STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165448	A. Building B. Wing	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Drumm Retirement Center	5837 Winwood Drive Johnston, IA 50131

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and family and staff interviews, the facility failed to carry out therapy recommendations and provide restorative exercises for 1of 4 residents reviewed for rehabilitation services and/or limited range of motion (Resident #10). The facility reported a census of 107 residents. Findings include:The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had diagnoses of dementia, mild intellectual disability, and failure to thrive. The MDS documented the resident required set-up assistance for eating, partial to maximum assistance for bed mobility, and had dependence on staff for transfers and toileting. The MDS indicated the resident's upper and lower extremity range of motion (ROM) not impaired. The resident required partial to moderate assistance to wheel a wheelchair 50 and 150 feet. Physical Therapy (PT) last completed on 12/15/23 and Occupational Therapy (OT) last completed 11/3/23. The MDS recorded a Restorative Nursing Program (RNP) completed zero (0) days during the seven day look-back period. The Quarterly MDS assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 1, indicating cognition severely impaired. The MDS documented the resident required substantial to maximum assistance for eating and bed mobility, and had dependence on staff for transfers and toileting. The MDS also indicated the resident had impaired ROM to the lower extremity on one side of the body. The MDS recorded the resident had no PT or OT services, and recorded a RNP Active Range of Motion (AROM) and transfers occurred 6 of the 7 days during the lookback period. The Significant Change MDS assessment dated [DATE] revealed the resident had impaired short-term and long-term memory. The resident required substantial to maximum assistance for eating, and had dependence on staff for bed mobility and transfers. The MDS documented the resident had impaired range of motion to the upper and lower extremities bilaterally. A RNP for AROM was recorded 5 of 7 days during the look-back period. The MDS revealed the resident on hospice. The Care Plan revised 3/13/24 revealed Resident #10 had an ADL (activities of daily living) performance deficit related to dementia, an intellectual disability, and limited mobility. The care plan directed staff to use a Hoyer (mechanical lift) and two staff for assistance with transfers, and provide set up assistance for eating. Hospice initiated on 4/28/25. Care plan revised on 5/2/25 revealed the resident had pain related to decreased mobility, osteoarthritis, and bilateral hand contractures. The Physician's Encounter Note documented in the Progress Notes on 4/9/25 and e-signed 4/13/2025 at 2:15 PM revealed Resident #10 seen for an acute visit due to muscle tightness and contractures in her bilateral hands, primarily affecting the fingers and wrists, with the left wrist being more affected than the right. Nursing staff expressed concerns that these contractures are compromising her hand hygiene. During the previous visit, new orders were given for occupational therapy to address the hand contractures. The possibility of prescribing a muscle relaxer was considered, but it was noted that the patient is already on several centrally acting medications, and adding a muscle relaxer could increase the risk of sedation or worsening cognitive status.A Nurse Practitioner (NP) Encounter Note e-signed on 6/2/25 at 1:44 PM revealed resident had significant bilateral hand contractures and the hands had a tight clenched fist/ grip. Resident given Dilaudid (opioid analgesic) for pain. Progress (continued on next page)

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

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Notes revealed the following: a. On 4/1/2025 at 3:35 PM, resident keeps her hands in a fist like hold. Her hands appear to be in pain when staff released her hands to examine the skin underneath. The skin appears to have cuts to where her nails dug into her skin and the skin appeared to have a foul odor present. Hands cleansed with soap and water and a gauze roll was placed between her nails and her skin. Resident had contractures previously to the ankles and OT and PT were used to establish positioning and release the contractures. The Care Plan was reviewed and updated to include Occupational Therapy to release contractures.b. On 4/14/2025 at 8:38 PM, resident's ongoing contractures and muscle tension discussed with NP. An order received for Baclofen (muscle relaxer) 5 mg twice a day.c. On 4/29/2025 at 3:30 PM, hospice NP saw resident and noted the resident had contractures and redness and pain to her right palm. Orders received for an antifungal treatment daily to her right palm for 14 days.d. On 5/13/25 at 2:08 PM, the IDT team met to review the skin wound that happened due to the resident's contractures to her bilateral hands. Resident's contractures were so severe that it caused broken skin to the right palm. Pain present when manipulated the hand and it was difficult to release the hands to reduce the pressure to the area. Baclofen muscle relaxer medication adjustments made to increase to 10 mg three times a day. As the contractures have been progressing, resident has been pulling back and has not been talking to team members. A wound care nurse specialist started to see the resident and treatment orders received. e. On 5/14/2025 at 8:21 AM, new splints applied to contracted hands. Splints will be applied in the AM and removed in the PM. The Treatment Administration Records (TAR) dated 5/1/25 to 6/30/25 revealed left and right splint on in the AM and off if the PM for contractures and reduced mobility had a start date 5/14/25 and discontinued on 6/16/25. The TAR also revealed OT carrots to bilateral hands during the day and removed at night for the right and left hand contractures started on 5/6/25. The Documentation Survey Report revealed the following Nursing Rehab tasks: Task: AROM: participate in activity of choice as tolerated--fold towels, match socks, sort papers 3-5 times per week2/1-2/28/25 documented 15x's3/1-3/31/25 documented 13x's5/1 - 5/31/25 documented 15 x's6/1 - 6/30/25 - documented 11x's. 7/1 - 7/15/25 - documented 9 x's Task: NURSING REHAB: Transfers/ROM: NuStep (sitting bicycle) x10 minutes, resistance as tolerated 3-5 times per week1/1-1/31/25 documented 6 x's2/1-2/28/25 documented 3x's3/1-3/31/25 documented 3x's4/1 - 4/30/25 - documented 5 x's 5/1 - 5/31/25 documented 5x's. 6/1 - 6/30/25 documented 2x's7/1 - 7/15/25 - documented 0 x's The Clinical Physician's Orders revealed the following: a. OT evaluation and treatment for hand contractures started on 4/1/25. b. OT carrots to bilateral hands during the day and take out at night related to contractures to the right and left hands started on 5/6/25. c. Apply left and right hand splint in the AM and off in the PM for contractures related to reduced mobility had a start date 5/14/25 and a discontinued date 6/16/25 due to resident unable to have splints applied. The Occupational Therapy (OT) Discharge summary dated [DATE] revealed OT recommended Resident #10 have assistance of one for transfers, and a RNP for bilateral upper extremities and bilateral lower extremities AROM. RNP recommended in order to maximize the resident's quality of life in her current living environment. An OT Evaluation and Plan of Treatment with a start of care date 4/1/25 revealed Resident #10 had diagnoses of bilateral hands stiffness and a contracture to her right hand. Staff H, OT, documented the resident presented with a severe decline and bilateral hand and ankle contractures as well as limited hip and knee extension, limited shoulder and elbow ROM. Functional limitations present due to contracture resulting in limitations in participation in tasks, feeding self, dressing, grasping and gathering. OT needed to evaluate and address positioning, bilateral upper and lower extremity ROM, and ADL performance. The resident had bilateral hand pain due to contractures. OT recommended the resident wear a carrot finger orthosis. An order for a muscle relaxer was pending. The resident had therapy services that ended 12/25/24. Prior treatment outcome included the resident discharged to the LTC facility and required assistance of one for transfers and ADL's, and used a wheelchair for mobility. The OT Treatment Encounter Notes revealed the following: a. On 4/1/25, Resident #10 had hand/ankle contractures. Waiting for an order for a muscle relaxer. Therapy needs to address the (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	resident's pain. Pain exhibited by resident's clenched fists, clenched jaw, facial grimacing and protective barriers to the area of pain. OT performed an in depth hand washing and drying of bilateral hand/digits due to severe contractures and foul odor. The resident's finger nails were clipped due to current skin breakdown and indentation on the left palmar aspect of her hand. Bilateral carrot orthoses applied. b. On 4/2/25, hand carrot orthotics placed in the resident's hands. OT recommended to keep the carrots in her hand until bedtime, and provide proper hand hygiene cares. c. On 4/8/25, the resident became tearful with ROM provided to left index finger and thumb digits. Hand hygiene provided and carrot placed in left upper extremity and a built-up foam roll placed in right upper extremity. d. On 4/11/25, OT found the resident had a carrot donned in the right hand. The left carrot was lying in her lap. Resident had increased tearfulness with bilateral wrist and digit ROM. e. On 4/14/25, OT discussed with the DON about a prior meeting regarding getting a muscle relaxer for the resident and she needed to relay the message to the Nurse Practitioner. f. On 4/15/25, nursing staff indicated the resident started on baclofen today (4/15/25). g. On 4/16/25, nursing reported a discussion about hospice if the resident's muscle tension does not improve. The OT Discharge Summary signed by Staff H on 4/21/25 revealed the resident had dependence for ADL's including eating, hygiene, dressing and transfers. Resident #10's Self Care Function Score (Score 0-12, with 12 being the highest function) was 0, indicating the lowest functional level. Skilled treatment interventions focused on education and training the resident and caregivers in positioning maneuvers, pressure relieving techniques and splinting/orthotic use in order to decrease pain and promote optimal positioning in the wheelchair. OT recommended continued placement of bilateral carrots for hand contractures to decrease skin breakdown and improve hygiene cares. At the time of discharge, the resident tolerated the carrots for 4 hours. Observations revealed the following: a. On 07/15/25 at 10:34 AM, Resident #10 sat in a high back wheelchair and had contractures to both hands. No carrots observed in the hands. b. On 07/16/25 at 7:52 AM, resident lying in bed. The resident had contractures to bilateral hands and the right foot turned inward. Staff B, CNA, and Staff C, CNA, used a mechanical lift and transferred the resident from the bed to the wheelchair. c. On 7/17/25 at 9:00 AM, Resident #10 sat in wheelchair across from the nurse's station. The resident had arms bent and her fingers were curled inward toward palms of her hands (contracted). The right foot also turned inward and was deformed. No carrots observed in the hands. In an interview on 7/16/25 at 10:20 AM, the Director of Nursing (DON) reported the facility no longer had paper charts. The nurse entered orders in the computer and noted the order whenever an order was received. The order went into the bin for another nurse to double check the order, then the orders got checked by the unit manager. Medical Records went to each unit and picked up the medical records / documents that needed to be scanned by 5 PM each day. Medical Records scanned the documents into the residents' records typically within 24-72 hours. In an interview 7/17/25 at 9:05 AM, Staff D, Certified Medication Aide (CMA), reported he had worked at the facility for one year. Resident #10 had hand contractures since he had worked at the facility. The staff gave the resident carrots to hold in her hands to keep her hands more open. They don't document when the carrots were donned or doffed. In an interview 7/17/25 at 9:10 AM, Staff F, Registered Nurse (RN), reported she had worked at the facility for two years. Resident #10 had contractures that developed about 3-4 months ago. Staff found it hard to open her hand so therapy saw her. Staff F reported the resident was suppose to use the carrots during the day and remove the carrots at HS (bedtime). In an interview 7/17/25 9:25 AM, Staff B, Certified Nursing Assistant (CNA), reported she had worked at the facility for a year but she had also worked at the facility previously. She was familiar with Resident #10, Staff B reported Resident #10 had the deformity in her hands and feet for at least a year but requested the surveyor to ask the nurse about the resident's contractures. In an interview 7/17/25 1:30 PM, Staff H, OT, reported she had worked at the facility since 2017. Therapy made recommendations such as a restorative exercise program when a resident's therapy services ended. Sometimes they had repeat residents that required therapy services such as when a resident had a decline or had multiple falls. Therapy also (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	screened residents at various times to determine transfer status or other ADL's. Staff H reported she was the one who found Resident #10's hand contracture. One day a few months ago, she was working with the resident's roommate and happened to notice Resident #10's hands were clenched in a fist. She opened Resident #10's fingers and saw wounds inside her hands. At that time, she requested orders for therapy services for Resident #10. Resident #10 was noted to be very tense and her fingers were curled up. OT evaluated the resident and used carrots to help open the hand up and prevent wounds from developing. No hand splints could be placed or used because the resident's hand/fingers were so tight. Carrots were recommended by OT and there was an order for use of the carrots. Resident #10 discharged from therapy services and went on hospice. Staff H reported she was unsure why Resident #10 didn't have carrots in place currently but thought maybe hospice had discontinued them. In an interview 7/21/25 at 8:15 AM, Staff M, Restorative Nursing Assistant, (RNA) reported she received a restorative program sheet for any resident who needed restorative exercise activity. She did restorative activities whenever she gave a resident a shower. Staff M reported she recently started in the RNA role but Staff L, RNA, had been doing restorative longer. In an interview 7/21/25 8:25 AM, Staff L, RNA reported she had worked as the restorative aide since 9/2024. Therapy gave her a program for the residents on a restorative program. If she noted a decline in the resident, she let therapy know. Restorative performed to maintain what level of function the resident had. Restorative exercises done Monday through Saturday in the dining room in a group setting as well. Staff L reported when she first took care of Resident #10, the resident had a transfer program to help with transfers and to do ROM. Resident #10 was very stiff. She worked with the resident in the beginning, but then she went to therapy services. Staff L reported the resident's arm was very tight when she did ROM exercises with her. She tried to put a brace on her arm but it didn't help. She had cones to put in her hands. Staff L reported when she tried to do ROM exercised with the resident it felt like she was fighting and she did not want to break her bones so she was careful on what she did with her. One day she went in to wash the resident's hands and noticed a break in the skin on the palm of her hand. She let the nurse know about it. Staff L reported she tried to work with the resident three times a week for restorative activities. Staff L reported she had 60 residents in her restorative program. The facility only had two restorative aides for the building (1 restorative aide on [NAME] and 1 on NE). Staff L reported she had been pulled to work on floor as a CNA or CMA when they needed her. Staff L shared that when restorative not done with the resident consistently because she had a day off or got pulled to work another area, she found it harder to work with the resident on ROM. No back-up restorative aide scheduled on RNA days off or when the RNA covered the floor as CNA or CMA. A Restorative Nursing Program policy revised 10/20/22 revealed the facility provided maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. RNP refers to nursing interventions that promoted the resident's ability to adapt and adjust to living as independently and safely as possible. All residents will receive maintenance nursing services as needed by CNA's including assisting residents with the use of assistive devices and assistance with ROM exercises. Passive ROM exercises performed for residents who lack AROM ability.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review the facility failed to document an accurate code status for one of thirty-two residents sampled for advanced directives (Resident #11). The facility reported a census of 107 residents.Findings include: The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had diagnoses that included a myocardial infarction (heart attack), cancer, renal insufficiency, diabetes, and chronic myeloid leukemia. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating cognition intact. The Care Plan initiated/revised [DATE] revealed Resident #11 desired to have limited end of life treatment for a DNR (Do Not Resuscitate) status. The staff directives included to review the advanced directives with the resident on a quarterly basis or as needed (PRN).The Electronic Medical Record (EHR) physician's orders revealed Resident #11's code status as a DNR. The order was created on [DATE] by the Director of Nursing (DON) and listed as active. The IPOST (Iowa Physician's Orders for Scope of Treatment) form signed by the Nurse Practitioner on [DATE] and Resident #11 on [DATE] revealed a request for Cardiopulmonary Resuscitation (CPR) in the event the resident had no pulse and not breathing. In an interview on [DATE] 10:20 AM, the DON reported the facility had no paper charts. All the resident's clinical records were located on the computer. The DON explained whenever an order was received, the nurse entered the orders in the computer and noted the order. The order went into the bin for another nurse to double check the order, then the orders got checked by the unit manager. Medical Records went to each unit and picked up the medical records and other documents by 5:00 PM each day and scanned the documents into the residents' records. Documents were typically scanned and in the EHR within 24-72 hours. In an interview on [DATE] at 9:05 AM, Staff D, Certified Medication Aide (CMA) reported he looked at the computer to check a resident's code status. In an interview on [DATE] at 1:35 PM, Staff C, CMA, reported he looked at the computer under the resident's EHR to check if the resident had a full code or DNR status. In an interview on [DATE] at 9:10 AM, Staff F, Registered Nurse reported she looked at the computer to check a resident's code status. A Cardiopulmonary Resuscitation policy effective [DATE] revealed it is the facility's policy to adhere to residents' rights to formulate an advanced directive.

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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** Based on observations, facility work orders, resident and staff interviews, and policy review, the facility failed to provide a safe, clean, comfortable and homelike environment. The facility identified a census of 107 residents.Findings include:Observations revealed the following: a. On 7/14/25 at 3:00 PM, the door to resident's room [ROOM NUMBER] and room [ROOM NUMBER] would not close even though the surveyor pulled on the door repeatedly in attempt to close the door to the room. b. On 7/16/25 at 12:30 PM, room [ROOM NUMBER] had a board for the window sill lying on the floor by the resident's bed.c. On 7/17/25 at 8:50 AM, the door to resident's room [ROOM NUMBER] and room [ROOM NUMBER] sprung open several times as the surveyor and staff attempted to close the door. room [ROOM NUMBER] continued to have a board for the window sill lying on the floor by the wall and bed. The platform (by the window) for the window sill had hard, dried glue and a rough surface. The bathroom call light in room [ROOM NUMBER] was not working. The 4-plex electrical outlet had a dorm sized refrigerator, a charger for a motorized wheelchair, and a charger for electronic devices plugged into 3 of the 4 outlets. Work Orders reviewed 4/18/25 to 7/17/25 revealed no open or active work orders for rooms [ROOM NUMBER]. A Work Order for room [ROOM NUMBER] revealed the windowsill lifted up due to the bed rising and the windowsill needed glued down. The work order was created and completed on 6/18/25. A Work Order for room [ROOM NUMBER] created on 7/15/25 and completed on 7/17/25 revealed the (electrical) outlet was not working.In an interview on 7/15/25 at 8:22 AM, Resident #40 reported the windowsill in her room had laid on the floor by her bed for more than a month. Resident #40 stated staff told her they would fix it but it didn't get done. In an interview on 7/14/25 at 2:57 PM, Resident #5 reported the bathroom call light was not working. The plug-in by the wall threw out sparks when staff plugged something into it. At the time a large dorm-sized refrigerator was plugged into one outlet, a charger for electronic devices was plugged into one outlet, and a charger for a motorized wheelchair was plugged into one of the 4-plex electrical outlet-In an interview on 7/17/25 at 9:25 AM, Staff B, Certified Nursing Assistant (CNA) reported a work order was entered in the computer when something needed repaired. She let the nurse know if maintenance had not fixed the broken item. The nurse could enter an updated work order request. In an interview 7/17/25 at 1:35 PM, Staff C, Certified Medication Aide (CMA) reported he entered a work order in the computer if someone reported something not functioning properly or needed repaired. In an interview 7/17/25 at 9:30 AM, Staff K, Maintenance, reported staff could enter a work request in the TELS system on the computer or verbally told him when something needed repaired. In an interview 7/17/25 9:35 AM, the Maintenance Director reported maintenance staff received notification about things that needed repaired or checked through the TELS system. A work order was prioritized according to urgency. The Maintenance Director reported he could run a report of the work orders completed or pending work orders. In an interview 7/17/25 at 9:45 AM, Staff A, Registered Nurse reported she entered a work request in the TELS system on the computer, or she paged maintenance to let them know if equipment or something needed repaired or wasn't working. In an interview 7/17/25 at 3:48 PM, the Administrator reported he believed the reason the windowsill in room [ROOM NUMBER] may be lying on the floor was due to the bed hit the window sill when staff raised the bed up, and the windowsill broke off. The Administrator stated they probably needed to order a board that fit the windowsill to reduce the chance of the bed hitting the windowsill when the bed got raised. The Administrator stated he planned to reopen the work order and have maintenance order the custom wood to go over the windowsill. The Administrator reported the work order for the electrical outlet in room [ROOM NUMBER] entered was created on 7/15/25. A Homelike Environment policy revised 1/3/22 and effective 5/22/25 revealed residents are provided with a safe, clean, and homelike environment.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review, facility record review and staff interview, the facility failed to provide notification to the Long Term Care (LTC) Ombudsman for 1 of 3 (Resident #1) reviewed. The facility reported a census of 107 residents. Findings include: Record review of Resident #1 Census in her clinical record documented she discharged to the hospital on 2/13/25 and returned to the facility on 3/4/25. She discharged to the hospital again on 5/30/25 and returned to the facility on 6/4/25. A Progress Note on 2/13/25 at 2:02 PM, documented Resident #1 had been sent out to the hospital at 1:35 PM. A Progress Note on 2/27/25 at 4:25 PM documented Resident #1 returned to the facility at 3:30 PM A Progress Note on 5/30/25 at 12:02 PM documented Resident #1's spouse called and informed the facility Resident #1 had been admitted to the hospital. A Progress Noted on 6/4/25 at 5:35 PM documented Resident #1 returned to the facility. The Admit/Discharge To/From Report dated 4/21/25 for hospitalized and discharged residents from 2/1/25 to 2/28/25 provided to the LTC Ombudsman revealed Resident #1 had not been included. The Admit/Discharge To/From Report dated 6/3/25 for hospitalized and discharged residents from 5/1/25 to 5/31/25 provided to the LTC Ombudsman revealed Resident #1 had not been included. In an interview on 7/17/2025 at12:18 PM with Staff E, Licensed Social Worker reported she is responsible for the sending the notification to the LTC Ombudsman. She verbalized she creates the report through the electronic health record and emails it to the LTC Ombudsman. Staff E verbalized Resident #1 hadn't been listed on the Admit/Discharge To/From Report provided to the LTC Ombudsman for the hospitalizations that occurred on 2/13/25 and 5/30/25 for Resident #1. In an interview on 7/17/2025 at 12:37 PM, the Administrator's expectation is the LTC Ombudsman will be notified of all hospitalized and discharged residents. The facility lacked a policy for LTC Ombudsman notification.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interviews, and policy review, the facility failed to develop and implement a comprehensive person-centered care plan for 2 of 23 residents sampled (Resident #100 and #62). The facility reported a census of 107 residents.Findings include: 1. The Quarterly Minimum Data Set (MDS) dated [DATE], indicated that Resident #100 had a Cerebrovascular Accident (CVA), Non-Alzheimer's dementia and aphasia following cerebral infarction. The MDS dated [DATE], indicated that Resident #100 did not trigger for behavioral symptoms.The resident's Care Plan with date initiated 2/29/20 indicates Resident #100 had a tendency to sit down on the floor which is a cultural lifestyle. It lacked documentation of her crawling on the floor, wandering and going into other resident's rooms. It also lacked specific interventions for staff when these behaviors occur.The Progress Note on 7/4/25 at 10:38 AM for Resident #100 revealed that she was found crawling on the floor and went into another resident's room. Resident was assisted to a wheelchair and taken to the lounge area.In an interview on 7/14/25 at 1:53 PM, Resident #79 stated that last night the lady across the hall that is Chinese and wanders around, Resident #100, came in to her room crawling and was feeling her legs. States Resident #100 then woke up her roommate (Resident #26). Roommate #26 confirmed the incident.In an interview on 7/17/25 at 7:45 AM Staff D, CMA states aware that Resident #100 crawls and wanders on floor. Was told it is her custom. Stated he is aware that she trespasses as well but not that often. States recently, maybe a couple days ago, when giving Resident #79 medications, she stated that Resident #100 entered her room and tried to take her blanket. Added, that Resident #79 asked about moving to a new room and he told her to talk to Staff E, Licensed Social worker.In an interview on 07/17/2025 3:15 PM the Director of Nursing (DON) states CNA's need to be empowered to document in order show a more accurate description of residents. Documentation does not show Resident #100's behaviors. States she tends to crawl and wander at night as she has more freedom at night due to less activity. States expectation of behaviors with respect to the Care Plan is that an incident report would be done and it would be reviewed in morning clinical meetings. States Resident #100 is care planned for crawling. Informed her that the Care Plan does not indicate crawling, wandering or going into other residents' rooms. States currently working on Care Plans in morning clinical meetings to improve them. States trying to read Care Plans and see if it really represents a true picture of the resident if they did not know them. Agreed that Resident #100's Care Plan did not show a true representation of her.Review of document titled Comprehensive Car Plans, approved 5/22/25, indicated the facility develops and implements a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs.2. The admission MDS assessment for Resident #62 dated 5/12/25, included diagnoses of Alzheimer's and Malnutrition. The MDS revealed the resident was receiving hospice care. Resident #62's MDS note dated 5/12/25 at 11:44 AM documented: admit with hospice services. Resident #62's Care Plan initiated 5/12/25, lacked a focus and interventions for hospice services for the resident. Facility policy, Comprehensive Care Plans effective 5/22/25 documented the comprehensive care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Interview on 7/17/25 at 1:15 PM, the MDS Coordinator stated her expectation for hospice to be included in the Care Plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident representative interview, staff interviews and facility policy review, the facility failed to conduct resident care conferences and offer the resident's Legal Guardian (an individual appointed by the court to make decisions for another person, known as the protected person, who is unable to care for themselves due to physical or cognitive limitations) to participation in their plan of care for 1 of 1 residents reviewed (Resident #3) . The facility reported a census of 107 residents. Findings include: Resident #3's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 10 out 15 indicating moderate cognitive impairment. The MDS included diagnoses of dementia, hemiplegia, malnutrition and depression. The MDS documented the resident has a legal guardian. On 7/15/2025 at 9:48 AM the Legal Guardian reported she is court appointed legal guardian for Resident #3. She reported she had not been invited to a care conference for quite awhile. Resident #3's Electronic Health Record (EHR) lacked documentation of a care conference since April of 2024 with the Guardian. It further lacked any documentation of the Guardian being notified of any care conferences. On 7/17/2025n at 12:41 PM the Administrator reported he was unable to locate documentation of care conference being completed. On 7/17/2025 at 2:09 PM the Social worker reported it had been awhile since the Guardian was at a care conference. She reported it should be done at least quarterly . She reported her assistant is the one who sets up the care conferences and did not do it correctly. The facility policy titled Care Planning-Resident Participation with a approved date of 5/22/25 documented the facility will discuss the plan of care with the resident representative at regularly scheduled care plan conferences.

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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** Based on observation, clinical record review, resident and staff interviews, and policy review the facility failed to report a resident's change in condition, and failed to assess and document a skin assessments for one of three residents reviewed (Resident #5). The facility reported a census of 107 residents.Findings include: The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had diagnoses of osteomyelitis to the left ankle and foot, diabetes, and renal insufficiency. The Care Plan created on 5/14/25 revealed Resident #5 had a break in skin integrity on the left third toe due to an amputation. The Care Plan directed staff to provide treatment as ordered. The Care Plan lacked information about a wound or area of concern on her bottom. An admission assessment dated [DATE] revealed the resident had a toe amputation. Section B of the assessment revealed the resident had bruises to her hands that were present on admission. The resident had no other skin abnormalities documented. The Braden Scale assessment dated [DATE] revealed the resident had a high risk for developing a pressure ulcer. The Braden Scale assessment dated [DATE] revealed the resident had a very high risk for pressure ulcers. An Order started on 5/22/25 to apply Calmoseptine ointment to the buttocks topically two times a day for pressure reduction until the area was healed. Encounter Note dated 5/22/25 documented Menthol-Zinc Oxide, Calmoseptine External Ointment 0.44-20.6% Apply to buttocks topically two times a day for pressure reduction until healed.The Clinical Assessments under the Assessment tab in the EHR revealed the last documented assessment on 7/14/25 for a venous wound to the left lateral lower leg and a surgical wound to the left third toe amputation. The Progress Notes documented the following: a. On 6/29/25 at 9:41 PM, a weekly skin assessment completed. A new area of concerns noted with a laceration on the left shin. Resident reported she got it during a fall yesterday (6/28/25). Treatment order in place. PCP notified. b. A Skin check documented on 7/7/25 at 12:21 AM, the skin was warm and dry, and skin turgor normal.c. On 7/14/25 at 1:00 PM, the resident had a laceration to the left shin that was acquired in-house. The skin issue to the buttocks was not evaluated. d. On 7/15/25 at 2:36 PM, resident complaining of diarrhea. e. On 7/16/25 at 9:11 PM revealed the resident had a yellow, dry scab on the right buttock measuring approximately 1 centimeter (cm) by 2 cm, possibly indicating a healing superficial skin loss. No signs or symptoms of infection were observed. Calmoseptine ointment applied to the buttocks as ordered. The Skin Assessments indicated the following: a. On 7/7/25, skin warm, dry, and within normal limits (WNL).b. On 7/14/25, skin warm, dry, and WNL. No signs or symptoms of infection noted to the left foot third digit amputation site. Several bruises present to the extremities that are resolving. The record lacked any other skin assessments about a wound or skin issue on the resident's bottom. The Treatment Administration Record dated 7/1 to 7/31/25 documented Calmoseptine applied 7/1 - 7/17/25 except on 7/7/25, 7/10/25 and 7/11/25 on the AM shifts. During observation on 7/16/25 at 4:40 PM, Staff I, Registered Nurse (RN) told Resident #5 she would look at her bottom per the surveyor's request. After the resident rolled onto her right side, Staff I removed the resident's brief and noted the resident incontinent of black liquid stool. Staff I stated needed to clean the resident up in order to view her bottom. At 4:45 PM, Staff J, Certified Medication Aide (CMA) entered the room, donned gloves, and cleansed the resident's buttocks area with disposable wipes. Staff I reported she didn't see any redness or open areas to the resident's bottom but she would look further after the resident had been cleaned up. Staff I proceeded to leave the room to find a different sling for transferring the resident. After Staff J changed gloves, he lifted the resident's left buttock up in order for the surveyor to view the buttocks area. A dime-sized reddened, raised area observed to the right inner buttock with a small open area in the middle of the wound area. Staff J changed his gloves and applied Calmoseptine to the buttock area. At 4:57 PM, Staff G, RN, brought a sling to the room. At 4:50 PM, Staff I, RN, returned to the room as staff had the resident in a sling and positioned the mechanical lift to transfer the resident from the bed into her motorized (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair. Resident #5 said she wanted to stay up and go to supper. Staff I was observed talking with Staff G, RN, in the hallway. In an interview 7/14/25 at 3:08 PM, Resident #5 reported she had a small slit on her bottom.In an interview 7/16/25 at 9:37 AM, Staff I, RN, reported skin assessments documented on the computer under the assessments tab. In an interview 7/16/25 at 10:39 AM, the Director of Nursing (DON) reported skin assessments documented on the computer on the Skin Evaluation V7 Assessment and the wound treatments were listed under the Orders in the computer. An Interdisciplinary Team (IDT) Review note related to any skin incidents listed in the progress notes. In a follow up interview on 7/16/25 at 4:30 PM, Resident #5 reported she believed her bottom still had a sore on it. She told staff about the area 4 days ago but no nurse had looked at the area yet. The resident reported she had been having loose stools but never got medication for the diarrhea. She asked Staff J to give her some medication for the diarrhea yesterday but he never did. On 7/16/25 at 4:35 PM, Staff I, RN, reported Resident #5 did not have any wounds or other treatments at this time except Calmoseptine ordered for preventative measures twice a day. The resident had a wound on her leg but it had recently resolved. In an interview 7/17/25 at 9:10 AM, Staff F, RN, reported whenever staff reported a skin concern, she assessed the area of concern, documented a progress note and filled out a Skin and Wound Assessment on the computer under the assessments section. There is also a Skin Check order on the MAR for staff to check the resident's skin. The skin assessment was typically performed on the resident's shower day. Staff F reported an area was discovered on Resident #5's bottom yesterday. The Wound Physician told them to monitor the area and apply Calmoseptine, and notify the physician if there was a change in the wound or it got worse. In an interview 7/17/25 at 9:45 AM, Staff A, RN, reported the CNA's and CMA's were supposed to let the nurse know if a resident had any skin concerns. She assessed the resident's skin, measured the area of concern, filled out a skin assessment on the computer, and contacted the physician to obtain orders for treatment. The facility also had an in-house protocol for what treatment to apply for certain things such as a skin tear. Staff A reported Resident #5 currently had a wound on her left shin and she also had some toes amputated. Staff A stated she had not seen the resident's bottom for a week. The resident's buttock had redness but no open areas when she saw the resident's bottom last week. They had an order to apply Calmoseptine to the buttocks mainly for preventative measures to keep the skin from breakdown. In an interview 7/17/25 at 3:05 PM, Staff G, RN, reported she was told by Staff I, RN, to look at the Resident #5's bottom. She looked at the resident's bottom on 7/16/25 after supper when the resident was lying down. The buttock area had what looked like a yellow scab. It measured 1 cm by 2 cm. She put Calmoseptine on the area. The resident has had loose stools. She gave Imodium to help reduce the occurrence of stools. Staff G stated she passed the information on during shift report to let the wound nurse know about Resident #5's bottom. She documented the observation in the progress note. The facility's Skin Assessment policy revised 6/26/25 revealed a full body skin assessment performed for prevention and management of pressure injury. A head to toe assessment conducted weekly and whenever a change of condition identified. Pressure injuries may result from tissue pressure of high concentration of adipose (fat) tissue and may be in areas other than bony prominences. Moisture and weight exerted by skin and/or body parts should be considered when determining pressure-related versus moisture-related etiology. Documentation of a skin assessment including the type of wound, wound measurements, drainage, odor, and the date and time of the assessment. A Guidelines for Notifying of Clinical Problems effective 5/22/25 revealed all significant changes in resident status are assessed and documented in the medical record.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on Resident council minutes, family interview, resident interview, and staff interview the facility failed to answer call lights in a timely manner (15 minutes or less) for 3 of 4 units (North, South and North East). The facility reported a census of 107 Residents. Findings include:Review of Resident Council Minutes for April, May and June of 2025 documented the residents in attendance each month expressed concerns regarding the length of time it takes staff to respond to call lights. During an interview on 7/14/25 at 1:53 PM, Resident #79, with a Brief Interview for Mental Status (BIMS) of 15 (indicating cognitively intact) explained it takes at least 20-30 minutes to get staff to respond to call lights. During the same interview, Resident #26 with a BIMS of 14 (indicating cognitively intact) agreed that it takes a long time to get call lights answered. During an interview on 7/14/25 at 3:08 PM, Resident #5 with a BIMS of 15, explained it takes a long time to get staff to respond to her call light. She explained she turned her call light on at 1:00 PM and no staff came in to help her as of the time off the interview. She further explained that staff will come in and turn off her call light saying they will be back but that could take another 50 minutes. During an interview on 7/15/25 at 10:29 AM, Resident #39 with a BIMS of 15 explained she watched the clock when she turned her call light on that morning. She explained she turned her call light at 7:35 AM and it was not answered until 8:15 AM. During an interview on 7/17/25 at 9:07 AM, a family member that is frequently in the facility reported it takes 30 minutes or longer for the call light to be answered. During an interview on 7/17/25 at 12:01 PM the Director of Nursing (DON) explained the standard and expectation for answering call lights is less than 15 minutes. She explained she was aware of the resident's concerns and had provided education, completed audits, hired another unit manager and adjusted staffing. She further explained there was no reason for the lights to not be answered

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and policy review, the facility failed to follow infection control practices for a resident with a feeding tube for 1 of 3 residents reviewed for medication review (Resident #79). The facility also failed to follow infection control practices for a resident with a catheter for 1 of 1 resident reviewed for catheter care (Resident #19). The facility reported a census of 107 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE], indicated that Resident #79 had hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia following cerebral infarction, aphasia following cerebral infarction and a feeding tube. The Care Plan for Resident #79, with a target date of 7/18/25, indicated a feeding tube related to dysphagia secondary to Cerebral Vascular Accident (CVA) requiring Enhanced Barrier Precautions (EBP). During an observation on 7/15/25 at 12:34 PM, Staff A, RN gave medications to Resident #79. Staff A, RN donned gloves and gown for EBP precautions. Prior to medication administration, blood sugar, blood pressure and pulse oximetry were obtained. Equipment of glucometer, automatic blood pressure cuff and pulse oximeter were placed back into the medication cart without being sanitized and without hand hygiene or glove removal. Insulin was given and returned to the medication cart. Scopolamine patch was placed and wrapper discarded in trash on the side of the medication cart. Medications were charted with gloves still on. Then, Staff A, RN got medications out of the medication cart, opening several draws without hand hygiene or glove removal. Medications were given via gastrostomy tube, documented and returned to the medication cart. Gloves were doffed and then she adjusted resident’s clothing. Finally, Staff A, RN doffed her gown and performed hand hygiene. During an observation on 7/16/25 at 9:10 AM, Staff B, CNA and Staff C, CNA were transferring and providing hygiene for Resident #79. Both staff members donned gown and gloves. Resident #79 was transferred to her wheelchair and Staff B doffed her gloves and began combing Resident #79’s hair. New gloves were donned without hand hygiene. Staff C doffed gown and gloves and unplugged feeding pole and moved next to resident. Staff C then donned new gloves without hand hygiene but did not don a new gown. During an interview with the Director of Nursing (DON) on 7/17/25 at 11:45, she stated that EBP here is by the splash factor when germs can splash on to other surfaces. If residents have all their clothes on and the area of concern like a catheter or wound is covered, EBP is not required. If their clothes are off or they are close to the area where it could splash, EBP is required. To clarify, stated if taking off a resident’s shirt who has a suprapubic catheter, EBP would be required. However, if a vaginal catheter and taking off resident’s shirt, EBP would not be needed. Stated EBP would be required for transfer out of bed to a wheelchair with a mechanical lift. Stated combing hair would require EBP as it is part of the process of getting up. Pertaining to hand hygiene, stated that it would be required between glove changes and between dirty and soiled areas. Reviewed findings of observations with her and she stated that staff should have performed hand hygiene in both situations. Review of document titled Hand Hygiene, approved 5/22/25, indicates that the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of document titled Enhanced Barrier Precautions has no approval date but copyright date of 2025 indicates to implement EBP with high-contact resident care activities including providing hygiene. The Center for Disease Control and Prevention (CDC) directs nursing facility staff to implement EBP for residents with wounds and/or indwelling medical devices, regardless of MDRO status, during high contact resident care activities to include providing hygiene. (https://www.cdc.gov/long-term-care-facilities/hcp/ prevent-mdro/ppe.html?CDC_AAref_Val=https:// www.cdc.gov/hai/containment/PPE-Nursing-Homes.html) 2.The MDS assessment for Resident # 19 dated 5/3/2025, included a diagnosis of neuromuscular dysfunction of bladder and revealed the resident had an indwelling catheter. During 3 different observations on 7/14/2025 at 3:08, 7/15/25 at 9:04 AM, and 7/16/25, Resident #19 was sitting in her recliner and the catheter bag was lying on the floor, with the drain port touching the floor. Interview on 7/17/25 at 1 PM, the Director of Nursing reported the catheter bag should not be on the floor.