STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Washington	601 E Polk St Washington, IA 52353

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48888 Based on observation, interviews with resident, family, and staff, clinical record review, and facility policy review, the facility failed to ensure residents were treated with dignity and respect, when staff used inappropriate language and derogatory remarks towards 1 of 2 residents reviewed for dignity (Resident #28). The facility reported a census of 29 residents. Findings include: The Minimum Data Set (MDS) assessment, dated 04/19/24, revealed a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicative of severe cognitive impairment. Resident #28 had impairment of both upper and lower extremities and had required substantial to maximal staff assistance with dressing, bathing, and toileting cares. Diagnoses included: anoxic brain damage, Type 1 Diabetes Mellitus, Cerebrovascular accident (CVA), depression, and malnutrition. The Care Plan focus area, created 12/14/23, revealed that Resident #28 stated he wished to die. Resident #28 had a communication problem related to head injury and encouraged to continue to state thoughts, even when having difficulty. Staff are instructed to speak to Resident #28, clearly and on an adult level. The Care Plan additionally revealed Resident #28 had impaired cognitive function or impaired thought processes and agitated behaviors related to diagnosis of anoxic brain injury, which instructed staff to provide opportunities for positive interaction. The Care Plan focus area, created 03/07/24, revealed Resident #28 made false accusations against staff related to disease process, instructed that two staff are to be present when care is provided, and staff to report any accusation to Director of Nursing (DON) and Administrator immediately. On 05/07/24 at 09:03 AM, within close hearing distance, staff could be heard loudly making the statements, You will go to jail!, You are going to go to jail!, It's not fair for you to be swinging on us, you will go to jail!. Observed Staff A, Certified Nursing Assistant (CNA), transport Resident #28, via wheelchair, out of 600 hallway shower room to Resident #28's room, as she made loud statements, with irritated tone of voice, to Resident #28 about him going to jail. A second CNA, Staff B, exited 600 hallway shower room and informed that Staff A had made the comments heard from hallway to Resident #28. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/07/24 at 09:35 AM, the facility's Nurse Consultant informed that the incident between Staff A and Resident #28, on 05/07/24 at 09:03 AM, would be a self-reported incident with facility investigation and submission to the Department of Inspections, Appeals, and Licensing (D.I.A.L.). Nurse Consultant informed that Staff A would be placed on suspension. On 05/07/24 at 10:48 AM, facility submitted a self-reported incident of alleged abuse to D.I.A.L. intake office. Incident summary indicated that Staff A, CNA, threatened, cursed at, and threw a blanket at Resident #28 with Staff B, CNA, present. According to the facility reported incident, Staff A used profanity and cursed at Resident #28. Facility interviews revealed Staff A stated she would not help lay resident down and that she was going home. Resident #28 asked why she wouldn't help and raised his fist, Staff A responded with the statements heard from hallway that Resident #28 would go to jail if he hit her. The facility interviewed Resident #28 following incident, resident informed that he and Staff A do not get along and that Staff A threw a blanket at him. The intake concluded that Staff A had been suspended pending investigation. In a witness statement, signed and dated by Staff B, CNA, on 05/07/24, Staff A and B had given Resident #28 a shower. According to statement, Staff B informed Staff A they would need to lay resident down after shower, Staff A cursed, stated she was going home, and stated she would not lay Resident #28 down. Resident #28 then asked why Staff A would not help and raised his fist, in response Staff A told resident if he hit her he would go to jail. On 05/08/24 at 01:00 PM, Staff B, CNA, stated that on multiple different occasions in the presence of Resident #28, Staff A, CNA, would call Resident #28 names, such as retard, use profanity towards or around resident, and irritate him. Staff B additionally reported Staff A had, on more than one occasion, taken Resident #28's cell phone and put it on top shelf of closet with the knowledge that he would be unable to reach due to inability to stand and had reported these concerns to the Director of Nursing (DON). On 05/08/24 at 02:14 PM, Social Services Director stated that Staff A, CNA, had been heard using profanity around residents in general and talked about things she shouldn't at times in the nurse's station, but had not heard Staff A use profanity or curse directly at a resident. Social Services Director stated that interactions seen between Staff A and Resident #28 were joking with one another. Social Services Director denied ever hearing about Staff A calling Resident #28 names or placing his cell phone out of reach but stated this would not be acceptable. On 05/09/24 at 09:50 AM, Staff E, CNA, stated that Resident #28 keeps his cell phone in a bag around his neck at all times unless it is being charged on a countertop, so resident can get to it. Staff E noted that on more than one occasion, when Resident #28 stated he could not find cell phone, she had found it on the top shelf of the closet. Staff E reported asking multiple staff members who worked these days, including Staff A, why his cell phone was in the closet and stated, no one had an answer. Staff E stated that Staff A and Resident #28, initially, had joking-types of interactions but changed to more bickering and that Staff A used a lot of sarcasm towards Resident #28, as well as co-workers. Staff E noted that Resident #28 was sensitive and easily got his feeling hurt. Staff E reported overhearing a loud and inappropriate conversation that involved use of profanity between Staff A and Resident #28 from outside the resident's room at the Nurse's Station. Staff E reportedly went into the room and told Staff A, they would report her if this type of interaction was heard again. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/09/24 at 10:47 AM, Staff D, Licensed Practical Nurse (LPN), stated that Staff A had been heard using inappropriate language and profanity when joking with Resident #28 and that he has had to remind Staff A this was inappropriate. Staff D stated Staff A has an abrupt personality, but had not heard anything negative to the point of a complaint from staff or residents. On 05/09/24 at 02:19 PM, Staff A, CNA, confirmed she often works with Resident #28 and had assisted Resident #28 with shower on 05/07/24 at 09:03 AM. Staff A confirmed making the statements to Resident #28 that he would go to jail if he hit her. Staff A stated after Resident #28's shower, she spoke with the Director of Nursing (DON), about what happened and denied the use of any profanity. Staff A revealed that shortly after speaking to the DON, the Nurse Consultant informed her of suspension. Staff A reported her suspension was due to telling Resident #28 he would go to jail and understood this could be seen as a threat. Staff A stated that Resident #28 is in his right mind and is very aware of what he is doing, Staff A explained that he resided at facility due to contracted legs and inability to walk. Staff A confirmed that calling residents names and use of profanity towards residents is considered verbal abuse, stated that verbal abuse is to be reported to DON or the nurse on duty immediately. Staff A stated she has used profanity around Resident #28 but not towards him, denied ever calling Resident #28 any derogatory names. Staff A revealed that Resident #28 keeps his cell phone in red bag and is unaware of any reason his cell phone would be in the closet. On 05/13/24 at 10:30 AM, Director of Nursing (DON), stated when Resident #28 had been interviewed shortly after the self reported incident had occurred on 05/07/24, he was very upset, and stated that Staff A cursed at him so he pulled his fist back. DON stated that Staff A had been known to use profanity and inappropriate language at the Nurse's Station with residents present, and that Staff A had been educated that inappropriate language is not to be used with residents in the area. DON reported Staff A had not received any disciplinary action prior to suspension. DON denied any complaints received from Resident #28 or staff about Staff A cursing at residents, name calling, or placing his phone on top shelf of closet. On 05/13/24 at 11:55 AM, a family member reported Resident #28 had informed them of a recent incident in which Staff A had cursed at Resident #28 when he had asked for a bath. Family denied Resident #28 voicing any previous concerns about Staff A. On 5/13/24 at 2:26 PM, Resident #28 stated within the last week, Staff A, CNA, had pushed him in the chest, hit him on the forehead, used profanity when telling him to, shut the f- up, and called him a fat bitch. Resident #28 stated that this makes him feel bad and does not make him feel good about himself. Resident #28 stated that Staff A uses the F word all the time and indicated they used to joke around a lot before Staff A started treating him bad. Resident #28 reported that his cell phone is usually kept with him in a red bag but there had been times where he cannot find it or reach it when found in the closet, resident unaware of who put cell phone in the closet. Resident #28 informed that he does not want to be around Staff A. A facility document titled, Position Summary, for Certified Nursing Assistant (CNA), signed by Staff A on 10/31/23, revealed the expectation that all employees are expected to demonstrate proper respect for residents and to assist in resident calls, fall prevention, and advocacy as appropriate. Position summary additionally revealed that employees are expected to communicate clearly, accurately, and respectfully with residents/patients, families, visitors, vendors, and center employees. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Freedom of Abuse, Neglect, and Exploitation Policy, revised 10/2023, revealed a zero tolerance of abuse, of any type or manner, and abuse would be addressed accordingly. Additionally, for all reports of abuse perpetrated by staff, the allegations must not be dismissed based on resident's cognitive status. Policy informed that staff members are expected to be in control of their own behavior and understand how to work with the nursing home population. Listed under the heading, Mental and Verbal Abuse, policy included the following examples: 1. Use of verbal or non-verbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. 2. Verbal abuse may be the use of written or gestured, oral, communication or sounds within resident hearing distance. 3. Harassing a resident. 4. Mocking, insulting, ridiculing 5. Yelling or hovering over a resident with intent to intimidate. 6. Threatening residents including depriving residents of care or refraining resident from seeing family. 7. Isolating residents from social interaction.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 48888 Based on interview, employee personnel file review, and facility policy review, the facility failed to ensure timely completion of Dependent Adult Abuse Training, within first 6 months of hire, for 1 of 5 Direct Care Worker staff reviewed for Dependent Adult Abuse Training (Staff A). The facility reported a census of 29 residents. Findings include: On 05/13/24 at 09:38 AM, Nurse Consultant confirmed that Staff A, Certified Nursing Assistant (CNA), had not completed Dependent Adult Abuse Training within 6 months of employment. On 05/13/24 at 12:13 PM, Human Resources Director, stated that Staff A had been notified that training was due, through multiple face to face encounters, which included verbal notification with Director of Nursing (DON) present, as well as notification via text message which included a link to access training. Human Resources Director stated that Staff A had been informed that if training did not get completed, she would not be able to work the floor to which Staff A often responded, just fire me then. Review of Staff A's personnel file revealed a start date of 10/31/23 for the position of Certified Nursing Assistant (CNA). Employee file lacked documentation of Dependent Adult Abuse training that had been completed prior to, or following, the start of Staff A's employment at facility. The facility policy titled, Freedom of Abuse, Neglect, and Exploitation Policy, revised 10/2023, revealed the following employee training expectations: 1. The section titled, Overview, under subcategory 3, revealed expectation of employee training regarding: Abuse identification, reporting, prevention, screening, investigation, and protection to occur upon hire and annually thereafter, unless performance indicates additional training is needed. 2. The section titled, Employee Review, instructed for employee abuse investigations to include review of personnel file for all implicated staff and witnesses. Subcategory 8, additionally instructed to review in-services attended by the employee and to ensure that mandatory training on abuse and resident rights were completed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, resident and staff interviews, the facility failed to provide showers/baths as scheduled for 4 of 5 residents reviewed (Residents #4, #5, #7 and #16). The facility reported a census of 29 residents. Findings include: 1. The MDS dated [DATE] identified Resident #4 as cognitively impaired with a BIMS score of 10 and had the following diagnoses: Diabetes Mellitus, Non-Alzheimer's Dementia and Seizure Disorder. The MDS also identified Resident #4 as occasionally incontinent of urine and independent with most activities of daily living, however required assistance with showers/baths. In an observation on 5/7/24 at 10:33 AM Staff C, CNA asked Resident #4 who sat in a recliner in the common area by the nurse's station, if she could help him change his underwear, he refused and said he could do it on his own. A review of the shower/bath record in the electronic medical record for the past 30 days had documentation that only one shower was documented with partial assistance on 4/27/24. A review of the shower schedules revealed Resident #4 was scheduled to have his showers on Mondays and Thursdays on day shift. A review of the shower sheets had documentation of the following: In February, Resident #4 was scheduled to have showers on February 1, 5, 8, 12, 15, 19, 22, 26, & 29. He did not have showers on February 1, 5, 8, 12, & 22. In March, Resident #4 was scheduled to have showers on March 4, 7, 11, 14, 18, 21, 25, & 28. The sheet dated 3/11/24 had documentation of no shower, short staffed He did not have showers on March 4, 11, 14, 21, & 25. In May, Resident #4 was scheduled to have showers on May 2, 6, 9, & 13. He did not have a shower on May 6. On 7/15/22, the Care Plan identified Resident #4 with the problem of having impaired cognitive function or impaired thought processes and it did not direct staff on need to shower on Mondays and Thursdays. 2. The MDS dated [DATE] identified Resident #5 as cognitively impaired with a BIMS of 4 and had the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following diagnoses: Peripheral Vascular Disease, Diabetes Mellitus and Non-Alzheimer's Dementia. It also identified Resident #5 required substantial assistance with toileting and showering. An observation on 5/7/24 6:25 AM revealed Resident #5 sat up in a wheelchair in her room, covered with a shawl and wore a hospital gown and non-skid shoes, watching TV. A review of the facility shower schedule revealed Resident #5 was scheduled to have her showers on Wednesday evenings and on Saturdays on day shift. A review of the shower/bath record in the electronic medical record for the past 30 days had documentation that she had showers on 4/27/24 and 5/4/24 and that Resident #5 refused on 4/20/24 and 5/11/24. A review of the shower sheets had documentation of the following: In February, Resident #5 was scheduled to have showers on February 3, 7, 10, 14, 17, 21, 24, & 28. She refused on February 24 and 28. She did not have showers on February 3, 7, 10, & 17. In April, Resident #5 was scheduled to have showers on April 3, 6, 10, 13, 17, 20, 23, & 27. She did not have any showers on April 3. In May, Resident #5 was scheduled to have showers on May 6, 9, & 13. She did not have showers on the May 9 and 13. On 12/30/15, the Care Plan identified Resident #5 with the problem of and ADL (Activities of Daily Living) self-care deficit and directed staff that one staff will assist to shower two times per week. Will refuse showers and re-approach and notify the nurse. If refusal continues, approach the next day. 3. The MDS dated [DATE] identified Resident #7 as cognitively intact with a BIMS of 15 and had the following diagnoses: Depression, Schizophrenia, and Asthma. The MDS also identified Resident #7 as independent with most activities of daily living and required set up or clean up assistance with showers. An observation on 5/7/24 at 11:54 AM revealed Resident #7 sat on the edge of his bed, hair appeared slightly disheveled, but wearing clean clothing and non-skid shoes. Resident #7 reported he had not had a shower for 2 weeks. He has been washing himself up at the sink in his room, but he would like a shower. A review of the facility shower schedule revealed Resident #7 was scheduled to have his showers once a week on Fridays on evening shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the shower/bath record in the electronic medical record for the past 30 days had documentation that Resident #7 did not have any showers documented as given. A review of the shower sheets had documentation of the following: In February, Resident #7 was scheduled to have showers on February 2, 9, 16, & 23. There were no shower sheets completed for the month of February. In March, Resident #7 was scheduled to have showers on March 2, 9, 16, 22, & 29. The sheet dated 3/15/24 only had documentation no shower, no staff He did not have showers documented on March 2, 9, 16, & 19. In April, Resident #7 was scheduled to have showers on April 5, 12, 19, & 26. He did not have showers documented on April 12 & 26. In May, Resident #7 was scheduled to have showers on May 3 & 10. He refused on May 4. He did not have a shower documented on May 10. In an interview on 5/14/24 at 3:49 PM, the DON reported the following: a. The facility did not have a bath aide. b. She expected the aides to document showers/baths on both paper and in the electronic medical record. c. Once the paper documents are turned in, the MDS coordinator is responsible for entering that data into the electronic medical record. The facility currently does not have one and she is also functioning as the MDS coordinator. d. When asked why there has not been consistent documentation on the shower sheets on the dates the residents were scheduled, she reported probably because someone called in sick. She will schedule and have enough staff to cover when there are 2 people in a shower. Once every 2 months, there will be staff will be a no-call/no show. Many times staff will call in less than two hours before their shift starts. 48888 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The Minimum Data Set (MDS) for Resident #16, dated 02/02/24, revealed a Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicative of severe cognitive impairment. Resident #16 required substantial to maximal amount of staff assistance with bathing and dressing tasks. Resident #16 was always incontinent of bowel and bladder. Diagnoses included: dementia, cancer, depression, and adult failure to thrive. The Care Plan, revised 12/05/22, revealed Resident #16 required assistance with Activities of Daily Living (ADLs) and is resistive to bathing related to anxiety. Interventions instructed to allow Resident #16 to make decisions about treatment regimen, educate on possible outcomes of not complying with treatment or care, and encourage as much participation as possible during care activities. The Care Plan lacked direction on bathing frequency or behavioral interventions. The Care Plan additionally revealed Resident #16 had potential for skin impairment related to fragile skin and episodes of incontinence, instructed staff to keep body parts from excessive moisture, keep fingernails short, keep skin clean and dry, and perform weekly full body skin assessment. The Electronic Health Record (EHR) bathing task revealed one shower documented on 04/24/24 between the dates of 04/14/24 and 05/14/24. Facility provided bathing sheets revealed the following bathing documentation: On 03/09/24, Resident #16 received a shower. On 03/16/24, Resident #16 did not receive a shower, charted reason as no staff. On 03/23/24, Resident #16 received a shower, 14 days after last recorded shower. On 05/14/24 at 12:03 PM, Director of Nursing (DON), revealed that Resident #16 scheduled for bath or shower twice per week on Wednesdays and Saturdays.

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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** 48888 Based on interviews, clinical record review, and facility policy review, the facility failed to monitor and assess Moisture Associated Skin Damage (MASD) following the identification of skin impairment for 1 of 1 residents reviewed for non-pressure skin injuries (Resident #1). The facility reported a census of 29 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], revealed Resident #1 required dependence on staff assistance for transfers, had not been able to stand or ambulate due to current illness, exacerbation, or injury, and required partial to moderate staff assistance with bed mobility. The MDS indicated Resident #1 was at risk for pressure injuries, currently had Moisture Associated Skin Damage (MASD), and required pressure reducing devices for chair and bed. Diagnoses included: Heart Failure, Peripheral Vascular Disease (PVD), Body Mass Index (BMI) of 70 or greater, muscle wasting or atrophy, respiratory failure, and depression. The Care Plan focus area, revised on 08/11/23, revealed Resident #1 had potential for skin breakdown related to immobility, edema, fragile skin, and history of ulcers with the goal that Resident #1 would maintain or develop clean and intact skin. Interventions included: avoid excessive moisture, follow facility protocols for treatment of injury, and complete weekly full body skin assessment. The Treatment Administration Record (TAR), dated May 2024, revealed the following treatment orders: 1. Cleanse and dry perineal area, apply Remedy cream topically twice per day, started 07/07/23. 2. Tolnaftate Powder applied to all skin folds topically every shift for yeast/excoriation, started 02/05/23. 3. Cleanse right thigh open area with skin integrity wound cleanser. Apply optifoam every 7 days as needed for recurrent moisture related breakdown, started 05/23/23. Facility Skin Assessment, dated 03/03/24, revealed a new skin issue in perineal region that caused redness and episodic pain. In a follow up skin assessment, dated 03/12/24, perineal region continued to have redness and episodic pain. Facility lacked any additional skin assessment documentation performed between the dates of 03/12/24 and 05/14/24. On 05/08/24 at 01:00 PM, Staff B, Certified Nursing Assistant (CNA), reported Resident #1 had redness in creases of bottom and breast folds and stated some areas are open, some are healing. Staff B informed that Remedy cream is applied every day with cares. On 05/08/24 at 01:27 PM, Staff C, Certified Medication Assistant (CMA), reported Resident #1 had redness within skin fold that receive treatment of powder daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/09/24 at 10:47 AM, Staff D, Licensed Practical Nurse (LPN), reported Resident #1 had a lot of MASD areas in skin folds and occasionally gets pin-point open areas, however did not currently have any open areas. On 05/13/24 at 10:30 AM, the Director of Nursing (DON), revealed being responsible for the completion of skin assessments and reported these are to be completed weekly. The DON informed she had gotten behind on the weekly skin assessments. DON informed that Resident #1 had a lot of moisture issues and confirmed the last skin assessment had been completed on 03/12/24. The facility policy, titled Skin Management Standard, revised 10/2023, revealed that all residents are expected to receive a head-to-toe body audit completed by a licensed nurse on a weekly basis and as needed to implement appropriate treatment interventions. Policy instructed wound care nurse and DON are to make weekly rounds to validate the wound reports received and to document on the condition of wounds including measurements and characteristics of wounds weekly.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, resident and staff interviews, the facility failed to prevent a pressure ulcer from increasing in size and depth for one of one residents reviewed (Resident #2). The facility reported a census of 29 residents. Findings include: The Minimum Data Set, dated dated dated [DATE] identified Resident #2 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 15 and had the following diagnoses: Stage IV Pressure Ulcer to the Sacral Region, Neurogenic Bladder and Quadriplegia (paralysis of all 4 limbs). The MDS also identified Resident #2 as dependent on staff for toileting, dressing, lower body dressing, transfers, and showers. The Clinical Admission assessment dated [DATE] had documentation of the following: Resident #2 had a stage IV pressure ulcer to the gluteal area which had the following measurements: Length = 1 cm (centimeters) Width = 0.5 cm D= none documented No odor, tunneling or undermining or drainage. Peri wound normal. On 3/19/24, the Care Plan identified Resident #2 with the problem of a stage 4 pressure ulcer of the coccyx related to immobility and directed staff to: a. Document location of wound, amt of drainage, peri-wound area, pain, edema, and circumference measurements. b. Evaluate wound for: Size, Depth, Margins: peri-wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated. A review of the facility Skin Only Evaluations had documentation on the following dates: 4/5/24 L (length) =1.3 cm, W (Width)=1 cm, D (Depth)=3 cm No wound odor, tunneling, undermining or drainage. Skin tissue painful. Wound bed with granulation. Wound exudate serous. Dressing saturation heavy >75% 4/13/24 L=2 cm, W= 2 cm, D=2.7 cm (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	No wound odor, tunneling, undermining or drainage. Skin tissue painful. Wound bed with granulation. Wound exudate serosanguinous. Dressing saturation moderate 4/18/24 L=2 cm, W=1 cm, D= 2.7 cm No wound odor, tunneling, undermining or drainage. Skin tissue painful. Wound bed with granulation. Wound exudate serosanguinous. Dressing saturation moderate 5/7/24 L= 2 cm, W= 2 cm D= 3.5 cm No wound odor, tunneling, undermining or drainage. Skin tissue painful. Wound bed with granulation. No wound exudate. A review of the Nurse Practitioner Note dated 5/10/24 at 4:16 PM revealed the following: Wound Assessment: The opening is circular measuring just under 2 cm in diameter, however the depth of the wound is concerning measuring approximately 3.75 cm in depth. The tissue of the wound appears healthy; it's pinkish red, there is no gray tissue, no bleeding noted. Up to this point Hydro Fair Blue has been used for packing of this wound. This resident however has multiple stools a day and the dressings become soiled and has to be changed which limits the effectiveness of the Hydro Fair Blue. Will try to reduce the number of stools a day by adding a bulking agent. Once this resident is not having such frequent stools reevaluation of dressing will be done, in hopes of healing the open area. Measurements/assessments were not documented weekly as follows from: March 17 through March 23, March 24 through March 30, April 21 through April 27, April 28 through May 4 In an interview on 5/6/24 at 2:04 PM, the resident laid on an air mattress with alternating pressure and reported she had a sore to her bottom that she thought she had when she first moved into the facility. The urostomy bag was connected to a large drainage bag with a dignity flap draining clear yellow urine. An observation of wound care on 5/8/24 at 3:41 PM revealed Resident #2 had a pressure ulcer to the coccyx area. The wound appeared to be beefy red, surrounding skin without signs of infection and no odor noted. Staff D, LPN used the correct technique to cleanse the wound and to place Hydrofera Blue dressing into the wound bed covered with dressings soaked in normal saline and Mepilex. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/9/24 at 10:08 AM, Staff E, CNA reported Resident #2 had the pressure ulcer to her coccyx when she was first admitted and she didn't have the air mattress for the first few days. In an interview on 5/9/24 at 10:30 AM, the DON (Director of Nursing) reported the following: a. She was the wound nurse at the facility, she was also the DON, also the MDS Coordinator, Infection Preventionist and Medical Records Coordinator. Because of all these additional tasks that needed to be completed, she became late on documenting the wound assessments. b. All the wound assessments on Resident #2 ulcer were documented in the electronic medical record under the assessment tab. c. The wound should be assessed and measured once a week. In addition to the other job duties she had picked up, she also has to cover the floor when the nurses call in sick. The assessments in the electronic medical records are the only ones that have been completed, I did change her dressing yesterday, the wound used to look gray, now it's looking beefy red and improving. In an interview on 5/8/24 at 10:46 AM, Staff D, LPN reported the following: a. Resident #2 was admitted with her current pressure ulcer b. Nurses should document on the wound weekly. The facility had a wound nurse, who was our MDS coordinator, so now the DON has been the wound nurse, and our nurse practitioner whenever she makes rounds. She's supposed to be here weekly, but not always here weekly c. If the DON is unable to work, he was not sure if her responsibilities were assigned to anyone regarding wound assessments. d. The wound did have depth when she came in, but it wasn't documented. e. When asked what is care planned to keep the wound from growing, he reported Resident #2 has the alternating pressure air mattress which she got within the day she got admitted . Before the alternating pressure mattress arrived, we were floating her, repositioning her from side to side every 2 hours, not supposed to be up in the wheelchair more than 2 hours. In an interview on 5/8/24 at 11:58 AM, Staff B, CNA reported Resident #2 had the wound when she was admitted to the facility and the wound has grown deeper and it has become harder to turn her to her right side because of the pain to her hip. In an interview on 5/13/24 at 9:49 AM, the DON reported the following: a. Resident #2 was not going to a wound care center. b. When Resident #2 first came to the facility, the wound was gray in color and she asked the Nurse Practitioner for an order for normal saline gauze to pack in the wound twice a day. The color of the wound became beefy red, but grew deeper. Orders were written to discontinue the Hydrofera Blue because the depth of the wound wasn't healing. The top of the wound was starting to close before the inner wound healed. Now we're back to the normal saline soaked packing twice daily. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/14/24 at 3:49 PM, the DON reported the following: a. She would expect nurses to document measurements and assessments of pressure ulcers under the assessment tab in the electronic medical record under skin evaluations b. To address the problem of wound assessments not documented weekly, she reported she would make sure that she documents them every week. Upon request of the facility policy on wound care, the facility provided a document titled: Review of Skin Management Standard dated October 2023. It had documentation of the following: a. Complete documentation of the wound assessment in the medical record, numbering each wound. b. Utilizing the information contained in the Weekly Wound Reports review and discusses each wound individually at the weekly Care Management Meeting. c. The interdisciplinary team determines the appropriateness of continuing current treatment or altering treatment, as indicated.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on interview, clinical record review, and facility policy review, the facility failed to implement physician order for monthly indwelling catheter changes and further failed to provide an appropriate indication for use of an indwelling catheter for 1 of 2 residents reviewed for urinary catheter use (Resident #1). The facility reported a census of 29 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], revealed Resident #1 utilized an indwelling urinary catheter and had a Moisture Associated Skin Damage (MASD) wound. Diagnoses included: Body Mass Index (BMI) of 70 or greater, muscle wasting/atrophy, and depression. The Care Plan focus area, initiated 01/16/24, revealed Resident #1 had an indwelling catheter related to skin breakdown with a goal to remain free from catheter-related trauma. Care Plan informed that Resident #1 used size 16 French (Fr), with a 10 milliliter(mL) bulb, Foley catheter and instructed staff to ensure catheter bag is below level of bladder, to check tubing for kinks, and to monitor and report signs and symptoms of Urinary Tract Infection to Provider. The Treatment Administration Record (TAR), dated May 2024, lacked orders for routine catheter changes to be performed to decrease risk of Urinary Tract Infection (UTI) related to build up of bacteria on catheter tubing. Review of Physician's Order Summary, revealed there had been an order written to change Foley catheter, 16 Fr with 30 mL bulb, monthly and as needed, initiated on 02/25/24. A Nursing Progress Note, dated 05/02/24, revealed that Resident #1 continued to have a Foley catheter with no related diagnosis. 05/13/24 at 03:00 PM, Resident #1 confirmed she used an indwelling catheter and stated she was unaware of a schedule for changing her catheter but informed that her catheter would be changed the times when it fell out. 05/13/24 at 04:45 PM, the Director of Nursing (DON) revealed Resident #1 previously had a wound in the perineal area (groin) and when it got healed, Resident #1 wanted to keep the catheter. The DON stated Resident #1 was very incontinent of bladder and at times leaks around the catheter. DON confirmed that Resident #1 had no diagnoses to indicate the ongoing use of an indwelling catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, titled Incontinent Management Standard, revised 10/2023, revealed that residents who enter the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. The policy revealed the expectation that an indwelling catheter is not used unless there is valid medical justification and that an indwelling catheter for which continuing use is not medically justified is to be discontinued as soon as is clinically warranted. The policy instructed that catheters will be changed only in the event of an obstruction in the drainage system, if contamination occurs, if malfunction occurs, or upon specific written order of a physician.

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F 0692 Level of Harm - Minimal harm or potential for 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** 48888 Based on interview, clinical record review, and facility policy review, the facility failed to implement Dietitian recommendations to prevent weight loss for 1 of 2 residents reviewed for nutrition (Resident #17). The facility reported a census of 29 residents. Findings include: The Minimum Data Set (MDS), dated [DATE] for Resident #17, revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15 indicating severe cognitive impairment. Resident #17 required staff supervision or touching assistance with eating. No weight loss, or unknown, at time of assessment. Diagnoses included: Non-Alzheimer's dementia, stroke, non-traumatic chronic subdural hemorrhage, malnutrition, adult failure to thrive, muscle wasting, and atrophy. The Care Plan, revised 04/26/23, revealed a focus area for nutritional risk related to history of adult failure to thrive, dementia, recurrent depression, and abnormal labs with a goal that nutritional status would be stable as evidenced by no significant weight loss or skin breakdown. A Care Plan intervention instructed staff to weight Resident #17 each month and monitor for significant weight change. The Nursing Progress Notes revealed the following entries: 1. On 02/19/24, Dietitian recommendation for health shake twice per day to promote gradual weight gain. 2. On 03/15/24, Dietitian noted weight trending up since health shake twice per day initiated on 02/21/24. Recommendation for Speech Language Pathology (SLP) referral and increase health shake to three times per day. 3. On 04/15/24, Dietitian noted Resident #17's Electronic Health Record (EHR) continued to reflect health shake given twice per day and needed updated. 4. On 05/02/24, a care management meeting had been held, Resident #17 noted to be a weight loss. Speech Therapy consulted for a texture test. The Nursing Progress Notes lacked documentation of Provider or responsible party notification related to weight loss between the dates of 03/15/24 thought 05/05/24. The Medication Administration Record (MAR), dated March 2024, revealed an order for house supplement two times a day for weight loss, started on 02/21/24 and discontinued on 04/19/24. The MAR, dated April 2024, revealed the same order for house supplement two times a day for weight loss, started 02/21/24 and discontinued on 04/19/24. The MAR, dated May 2024, revealed an order for house supplement three times a day for weight loss, started 04/19/24 and continued through May. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Electronic Health Record, revealed the following weights for Resident #17: On 03/03/2024, the resident weighed 148.6 lbs. On 04/03/2024, the resident weighed 139.8 pounds which is a -5.92 % Loss. On 05/06/24 resident weight further decreased to 135.8 pounds. On 05/09/24 at 08:20 AM, Resident #17 had a moderate amount of thick brown liquid that had drooled from side of mouth following breakfast. On 05/08/24 at 01:27 PM, Staff C, Certified Medication Assistant (CMA), reported that Resident #17 pocketed food and not eating like he used to. On 05/09/24 at 10:47 AM, Staff D, Licensed Practical Nurse (LPN), reported Resident #17 had lost some weight and drinks house shakes. LPN unsure how often house shakes are provided. On 05/13/24 at 10:00 AM, the Director of Nursing (DON) reported Dietitian recommendations are given to the DON and Dietary Manager, and that DON is responsible for updating Electronic Health Record (EHR) with recommendations. DON revealed the update for health shake frequency may have been missed and stated Resident #17's Provider was made aware of weight loss and ordered a Speech Therapy evaluation. The facility policy titled, Nutrition and Weight Management Standard, revised 10/2023, revealed the purpose of policy to assure that the resident maintains acceptable parameters of nutrition status, taking into account the resident's clinical condition or other appropriate intervention, when there is a nutritional problem. Policy revealed that a significant weight loss is a loss of 5 or more percentage of body weight loss in a month. If a resident triggered as weight loss or gain the follow steps are to be completed: -DON to run a Weight Variance Report to see all triggered weights. -Re-weight if indicated -Registered Dietitian consultation -Medical Doctor (MD) notification. -Family notification. -Implement new orders. -Medication review -Increase weight frequency -Update Care Plan. -Weekly weights on residents who have a 5% weight loss in 30 days -Weight change investigation completed by Dietitian, Dietary Manager, or a licensed nurse.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, resident and staff interviews, the facility failed to answer a resident's call light in a timely manner for one of three residents observed (Resident #2). The facility reported a census of 29 residents. Findings include: The Minimum Data Set, dated dated dated [DATE] identified Resident #2 as cognitively intact with a BIMS of 15 and had the following diagnoses: Stage IV Pressure Ulcer to the Sacral Region, Neurogenic Bladder and Quadriplegia (paralysis of all 4 limbs). The MDS also identified Resident #2 as dependent on staff for toileting, dressing, lower body dressing, transfers, and showers. Observations on 5/6/24 revealed the following: 1:40 PM Resident #2's call light was on. The only staff in the hallway was Staff F, housekeeper. The call light was not audible from hallway. 1:47 PM Resident #2's call light remained on. Staff F entered room, no other staff in the hall. Resident #2 asked Staff F to turn on the fan in her room which Staff F did. 1:54 PM Staff C, CNA stood outside Resident 2's room and asked what she wanted. Staff C checked the isolation bin and walked down the other hall to retrieve more isolation supplies. Resident #2's call light remained on. 1:56 PM the call light remained on, Staff F walked out of Resident 2's room carrying her water pitcher. 1:59 PM Staff F returned to Resident #2's room with refilled water pitcher. The call light remained on. No other staff in room. 2:03 PM Staff C returned to Resident #2's room, replenished supplies for isolation bin, entered room and turned off call light which had been on for 23 minutes. In an interview on 5/6/24 at 2:04 PM, Resident #2 reported, she had a large digital clock which was highly visible from her bed and that it takes the staff a long time to answer her call light. She reported this happens several times a week mostly on second shift. Resident #2 reported it can take them up to two hours to answer her call light. On 4/16/24, the Care Plan identified Resident #2 with the problem of a behavior turning light on frequently and directed staff to: a. Remind her that she had just had the staff in the room. b. Staff to ask what she needs then ask again before they leave the room. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Staff to document times light is turned on In an interview on 5/9/24 at 10:08 AM, Staff E, CNA reported the following: a. Staff are expected to answer call lights in 10 minutes. She tried to answer as quickly as possible and reported they no longer have 2 way radios to contact each other. b. She felt there were not enough staff to provide the care the residents need c. The facility used to staff the floor with 3 aides, one med aide and a charge nurse. Now they only have 2 aides, one med aide and one nurse. d. She has seen the DON (Director of Nursing) working more and more on the floor because nurses have called in sick. e. When asked how often staff called in sick, she reported Staff A, CNA called in sick daily In an interview on 5/8/24 at 10:46 AM, Staff D, LPN reported the following: a. Staff are expected to answer call lights within 15 minutes. b. He had seen staff answer the call light, tell the resident they'll get to them next, then the residents will have to wait so long for staff to return. c. He felt there were not enough staff to provide the care residents need. He typically worked 6:00 AM to 6:00 PM and there was usually just one nurse, one CMA and 2 CNAs. d. Staff call in sick at least several times a week. There are a lot call ins from both full time staff and agency. It has been mostly their own staff. Both nurses and aides have called in. In an interview on 5/8/24 at 11:58 AM, Staff B, CNA reported the following: a. Staff are expected to answer the call light within 15 minutes. Anyone can answer a call light, but it does not always work out that way. b. She felt there were not enough staff to provide the care residents need. c. Typically on the day shift there is one nurse, one CMA and 2 CNAs for the 29 residents we have. She worked 12 hours and after she leaves at 6 PM there has not been another aide to relieve her so there will be only one CNA from 6:00 PM to 10:00 PM. d. Staff A, CNA has called in sick a couple of times a week. During the week, Staff B and Staff A were scheduled to work day shift Monday through Thursday. Staff A will leave during the day when her child gets sick and the CMA will have to stop passing medications to help out on the floor. e. The weekends are staffed better where they have 3 aides, one CMA and one nurse. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/13/24 at 10:34 AM, the Director of Nursing (DON) reported the following: a. She expected staff to answer call lights within 15 minutes. b. The day shift is typically staffed with one nurse, one CMA and 2 CNAs. c. Staff A, CNA called in frequently. d. The DON has had to work the floor because they are short nurses and this happens at least 3 times a week. If the scheduled nurse calls in, then the DON has to work on the floor.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on interview, clinical record review, and facility policy review, the facility failed to submit a Preadmission Screening and Resident Review (PASRR) following the addition of anti-psychotic medication for new mental health condition and further failed to document appropriate indication for antipsychotic medication on 1 of 5 residents reviewed for unnecessary medication review (Resident #28). The facility reported a census of 29 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], revealed Resident #28 required anti-psychotic medication on a routine basis, without an attempted Gradual Dose Reduction (GDR) or physician documented clinical contraindication for a GDR attempt. Diagnoses included: Anoxic brain injury, Cerebrovascular accident, and depression. The Care Plan focus area, initiated 11/07/23, revealed Resident #28 utilized psychotropic medications related to anoxic brain injury with the goal to remain free of psychotropic drug related complications, which included: movement disorder, discomfort, hypotension, gait disturbance, constipation, or cognitive/behavioral impairment. The Care Plan informed that Resident #28 had a behavior problem that indicated the resident would call out, swing at staff, and get agitated. The Medication Administration Record (MAR), dated May 2024, revealed orders for the anti-psychotic medication: Quetiapine Fumarate (Seroquel) 25 milligrams (mg) taken at bedtime for agitation, started on 12/01/23 and an additional order for Quetiapine Fumarate (Seroquel) 50 mg taken daily for agitation, started on 02/06/24. A Nursing Progress Note, dated 04/03/24, revealed a Telehealth Psychiatric encounter that listed the diagnosis unspecified psychosis, not due to a substance or know physiological condition and instructed the facility to continue with order for the anti-psychotic medication Quetiapine 50 mg daily for agitation. The Admission Record, also referred to as the Face sheet, dated 05/07/24 revealed diagnoses included: anoxic brain injury, cerebrovascular accident, and depression. The diagnoses list, updated on 05/14/24, included diagnosis of F29, or unspecified psychosis not due to a substance or known physiological condition. A Preadmission Screening and Resident Review (PASRR) report, dated 09/06/23, submitted by a Hospital, prior to Resident #28 admission to facility on 10/13/23, revealed a level 1 screen with no level 2 screening required for the determination of appropriateness for nursing home placement. The PASRR instructed that no further level 1 screening would be required unless resident is known to have or is suspected of having a serious mental illness, intellectual disability, or developmental disability and exhibit a significant change in treatment needs. The section for mental health diagnoses revealed that Resident #28 had depression. The PASRR also instructed that if changes occur, or new information refutes findings, a new screen must be submitted. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Hospital Discharge Summary, dated 10/13/23, revealed that throughout the prolonged hospitalization , Resident #28, was noted to have a tendency to develop acute somnolence and at times even agitated delirium with the administration of various centrally active agents such as, opioid, anticholinergic, and antipsychotic medications. Discharge Summary recommended to refrain from using any benzodiazepine or opioid medications unless acute indications arise. The facility assessment for Abnormal Involuntary Movement Scale (AIMS) evaluation, dated 03/07/24, revealed a score of 0, which indicated no involuntary movements noted while taking psychotropic medications. The AIMS evaluation, dated 04/19/24, revealed a score of 3, which indicated Resident #28 had moderate involuntary movements while taking psychotropic medications. On 05/14/24 at 01:43 PM, the Facility Administrator confirmed, via electronic mail, that Resident #28's PASRR had not been updated when antipsychotic medication was started and notified that Telehealth Psychiatrist wrote an order with the diagnosis for F29, unspecified psychosis. Administrator revealed education would be provided to Social Services Director on PASRR submission. The facility policy titled, PASRR Policy, revised 10/2023, revealed that PASRR is required under the State Medicaid program with purpose to identify specialized services for an individual with mental illness and mental retardation (MI/MR) residing in a nursing facility and offer the most appropriate setting for their needs. Additionally, the policy informed that PASRR assures that psychological, psychiatric, and function needs are considered in long term care and revealed that the facility Social Services Director would be accountable for this process. The PASRR Policy instructed that if one of the conditions (MI/MR) is identified, the Social Worker will make a referral for a level 2 assessment and must submit documentation of medical history, current medications, physical exam, and psychological evaluation including intelligence testing and functional evaluation will be needed. Policy further instructed that resident care planning should include a review of diagnoses and/or change in status which would include the need for specialized services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, and staff interview, the facility failed to administer Tresiba insulin as ordered, failed to prime the needle of the Novolog insulin pen, and failed to write the open and expiration dates for 3 insulin pens for one of one residents reviewed with insulin (Resident #26). The facility reported a census of 29 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #26 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and had the following diagnoses: Diabetes Mellitus, COPD (Chronic Obstructive Pulmonary Disease) and an open wound. The MDS also identified Resident #26 as independent with most activities of daily living. During an observation of a medication pass on 5/8/24 8:11 AM, Staff D, LPN removed an insulin pen of Tresiba and another insulin pen of Novolog from Resident #26's medication drawer. The pens were not dated when they were opened. When he dialed the amount to be given on each pen, he did not prime the needles. When the surveyor noted there were no dates on the pens when opened, he said he would waste those and get new pens. When Staff D returned, he reported there were no additional Tresiba pens and would need to call the doctor to get a hold order until a new pen arrives. He wrote the date opened on the new Novolog pen and did not write the date the pen would expire (should be 28 days after opened). He placed a needle on the pen, dialed it to 10 units, however, he did not prime needle with 2 units before he administered the Novolog to Resident #26. A review of the May 2024 Physician Orders and May 2024 Medication Administration Records (MARs) had documentation of the following: 3/20/24 Tresiba Subcutaneous Solution Pen-injector Inject 28 units subcutaneously one time a day Discontinued on 5/8/24. 3/20/24 order for Novolog FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML Inject 8 units subcutaneously in the afternoon 3/20/24 Novolog Subcutaneous Solution Pen-injector Inject 10 units subcutaneously two times a day 5/8/24 Tresiba Subcutaneous Solution Pen-injector Inject 28 units subcutaneously one time a day. No dose signed out for 5/8/24 The MARs did not provide instructions to prime the needles of the insulin pens prior to administration. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/24, the Care Plan identified Resident #26 with the problem of Diabetes Mellitus Type II and directed staff to administer diabetes medication as ordered by the doctor. The Care Plan did not instruct the nurses to prime the needle with 2 units on the insulin pens and to write the open date and expiration date of pens once opened. A review of the Progress Notes from 5/7/24 to 5/14/24 revealed no documentation to show the physician was notified of the dose of Tresiba that had not been given. A review of the facility's form titled: OMNICARE Guidance for Using Insulin Products, dated 2024, revealed documentation of the following: Prime pen-like devices prior to each and every injection to minimize air bubbles. Dial units as per below guidance and push until a drop of insulin is seen at the top of the needle. Other Insulin Pen Devices prime with 2 units. A review of the facility's form titled: OMNICARE poster of Safe Insulin Pen Practices, dated 2023, had documentation of the following: Insulin pens must be stored in the refrigerator and dated once removed Always prime then dial to ensure correct dosage In an interview on 5/8/24 at 10:46 AM, Staff D, LPN reported when opening up a new insulin pen, he should write the date it is opened and the date it expires. Before he gets ready to administer insulin from a pen, he should prime the needle with 2 units first then give the amount ordered. In an interview on 5/13/24 at 10:34 AM, the Director of Nursing (DON) reported when opening up a new insulin pen, she would expect the nurse to write the date they opened it and the date it is supposed to expire. Before administering insulin from an insulin pen, she would expect the nurses to prime the needle with 2 units first. In an interview on 5/14/24 at 3:49 PM, the DON reported she would not expect to see the issues with dating insulin pens with open and expiration dates and the need to prime insulin pens with 2 units to be addressed on the care plan. She also reported she did not think there were instructions on the MARs, that it should be second nature. They should know they should prime those needles, just like dating the pens. This is a big problem with a lot of the nurses with dating anything that they open.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, resident and staff interviews, the facility failed to serve food at a palatable temperature for one lunch meal observed and for one of three residents interviewed (Resident #2). The facility reported a census of 29 residents. Findings include: The Minimum Data Set, dated dated dated [DATE] identified Resident #2 as cognitively intact with a BIMS of 15 and had the following diagnoses: Stage IV Pressure Ulcer to the Sacral Region, Neurogenic Bladder and Quadriplegia (paralysis of all 4 limbs). The MDS also identified Resident #2 as dependent on staff for toileting, dressing, lower body dressing, transfers and showers. On 3/19/24, the Care Plan identified Resident #2 with the problem of potential for nutritional problem and directed staff to administer medications as ordered, monitor and document for side effects and effectiveness. In an interview on 5/6/24 at 2:04 PM, Resident #2 complained that food is not always warm and this happened with most meals. In an interview on 5/8/24 at 6:51 AM, when asked how the temperature of her meals have been the past 2 days, Resident #2 reported they were lukewarm and not as warm as she would like her food to be. In an interview on 5/9/24 at 10:08 AM, Staff E, CNA reported when room trays are delivered to the rooms, they are delivered in carts that are open on all sides. There is a hard plastic dome to cover the plate. In an interview on 5/8/24 at 10:46 AM, Staff D, LPN reported when room trays are delivered to the rooms, they are delivered in a cart that is open on all sides. The food is covered with a plate cover. In an interview on 5/8/24 at 11:58 AM, Staff B, CNA reported when room trays are delivered to the rooms, they are delivered in a cart that is open on all sides. In an interview on 5/13/24 at 10:34 AM, the DON reported when room trays are delivered to the rooms, they are delivered in a cart that is open on all sides. She thought the kitchen had thrown away the plate warmers they used to utilize. 48888 On 05/07/24 at 11:30 AM, observed lunch served from the main kitchen. The cook checked temperatures of food to be served from steam table as follows: Chicken noodle casserole= 166 degrees Fahrenheit (F) Fish sandwich= 194 degrees F (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Steamed Peas= 187 degrees F Alternate Capri vegetables= 186 degrees F On 05/07/24 at 12:15 PM, final meal tray served and transported to room. The temperature of food served after transportation from kitchen was as follows: Chicken noodle casserole= 126.6 degrees F Steamed Peas= 118 degrees F On 5/07/24 at 02:55 PM, the Dietary Manager revealed the expectation that the temperature range of hot food served is between 135 to 145 degrees Fahrenheit (F).

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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. 25855 Based on record review, staff interview, and facility policy review, the facility failed to provide surveillance data on employee illnesses and documentation of results for testing the water for Legionella. The facility reported a census of 29 residents. Findings include: 1. Upon review of the facility surveillance data on 5/13/24 at 9:26 AM, there was no documentation to show surveillance on any of the employee illnesses. In an interview on 5/13/24 at 9:26 AM, the DON (Director of Nursing)/Infection Preventionist reported the following: a. She became the Infection Preventionist on April 2023 and became the DON in November 2023. b. She did not track any of her employee illnesses and when they tested positive for COVID. c. The facility had an outbreak of COVID in January 2024. The first resident that tested positive came to the facility from the hospital and 8 residents tested positive. 4 staff tested positive. d. She did not track employee illnesses from other departments as they have not been reporting it to her. She thought she was only responsible for tracking nursing department illnesses, but she was not documenting surveillance data on them. A review of the certificate of completion of the Center for Disease Control Nursing Home Infection Preventionist Training Course revealed the DON completed the course on 2/10/20. A review of the Infection Surveillance Policy dated as last revised September 2023 had documentation of the following: Overview: The facility will use a systematic method of collecting, consolidating, and analyzing data concerning the distribution and determining factors of a given disease or event. An outbreak may be defined as an increase of an incidence of a disease, complication or above the background rate. The facility will have baseline surveillance data on the incidence of nosocomial infections in order to identify outbreaks. Following the collection and analysis of the data, the information will be provided to the staff for education purposes to strive to improve infection prevention/control outcomes. The policy failed to address the need to collect data on employee illnesses. The process only included data collection specific to residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. When asked to provide documentation the facility water had been tested for possible Legionella on 5/14/24 at 11:15 AM, the Administrator reported the former Maintenance Supervisor did not document any testing results. She provided a plastic bag with 2 cartridges that she reported were used to test the water. One cartridge was dated 2/27/23 and the other dated 4/3/23. A review of the facility document titled: CDC (Center for Disease Control) Guidelines to Develop a Water Management Program to Reduce Legionella Growth and Spread in Buildings dated 6/5/2017 had documentation of the following: Your written program should include at least the following: Program team, including names, titles, contact information, and roles on the team. Building description, including location, age, uses, and occupants and visitors. Water system description, including general summary, uses of water, aerosol-generating devices (e.g., hot tubs, decorative fountains, cooling towers), and process flow diagrams. Control measures, including points in the system where critical limits can be monitored and where control can be applied. Confirmatory procedures, including verification steps to show that the program is being followed as written and validation to show that the program is effective. Document collection and transport methods and which lab will perform the testing if environmental testing is conducted. The facility did not have a policy to address: a. Measures to prevent the growth of Legionella. b. A way to monitor the measures in place (i.e.: testing protocols and acceptable ranges) and ways to intervene when control limits are not met.