04 PM documented Resident #1 had poor intake at supper, only eating strawberries and bananas. Resident #1 acted confused and had difficulty following instructions. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A Progress Note dated [DATE] at 1:47 PM documented Resident #1 as sitting up in a wheelchair with her husband visiting. Resident #1 acted incoherent with terminal restlessness. A Progress Note dated [DATE] at 9:55 PM identified Resident #1's husband told the nurse Resident #1 didn't eat much of her dinner. The note indicated someone would offer her snack, if Resident #1 seemed to be hungry throughout the night. A facility form titled Nursing Memo Form dated [DATE] at 3:20 AM documented the facility notified Resident #1's Physician of her difficulty swallowing thin liquids, dry/chapped lips, and she didn't have a BM since [DATE]. She received a suppository on [DATE] with no results. A Progress Note dated [DATE] at 3:30 AM reflected Resident #1 received a small amount of thin liquids and immediately started coughing. Resident #1 didn't have bowel movement. A Progress Note dated [DATE] at 11:01 AM indicated the facility received a fax regarding Resident #1's current condition. The fax included new orders to send her medication list, speech therapy (ST) to evaluate and treat. In addition, apply Vaseline to upper and lower lips. A Progress Note dated [DATE] at 11:17 PM indicated the facility faxed Resident #1's Medication Administration Record (MAR) to Resident #1's PCP. The staff notified therapy and her husband of her new orders for ST. A Progress Note dated [DATE] at 6:56 PM documented Resident #1 had a 9.1% weight loss in 30 days, 11. 8% weight loss in 90 days and 10.4 % weight loss in 180 days. Weights as follows: a. ,d+[DATE] was 128.8 pounds (#) b. ,d+[DATE] was 134# c. ,d+[DATE] was 132.8# d. ,d+[DATE] was 130.8# e. ,d+[DATE] was 133.2# f. ,d+[DATE] was 127# g. ,d+[DATE] was 119.6# The progress note documented current weight 115.4# and a body mass index (BMI) 22.5. The note described Resident #1 as independent at meals and with a stable weight until [DATE] - [DATE]. PO (by mouth) intakes have noted to have decreased since fall on [DATE]; general decline potentially occurring. Resident #1 had an order for speech therapy and was coughing on small sips of thin liquid. Estimated needs include 1300 - 1560 kcals, 42 - 52 grams of protein, and 1500+ ml (milliliters) fluids per day. The dietician recommended a house supplement 4 ounces twice a day between meals. The clinical record lacked documented Resident #1's PCP or family wasn'tified regarding the weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The clinical record reflected no one notified Resident #1 s Physician of her poor meal intakes, poor fluid intakes, and recent weight loss. Resident #1 started having difficulty swallowing on [DATE], went to the ER (emergency room) on [DATE] and returned to the facility. Resident #1 continued to have difficulty with swallowing with decreased oral intakes after returning from ER. The facility didn't notify Resident #1's Physician of the continued decline until [DATE], the day she received a new order for Speech therapy. The facility failed to document interventions to help with self-feeding and improve oral intakes such as weighted silverware, divide plates, or handled cups with lids. The Care Plan lacked additional interventions related to self-feeding. A Progress Note dated on [DATE] at 6:46 PM documented a new order for Resident #1 to receive Miralax 17 grams daily for constipation. A Progress Note dated [DATE] at 9:28 PM documented the staff encouraged Resident #1 to drink water throughout the shift. Resident #1 had difficulty swallowing medications with each medication pass, as she pocketed medications and held water under her tongue. Resident #1 didn't eat much dinner that evening. Family at bedside and encouraged fluids. The facility report titled Intake: Breakfast, Lunch, and Dinner from [DATE] to [DATE] listed meal intakes documented only on the following dates: [DATE] = Dinner - 76 - 100% [DATE] = Dinner 76 - 100% [DATE] = Dinner 26 - 50% [DATE] = Breakfast 76 - 100% [DATE] = Dinner 26 - 50% [DATE] = Dinner 26 - 50% [DATE] = Dinner 26 - 50% [DATE] = Dinner 26 - 50% [DATE] = Dinner 51 - 75% [DATE] = Dinner 26 - 50% [DATE] = Dinner 51 - 75% [DATE] = Dinner 26 - 50% [DATE] = Dinner - none [DATE] = Dinner - 26 - 50% (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	[DATE] = Breakfast 26 - 50% The facility report titled Intakes: Fluids from [DATE] to [DATE] documented fluid intakes only on the following dates: [DATE] - 60 ml [DATE] - 450 ml [DATE] - 500 ml [DATE] - 150 ml [DATE] - 400 ml [DATE] - 300 ml [DATE] - 1400 ml [DATE] - 240 ml [DATE] - 50 ml [DATE] - 200 ml [DATE] - 500 ml [DATE] - 950 ml [DATE] - 500 ml [DATE] - 550 ml [DATE] - 50 ml [DATE] - 50 ml [DATE] - 1000 ml [DATE] - 450 ml [DATE] - 100 ml [DATE] - 590 ml [DATE] - 240 ml [DATE] - 400 ml (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	[DATE] - 50 ml [DATE] - 100ml [DATE] - 50 ml [DATE] - 50 ml [DATE] - 50 ml A Progress Note dated [DATE] at 12:00 PM documented the facility received a phone call from Resident #1's PCP. The PCP reported the family had concerns from the weekend regarding Resident #1 not acting like herself and having a sore throat. The nurse informed the PCP that Resident #1 had a general decline recently and the staff discussed hospice care with her husband. The PCP provided a new order to transfer Resident #1 to the ER for evaluation and treatment. A Progress Note dated [DATE] at 12:30 PM, the facility sent Resident #1 to the ER by the facility van for evaluation and treatment per family request. A Progress Note dated [DATE] at 9:36 AM documented the hospital admitted Resident #1 for acute renal failure and dehydration. The Hospital Discharge Summary dated [DATE] documented they admitted Resident #1 on [DATE] for acute kidney injury (AKI). The hospital determined the AKI to be prerenal due to decreased oral intakes. Resident #1 received IV fluids with good urinary output and the AKI resolved. Speech therapy followed Resident #1 during the hospital stay for dysphagia (difficulty swallowing). The staff advanced Resident #1's diet to a pureed diet with regular thin liquids. She tolerated the diet change well. Resident #1 received treatment for MRSA pharyngitis (antibiotic resistant bacteria in the throat) with clindamycin (antibiotic) based on the culture and sensitivity report. The hospital contacted Resident #1's neurologist, who recommended to continue with the current medication regimen and follow-up in September. On [DATE] at 11:33 AM, Staff D, Licensed Practical Nurse (LPN), reported Resident #1 had Parkinson's and restless legs. She described her as very restless and shaky. Staff D stated Resident #1's eating was going downhill. She stated Resident #1's intake and swallowing got worse, she felt Resident #1 was declining. Staff D reported management tried to talk to the family about her decline but felt the family were in denial. Staff D stated Resident #1 had very dry lips and complained about one area on the corner of her lip. Staff D reported Resident #1 had a physician's order for Vaseline for her lips. Staff D reported the 3rd shift nurse had sent out a fax about Resident #1's difficulty swallowing and her dry lips. Staff D reported Resident #1 took her pills whole in applesauce and struggled a little bit to take them. Staff D reported Resident #1 came out to eat in the dining room at lunch and stayed in her room for breakfast. She reported she didn't know what she did at supper time. She stated Resident #1 fell asleep a lot during breakfast and that Staff D went in her room to give her encouragement to wake her up. Staff D stated she told the aides if Resident #1 needed assistance with eating. Staff D reported she didn't think Resident #1 had adaptive equipment for her shakes and jerks. (continued on next page)

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	165443	A. Building B. Wing	07/11/2024

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Grand Ji Vante	502 Butler Street Ackley, IA 50601

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 11:45 AM, Staff A, CNA, reported Resident #1 liked to sleep in during breakfast so she received a room tray. Staff A stated she would elevate Resident #1's head of the bed and check on her to make sure she ate. Staff A reported she provided Resident #1 oral care after she ate. She reported Resident #1 would sometimes do her oral care herself and other times need assistance. Staff A stated Resident #1 voiced complaints of a sore mouth so the staff switched to using swabs instead of a toothbrush. Staff A stated Resident #1's lips had a couple of sores and she would pat the sores with a warm washcloth. Staff A stated she told the nurse about the sores sometime in June. Staff A stated they applied lip balm to Resident #1's lips. Staff A reported Resident #1 came out to the dining room for lunch and ate with a group of ladies. Staff A reported Resident #1 didn't eat or drink as much closer to the time she went to the hospital. Staff A stated she put food on the spoon and tried to give it to her. Staff A reported meal intakes they are supposed to record each meal but they missed it sometimes. She stated they had a lot of charting to do. On [DATE] at 12:07 PM, Staff E, CNA, reported Resident #1 didn't want to get woke up for breakfast. She stated Resident #1 ate in her room, usually cereal and milk. Staff E reported Resident #1 would complain that her mouth was dry. She stated she couldn't suck from a straw because of her dry mouth so they would use a regular cup. Staff E reported Resident #1 had a sore in the corner of her mouth, she put Vaseline on it. She stated she told a nurse about the sore. Staff E reported at the beginning of June she started to see a decline in Resident #1. She stated Resident #1 got stiff and shook really bad. Staff E reported when Resident #1 started to decline, the staff helped cut up her food and put the food on her fork. She stated Resident #1 didn't like the staff feeding her and wanted to do it herself. Staff E reported Resident #1 sat at a regular table and then they moved her to an assisted table when she didn't eat well. Staff E stated Resident #1 would eat in her room at times when her husband visited and helped her. Staff E reported she didn't know of any adaptive equipment. Staff E remarked it was hard to document intakes. She stated it is so busy during the day but they tried their best to get it done. She stated they expected them to document meal intakes. On [DATE] at 12:56 PM, Staff F, CNA reported Resident #1 had a gradual decline and that she had mentioned to the nurses she felt she would be a hospice candidate but she was a full code. Staff F stated Resident #1 had tremors and shakes that got really bad. Staff F described Resident #1 as never a big eater. Staff F stated Resident #1 got out of bed between 9 - 9:30 AM. She stated Resident #1 would lie in bed and eat dry cheerios. She described Resident #1 prior to her hospitalization , as very jumpy and dropped silverware/cups. Staff F stated they moved Resident #1 to an assisted table a week or two before she went to the hospital. Staff F stated she tried to give Resident #1 a bite of food and she would turn her head. Staff F reported Resident #1 had sores in the corner of her mouth and they received orders for Vaseline. She stated the regular Chapstick didn't work. She described Resident #1's lips as very sore. She would pull her head away when they tried to apply the squeeze tube gel. She stated she told a nurse about the sores to her lips. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 1:44 PM, Staff G, CNA, reported Resident #1 didn't eat a whole lot. He stated Resident #1 was never a breakfast person. Staff G reported Resident #1 sat at an assistive table for a few weeks before she went to the hospital. Staff G reported Resident #1 had a poor appetite and intake. Staff G stated Resident #1 didn't respond to the food. Staff G reported Resident #1's had a better fluid intake than food intake. He stated Resident #1 had Parkinson's really bad, due to this the staff had a difficult time providing her due to being really shaky. He stated he offered oral care when Resident #1 got up in the morning and at lunch after she ate. Staff G stated Resident #1 would close her mouth at times and they couldn't get a swab in there. He stated he had difficulties putting on the Chapstick, too. Staff G stated Resident #1's lips looked sore but she didn't complain of any mouth or throat pain. He reported Resident #1 had a water pitcher in her room. He described her as shaky and would spill, so he went and give her drinks. She took one swallow and quit. He reported he didn't know of any adaptive equipment. On [DATE] at 4:00 PM, Staff B, Registered Nurse (RN) reported learning in report on the weekend of [DATE] that Resident #1 had difficulty swallowing her medication. She stated she noted Resident #1 had a as needed (PRN) order to crush medications. Staff B stated she liked to try putting the pills in applesauce first. She stated Resident #1 could take the pills in applesauce but the bigger pills she pocketed. She stated Resident #1 needed a lot of encouragement to swallow and it would take 5 - 10 minutes to give her medications. Staff B reported she liked to offer a full glass of water at each medication pass but Resident #1 wasn't wanting to drink. Staff B reported Resident #1 would only take sips of water. Staff B stated Resident #1's daughter sat at her bedside on [DATE] and told her mom that she needed to drink water, but Resident #1 didn't want to. Staff B stated on the last day of her rotation, Resident #1's husband told her he thought Resident #1 might have a sore throat. Staff B stated she was pretty positive it was Sunday night ([DATE]). Staff B stated she told the husband she would assess Resident #1. Staff B reported she looked into Resident #1's mouth with a light. Staff B stated she didn't see any redness or irritation. When she asked Resident #1, if her throat hurt she said no. Staff B stated she didn't see any signs or symptoms of pain when Resident #1 swallowed. Staff B reported she didn't document her throat assessment in the clinical record but passed on the husband's concern in the report but couldn't recall which nurse she passed it on to. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 6:41 AM, Staff H, RN, reported she worked the weekend before Resident #1 went to the hospital. Staff H reported the staff usually checked the residents for incontinence twice a shift. They checked on Resident #1 more frequently due to her high risk for falls. Staff H stated she applied a mouth moisturizer to Resident #1's lips and mouth as they were so dry. She described Resident #1's tongue as dry and red. She stated she didn't see any rashes. Staff H stated she gave Resident #1 mouth swabs and tried to get her to suck on the swab due to the dryness. Staff G stated she tried thickened liquids to see if it would help. She stated she messaged the Physician about Resident #1's bowels not moving and also about her swallowing problems. Staff H reported when she tried to put Chapstick on Resident #1's lips, she said it hurt. She described Resident #1's lips as very dry and scabbed. She felt that caused her to hurt. Staff H stated the facility talked about her decline and exploring hospice. She stated at the time she didn't know Resident #1 wished to be a full code. She stated she thought the facility was heading for the direction of hospice care. She stated the first step she thought would be to change Resident #1 s code status. Staff H stated she did think about sending Resident #1 out to the hospital for an evaluation but she being pretty new, she didn't know the procedures. She stated Resident #1 had dark urine output. Staff H stated during report they said Resident #1 had more difficulty feeding herself and they moved her to an assisted table. She stated she didn't know when they moved her to the assisted table, but it wasn't too many days before she went to the hospital. She stated working overnight a lot of people are sleeping and you don't get to interact as much as days/evening shifts. She stated she assisted the CNA with Resident #1's cares. Staff H stated she tried her best to get Resident #1 to drink, offering small amounts of water frequently. On [DATE] at 9:15 AM, Staff I, RN, reported she worked on [DATE] and she learned in report that Resident #1 had a hard time taking her medications and needed her medications crushed. She stated when they put Resident #1 to bed that night she had a hard time understanding her but the one thing she did understand is that Resident #1's mouth hurt. She described her mouth around her lips as really dry, with some dried blood. She stated she cleaned Resident #1's mouth up and applied Chapstick cream. She reported Resident #1 had trouble swallowing so she filled up a straw with water and put a drop in her mouth. She stated Resident #1 didn't voice any throat pain. She stated the pain came from the cause of the dried blood around her mouth. She stated there was nothing in Resident #1's mouth. She stated she didn't look at her throat as she didn't have a flashlight. Staff I reported a couple days later, they moved Resident #1 to the feeding table. She stated she didn't know if speech was involved or not. She stated she did ask about hospice and they said the family won't do that. On [DATE] at 9:30 AM, the DON knew about Resident #1's weight loss. The DON stated the Nurse Manager received the information on Friday, [DATE] and she re-sent the information via email to the Nurse Manager on Monday, [DATE] to address. The DON reported with swallowing difficulties she would expect the nurses to assess the situation, notify the provider right away and follow what they advise. She stated she expected someone to notify the provider prior to [DATE] regarding Resident #1's swallowing difficulties. On [DATE] at 9:30 AM, Staff C, RNC (Regional Nurse Consultant) reported she expected the staff to chart intakes for meals and fluids, if they were on a monitoring program. She stated she expected the staff to document whatever the resident had on their task list. Staff C verified Resident #1 should have intake documentation completed for each meal and hydration on days, evenings and overnights. On [DATE] At 12:30 PM, Staff C acknowledged Resident #1 didn't receive speech therapy and the facility didn't follow through on the Physician Order from [DATE]. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 8:41 AM, Resident #1's husband described his wife as not doing very well at that time. He stated his wife had a stay in the hospital and then moved to another nursing home. Resident #1's husband reported he thought his wife had a sore throat for a couple of weeks. He stated he knew his wife told the staff about her sore throat. He reported being there when she told the staff. When asked what the staff did regarding her throat hurting, he stated not much. He reported the staff would give her water but she could hardly talk, she had very dry and sore lips. He stated it was hard to say what the staff did behind the scenes. He stated he didn't see the staff examine or inspect her mouth or throat when he was present. He stated he knew of his wife's swallowing difficulties and her poor intakes. He stated his daughter had to call his wife's doctor to set it up for his wife to go to the hospital. On [DATE] at 9:14 AM, Resident #1's daughter reported she learned for the first time on [DATE] of her mom's sore throat. She stated she visited her mom and asked to look in her mouth. She described her tongue as bright red and the back of her throat appeared red with spots. She stated she knew the week before her mom didn't eat well and they switched her to an assisted table that Thursday, so she decided to look into her mouth to see if that caused her to not eat. She stated she called her mom's provider the next day, [DATE] to see they could do. She stated the Provider said they should probably see her mom in the ER. She stated she didn't think she talked to anyone at the nursing home on the evening of the 30th as she didn't see anyone around. She stated prior to the 30th she didn't recall her dad mentioning anything about her mom having a sore throat. She stated her dad had more concern about her not eating. She stated in theER on Monday her dad did mention her mom had told him she had a sore throat. She reported she didn't know when her mom told her dad about the sore throat. She stated she called him Sunday night to tell him about what she saw in her throat. She didn't recall if he had mentioned anything about a sore throat then or not. She stated she didn't think about looking into her mom's mouth until Sunday. She reported she couldn't tell how long her throat had been like that. She stated she honestly didn't know, it could be the day before or weeks before. She stated her mom had a lot of ups and downs, she usually associated it with a UTI (urinary tract infection) or her Parkinson's. She stated her mom received the all clear of a UTI on [DATE] in the ER, so she knew it wasn't that. She reported at the hospital on [DATE] her mom had lunch and fed herself, eating and drinking on her own okay. She stated in the ER the doctor talked about Lewy body dementia and how the symptoms could come and go. She described her mom's Parkinson's as finicky and they struggled figuring out the right dosage of medication. She stated her mom's primary care provider (PCP) didn't see her since the last certification, when she was doing well. She stated when she called the PCP on [DATE], the provider didn't know about her mom's condition change related to the poor intakes, difficulty swallowing, and/or her sore throat. A facility policy titled Hydration Program effective date [DATE] documented the purpose of the policy was to provide adequate fluid for residents, encourage fluid intake and prevent dehydration. The policy documented these procedural steps: 1. Each resident must have fresh water at the bedside. 2. The staff need to change water pitcher and glass once each 24 hours. 3. Offer each resident a fresh drink when they pass the water. 4. Offer fluids at least mid-morning, mid-afternoon, before retiring at night, and early in the morning. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	5. Encourage residents to drink all of their fluids at mealtime. 6. Encourage residents to drink 4 - 8 ounces with each medication pass. 7. Residents with poor fluid intake should have alternative approaches offered, such as popsicles, gelatin, or sugar-free drinks. 8. The staff should monitor the intake of fluids for all residents with feeding tubes or those with fluid restrictions. 9. Monitor for increased signs of thirst; e.g. dry mouth, wetting lips, taking beverage from others. 10. Monitor medication side effects that cause hydration. 11. Monitor for increased confusion, fatigue (tiredness), hot or cold sensations, muscle cramping, headache, dry mouth, crusty dry eyes, dry mucous membranes, and excessive diaphoresis (sweating). 12. Monitor for dark concentrated urine. 13. Monitor for constipation. 14. Monitor abnormal vital signs, orthostatic hypotension (low blood pressure), tachycardia (fast heart rate greater than 100 beats per minute), fever. The policy directed the following regarding documentation: 1. Record intake and output for all residents with catheters, restricted fluids, tube feedings, or forced fluids, then total every 24 hours. 2. Record any unusual pattern of fluid intake in nurse's notes and/or monthly summary[TRUNCATED]

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review and staff interviews, the facility failed to provide Speech Therapy (ST) as ordered by the Physician order for 1 of 1 resident reviewed (Resident #1) for therapy services. The facility reported a census of 32 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #1 was independent with bed mobility. Resident #1 required partial/moderate assistance of one staff member with transfers and toilet use. The MDS indicated Resident #1 was ambulatory walking 10 feet and required a wheelchair for locomotion. The MDS documented Resident #1 had frequent incontinence of bowel and bladder. Resident #1's MDS included diagnoses of hypertension (high blood pressure), non-Alzheimer's dementia, depression, parkinsonism, paroxysmal atrial fibrillation (irregular heartbeat), and fibromyalgia (disorder that causes musculoskeletal pain/tenderness). A Physician order dated 5/21/24 directed the facility to provide Physical (PT), Occupational (OT), and ST evaluation and treatment. A Progress Note dated 5/21/24 at 1:46 AM documented Resident #1 returned from her appointment with new orders for PT, OT, ST for Parkinson's disease and falls. A Progress Noted dated 5/22/24 at 1:39 PM documented the Physical Therapy Assistant (PTA) at the facility. The staff informed her in person regarding Resident #1's new orders for PT, OT and ST therapy. The Clinical Record lacked documentation that Resident #1 received a ST evaluation and treatment as ordered by the Physician. On 7/10/24 At 12:30 PM, Staff C, Regional Nurse Consultant (RNC) confirmed Resident #1 did receive ST and the facility didn't follow-up through on the Physician's Order from 5/21/24. The Physician/Extenders Orders policy effective date April 2024 documented the charge nurse must record the physician orders in the electronic medical record or other appropriate places as designated by the nursing policy. In addition, if the facility didn't follow through on orders, they need to notify the Primary Care Physician and Power of Attorney within approximately 24 hours and document it in the electronic health record.

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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** 46875 Based on clinical record review, staff interviews, and policy review the facility failed to accurately document a fall and the required assessment related to a fall in the medical record for 1 of 4 residents reviewed (Resident #4). The facility failed to complete thorough incident reports for 3 out 4 residents (Residents #4, #1, and #2). The facility reported a census of 32 residents. Findings include: 1. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #4 required supervision/touching assistance with bed mobility. Resident #4 required partial/moderate assistance of one staff member with transfers and toilet use. The MDS indicated Resident #4 was ambulatory walking 50 feet and required a wheelchair for locomotion. Resident #4's MDS included diagnoses of pneumonia, diabetes mellitus, COPD (chronic obstructive pulmonary disease), dementia, and intellectual disabilities. A Facility Event Report (facility incident report) dated 6/6/24 at 12:45 PM reflected Resident #4 had an unwitnessed fall in her room. The description stated Resident #4 put on her call light and then tried to get up to use the restroom. She tripped on either the call light or the oxygen tubing. She denied hitting her head and reported she landed on her bottom. The review of the event report revealed an incomplete form. The following sections on the event form were blank and not filled out: event details, subjective data, environment, pain observations, body observations, neurological check, mental status, and interventions. Review of the Progress Notes dated 6/6/24 and 6/7/24 lacked documentation that Resident #4 fell . The progress notes lacked documentation of a fall assessment, neurological assessment including vital signs, post fall evaluation and a fall risk evaluation. 2. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #1 was independent with bed mobility. Resident #1 required partial/moderate assistance of one staff member with transfers and toilet use. The MDS indicated Resident #1 was ambulatory walking 10 feet and required a wheelchair for locomotion. The MDS documented Resident #1 had frequent incontinence of bowel and bladder. Resident #1's MDS included diagnoses of hypertension (high blood pressure), non - Alzheimer's dementia, depression, parkinsonism, paroxysmal atrial fibrillation (irregular heartbeat), and fibromyalgia (disorder that causes musculoskeletal pain/tenderness). The Progress Note dated 6/21/24 at 4:00 PM documented the CNA notified the nurse Resident #1 fell . The nurse discovered Resident #1 laying on the floor beside her bed on her left side facing her nightstand. Resident #1 reported she tried to get from there to the bookcase. Neurological checks within normal limits. Resident #1 had two new open injuries, a small skin tear to left anterior forearm, and to her right toe. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Event Report dated 6/21/24 at 4:00 PM identified Resident #1 had an unwitnessed fall. The event report lacked documentation regarding the event detail, subjective data obtained from the resident, environment details, pain observation, body observation, mental status, possible contributing factors, and the immediate intervention taken. 3. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS listed Resident #2 as independent with bed mobility, transfers, and walking 150 feet. Resident #2' s MDS included diagnoses of syncope (fainting) and collapse (fall), muscle weakness, pain in the right hip and lack of coordination (balance). A Progress Note dated 4/15/24 at 7:52 AM documented Resident #2's husband notified staff that his wife fell on the floor. The staff observed Resident #2 sitting behind the door of her room on her bottom with her legs extended out in front of her. Resident #2 held herself up with both of her hands open on the floor with her elbows locked. Resident #2 explained as she looked in her closet, she slipped and landed on her bottom. Resident #2 had pain/discomfort in her right leg along with shortening and external rotation. The staff called the Primary Care Provider (PCP), who gave an order to send Resident #2 to the emergency room . An Event Report dated 4/15/24 at 7:52 AM documented Resident #2's husband notified the staff that his wife fell on the floor. Review of the event report revealed an incomplete form. The following sections on the event form were blank and not filled out: event details, subjective data, environment, pain observations, body observations, neurological check, mental status, possible contributing factors, notification guidelines, and interventions. On 7/11/24 at 8:15 AM, Staff C, Regional Nurse Consultant (RNC), reported she expected the staff to fill out the event form (incident report) entirely. She also stated she expected the staff to document a fall in the progress notes. On 7/11/24 at 1:45 PM, Staff C acknowledged the facility had a concern with the completion of incident reports. She reported the facility planned to start a Process Improvement Plan (PIP) team to review the process and provide staff education. The Electronic Medical Record policy effective April 2024 instructed the facility to maintain medical records on each resident within accepted professional standards of practice. The policy further documented that the electronic medical record will contain sufficient information to identify the resident, a record of the resident assessments and incident/risk management records completed by nursing staff upon unusual occurrences taking place in the facility.