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	01/30/2025

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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observations, clinical record review, facility policy and staff interviews the facility failed to ensure a dignified dining experience for 5 of 5 residents reviewed for dignity with dining, and failed to ensure a resident treated in a dignified manner during interactions between staff and residents for 1of 4 residents reviewed for dignity (Resident #10, Resident #17, Resident #19, Resident #28, and Resident #30). The facility reported a census of 35 residents. Findings include: 1. Review of Resident #17's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored 8 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated the resident had moderately impaired cognition. Review of Resident #17's Care Plan dated 8/21/24, revised on 9/12/24, revealed, I have behaviors including hallucinations, delusions, agitation, restlessness, yelling out r/t (related to) dementia. Review of interventions per the resident's Care Plan revealed the following: a. (Date Initiated 8/21/24): Caregivers to provided opportunity for positive interaction and attention. Stop and talk with me when passing by. b. (Date Initiated 8/21/24): Explain all procedures to me before starting and allow me time to adjust to changes. c. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from the situation and take to alternate location as needed. Observation conducted 1/12/25 at 2:10 PM revealed Resident #17 in their wheelchair, and the resident attempted to go into another resident's room, the room of Resident #5. Resident #5 observed in their wheelchair inside the doorway area to their room at time of observation. On 1/12/25 at 2:13 PM, the facility's Director of Nursing (DON) said in presence of Resident #17, Hey, hey, hey, what are you doing going into other people's room .no. Resident #17 then mentioned something about a bed spread, and the DON responded, .you do not go into other people's rooms .they are their private rooms. The DON further told Resident #17 you can't open people door and go into other people's rooms. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25 at 6:34 PM, the facility's Administrator queried about the following interaction: Hey, hey, hey, what are you doing going into other people's room .no. The Administrator explained Resident #17 was very hard of hearing, and sometimes if try to explain detailed things, might not understand. The Administrator further explained tried to not let residents go in there (Resident #5's room), sometimes Resident #17 was very hard of hearing, and sometimes staff talked very loudly. 2. On 1/12/25 at 11:51 AM, observation of dining in the small dining area near the facility's conference room, referred to by the facility as the ADR or assisted dining room, revealed the following: Five residents (Residents #10, #17, #19, #28, #30) were present around two U shaped tables that were pushed together to make a circle shape. Staff B, Certified Nursing Assistant (CNA)/Certified Medication Aide (CMA) present at the time of observation. Review of the MDS assessment for Resident #10 dated 1/10/25 revealed the resident scored 5 out of 15 on a BIMS exam, which indicated severely impaired cognition. Per this assessment, the resident required partial/moderate assist for eating. Review of the MDS assessment for Resident #19 dated 11/29/24 revealed the resident scored 5 out of 15 on a BIMS exam, which indicated severely impaired cognition. Per this assessment, the resident was independent with eating and was always incontinent of urine. Review of the MDS assessment for Resident #28 dated revealed the resident scored 6 out of 15 on a BIMS exam, which indicated severely impaired cognition. Per this assessment, the resident required supervision/touching assist for eating. Review of the MDS assessment for Resident #30 dated 12/6/24 revealed the resident scored 14 out of 15 on a BIMS exam, which indicated intact cognition. Per this assessment, the resident was independent with eating. On 1/12/25 at 11:55 AM, there were 5 residents present and one staff member. On 1/12/25 at 11:56 AM, surveyor heard a dripping type noise, and resident (Resident #19) observed to have a puddle underneath the resident's wheelchair. At 12:00 PM, Resident #19 remained at the table. At 12:03 PM, Resident #19 still at the table with liquid observed on the floor underneath him. On 1/12/25 at 12:09 PM, Resident #19 remained at the table with a drink in front of him and a bowl. On 1/12/25 at 12:12 PM, Resident #12 remained at the U shaped table in the common area/dining room space at end of hall by the conference room. On 1/12/25 at 12:13 PM, staff queried Resident #19 if resident was all finished, and Resident #19 responded yeah, but there's a puddle of water down here. On 1/12/25 at 12:14 PM, when Resident #19 lifted their feet observation revealed the spill on the floor. On 1/12/25 at 12:22 PM, Resident #19 observed in the hallway coming from the common area/dining area at the end of the hallway by the conference room. On 1/12/25 at 12:24 PM, Resident #19 remained the hallway coming from the end of the hall by the conference room where residents ate the meal. 3. Observation of dining in the main dining room, conducted 1/13/25 at 11:39 AM, revealed the following: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/13/25 at 11:46 AM, Staff assisted Resident #28 to the table. At 11:52 AM, Resident #28 served food, and staff not next to the resident to assist. On 1/13/25 at 11:53 AM, Resident #10 and Resident #28 had their food, and Resident #17 and Resident # 30 did not. On 1/13/25 at 11:57 AM, Staff C, CNA assisted Resident #28 with the meal while standing. Staff C walked away from Resident #28 and got a chair. Resident #19 observed with his utensils in his hand and napkin in his hand, and was approximately a foot from the table. Resident #19 tried to put their napkin on the table, and Resident #19's arm was fully extended when doing so. At 11:59 AM, Resident #19 held utensils in hand, the resident's napkin was half on and half off the table, and one of the utensils was slipping. At 12:01 PM, Resident #19 not feeing self, at 12:02 PM the resident dropped their knife on the floor, and Resident #19 approximately a foot from the table. Staff not observed to respond when resident dropped his knife. On 1/13/24 at 12:04 PM Resident #19 had hand on his fork, and was not eating. The resident's fork dropped, the resident had the napkin in his hand, and the resident leaned forward. At 12:05 PM, Resident #19 had a spoon sitting on untouched food, and Staff C said would scoot the resident up. When Staff C assisted Resident #19, Resident #28 did not receive assistance, Resident #28 had built up silverware, and lifted it, however not to their mouth. On 1/13/25 at 12:09 PM, Resident #19 not feeding themselves. Staff C walked away from the table to the kitchen, and Resident #10, Resident #28, Resident #30, and Resident #17 present at the table. On 1/13/25 at 12:11 PM while Staff C assisted Resident #30, Resident #28 looked on with weighted silverware in hand, Resident #19 was not eating, and Resident #10 not eating. On 1/13/25 at 12:18 PM, Staff C not present at the table with residents. Resident #10, Resident #19, Resident #28, and Resident #30 present at the table when Staff C went to an office off of the main dining room, then was present in the doorway to the kitchen. On 1/29/25 at 4:00 PM, Staff K, CNA queried if Resident #19 could feed himself, Staff K responded the resident could, and when queried if any issues with that, Staff K explained, in part, he would really say saw a decline in feeding self lately. Per Staff K, it was hit or miss with him (Resident #19) on the day, sometime did ok, and other times Staff K had to help him. On 1/29/25 at 9:56 AM, Staff C, CNA explained usually had one aide for each dining room and one on the floor, they did not think it worked, and further explained a lot of people finished before others, call lights went off, and needed to leave the dining room to answer call lights. Per Staff C, if short staffed the assisted dining room moved to the main dining room to be able to better control everything. Staff C explained with the ADR, was a lot of running down the hall trying to assist, Staff C asked what if a resident needed something and no one back here (ADR) other than an aide, which meant needed to leave and come back. When queried about the residents in the ADR, Staff C explained most of them required watching to make sure they were actually eating, and there was one resident who required assistance with feeding if needed it, identified as Resident #28. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When queried about sitting or standing to assist a resident with the meal, Staff C explained she had never been told sitting or standing as long as assisted all times. When queried about the scenario of a resident having a puddle underneath their chair, Staff C explained they would try to get another aide, pull and change resident and bring him back. When queried about having the puddle remain underneath the resident, Staff C explained they would try to take resident out and have them come back, and further explained there were times no aide down there and couldn't get a hold of anyone. Staff C explained the facility had the ADR 2 weeks, and Staff C unaware why it had been initiated. On 1/30/25 at 4:28 PM, the facility's DON queried how staff should be positioned when assisting residents, and responded so can see them, sitting at the table preferably. When queried if appropriate for staff to stand, the DON explained they themselves had been known to stand and walk around table, and as long as still watching them, was good with that. The DON acknowledged staff not to leave the assisted dining, and there was to be one staff member at all times until done eating and transported out. When queried if the same was true if the ADR table was present in the main DR, DON explained somebody was supposed to be with them, When queried about puddle forming underneath Resident #19, the DON explained staff should come in, borrow the phone, call someone to come get (resident) changed, and floor mopped up. When queried about resident remaining to finish his meal, the DON responded prefer to get changed, and go back with dry pants on to finish his meal. When queried if residents at the same table should be the meal at the same time, the DON acknowledged yeah. On 1/30/25 at 6:36 PM, the Administrator queried about positioning during assistance with meal, explained standing not appropriate, and per Administrator did not agree with standing over residents at all. The Administrator queried what should happen if puddle forming underneath Resident #19, and responded as soon as staff member notified, the resident out of the dining room to be changed, and housekeeping notified to be cleaned up promptly. The Facility Policy titled Resident Rights 483.10 F 550-F 586, origination date 11/2016 last revised 12/2024, revealed the following: 3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.

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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** 47336 Based on the clinical record review, staff interviews, and the facility policy, the facility failed to have a resident's code status in the the electronic medical record match their IPOST(Iowa Physician Orders for Scope of Treatment) for 1 of 14 residents reviewed for advance directives (Resident #18). The facility reported a census of 35 residents. Findings include: 1. The Minimum Data Set assessment dated [DATE] revealed Resident #18 scored a 15 out of 15 on the Brief Interview for Mental Status which indicated intact cognition. The EMR (electronic medical record) revealed the following orders: a. CPR (Cardiopulmonary resuscitation) ordered on [DATE] and discontinued on [DATE] b. DNR/DNI (Do Not Resuscitate/Do Not Intubate) ordered on [DATE] The IPOST signed on [DATE] by the resident and signed by the physician on [DATE] indicated DNR. The Care Plan revealed a focus area dated [DATE] for resident expressed desire for Advanced Care Planning interventions for CPR. The interventions dated [DATE] revealed CPR. The interventions dated [DATE] revealed full treatment: include additional treatment and intubation (putting a tube into the trachea to maintain an airway), mechanical ventilation, and cardioversion (procedure to restore a regular heart rhythm) as indicated. Includes intensive care. Transfer to hospital if indicated. The Care Conference Note dated [DATE] at 3:41 PM, revealed the team spoke with [name redacted] about his care, his weight is maintained, his back is hurting going to see if they will increase pain med, would like to start coming to BINGO, social worker will contact [name redacted] to help find a group home possibly for placement, he would like to do a walk to dine, code status change is on effect will update once DR (doctor) signs off, going from CPR to DR. During an interview on [DATE] at 3:56 PM, the (Director of Nursing) DON queried on the Resident #18 code status and she stated the last she knew he was a full code and looked at the computer and said, yes he was a full code. DON informed of the progress note concerning Resident # 18 code statue. She stated let me check and see if he signed a new sheet and left the room and returned moments later. She stated yes, he did sign a new sheet, and it didn't help she was so far behind on records. During an interview on [DATE] at 8:51 AM, the Social Services Director queried if she spoke to the residents about their code status stated she spoke to them about their code status quarterly and during their care conference. She said they signed the back of the IPOST of it being reviewed. She stated if they change their code status they fill out a new form and then she sends it to the doctor to have him sign it and then it goes into the hard chart. Social Services Director stated the nurse or the DON need to change the order in the computer because she can't do that. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:10 PM, the DON asked how the process works if a resident changes their code status and she stated the Social Services Director is supposed let us know if it gets changed. The DON stated the Social Services Director cannot go in and make the change. She explained, we need to update the hard chart with the different status. The DON stated the Social Service Director puts the new form in the doctor's folder to sign and then it goes into medical record. The DON stated she organizes the files and looked at the peach forms to make sure they haven't changed and change it if needed and she hadn't been through the records in awhile. The Facility Advance Directives Policy dated ,d+[DATE] revealed the following: a. Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. b. The Interdisciplinary Team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident assessment instrument (MDS). c. Changes or revocations of a directive must be reviewed by the IDT. The IDT may require new documents if changes are extensive. The Care Plan Team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment (MDS) and care plan.

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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** 47336 Based on clinical record review, facility policy review, resident and staff interviews, the facility failed to find, and then replace a residents personal bed pad for 1 of 2 residents reviewed for personal property (Resident #15). The facility reported a census of 35 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed the resident dependent with toileting hygiene and occasionally incontinent of bladder. The MDS revealed the resident took a diuretic. The Resident Inventory for Resident #15 dated 12/1/23 revealed the resident has 2X monogrammed pads. During an interview on 1/12/25 at 2:29 PM, Resident #15 stated he was missing one of his pads and it had his name on it. He stated one side was blue and the other side was white. He stated he said he had been missing for a few months, probably longer. He stated he told laundry about it and they said they had problems finding one with the same material. The Patient Grievance Form revealed the following: a. Nature of grievance: Missing pad with name on it, socks, and pjs. (pajamas) b. Date assigned: 1/21/25 c. Returned by 1/22/25 d. Resolution of grievance: pjs in wash, will get to resident once dried. Still looking for pad. Haven't been able to locate. Will return socks once dried. Looking for blue pjs, I let him know Ill look in all closets. During an interview on 1/22/25 at 11:26 AM, Staff S, Housekeeping Aide queried about Resident #15 bed pad stated he had 2 when he came in and one came up missing. She said they had looked for it everywhere and they couldn't find it. Staff S asked if the facility would replace it and she said she didn't know the process and to ask the housekeeping supervisor. During an interview on 1/27/25 at 9:59 AM, the Housekeeping Supervisor asked if she knew anything about Resident #15 bed pad missing and she stated yes, they discussed it often and searched for it. She stated they think it might of gotten thrown away. She stated she needed to follow up and make sure it got replaced. The Housekeeping Supervisor stated the pad had been missing since before she started [job] at the end of October. The Housekeeping Supervisor stated the DON (Director of Nursing) would be the one who ordered the bed pads. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/25 at 12:19 PM, the DON queried if she knew about Resident #15 bed pad missing stated she tried to find one to buy to replace it and it was a big one and having a hard time finding one. She stated the staff continued to look for it. The DON asked how long it was missing and she stated for a couple of months. During an interview on 1/30/25 at 6:00 PM, the Administrator queried if she knew anything about Resident #15 pads stated she thought he bought them. She stated when he first reported it missing housekeeping and other staff looked for it. The Administrator stated she told him they would replace it even though the admission packet says the facility wasn't responsible for personal items. The Administrator asked how long the pad had been missing and she stated for a couple of months but at first they gave him extra bed pads to use and that seemed to make the resident happy but now he wants the pad replaced. The Administrator asked the time frame the facility would look for missing items before replacing them and she stated a couple of weeks. The Facility Personal Property Policy dated 10/24 revealed the following: a. The resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished. b. The facility will promptly investigate any complaints of misappropriation or mistreatment of resident property.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 47336 Based on record review, staff interviews, and the facility policy the facility failed to complete a baseline care plan within 48 hours of admission for 2 of 14 residents reviewed for baseline care plans (Resident #31, and Resident #133). The facility reported a census of 35 residents. Findings include: 1. A review of a Nurse ADV Admission note, dated 12/6/24 at 1:38 PM revealed Resident #31 arrived at the facility for admission by ambulance. A review of the clinical record revealed a lack of baseline care plan completed within 48 hours. The electronic health record page Standard Assessments indicated a Next Assessment Due - Baseline Care Plan v.01: 39 days overdue - 12/6/24. During an interview on 1/29/25 at 11:41 AM, the Director of Nursing (DON) stated she hadn't gotten around to doing the baseline care plans, including Resident #31 plan. The DON stated the nurses did some of the paperwork and she tried to do the Baseline Care Plan the next day to learn more about the residents. 2. A review of an Admission Summary note, dated 1/8/25 at 4:37 PM revealed Resident #133 admitted to the facility from a local hospital. A review of the clinical record revealed the lack of a baseline care plan completed within 48 hours. The electronic health record page Standard Assessments did not list the description Baseline Care Plan. During an interview on 1/30/25 at 3:40 PM, the DON stated she tried to get them done. She stated she had a worksheet for the nurses to check off of when they have a new admission to make sure it gets done. A review of the facility policy, effective date 8/2024, titled Baseline Care Plan Policy statement declared: A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty eight (48) hours of admission. Guidelines included, in part: 1. A baseline care plan will be developed within forty-eight (48) hours of the resident's admission. 2. Included baseline information to be included, but not limited to; a. Initial goals based upon admission orders; b. Physician orders; c. Dietary orders; (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Therapy services needed; e. Social services needed; and f. PASARR recommendation, if applicable. 4. The Interdisciplinary Team will review the Attending Physician's orders (e.g. dietary needs, medications, and routine treatments, etc) and implement a baseline nursing care plan to meet the residents immediate care needs. 5. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary care plan.

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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** 45338 Based on observation, clinical record review, facility policy review, and staff interviews, the facility failed to ensure targeted behaviors for the use of an antipsychotic medication and pain were included on the comprehensive care plan for 2 of 14 residents reviewed for care planning (Resident #12, Resident #25). The facility reported a census of 35 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment, dated 8/7/24 for Resident #12 revealed the resident scored 11 out of 15 on a Brief Interview for Mental Status (BIMS) which indicated moderately impaired cognition. Per this assessment, the resident took antipsychotic medication on a routine basis only. Review of the Medical Diagnoses for Resident #12 revealed the following diagnoses added in the resident's electronic health record (EHR) on 8/1/24: major depressive disorder, recurrent, with severe psychotic symptoms, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of Resident #12's Census documentation in the EHR revealed the resident admitted to the facility on [DATE]. The Physician Order active 8/1/24 to 11/28/24 revealed, QUEtiapine Fumarate ER Oral Tablet Extended Release 24 Hour 150 MG (Quetiapine Fumarate), an antipsychotic medication, with directions to give 1 tablet by mouth at bedtime related to major depressive disorder, recurrent, severe with psychotic symptoms. The resident also had an additional order for Quetiapine Fumarate active 11/27/24 to 12/2/24, and also had a current order for the medication initiated 12/4/24 that remained active for the resident. Review of Resident #12's Care Plan dated 9/6/24 revealed, [Resident #12] uses psychotropic medications r/t (related to) Behavior management. Interventions per the Care Plan, all dated 9/6/24, included the following and lacked specific targeted behaviors for Resident #12: a. Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness. b. Consult with pharmacy, MD (Medical Doctor) to consider dosage reduction when clinically appropriate at least quarterly. c. Do AIMS (abnormal involuntary movement scale) quarterly. (continued on next page)

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Aspire of Washington	601 E Polk St Washington, IA 52353

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Monitor/document/report PRN (as needed) any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles,shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression,suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Observation on 1/12/25 at 2:21 PM revealed Resident #12 in bed in their room, with the resident's room dark. On 1/30/25 at 4:29 PM, the facility's Director of Nursing (DON) queried if targeted interventions/behaviors were part of the care plan and responded she tried to. The DON explained behaviors were part of social work position. When queried who identified targeted behaviors, the DON responded anyone who saw what they were. When queried who could add to the care plan, the DON responded social work and DON, and activities could and was learning how to do care plans in [EHR system] too. The DON explained with the resident it was trying to find where comfortable, and the resident was up and down and up and down which the DON knew had to be uncomfortable to do that for so long. The DON explained the resident would then finally fall asleep. The DON explained not to wake the resident up when resident finally got to sleep, and further explained not to let the resident sleep past noon because wanted the resident up for lunch. When queried about the indication for use for the medication, the DON responded if she remembered right, said manic depressive. 47336 2. The MDS assessment dated [DATE] revealed Resident #25 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed the resident had frequent pain that occasionally affected sleep and he received pain medications as needed and scheduled, along with non medication interventions. The MDS revealed the resident took an opioid. Review of the Medical Diagnoses for Resident #25 revealed the following diagnoses added in the resident's electronic health record (EHR) on 8/21/24: paraplegia, unspecified, chronic pain syndrome, polyneuropathy (multiple damaged nerves throughout the body that can cause pain), unspecified. A review of the MDS Identification Information section revealed the resident admitted to the facility on [DATE]. The Physician Orders included: a. ordered 10/4/24- hydrocodone-acetaminophen oral tablet 10-325 mg (milligrams) - give 1 tablet by mouth four times a day related to cramp and spasm; polymer, unspecified. b. ordered 8/21/24- Are you free of pain? If no, indicate response of pain level 1-10 with little to no pain as 1 and worst as 10. (If new or change in pain, complete [pain evaluation]- every shift A review of the Care Plan revealed a lack of a focus area to address chronic pain. During an interview on 1/29/25 at 11:28 PM, the DON (Director of Nursing) queried if the resident's chronic pain should be care planned and she stated he should have a pain care plan and she didn't do that one either. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy, effective date 8/2024, titled Comprehensive Care Plan Policy statement declared: An individualized comprehensive person centered care plan that includes measurable objectives and time frames to meet the resident's medical, nursing, mental, cultural and psychological needs is developed for each resident. Guidelines included, in part: 1. The facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS and physicians orders. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. 7. The Care Plan should describe the resident's nursing, medical, physical, mental and psychosocial preferences. They should include person specific, measurable objectives and time frames with a goal to measure their progress towards meeting such.

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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** 45338 Based on interview, record review, and facility policy review the facility failed to revise the care plan to reflect current code status, oral care and/or rejection of oral care for 2 of 14 residents reviewed for care plans (Resident #12 and Resident #2). The facility reported a census of 35 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment for Resident #12 dated [DATE] revealed the resident scored 9 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated moderately impaired cognition. On [DATE], review of Resident #12's Care Plan dated [DATE] revealed, Full Code--Attempt Resuscitation (CPR). Review of the Physician Order dated [DATE] for Resident #12 revealed, DNR (Do Not Resuscitate) and Allow Natural Death On [DATE] at approximately 3:55 PM, review of the resident's paper chart revealed an IPOST (Iowa Physician Orders for Scope of Treatment) form which revealed DNR. On [DATE] at 4:32 PM, the facility's Director of Nursing (DON) explained, in part, social work should update what code status is in the care plan. 48452 2. The MDS for Resident #2 dated [DATE] documented the resident had diagnoses of quadriplegia, cognitive communication deficit, and depression. The resident scored 15 out of 15 on the BIMS which indicated intact cognition. The resident was admitted [DATE]. A Progress Note dated [DATE] at 1:11 PM, titled N ADV Clinical Admission, recorded the resident had her own teeth with an obvious or likely cavity or broken tooth. During an interview on [DATE] at 8:44 AM Resident #2 reported she asked facility staff to see a dentist at least a month ago for a hole in a tooth on the right side of her mouth because it caused her pain. She confirmed it was still causing her pain. She reported she had not been asked if she wanted to see a dentist at all, including at admission, and if she had been asked she would have told staff she definitely wanted to see a dentist. She stated she would be willing to see one at the facility or go outside of the facility. The resident also reported not getting help brushing her teeth daily. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan initiated [DATE] indicated Resident #2 required assistance with ADLs related to quadriplegia and limited range of motion. It further documented the resident was totally dependent on staff for personal hygiene and oral care also initiated [DATE]. The Care Plan did not include a focus area to address oral care, including dental care needs, and associated interventions for care. During an interview on [DATE] at 9:07 AM the DON stated every resident on the Dental Plan was checked when the provider was in the building. She stated 'I never know' who is and isn't on the list. She didn't think in house provider visits were on the care plan. During an interview on [DATE] at 3:43 PM, when asked who was responsible for ensuring care plans were reviewed and revised the Administrator stated the DON was responsible. 47336 A review of the facility policy, effective date ,d+[DATE], titled Comprehensive Care Plan Policy statement declared: An individualized comprehensive person-centered care plan that includes measurable objectives and time frames to meet the resident's medical, nursing, mental, cultural and psychological needs is developed for each resident. Guidelines included, in part: 1. The facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS and physicians' orders. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. 7. The Care Plan should describe the resident's nursing, medical, physical, mental and psychosocial preferences. They should include person specific, measurable objectives and time frames with a goal to measure their progress towards meeting such.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on clinical record review and staff interviews the facility failed to ensure parameters for monitoring blood sugars for a resident with recent hospitalization related to a diabetic ketoacidosis (potentially life threatening complication of diabetes associated with a high blood sugar) for 1 of 1 residents reviewed for blood sugars. The facility reported a census of 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment, dated 1/07/25, revealed Resident #184 admitted to the facility on [DATE] from the hospital. Resident #184 had diagnosis of diabetes mellitus and received daily insulin injections and hypoglycemic medication. A review of the clinical record revealed Resident #184 admitted to facility on 12/31/24, with recent history of influenza, acute kidney injury, and diabetic ketoacidosis. The Care Plan, initiated on 1/10/25 included a Focus area diagnosis of diabetes mellitus. Interventions included: Diabetes medication as ordered and monitor/document for side effects and effectiveness; Fasting blood sugar as ordered; Monitor/document/report PRN (as needed) any s/sx (signs and symptoms)of hyperglycemia (high blood sugars): increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abd (abdominal) pair, Kussmaul breathing, acetone (fruity) breath, stupor, and coma; Monitor/document/report PRN any s/sx of and hypoglycemia (low blood sugars); Sweating, tremor, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. Review of the Medication Administration Record (MAR), dated January 2025, revealed an order for Insulin Lispro Injection Solution 100 units per milliliter (mL), with instructions to administer 6 units intramuscularly (typically administered subcutaneously) with meals and hold if Resident #184 not eating. Additional Insulin Lispro Solution instructed to inject insulin per sliding scale as follows: Blood sugar between 150-199 mg/dl (milligram/deciliter) give 1 unit of insulin; between 200-249mg/dl, give 2 units; blood sugar between 250-299mg/dl, give 3 units; blood sugar between 300-349mg/dl, give 4 units; and blood sugar between [PHONE NUMBER] mg/dl, give 5 units. Insulin Lispro order instructed to give intramuscularly (typically administered subcutaneously) with meals related to Type 2 Diabetes Mellitus. The insulin order did not provide direction for when to call the physician in the event of an abnormally high or low blood sugar. On 1/13/25 at 3:00 PM, Staff A, Licensed Practical Nurse (LPN), stated that residents blood sugars would be reported to physician based on ordered parameters and said if no parameters were in place, nursing should notify physician of blood sugars greater than 400 mg/dl. A review of the January 2025 MAR revealed an order to check Resident #184's blood sugar four times per day. Blood sugars recorded as follows: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/02/25 at 7:30 AM, blood sugar was 549 mg/dl. On 1/03/25 at 7:30 AM, blood sugar was 418 mg/dl, and at 11:30 AM, blood sugar was 426 mg/dl. On 1/06/25 at 7:30 AM, blood sugar was 411 mg/dl, and at 5:30 PM, blood sugar was 506 mg/dl. On 1/07/25 at 7:30 AM, blood sugar was 423 mg/dl, and at 11:30 AM, blood sugar was 520 mg/dl. On 1/11/25 at 11:30 AM, blood sugar was 406 mg/dl. On 1/12/25 at 5:30 PM, blood sugar was 500 mg/dl. On 1/14/25 at 11:30 AM, blood sugar was 435 mg/dl. On 1/15/25 at 7:30 AM, blood sugar was 501 mg/dl. On 1/16/25 at 7:30 AM, blood sugar was 518 mg/dl. On 1/19/25 at 7:30 AM, blood sugar was 412 mg/dl. On 1/30/25 at 2:30 PM, Director of Nursing (DON) stated that Resident #184 had been in hospital prior to facility admission because her blood sugars were way out of control. The DON stated that the nurse on duty would do resident admission assessments and DON would take care of admission orders. DON explained that physician signs admission orders during facility visits which may not be the same day as a resident's admission. DON reported that a sliding scale blood sugars from [PHONE NUMBER] mg/dl was not a typical order and revealed the expectation that nurses notify physician if Resident #184's blood sugars were greater than 500 mg/dl. DON confirmed that parameters for when to notify physician had not been implemented and that Resident #184's medical records lacked documentation of physician notification related to blood sugars greater than 500 mg/dl.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47336 Based on clinical record review, facility policy review, and resident and staff interview, the facility policy, the facility failed to provide at least 2 baths/showers a week for 1 of 1 residents reviewed for baths (Resident #31). The facility reported a census of 35 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 scored a 12 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition moderately impaired. The MDS revealed the resident required substantial/maximal assistance with showering/bathing; upper and lower body dressing. The MDS indicated the medical diagnosis for fractures and other multiple trauma. The Care Plan revealed a focus area dated 12/25/24 for required assistance with ADL's (Activities of Daily Living) related to impaired balance, history of falls, [NAME] fracture, C2 fracture, seizures, and intellectual disability. The interventions dated 12/25/24 revealed bathing/showering: resident required assistance by 1-2 staff with showering twice a week and as necessary. Had a neck brace on that cannot be removed. Nurse to check daily under brace for sores. During an interview on 1/12/25 at 10:45 AM, Resident #31 stated he hadn't showered since he had the neck collar on. Resident #31 stated he maybe got a bed bath here at the facility. Reviewed the shower calendars and skin sheets for the month of December. The facility lacked documentation for the resident receiving a bath bath/shower/bath for the month of December. The resident admitted to the facility on [DATE]. Review of the shower calendars and skin sheets in the shower binder revealed the following dates the resident received a bed bath on 1/4/25 and 1/8/25. During an interview on 1/22/25 at 12:23 PM, Staff Y, CNA (Certified Nurse Aide) queried when Resident #31 received a shower/bath and she stated they moved him to day shift. Staff Y asked if she ever given Resident #31 a shower/bath and she stated no. Staff Y asked if showers were documented and she stated yes, they were always documented when she did them. During an interview on 1/22/25 at 1:15 PM, Staff K, CNA queried if he ever gave Resident #31 a bed bath/shower and he stated no, he never did. During an interview on 1/29/25 at 9:26 AM, Staff D, CNA queried if she ever gave Resident #31 a bed bath or shower and she stated she gave him a partial bed bath a couple of weeks ago. Staff D asked when Resident #31 scheduled for showers and she stated she thought day shift. Staff D asked if skin sheets filled out with bed baths and she stated she filled out skin sheets with bed baths. During an interview on 1/29/25 at 9:52 AM, Staff C, CNA queried if she ever given Resident #31 a bath/shower and she stated no. Staff C asked when he received his showers and she stated she believed in the mornings on Tuesday and Friday. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/25 at 11:02 AM, the Director of Nursing (DON) queried on how she thought the showers were going and she stated they were better but still had problems with getting them done because sometimes they only have 2 aides on second shift and they try to get them all completed. The DON asked about Resident #31 shower/baths and she stated he got a bed bath up to the last appointment when he got a new brace that could get wet. The DON informed no documentation found in December and only 2 skin sheets found for January and she stated the staff knew they were supposed to fill out the shower sheets. The DON stated the staff forget to mark in the book. The DON stated there should be shower sheets because the girls asked her how to do his baths. The facility policy, dated 10/2024, titled Shower/Tub Bath Policy statement declared: The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the residents skin. The Documentation section of the policy directed staff to: 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath. 3. All assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath. 4. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. 5. The signature and title of the person recording the data. The Reporting section of the policy directed staff to, in part: 1. Notify the supervisor if the resident refuses the shower/tub bath.

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F 0684 Level of Harm - 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** 45338 Based on observations, clinical record review, and staff interview, the facility failed to ensure timely, consistent, accurate assessments occurred for non-pressure skin wounds including redness to a resident's hand and a wound to a resident's abdomen, and recognition of a condition change for a resident who experienced falls and pain for 4 of 4 residents reviewed for assessment/intervention (Resident #5, Resident #11, Resident #12, Resident #183). This deficient practice resulted in a hospitalization , and the worsening of a fracture. The facility reported a census of 35 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment for Resident #5 dated 10/18/24 revealed the resident scored 4 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which revealed severely impaired cognition. Review of the resident's Care Plan dated 8/25/17, revised on 6/4/19, revealed the following: I have the potential for skin breakdown r/t (related to) poor hygiene and fragile skin. Continued review of Interventions per the Care Plan revealed, in part, the following interventions: a. Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Created Date 8/25/17. b. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration etc. to MD (Medical Doctor). Created Date 8/25/17. c. Weekly full body skin assessment. Created Date 12/7/22. The Progress Note dated 1/8/25 at 9:26 PM revealed, Skin: Skin warm & dry, skin color WNL (within normal limits) and turgor is normal .Skin Issues: Skin Issue: #001: New skin Issue. Location: Right Lower Quadrant Midline. Laterality / Orientation: Middle. Additional location information: Chronic lesion where resident picks at wound Issue type: Open lesion. Wound acquired in-house. It is unknown how long the wound has been present .Length (cm) (centimeter): 0.5 Width (cm): 0.5 Depth (cm): 0 Undermining: No. Surrounding tissue: Normal in color. Periwound temperature: Normal. Skin issue education: Treatment of skin issue. Additional skin issue education documentation: Instructed resident to not pick at wound. The Bath/Skin Sheet dated 1/15/25 indicated the resident's abdominal folds were reddened. The Bath/Skin Sheet dated 1/19/25 revealed under the Reddened Areas section of the form the resident's abdominal folds were reddened. The word stomach had been written on the assessment and circled. The following comment had been written on the Bath/Skin Sheet: [NAME] and red spot on stomach side rolls very red. On 1/22/25, review of the resident's N-Adv Skin Check history revealed the most recent assessment completed on 1/8/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an observation on 1/29/25 at 10:38 AM, Resident #5 in their room, and the resident's abdomen observed with Staff C, Certified Nursing Assistant (CNA). The resident had a wound open approximately smaller than a dime size to the resident's left lower abdomen, with surrounding redness present. Staff C queried if had known the wound present, and responded she did not, was not sure if the other ladies had noticed it, and acknowledged she had not. Review of a N Adv-Skin Check for Resident #5 dated 1/29/25 at 3:53 PM revealed right lower quadrant midline chronic lesion where resident picks at wound, described as in house acquired open lesion which measured 0.5 centimeter (cm) by 0.5cm by 0 cm. During an interiew on 1/30/25 at approximately 5:00 PM, the Director of Nursing (DON) queried about whether familiar with Resident #5 picking, and responded right here, and indicated the abdomen. When queried if resident normally picked left or right, the DON indicated left. The DON acknowledged in the assessment tab was skin tab supposed to be done every week, and if problem with wounds needed to call the DON in to look at it. When queried if everyone should have a skin check in the [electronic health record (EHR)] weekly, DON explained they are behind. During an interview on 1/30/25 at 6:48 PM, the facility Administrator queried regarding skin assessments, explained last survey had issues, had explained had constantly been asking [DON] if getting done, and response given was yes. 2. Review of the MDS assessment for Resident #12 dated 11/1/24 revealed the resident scored 9 out of 15 on a BIMS which indicated moderately impaired cognition. Per this assessment, the resident was always continent of urine. Review of Resident #12's Care Plan dated 9/6/24 revealed, [Resident #12] has FUNCTIONAL bladder incontinence r/t (related to) Dementia. Review of the intervention dated 9/6/24 revealed, Monitor/document for s/sx (signs/symptoms) UTI (urinary tract infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse,increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. The Behavior Note dated 11/24/24 at 7:47 AM revealed, The resident started to put herself on the floor as a behavior. Resident came out of her room into the hallway and sat down on the floor and proceeded to lay down in the hallway. Resident is also putting herself on the floor in her room and rolling around on the ground. all these behaviors have been witness from staff as she puts herself on the floor. The next Progress Note documented in Resident #12's EHR was dated 11/24/24 at 6:25 PM. The Health Status Note dated 11/24/24 at 6:25 PM documented by Staff L, Registered Nurse (RN) revealed, Resident put self on floor at 1803 (6:03 PM) and hit her head when she landed on butt and went to her right side. V/S (vital signs) 118/77, O2 (oxygen) 82 RA (room air), P (pulse) 133, R (respirations) 18, T (temp) 97. 3. Resident assisted to sitting position and then standing with no injuries noted. Resident taken to room resident found on floor at 1810 (6:10 PM). Resident cool and clammy at this time. BG (blood glucose) was 170. Staff reports 15-20 incidents on day shift of resident sitting her self on floor. Call to [Dr. Name Redacted] and order to send t <sic> ER (emergency room) for eval. (continued on next page)

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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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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/28/25 at 12:02 PM, Staff L explained they had gotten report resident had fallen or put self on the floor multiple times that day, and Staff L thought they said 15 times. Staff L explained resident sent to the ER that night she did believe, and thought did send her (resident). Staff L explained when the resident did so again when Staff L was there, Staff L thought oh my gosh, something else is going on with her (resident). When queried if Resident #12 hit her head on that incident Staff L acknowledged resident did, and further explained she was told (resident) hit her head multiple times that day. Staff L queried if anything had been going on with the resident's urine, and responded off the top of her head she could not remember. On 1/28/25 at 10:09 AM, incident/accident reports and any corresponding investigation for Resident #12 for the last six months requested via email from the facility's Administrator. On 1/28/25 at 4:40 PM, the facility Administrator responded via email the resident had two incident reports for the last six months, noted to to lack documentation for 11/24/24. Review of the ED (Emergency Department) Provider Notes dated 11/24/24 at 6:51 PM revealed, Chief Complaint Patient presents with fall. The History of Present Illness (HPI) section revealed, [Resident #12] is a [age redacted] yo (year old) female presenting from [Facility Name Redacted] with abdominal pain and multiple falls today. She presents with EMS (Emergency Medical Services) who give history. EMS reports the patient has Alzheimer's/dementia and she is unable to give history. EMS reports that patient was endorsing abdominal pain en route but has not had any vomiting. They report that his prior reported to them the patient had multiple falls today, potentially up to 10 different falls. They also reported that the patient seemed to be throwing herself on on the floor. Patient is usually cooperative and follows commands however today she has not been listening to instructions. Review of the Physical Exam section revealed the resident had abdominal tenderness and back pain. Review of the ED Handoff Note dated 11/24/24 at 7:05 PM revealed, in part, [Resident #12] was sent from nursing home after having multiple abrupt sit downs where she sat down very hard onto her buttock. I spoke with [Name Redacted] from the nursing home and provider who witnessed 2 of these events stating she fell back and hit her head after sitting abruptly. No loss of conciousness. She is not redirectable, restless and has been like this all day although it has not been documented. Review of the After Visit Summary from [Hospital Name Redacted] dated 11/24/24 revealed, we are culturing [Resident #12's] urine. She has a very apparent urinary tract infection and was given 2 g (gram) of ceftriazone here in the emergency department. Per the After Visit Summary, the resident had the following reasons for visit listed: fall, initial encounter, complicated UTI, and delirium. Review of Progress Notes for Resident #12 dated 11/24/24 lacked documentation of any urinary symptoms or pain on 11/24/24. The Urinalysis with Microscopy included in the hospital records with collection date 11/24/24 at 8:27 PM revealed the resident's urine was turbid, had trace ketones and blood, had 1+ protein, had 2+ nitrites, 500 leukocyte esterase, greater than 100 white blood cell,6-10 red blood cell, many bacteria, and 1+ hyaline casts. The Infection Note dated 11/24/24 at 9:42 PM revealed, Call report from [Hospital Name Redacted] ER resident update given. Rocephin 2 for UTI .Resident has bad UTI Resident will return on oral ABT (antibiotics) per ER nurse. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Progress Note dated 11/24/24 at 11:00 PM for Date of Service 11/25/24 revealed, Patient had multiple falls this weekend. Was evaluated for back pain. Patient had multiple falls this weekend. Was evaluated at the hospital yesterday and diagnosed with UTI. Was prescribed cephalexin 500mg 4 times a day for 7 days. Patient is still experiencing significant painful urination. During an interview on 1/29/24 at 10:02 AM, Staff C queried if had ever been at facility when resident fell , and responded no, not accidentally. Per Staff C, the resident would put self on the floor sometimes, and would lay elegantly, described as slow motion. When queried if had ever seen resident put herself on the ground and hit their head, Staff C responded no. When queried if it was a pretty controlled movement, Staff C responded yeah, absolutely. During an interview on 1/30/24 at 12:08 PM, Staff Q, Registered Nurse (RN) explained she had been in shift where the resident would say help me, to room, then would throw self to ground. When queried if an incident report would be written up when resident did so, Staff Q responded she did not know, and if fall do risk management. Per Staff Q, did not think there would be incident report because everybody knew. During an interview on 1/30/25 at 4:34 PM, the Director of Nursing (DON) explained resident would tell everybody that going to put self on the floor, if put self on the floor and hit head should be treating it as a fall, and no one ever told her about that. The DON explained if fell and hit head needed to be incident, and should start neuros. When queried if any urinary complaints for resident were passed to the DON, the DON responded no, and per DON standard diagnosis from the hospital was UTI. The DON further explained the problem was never see the culture result back, and needed to see the culture. Regarding a change in clinical presentation, the DON explained she needed documentation number one of what the change was, and if significant enough DON needed to be called and let DON know. When queried if she was being called, the DON responded once in a while, and most of the time called with fall/no injury. 48888 3. The Minimum Data Set (MDS) assessment, dated 10/25/24, revealed Resident #183 had both short term memory and long term memory problem, as well as fluctuating symptoms of inattention, disorganized thinking, and altered level of consciousness. Diagnoses included diabetes mellitus, non-Alzheimer's dementia, anxiety disorder, depression, and schizophrenia (schizoaffective disorder). The MDS revealed Resident #183 had 2 or more falls without injury, 2 or more falls with injury (except for major), and 0 falls with major injury during this assessment period. The MDS, dated [DATE], revealed Resident #183 dependent on staff for transfers and unable to ambulate. The MDS indicated during this assessment period Resident #183 had 2 or more falls without injury, had 2 or more falls with injury (except for major), and had 1 fall with major injury. Major injury defined in MDS assessment as bone fractures, joint dislocations, closed head injuries with altered level of consciousness, or subdural hematoma. A review of Progress Notes in the electronic health record revealed: a. On 12/06/24 at 9:12 PM, Resident #183 had an unwitnessed fall in room without apparent injury or indicators of pain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of hospital records from Resident #183's 12/30/24 admission included a History and Physical (H&P). The H&P revealed .[Name redacted] .suffered a ground-level fall at her care facility on the evening of 12/12/24. She presented to the emergency room where x-rays of the right elbow and right hip were obtained as well as CT (computed tomography scan, a non-invasive image) A Hospital Note, dated 12/30/24 indicated Resident #183 seen in Orthopedic Clinic for follow up appointment 2.5 weeks after injury and noted that resident continued to struggle with fairly severe pain in both right hip and right elbow. Resident #183 unable to bear weight of right lower extremity due to severity of pain and is standing with assistance of 2 staff members. Hospital Note indicated that Resident #183 presented to clinic with complications stemming from original injuries, including a wound over olecranon (elbow) which probed deep to bone and progression of greater trochanteric (hip) fracture to an intertrochanteric femur fracture. Hospital Note revealed that facility reported resident had been observed hitting elbow on nearby objects during emotional outbursts, otherwise Resident #183 had no falls or trauma to hip or elbow since seen couple weeks ago, and right elbow splint not removed until today. Hospital Note indicated that information from facility raised concern that these complications were secondary to dementia related agitation and possibly unwitnessed falls at the facility. Resident #183 admitted to Hospital from Orthopedic Clinic, in anticipation for surgical intervention for the right elbow and right hip. During an interview on 1/14/25 at 1:00 PM, Certified Medication Assistant (CMA), Staff J, reported that Resident #183 would cry and report pain after fractures found in December. Staff J reported Resident #183 would tell you she was in pain and received PRN Tramadol and Tylenol for pain. During an interview on 1/14/25 at 1:23 PM, Certified Nursing Assistant (CNA), Staff D, reported that following fractures, Resident #183 could not stand and required 2-3 staff assistance to transfer and stated this being a big change for resident used to walk down the hallway to not being able to stand. Staff D recalled that Resident #183 would cry and stated you could tell she had pain and when her pain medications were wearing off. Staff D stated Resident #183 also showed signs of restlessness and anxiety when she was in pain. Staff D informed that she would notify the nurse when signs of pain had been observed. During an interview on 1/14/25 at 1:40 PM, Staff C, CNA, stated she was tasked with transporting and accompanying Resident #183 to the Orthopedic Clinic follow up appointment on 12/30/24. Staff C stated she was informed by Clinic that Resident #183 would be admitted to the Hospital and required surgery, Staff C informed that she notified the Director of Nursing via phone and returned to the facility. During an interview on 1/15/25 at 9:08 AM, Staff DD, Registered Nurse (RN), recalled during a fall follow up assessment, it was noted Resident #183 had limited ROM of right arm and would moan and groan. Resident #183 had bruise around right elbow and Staff DD attempted to use ice to area. Staff DD stated she reported this to the oncoming nurse. She stated when she returned 1 or 2 days later she had learned in report of an additional fall. She stated she noted hand had been more swollen with limited ROM and stated the physician had been notified on a Sunday with order received for X-Ray of right elbow. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/22/25 at 2:00 PM, Director of Nursing (DON) stated that no discharge orders of follow up care instructions had been received from the Hospital Emergency Department (ED) on 12/13/24 following fractures noted to right elbow and right hip. DON stated that the hospital didn't say anything, so she had staff put resident in wheelchair and pivot transfer resident on the good foot. DON stated Resident #183 was having pain and receiving PRN Tramadol, DON confirmed this order had been initiated prior to current injury on 6/27/24. When asked about Resident #183 pain management regimen, DON informed that staff were to keep pain controlled, and provide PRN medication around the clock for resident. DON stated pain medication had been effective because Resident #183 would fall asleep and not cry, noted that if resident had been crying she was hurting. DON revealed the expectation of nurses to call physician if resident pain was rated at 10/10 (severe). During an interview on 1/27/25 at 12:18 PM, a Physician's Assistant (PA-C) from Hospital Orthopedic Clinic, stated discharge instructions for right elbow fracture included non-weight bearing status and Resident #183 sent with slab splint and sling which would stay in place until 1st follow up appointment 12/30/24, and instruction for right hip to weight bear as tolerated and avoid abduction (away from body) movement of hip. PA-C revealed expectation for facility to call Orthopedic Provider if Resident #183 were to have a fall or additional trauma that may cause worsening of injuries and to to call if Resident #183 experienced new, worsening, or unresolved pain. During an interview on 1/30/25 at 2:30 PM, DON again confirmed that no discharge instructions or paperwork had been received from Hospital on 12/13/24 following identification of both right elbow and right hip fracture. DON stated that facility should call hospital if there's no discharge paperwork and that information should then be faxed or emailed to the DON. The DON denied having called hospital for discharge instructions or care orders of right elbow or right hip fractures. DON stated if Resident #183 fell when she had fractures identified, she would expect staff to start assessments and to call Orthopedics to see if resident would need to be seen sooner. DON confirmed documentation lacked notification to Orthopedics for fall on 12/14/24 or for increased pain documented in Progress Notes and Medication Administration Record. 4. The Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. Resident #11 utilized a walker for mobility, able to transfer and ambulate in facility independently. Diagnoses included: anemia, hypertension, viral hepatitis, Schizophrenia, Chronic Obstructive Pulmonary Disease (COPD), osteoarthritis of knee, and history of falling. The MDS revealed Resident #11 had 2 or more falls without injury during assessment period. The Care Plan, revised on 1/27/25, identified Resident #11 at moderate risk for falls related to deconditioning and COPD. Care Plan revealed Resident #11 is independent with transfers, toileting, dressing, and personal hygiene and instructed staff to monitor/document/report as needed any changes, any potential for improvement, reasons for self-care deficit, expected course, and declines in function. Review of facility provided incident reports revealed Resident #11 had 12 falls between 1/01/25-1/23/25, with 9 of the falls unwitnessed, and no injuries related to falls documented on incident reports. Dates of unwitnessed falls included: 1/03/25 at 7:25 AM, 1/03/25 at 8:00 PM, 1/06/25 at 8:38 PM, 1/08/25 at 8:15 AM, 1/10/25 at 6:10 PM, 1/12/25 at 9:00 AM, 1/13/25 at 12:25 AM, 1/15/25 at 6:00 PM, and 1/22/25 at 9:07 AM. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of facility provided document, titled Neurological Flow Sheet revealed neurological assessments had been initiated on the following dates/times: 1/04/25 at 11:00 AM, 1/06/25 at 12:20 PM, 1/12/25 at 6:30 PM, and 1/22/25 at 8:30 AM During an observation on 1/11/25 at 11:45 AM, Resident #11 sat in a recliner in her room wearing nightgown and supplemental oxygen set between 2-3 liters, via nasal cannula, resident alert and oriented when approached and reported that oxygen was new for her. Resident #11 denied concerns. During an observation on 1/12/25 at 12:00 PM, Resident #11 sat in a recliner with meal tray on a overbed table, and eating. Oxygen in place at 2 liters via nasal cannula. Review of Resident #11's Progress Notes revealed the following documentation: On 1/03/25, Resident #11 had 3 falls on this day, new order received to check urinalysis. On 1/05/25, Resident #11 received order to start antibiotic (Macrobid) for Urinary Tract Infection (UTI), resident also started on supplemental oxygen at 2 liters via nasal cannula as needed. On 1/08/25 at 9:38 PM, Note revealed that neurological assessments do not need to be restarted at this time per Director of Nursing (DON). On 1/14/25, Resident #11 had witnessed fall, reported dizziness when bending forward, blood pressure noted to be 93/52. On 1/15/25, Resident #11 had unwitnessed fall, reported hitting her head, blood pressure noted to be 138/100 and pulse 110 beats per minute. On 1/23/25, Progress Note revealed multiple falls had been reported by previous shift, indicated approximately 4 falls, review of notes lacked any additional information related to multiple falls occurring on 1/22/25. On 1/23/25 at 12:50 PM, Resident #11 had an unwitnessed fall with blood pressure noted to be 94/71 and at 4:00 PM facility received therapy recommendations for Resident #11 to transfer with assistance of one staff using walker and gait belt at all times. On 1/23/25, Primary Care Provider (PCP) visit note, identified that Resident #11 continued to have falls, no new orders. On 1/24/25 at 9:39 PM, Note informed that Resident #11 is non-compliant with calling for help which leads to multiple falls. Indicated resident already on fall initiated neurological checks and resident falls in between checks due to non-compliance. Note revealed instruction from DON to not start neurological starts over. On 1/26/25 at 2:52 AM, Resident #11 noted to have brown urine with red slimy discharge, strong smell, history of multiple falls in past few days. Physician notified and new order received to check urinalysis, then at 9:05 AM, new order received to start antibiotic (Bactrim) for UTI. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 1/27/25, urinalysis preliminary results received and showed urine positive for blood, protein, and had greater than 100,000 [NAME] Blood Cell (WBC) Colony-Forming Units (CFU) per milliliter of urine, Resident #11 remained afebrile. On 1/27/25 at 9:08 AM, Resident #11 had witnessed fall out of wheelchair in common area near nurses station and at 1:20 PM, Resident sent to Emergency Department via ambulance to be evaluated for blood pressure 92/68, weakness, not being able to hold silverware or feed self, and requiring assist of 2 with gait belt to wheelchair when normally assist of one with gait belt and walker. On 1/27/25 at 12:21 PM, Resident #11 observed in common area by nursing station sat in wheelchair and reaching towards her oxygen concentrator, heard another resident tell Resident #11 she was going to fall out. Resident #11 explained she was trying to move her oxygen concentrator, Staff I, Certified Nursing Assistant (CNA) approached, bringing Resident #11 a sensory ball. At 12:23 PM observed sensory ball on the ground between resident's feet on the floor, staff member picked it up and handed to her, and at 12:24 PM ball again on the floor, Resident #11 reaching to left side, grabbed onto the oxygen tubing and pulled on the tubing, held taught in her hand. At 12:27 PM Resident #11 observed leaning forward attempting to pick ball up from floor again. Hospital Note, dated 1/27/25, revealed Resident #11 presented to Emergency Department (ED) via ambulance after a change in mental status, hypotension, and general weakness. Note informed that resident had started on the antibiotic Bactrim for UTI on 1/26/25 and had urine culture 3 weeks ago which grew E. Coli bacteria that was resistant to Bactrim. Hospital note revealed Resident #11 had Acute Kidney Injury (AKI) with creatinine level (used to monitor kidney function) 2 times her base line, in a setting of likely cystitis (bladder infection). Resident #11 admitted to hospital observation level of care for antibiotics for acute cystitis and monitoring of AKI. Resident #11 given intravenous (IV) antibiotic Ceftriaxone and IV fluids with improvement in blood pressures, and urine culture pending. Hospital Note, dated 1/28/25, revealed Resident #11 had result for positive blood culture of E. Coli and Enterobacterales bacteria. Resident #11 switched from observation to inpatient hospital admission, and bacteremia (bacteria present in blood stream) added to hospital diagnoses/problems list. On 1/28/25 at 12:04 PM, Staff L, Registered Nurse (RN), reported Resident #11 recently had gotten a lot weaker, unable to stand as well and knees would drop down. Staff L recalled that recently staff had to transfer resident as a 2 person assist with gait belt, when previously had been independent to transfer/walk. Staff L stated Resident #11 had been falling a lot lately, with a lot of unwitnessed fall and said when she comes in to work there's no notes on her falls that are verbally passed along in shift report. Staff L stated she received instruction from the Director of Nursing (DON) to not restart neurological assessment, instead continue where you were due to having multiple falls in a day. Staff L stated that on 1/26/25 she requested CNA staff to report appearance of Resident #11's urine because she was falling and had UTI in the past when increased falling occurred. Staff L confirmed urine appeared thick and brown with strong odor and reported to physician with order for to check urinalysis. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 1/29/25 at 9:24 AM, Staff D, Certified Nursing Assistant (CNA), stated Resident #11 had been falling frequently, almost everyday, multiple times a day for at least the past 2 weeks. Staff D stated Resident #11 had more weakness recently and now required a 2 person assist to transfer. Staff D reported Resident #11 would try to get up but couldn't which had been a big adjustment for resident to need staff to help her when previously was independent. Staff D recalled that a day or two before being hospitalized , on 1/27/25, Resident #11 had a change in cognition, when she was normally very with it, was observed grabbing for things that were not present in the air, Staff D stated reporting this information to the nurse. On 1/29/25 at 9:52 AM, Staff C, CNA, reported Resident #11 required assist of 2 for the past week, including use of full body lift. Staff C recalled Resident #11 had been assist of 1 for brief time before current transfer status and previously had been able to transfer and ambulate independently in facility with walker. Staff C recalled fall interventions for Resident #11 included checking on her more frequently and more recently bringing out to nurses station. Staff C stated that Resident #11 may use call light more during the past week as she had been less independent. On 1/29/25 at 1:41 PM, Staff R, Licensed Practical Nurse (LPN), stated neurologic checks should be initiated for each of Resident #11's falls because the falls are not witnessed. Staff R stated fall notification had only included letting the DON know about a fall, because DON informed LPN that physician notification was done by DON. Staff R stated that Resident #11 having multiple falls in a day would be change in condition and physician would need to be called to see if he wanted to get a urinalysis. Staff R confirmed working on 1/22/25 when Resident #11 had multiple (approximately 4 falls during shift) and denied calling physician to notify of falls on this date. On 1/30/25 at 2:30 PM, Director of Nursing (DON) confirmed that Resident #11 had history of UTI's and explained that she typically presented with increased falls when she had a UTI. DON stated she was unaware of Resident #11 requiring assistance of 2 staff to transfer until 1/27/25 at 12:30 PM, just before resident was sent out to the hospital. DON revealed the expectation of nurses to notify the physician, responsible party, and DON, if a resident falls multiple times in a day and informed that the protocol for unwitnessed falls included treating the fall like resident hit their head, by starting neurological exam. DON denied having called the physician on 1/22/25 for multiple falls noted on that day, and did not know if charge nurse on duty had notified resident's physician. DON confirmed that she has informed staff not to restart neurological assessment checks for falls that occur between neurological checks, if resident doesn't hit head, because they would never finish doing vitals on Resident

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on clinical record review, staff interviews, and the facility policy the facility, the facility failed to perform consist wound assessments for 1 of 3 residents reviewed for pressure ulcers (Resident #25). The facility reported a census of 35 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS indicated resident dependent with roll left and right; and chair/bed to chair transfer. The MDS indicated the resident impaired in both upper and lower extremities. The MDS revealed medical diagnoses for traumatic spinal cord dysfunction; paraplegia; and polyneuropathy (nerve damage in multiple locations), unspecified. The MDS revealed one unstageable pressure ulcer present on admission with pressure reducing device on chair and bed. The Care Plan, dated 9/4/24, included a Focus area to address pressure ulcers. Interventions,dated 9/4/24, included, in part: Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. A review of Physician Orders revealed: a. Ordered 12/5/24- Calcium Alginate-Silver External Pad 4- Apply to right buttock topically every evening shift for wound care clean c wound cleanser, apply skin prep to peri-wound, apply silvadene to wound bed then loosely pack with calcium alginate to wick away moisture, cover c (with) abd (abdominal) pad et (and) secure c tape and apply to right buttock topically every 12 hours as needed for soiling >75% b. Ordered 12/10/24 to 12/15/24- Left Ischial wound- apply silvadene and 4 x 4 mepilex daily at bedtime. On 12/15/24 to 1/20/25 time of order changed to one time a day. A review of Skin Check documentation revealed: a. On 12/10/24 at 8:19 AM: Skin check: skin warm and dry, skin color WNL (within normal limits), turgor (elasticity of skin) normal- not met; location- right gluteal fold; skin issue: right pressure ulcer; pressure ulcer staging: Stage 4 Pressure Ulcer/Injury: Full-thickness skin and tissue loss; acquired: present on admission; staged by: wound care clinic; length 7.7 cm x width 7 cm x depth 0.5 cm. b. On 12/18/24 at 7:51 PM: skin check: skin warm and dry, skin color WNL, turgor normal- met; location: right gluteal fold; skin issue: right pressure ulcer; pressure ulcer staging: Stage 4 Pressure Ulcer/Injury: Full-thickness skin and tissue loss e. acquired: present on admission; staged by: wound care clinic; length 7. 7 cm x width 7 cm x depth 0.5 cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. On 1/1/25 at 5:19 PM: skin check: skin warm and dry, skin color WNL, turgor normal- not met; location: right gluteal fold; skin issue: right pressure ulcer; pressure ulcer staging: Stage 4 Pressure Ulcer/Injury: Full-thickness skin and tissue loss; acquired: present on admission; staged by: wound care clinic; length 7.7 cm x width 7 cm x depth 0.5 cm. The Skin Checks dated 12/10/24; 12/18/24; and 1/1/25 lacked documentation of two wounds present on the buttocks. During an interview on 1/29/25 at 11:41 AM, the Director of Nursing (DON) queried on the process for wound assessments and she stated the wound assessments were scheduled on a weekly basis and the nurses were not doing the skin sheets for the skin assessments in the computer and the wound assessments did not get done on a routine basis. The DON stated the nurses were supposed to be do measurements on the weekly checks. The DON stated if the nurse saw a change, they had the ability to right a progress note. The DON stated the nurses should chart on the wound daily and do weekly skin checks with measurements. The DON stated she continued to educate the nurses to do them and made a sheet for the day shift nurse and the night shift nurse responsibilities and no one looked at them. The facility policy, dated 6/2024 titled Injury/Skin Breakdown - Clinical Guidelines directed the following: a. Assessment and Recognition 1. The nursing staff will complete an evaluation of the skin weekly.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observations, facility policy review, resident and staff interviews the facility failed to thoroughly investigate falls including identifying root cause analysis, failed to ensure interventions implemented to prevent further falls, failed to ensure gait belt utilized during transfer, failed to care plan and reassess a resident for the ability to safely smoke, and failed to timely update interventions for a resident who had previously exited the facility unaccompanied for 5 of 8 residents reviewed for accidents (Resident #4, Resident #11, Resident #19, Resident #25, Resident #184). Resident #4 sustained eight falls between 6/7/24 and 1/2/25, four of which resulted in injuries including the following: laceration to the scalp requiring 4 staples, laceration to top of head, laceration to right eyebrow requiring 2 sutures, and small hematoma to back of head. The facility reported a census of 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #4 dated 6/14/24 revealed the resident scored 9 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated moderately impaired cognition. Per this assessment, the resident had falls since admit, entry, reentry, or prior assessment, two with no injury and one with injury except major. Per this assessment, the resident was independent for chair/bed to chair transfer, and was frequently incontinent of urine. Review of Medical Diagnoses for Resident #4 included Parkinson's, unspecified, dementia with other behavioral disturbance, cognitive communication deficit, unsteadiness on feet, unspecified lack of coordination, personal history of traumatic brain injury, and other seizures. Review of the MDS dated [DATE] assessment for Resident #4 revealed the resident scored 11 out of 15 on a BIMS assessment,which indicated the resident had moderately impaired cognition. Per this assessment, Resident #4 had two or more falls with no injury, and none with injury except major or major injury. Review of Resident #4's Care Plan dated 6/8/22, most recently revised on 6/8/22 revealed the following: Risk for falls a. Fall 1/9/24 after seizure b. Fall 2/22/24, No injury c. 3/31/24 Fall, no injury d. Fall 5/9/24, no injury e. Fall 5/10/24, laceration (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	f. 6/7 Fall, No injury g. 6/29/24 Fall, No injury h. 7/11/24 Fall, laceration i. 7/24/24 Fall, No injury j. 10/15/24 Fall, Laceration to top of head k. 11/10/24 Fall, No injury l. 11/26/24 Fall, Laceration to right eyebrow m. 1/2/25 Fall, small hematoma back of head Review of interventions added to Resident #4's Care Plan from June 2024 to present included the following: a. (Created Date 6/6/24): Fall 5/9/24 intervention, stool riser placed. b. (Created Date 6/6/24, revised 6/11/24): Fall intervention 5/9/24 - PT/OT (Physical Therapy/Occupational Therapy) to eval (evaluation) & Tx (treat). Stool raiser placed over toilet seat. c. (Created Date 6/11/24): Fall 5/10/24 Intervention- Observe resident to be sure he is using wheelchair for mobility. d. (Created Date 7/1/24): Fall 6/29/24 Intervention- Dycem in chair. e. (Created Date 7/12/24): Fall 7/11/24 Sent to ER (emergency room) for staples to back of head laceration. Intervention- Staff to observe when going to room if he needs assist. f. (Created Date 7/29/24, revised 8/21/24): Fall 7/24/24-Intervention- Staff to check on him when he goes to room to be sure he is safe. g. (Created Date 10/21/24): Fall 10/15/24 Injury-laceration to top of head Intervention- Resident reminded to ask for assistance. h. (Created Date 11/22/24): 11/10/24 Fall- Intervention- Staff to be sure bed brakes are on. i. (Created Date 12/10/24): 11/26/24 Fall - Intervention- Staff to make check and change rounds with resident due to more incontinent. j. (Created Date 1/3/25): 1/2/25 Fall Intervention- Staff and resident educated on him to ask for help. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The N-Adv Fall Risk Evaluation dated 6/7/24 at 8:39 AM revealed the resident had 3 or more falls in the past 3 months, and the resident's Fall Risk Score was 21.0. Per the evaluation, a score of 10 or higher indicated the resident is at high risk of fall. Another Fall Risk Evaluation dated 6/7/24 at 1:00 PM revealed the resident had 1-2 falls in the past 3 months, and the resident's Fall Risk Score was 11.0. Although the resident's Care Plan revealed the resident fell on ,d+[DATE], Resident #4's Progress Notes lacked documentation of a fall. The Incident Report dated 6/7/24 at 10:12 AM revealed, Resident was found sitting on the floor. Resident stated he was trying to straighten his bed and fell out of his chair. The Incident Report dated 6/29/24 at 4:10 PM revealed, Resident was found on the floor of his bedroom. Resident stated he just slipped out of WC (wheelchair). Presdisposing factors revealed incontinent, weakness/fainting, and impaired memory had been selected. The Health Status Note at 6/29/24 at 4:14 PM revealed, Resident is independent with transfers. Resident was found on floor and there was a puddle of water or urine next. to him. Resident stated that he would have gotten up himself. Resident does not have any injuries. Fall was not witnessed. Review of Resident #4's Progress Notes lacked documentation of a fall on 7/11/24, although a fall on 7/11/24 was noted in the resident's Care Plan. The Incident Report for an unwitnessed fall dated 7/11/24 at 10:10 PM revealed, resident rolled up to the nurse's station with blood coming from his head and hands. he was pulled into the nurse's station where his head was cleaned, and vitals were taken and WNL (within normal limits). small bleeding wound noted in the middle of resident's head from what appears to be from a previous occurrence. no other injuries noted. bleeding was stopped and EMS was called along with admin, his [family member, name redacted], and provider was notified. residents' room was cleaned, assessed for pain, and any fall risk .resident said he was trying to go to the bathroom when he fell forward although the wound is on the back of his head. resident says he is not in pain. will continue to monitor. The Immediate Action Taken section documented, in part, Staff to observe when going to room if he needs assist. The ED (Emergency Department) Provider Note dated 7/11/24 revealed, Pleasant [age redacted]-year-old-male presenting with scalp laceration after fall .We thoroughly cleaned this here in the emergency department and this was closed with 4 staples. Review of the Health Status Note dated 7/12/24 at 2:42 PM revealed, Resident denies complaints r/t (related to) fall, does admit to minor pain at site of cranial laceration. Neuro checks WNL (within normal limits), VSS (vital signs stable), appetite poor at noon. The Health Status Note dated 7/13/24 at 5:17PM revealed, No complaints of pain from fall. Staples intact on back of head. The Incident Report dated 7/24/24 at 4:00 AM revealed, Resident's next door neighbor alerted staff that resident was on the floor in the bathroom. Found resident sitting on the floor, fully dressed in puddle of urine. Physical assessment and questioning regarding injury, and he denied any. Assisted to wheelchair, vitals assessed, clothing and bedding changed and he went back to bed. The Immediate Action Taken section documented the following intervention: Staff to check on him when he goes to room to be sure he is safe. Predisposing physiological factors revealed drowsy, incontinent, and gait imbalance were selected. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	It was noted that the resident's falls on 6/29/24, 7/11/24, and 7/24/24 mentioned need for the bathroom, incontinence, or water/urine on the floor, although an intervention to address toileting was not added to the resident's falls care plan until 12/24. The Incident Report dated 10/15/24 at 6:11 AM revealed, Called to room by CNA. Resident was witnessed falling out of bed and hitting his head and right shoulder on the air conditioner in room. Resident has a laceration to top of had <sic> and an abrasion to left shoulder. Resident stated he was trying to get out of bed to get dressed. The Immediate Action Taken section documented the following intervention: Resident reminded to ask for assistance. The Incident Note dated 10/15/24 at 6:25 AM revealed, in part, Resident's bed was wet and floor was wet. Resident spilled urine from his urinal onto the floor. Room was cleaned and resident assessed. No complaints of pain. No abnormal or out of ordinary deformities .Laceration was cleaned with wound cleanser, applied TAO (triple antibiotic ointment) with Band-Aid. Progress Notes for Resident #4 lacked documentation of a fall on 11/10/24, although it was noted in Resident #4's Care Plan. The Incident Report dated 11/10/24 at 7:05 PM revealed, this nurse was alerted to res's room by cna who stated res was noted on the floor between his wall et bed. res was on his bottom c (with) knees bent et arms around knees with his head resting on his forearms. res denied pain et demonstrated a rom (range of motion) x4, no injuries observed at this time, res was assisted to wc et came out to common area to watch tv et eat a snack. The Immediate Action Taken section revealed, assisted to wc et taken to common area for close monitoring. Intervention-staff to be sure bed brakes are on. The Mental Status section of the Incident Report revealed the resident was oriented to person and confused, and included the following narrative: res stated that he ate supper, but he went to bed prior to eating, res also stated that he didn't have his eve meds, and he did. Review of an Incident Note dated 11/22/24 at 11:00 AM revealed, Resident was found on floor sitting with his buttocks in-between his unlocked wheelchair and his bed. A/O (alert/oriented) per baseline, ROM (range of motion) WNL (within normal limits). no injuries noted. all assessments negative as of this time. resident reports he was self transferring from his bed to his wheelchair and forget to lock in. the the process of doing so, his chair moved and he felt. he refused hitting his head and denies any pain/discomfort. resident had his glasses and shoes on, floor was dry, bed in low position with call light on it. his room was well lit and free of clusters. he was assisted to his wheelchair. resident stable, vitals noted 97.2-84-165/85-18-99% RA (room air). Neurochecks initiated per protocol, family, doctor and hot chart all updated. monitor continues per policy. The eMar-Medication Administration Note dated 11/26/24 at 09:11 AM revealed, in part, At approximately 0852 (8:52 AM), this nurse walked back to the nurse's station from the dining room and witnessed this resident having a seizure. He was sitting in the lounge area, in his wheelchair. Resident's arms and legs were positioned at his sides (arms), and in front of him (legs); BILATERAL upper and lower extremities were rigid and jerking repeatedly. This nurse went to the med cart and retrieved one of the resident's Nayzilam 5mg single-use sprays from the narc box, and administered it into his left nasal passage. Resident's convulsions halted approximately 5 seconds after administration of the spray .Once the convulsions ended, resident was very lethargic. Resident was taken to his room and put in his bed by this nurse, and [Name Redacted], LPN (Licensed Practical Nurse) on shift with me today. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Health Status Note dated 11/26/24 at 3:24 PM revealed, At 1430 (2:30 PM) resident observed having seizure in common area. Assessed for safety and after convulsions ceased resident was assisted back to bed and bed left in low position. After a short while was notified that resident was on the floor in his room. Enteredto find resident on floor and bleeding from laceration on right side of head. EMS (Emergency Medical Services) notified. While awaiting arrival resident was delusional and scooting self around room, was unable to obtain VS (vital signs) or assess d/t (due to) this. The Incident Report dated 11/26/24 at 3:45 PM authored by Staff revealed, Called to resident's room by CMA (Certified Medication Aide) due to resident being observed lying on the floor, with blood coming from an area on his forehead. The Immediate Action section documented the following intervention: Staff to make check and change rounds with resident due to more incontinent. Predisposing Physiological Factors included the following: confused, gait imbalance, impaired memory, recent change in cognition, and other. Review of the Other Info section revealed, Resident has had seizure activity today, 2 witnessed, lasting approximately 1. 5 minutes x1, and 2 minutes x1. The Physician Order for Resident #4 dated 5/22/23 revealed, Nayzilam Nasal Solution 5 MG/0.1ML (Midazolam (Anticonvulsant)) 5 mg (milligram) Alternating nostrils as needed for as needed for seizures related to OTHER SEIZURES (G40.89) administer 1 bottle (0.1ml/5mg) into 1 nare, administer 2nd dose (0. 1ml/5mg) in opposite nare 10 minutes after 1st dose is given if still seizing or if another seizure occurs. DO NOT give more than 10mg in 24 hours. Do not give more than 10mg q (every) 3 day. Although review of Resident #Progress Notes revealed the following two episodes of seizure activity on 11/26/24, review of the resident's November 2024 Medication Administration Record (MAR) revealed one dose of Nayzilam given on 11/26/24 at 9:09 AM. Review of a Controlled Substances Proof of Use sheet for Nayzilam for the resident revealed two doses received by the facility on 3/11/24, and administration of the medication on the morning of 11/26/24 brought the medication count to zero. However, review of an additional Controlled Medication Utilization Record for Resident #4 revealed 2 doses of Nayzilam were received by the facility on 7/25/24, with none signed off as administered to the resident. Review of History and Physical documentation dated 11/26/24 at 11:39 PM revealed the following: Chief Complaint: Seizure, fall. History of Present Illness: The patient is a [age redacted] year old male .who presented to the emergency roiagnom on [Hospital Name Redacted] on 11/26/2024 after having a seizure and falling down. According to the report of nursing staff at [Facility Name Redacted] where he resides, the patient had two seizures on 11/27/2024. Shortly after his second seizure, he was noted to have fallen out of his bed, striking his head resulting in a laceration. During chart review it is noted that he has had multiple visits to the emergency room this year with seizures and falls resulting in head injuries. On arrival to the emergency room , the patient appeared to be postictal (period immediately following seizure activity) and was not responding to questions. Over time he had become more alert, and would intermittently answer questions He received 2 sutures to a laceration above his right eyebrow .Maxillofacial CT (computed tomography) showed mild right frontal scalp and periorbital soft tissue swelling. CT of head and neck were negative for acute process. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The N-Adv Post Fall Evaluation dated 11/28/24 at 11:19 AM revealed, Fall was not witnessed. Fall occurred in the Resident's room. Activity at the time of fall: Resident had a seizure and fell from bed Reason for the fall was evident. Reason for fall: seizure activity Did an injury occur as a result of the fall: Yes. Injury details: Laceration on R (right) eye Did fall result in an ER visit/hospitalization : Yes .Skin: Skin Issue: #001: Skin issue has not been evaluated. Location: Right eye. Laterality / Orientation: Right. Issue type: Laceration. Wound acquired in-house. Wound is new. Incision approximated: Yes. Closure method: Sutures. Painful: No. Length (cm):2 Width (cm): 0.2. The Incident Report dated 1/2/25 at 2:24 PM revealed, Resident had a fall at 1400 (2:00 PM). Resident c/o (complained of) hitting head. Resident has small hematoma to middle of head .I was trying to get up and go to the bathroom. The Immediate Action Taken section revealed, Staff and resident educated on him to ask for help. Predisposing physiological factors revealed incontinent had been selected. The Health Status Note dated 1/2/25 at 2:33 PM revealed, Resident had a fall at 1400 (2:00 PM) in his room attempting to self transfer to the bathroom. Resident c/o (complained of) hitting head. Resident has a small hematoma to the middle of his head with some tenderness to touch. Able to move upper and lower extremities. VS (vital signs) are stable at this time. The Incident Note dated 1/16/25 at 4:20 PM revealed, This nurse was told that resident was on the floor. Upon arriving, resident was sitting on the floor behind the recliner in the living room. Resident stated that he was trying to walk to his room. He was assessed and vitals obtained. No injuries noted andhe denies any pain of discomfort. Resident was also explained to that if he wants to go to his room he is to use the wheelchair and not to walk unassisted. Will continue to monitor. On 1/23/25 at approximately 4:08 PM and on 1/28/25 at 11:40 AM, Resident #4 observed in their wheelchair in the dining room. On 1/29/25 at 9:25 AM, Staff D, Certified Nursing Assistant (CNA) queried as to how the resident transferred, and responded 1 assist with a walker as long as Staff D worked at the facility, clarified as 90 days. When queried if Staff D had been at the facility when the resident had fallen, Staff D responded one time was sitting on bottom on the unit, with wheelchair by the fireplace and resident over by the beauty shop. Staff D explained they were surprised no one saw resident walk that far. On 1/29/25 at 10:04 AM, Staff C, CNA queried how the resident transferred, and responded stand pivot. When queried how long had been that way, Staff C responded a month max, and further explained the resident used to be fairly independent, had a fall, and Staff C felt seeing the resident everyday did not think resident been the same since. When queried in what ways, Staff C responded a lot more contused, agitated very fast. When queried if Staff C was at the facility when the resident fell at that time, Staff C responded they were not. On 1/29/25 at 1:19 PM, Staff R, Licensed Practical Nurse (LPN) queried if had been at facility when Resident #4 had fallen, and responded no. When queried about the incident report she authored for the resident dated 1/2/24, Staff R explained resident trying to get out of chair, and chair went from underneath him, and ended up with a bruise to middle of head. When queried if resident transferred self, Staff R responded she did not think resident supposed to. Per Staff R, the resident was a check and change now, further explained she thought the resident wet themselves, was not aware fully wet, and they took him. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/30/25 at 4:43 PM, the facility's Director of Nursing (DON) explained Resident #4 was getting more confused, and had caught him standing in the dining room area, and caught him trying to walk from wheelchair to another area. The DON explained how resident's feet positioned not safe, and when the resident went to sit down on the toilet he basically thumped down, and he broke a couple of the stools that way. Per the DON, a commode put over top of it to see if it worked, and that had worked. The DON further explained the resident continued to have the falls, and per DON did not know if the resident was having fall because had a seizure or not. The DON explained after a seizure the resident slept, and got very sleepy. The DON explained she did not think he was, but there was that possibility. Per the DON, the resident generally had grand mal seizures and generally after had one he slept. When queried as to what staff should do if the resident seized and was not given Nazilym, the DON responded to get the resident away so everyone not seeing him, not able to put in bed if seizing, watch him, wait till the seizure goes,and if no longer seizing hoyer off the floor, and to bed to rest. The DON explained the resident was generally out one to two hours after seizures. Per the DON, the Nazyilam worked, and you could do the nasal spray and within 5 seconds the resident was done seizing. The DON explained the following about the falls process: DON would ask what happened, know exact reason what happened, and DON needed to figure out what to do for an intervention. The DON would enter into the incident report, and it would go into the care plan too. The DON explained would do a study of the root cause, and a lot of times it was unknown. Per the DON, Resident #4's happened all over the place, the resident had been more incontinent the last six months, and were finally getting resident to wear briefs. The DON explained she told staff can't just do him once a day, need to see if go down to his room to change, and have another person try. When queried if root cause was documented, the DON responded no. When queried if the resident could unlock his bed himself, the DON responded she did not think he would be able to do that. When queried about educating the resident, as noted in his interventions, the DON explained you could not educate Resident #4. When queried if the resident would be able to receive education during the last six months, the DON responded no, and clarified the resident doesn't understand if explain to him. The DON explained she did not think it was so much the seizures as resident's balance getting worse and worse, explained the resident used to zip up and down the hall with the walker, and after falls said need to go to wheelchair. Per the DON, the resident would go up and down the hall in their wheelchair as fast as could go, and was not doing that anymore. Per the DON, the resident was slowing down. On 1/30/25 at 6:57 PM, the Administrator explained the following about root cause analysis: The facility talked through it, and didn't do formal root cause analysis. The Administrator believed the DON did one with incident report. 2. Review of the MDS assessment for Resident #19 dated 11/29/24 revealed the resident scored 5 out of 15 on a BIMS assessment, which indicated severely impaired cognition. Review of Resident #19's Care Plan dated 9/8/24 revealed, I requires assistance with ADL's (activities of daily living r/t (related to) Dementia. The intervention dated 9/8/24, revised on 12/6/24, revealed the following: TRANSFER: I need assistance by staff to move between surfaces as necessary. Sit to stand t <sic> be used when unable to transfer 2 assist. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation on 1/27/25 at 12:28 PM revealed the following: Resident #19 present in the common area by nurses station, and resident in wheelchair. Staff I, CNA and Staff C, CNA attempted to get resident up without the use of a gait belt. The resident's legs were not straight, and the resident was asked if he wanted to sit back down. At 12:29 PM, Staff C got a gait belt, and Staff I and Staff C applied the gait belt to the resident. Next, Staff I and Staff C assisted the resident back up using the gait belt, and Resident assisted up to their walker. Resident #19 still not standing straight up, and Staff J, CMA assisted the other staff, and held the resident's gait belt from a position behind Resident #19. On 1/29/25 at 9:25 AM, Staff D, CNA queried about transfers for Resident #19, explained did stand pivot on him, as well as night shift stand lift. Per Staff D, in the mornings the resident stood well. When queried if gait belt put on if resident moving from wheelchair to walker, Staff D responded could do so, and won't hurt. On 1/29/24 at 10:06 AM, Staff C, CNA explained could usually get the resident to stand with a walker, and arm and arm him, and would do a lot of the work by self. Staff C explained the other day they were not sure what that was about, and further explained was never that hard, and no clue what to do. When queried if the resident normally had a gait belt on, Staff C responded sometimes, and further explained it was usually not that difficult that had to have the gait belt. Per Staff C, the gait belt not as helpful as the stand lift. When queried if the resident normally stood pretty good, Staff C responded, yeah. On 1/29/25 at 4:00 PM, Staff K, CNA queried about transfers for Resident #19 from wheelchair to walker, responded should be 2 (assist), and when queried if would use a gait belt, Staff K responded, definitely. When queried why so, Staff K responded the resident was a pretty big guy, and it could be difficult to get resident up from a sitting situation. Staff K explained they would generally prefer to have another CNA be with them any time taking care of him (Resident #19), explained he (Resident #19) was a pretty big guy, and depending on mood could have behaviors. On 1/30/25 at 4:55 PM, the DON explained if staff getting resident up from wheelchair, should use the stand lift. Per the DON, if trying to transfer, even two trying to do gait belt was not safe. When queried if staff did 2 person transfer if a gait belt should be used for him, the DON responded yeah. 48888 3. The MDS dated [DATE], revealed a BIMS score of 13 out of 15, indicating intact cognition. Resident #11 utilized a walker for mobility, able to transfer and ambulate in facility independently. Diagnoses included: anemia, hypertension, viral hepatitis, schizophrenia, chronic obstructive pulmonary disease (COPD), osteoarthritis of knee, and history of falling. The MDS revealed Resident #11 had 2 or more falls without injury during assessment period. The Care Plan, revised on 1/27/25, identified Resident #11 at moderate risk for falls related to deconditioning and COPD. Incident of fall and corresponding intervention listed in Care Plan as follows for the month of January: a. 1/03/25: Resident education to use call light to ask for help at all times. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	b. 1/03/25: Resident re-educated to always call for help whenever she has to do anything requiring her to bend over or let go of walker. c. 1/03/25: Re-educated on wearing gripper socks. d. 1/06/25: Repeat education on calling for assist to transfer. e. 1/06/25: Resident reluctantly move to middle of the bed and socks switched to non-skid sock, oxygen put on. f. 1/08/25: New gripper socks and placed on correctly. g. 1/10/25: Remind Resident #11 again to call for assistance. h. 1/12/25: Facility reviewed resident's call light use. i. 1/13/25: Went over call light use with resident again. j. 1/14/25: Sign placed in resident's room to call for assistance k. 1/15/25: Staff to check on Resident #11 every half hour l. 1/22/25: Sign placed on walker to call, not fall. Review of facility provided incident reports revealed Resident #11 had 12 falls between 1/01/25-1/23/25, 9 of the falls had been unwitnessed, no injuries related to falls documented on incident reports. Dates of unwitnessed falls included: 1/03/25 at 7:25 AM, 1/03/25 at 8:00 PM, 1/06/25 at 8:38 PM, 1/08/25 at 8:15 AM, 1/10/25 at 6:10 PM, 1/12/25 at 9:00 AM, 1/13/25 at 12:25 AM, 1/15/25 at 6:00 PM, and 1/22/25 at 9:07 AM. Review of facility provided document, titled Neurological Flow Sheet revealed neurological assessments had been initiated on the following dates/times: a. 1/04/25 at 11:00 AM b. 1/06/25 at 12:20 PM c. 1/12/25 at 6:30 PM d. 1/22/25 at 8:30 AM Review of Resident #11's Progress Notes revealed the following fall documentation: a. On 1/08/25 at 9:38 PM, Note revealed that neurological assessments do not need to be restarted at this time per Director of Nursing (DON). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	b. On 1/23/25 at 5:32 AM, an off-going nurse reported resident had multiple falls on their shift, approximately 4, and neurological assessments continue from fall follow up 1/22/25. Note revealed Resident #11 non-compliant with asking for assistance, has poor impulse control when she wants to get up and that she had been educated multiple times to ask for help. c. On 1/23/25 at 4:00 PM, recommendations received from therapy department for Resident #11 to be assist of one staff using walker and gait belt at all times in room and hallway. Recommendation for Resident #11 to walk to all meals with wheelchair to follow. d. On 1/24/25 at 9:39 PM, Note informed that Resident #11 is non-compliant with calling for help which lead to multiple falls. Indicated resident already on fall initiated neurological checks and resident falls in between checks due to non-compliance. Note revealed instruction from DON to not start neurological starts over. 6. On 1/27/25 at 2:08 AM, Resident #11 noted to have Urinary Tract Infection with antibiotics initiated and now required assist of 2 staff using gait belt related to weakness and balance issues. On 1/28/25 at 12:04 PM, Staff L, RN, reported Resident #11 recently had gotten a lot weaker, unable to stand as well and knees would drop down. Staff L recalled that recently staff had to transfer resident as a 2 person assist with gait belt, had previously been independent to transfer/walk. Staff L stated Resident #11 had been falling a lot lately, with a lot of unwitnessed fall and said when she comes in to work there's no notes on her falls that are verbally passed along in shift report. Staff L stated she received instruction from the Director of Nursing (DON) to not restart neurological assessment, instead continue where you were due to having multiple falls in a day. On 1/29/25 at 9:24 AM, Staff D, CNA, stated Resident #11 had been falling frequently, almost everyday, multiple times a day for at least the past 2 weeks. Staff D stated Resident #11 had more weakness recently and now required a 2 person assist to transfer. Staff D reported interventions for Resident #11 included sign on walker and in her room. Staff D stated that Resident #11 would not call for help, even if reminded. On 1/29/25 at 9:52 AM, Staff C, CNA, reported Resident #11 required assist of 2 for the past week, including use of full body lift. Staff C recalled Resident #11 had been assist of 1 for brief time before current transfer status and previously had been able to transfer and ambulate independently in facility with walker. Staff C recalled fall interventions for Resident #11 included checking on her more frequently and more recently bringing out to nurses station. Staff C stated that Resident #11 may use call light more during the past week as she had been less independent. On 1/29/25 at 1:41 PM, Staff R, LPN, stated neurological checks should be initiated for each of Resident #11's falls because the falls are not witnessed. Staff R stated fall notification had only included letting the DON know about a fall, because DON informed her that DON would notify the physician. Staff R stated that Resident #11 having multiple falls in a day would be change in condition and physician would need to be notified. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/30/25 at 2:30 PM, the DON stated interventions used to prevent Resident #11's falls included talking to resident, asking her to please use call light, put a sign on wall, but resident continued to still be very impulsive. DON reported that staff are to look in every time they walk by her room to catch resident before fall. DON reported Resident #11 knows how to use call light but does not often use it. DON stated nothing has been effective for prevention of Resident #11's falls. DON revealed the expectation of nurses to notify the physician, responsible party, and DON if a resident falls multiple times in a day and informed that the protocol for unwitnessed falls included treating the fall like resident hit their head, by starting neurological exam. DON confirmed that staff have been informed not to restart neurological assessment checks for falls that occur between neurological checks, if resident doesn't hit head because they would never finish doing vitals on Resident #11. DON reported that staff would know if Resident #11 hit head in an unwitnessed fall due to location of fall and resident position. 4. The MDS assessment, dated 1/07/25, revealed a BIMS score of 15 out of 15, indicated intact cognition. No behavioral symptoms indicated on MDS. Resident #184 independent with mobility throughout the facility, without assistive device. Diagnoses included: type 2 diabetes mellitus, post traumatic stress disorder (PTSD), attention deficit hyperactivity disorder (ADHD), moderate intellectual

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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. 45338 Based on clinical record review, facilty policy review and staff interviews the facility failed to ensure timely treatment of a urinary tract infection (UTI) for 1 of 3 residents reviewed for urinary tract infection (Resident #5). The facility reported a census of 35 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment for Resident #5 dated 10/18/24 revealed the resident scored 4 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely intact cognition. Per this assessment, the resident was always incontinent of urine and bowel. The Care Plan dated 6/22/18, revised 4/11/19, included a Focus area to address I have bladder incontinence r/t (related to) functional incontinence. Review of the Interventions revealed the following: a. (Created Date 4/11/19): ACTIVITIES: notify nursing if incontinent during activities. b. (Created Date 7/17/18, revised 6/10/21): Apply house barrier cream as needed following incontinence cares and when indicated. c. (Created Date 7/17/18, revised 6/10/21): Encourage compliance with incontinence cares and toileting. d. (Created Date 7/17/18, revised 6/10/21): INCONTINENT: Check [Resident #5] for toileting and incontinence care needs as required per nursing protocols. Change clothing PRN (as needed) after incontinence episodes as [Resident #5] allows. e. (Created Date 4/11/19): Monitor/document for s/sx (signs/symptoms) UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse,increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. The Behavior Note dated 1/12/25 at 3:54 PM revealed, Resident is wet with urine but refused to let staff change her. Is also exit seeking at this time. The Behavior Note dated 1/13/25 at 6:00 PM revealed, Resident with behaviors this shift. Refused to let staff give her cares and refused supper meds. The eMar-Medication Administration Note dated 1/13/25 at 7:39 PM revealed, in part, Resident refused cares from staff and refused supper meds. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Note dated 1/14/25 at 11:00 PM with date of service 1/15/25 revealed, in part, [age redacted]-year-old female history of CVA (cerebrovascular accident) and vascular dementia who is being seen for increased behaviors and reporting dysuria (painful urination). Orders given for UA (urinalysis) (may cath [use catheter to collect specimen] if needed) and will continue to monitor. Per the Progress Note, the resident had changes in urination. The Health Status Note dated 1/15/25 at 5:45 AM revealed, New order recv (received) and noted for UA may cath if needed R/T (related to) increased behaviors, pain burn with urination. Per Dr. [Name Redacted]. The Physician Order entered by Staff L, Registered Nurse (RN) dated 1/15/25 to 1/16/25 revealed, UA (urinalysis) with C&S (culture and sensitivity) if indicated may cath if needed one time only for increased behaviors, burn with urination for 1 Day. Review of the resident's Medication Administration Record (MAR) dated January 2025 revealed a code of 9, which indicated other/see nurses notes marked for the order on 1/15/25. Progress Notes for Resident #5 lacked why the order had been marked with the code 9. The MAR lacked documentation a UA completed on 1/16/24, then the order no longer populated to mark off on the resident's MAR. On 1/25/25 at 1:28 PM during an interview with Staff J, Certified Medication Aide (CMA), Staff J explained her signature on the MAR, which were noted to match the staff who had marked the resident's UA order with a code of 9) on 1/15/24. Staff J did not know why they had marked the code of 9, and explained they knew had gotten one (urine) recently and resident on Macrobid. The Health Status Note dated 1/17/25 at 8:05 PM revealed, in part, Resident in room the entire shift. she stayed calm but for when she has to be check and change then she becomes agitated, swinging and vocal. i will bite you b****s she turns to be somewhat complaint with cares. after several attempts and negotiation, she was able to be changed with the help of 3 staff. urine had bad odor to it unable to answer when ask about voiding discomfort, water encouraged. The Health Status Note dated 1/27/25 at 4:46 AM revealed, UA collected and sent per order, UA via cath. Resident tolerated well. Review of Resident #5's MAR lacked documentation the UA had been collected. Review of the Physician Order dated 1/27/25 to 2/3/25 revealed, Macrobid Oral Capsule 100 MG (Nitrofurantoin Monohyd Macro) Give 1 capsule by mouth two times a day for UTI (urinary tract infection) for 7 Days. The Health Status Note dated 1/27/25 at 10:03 PM revealed, Ekit (small supply of medications kept at facility to quickly treat symptoms) accessed and Macrobid initiated at 1745 (5:45 PM). No s/e (side effects) noted from atb (antibiotics), fluids encouraged, resident remains afebrile (free from fever) at 98. Review of Resident #12's Urinalysis with Microscopy lab results collected 1/27/25 revealed the resident had turbid urine with trace amounts of blood, 2+ nitrites, 500 leukocyte esterase, greater than 100 WBC (white blood cell), 6-10 RBC (red blood cell), and rare for bacteria. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/24 at 12:10 PM during an interview with Staff L, Registered Nurse (RN) revealed she last worked not the previous night, but the night before, and sent urine the night before as afraid had a UTI. Per Staff L, last week Staff L got an order to send urine out, and per Staff L, the Director of Nursing (DON) told another nurse didn't need it and took the order out last week. Staff L explained she sent the urine out yesterday. Staff L explained a lot of time, the resident sat in own BM (bowel movement) and won't let check or change, and Staff L explained was a breeding ground for bacteria. Per Staff L, when the resident had more behaviors, was afraid possible UTIs. When queried about who she got the order from the last week, Staff L responded Dr. [Name redacted]. Staff L explained the resident was incontinent, could not urinate in the hat, and needed to be catheterized. Staff L explained she clean catheterized the resident the other morning. When queried what made Staff L think last week the resident needed a UA, Staff L explained in November, the resident got Haldol shots, had behaviors and aggression, and wondered if UTI, got urine then, had a UTI, was treated, and better. Staff L further explained the resident was not trying to escape, was good as gold for weeks and weeks, and then started again. On 1/29/25 at 10:08 AM, Staff C, Certified Nursing Assistant (CNA) queried about Resident #5's urinary continence, explained she thought the resident was incontinent, and explained a lot of the time changed the resident, and the resident ripped the [brief] right off. Per Staff C, would change the resident and find the resident 5 minutes later with nothing on. When queried if Resident #5 let Staff C change her, Staff C responded, not all the time, no. When queried if Resident #5 allowed herself to be changed after a bowel movement, Staff C responded not all the time, and if having a great day, yeah, and if having not so good day would refuse care all day long. On 1/29/25 at 3:39 PM, Staff J, Certified Medication Aide (CMA) notified the State Agency that a 9 had been documented on 12/16 for UA on [Resident #5] because [the Director of Nursing] told [Staff J] and [Staff R], the nurse that also worked that day, not to get UA because resident was being combative. On 1/30/25 at 4:57 PM, the DON explained the resident had been having behaviors that day, staff asked about doing it, and DON said don't do it as going to get beat up. The DON also explained was not going to put the resident through the cath UA and it was not fair to her. Per the DON, she understood wanted a cath UA, and needed to try to get a hat if could before went to cath UA, and if not going to do it, needed to figure out how to. When queried as to what happened next and whether it got passed to the next shift or not, the DON responded they probably didn't or did and the person did not do anything about it/not passing on the orders. When queried if staff asked the DON about it after the 15th, the DON explained she did not know that had had the order, and did not know go the order in the first place. Per the DON, all she knew was the resident's UA was handed to her (DON), so could scan and send to the Doctor. The DON explained they still did not have the resident's culture back. The facility policy, titled Urinary Tract Infections/Bacteriuria-Clinical Protocol/Guidelines F 690, dated 8/2015 and last revised 11/2017, revealed the following per the Treatment/Management Section: 1. Obtain orders for verified or suspected UTIs based on a pertinent assessment. Notes below. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Non catheterized residents with symptoms associated with a UTI, an order for a urine culture should be obtained prior to initiating antibiotic therapy. This should be obtained through clean catch or midstream for residents able to follow instructions. For those unable, it is recommended to catch with a condom catheter for males or an in-out catheter for females or males whom a condom is not easily applied.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety 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 observation, clinical record review, facility policy review, Registered Dietitian and staff interviews the facility failed to address the severe weight loss of 2 of 3 (Resident #183 and Resident #12) residents reviewed for weight loss. Per the Registered Dietician note dated 10/23/24, Resident #183 a cognitively impaired resident experienced a severe weight loss of 12.6% in 180 days. The facility failed to complete weekly weights as ordered, failed to increase interventions after initiation of a house supplement failed to maintain weight in August 2024, failed to notify the physician of the weight loss, and failed to care plan the actual weight loss. This failure resulted in Immediate Jeopardy to the health, safety, and security of the resident. The facility also failed to ensure Resident #12 was free from severe weight loss of 6.2% in 30 days, 7.9% in 90 days, and 13.1% in 180 days. The facility failed to care plan the resident's severe weight loss, failed to ensure the resident had a physician order implemented timely for nutritional supplements, and failed to revise interventions to address the resident's weight loss. The facility reported a census of 35 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) on 1/21/25 at 1:35 PM. The IJ began on 10/23/24, the day facility documented knowledge of Resident #183's weight loss of 12.6% or 17.2 pounds in 180 days. Facility staff removed the Immediate Jeopardy on 1/23/25 at 2:12 PM through the following actions: a. Facility re-weighed and reviewed for significant and/or severe weight loss for all current residents to implement interventions as needed. b. Facility reviewed medical records for presence of eating disorder and behavioral problems that could impact nutrition. c. Resident identified to have significant and/or severe weight loss reviewed by the Registered Dietitian for recommendations. d. Current residents with significant and/or severe weight loss had their physicians and responsible parties notified. e. Facility met with Medical Director to review residents' weight loss and facility corrective action on 1/21/25. f. Interdisciplinary Team (IDT) re-educated on criteria for a significant and severe weight loss for 1 month, 3 months, and 6 months. g. Current staff educated on changes in resident condition to report, such as poor appetite, behavioral changes, difficulty eating, and/or vomiting. The scope lowered from J to G at the time of the survey after ensuring the facility implemented education and their policy and procedure Findings include: (continued on next page)

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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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The Minimum Data Set (MDS) assessment, dated 10/25/24, revealed Resident #183 had both short term memory and long term memory problem, as well as fluctuating symptoms of inattention, disorganized thinking, and altered level of consciousness. Resident #183 assessed as able to feed self with supervision at the time of assessment. The MDS assessment identified a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and indicated Resident #183 not on a physician prescribed weight loss regimen. The MDS list of diagnoses included: diabetes mellitus, non-Alzheimer's dementia, anxiety disorder, depression, and schizophrenia (schizoaffective disorder). The MDS, dated [DATE], revealed Resident #183 required set up assistance with meals and identified a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and indicated Resident #183 not on a physician prescribed weight loss regimen. Diagnoses list included bulimia nervosa, a mental health disorder of self-induced vomiting related to a perceived concern for one's own weight. Per the Care Plan, revised on 6/10/21 Resident #183 ordered CCD (carbohydrate controlled diet), regular texture, thin consistency. The Care Plan, revised on 10/22/24, revealed Resident #183 had nutritional risk related to diabetes and abnormal labs with the goals to maintain weight and eat 50% of 3 meals daily. The Care Plan lacked identification of Resident #183's severe loss of weight (greater than 10% of body weight in 6 months). Interventions included: a. Allow Resident #183 to express that she is not hungry, initiated on 8/21/18. b. Provide health shakes three times a day, initiated on 7/24/24. c. Monitor labs as ordered and refer to physician as needed, initiated on 3/29/20 d. Offer resident an alternative food item or snack if they become hungry after refusing a meal, initiated on 8/21/18. e. Offer Resident #183 set up help at meals, initiated on 3/29/20. f. Weigh as ordered and record. Monitor for significant weight change and refer to physician as needed, initiated on 3/29/20. The Medication and Treatment Administration Record (MAR/TAR), for December 2024, revealed an order for weekly weight to be checked every Friday, start date 5/24/24. The MAR/TAR documented: a. On 12/6/24 a check mark indicated the completion of weekly weight b. On 12/13/24 a code of 6 used to indicate hospitalization c. On 12/20/24 no results indicated or codes used to explain the lack of a weight. d. On 12/27/24 a check mark indicated the completion of the weekly weight. The December 2024 MAR/TAR did not document the results of completed weekly weights. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The December MAR/TAR revealed an order for a House Supplement TID three times daily for recommendation from RD (Registered Dietician). A review of the electronic health record (EHR) Weight Summary indicated on 5/31/24 Resident #183 weighed 130.0 pounds. On 11/11/24, the Weight Summary recorded the resident weighed 113.4 pounds. The change in weight from 130.0 pounds to 113.4 pounds represented a weight loss of 12.77% in 112 days. A weight loss is considered severe if greater than 7.5% in 3 months, and greater than 10% in 6 months. A Nutrition/Dietary Note, dated 10/23/24, listed Resident #183 had past medical history of schizoaffective disorder, bulimia nervosa, type 2 diabetes mellitus, mental disorder, and anxiety .CBW (current body weight): 118# (pounds) .Weight down 12.6% or 17.2 # x 180 days. Weight stable x 30/90 days. House supplement BID (two times daily), increased to TID on 8/2[2024] .Weight appears to be stabilizing continue POC (Plan of Care). A Mini Nutrition Assessment (MNA), dated 10/23/24, completed by Registered Dietitian documented . Resident has no decrease in food intake is last 3 months. Weight loss greater than 3kg (kilograms) (6.6 lbs [abbreviation for pounds] in the last 3 months. Goes out. Has not suffered psychological stress or acute disease in the past 3 months. Resident has no psychological problems .Mini Nutrition Score: The Score is 9. Per the scale 8-11 points: At risk of malnutrition. A Nutrition/Dietary Note, dated 11/06/24. documented RD WEIGHT NOTE: CBW: 113.4# .Weight stable 30/90 days. Weight down 12.8% or 16.6# x 180 days. House supplement BID, Increased to TID on 8/2[2024] .Weight appears to be stabilizing continue POC. A review of Nursing Progress notes from 10/23/24 to 12/30/24 revealed no documentation of physician notification related Resident #183 weight loss. During an interview on 1/20/24 at 10:30 AM, the facility RD stated Resident #183 had lost weight gradually at first, weight was approximately 140 pounds in June 2024 and then in August 2024, there had been around a 10 pound weight loss and started Resident #183 on House Supplement three times a day and reported that with intervention Resident #183 would stabilize then continue to lose weight. RD stated Resident #183 had orders for weekly weights to be completed, then facility may have switched to monthly. RD reported recommendations for residents would be given to Director of Nursing to notify Provider. During an interview on 1/21/24 at 11:30 AM, Director of Nursing (DON), stated that Resident #183 was supposed to be on weekly weights, but said the staff are not good about getting the weekly weights. DON claimed a list of weekly weights for staff reference often went missing and stated Resident #183's weights had been checked about twice per month. DON stated that Resident #183's intervention for weight loss had been to give House Supplement three times a day and confirmed this intervention was put into place in August 2024. DON stated that Resident #183's physician would be notified verbally by DON of an identified weight loss, DON unable to recall if Provider had been notified verbally and unable to recall if there had been documentation of Provider notification in Resident #183's EHR. 45338 (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Review of the MDS assessment for Resident #12 dated 11/1/24 revealed the resident scored 9 out of 15 on a BIMS which indicated moderately impaired cognition. Per this assessment, the resident was independent with eating. The assessment revealed the resident's height was 63 inches and weight was 194 pounds. Review of Resident #12's Care Plan dated 9/6/24 revealed, [Resident #12] has a potential nutritional problem r/t (related to) Dementia. Interventions per the Care Plan, all dated 9/6/24, revealed the following: a. Monitor/document/report PRN (as needed) any s/sx (signs/symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. b. Monitor/record/report to MD (Medical Doctor) PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3 lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. 9/6/2024 c. Provide and serve diet as ordered. d. RD (Registered Dietician) to evaluate and make diet change recommendations PRN. Review of Resident #12's Physician Order dated 8/1/24 at 12:27 PM revealed, Regular diet, Regular texture, Thin consistency for 2 L (Liter) fluid restriction. A review of the EHR Weight Summary listed the following weight results for Resident #12: a. 8/13/24 at 3:25 PM: 206.0 Lbs b. 9/3/24 at 2:29 PM: 201.8 Lbs c. 10/7/24 at 9:34 AM: 194.4 Lbs d. 11/5/24 at 9:37 AM: 190.8 Lbs e. 11/20/24 at 1:42 PM: 190.8 Lbs f. 12/16/24 at 10:18 PM: 179.0 Lbs g. 1/6/25 at 2:42 PM: 168.0 Lbs Review of the Nutrition/Dietary Note dated 8/14/24 at 10:29 AM for the RD (Registered Dietician) Admission Note revealed, in part, the resident had no chewing or swallowing difficulty noted, weight was 206 pounds, body mass index 36.5, and resident's height documented as 63 inches. The Goal section of the note revealed, weight will remain stable. within 7.5% of CBW (current body weight) through review date. The Plan section revealed the following: Monitor weight per orders. Follow diet and supplements per orders. RD to monitor and f/u (follow up) prn (as needed). (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The N-Adv Mini Nutritional assessment dated [DATE] revealed the resident weighed 190.8 pounds, revealed no decrease in food intake, no weight loss, had severe dementia or depression, The next Nutrition/Dietary Note present in the resident's electronic record dated 12/18/24 at 3:57 PM revealed, RD WEIGHT NOTE: CBW: 179# .Weight down 6.2% or 11.8# x 30 days. Weight down 15.4# or 7. 9% x 90 days. Weight down 13.1% or 27# x 180 days. Reg/reg/thin diet. Intakes sporadic and avg 50%. Resident noted for recent diarrhea. Gatorade has been provided at times per nursing documentation. On 12/7/24 resident was admitted to the hospital r/t (related to) dehydration, resident noted to pull out two IVs (intravenous). Resident noted for confused behaviors .Continue to provide resident with Gatorade or otherelectrolyte drink when resident experiences diarrhea. RD to continue to monitor and make rec prn. The Nutrition/Dietary Note dated 1/6/25 at 3:35 PM revealed, RD WEIGHT NOTE: CBW: 168# .Weight down 6.1% or 11# x 30 days. Weight down 11.9% or 22.8# x 90 days. Weight down 18.4% or 38# x 180 days. Reg/reg/thin diet. Intakes sporadic and avg 50%. Resident noted for recent diarrhea. Gatorade has been provided at times per nursing documentation. On 12/7/24 resident was admitted to the hospital r/t dehydration, resident noted to pull out two IVs. Resident noted for confused behaviors .Continue to provide resident with Gatorade or otherelectrolyte drink when resident experiences diarrhea. On 1/6/24 nursing notes resident continues to have diarrhea. Resident receives Health Shake TID (three times per day) r/t (related to) recent weight loss. RD to continue to monitor and f/u (follow up) prn. Observation in the dining room on 1/13/25 at 11:43 AM, Resident #12 stood up, and staff said resident was not going to stay, and couldn't make her stay. Staff told Resident #12 let's sit down and eat, and asked resident you're not going to eat lunch? Resident #12 observed leaving the dining room with her walker, and walked away from the dining room. Record review revealed as of 1/13/25, Resident #12's Physician Orders lacked an order for a supplement. Review of the resident's MAR/TAR printed from the facility's EHR system on 1/13/25 did not include a supplement order, or charting of receipt. Review of the Physician Order dated 1/21/25 at 10:51 AM revealed, [Brand Name] Shake three times a day. During an interview on 1/14/25 at 8:57 AM, the Dietary Manager (DM) interviewed about Resident #12. The DM explained at the facility 9 years, and said when first got to facility resident would come up to every meal, would sit there, and never ate a whole lot. Per the DM, the resident liked desserts. The DM further explained lately it was so much work for them to get resident there, or if took tray to resident, to get resident to sit still. Per the DM, the intervention done was a health shake and even if the resident didn't come to the meal, the DM explained the resident did pretty good with those, and at first the resident would bring the shake out to the nursing station, set down, and say don't want it. The DM queried when the health shakes started, and responded they would have to see, probably about a month ago. Per the DM, the kitchen would give the shakes, they were called house supplements, and right now the facility had [brand name supplement] which gave resident a little more protein. Per the DM, supplements discussed 12/20/24, and when queried if they started then, the DM explained yeah, [DM] always started right away. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When queried if facility did weight meetings, the DM explained the Dietician at the facility every two weeks, and went over any concerns had, tried to get interventions in place, and adjust from there. When queried if amount of shakes consumed was charted, the DM responded that would be on nursing charting, and DM acknowledged could not tell [State Agency] for sure what was going on there. The DM explained currently he wished would get the resident to calm down, sit still, and get the resident to eat a little more. The DM explained the resident was quick to take off from wherever she was at, she would get to the dining room, would feed the resident as soon as possible or the resident was gone as soon as possible. Per the DM, the resident would eat dessert, couple bites, drink, then left. The DM explained was sure resident was going to be an ongoing need to keep closer eye on. When queried if the resident could eat in their room, the DM explained resident always wanted to run off, and a little better if little supervision. During an interview on 1/14/25 at 1:24 PM, Staff D, Certified Nursing Assistant (CNA) explained Resident #12's eating was very sporadic, and definitely based off of mood, lack of sleep, factors like that. When queried about a supplement observed and whether resident had been drinking it,Staff D responded they thought so. Per Staff D, CNAs did chart meal intake, and when queried about supplement intake, Staff D explained the facility did a fluid intake, described as total fluids for the general time frame. When asked if could tell if resident drank the supplement versus, for example a different fluid, if could tell which one consumed, Staff D responded no. During an interview on 1/14/25 at 1:40 PM, Staff C, CNA explained the following about Resident #12 and eating: Per Staff C, tried to get resident to come down for meals every meal, and sometimes could be a fight, like a literal she (resident) is not happy kind of fight. Per Staff C, if the resident did not want to come to eat resident did not come to eat. Staff C explained would take a tray to resident and resident would eat in her room. When queried what had been done, Staff C explained at first talking to resident that want a full stomach, and learned to let the resident have her own space. Per Staff C, the resident was doing a lot better. When queried whether CNAs checked weights at the facility, Staff C responded weight was getting checked, for sure at least once a month which was all told to do so far. During an interview on 1/14/25 at 2:36 PM, Staff E, Licensed Practical Nurse (LPN) explained Resident #12's eating depended on the day, and if could get the resident to come out for meals the resident ate really well. Per Staff E, motivating the resident to come down to eat was the issue. When queried as to interventions, Staff E explained for awhile resident given health shakes. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/15/24 at 9:51 AM during an interview with the RD explained the following about Resident #12: The resident came in, lost quite a bit of weight, came in on a 2L (liter) fluid restriction, and one of the first things did was remove that. Per the RD the resident had dehydration, so didn't want restriction there. The RD described sporadic intakes for resident average 50%, and not sufficient amount calories for resident, and health shake started for resident. Per the RD, started health shake on 1/6/25, and it was started three times day because resident dropping pretty rapidly. The RD explained the resident was given [electrolyte drink] and had dehydration and diarrhea trying to resolve, at last visit talked to DM, and trying to include foods in brat diet. Per the DM, the resident started dropping weight in November, December really stated losing weight. When queried how often staff should be getting weights on the resident, the RD responded she believed resident was a monthly weight now, on admission was usually every week for four weeks, and explained may have to switch to increasing weights which may be next intervention as well. When queried about the policy for a reweight, the RD explained she was not sure if set in stone policy, and a lot of time RD came in and recommend reweights if saw them and thought weight was off. When queried if there should be an order for a shake if resident on nutritional shake, the RD responded yes. When queried who would put that in, the RD responded usually the DON. Per the RD, she had her own individual report, and on the RD's last report she put in a note hadn't updated orders in [electronic health record (EHR)]. The RD explained the DM had a spreadsheet of shakes kitchen provided. On interview, the RD confirmed thought it was correct that order was not in EHR, and explained she would have to send another email to make sure got that in there. The RD explained usually charting was that supplement was provided, did not have percentage drank usually, and some facilities did while others did not. The RD further explained the following about supplement intake: The RD could ask the Dietary Aides, the DM was usually pretty well informed of how resident drinking shake, or asked the DON. The RD would ask around if people remembered how much the resident drank. When queried about the resident's diet, the RD responded the resident on a regular diet since 8/1/24. When queried what the resident's weight loss was attributed to, the RD responded poor and sporadic intakes and diarrhea, and thought struggling to hold on weight in that regard. The RD explained the resident was admitted to the hospital on IV fluids at one point to help with that, which was why started on [electrolyte drink], health shake. The diarrhea continued, brat diet so could keep weight on, and explained if resident on toilet constantly hard to put on weight. When queried about interventions prior to the health shake, the RD responded [electrolyte drink] soon as diarrhea, and hospital on 12/7 to help with dehydration. When queried about the resident's diarrhea, RD explained facility had been trying to figure it out also, resident did not have diagnosis why diarrhea. The RD explained they were probably going to have to get the resident reviewed and sent to the hospital, as it had been going on too long. Observation on 1/27/25 at 12:18 PM revealed Resident #12 in their room in bed sleeping, with full plate of food. Two cartons of [Brand Name] supplement present with the resident's food, with one carton laying on its side. Some beverages observed to be full, and staff not in room with resident at time of observation. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/21/25 at 11:30 AM, the DON queried about Resident #12, and explained even from the beginning when resident came to facility had a problem with resident eating. Per the DON, the resident won't say in the dining room, and always headed back to her room. The DON explained the resident went through a phase, had a lot of behaviors, put self on he floor constantly, came up to the nursing station every two to three minutes, would send the resident back to her room, resident asked to cover her up, resident given a drink, and can't have more than fluid restriction. Then the resident caught COVID, took resident off fluid restriction, gave resident what should eat, and resident had [electrolyte drink] at nursing station. Per the DON, the resident was starting to eat a little better, still hit and miss with her (Resident #12). The DON explained the resident would drink the health shakes, and explained she saw the girls never got those entered in. When queried when they started, the DON didn't recall, said hadn't been that long, and said only been a couple of months. When queried about an order put in 1/21/25 for the shakes, the DON explained realized they hadn't been put in, and tried to explain to DM that he could put them in too, the DM didn't do it, and was left on DON. When queried if would be charted if drank the shake or not doing so, the DON explained if put into [EHR] like supposed to be, would put down how much drink of the shake. The DON explained trying to get the resident to come up for meals, would take it to her room and resident said not hungry, and got to eat something. Per the DON, once and a while resident came to main dining room, and didn't have the resident come up until her food was served right away. The DON explained if served right away, resident had tendency to eat some of it. Per the DON, the resident had diarrhea every once and awhile, and it was a tendency the resident had. Per the DON, when the resident first came in, the resident had no known allergies. Per the DON, the resident's [family member] then said the resident was allergic to eggs, the DON gave guidance to not give the resident eggs. The DON queried when resident not given eggs if diarrhea stopped, and the DON responded saw no complaints and didn't use loperamide (medication used for diarrhea). When queried if giving resident eggs again, DON responded yes, and resident still had some diarrhea occasionally, not like resident had been. The DON explained the following about Resident #12's weights: it was still monthly but facility was weighting resident more often, and they (staff) were not doing them like DON wanted them to. When queried as to when this started, the DON responded she could not remember. When queried how staff knew to do so, the DON responded if weekly would pop up dates, and supposed have in [EHR]/MAR. The DON explained whoever on the med cart would say needed weight on this person today. The DON explained there was a weekly weight sheet, and said it might have disappeared again. Review of Resident #12's Physician Orders printed on 1/13/25 revealed the resident had been ordered monthly weights as 12/17/24. A Physician Order for weekly weight as indicated one time a day every Tue (Tuesday) was entered into the resident's EHR on 1/21/25 by the DON. During an interview on 1/30/25 at 12:08 PM, Staff Q, Registered Nurse (RN) explained she worked at the facility maybe every other weekend, every two weekends. Per Staff Q, the last time she (Staff Q) worked (later clarified as 12/14) the resident had lost so much weight, and Staff Q was asking because before Staff Q left, was taking resident to the dining room to feed her. Per Staff Q, the resident used to eat in room, and the resident needed to be whether other people were. Staff Q explained the shift Staff Q picked up the resident had lost so much weight, and said no one had motivation to go in and feed her. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility policy titled Weight Assessment and Intervention F 692, dated 9/2012 and last revised 10/2022, revealed the following: The interdisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss or gain for our residents .5. The threshold for significant unplanned and undesirable weight change will be based on the following criteria [where percentage of body weight loss = (usual weight-actual weight)/(usual weight) x100]: a. 1 month-5% weight change is significant; greater than 5% is severe. 3 months-7.5% weight change is significant; greater than 7.5% is severe. 6 months -10% weight change is significant;greater than 10% is severe. The Interventions section of the facility policy revealed, in part, Interventions for undesirable weight loss shall be based on careful consideration of the following: a. Resident choices and preferences; b. Nutrition and hydration needs of the resident; c. Functional factors that may be inhibiting independent eating; d. Environmental factors that may inhibit appetite or desire to participate in meals; e. Chewing and swallowing abnormalities and the need for diet modifications; f. Modifications that may interfere with appetite, chewing, swallowing, or digestion; g. The use of supplementation and/or feeding tubes; and h. End of life decisions and advanced directives.

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on clinical record review, facility policy review and staff interviews the facility failed to provide effective pain management for a resident who suffered a fall on 12/06/24, which resulted in limited range of motion (ROM) and bruising/swelling to the right upper extremity (RUE) on 12/07/24. Documentation from 12/07/24 to 12/11/24, revealed Resident #183 experienced severe pain when touching the right elbow, straightening the right elbow, moaning/groaning with ROM, and acting afraid to walk. The facility failed to conduct follow up pain assessments to determine whether or not effective pain management achieved by the administration of as needed (PRN) Tylenol and/or Tramadol. The facility failed to notify the physician of the pain symptoms prior to 12/11/24. An x-ray on 12/12/24 revealed an acute moderately displaced avulsion fracture of the right elbow and a fracture of the right trochanter (hip fracture) found by the hospital on 12/13/24. The facility failed to obtain treatment orders upon return from the hospital. Resident #183 returned to the facility and rated pain a 10/10 (severe), crying out in pain, with increased pain during transfers with no indication that alternative pharmacological or non-pharmacological interventions attempted nor documentation of effective pain management being achieved from 12/13/24-12/30/24. This failure resulted in Immediate Jeopardy to the health, safety, and security of the resident. The facility reported a census of 35 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) on 1/22/25 at 3:30 PM. The IJ began on 12/07/24, the day the facility documented Resident #183 had severe pain in right arm and both knees. Facility staff removed the Immediate Jeopardy on 1/27/25 at 12:05 PM through the following actions: a. Facility assessed current residents for unresolved pain, notified their doctors of unresolved pain, and updated Care Plans to include non-pharmacological interventions. b. Residents returning to facility from the Hospital, clinic, or emergency room (ER) visit to have orders reviewed upon arrival and ensure new orders are in place and updated. c. Facility plan to follow up with Primary Care Providers if a resident's pain continues and to monitor this weekly at Interdisciplinary (IDT) meetings. d. Licensed nurses and nursing administration re-educated on reporting changes in resident condition, including unresolved pain, and to review residents experiencing unresolved pain for root cause and implement intervention, including non-pharmacological interventions. e. Facility had meeting with Medical Director on 1/22/25 to review residents with unresolved pain and the facility corrective action. The scope lowered from J to D at the time of the survey after ensuring the facility implemented education and their policy and procedures. Findings include: (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Minimum Data Set (MDS) assessment, dated 10/25/24, revealed Resident #183 had both short term memory and long term memory problems, as well as fluctuating symptoms of inattention, disorganized thinking, and altered level of consciousness. Diagnoses included diabetes mellitus, non-Alzheimer's dementia, anxiety disorder, depression, and schizophrenia (schizoaffective disorder). The MDS revealed Resident #183 required staff supervision for transfers and ambulation. The MDS indicated pain medications were given only on an as needed (PRN) basis, no scheduled or non-medication interventions were being used for pain. Pain assessment interview with Resident #183 not completed due to resident being rarely or never understood. The MDS, dated [DATE], revealed Resident #183 dependent on staff for transfers and unable to ambulate. The MDS indicated pain mediations were given on an as needed (PRN) basis, no scheduled or non-medication interventions were being used for pain. A pain assessment interview completed with staff revealed observations of pain indicators, including non-verbal sounds, verbal complaints of pain, and facial expressions which were observed for 3-4 days of the 5 day look back period. The Care Plan, initiated on 11/16/18, included a Focus area to address I am at risk for Falls r/t (related to) poor impulse control, dx of schiizoaffective disorder, restlessness, dx (diagnosis) dementia, behavior disorders, anxiety, insomnia, incontinent status; I have hx (history) of frequent falls. The list of falls (total of 20 falls from 2/21/24 to 12/14/24) included: 12/6/24 Fall, no injury; 12/9/24 fall, Skin split forehead; and 12/14/24 Fall, no injury. The Care Plan, initiated on 11/16/18 and revised on 10/22/24, included a Focus area to address I am at increased risk of pain r/t arthritis, frequent falls. Interventions included: a. Evaluate the effective of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Initiated on 11/27/28, revised on 6/10/21. b. Monitor/document probable cause of each pain episode. Remove and limit causes where possible. Initiated on 11/27/18. c. Monitor/record/report to Nurse any s/sx (sign/symptom) of non verbal pain: Changes in breathing . Vocalizations (grunting, moans, yelling out, silence); Mood/behavior .Eyes .Face (sad, crying, worried, scared clenched teeth); Body . Initiated on 11/27/18 and revised 11/07/24. d. Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. Initiated on 11/27/18. e. Notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain. Initiated on 11/27/18. f. Observe and report change in usual routine, sleep patterns, decrease in functional abilities, decreased ROM (range of motion), withdrawal, or resistance to care. Initiated on 11/27/18. g. Observe for pain every shift and PRN. Initiated on 11/26/22. h. Offer pain medication when she says she hurts. Initiated on 6/17/24. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	i. Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to s/sx of c/o (complaint of) pain or discomfort. Initiated on 11/27/18. The Care Plan, initiated on 7/26/24 and revised on 11/7/24, included a Focus area to Acute Pain/Chronic Pain. Interventions included, in part: a. Establish a pain management treatment plan. Initiated on 11/07/24. b. Medicate with PRN medications if non-medication interventions are ineffective. Initiated on 9/23/24 and revised on 11/07/24. c. Utilize non-medication interventions for pain relief. Initiated 9/23/24 and revised on 11/07/24. A review of the Medication Administration Record (MAR) for December 2024, revealed the following medications Resident #183 had ordered for pain relief: a. Acetaminophen (Tylenol) 325 milligrams (mg), Give 2 tablets by mouth every 4 hours as needed for general discomfort. Start Date 2/28/23. b. Tramadol HCL Oral Tablet 50 mg (Tramadol HCL). Give 1 tablet every 8 hours as needed for pain. Start date 6/27/24. A review of the Treatment Administration Record (TAR) for December 2024, revealed the following orders: a. Are you free of pain? If no, indicate response of pain level 1-10 with little to no pain as 1 and worst as 10 (If new or change in pain, complete [pain evaluation]) every shift. Start Date 9/26/22. b. BEHAVIOR(S) - Monitor for: RESTLESSNESS (AGITATION), Removing clothes in inappropriate places, exit seeking, AGGRESSION, REFUSING CARE. Document: 'N' if monitored and none of the above observed. 'Y' if monitored and any of the above were observed, select chart code 'Other/ See Nurses Notes' and document specific behavior(s) every shift for Behavior Monitoring Document each behavior observed and number of occurrences. Start Date 10/01/2024 Between the dates of 12/1/24 to 12/7/24 Are you free of pain?' asked of resident twice daily. A 0 (zero) documented 13 out of 14 of opportunities with 1 (one) NA documented for the day on 12/3/24. The TAR Chart Codes did not include an explanation of NA. Review of Resident #183's electronic health record Progress Notes and the December MAR from 12/7/24 to 12/13/24 revealed the following: 1. On 12/07/24: a. The December 2024 MAR documented Tramadol 50 mg administered at 7:36 AM for a pain of 5/10, with an E documented. The MAR Chart Code indicated an E = Effective. A eMar-Medication Administration Note at 8:38 PM indicated follow up pain 0/10. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. A Health Status Note at 8:09 PM revealed Resident's right elbow swollen and warm to touch. Can straighten out right arm but does state it hurts .Right arm placed on small pillow to elevate her arm. Ice pack attempted but resident will not leave it on. c. The December 2024 MAR Acetaminophen 325 mg not documented as administered to the resident on 12/7/24. d. The December TAR documented responses to Are you free of Pain? documented for day pain level of 0 (zero), and night pain level of 0 (zero). e. The December TAR documented number of NA, and NO for Behavior Observed for day, and NA, and NO for Behavior Observed for night. The TAR Chart Code did not indicate a code for NA. 2. On 12/8/24: a. The December 2024 MAR documented Tramadol 50 mg administered at 8:08 AM for a pain of 8/10, with an E documented. An eMar-Administration Note at 10:51 AM indicated follow up pain 4/10. And at 8:06 PM for a pain of 4/10 with an E documented. A eMar-Administration Note at 9:30 PM indicated follow up pain 0/10. No further doses of Tramadol documented. b. The December 2024 MAR documented Acetaminophen 325 mg administered at 6:41 PM for pain of 4/10, with an E documented. An eMar- Administration Note at 9:31 PM indicated follow up pain 0/10. No further doses of Acetaminophen documented. c. A Health Status Note at 8:51 PM revealed noted abrasion to right supraobrital area and above right eyebrow. Bruised area to right periorbital area healing appropriately. Slightly limited ROM (range of motion) to right upper extremity as result of bruised mildly swollen area to lateral elbow. Ice applied and pain med given. d. The December TAR documented responses to Are you free of Pain? documented for day pain level of 5 (five), and night pain level of 0 (zero). e. The December TAR documented number of NA, and NO for Behavior Observed for day, and NA, and NO for Behavior Observed for night. 3. On 12/09/24: a. The December 2024 MAR indicated Tramadol 50 mg not administered on 12/9/24. b. The December 2024 MAR indicated Acetaminophen 325 mg not administered on 12/9/24. c. A Health Status Note at 2:34 PM revealed .States pain in right elbow. Swelling had gone down. Vitals within normal limits with BP (blood pressure) being a little high at 153/96. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. A N Adv Vitals and Pain Only note entered at 5:45 PM revealed .BP 165/85 .Pain: Pain assessment interview should not be conducted, Resident is rarely/never understood. Indicators of pain: Facial expressions Indicators of pain: Vocal complaints of pain. Pain issue: #001: New. Location: Right elbow. Pain score: ? (Non-verbal sound or facial expressions of pain). Completed Clinical Suggestions: [no text present]. e. A N Avd-Post Fall Evaluation at 5:47 PM revealed Date/Time of Fall: 12/9/24 at 5:25 PM Fall was witnessed. Who witnessed fall: staff Fall occurred in the Resident's room .Did an injury occur as a result of the fall: Yes. Did fall result in ER (emergency room)/hospitalization : No Pain: Indicators of pain: Vocal complaints of pain. Indicators of pain: Facial Expressions. Pain issue: #001: New. Location: Right elbow. Pain score: ? (Non-verbal sound or facial expressions of pain). f. The December TAR documented responses to Are you free of Pain? documented for day pain level of 0 (zero), and night pain level of 0 (zero). g. The December TAR documented number of 1 (number), and YES for Behavior Observed for day, and NA, and 0 (zero) for Behavior Observed for night. 4. On 12/10/24: a. A Health Status Note entered at 1:59 AM revealed .Resident acting like she is afraid to walk from fall. Resident has no c/o pain or discomfort. No s/s (signs/symptoms) of pain. b. The December 2024 MAR documented Tramadol 50 mg administered at 7:06 AM for a pain level of 7, with an E documented. c. The December 2024 MAR documented Acetaminophen 325 mg administered at 7:07 AM for a pain of 7, with an E documented, and administered at 1:07 PM for a pain level of 5, with an E documented. d. The December TAR documented responses to Are you free of Pain? documented for day pain level of 2 (two), and night pain level of 2 (two). e. The December TAR documented number of NA and NO for Behavior Observed for day, and 1 (one) number documented and YES for Behavior Observed for night. 5. On 12/11/24: a. The December 2024 MAR indicated Tramadol 50 mg not administered on 12/11/24. b. The December 2024 MAR documented Acetaminophen 325 mg administered at 7:21 AM for pain level of 4, with an E documented. An eMar-Administration Note at 9:22 AM indicated follow-up pain scale was: 0 (zero). Acetaminophen documented as given at and at 7:19 PM for pain level of 4, with an E documented. An eMar-Adminsitration Note at 9:23 PM indicated follow-up pain scale was: 0 (zero). c. The December TAR documented responses to Are you free of Pain? documented for day pain level of 0 (zero), and night pain level of 0 (zero). (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. The December TAR documented number of no and NO for Behavior Observed for day, and 0 (zero) number documented and NO for Behavior Observed for night. e. A Health Status Note entered at 7:43 PM revealed Resident #183 reported to have lastly been known wet at 4AM this morning. She has been sleeping for most part of the day, drinking with meal. No distention/discomfort noted on palpation. Limited ROM on right upper and lower extremities with noted resolving bruises and swollen are to right upper extremity. Resident groans and moans with passive ROM, unable to walk, will just pivot to w/c (wheelchair). When ask what is wrong, she states it hurts when asked where she touches her right elbow and right knee. 6. On 12/12/24: a. The December 2024 MAR documented Acetaminophen 325 mg administered at 9:13 AM for pain level of 3, with an E documented. An eMar- Administration Note at 11:43 AM indicated follow- pain scale was: 2. b. The December 2024 MAR documented Tramadol 50 mg administered at 10:24 AM for pain level of 5, with an E documented. An eMar- Administration Note at 11:42 AM indicated follow- pain scale was: 2. c. A Health Status Note entered at 6:45 PM revealed Received call from [provider name redacted] xray and resident has a acute moderately displaced avulsion fracture arising from the dorsal olecranon (a bone fracture where a piece of the olecranon (the bony prominence at the back of the elbow) has been pulled away from the main bone by the force of the triceps tendon). Spoke with MD (medical doctor) [Name redacted] and received order for ortho (orthopedic) consult. d. The December TAR documented responses to Are you free of Pain? documented for day pain level of 0 (zero), and night pain level of 0 (zero). e. The December TAR documented number of no and NO for Behavior Observed for day, and number documented of NA and NO for Behavior Observed for night. 7. On 12/13/24 a. A Health Status Note entered at 8:25 AM revealed Call placed to [hospital name redacted] to report fracture in right elbow. Stated we should send to [hospital name redacted] as no ortho. b. The December 2024 MAR documented Acetaminophen 325 mg administered at 7:33 AM for pain level of 5, with an U documented. The MAR Chart Code indicated an U = unknown. c. The December 2024 MAR documented Tramodol 50 mg administered at 7:34 AM for pain level of 5, with an U documented. d. The December TAR documented responses to Are you free of Pain? documented for day pain level of 0 (zero), and night pain level of 0 (zero). e. The December TAR documented number of NA and NO for Behavior Observed for day, and number documented of NA and NO for Behavior Observed for night. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	f. A Health Status Note entered at 6:15 PM revealed Received call from social worker at [hospital name redacted] and she stated resident has a mildly displaced FX (fracture) of the her right greater trocanter (a bony prominence located at the top of the femur (thigh bone) on the outer side of the hip). Awaiting decision if surgical or note. DON aware. g. A Health Status Note entered on 9:45 PM revealed Resident returned from [name of hospital redacted] via 2 attendants via stretcher. Resident placed in low position bed with fall mat beside her bed. Snack given as she was hungry. Right arm in splint and sling for comfort. A review of Resident #183's December 2024 MAR/TAR from 12/13/24 to 12/30/24 revealed the following: a. Resident continued prescribed Tramadol 50mg every 8 hours as needed; and Tylenol 650mg every 4 hours as needed for pain. No documentation of pain medication changes. b. A pain level of 10 documented on the December 2024 TAR on: 12/14/24, 12/16/24 x2, 12/20/24, 12/24/24 x2, 12/25/24 x2, 12/26/24 x2, and 12/30/24. c. A pain level of 9 documented on December 2024 TAR on 12/27/24. d. A pain level of 8 documented on December 2024 TAR on: 12/14/24 x2, 12/17/24 x3, 12/23/24 x2, 12/27/24 x2. e. The December TAR documented responses to Are you free of Pain? documented a pain level of 5 on 12/19/24, 12/21/24, 12/29/24 for day, and 12/22/24 for night; a pain level of 6 on 12/22/24 day; a pain level of 7 on 12/14/24 night; a pain level of 8 on 12/15/24 night; and a pain level of 9 on 12/25/24 day. Pain level of 0 (zero) documented on for day and night on 12/16/24, 12/17/24, 12/18/24, 12/20/2412/23/24, 12/24/24, and 12/26/24. A review of Progress Notes from 12/13/24 to 12/30/24 revealed: a. An Incident Note entered on 12/16/24 at 2:44 AM, Late Entry: Resident #183 asleep in recliner by nurses' station. Resident awakens and occasionally cries out in pain. PRN medications given, attempts to put resident in her bed unsuccessful. Resident yelling out while staff attempting to put her in bed. Resident attempting to remove self from bed. Resident is unstable with standing and walking without assist. Resident paced backed into recliner where she again is comfortable and falls asleep. b. A Health Status Note entered on 12/17/24 at 4:41AM revealed Resident has little pain while in bed or in recliner chair. Resident has increased pain and yells out during transfers for peri care. Gait belt x3 staff for stand pivot. Pain medication given this shift. c. A Progress Note entered on 12/18/24 at 11:00 PM by [name redacted] NP (Nurse Practitioner) noted Pain Level: 5. Medications, in part: Acetaminophen 325 mg. Give 2 tablets by mouth every 4 hours as needed for general discomfort. Tramadol HCL 50 mg. Give 1 tablet by mouth every 8 hours as needed for pain. The note did not address recent fractures of increase in pain. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. A Health Status Note entered on 12/20/24 at 10:49 PM revealed Cast and sling to RUE (right upper extremity) in place. No s/s of compartment syndrome. Resident still moans and groans with position changes and transfer, unwilling to bear weight to BLE (bilateral lower extremities). d. A Health Status Note entered on 12/21/24 at 9:15 AM, noted res (resident) has facial grimacing c (with) position changes, has been resting at long intervals c ou (eyes) closed, did not eat am (morning) meal . e. An Incident Note entered on 12/22/24 at 12:05 PM revealed fall f/u (follow up) res has utilized prn pain meds this shift, she has been tearful, crying out, difficulty c position changes, res up for meals et (and) resting in bed c ou closed after meals. The review of the electronic health record progress notes revealed a lack of documentation of physician notification for pain of 10 the resident experienced on 12/14/24, 12/16/24 x2, 12/20/24, 12/24/24 x2, 12/25/24 x2, 12/26/24 x2, and 12/30/24. A review of a hospital note dated 12/30/24 revealed Resident #183 in Orthopedic Clinic for follow up appointment 2.5 weeks after injury and noted that resident continued to struggle with fairly severe pain in both right hip and right elbow. Resident #183 unable to bear weight of right lower extremity due to severity of pain and is standing with assistance of 2 staff members. The note documented Resident #183 presented to clinic with complications stemming from original injuries, including a wound over olecranon (elbow) which probed deep to bone and progression of greater trochanteric (hip) fracture to an intertrochanteric femur fracture. Resident #183 admitted to Hospital from Orthopedic Clinic in anticipation for surgical intervention for the right elbow and right hip. During an interivew on 1/14/25 at 1:00 PM, Certified Medication Assistant (CMA), Staff J, reported that Resident #183 would cry and report pain after fractures found in December. Staff J reported Resident #183 would tell you she was in pain and received PRN Tramadol and Tylenol for pain. During an interview on 1/14/25 at 1:23 PM, Certified Nursing Assistant (CNA), Staff D, reported that after the fractures Resident #183 could not stand and required 2-3 staff assistance to transfer and stated this being a big change for resident used to walk down the hallway to not being able to stand. Staff D recalled that Resident #183 would cry and stated you could tell she had pain and when her pain medications were wearing off. Staff D stated Resident #183 also showed signs of restlessness and anxiety when she was in pain. Staff D informed that she would notify the nurse when signs of pain had been observed. During an interview on 1/14/25 at 1:40 PM, Staff C, CNA, stated she was tasked with transporting and accompanying Resident #183 to the orthopedic clinic for a follow up appointment on 12/30/24. She stated she was informed by the clinic that Resident #183 would be admitted to the hospital, for possible surgery, Staff C informed that she notified the Director of Nursing via phone and returned to the facility when Resident #183 was admitted . During an interview on 1/14/25 at 2:45 PM, Staff E, Licensed Practical Nurse (LPN) stated when returning to work following a couple of weeks off, noted Resident #183 had severely bruised elbow and had been unable to walk and screamed in pain. Staff E stated she notified the physician of this on a Sunday and received order to obtain X-Ray of right elbow and right knee, which had been completed the following day. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/15/25 at 9:08 AM, Staff DD, Registered Nurse (RN), recalled during a fall follow up assessment, it was noted Resident #183 had limited ROM of right arm and would moan and groan. Resident #183 had bruise around right elbow and Staff DD attempted to use ice to area. Staff DD stated she reported this to oncoming nurse about and when returned 1 or 2 days had learned in report of an additional fall, noted hand had been more swollen with limited ROM and stated the physician had been notified on a Sunday with order received for X-Ray of right elbow. Staff DD stated when she returned approximately 3-4 days later Resident #183 had come back from the hospital and was noted to have hip fracture which was decided no surgery. During an interview on 1/22/25 at 2:00 PM, Director of Nursing (DON) stated that no discharge orders of follow up care instructions had been received from the Hospital Emergency Department (ED) on 12/13/24 following fractures noted to right elbow and right hip, informed that the hospital didn't say anything, so she had staff put resident in wheelchair and pivot transfer resident on the good foot. DON stated Resident #183 was having pain and receiving PRN Tramadol, DON confirmed this order had been initiated prior to current injury on 6/27/24. When asked about Resident #183 pain management regimen, DON informed that staff were to keep pain controlled, and provide PRN medication around the clock for resident. DON stated pain medication had been effective because Resident #183 would fall asleep and not cry, noted that if resident had been crying she was hurting. DON revealed the expectation of nurses to call physician if resident pain was rated at 10/10 (severe). The facility policy, titled Pain Assessment and Management, dated effective 10/2024, Purpose statement declared the purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs, and that addresses underlying causes of pain. General Guidelines included, in part: 3. Pain management is a multidisciplinary care process that included the following: a. Assessing the potential for pain; b. Effectively recognizing the presence of pain; c. Identifying the characteristics of pain; d. Addressing the underlying causes of pain; e. Developing and implementing approaches to pain management; f. Identifying and using specific strategies for different levels and sources of pain; g. Monitoring for the effectiveness of interventions; and; h. Modifying approaches as necessary. Steps in the Procedure section included: Recognizing Pain: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on clinical record review, facility policy review, nurse job description review, and staff interviews the facility failed to implement or restart neurological assessments after unwitnessed falls for 1 of 2 residents (Resident #11) reviewed for falls. The facility reported a census of 35 residents. Findings include: The Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 for Resident #11, which indicated intact cognition. The MDS list of diagnoses included schizophrenia, chronic obstructive pulmonary disease (COPD), osteoarthritis of knee, and history of falling. The MDS indicated use of a walker for mobility, resident able to able to transfer and ambulate in facility independently. The MDS revealed Resident #11 had 2 or more falls without injury during assessment period. Review of facility provided incident reports revealed between 1/3/25 and 1/15/25, Resident #11 had 7 falls. falls between 1/01/25-1/23/25, with 9 of the falls unwitnessed, no injuries related to falls documented on incident reports. Dates of unwitnessed falls included: 1/03/25 at 7:25 AM, 1/03/25 at 8:00 PM, 1/06/25 at 8:38 PM, 1/08/25 at 8:15 AM, 1/10/25 at 3:10 PM, 1/12/25 at 9:00 AM, 1/13/25 at 12:25 AM, and 1/15/25 at 6:00 PM. Review of Neurological Flow Sheet revealed the following schedule for vital signs and neuro (neurological checks): a. q (every) 15 mins. (minutes) x1 hour (vitals and neuro checks to be completed every 15 minutes for the 1st hour after the fall), then; b. q 30 mins x1 hour (every 30 minutes for 1 hour), then; c. q 1 hour x4 hours (every 1 hour for the next 4 hours), then; d. q 4 hours x 24 hours (every 4 hours for the next 24 hours). A review of the falls between 1/3/25 and 1/15/25, and completed Neurological Flow Sheets revealed: a. Unwitnessed fall on 1/03/25 at 7:25 AM: No vital and neuro checks indicated on Neurological Flow Sheet provided. b. Unwitnessed fall on 1/03/25 at 8:00 PM: Vital and neuro checks started on 1/4/25 at 1100 AM, there after completed at: 11:15, 11:30, 11:45, 12:15 PM, 12:45, 1:15, 1:30, 2:30, 3:30, 4:30, 5:30, 9:30 PM, 1/5/24 at :30 AM, and at 5:30 AM. Next check undated with time labeled D, next check undated with time N, 1/6/25 labeled N, with next check labeled N with no documentation. The last check dated 1/7/25, labeled D with no documentation. The sheet did not indicate the meaning or time for D or N. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, dated 10/2024, titled Neurological Assessment (Neuro Evaluation) General Guidelines directed staff, in part, to: 1. Neurological assessments (neuro evaluation) are indicated: revealed the following indications for neurological assessments: b. Following an un-witnessed fall when there are signs and symptoms of subdural and epidural hematoma, which may include: lethargy, reduced level of consciousness, and/or significant weakness in one or more of the extremities. c. If a resident hits their head on an inflexible object (from a fall or hitting a hard object). d. Following an unwitnessed fall and the resident cannot verbalize what happened. e. Following a fall or other accident/injury involving head trauma and when there are signs and symptoms of subdural and epidural hematoma; or f. When indicated by resident's condition when there are signs and symptoms of subdural and epidural hematoma. An undated, facility Job Description for Registered Nurse (RN) revealed expectation of nursing staff to implement established policies and procedures and to complete accurate accident/incident reports as necessary.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 45338 Based on observation, interview, and record review the facility failed to ensure staff equipped with appropriate skills to address the needs of residents with mental health disorders and their behaviors for 2 of 4 residents reviewed for behaviors (Resident #5 and Resident #30). The facility reported a census of 35 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment for Resident #5 dated 10/18/24 revealed the resident scored 4 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which revealed severely intact cognition. Review of Medical Diagnoses for Resident #5 included dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, bipolar disorder, and personal history of other mental and behavioral disorders. Review of the resident's Care Plan dated 8/25/17, revised on 6/4/19, revealed the following: I have the potential for skin breakdown r/t (related to) poor hygiene and fragile skin. Continued review of Interventions per the Care Plan revealed, in part, the following interventions: a.(Created Date 8/25/17): Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. b.(Created Date 8/25/17): Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration etc. to MD (Medical Doctor). c. (Created Date 12/7/22): Weekly full body skin assessment. It was noted the resident's most recent intervention had been added in 2023, and did not specifically address picking behaviors. The Progress Note dated 1/8/25 at 9:26 PM revealed, Skin: Skin warm & dry, skin color WNL (within normal limits) and turgor is normal .Skin Issues: Skin Issue: #001: New skin Issue. Location: Right Lower Quadrant Midline. Laterality / Orientation: Middle. Additional location information: Chronic lesion where resident picks at wound Issue type: Open lesion. Wound acquired in-house. It is unknown how long the wound has been present. Incision approximated: No. Dehiscence: partial or complete separation of the outer layers of the joined incision: No. Healing Ridge: induration beneath the skin under the suture line: No. Signs and symptoms of infection: None. Painful: No. Length (cm) (centimeter): 0.5 Width (cm): 0.5 Depth (cm): 0 Undermining: No. Surrounding tissue: Normal in color. Periwound temperature: Normal. Skin issue education: Treatment of skin issue. Additional skin issue education documentation: Instructed resident to not pick at wound. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/22/25 at 1:10 PM, Staff H, Certified Nursing Assistant (CNA) queried if resident had any picking behaviors at herself or skin. Staff H responded, Oh yeah, all the time. Staff H explained any time the resident had a scab or skin tear resident would sit there and pick at it until she bled. When queried if the resident had any wounds from picking, Staff H responded she did not think so. Staff H then explained the resident had a spot on the stomach from picking at, and did not know how recent that was from. Staff H explained the wound was open when Staff H worked last, and when queried if there was a dressing on it, Staff H responded no. It was noted Staff H worked at the facility on 1/12/25. When queried as to whether the picking was new or had occurred longer, Staff H responded she had always done it. During an interview on 1/22/25 at 2:21 PM, Staff E, Licensed Practical Nurse (LPN) queried about Resident #5 and picking behaviors. Staff E explained the resident did sometimes if anxious, if in one of those moods ready to beat anybody down. Staff E explained the resident did pick sometimes, not very often. When queried if there were certain spots the resident normally picks, Staff E responded the right hand. Staff E explained she worked the past Sunday. When queried if there were wounds then, Staff E responded small picking on right hand, and went and cleaned it up. When queried about the resident's abdomen, Staff E responded she did not see anything and the CNAs did not say anything. During an interview on 1/29/25 at 10:38 AM, Resident #5 observed in their room, and the resident's abdomen observed with Staff C, Certified Nursing Assistant (CNA). The resident had a wound open approximately smaller than a dime size to the resident's left lower abdomen, with surrounding redness present. Staff C queried if had known the wound present, and responded she did not, was not sure if the other ladies had noticed it, and acknowledged she had not. During an interview on 1/29/25 at 1:28 PM, Staff J, Certified Medication Aide (CMA) explained the resident would dig and she picked and would see blood under fingernails and sheet. Per Staff J, the nurse would cover and the resident would take if off. Staff J explained the resident was a picker. When queried if resident had wounds currently, Staff J responded, in part, the resident had one on her belly, when queried as to how long Staff J explained for a month, and per Staff J you could see it start to heal and resident would pick and pick. Per Staff J, the resident had always been a picker. During an interview on 1/30/25 at 2:20 PM, the Social Services Director (SSD) queried if the resident picked, acknowledged resident did, the SSD said did not know if was a nervous twitch, and further explained would see on resident's arms and things. Per the SSD, the other day saw resident picking at her belly. The SSD queried as to when this occurred, and responded they were not for sure. When queried about interventions for the resident's picking, the SSD said they didn't know for sure, and would have to look. When queried where to find them, the SSD responded the Care Plan, explained she needed to read through it again, and if not specific did not know then. The SSD explained she could find out and let know. During an interview on 1/30/25 at approximately 5:00 PM, the Director of Nursing (DON) queried about whether familiar with Resident #5 picking, and responded right here, and indicated the abdomen. Per the DON, would go in and dress it and resident would get it off. When queried if resident normally picked left or right, the DON indicated left. When queried about interventions to not pick, the DON responded she did not know whether phases of the moon or not. Per the DON, the resident would do so for awhile, then would stop, and hadn't done anything different the resident just stopped doing it. Per the DON, picking had been an on and off behavior for long time for the resident. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the MDS assessment for Resident #30 dated 12/6/24 revealed the resident scored 14 out of 15 on a BIMS exam, which indicated intact cognition. Per this assessment, the resident had delusions, and had verbal behavioral symptoms directed towards others for one to three days. Review of Medical Diagnoses for the resident included post traumatic stress disorder, mild intellectual disabilities, and schizoaffective disorder, bipolar type. Review of Resident #30's Care Plan dated 10/1/24 revealed, [Resident #30] has a behavior problem r/t (related to) PTSD (Post Traumatic Stress Disorder), dx (diagnosis) mild intellectual disability, schizoaffective disorder (bipolar type). Interventions per the Care Plan included the following: a. (Created 9/5/24): Administer medications as ordered. Monitor/document for side effects and effectiveness. a. (Created 9/5/24): Assist me to develop more appropriate methods of coping and interacting . Encourage me to express feelings appropriately. b. (Created 9/8/24): I prefer to not have men around me. If needed a female needs to enter the room with them c. (Created 9/5/24): If reasonable, discuss my behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to me. d. (Created 9/5/24): Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. During an interview on 1/15/25 at 2:42 PM, Staff J, Certified Medication Aide (CMA) explained, in part, the following about Resident #30's behaviors: Per Staff J, when the resident first at facility walked, was respectful, and totally normal. Staff J explained now it had gotten to where resident sat there, refused to pedal self, walk, and would sit there and scream bloody murder and cry. Staff J further explained the DON said to take Resident #30 to room to stop, and the resident would go to the room and scream. Staff J explained the ADR table (assisted dining room) moved to the back. Resident #30 was on puree, thickened liquids, and would ask for barbeque which would change the consistency. Staff J explained had other residents that did not want out of their room until moved, explained another resident refused to eat, couldn't take it, shoved tray, and couldn't do it. Per Staff J, sometimes the resident would wear headphones, and that was very rare. Staff J explained resident would be removed from out (at facility), would be taken to her room, and the residents in [number redacted] hall were sick of hearing resident scream and cry. Staff J explained she really did not know what to do with Resident #30, and further explained had no education on residents with mental issues. Staff J further explained, in part, that Resident #30 was no longer let into activities because of the resident's behaviors. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/25 at 12:09 PM, Staff L, Registered Nurse (RN) queried if was given training on how to address resident behaviors, and responded no. When queried about Resident #30's behavior, Staff L explained Resident #30 liked to call family, wanted snacks could not have because of pureed diet, wanted the snacks she could not eat, wanted pushed to her room, wanted radios/CDs, was very needy, and if didn't something right away resident cried out and hollered out. When queried how staff addressed, Staff L responded tried to redirect into activity, calmed down and took to room, and the resident asked to call sister multiple times. On 1/22/25 at 4:54 PM, Staff G, Certified Nursing Assistant (CNA)/Certified Medication Aide (CMA) queried about guidance for managing behaviors, and explained the facility had done some pretty good inservices, but there was some stuff that had come up, like Resident #30, that's new. Per Staff G, especially a lot of the younger girls felt like the resident was more mentally challenged than dementia, and Staff G queried so, like what do we do? Per Staff G, in Staff G's opinion resident had mind of a kid, and that was the behaviors. Per Staff G, the resident threw a lot of temper tantrums, and it kind of scared Staff G. Staff G further explained sometimes the resident would just go forward, and voiced concerns if the resident toppled. When queried if the resident was presenting differently than behaviors previously, Staff G explained when got to facility, resident would just scream I want a drink, want it now. Per Staff G, the resident still did a lot of childish whining, and explained the following: instant gratification right now. When queried if given guidance by the facility, Staff G explained a little bit, and explained needed more. Staff G explained another staff was very attached to the resident, and provided a lot of good suggestions with behaviors. Per Staff G, the other staff member said no matter what yelling about stay calm, and explained if got a little upset increases immensely, and if really frustrated to step away and get someone else to sit with her. When Staff G queried as to her approach, Staff G explained she tried to listen, help as much as could, tried to encourage to do a little more for self, and was told resident did more for self before came to facility. Per Staff G, they had a talk with coworkers, and were going to ask the Administrator and Director of Nursing (DON) at next meeting if could get a class online or someone to come in who specialized in mentally challenged adults. Staff G explained needed to be more educated so could help them (Resident #30). During an interview on 1/22/24 at approximately 12:20 PM, Staff Y, CNA explained the following about Resident #30's behaviors: Per Staff Y, Resident #30 yelled a lot. When queried how the facility told them to handle that, Staff Y explained removed from the room yelling in, and one point said to bring her down last so resident was not in the dining room as long. During an interview on 1/27/25 at 10:05 AM, Resident #30 observed in a wheelchair in the common area by the nursing station. The resident had coloring books on the table in front of her. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 10:10 AM, Staff C, CNA explained Resident #30 cried a lot when tried to promote independence with her. Staff C provided the following example: would go behind her to use walker, and resident would refuse. Staff C queried how managed the resident's behaviors and responded tried to get the resident to color, would talk about how beautiful her hair was, and would bring positive energy and hope for the best. Staff C explained it usually worked, and some days definitely not. Per Staff C told by therapy to walk, resident refused, and staff pushed resident around in wheelchair. When queried how facility told to address, Staff C responded other than to divert the attention to something that makes resident happy. Staff C explained when it came to the resident trying to help self, or for the future, was kind of like a big question mark. Staff C explained didn't know how to help her (Resident #30), and further explained this was a completely new Resident #30 for her. Per Staff C, Staff C thought a lot of people didn't know how to handle the resident's behaviors in a positive way, and explained puling coloring books and music for resident. When queried if were kardex for residents, Staff C explained she did not believe so. Staff C explained there was a book what behaviors could be and how could help resident. During an interview on 1/30/25 at 2:24 PM, the Social Services Director (SSD) explained the facility had a behavior book to notify what behaviors had, and further explained was going to get a book together for tips for how to address, etc. The SSD queried as to when started putting together behavior book, responded was updating it, and explained new behavior book present. When queried if staff had expressed concerns on not knowing how to handle Resident #30's behaviors, the SSD responded not to her. Per the SSD, the facility had not had every resident in the behavior book, did now, and was working on updating how to redirect and things hadn't gotten to yet. The SSD acknowledged Resident #30 would not have been in the old behavior book, now was, and didn't have how to redirect yet, and really needed to update redirect. On 1/29/25 at 3:58 PM, Staff K, CNA queried about Resident #30's behaviors and described the following behaviors: screaming, and further explained resident did not want to ambulate her wheelchair herself. When queried if the facility told how to address that type of behaviors, Staff K responded not specifically. Staff K explained they had enough experience with behaviors to just try to negotiate with her, explained the resident liked to color, and further explained was generally one way to calm resident down. During an interview on 1/30/25 at 5:08 PM, the explained when out in middle of group, Resident #30 would start yelling, would talk with a high pitched voice that couldn't understand, and would mumble with it. The DON explained she responded [Resident #30], got to talk so [DON] can understand you, yelling out here not appropriate for these people, don't want to hear yelling. Per the DON, the resident stopped. The DON explained she told girls yelling at her was not going to do anything, and was not going to give her treats for misbehavior. Per the DON, the facility had a behavior book, and wasn't finished. The DON explained it had what people's behaviors were, and did not tell what triggers were or how to react to them. The DON further explained needed to get more stuff in the behavior book, behaviors and how to react to them. When queried if those were getting added, the DON responded they would be, yes. The DON explained staff had been told how to address Resident #30's behaviors, the staff would go get the DON, and the DON said you guys (staff) got mom voices, use them. When queried about documentation for staff somewhere as to how staff to address individual residents' behaviors, the DON responded no, had some in the care plan, needed to get pulled over to the kardex, and acknowledged the facility did not currently use a kardex. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, last revised on 6/2023, titled Behavior Health Services Policy statement declared Residents of our community will receive necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and care plan. The Guidelines section included: #18. Provide competency based education for the direct care staff as outlined in the facility assessment, MDS Data, resident assessments, individual plans of care and needs of residents as a whole for those with a history of trauma and/or post-traumatic stress disorder. Include education at a minimum on specific mental disorders, psychosocial disorders, PTSD or substance abuse disorders (as determined by the community need). The Facility Assessment revised on 11/20/24 revealed the following: a. Behavioral Health Services: The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with 483.70(e). b. These competencies and skills sets include, but not limited to, knowledge of and appropriate training and supervision for 483.40(a)(1) caring for residents with mental and psychosocial disorders, as well as residents with history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to 483.70(e)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47336 Based on observation, clinical record review, and staff interviews the facility failed to ensure a medication is not discard on 28 days of being opened prior to administration for 1 of 6 residents reviewed for medication administration (Resident #3). The facility reported a census of 35 residents. Findings include: The Minimum Data Set assessment, dated 10/18/24 revealed Resident #3 scored a 12 out of 15 on the Brief Interview for Mental Status, which indicated moderately impaired cognition. The MDS revealed a medical diagnoses of diabetes mellitus (DM), and the resident received insulin injections 7 out of 7 days. The Care Plan revealed a focus area revised on 8/10/21 for Resident #3 being an insulin dependent Type II diabetic. The interventions revised on 6/10/21 indicated administration of diabetic medication as ordered by doctor with monitored and documented side effects and effectiveness. A review of Physician Orders revealed: a. Novolog solution 100 unit/ml (milliliter)- inject 7 unit subcutaneously before meals b. Novolog solution 100 unit/ml- inject as per sliding scale: if blood sugar 150mg/dl (milligrams/deciliter) - 200 mg/dl = 1 unit; 201mg/dl - 250 mg/dl = 2 units; 251mg/dl -300mg/dl = 3 units; 301mg/dl - 350 mg/dl = 4 units; 351mg/dl - 400mg/dl = 5 units, subcutaneously before meals in addition to 7 units scheduled. The January 2025 Medication Administration Record revealed on 1/14/25 at the 11:00 AM the Novolog sliding scale of 1 unit and the scheduled Novolog 7 units administered to the resident. The record revealed the resident's blood glucose was 197. During an observation on 1/14/25 at 12:08 PM, Staff A, LPN (Licensed Practical Nurse) took the resident's blood glucose after she ate her lunch and then drew up 8 units of Novolog insulin from a vial dated 12/11/24 with an expiration (discard) date of 1/9/25 written on the vial. Staff A then administered Novolog insulin 8 units in resident right upper quadrant. During an interview, Staff A confirmed the expiration date on the vial of 1/9/25. During an interview on 1/14/25 at 3:30 PM, Staff A queried if the Novolog vial opened on 12/11/24 and she said she didn't see the open date. Staff A stated when a medication expires depends on the facility, She explained it can be 28 days, 31 days, or 42 days. Staff A stated she tried to take a residents blood sugar prior to them eating, but today she explained she was in a room with another resident and did not get to Resident #3 to take her blood sugar before she ate. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/25 at 12:06 PM, the Director of Nursing (DON) queried about the insulin vial being opened on 12/11/24 and observed insulin administration on 1/14/24, and she stated the expiration date would be 1/9/24. The DON stated she told them to watch their dates and told them to check the refrigerator to make sure we had extra vials for the residents. The DON informed of the blood glucose given after the resident ate and she stated she didn't know why the girls had issues getting the blood glucose done before before the residents ate. The Novolog insulin Aspart injection 100 units/ml manufacturing instructions revealed: a. Storage conditions for vial: in use (opened) 28 days refrigerated/room temperature. The facility policy, revised on 5/2021 titled Insulin Administration Policy statement declared To provide guidelines for the safe administration of insulin to residents with diabetes. The Steps in Procedure section provided the following guidance: 4. Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening).

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on clinical record review, facility policy review, staff and resident interviews the facility failed to obtain a mental health diagnosis, ensure adequate indication for the use of a psychotropic medication, respond to a request for an evaluation for a dose reduction, care plan for behavioral concerns, and obtain a signed consent for 1 of 6 residents reviewed for unnecessary medications (Resident #25). The facility reported a census of 35 residents. Finding include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 scored a 15 out of 15 on the Brief Interview for Mental Status exam, which indicated intact cognition. The MDS revealed medical diagnoses for PTSD (post traumatic stress disorder) and depression and took antipsychotic medication. A review of Physician Orders revealed an order on [DATE] for Seroquel oral tablet 25 mg (milligrams). Give 1 tablet by mouth three times a day for behaviors. The Care Plan revealed a focus area dated [DATE] for PASRR (Preadmission Assessment Screening and Resident Review) had identified that resident in need of Specialized Services The interventions dated revised on [DATE] indicated [name redacted] of [name redacted] will provide ongoing psychiatric services starting on [DATE] in order to help me reach my recovery goals and maintain an optimal level of stability and recovery. Resident will attend ongoing psychiatric services every 4 weeks for 1 year at facility through telehealth. Progress notes from the provider of psychiatric services shall demonstrate that this service was delivered. The Care Plan lacked documentation for a focus area and interventions for the resident's behaviors and monitoring/administration of Seroquel. Treatment Administration Record (TAR) revealed an order for behavior(s) -monitor for picking at ostomy bags and removing them, restlessness (agitation), increase in complaints, cussing, racial slurs, delusions, aggression, refusing care. Document N' if monitored and none of the above observed. Y if monitored and any of the above were observed, select chart code Other/See Nurses Notes' and document specific behavior(s) every shift for behavior monitoring, document each behavior observed and number of occurrences. A review of the [DATE] TAR revealed documented behavior observed on 8 days; and the [DATE] TAR documented behavior observed on 5 days. A review of Behavior Notes revealed: a. On [DATE] at 6:27 PM, revealed resident hit the window with his fist. Following that he opened the ostomy back clip. He shouted at the aides. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On [DATE] at 1:38 AM, revealed resident picking and removed ostomy x 2 so far this shift. Has removed urostomy x 2 this shift also. Both re-enforced with tape. Resident upset with staff, cussing and calling names. c. On [DATE] at 3:24 PM, revealed res (resident) calling to say his bags were off and I'm soaked. CNA went to room to tend to resident when he became angry .Urostomy and Colostomy bags replaced and wafers secured using skin prep and covered with tape. d. On [DATE] at 5:07 PM, revealed res called saying his bags had fallen off again. Explained that staff was getting supper to other residents and that I would get bags replaced as soon as possible. At approximately 1730, I received a call from the sheriff's dept that a caller named [Resident #25] was calling for help. Reportedly told EMS (Emergency Medical Staff) dispatcher that they've neglected me all day. I need out of here. Apologized to officer for taking their time and resident would be tended to. A review of a Progress Note dated [DATE] at 11:00 PM revealed: Date of Service: [DATE]; Visit Type: Follow Up; Details: General: [AGE] year-old male with a history of paraplegia s/p (status post) GSW (gun shot wound), colostomy, chronic pain, hypotension, MDD (Major Depressive Disorder), and malnutrition being seen for follow up. He has been very agitated. Seroquel oral tablet 25 mg: Give 1 tablet by mouth three times a day for behaviors / 25 MG / [DATE] A review of a Consultation Report dated [DATE] through [DATE] revealed the following: a. The resident receives the following psychotropic medications: venlafaxine ER (extended release) 75 mg po (by mouth) daily, trazodone 100 mg po hs (at bedtime); carbamezepine ER 200 mg po bid (twice a day); and quetiapine (generic name for Seroquel) 25 mg po tid (three times a day) b. Recommendation: Please continue to evaluate for the lowest possible doses. If no changes are indicated, please provide specific rationale. During an interview on [DATE] at 12:24 PM, Resident #25 stated about a month and half ago the DON got sneaky. Resident #25 told her he didn't like the Seroquel and it dropped his blood pressure and she would not listen and forced him to take Seroquel. Resident #25 looked up Seroquel and the warnings, and the FDA (Federal Drug Administration) flagged this pill to not give to anyone, because they gave it to people with senility and they died , it rushed their death, they died quicker and they would not give to teenagers up to 24 because they were depressed and suicidal and the pill made them more suicidal. He stated why would he take this pill. Resident #25 stated he was not suicidal and I am not depressed, why are you giving me this pill. I called [NAME] A review of Emergency Department notes dated [DATE] at 9:15 PM revealed the following: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. HPI (History of Present Illness): The patient was asked about each 1 of these allegations. He reports that the medication that he refuses to take is his Seroquel which was started when he was in the nursing facility. He reports that the provider that prescribed this medication never performed an actual examination. He reports that his concerns related to the Seroquel are that it decreases his blood pressure. He has low blood pressure at baseline related to his comorbidities as well as some of the other medications that he takes. He reports that he does become symptomatic when he becomes hypotensive. He takes midodrine to help regulate some of his hypotension episodes. Patient reports that he is a poor relationship with the director of nursing. Patient reports that due to this poor relationship, he does not trust that the medications that he is told he is receiving are correct. For example, he reports that while he is amendable to taking many of his medications, as he does not want to take the Seroquel, sometimes he refuses to take all of his medications because he is unsure if the Seroquel pill is mixed in with the cup of his other medications. Patient has seen our psychiatry colleagues, most recently [DATE]. In that note, he had diagnoses of PTSD and major depressive disorder. Patient recalls this visit. He also recalls his dose of venlafaxine being adjusted at that time from 150 mg back down to 75 mg. The venlafaxine was for depression and neuropathy. No other psychiatric diagnoses were indicated. Patient would be amendable to meeting with our psychiatry providers in the emergency department today for a psychiatric evaluation, however he does not feel that he is manifesting any concerning psychiatric symptoms. b. Consults: Psychiatry: 1. Emergency Department Course: I think the patient's concern of the Seroquel contributing to hypotension is a legitimate concern. In the interest of having him be more compliant with his other medications, I would recommend considering discontinuation of this medication. It seems that this is being largely used for sedation. The Health Status Note on [DATE] at 10:00 PM, revealed resident came back to facility from ER (emergency room) visit at 10:00 PM, BP (blood pressure) ,d+[DATE], t (temperature) 97.6, P (pulse) 80, R (respirations) 18, O2 (oxygen) 96%, denies pain at this time. Note that states patient was evaluated by ED (emergency department) and psychiatry staff, no indication for psychiatric hospitalization , with a recommendation to consider discontinuing Seroquel to improve compliance with other medication . During an interview on [DATE] at 10:50 AM, Staff EE, LPN (Licensed Practical Nurse) queried about Resident #25 Seroquel and he stated there were times he took it and other times he refused it, and it depended on the day. During an interview on [DATE] at 4:50 PM, Staff G, CMA queried if Resident #25 took his Seroquel and she stated he recently started refusing and she thought they were going to discontinue it. During an interview on [DATE] at 1:00 PM, Staff L, RN (Registered Nurse) stated Resident #25 can turn on you real quick and one minute you were [redacted derogatory names] and people were trying to poison him. Staff L queried on his order for Seroquel and she stated he pulled of his ostomy and urostomy bag and the Seroquel helped when they could get it down him. Staff L stated they went from changing his bags 2 to 3 times a day to every 5 to 6 days. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:41 AM, the DON queried on the resident order for Seroquel and she stated he refused to see psych and they had him set up for [name redacted] and Social Services went in to give him consent papers and he said no, he would see his own psychiatrist in [city name redacted]. The DON stated Resident #25 would not tell her who he saw and he was supposed to be seen in August but never did. The DON said she had him scheduled for [DATE] but she thinks he will refuse. The DON stated she had him scheduled to see psych in October and had Social Services go and talk to him and sign the consent papers. The DON confirmed the resident hadn't seen psych services since admitted in August of last year. During an interview on [DATE] at 11:41 AM, the DON asked about Seroquel being ordered for behaviors and she stated yeah, he broke a window in his room and constantly cursing at staff, said racist names, and threw stuff at people, he would scream at them so bad, they would cry. The DON asked of any interventions and she stated they tried to talk to him and tried to get him to stop, but he knew exactly what he was doing. The DON asked if the Seroquel helped and she stated yes, he was calmer and nice to people. The DON asked if the resident signed the consent to psychotropic medication and she stated no, she needed to find out if they had one in the building. The DON asked if the his behaviors and Seroquel care planned and she stated no, only the antidepressants and for false allegations. The DON stated the Social Worker puts in the behaviors. During an interview on [DATE] at 2:42 PM, Social Services queried on Resident #25 psych appointments and she stated she went to him about seeing psych because his PASRR indicated he needed to see a provider and the facility set him up an appointment with [name redacted]. The Social Services stated when she went into his room to discuss the appointment Resident #25 stated they were not going to force him to see a psych doctor and he refused the appointment and he stated he already seen psych and got his medications from them. Social Services stated she informed the DON of the encounter and she said they would reapproach. Social Services asked when she set up the appointment and she said just this month. Social Services asked if she set him up an appointment between August and October and she stated no. Social Services asked if she updated the care plan with resident's behaviors and she stated no, she thought the DON did. During an interview on [DATE] at 10:40 AM, the DON stated she needed a med manager for psych services because the other one quit. She stated they did telemed psych at the facility right now. The Email received from the DON on [DATE] at 11:57 AM the following: a. I got these [DATE]. I have not had a new med manager to be able to get recommendations. Am still waiting for [name redacted] to supply one. The Facility Unnecessary Drugs dated ,d+[DATE] revealed the following: a. Physician orders will include 1. Diagnosis; 2. Condition or symptoms for what is being ordered; and 3. Dose. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. complete an evaluation of the resident prior to starting a standing order of a psychotropic. This includes: 1. goals of therapy 2. reason for use (indication, diagnoses); and 3. non-pharmacological interventions attempted, but the residents quality of life is negatively impacted by the non-use of the medications c. During the comprehensive, person centered care planning process, the resident and/ or their representative should be informed of the prescribed treatment. If the resident and/or their representative refuse the treatment, then the IDT (Interdisciplinary team) member (including the physician) should inform the resident about the risks for refusal and discuss appropriate alternatives, such as offering the medication at a different time, in another dosage form, or an alternative medication or non-pharmacological approach if available. Document such in the clinical record.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on observation, clinical record review, facility policy review and staff interviews, the facility failed to ensure anti-seizure, anti-depressant/anti-anxiety medications available for administration as prescribed for 3 of 3 residents (Resident #4, Resident #31, and Resident #184) reviewed for medication errors. The facility reported a census of 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment, dated 1/07/25, revealed Resident #184 admitted on [DATE]. A Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicated intact cognition. No behavioral symptoms recorded on MDS. The MDS listed diagnoses included: post-traumatic stress disorder, moderate intellectual disability, and insomnia. The MDS listed Resident #184 took medication in the following drug classes: antianxiety and antidepressant. The Care Plan, initiated 1/10/25, revealed Resident #184 utilized venlafaxine an antidepressant related to a diagnosis of depression with the goal to be free from discomfort of adverse reactions related to antidepressant therapy. Interventions included monitoring and documenting effectiveness of medication A review of Resident #184 January 2025 Medication Administration Record (MAR), revealed an order for Venlafaxine HCl ER Oral Capsule Extended Release 24 hour. Give 1 capsule by mouth one time a day for Anxiety Disorder, Unspecified. Start date 1/1/25, D/C (discontinue) Date 1/8/25. The MAR documented a 9 on 1/01/25, 1/02/25, 1/03/25, 1/04/25, 1/05/25, and 1/06/25. Per the Chart Codes on the MAR a 9 is used for Other/See Nurse Notes. A review of e-Mar- Medication Administration Notes revealed: a. On 1/1/25 lack of a note to indicate the reason a 9 charted for the AM (morning) dose of venlafaxine. b. On 1/2/25 at 7:35 AM, a note documented Venlafaxine HCl ER Oral Capsule Extended Release Not on Hand. c. On 1/3/25 lack of a note to indicate the reason a 9 charted for the AM dose of venlafaxine. d. On 1/4/25 at 8:26 AM, a note documented Venlafaxine HCl ER Oral Capsule Extended Release Not on Hand. e. On 1/5/25 lack of a note to indicate the reason a 9 charted for the AM dose of venlafaxine. f. On 1/6/25 lack of a note to indicate the reason a 9 charted for the AM dose of venlafaxine. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A Health Status Note entered on 1/6/25 at 12:45 PM, revealed Resident with increased anxiety. Crying, saying she feels as if she can't breathe, and she thinks she might have pneumonia. On her phone with her daughter telling her [daughter] she doesn't know what's going on with her. Assessment completed on her. Lungs sounds clear .[doctor name redacted] notified and gave one-time order for Lorazepam 0.5 mg . #184 had increased anxiety, crying, and saying she felt as if she can't breathe, physician notified and one time order given for Lorazepam 0.5 mg (antianxiety medication). The January 2025 revealed an order for Venlafaxine HCl ER Oral Capsule Extended Release 24 Hour. Give 75 mg by mouth one time a day related to Anxiety Disorder, unspecified. Start Date 1/7/25. Documentation on the MAR revealed the medication started on the AM of 1/7/25 and continued as ordered through AM on 1/12/25. During an interview on 1/30/25 at 10:00 AM, a Pharmacy Technician from the consulting pharmacy stated the stated the pharmacy received a script for venlafaxine on 1/06/25 at 11:30 AM and sent 6 capsules the same day. The pharmacy delivered 30 capsules of venlafaxine on 1/12/25. Pharmacy Technician stated the pharmacy did not receive communication from facility about this medication until 1/06/25. During an interview on 1/29/25 at 3:49 PM, Staff K, Certified Nursing Assistant (CNA), stated staff knew Resident #184 was having anxiety symptoms when seen [her] rocking in recliner and would notify the nurse when episodes of anxiety had been observed. During an interview on 1/29/25 at 1:06 PM, Staff X, Certified Medication Assistant (CMA) stated that when a 9 was documented in MAR, this would indicate the medication had not been available or could not find the medication and the nurse on duty would need to be notified that the medication had not been given. During an interview on 1/30/25 at 3:30 PM, the Director of Nursing (DON) confirmed a code 9 on the MAR would inform staff to see a Nurse Note and would be selected if the medication was not available. DON claimed Resident #184 had been unable to get venlafaxine due to payment issues and was unaware original order for this medication lacked dosage. DON stated Resident #184 would rock pretty hard in chair when anxious and said this would happen pretty often when she first got to the facility. 45338 2. The MDS Assessment for Resident #4 dated 12/13/24 revealed the resident scored 11 out of 15 on a BIMS assessment, which indicated moderately impaired cognition. The Care Plan dated 5/25/23 revealed, [Resident #4] has a seizure disorder r/t (related to) Head injury. The Intervention dated 5/25/23 revealed, Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness. The Physician Order for Resident #4 dated 5/22/23 revealed, Nayzilam Nasal Solution 5 MG/0.1ML (Midazolam (Anticonvulsant)) 5 mg (milligram) Alternating nostrils as needed for as needed for seizures related to OTHER SEIZURES (G40.89) administer 1 bottle (0.1ml/5mg) into 1 nare (nostril), administer 2nd dose (0.1ml/5mg) in opposite nare 10 minutes after 1st dose is given if still seizing or if another seizure occurs. DO NOT give more than 10mg in 24 hours. Do not give more than 10mg q (every) 3 day. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The eMar-Medication Administration Note dated 11/26/24 at 09:11 AM revealed, in part, At approximately 0852 (8:52 AM), this nurse walked back to the nurse's station from the dining room and witnessed this resident having a seizure. He was sitting in the lounge area, in his wheelchair. Resident's arms and legs were positioned at his sides (arms), and in front of him (legs); BILATERAL upper and lower extremities were rigid and jerking repeatedly. This nurse went to the med cart and retrieved one of the resident's Nayzilam 5mg single-use sprays from the narc box, and administered it into his left nasal passage. Resident's convulsions halted approximately 5 seconds after administration of the spray .Once the convulsions ended, resident was very lethargic. Resident was taken to his room and put in his bed by this nurse, and [Name Redacted], LPN (Licensed Practical Nurse) on shift with me today. The Health Status Note dated 11/26/24 at 3:24 PM revealed, At 1430 (2:30 PM) resident observed having seizure in common area. Assessed for safety and after convulsions ceased resident was assisted back to bed and bed left in low position. After a short while was notified that resident was on the floor in his room. Entered to find resident on floor and bleeding from laceration on right side of head. EMS (Emergency Medical Services) notified. While awaiting arrival resident was delusional and scooting self around room, was unable to obtain VS (vital signs) or assess d/t (due to) this. The Incident Report dated 11/26/24 at 3:45 PM revealed, in part, Resident has had seizure activity today, 2 witnessed, lasting approximately 1.5 minutes x1, and 2 minutes x1. Although review of Resident #4's Progress Notes revealed two episodes of seizure activity on 11/26/24, review of the resident's November 2024 Medication Administration Record (MAR) revealed one dose of Nayzilam given on 11/26/24 at 9:09 AM. Review of a Controlled Substances Substances Proof of Use for Nayzilam for the resident revealed two doses received by the facility on 3/11/24, and administration of the medication on the morning of 11/26/24 brought the medication count to zero. However, review of an additional Controlled Medication Utilization Record for Resident #4 revealed 2 doses of Nayzilam were received by the facility on 7/25/24, with none signed off as administered to the resident. On 1/23/25 at approximately 4:08 PM and on 1/28/25 at 11:40 AM, Resident #4 observed in their wheelchair in the dining room. On 1/29/25 during an observation conducted with the facility's DON, a Nayzilam box observed in the medication cart. The DON described the effect of the medication as instantaneous. On 1/30/25 at 1:16 PM, Staff AA, Pharmacy Technician explained resident's Nayzilam had last been sent out on 7/25/24, the pharmacy filled it, and explained the package size was two. 47336 3. The MDS assessment dated [DATE] revealed Resident #31 scored a 12 out of 15 on the BIMS, which indicated moderately impaired cognition. The MDS list of diagnoses included: seizure disorder or epilepsy, intermittent explosive disorder, schizoaffective disorder. The MDS indicated the resident took antipsychotics, antidepressants, and anticonvulsants. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The Care Plan revealed a focus area dated 12/25/24 for a seizure disorder. The interventions dated 12/25/24 revealed give seizure medication as ordered by doctor, and monitor/document side effects and effectiveness. A review of Physician Orders on 12/6/24 revealed Xcopri oral tablet 50 mg- give 1 tablet by mouth in the evening related to .SYMPTOMATIC EPILEPSY AND EPILEPTIC SYNDROMES .; Xcopri oral tablet 100 mg- give 1 tablet by mouth in the evening; Xcopri oral tablet 200 mg- give 1 tablet by mouth in the evening; and Rufinamide oral tablet 400 mg- give 3.5 tablet by mouth two times a day related to . SYMPTOMATIC EPILEPSY AND EPILEPTIC . A review of the December 2024 MAR revealed rufinamide 400 mg tablet- 3.5 tablet by mouth two times a day- marked with a 9 on 12/21/24 morning and evening dose. A review of the January 2025 MAR revealed the following information: a. Xcopri 200 mg give 1 tablet by mouth in the evening- marked with a 9 on 1/7/25, 1/8/25, 1/9/25, 1/10/25, 1/11/25, 1/12/25, 1/13/25. b. Xcopri 50 mg give 1 tablet by mouth in the evening- marked with a 9 on 1/7/25, 1/8/25, 1/9/25, 1/10/25, 1/11/25, 1/12/25, 1/13/25. c. Xcopri 100 mg give 1 tablet by mouth in the evening- marked with a 9 on 1/7/25, 1/8/25, 1/9/25, 1/10/25, 1/11/25, 1/12/25, 1/13/25. Per the MAR Chart Codes, a 9 used to indicate Other/See Nurse's Notes. A eMar- Medication Administration Note dated 1/8/25 at 6:37 PM, revealed Xcopri Oral Tablet 100 MG- Give 1 tablet by mouth in the evening related to localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, without status epilepticus- Waiting to receive from pharmacy During an interview on 1/14/25 at 3:30 PM, Staff A, Licensed Practical Nurse (LPN) she stated sometimes there is an issue getting medications from the pharmacy and if she had issues, she called the pharmacy. Staff A asked if the CMA let her know if they don't have a medication and she stated yes, Resident #31 xcopri, and she didn't believe it had come in yet. Staff A asked if she knew why the medication had not came from the pharmacy yet and she stated no, the facility spoke to them with the DON been the last one to contact them. During an interview on 1/15/25 at 9:00 AM, Staff DD, Registered Nurse (RN) queried about Resident #13 being out of any of his medications and she stated not that she noted or been reported to her. She stated the pharmacy sent some of his seizure medications but some didn't come in. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/15/25 at 2:35 PM, the DON queried if they had any issues with pharmacy sending Resident #31 xcopri and she stated the pharmacy sent what we had in the computer. The DON stated it was a high cost medication and she had to sign for the next 14 days. The DON informed the medication had not been administered since 1/7 and stated she knew the medication was here and she would go and look for the pills and no one said anything to her about Resident #31 medication not being sent from pharmacy. The DON asked if she had any concerns with the resident not receiving his seizure medication and she stated yes, he could have a seizure. The DON stated the staff were not good at telling her when they don't have medication and she told them to let her know and she would contact the pharmacy and get it fixed immediately. During an interview on 1/15/25 at 3:37 PM, the DON spoke of the rufinamide not given and she stated it was refilled on 1/3 and they received it 2 days later. The DON informed the rufinamide not given on 12/21/24 and she stated maybe they ran out, but then she stated but it was given the next day and she didn't know what happened. The DON stated the xcopri refilled on 1/1/25 but didn't get refilled because the pharmacy stated it was discontinued, but the electronic health record doesn't show it discontinued. The DON stated the nurses called them [pharmacy] several times and they were told to tell me and she would call pharmacy. The DON stated the order put in on 12/6/24 and never changed. The DON confirmed Resident #31 would receive his medication tonight. During an interview on 1/28/25 at 12:48 PM, Staff L, RN queried on Resident #31 seizure medications and she stated she told day shift to call the pharmacy because when called pharmacy they told to call back in the morning because they didn't refill medication at night unless an emergent situation. Staff L stated they were told the medication was discontinued and we needed a copy of the order. Staff L stated Resident #31 had been out of his medication for a while and they told the DON. During an interview on 1/28/25 at 3:15 PM, the Pharmacy Technician stated the xcopri was a controlled medication and wondered if we [pharmacy] didn't have a script so the pharmacy didn't fill it. The Technician stated they had a script on 12/6 and sent 210 tablets with the resident taking 7 tablets a day, they would be out in 30 days. The Technician stated they [pharmacy] received a new script on 1/14 and they filled it. Staff AA stated they didn't have a script from 1/6/25 to 1/14/25 for the medication. During an interview on 1/28/25 at 3:26 PM, the Pharmacist queried if she could see if the facility sent refill requests for the xcopri and she stated she couldn't answer that because there were lots of ways to request. She stated she vaguely remembered talking to a nurse and they attempted to refill it but the medication was discontinued at that time and didn't see any requests until they filled it again. The Pharmacist stated when talking to the nurse she learned he went to the hospital and the computer system communicated discontinued messages whether controlled or not controlled medication and then when they come back the system will restart the medication unless they are a controlled medication and we would need a new script for them. She stated when they received the new script for the xcopri they sent it out the next day. During an interview on 1/29/25 at 11:07 AM, the DON asked what should have happened concerning Resident #31 xcopri and she stated the staff should have notified me on the first day he didn't have medications. She stated the medication was controlled and they still had a script for it, but said it was discontinued. The DON stated the staff were supposed to order the medications when they went into the blue section of the card so they didn't run out of the medication. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A review of the facility policy, dated 10/1024 titled Pharmacy Services Overview revealed a Policy Statement which declared the facility shall accurately and safely provide or obtain pharmacy services, including provision of routine and emergency medications and biological's, and the services of a licensed Pharmacist. A review of the facility policy, dated 10/1024, titled Administering Medications revealed a Policy statement which declared Medications shall be administered in a safe and timely manner, and as prescribed. Guidelines #2. The Director of Nursing Services shall supervise and direct all nursing personnel who administer medications and/or have related functions.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 45338 Based on observation, interview, and record review the facility failed to ensure a medication cart remained locked when unattended for one of two medication carts. The facility reported a census of 35 residents. Findings include: On 1/13/25 at 2:05 PM, the 400/500 nurses cart observed unlocked outside of the nursing station, and nursing staff not present by the medication cart. The lock on the medication cart was not depressed at the time of the observation, and the top two drawers of the medication cart were able to be opened without the use of a key. Once staff became aware, a staff member locked the medication cart. On 1/13/25 at 3:00 PM, Staff A, Licensed Practical Nurse (LPN) explained she was told one of the residents was screaming in pain, Staff A went to draw a med up, could hear screaming, was rushing and acknowledged the medication cart had been related to her. The Facility Policy titled Storage of Medications F 761, dated 4/2007 and last revised 10/2024, revealed the following: 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on clinical record review, resident and staff interviews the facility failed to provide or obtain routine and emergency dental services for 2 of 2 residents (Residents #2 and #25). The facility reported a census of 35 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #2 dated 11/8/24 documented the resident had diagnoses of quadriplegia, cognitive communication deficit, and depression. The resident scored 15/15 on the Brief Interview for Mental Status (BIMS) which indicated intact cognition. The electronic health record for Resident #2 included orders for dental, podiatry, and ophthalmology consults and treatment as needed for patient health and comfort, active as of 03/15/2024. A N ADV Clinical Admission Note dated 3/15/24 at 1:11 PM, documented the resident had her own teeth with an obvious or likely cavity or broken tooth. The Care Plan indicated the resident required assistance with ADLs related to quadriplegia and limited range of motion, initiated 06/03/2024. It further documented the resident was totally dependent on staff for personal hygiene and oral care also initiated 06/03/24. The Care Plan lacked focus areas or interventions to address oral care such as biannual teeth cleaning, broken or loose teeth, mouth pain interventions, or access to providers. A N Adv - Long Term Care Evaluation note dated 11/6/24 at 12:30 AM, documented the resident had her own teeth and was not assessed for abnormal mouth tissue, natural teeth or tooth fragments, obvious or likely cavity or broken natural teeth, inflamed or bleeding gums, mouth or facial pain. It included a statement that the nurse was unable to examine oral/dental status. It further documented the mucous membranes were moist and oral care was performed. During an interview on 1/23/25 at 8:44 AM Resident #2 reported she asked facility staff to see a dentist at least a month ago to address a hole in a tooth on the right side of her mouth because it caused her pain. She stated she had not been asked if she wanted to see a dentist, and if she had been asked she would have told staff she definitely wanted to. She stated she would be willing to see one at the facility or go outside of the facility. The resident also reported not getting help brushing her teeth and was unable to tell me where to find a toothbrush in her room. The resident's roommate added she did not have a toothbrush or toothpaste either, but wanted one. 2. The MDS dated [DATE] for Resident #25 documented Traumatic Spinal Cord Dysfunction and diagnoses of paraplegia, chronic pain syndrome, and malnutrition. The resident scored 15/15 on the BIMS, which indicated intact cognition. The electronic health record for Resident #25 included orders for dental, podiatry, and ophthalmology consult and treatment as needed for patient health and comfort, active as of 08/21/2024. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A N Adv Skilled Evaluation note dated 10/30/24 at 10:07 AM, recorded the resident had his own teeth, broken or loose fitting dentures, tooth fragments, obvious or likely cavity or broken natural teeth, and that oral care was performed. His pain score during the evaluation was listed as 4/10. The Care Plan, with a focus area created 9/4/24, documented he had oral/dental health problems, cavities, and broken teeth related to poor nutrition and poor oral hygiene. Staff were instructed to monitor/document/report as needed any signs or symptoms of oral/dental problems needing attention including missing teeth and loose, broken, eroded, and decayed teeth. Staff were also directed to provide mouth care according to the Activities of Daily living personal hygiene section. During an interview on 1/23/25 at 8:50 AM Resident #25 reported he has not been offered dental care at the facility. He reported not knowing why he isn't on the dental visit list, and said he spoke to the administrator but didn't hear anything back. He reported that no one was helping him set up dental or vision appointments, and that if he was offered a dental appointment he would have accepted it. During an interview on 1/23/25 at 9:50 AM the Social Services Director stated she had records of who had been seen by the in house provider and referrals came through her. When asked how that information got to her, she said she would hope that the nurses or Certified Nurses Aides (CNAs) would pass the information on to her. The documentation she provided confirmed neither resident was on the list to be seen by the in house dental team. During an interview on 1/23/25 at 3:32 PM, Staff K, CNA, stated Resident #2 and Resident #25 would usually have dental care in the morning. Sometimes he would help them if they wanted it during the evening. He stated resident's toothbrushes and toothpaste were by their sink. He was not aware these residents reported not getting help or that they did not have the supplies they needed. On 1/23/25 at 3:43 PM, when asked how appointments for dental care should be arranged, the Administrator stated it was a shared responsibility between the Director of Nursing and Social Services. She didn't recall either resident requesting dental services and stated residents were asked about dental care on admission.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observation, staff interview, clinical record review, and job description review, the facility failed to ensure effective administration to ensure prompt and thorough response to allegations of abuse and mistreatment, failed to maintain current registration for a vehicle utilized to transport residents, failed to ensure a process in place at facility for bed holds, and failed to ensure narcotics were consistently counted with medication keys remained accessible to qualified staff. The facility reported a census of 35 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment for Resident #5 dated [DATE] revealed the resident scored 4 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which revealed severely intact cognition. On [DATE] at 11:37 AM, the facility's Director of Nursing (DON) notified by the State Agency of allegations that a staff member (Staff G, Certified Medication Aide) had allegedly pulled Resident #5's hair, and a staff member (Staff Q, Registered Nurse) had allegedly called Resident #5 a b***h. During the conversation, the DON responded she had told everybody, said if having a problem with Resident #5 get pop and potato chips and will distract her immediately. The DON explained Staff Q worked night shifts, and wouldn't have been [at facility]. Review of the Investigation Report for incident date [DATE] involving Resident #5 revealed, in part, the following per the Timeline of Events: a. [DATE] @ 1214: [Name Redacted] DON called administrator [Name Redacted], LNHA (Licensed Nursing Home Administrator] via phone and mentioned [State Agency] surveyors concerns about how the behaviors of [Resident #5] were handled by staff. b. [DATE] @ 1345 (1:45 PM): Administrator [Name Redacted] LNHA was approached in the facility by [State Agency Representative], who reported the incident with [Resident #5] involved staff member [Staff G], CMA pulling resident's hair and an agency nurse [Staff Q], RN calling the resident, [Resident #5], names. Investigation Initiated. On [DATE] at 709 PM, when queried about the above incident, the Administrator explained the DON should have reported the exact conversation, was kind of upset didn't pass on word for word, and explained she had spoken to the DON about that. Review of the Director of Nursing Job Description dated [DATE] revealed the following per the Resident Rights Responsibilities Section: Report and investigate all allegations of resident abuse and/or misappropriation of resident property. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On [DATE] at 10:33 AM, Staff F, [redacted] queried about staff treatment towards residents, and Staff F explained there was one Certified Nursing Assistant (CNA) in particular that treated residents terribly. Per Staff F, she pushed her concerns to [Administrator name redacted] a few times about that CNA. The CNA was identified by first name as Staff G, CNA. Staff F explained she had heard [Staff G] get very verbal with several of the residents, and heard quite a bit talking to residents, and further explained a lot of them (residents) had dementia and didn't understand. Staff F explained, in part, Staff G had a short fuse with them, it was hard to listen to, and Staff F expressed it numerous times. Staff F then named four different residents and provided examples of what had been said, including, in part, the following: Get out of my face, I'm sick of you, stop your boo hooing sick of it, stop your crying it's all you do, quit asking the same question, and [Staff G] was done, not doing cares on [resident] anymore. Staff F explained they had worked in healthcare long time never heard someone be so awful to those residents. Per Staff F, there had been a few times they had said how CNA treating this person and talking to them getting out of hand. Staff F then said they had heard it. Staff F explained had been told by a few people during meetings and stuff that sometimes those residents need to be talked to that way related to behaviors. Staff F explained communication of sometimes you have to be firm with them, and Staff F explained Staff F didn't know if agreeing how has to be talked to. Staff F was queried in regard to how many times approximately they had reported to [Administrator] concerns about Staff G, and explained a few times in meeting, later clarified as probably two or three times at least when it got really bad. When asked for further clarification as to description of what was really bad, Staff F responded the stuff about [one of four residents previously identified by Staff F]. When queried how she reported to the Administrator, and whether it was verbal, Staff F confirmed. Staff F explained the following process: we bring it up, talk about it, the DON would pull in (staff) and talk. When queried if the staff continued to work the shifts, Staff F responded, yeah. On [DATE] at 11:06 AM, Staff GG, [Redacted] explained they had witnessed verbal abuse from one certain CMA (Certified Medication Aide) who also did CNA work (Staff G). Staff GG explained Staff G told a resident to shut up all the time, said sick of [resident], stop your whining, you're driving me crazy. Staff GG explained it was abuse, and then identified two additional residents. Pre Staff GG, Staff G would yell at a resident, would argue with the resident until the resident was in totally full blown into anger, would look at the resident and said [Staff G] would not come into [resident's] room anymore today, and explained she (Staff GG) had been present. Per Staff GG, to tell someone sick of taking care of them and not going to care for them anymore was abuse. Per Staff GG, the Administrator tried, put a plan in place to correct, and it was not followed once hit the DON and the CNAs. Staff GG explained the Administrator would deal with it right away. Staff GG explained told the Administrator what was happening right in the moment. Staff GG queried when brought up concerns if felt listened to, explained in the morning meeting the DON right there, there was always an excuse, and the DON said would talk to them and handle. When queried if GG had told the Administrator Staff GG felt it was abuse, Staff GG responded yes. When queried if staff sent home or kept in building, Staff GG responded were kept in building. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 3:11 PM, the facility's Administrator queried if any staff brought anything her way talking about Staff G, and explained knew had talked about how Staff G talked sometimes. Per Administrator, had been brought up by [Staff GG] in morning meetings. When queried what Staff GG shared, the Administrator responded over the past months the CNAs had a lot of drama, and Staff GG's concerns had been with how talked to [a resident] and did not help push [resident] up and down the halls. The Administrator explained they were trying to think of other residents, and thought previous resident named was main one worried about. The Administrator explained in one of the morning meetings Staff GG and Staff F mentioned the way CNAs talking to residents or around residents. Per the Administrator, when asked if they were name calling or saying anything derogatory, response was no it was just their tone. When queried if anyone else brought up concerns with Staff G, the Administrator responded not that she could think of. When queried if concerned with Staff G's behavior for any reason, the Administrator responded not really, and explained with behaviors staff had to talk very sternly with them. When queried if concerns brought up in morning meeting were documented, the Administrator explained they would need to look back in their notes, and usually documented resident issues. When queried at what point would consider an allegation, the Administrator responded with the verbal, if they were making the resident upset at any way, any name calling, and anything physical for sure was an allegation. Per the Administrator, with the tones how they talk to the resident, if resident upset would become an allegation. On [DATE] at 5:22 PM, the DON explained morning meeting occurred Monday though Friday, and DON and Administrator always there, one or other. When queried if heard of staff tone concerns, the DON responded yep, and she had noticed it and talked to them about it, and had told before, don't raise voice, lower voice if have to, and high pitched voice won't hear most of the time. The DON explained staff were getting a little bit burnt, and had people not treating them nice in their rooms. When queried about not wanting to take care of resident, DON explained didn't have a problem with it, and explained to find someone else to take care of them. When queried who staff said didn't want to care for, the DON mentioned a specific resident and said resident threatened staff every day, then named another resident as well. When queried if there were certain staff pulled in to discuss their tone, the DON responded Staff J, CMA. When queried if anyone else, the DON responded Staff G, CMA, and said she was the same way too, and DON had pulled her in and talked to her. The DON then mentioned another staff member she had not pulled in yet. When queried if staff came to her with concerns, the DON explained that was why the staff got pulled in. Per the DON, Staff G could get loud. When queried if staff had told in meeting that Staff G was abusive, the DON denied. When queried the following statements: Shut up, get out of my face, the DON denied knowledge, and said if she heard those two things should be instantly pulled in. Per the DON, it was more like they probably recognize at the stress point, put in too many hours (for Staff G). The DON explained with certain residents, joke around and say things too and they come right back, nothing hadn't done before, they weren ' t;t going to complain about it, and they liked it, how joke around with each other. When queried if there were resident complaints with Staff J, Staff G, or Staff C, the DON responded had not had any on their desk for awhile, probably 4 months. The DON explained when a resident had a grievance, came to DON and DON investigated. On [DATE] at 7:10 PM, the Administrator queried if able to find documentation of concerns brought up related to tone, and responded wasn't able to. Per the Administrator, was not aware staff went to the DON about concerns with Staff G's tone. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	48888 3. On [DATE] at 12:04 PM, Staff L, Registered Nurse (RN), reported having worked an evening shift on [DATE] starting at 6:00 PM, in which another staff, scheduled to work the medication cart, admitted to not counting narcotics with the nurse going off shift and did not receive keys to the narcotic box in medication cart. Staff L stated at approximately 7:00 PM, she called the Facility Administrator and Director of Nursing (DON) to report the incident and need for medication cart keys to administer evening narcotic medications to residents. Staff L stated at approximately 11:30 PM on [DATE], the DON brought in a set of keys to the facility. Staff L stated she asked DON to count narcotics in the medication cart, as this had not been done at evening shift change and she was the only nurse on duty, DON refused to do so and left the facility. Staff L claimed to have called the Facility Administrator again following DON refusing to count narcotics and was instructed to count narcotics with a Certified Nursing Assistant (CNA) while Facility Administrator was on the phone. 47336 4. The Facility Employee Vehicle Sign In/Out Log for Dodge Caravan revealed the van driven from [DATE] to [DATE] and then from [DATE] to [DATE]. The log lacked documentation of van use of the month of [DATE]. A picture of the facility van's license plate revealed the date of [DATE]. A text message dated [DATE] at 12:01 PM sent from the Administrator to a staff member revealed the following, in part:. AL overview- In Iowa an expired registration is considered a violation against the vehicle owner .however, the driver could still be cited for operating a vehicle with an expired registration; and remember to relatch the back door. During an interview on [DATE] at 3:02 PM, the Senior [NAME] President of Operations (SVPO) queried about the license tags on the van and she stated the Administrator tried to renew the tags, but was not able to. The SVPO stated they were unable to find the registration for the van and since they took over, the tags were not on the priority list. The SVPO stated the van came from another facility and they were currently trying to find the title for it. The SVPO stated she found out about the expired tags a couple of weeks ago. During an interview on [DATE] at 2:00 PM, Staff J, CNA (Certified Nurse Aide) stated she used the van until she realized the tags were expired. Staff J said they were last updated in 2023 and the facility still expected them to drive the van. Staff J stated the Administrator knew and sent a text that said if staff got pulled over, the citation would be on the facility but if you read down, it said the driver could also get a ticket. Staff J stated she didn't want a ticket. Staff J stated she told them she wouldn't drive it with expired plates and they ended up canceling the appointment. Staff J queried on who took Resident #25 to the emergency room this month and she stated Staff D and she had to keep pulling over because the back latch didn't latch right. During an interview on [DATE] at 9:20 AM, Staff D, CNA queried if she drove the van this month and she stated yes she did and she didn't realize the tags were expired. Staff D stated she took Resident #25 to the emergency room a A couple of Saturdays ago. Staff D stated she pulled over multiple times to relatch the back gate because the dash alarmed it wasn't latched and she could hear it rattling. Staff D stated she hadn't drove it since. (continued on next page)

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	165453	A. Building B. Wing	01/30/2025

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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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 9:46 AM, Staff C, CNA queried if she drove the van in the month of January and she stated yes, at the beginning of the month she took Resident #25 to an appointment. Staff C denied any issues with the van. Staff C stated she did not know the tags were expired and other people might of and we explained it bothered us to drive the van with expired plates. During an interview on [DATE] at 6:22 PM, the Administrator queried on the license plate tags on the van and she stated she started last year and thought everything good with the van because she saw December on the sticker and didn't realize the date of 2023. The Administrator stated she spoke to Human Resources and she stated sometimes they get mailed to the other facilities. The Administrator stated they are working on getting the title and registration for the van. She stated she emailed on [DATE]th about getting the tags renewed. The Administrator asked if staff drove the van with expired plates and she stated before she realized the plates were expired and no one had driven the van for a couple of weeks. The Administrator asked how they transport residents and she stated they used insurance and the Medicaid transport and other transportation around the facility. A review of the document Administrator Job Duties and Responsibilities revealed the following: a. Finance: Ensure protection of facility assets (insurance coverage, risk management) b. Physical Environment and Safety: Maintain responsibility for adequate supplies and equipment being on hand to meet the day-to-day operational needs of the facility and residents. 4. An email received from the Administrator on [DATE] at 1:35 PM revealed the following information for bed holds: a. Resident #31 was skilled and sent out emergently billing was stopped and he returned to the facility. b. Resident #183 was out to an ortho appointment and was admitted to the hospital. The sister/POA (Power of Attorney) told the DON (Director of Nursing) over the phone she did not want her to return to the facility. c. Resident #11 was not out for an overnight. d. Resident #12 (Medicaid pending) went out emergently on a Saturday and returned on a Sunday. e. Resident #4 POA was left a message and did not return call until the resident had returned to the facility. During an interview on [DATE] at 12:48 PM, Staff L, RN (Registered Nurse) queried on bed holds and she stated she was never told to do bed hold and wouldn't know where the paper would be. During an interview on [DATE] at 11:07 AM, the DON queried about bed holds and she stated most of the staff forgot to do bed holds and they needed to know which residents who sign for themselves and who couldn't. The DON asked if bed holds got completed and she stated not as much as they should and she needed to pull the paperwork to the front of the cabinet for all the staff nurse to use. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 6:11 PM, the Administrator queried on bed holds and she stated the nurse were supposed to do them and they didn't happen when the resident went out emergently and they just hold their bed for 10 days. The Administrator stated she looked in the policy and went over it in the morning meeting that we need to get the bed hold from family. The Administrator stated they completed them over the holidays for leaves and the urgent ones were the ones not getting done. A review of the policy, dated ,d+[DATE], titled Bed Hold Policy revealed the following: a. When emergency transfers are necessary, the facility will provide the resident and the resident representative with information concerning our bed-hold policy per state law as applicable. b. Non-Medicaid residents will be required to provide the facility with written authorization to either reserve or release the bed space within 24 hours of the resident's transfer from the facility. c. A copy of the resident's bed-hold or release record will be filed in the resident's medical record.

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F 0865 Level of Harm - Potential for minimal harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 47336 Based on staff interview, review of CMS-2567 reports, and facility QAPI (Quality Assurance and Performance Improvement) Plan, the facility failed to ensure an effective QAPI (Quality Assurance Performance Improvement) process to address previously identified quality deficiencies, resulting in multiple repeat deficiencies identified on the facility's current recertification and complaint survey previously identified during surveys completed in the last eight months. The facility reported a census of 35 residents. Findings include: a. The CMS-2567 form from a recertification and incident survey dated 5/6/24 to 5/14/24 revealed the facility issued a deficient practice for harm level citation for treatment of pressure ulcers; and no actual harm level citation for dignity; activities of daily living; assessment and intervention; UTI (urinary tract infection) or urinary catheter; nutrition; and unnecessary drug use and during this specific survey. b. Review of the facility's CMS-2567 form from an incident and complaint survey which occurred 10/2/24 to 10/10/24 revealed the facility received a no actual harm level citation for Activities of Daily Living. c. Review of the CMS-2567 form from a incident survey dated 10/21/24 to 10/23/24 revealed the facility issued an Immediate Jeopardy (IJ) deficient practice for accidents/supervision. The facility's current recertification survey, entrance date 1/12/25, resulted in an IJ harm level deficient practice for nutrition. The facility issued a deficient practice with a harm level for assessment and intervention and accidents/falls; no actual harm citation for ADLs, pressure ulcers, dignity, urinary catheter/UTI; and unnecessary drug use. During an interview on 1/30/25 at 7:36 PM, the Administrator queried on the repeat tags and she stated when she first came to the facility her focus was better staffing and improving the quality with that. She stated the DON (Director of Nursing) overwhelmed and they needed more help in the clinical department. The Administrator queried on the plan of correction with nutrition and she stated she didn't think they had previous issues with nutrition and they were meeting with the dietician more. The Administrator asked about baths and she stated she thought that gotten better with her audits, she stated they did a PIP (Performance Improvement Project) on it. The Administrator asked about skin assessments and she stated the DON said they were getting done or she would do them that day. The Administrator asked where she would wanted improvements and she stated in the clinical section, a lot needs to start with the care plans and the care plan needs to indicate if more skin assessments need done, making sure the wounds were taken care of; and if the care plan was educated to the staff. A review of the document titled QAPI Plan/2025, dated 12/26/24 revealed the Purpose of the plan which declared: To develop, implement and maintain an ongoing program designed to monitor and evaluate customer satisfaction and the quality of resident care, pursue methods to improve quality care and other facility services and to resolve identified problems. Guiding Principles included, in part: (continued on next page)

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F 0865 Level of Harm - Potential for minimal harm Residents Affected - Many	2. The facility outcomes and resident outcomes are utilized for analysis and identification of trends to strategize for improvement. 4. The Quality Assurance Performance Improvement program gives focus on systems and process in each department to identify service failures or gaps and to improve care and services provided. The document included The QAPI Plan: The QAPI plan will include a drive towards enhanced resident care and services as well as employee growth and development. All determined goals and identified QAPI projects will be reviewed and monitored monthly to ensure compliance as well as quality outcomes. The Duties and responsibilities of QAPI committee identified in part to: a. Prioritizing areas of concern and identifying QAPI Special Projects and the completion of root cause analysis to determine why deviation of performance has occurred.