STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Carroll	2241 North West Street Carroll, IA 51401

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review and staff interviews, the facility failed to complete family notification for 1 of 13 residents reviewed (Resident #35). The facility failed to notify Resident #35's family that an antiviral medication was started due to possible shingles infection. The facility reported a census of 48 residents. Findings include: Resident #35's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) was not completed. A Staff Assessment for Mental Status documented Resident #35 was severely impaired with decision making. Resident #35's MDS included diagnoses of down syndrome and intellectual disabilities. A Progress Note dated 3/4/25 at 9:31 AM documented Resident #35 had 12 intact blisters on his left side and the nurse suspected shingles. The note documented a fax was sent to the Physician. A Progress Note dated 3/4/25 at 6:39 PM documented the facility received a new order to start Valcyclovir (antiviral drug used to treat herpes virus infection including shingles) 1000 MG (milligrams) TID (three times a day) for 7 days for possible shingles. The clinical record lacked documentation Resident #35's family was notified of the new physician order for the antiviral medication and the blister areas related to a possible shingles infection. On 3/12/25 at 8:25 AM, the ADON (Assistant Director of Nursing) verified family was not notified of the blister areas, antiviral medication and diagnosis of possible shingles. She reported she would expect the family to be notified and the notification to be documented in the progress notes. On 3/12/25 at 3:19 PM, the Corporate Nurse reported the facility does not have a policy on family notifications as the facility follows standard of care.

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review, staff interview, guidance from the 2024 Resident Assessment Instrument (RAI) Manual, and facility policy review, the facility failed to complete and transmit a Minimum Data Set (MDS) Assessment within federal guidelines for 1 of 13 residents (Res. #45) reviewed for MDS Assessments. The facility reported a census of 48 residents. Findings include: The Census Line portion of the Electronic Health Record (EHR) of Resident #45 documented the resident discharged from the facility on 11/8/24. The Discharge Summary Note documented the resident had discharged on [DATE] at 9:45 am. The MDS Section of the EHR, reviewed on 3/11/25, failed to reveal a discharge MDS had been set up or completed. On 3/11/25 at 3:14 pm, the MDS Coordinator stated she sets up discharge MDS Assessments on the day of discharge and the social worker also double checks discharges. She stated she was not sure how she had missed completing the assessment. On 3/12/25 at 4:44 pm, the Nurse Consultant stated the facility does not have a policy regarding MDS completion. She stated they follow the RAI guidelines. According to the 2024 RAI, a discharge assessment must be dated for the date of the resident's discharge from the facility and must be completed no later than 14 days following the discharge date .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review, staff interview, and guidance from the 2024 Resident Assessment Instrument (RAI) Manual, the facility failed to accurately reflect the status of 7 of 13 residents in the Minimum Data Set (MDS) Assessments (Resident #1, #5, #20, #30, #34, #35, #41). The facility reported a census of 48 residents. Findings include: 1. The Pre Admission Screening and Resident Review (PASRR) of Resident #1, dated 1/27/23, identified the resident to require PASRR Level II Services. (Considered by the State Level II process to have a serious mental illness and/or intellectual disability or a related condition). The PASRR identified the Resident to have diagnoses of Down Syndrome, major depressive disorder, mild intellectual disability and unspecified neurodevelopmental disorder. The PASRR identified specialized services the facility needed to provide to the resident while remaining in the nursing facility. The MDS of Resident #1, dated 8/6/24, failed to document the resident to be considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. 2. The PASRR of Resident #5, dated 8/13/21, revealed the resident to have a PASRR Level 1 Screen Outcome. Page 2 of the PASRR documented the evaluation had determined the resident to have a PASRR condition, and directed that The facility should mark yes for question A1500 on the Minimum Data Set, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? Also, your specific PASRR condition(s) should be checked in question A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. The MDS of Resident #5, dated 1/15/25, revealed question A1500 was marked No and A1510 was left blank. 3. The Active Orders Section of the EHR of Resident #20 revealed an order dated 3/29/23 for oxygen at 1-2 liters at all times and CPAP (continuous positive airway pressure) dated 3/15/23 with oxygen at 2 liters when sleeping. The MDS of Resident #20 dated 1/15/25 failed to document oxygen usage or CPAP usage. 4. The PASRR of Resident #30, dated 5/21/24, revealed the resident to have a PASRR Level 1 Screen Outcome. Page 2 of the PASRR documented the evaluation had determined the resident to have a PASRR condition, and directed that The facility should mark yes for question A1500 on the Minimum Data Set, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?. Also, your specific PASRR condition(s) should be checked in question A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS of Resident #30, dated 9/11/24, revealed question A1500 was marked No and A1510 was left blank. 5. The Active Orders Section of the EHR of Resident #34 revealed an order dated 1/4/24 for Oxygen at 2 liters continuously. The MDS of Resident #34 dated 2/12/25, failed to document oxygen usage. 6. The Census Line Section of the Electronic Health Record of Resident #35 revealed he was admitted to the facility on [DATE] on hospice care. The MDS of Resident #35, dated 2/5/25 failed to document he was receiving hospice care. 7. The PASRR of Resident #41, dated 5/21/24, revealed the resident to have a PASRR Level 1 Screen Outcome. Page 2 of the PASRR documented the evaluation had determined the resident to have a PASRR condition, and directed that The facility should mark yes for question A1500 on the Minimum Data Set, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?. Also, your specific PASRR condition(s) should be checked in question A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. The MDS of Resident #41, dated 12/4/24, revealed question A1500 was marked No and A1510 was left blank. On 3/11/25 at 3:14 pm, the MDS Coordinator stated she looks at the PASRR's in the resident EHR. She stated she only looked at Page 1 of the PASRR and didn't read the instructions on Page 2 for documentation on the MDS. On 3/12/25 at 4:44 pm, the Nurse Consultant stated the facility does not have a policy regarding MDS completion. She stated they follow the RAI guidelines. The 2024 RAI Manual, under Steps for Assessment of question A1500, directed: Point 2: Review the Level I PASRR form to determine whether a Level II PASRR was required. Point 3: Review the PASRR report provided by the State if Level II screening was required. In the next section, titled Coding Instructions, the RAI Manual directed: Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. The manual directs for question O0110C1, Oxygen therapy: Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The manual directs for question O0110K1, Hospice care: Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on observation, clinical record review, staff interviews and policy review, the facility failed to complete and document appropriate assessments and interventions for the necessary care and services, to maintain the residents' highest practical physical well-being for 1 of 3 residents reviewed (Resident #22) with skin impairments. The facility reported a census of 48 residents. Findings include: Resident #22's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #22 required substantial to maximal assistance with bed mobility and transfers. The MDS included diagnosis of hypertension (high blood pressure), diabetes mellitus, septicemia (life threatening blood infection) and cerebral infarction. The MDS revealed Resident #22 had a stage three pressure ulcer and moisture associated skin damage (MASD). The MDS documented skin and ulcer/injury treatments were in place that included a pressure reducing device to chair/bed, pressure ulcer/injury care and application of ointments/medications. The Care Plan with a target date of 5/7/25 revealed Resident #22 had a diagnosis of bullous pemphigoid (rare skin condition causing large, fluid filled blisters) and had actual alteration in skin integrity related to type 2 diabetes, bullous pemphigoid and muscle weakness. The Care Plan directed the following interventions: -Staff to complete treatment as ordered by the Physician. -Staff to monitor skin with cares and to alert the nurse of any red/open area so the Physician could be contacted. -Staff to assess pain and medicate as appropriate. -Staff to assess wounds, obtain measurements and document weekly on the alteration until healed. -Staff to provide a balanced diet to promote healing of the wounds. -Specialty cushion to wheelchair and recliner. -Alternating air mattress to bed. The March Medication Administration Record 2025 directed staff to complete the following skin treatments: -Triamcinolone Acetonide External Cream 0.1 % staff to apply to affected areas one time a day related to bullous pemphigoid- start date 10/29/24 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cleanse areas to sacrum and right buttock with foaming cleanser and cloth. Apply Vashe and gauze and allow to soak for 3-5 minutes. Apply skin prep to the peri wound and around all open areas. Apply zinc paste to all open areas. Complete treatment three times a day and after stool/urination for pressure ulcer of right buttocks and bullous pemphigoid- start date 12/19/24. A Progress Note titled Nutrition/Dietary Note dated 11/6/24 documented the RD (Registered Dietician) recommended Juven (nutritional supplement) one packet twice a day due the Resident #22 pressure injury. Review of a facility fax form dated 11/6/24 documented the RD recommendations for Juven one packet twice a day due to pressure ulcer. The fax form was returned on 11/15/24 and the ARNP (Advance Registered Nurse Practitioner) did not address the recommendations. Review of the clinical record lacked clarification or follow up with the ARNP regarding the recommendations for the Juven. A Progress Note titled Nutrition/Dietary Note dated 1/27/25 documented Juven one packet twice a day was recommended for wound support and was not in the Physician orders. The note documented the RD was going to follow up with nursing regarding the recommendations for the Juven. The clinical record lacked documentation or follow up from nursing regarding the recommendations. On 3/11/25 at 11:00 AM, observed Staff G, LPN (Licensed Practical Nurse) complete would cares and observed multiple open areas various sizes to the left buttocks/posterior left thigh, open areas to coccyx/sacral region, multiple open areas various sizes to the right buttocks with bloody drainage. Staff G cleansed the areas with wound cleanser/gauze and then applied gauze soaked in vashe to all open areas for 5 minutes. Staff G removed the gauze and then applied skin prep to the peri wounds and allowed it to dry. Staff G then applied zinc ointment to each open area and applied five foam mepilex dressings to the open areas. Review of the March 2025 MAR treatment order for the sacrum and right buttocks did not include directions to treat the left buttocks and posterior left thigh with zinc paste. The treatment order did not direct staff to apply foam mepilex dressings to the open areas. Review of the clinical record lacked documentation of weekly skin assessments and measurements for the left buttocks/posterior thigh and right buttocks. The clinical record lacked documentation on the progress of the skin areas, whether the areas were improving, deteriorating, or not changing and if there were any signs or symptoms of infection. The Hospital Wound Care Clinic notes dated 1/22/25 documented Resident #22 had open areas to her right buttocks, sacral area, and coccyx. The note did not document any skin areas to the left buttock/posterior thigh. On 3/11/25 at 12:30 PM, the ADON (Assistant Director of Nursing) reported Resident #22's open areas to the left buttocks/posterior thigh and right buttocks are caused by bullous pemphigoid and she does not measure or complete weekly skin assessments on those areas. When asked about the treatment order, the ADON said the treatment order was written generically and directed to apply zinc paste to all open areas. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 2:00 PM, the Corporate Nurse reported she would expect weekly assessments to be completed for all skin areas and the treatment order be clarified. She reported the mepilex dressings were applied due to drainage from the wounds. On 3/11/25 at 3:45 PM, the ADON reported she did not know when the areas on the left buttocks/posterior left thigh developed as she was not doing weekly skin assessments/skin sheets on those areas. The ADON reported a verbal physician order was received and the treatment order was updated to include the left buttocks/posterior thigh. On 3/12/25 at 8:30 AM, the ADON reported the RD fills out the fax form with dietary recommendations and nursing gives the fax to the Physician. The ADON reported the Physician did not address the Juven on the fax on 11/6 so she assumed the Physician did not want to order it. She reported on 1/27/25 the Juven would have been discussed in the weekly meeting. The ADON verified there had not been any other communication to the Physician regarding the Juven and that it was not started per the dietician recommendations. On 3/12/25 at 10:33 AM received Resident #22 hospital wound clinic notes dated 2/24/25. The wound clinic notes were not in the clinical record and the facility had to obtain the notes from the hospital. The wound clinic notes documented Resident #22 had open areas to the right buttocks, left hip, sacral area and coccyx. The note documented staff had been applying zinc paste to all the open areas three times a day. The note documented the following wound assessments: a. Coccyx- Pressure Injury, stage 3, Length- 2.0 cm (centimeter) x width 1.0 cm and depth 0.8. b. Sacral area: cluster 4 x 6.0 x 0.1 cm; pale pink wound base. c. Right buttocks: cluster of open areas- 6.5 x 5.5 x 0.1 cm (moist, red, peeling similar to the bullous pemphigoid lesions). d. Left Hip: 6.0 x 7.0 clusters of open bullous pemphigoid lesions. The note documented the wounds were stable with current cares and to continue to use zinc paste three times daily to all open areas. Review of the clinical record and February and March 2025 MAR lacked documentation the left hip skin areas were being treated with zinc paste per the hospital wound clinic directions. A facility policy titled Skin Management Protocol updated 5/16/23 documented the following wound notification standards: a. Notify DON (Director of Nursing) and Wound Nurse of new skin alteration or skin ulcer. b. Complete incident report in risk management in the electronic medical record and skin sheet. c. All skin sheets, Non-Ulcer or Ulcer Assessment will be updated weekly by designated Wound Nurse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. The facility will report to the physician if there is any deterioration or signs of infection if observed. e. If the Skin Ulcer or Non-Ulcer has not made improvement after the first two weeks, the community must notify the resident's physician.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46873 Based on observation, clinical record review, staff interview and facility policy review, the facility failed to have interventions in place to prevent the development of a pressure ulcer for 1 of 4 residents reviewed (Resident #14). This resulted in harm to Resident #14 when she developed a Stage III pressure ulcer. The facility reported a census of 48 residents. Findings include: Determining the Stage of Pressure Injury: Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI (see below). Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full-thickness skin loss Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI. Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable PU/PI. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident ' s physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur. Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. The Admission Minimum Data Set (MDS) of Resident #14 dated 11/15/24 recorded the resident had no pressure ulcers, but was at risk of the development of pressure ulcers. The MDS coded the resident had a pressure reducing device for the chair, no pressure reducing device for bed. The MDS coded the resident was not on a turning/repositioning program. The MDS coded no nutrition or hydration interventions in place to manage skin problems. The MDS documented diagnoses that included Type 2 diabetes with foot ulcer; peripheral vascular disease, cerebrovascular accident (CVA/Stroke), hemiplegia (paralysis of one side of the body) bipolar disorder. The MDS coded the resident required substantial assistance to roll left to right in bed. The Quarterly MDS of Resident #14 dated 12/15/24 coded the resident dependent on staff for rolling left to right in bed. The MDS coded the resident had no pressure ulcers. The MDS coded the resident to be at risk of pressure ulcer development. The Care Plan of Resident #14 identified a focus area of risk of falls due to hemiplegia (paralysis or weakness on one side of the body) of the resident's left non-dominant side. The Care Plan identified a focus area of being at risk for skin integrity impairment related to Type 2 diabetes. The Care Plan identified a focus area of ADL (Activities of Daily Living), deficit due to hemiplegia of the left side, dated 11/4/24 . The Care Plan failed to document any need for turning/repositioning for the prevention of pressure ulcers. The Care Plan failed to identify what assistance the resident needed for bed mobility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Skin/Wound note dated 3/2/25 at 12:54 pm identified treatments were completed to wounds on resident's heels (diabetic ulcers). The noted documented education was provided about changing positions frequently and the resident got upset. The note documented a recommendation to get a pressure relieving mattress on the bed. The Skin/Wound note dated 3/2/25 at 4:08 pm documented an open area was identified on the resident's right buttock with purulent drainage. The Ulcer Skin Assessment sheet documented a Stage III pressure ulcer was first observed on 3/2/25 on the right buttock of the resident. Assessments were completed on 3/4/25 and 3/11/25. 3/4/25: 3 x 2 x 0.3 mm. Moderate amount of purulent exudate (thick, opaque fluid). Wound bed red, surrounding skin within normal limits, wound edges macerated, jagged edges. 3/11/25: 3 x 2 0.3 mm. Moderate amount of serosanguinous exudate (fluid containing both serum [clear, watery liquid] and blood). Wound bed red, surrounding skin within normal limits, wound edges macerated, jagged edges. The Kardex, revision date 3/7/25, used by the facility Certified Nurse Aides as a snapshot of resident care, noted Resident #14 to be at risk of pressure ulcers and required frequent repositioning. On 3/12/25 at 9:11 am, the Assistant Director of Nursing (ADON) stated the wound on the resident's buttocks was a pressure ulcer. She stated it developed during a time the resident was primarily in her recliner and not using her bed. She stated the recliner became saturated with urine from her catheter clogging and was removed from the room by the resident's family. Observation of wound care began on 3/12/25 at 9:15 am with Staff G, Licensed Practical Nurse (LPN) and the ADON. Wound care was completed on diabetic ulcers of the resident's heels. After this was completed, Staff G, LPN and the ADON told Resident #14 they needed to reposition her to complete wound care on her buttocks. It was observed it took both staff members to turn Resident #14 onto her right side in the bed which the resident appeared to be resistive to. The ADON assisted the resident to stay on her right side while Staff G opened the resident's incontinent brief. It was noted there was no current dressing in place covering the resident's pressure ulcer. Staff G stated there was a dressing in place on the prior day. The ADON stated the Certified Nurse Aides (CNA) sometimes remove the dressing if the resident was incontinent of bowel. Staff G, after having performed hand hygiene and donning gloves, cleansed the pressure ulcer. She removed her gloves, performed hand hygiene, donned new gloves, and applied triad paste (a paste which helps maintain a moisture wound healing environment) and applied a mepilex (absorbent foam) dressing over the wound. On 3/12/25 at 12:11 pm, Staff H, Certified Nurse Aide (CNA) stated the normal routine for the resident was to provide cares for her in the morning, and clean her if she was incontinent of bowel. She stated the resident ate in her room and received room trays. She stated near the end of the shift, staff emptied her catheter. She stated that was about it and the resident rang her call light if she wanted or needed anything additional. Staff H did not state anything regarding the resident requiring or receiving any repositioning in bed. (continued on next page)

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Accura Healthcare of Carroll	2241 North West Street Carroll, IA 51401

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/12/25 at 2:16 pm, the MDS Coordinator stated Resident #14 has an overlay mattress on her bed for prevention of pressure ulcers. She stated she had asked the CNAs to put this on her bed sometime in the last two weeks or so. On 3/12/25 at 2:19 pm, the MDS Coordinator verified placement of the overlay mattress on the bed. She offered repositioning to Resident #14. The resident declined and remained on her back in bed with the head of bed elevated. Continuous observation of cares revealed the following: On 3/12/25 at 2:20 pm Staff I, CNA provided the resident with fresh ice water. She asked the resident if she needed anything else. No repositioning was completed. On 3/12/25 at 3:09 pm, Staff H and Staff I were observed rounding on residents on the hall Resident #14 resided on. On 3/12/25 at 3:17 pm, Staff H and Staff I knocked on the door of Resident #14 and entered her room, they exited approximately 15-20 seconds later. The State Surveyor entered the room immediately after Staff H and Staff I left the room and observed Resident #14 to still be on her back, in the same position she was in one hour earlier. On 3/12/25 at 5:00 pm, Staff H, CNA was observed to start passing room trays on the hallway. On 3/12/25 at 5:02 pm, the Nurse Consultant was informed of the continuous observation and lack of repositioning provided. She stated residents unable to turn themselves should be repositioned a minimum of every two hours or following any specific physician orders. On 3/12/25 at 5:09 pm, Staff H arrived at the door of Resident #14's room with her evening meal. Staff J, CNA was also nearby. The Nurse Consultant told Staff H and Staff J she was able to assist them in repositioning Resident #14. Upon entering the room, Staff J told Resident #14 it was time to reposition in bed and Resident #14 agreed. Per observation, Resident #14 was dependent on both Staff H and Staff J to be repositioned towards her left side. Staff J provided the resident with her meal and told her she would need to be repositioned again in another 2 hours. Resident #14 was repositioned 2 hours and 50 minutes after continuous observation began. On 3/13/25 at 8:36 am, the ADON stated the resident did have a pressure reducing cushion in her recliner during the time she was spending most of her time in the recliner rather than the bed. She stated the CNA staff should be repositioning every two hours for any resident unable to reposition themselves. The facility policy Skin Management Protocol, updated 5/16/23, failed to document any interventions such as repositioning.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interviews, and policy review the facility failed to provide adequate nursing supervision to prevent accidents and injuries for 1 of 1 resident reviewed (Resident #22) for falls. The facility failed to complete a root cause analysis (RCA), follow up fall assessments and implement a fall intervention after a fall occurred. The facility reported a census of 48 residents. Findings include: Resident #22's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #22 required substantial to maximal assistance with bed mobility and transfers. The MDS included diagnosis of hypertension (high blood pressure), diabetes mellitus, septicemia (life threatening blood infection) and cerebral infarction. The MDS documented Resident #22 had one fall with no injury since last assessment. The Care Plan with a date initiated 10/28/24 documented Resident #22 was at risk for fall and had an ADL (Activity of daily living) deficit due to diagnosis of urinary tract infection and weakness. The Care Plan directed the following interventions: -Resident #22 independent with stand pivot transfers to and from wheelchair and on and off the toilet. Resident #22 to utilize a call light for assistance with peri care after toileting. Resident #22 may ask for assistance with transferring when feeling weak. -Staff to assess fall risk quarterly and as needed. -Staff to assure Resident #22 has appropriate footwear when up. -Nonskid strips in front of the toilet for safe transferring. -Nonskid strips in front of the recliner for safety. An Incident Report (IR) titled Unusual Event dated 1/16/25 at 6:15 PM documented a CNA (certified nursing assistant) reported she had lowered Resident #22 to the floor during transfer from commode to recliner in the resident's room. The CNA requested assistance to get Resident #22 off the floor. The IR documented Resident #22 reported she got weak when she was trying to get into the recliner. Resident #22 said she started to go down and the CNA was able to lower her to the floor and not let her fall. The IR documented Resident #22 received a 4 cm (centimeter) x 8 cm abrasion to her right posterior upper buttocks from the anti-skid strips on the floor in front of the recliner. The IR lacked documentation of a new fall intervention and lacked root cause analysis . Review of the Progress Notes and vital sign tab in the clinical record lacked documentation/follow up fall assessments and vital signs after the fall occurred on 1/16/25. In addition the Progress Notes lacked documentation of a new fall intervention or RCA. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan lacked documentation of a new fall intervention after the fall occurred on 1/16/25. On 03/10/25 at 3:08 PM, Resident #22 reported a couple of months ago she went to the floor gently when trying to to turn to sit down on the commode. She said she lifted up her right foot, lost balance and fell backwards. She said Staff L, CNA (certified nursing assistant) was there and helped her sit on the floor. She said Staff A had ahold of her shoulder. When asked if she had a gait belt on, she said she did not remember. She reported some staff members use the gait belt and others don't. She reported she does not call the incident a fall. She said she sat down more gently on the floor then she does when she sat down on the recliner chair. On 3/11/25 at 12:30 PM, the ADON (Assistant Director of Nursing) reported when a fall occurs the nurse completes a risk management form which triggers a change in condition. She stated there was a separate form that Administration was to complete that was not done. She reported she could not locate a formal root cause analysis assessment. She reported that according to the Progress Notes, Resident #22 got weak. On 3/11/25 at 1:07 PM, Staff L, CNA reported Resident #22 was supposed to be independent in her room with pivot transfers but she would ask for help quite often. She said Resident #22 used her call light, reported she felt weak and requested assistance to the commode from the recliner. Staff L reported she went to pivot Resident #22 to the commode, her foot got caught or something happened and she started to fall backwards. She said she grabbed Resident #22's hands and lowered her to the floor. She said Resident #22 sat down on the skid strips on the floor that were in front of her recliner. Staff L reported Resident #22 seemed okay so she went to get help. She said while she was gone Resident #22 got uncomfortable and tried to position herself up against the recliner and scraped her lower back on the skid strips. She said Resident #22 did not have any clothing on from the waist down as she was going to the commode. When asked if she used a gait belt during the transfer, she said she did not recall if she used the belt or not, she said normally she would have. On 3/11/25 at 1:18 PM, Staff M, RN (Registered Nurse) verified she had worked on 1/16/25 when Resident #22 fell . She reported Resident #22 was going from the commode to her recliner, became weak and was lowered to the floor. She said while the aide was getting the nurse, Resident #22 had wiggled her way and got her back up against the recliner to be more comfortable. When asked if Resident #22 was wearing a gait belt when she got to the room, she said she did not recall if a belt was on or not. She said Resident #22 preferred to have the gait belt under her arms/breast area and does not like the belt around her belly. She said Resident #22 got an abrasion/red area on her back due to scooting across the floor on the skid strips. She said the redness/abrasion was the exact width of the skid strip. When asked if she put an intervention in place after the fall, she said she remembered that she was not sure what she was going to do as everything was already in place. She said the commode was next to the recliner and the skid strips were in place in front of the recliner. When asked what the expectations were after a fall occurred, she said vital signs and assessments are to be completed each shift for three days. She reported the assessments should be in the Progress Notes and vitals signs documented in the vitals tab in the electronic medical record. She said if she put an intervention in place it would be documented on the Risk Management Form (IR) and management would review the intervention and add it to the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 2:00 PM, the Corporate Nurse reported Risk Management form (IR) was not coded correctly by the charge nurse so the RCA for the fall was not triggered or completed. The Corporate Nurse verified follow up fall assessments and vitals signs were not completed after the fall. On 3/11/25 at 2:32 PM, the Corporate Nurse reported the facility does not have a policy related to falls and that the facility followed regulations/standard of care. A facility policy titled Risk Management dated 9/27/24 documented all accidents/incidents involving residents would be reported, investigated and reviewed through facilities QAPI (Quality Assurance Performance Improvement) Process to ensure residents receive the highest quality of care. The policy documented the nurse identifying an incident would be responsible for completing the incident report in the electronic medical record including details regarding immediate action taken, assessment at time of incident and intervention initiated (care plan intervention). The policy further documented Administrative staff would review Risk Management Monday through Friday to identify new incidents and ensure interventions were appropriate and care planned.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interviews and policy review the facility failed to conduct appropriate weight monitoring, nutritional assessments, interventions and timely Physician/family notifications for 1 of 2 residents reviewed (Resident #13) for weight loss resulting in severe unplanned weight loss. The facility reported a census of 48 residents. Findings include: Resident #13's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #13 was independent with eating and was on a therapeutic diet. The MDS documented Resident #13 did not have a 5% weight loss in the last month or 10 % weight loss in the last 6 months. Resident #13's MDS included diagnoses of anemia, diabetes mellitus, paraplegia (loss or impairment of motor and sensory functions in the lower half of the body), depression, cirrhosis and chronic kidney disease. The MDS identified Resident #13 had a stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle). The Care Plan with target date of 5/13/25 documented Resident #13 had a potential for altered nutrition related to diagnosis of diabetes, depression, Barrett's esophagus, cirrhosis of the liver, paraplegia, chronic kidney disease, body mass index greater than 24.9, pressure area and colostomy. The Care Plan directed staff to obtain weights per facility protocol, record and report any significant changes and encourage good oral intake at meals, especially protein. The Medication Administration Record March 2025 directed staff to administer the following physician orders: -Beneprotein oral powder (protein) 1 scoop one time a day mixed in food or beverage of choice for stage 4 pressure ulcer to left buttocks. -Boost Glucose Control Oral Liquid (nutritional supplement) 8 ounces one time a day for stage 4 pressure ulcer to left buttocks. -Juven oral packet (nutritional supplement) one packet two times a day for wound healing. -Multivitamin one tablet one time a day. -Vitamin C 500 mg (milligrams) one tablet one time a day. The Weight Summary documented the following weights over the past three months and the scale used to obtain the weight: 3/12/2025- 233.9 lbs (pounds)- mechanical lift 3/10/2025- 230.6 lbs- mechanical lift (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	2/21/2025- 239.0 lbs- mechanical lift 1/7/2025- 274.0 lbs- wheelchair scale 12/27/2024- 272.8 lbs- wheelchair scale 12/26/2024- 270.6 lbs- wheelchair scale 12/25/2024- 270.4 lbs- wheelchair scale 12/24/2024- 268.2 lbs- wheelchair scale 12/22/2024- 271.0 lbs- wheelchair scale 12/9/2024- 273.8 lbs- wheelchair scale Review of the Weight Summary revealed on 1/7/25, Resident #13 weighed 274 lbs and on 2/21/25, weighed 239 pounds which was a -12.77 % weight loss. Review of the Weight Summary revealed on 1/7/25, Resident #13 weighed 274 lbs and on 3/10/25, weighed 230.6 pounds which was a -15.84 % weight loss. Review of the Weight Summary revealed on 1/7/25, Resident #13 weighed 274 lbs and on 3/12/25, weighed 233.9 pounds which was a -14.64 % weight loss. A Progress Note dated 1/13/25 documented Resident #13 had complaints of sores in his mouth and was seen by the facility ARNP (Advance Registered Nurse Practitioner). The note documented that a new order was received for magic mouth wash four times a day for 10 days. A Progress Note dated 1/14/25 documented Resident #13 was lethargic, pasty, vomiting and had excessive loose stools in his colostomy bag. The note documented the following vital signs: blood pressure 88/56, pulse 95, pulse oximetry (oxygen in the blood) 94 % on room air and blood sugar 123. The on call Physician was notified and new orders received to send Resident #13 to the emergency room for fluids and evaluation. A Progress Note dated 1/15/25 documented Resident #13 was admitted to the hospital for dehydration. A Hospital Note dated 1/15/25 documented Resident #13 was admitted to the hospital for nausea, vomiting and norovirus (a highly contagious virus that causes acute gastroenteritis, or inflammation of the stomach and intestines). A Hospital Note dated 1/16/25 documented Resident #13 reported that he can't eat well due to oral thrush (fungal infection) and to continue the nystatin (medication to treat fungal infections) swish and swallow. A Progress Note dated 1/17/25 documented Resident #13 returned to the facility from the hospital. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A facility form titled Return Admission Assessment on 1/17/25 documented Resident #13 returning diagnosis was recovered from Norovirus. The vital section of the form documented the most recent weight of 274 lbs on 1/7/25. The assessment lacked documentation of a new weight being obtained following the hospitalization . A Progress Note dated 1/18/25 documented Resident #13 complained of weakness, left abdominal pain and decreased appetite. A Progress Note dated 1/22/25 at 11:31 AM documented Resident #13 had 4+ (severe) edema to lower legs. A Progress Note dated 1/22/25 at 11:52 AM documented Resident #13 PCP (Primary Care Physician) was notified of the edema and ordered edema wear on in the morning and off at bed time. A Progress Note dated 1/29/25 documented Resident #13 complained of his mouth bothering him. The note indicated there were no visual areas of concern. The facility ARNP was notified and new orders received for Nystatin Mouth Throat Suspension Swish and Spit, may give 30 ml (milliliters) every 6 hours as needed until bottle is gone or expires on 2/3/25. A Progress Note titled Nutrition/Dietary Note dated 1/31/25 documented RD (Registered Dietician) annual assessment completed. The assessment indicated Resident #13 was on a regular diet with small servings and intakes averaging 50% for most meals with 240-480 ml of fluid per meal. The assessment documented Resident #13 weighed 274 lbs on 1/7/25 and the weight was used to calculate Resident #13 weight trends in the past 30 days, 90 days and 180 days. The note documented Resident #13 weights were not clinically significant. The note indicated that there was some edema noted and that there were no new nutrition recommendations at this time. The Progress Note lacked documentation that the RD requested or recommended a weight be done post hospitalization to ensure the nutrition assessment was accurate. A Progress Note dated 2/24/25 documented a new order was received for lidocaine mouth/throat solution 15 ml every 6 hours as needed for complaints of mouth pain. A Progress Note titled 2/26/25 titled Nutrition/Dietary Note documented Resident #13 showed a weight of 239 lbs on 2/21/25 which was a 35 lb weight loss in 6 weeks. The note documented the RD questioned if the weight was accurate and requested nursing to obtain a reweigh. The note documented Resident #13 continued to have a stage 4 pressure area to the left buttocks which was deteriorating per latest skin assessment and the treatment was ongoing. The note documented Resident #13 received multiple supplements for wound healing: Juven 1 packet twice a day, Boost Glucose Control 8 ounces every day, and beneprotein 1 scoop everyday. The note documented the RD would wait for the reweigh and then would reassess. The note documented staff was to notify the RD of any significant changes or concerns. Review of the clinical record revealed Resident #13 was weighed on 3/10/25, 12 days after the request for a reweigh, and weighed 230.6 lbs which was an additional weight loss of 8.4 lbs. The clinical record lacked documentation that the RD was notified of the reweigh. The clinical record lacked any further dietary assessments, interventions, and Physician/family notifications. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The Weight Summary on 3/12/25 documented Resident #13 weighed 233.9 lbs. The weight on 3/12/25 was obtained after the surveyor voiced concerns regarding Resident #13's weight loss. Review of the February meal intakes documented for Resident #13 revealed the intake varied daily and averaged above 50%. On 3/12/25 at 9:38 AM, Resident #13 reported he felt the weight loss was due to his kidney stones and hospitalization s. He said he could not keep anything down when he would try to eat. He said he started not to feel good after Christmas time. He said his appetite and intakes have improved. He reported the staff either weigh him with the mechanical lift or the wheelchair scale. When asked about the weight of 230 lbs, Resident #13 said that was a low weight for him and questioned the accuracy of the weight. He reported he did not feel like he had lost that much weight. On 3/12/25 at 11:30 AM, the Corporate Nurse reported Resident #13 was reweighed with both the mechanical lift and the wheelchair scale and the weight was still in the 230's. The Corporate Nurse acknowledged the concern with the significant weight loss. She reported she would expect staff to obtain a reweigh in a timely manner and for the management staff to be reviewing and auditing the medical record and updating the dietician. She reported she would expect assessment and interventions to be put in place for the weight loss. When asked how often Resident #13 should be weighed, the Corporate Nurse reported she would have to check but would expect the weight to be obtained according to the Physician's order. Review of the clinical record lacked a Physician order regarding how often staff was to obtain a weight for Resident #13. On 3/12/25 at 4:30 PM, the Corporate Nurse reported the facility would follow standards of care and expect monthly weights to be obtained if there was not a physician order. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 3/13/25 at 9:00 AM, the facility RD (Registered Dietician) reported that each week she would run a weight/vital report and any residents triggered with significant changes were assessed. She reported she would discuss any concerns with dietary and nursing as needed and make recommendations. She reported she would fill out a Physician Fax Form with any new recommendations and attach the Physician Fax Form to the weight loss report. She reported she gives the information to nursing to send to the Physician. She reported nursing was responsible for ensuring the fax was returned and recommendations addressed. When asked what the expectations were for weighing residents at the facility, she reported the facility was currently taking a look at the process as weights are all over the board. She reported she would like the weights to be individualized based on the situation, needs and what the provider wants. She reported residents with wounds she would usually recommend weekly weights. She reported Resident #13 was hospitalized in January and when he returned weekly weights were not started/obtained. She verified a weight for Resident #13 was not obtained upon return from the hospital on 1/17/25 and he was not weighed until 2/21/25. She reported on 2/26/25 she had requested a reweigh and she was not sure why the weight was not obtained until 3/10/25. She reported she did not have any notes written down for Resident #13 from the week of 3/3/25. She reported she worked on an assessment for Resident #13 last night and had emailed nursing asking for additional information regarding his fluid retention and what scales were used to obtain the weights. She reported once she got the information she requested from nursing, she would make additional recommendations for supplements. When asked if she felt the weight loss was avoidable or unavoidable, she reported that the question was hard to answer without having all the information and without having the weights to look at after his hospitalization . The RD verified Resident #13 had a very significant weight loss and she was not sure if the weight loss was fluid related or if his intake documented might not be accurate. She reported the facility was trying to figure out what was going on and determining what Resident #13 needs are. On 3/13/25 at 10:10 AM, the Corporate Nurse reported the facility does not have a policy that addressed significant weight loss. She reported the facility would follow standards of practice and follow the regulations which include physician notifications and implementing interventions for weight loss. A facility policy titled Weight and Height Measurement dated 10/25/21 documented Residents are weighed on admission daily for three days, then weekly for three weeks, then monthly unless otherwise ordered by nursing order or the attending physician to monitor the resident's condition. Residents' height is measured on admission. The purpose of the policy was the following: a. To obtain accurate baseline weight and height of each resident. b. To maintain constant control of weight changes. c. To assess the nutrition and hydration status of the resident. d. To identify significant changes in condition. The policy directed staff that if a resident had gained or lost three or more pounds the resident needs to be reweighed with nurse supervision. If the nurse has verified weight change, the nurse must notify the physician and nursing leadership.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46873 Based on observations, clinical record review, family interview and staff interview, the facility failed to accurately provide physician ordered respiratory services for 3 of 3 residents reviewed (Resident #20, #21, #34). The facility reported a census of 48 residents. Findings include: 1. The Minimum Data Set (MDS) of Resident #20 dated 1/15/25 documented diagnoses which included atrial fibrillation, heart failure, and respiratory failure. The Active Orders Section of the EHR of Resident #20 revealed an order dated 3/29/23 for oxygen at 1-2 liters at all times and CPAP (continuous positive airway pressure) with oxygen at 2 liters when sleeping. On 3/10/25 at 10:47 am, Resident #20 was observed sitting in her recliner, with her oxygen cannula in place in her nares (nostrils). The end of the oxygen cannula was observed lying on the floor, not hooked to her oxygen concentrator. The concentrator was turned on at 2 liters. On 3/11/25 at 9:14 am, a family member of Resident #20 reported having found her oxygen on the floor in the past. He stated she has been sent to out of facility physician appointments with a portable oxygen tank that ran empty before she returned to the facility. He stated he has also seen the hose of her CPAP (continuous positive airway pressure) machine on the floor. The family member said he has brought these issues up in care conferences to the facility staff. The Care Conference Note dated 5/2/24 revealed the family raised concerns of the resident being in the dining room and her portable oxygen tank is in the red (empty or very low) and staff are not aware of it. The Care Conference Note dated 8/1/24 revealed the family had visited the resident and 30-45 minutes into the visit, he realized the resident was wearing her oxygen cannula but the concentrator was not turned on. The Care Conference Note dated 10/24/25 revealed the family stated the oxygen issues had improved at that time. 2. The MDS of Resident #21 dated 12/9/24 documented diagnoses which included atrial fibrillation and pneumonia. The Active Orders of Resident #21 revealed an order for oxygen at 1-2 liters per nasal cannula to keep oxygen saturation above 90%. Observation on 3/10/25 at 10:52 am revealed Resident #21 to be wearing oxygen cannula with the oxygen concentrator set at 3 liters. Observation on 3/11/25 at 10:38 am, Resident #21 remained on 3 liters of oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/11/25 at 3:56 pm, Resident #21 remained on 3 liters of oxygen. Observation on 3/12/25 at 8:51 am, Resident #21 remained on 3 liters of oxygen. On 3/12/25 at 9:47 am, Staff K, Registered Nurse (RN) stated Resident #21 uses his oxygen continuously at 3 liters. She stated his orders were to keep his oxygen saturation above 90%. Review of hospital records dated 3/7/25, when the resident was released from the hospital, revealed his order at hospital discharge was for 2 liters continuously. Review of active orders on 3/12/25 at 7:05 am revealed this order had never been processed by facility staff. On 3/13/25 at 8:31 am, the Assistant Director of Nursing (ADON) stated the provider should have been updated if the resident was unable to maintain oxygen saturation at the ordered level and got new orders. 3. The MDS of Resident #34 dated 2/12/25 documented diagnoses which included coronary artery disease and respiratory failure. The Active Orders Section of the EHR of Resident #34 revealed an order dated 1/4/24 for oxygen at 2 liters continuously. On 3/11/25 at 3:38 pm, Resident #34 was observed self propelling her wheelchair down the hall. She appeared to have a flushed face and to be short of breath. The oxygen tank regulator was set at 2 liters and the indicator registered 0 in the red refill zone. The ADON was notified of this so staff could check on her. The ADON stated the charge nurse is to turn the oxygen on when residents use portable tanks and if the tank is running low, they are to change out the tank. On 3/12/25 at 4:44 pm, the Nurse Consultant stated the facility does not have a policy regarding following or noting physician orders. She stated the facility would follow standards of care.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 46873 Based on observation, staff interview, and review of facility menus, the facility failed to follow the posted menu and serve the appropriate portions for 2 of 2 residents who received pureed diets (Res #25 and Res #35), and failed to serve the ordered therapeutic menu for 6 of 6 residents (Res #1, #6, #18, #30, #38, #43) who were ordered to receive mechanical soft diets. The facility reported a census of 48 residents. Findings Include: Posted lunch menu for 3/10/25: 1 Maple Bacon Chicken Sandwich 4 oz French Fries 4 oz Hot Spiced Beets 1 sq Orange Poppyseed Cake 8 oz Milk The menu spreadsheet documented residents with mechanical soft diet orders should receive orange cake with no poppyseeds and residents with puree diet orders should receive pureed orange cake with no poppyseeds. On 3/10/25 at 12:05 pm, Resident #25 and Resident #38 were observed during noon meal service. The Certified Dietary Manager (CDM) served dessert to both residents, and stated to the staff member sitting at the table that Resident #25 was getting pudding instead of cake because poppyseeds cannot safely be pureed. Resident #38, who had an order for a mechanical soft diet, was observed receiving poppyseed cake and eating it. Posted lunch menu for 3/11/25: 8 oz Spaghetti with Meat Sauce 4 oz Seasonal Vegetables 1 slice Garlic Toast 1 square Pumpkin Dessert 8 oz Milk (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The menu spreadsheet documented residents with mechanical soft diet orders should receive seasonal vegetables, no corn and no peas, soft garlic toast, and residents with puree diet orders should receive one serving of puree garlic toast and pureed seasonal vegetables. Continuous lunch observation began on 3/11/25 at 10:56 am. The Certified Dietary Manager (CDM) began the puree process. She used a 4 oz scoop and obtained 2 scoops of spaghetti with meat sauce and pureed it to the appropriate texture. She transferred the food from the food processor bowl to a steam pan with no measurement. (Posted menu was for 8 ounces of spaghetti with meat sauce) On 3/11/25 at 11:07 am, the CDM picked up 2 slices of garlic toast with tongs, placed them on a plate, and brought them to the puree area. She warmed an unmeasured amount of milk in the microwave. She picked up the garlic bread and tore it into smaller pieces, added milk and pureed the bread to the appropriate texture. She then transferred it to a steam pan with no measurement and placed it and the pureed spaghetti on the steam table. The CDM next obtained a clean food processor bowl and blade and two servings of the pumpkin dessert. She added the dessert and an unmeasured amount of milk to the food processor and pureed to an appropriate texture. She transferred the food to a steam pan with no measurement. She then carried the steam pan to the table and used a two oz scoop and put one serving in one bowl. Using the two ounce scoop, she placed food in the second bowl but the scoop was not full and one serving was visibly smaller than the other. Using a spatula, she scraped the remaining dessert from the steam pan and added it to the second bowl. Staff A, [NAME] was ready to begin meal service on 3/11/25 at 11:24 am. She obtained beginning meal temperatures. She stated the garlic bread had been separated in the steam pan. The more toasted, firmer toast was on the left side and the softer toast was on the right side for the residents who have orders for mechanical soft diets. On 3/11/25 at 11:35 am, Staff A made a plate for Resident #38 who had a mechanical soft diet. A dinner salad with chopped lettuce was being served as the seasonal vegetable and was included on her plate. The State Surveyor asked the CDM if the chopped lettuce was appropriate for a mechanical soft diet. She replied that residents with a mechanical soft diet order should receive shredded lettuce instead. Staff A stated other mechanical soft diet plates had been made but they had received a baked potato and no salad. She verified Resident #30 and Resident #43 had already been served their plates, both having orders for mechanical soft diets. The State Surveyor entered the dining room and verified both Resident #30 and Resident #43 had been served the chopped lettuce salad and not baked potatoes. A staff member notified Staff A that there was nobody available to sit with Resident #38 yet so her plate was set aside and not served. It was remade later in service and a baked potato was served in place of the salad. The two plates for pureed diet residents were observed to receive four ounces of pureed spaghetti and the pureed garlic bread was served with a #12 scoop, which is approximately 2.7 ounces, as well as the pureed dessert. No vegetable was observed. After both plates were served, the steam pan of pureed spaghetti was empty but the steam pan of pureed garlic bread still had puree leftover in the pan. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	After meal service ended, the CDM was interviewed regarding the puree process. She stated she had never heard of measuring the food after pureeing. She stated she just divided the food up and remarked that she often had puree food left over after serving and that now made sense that adding liquid to the puree would change the volume of the food. The CDM stated on the prior day, 3/10/25, she had not read the spreadsheet and she was not aware she was supposed to make two types of cake. She stated that was the fourth or fifth time of the menu rotation and she had always served the poppyseed cake to the mechanical soft residents and a substitute to the puree diet residents. On 3/11/25 at 1:55 pm, the Registered Dietitian stated she was also unfamiliar with the volume method of pureeing and believed the residents should be served the amount stated on the menu spreadsheet. She stated the residents on mechanical soft diets should not have received poppyseeds or the chopped lettuce. She stated they should have had shredded lettuce.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46873 Based on observation, staff interview, guidance from the 2022 Food & Drug Administration (FDA) Food Code and facility policy review, the facility failed to use proper sanitation and glove use during lunch service, and also failed to regularly clean and monitor the internal temperature of a refrigerator designated for resident food items. The facility reported a census of 48 residents. Findings Include: Initial kitchen walk through was initiated on 3/10/25 at 9:36 am. During the kitchen walk through, the Certified Dietary Manager (CDM) was asked about a policy regarding food brought to the facility by resident families/visitors. She stated there is a refrigerator in the employee break room and that is where those foods are stored. She stated the food gets thrown out if not eaten after three days. On 3/11/25 at 10:42 am, observed the break room resident upright refrigerator/freezer and both the refrigerator and freezer were visibly very soiled. No thermometers were observed. No cleaning logs and no temperature logs were observed. On 3/11/25 at 10:50 am, the State Surveyor entered the kitchen to observe lunch service. Staff B, dishwasher, was observed in the kitchen with very short hair, but not wearing a hairnet. The corporate Nurse Consultant, the CDM and Staff A, [NAME] were all in the kitchen and nobody corrected Staff B about wearing a hairnet. The State Surveyor questioned why Staff B was not wearing a hairnet and he was then reminded he needed to wear one. The puree process was observed prior to lunch service beginning. After having pureed the spaghetti, the CDM on 3/11/25 at 11:07 am picked up two slices of garlic toast using tongs. She placed them on a plate and brought them to the puree area. She poured some milk into a glass and warmed it in the microwave and brought it over to the puree area. She washed her hands and donned gloves. She picked up a clean food processor bowl and a set of blades for the food processor. She put the blades in place, and picked up the garlic toast with her gloved hands, tore it into pieces, then poured in some milk. She placed the processor bowl cover on and pureed the garlic toast. She was having difficulty with the blades of the food processor. She removed the lid, and adjusted the blades in place. She added more milk and continued to puree to the appropriate texture. She then transferred the pureed toast to a steam pan. She took the soiled dishes to the dishwasher area. The CDM removed her gloves, washed her hands, and donned new gloves. She obtained two servings of the pumpkin dessert and another glass of milk. With the gloved hands, she set up the food processor with a clean bowl and blades. She added the dessert and milk and pureed to an appropriate texture. She used a spatula to transfer the food to a steam pan. She used her gloved finger to wipe the food off of the spatula and into the steam pan. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/25 at 11:24 am, Staff A, [NAME] was ready to begin meal service. Staff A had also performed hand hygiene and donned gloves. She picked up a stack of plates, and gathered all the serving utensils required for meal service. Some residents had ordered a substitute item of baked potato for their meals. When making plates that included baked potatoes, Staff A was observed using a set of tongs to place the baked potatoes on the dinner plate. She then used a knife to slice the potato open down the middle, then used her gloved hands to press in the sides of the potato to fluff it before serving to the residents. This was observed multiple times throughout meal service. Staff A, dishwasher, had left the kitchen during meal service. He returned to the kitchen at 11:50 am, again not wearing a hairnet. No other staff members reminded him of the need to wear a hairnet. Meal service was concluded approximately 12:20 pm. At 12.22 pm, the CDM stated she would re-educate Staff A, [NAME] about touching the baked potatoes with her hands. At 12:28 pm, two Certified Nurse Aides were observed walking into the kitchen with no hairnet on to obtain leftover food for their employee meals. The CDM corrected both of them saying they needed to wear hairnets. On 3/11/25 at 1:55 pm, the Registered Dietitian stated her expectation if gloves are used is for them to be changed frequently, and staff should use utensils rather than the gloves when touching food. She also stated all employees need to wear a hairnet regardless of the length of his/her hair. On 3/11/25 at 3:27 pm, the Environmental Services Director stated he believed the nursing staff should be monitoring the temperature of the break room refrigerator. He stated cleaning it was his responsibility but he wasn't sure how long it had been since it had been cleaned. He said he knew it had been quite a while since it was last cleaned. On 3/11/25 at 3:42 pm, the Assistant Director of Nursing stated the nursing staff monitors refrigerator temperatures in resident rooms and in the medication room. She stated she was unaware of who was responsible for monitoring the temperatures in the break room. On 3/12/25 at 7:14 am, the Environmental Services Director stated he had cleaned the break room refrigerator. He stated there were thermometers in both the fridge and freezer areas but they were pushed way to the back and he moved them to the front. Chapter 3 of the 2022 FDA Food Code documented the following: 3-304.15 Gloves, Use Limitation. (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. The undated facility policy Employee Sanitary Practices documented the following: Point 1: Wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	exposed food. Note: This does not apply to employees who have a totally shaved or bald head; nor does it apply to employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food, clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. Point 6: Use utensils to handle food, avoiding bare hand contact with food. Disposable gloves are a single use item and should be discarded after each use. Hands must be washed prior to using gloves and after removing gloves.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41785 Based on observation, interview and record review the facility failed to ensure that staff used Enhanced Barrier Precautions (EBP) during resident cares for 1 of 3 residents reviewed. Staff K, Registered Nurse (RN) failed to use the recommended Personal Protective Equipment (PPE) while administering tube feedings to Resident #21. The facility reported a census of 48 residents. Findings include: Nursing Notes for Resident #21 showed the following entries: a. On 3/1/25 at 11:38 PM, Resident #21 was transferred to the hospital. b. On 3/7/25 at 1:02 PM, he returned to the facility totally dependent on staff assistance for transfers, toileting and meals. c. On 3/7/25 at 9:07 PM tube feedings initiated. In an observation on 3/11/25 at 6:30 AM, Resident #21 was sitting in his recliner in his room with nasal cannula supplemental oxygen. The resident had some difficulty answering questions as his speech was soft with limited words. Staff K said that the resident had recently returned from the hospital with a feeding tube due to aspiration pneumonia. Staff K prepared the tube feedings and water flushes, administered through a syringe via gravity flow. The nurse donned disposable gloves but failed to apply a gown. On 3/12/25 at 1:00 PM the Assisted Director of Nursing (ADON) said that the nurses had all been educated on EBP and if she did not have gown on during tube feedings, they would need to reeducate. A facility policy titled: Enhanced Barrier Precautions dated 11/13/24, showed that all staff would receive training through Relias (on-line education) on enhanced barrier precautions upon hire and at least annually and were expected to competent with all designated precautions. An order for enhanced barrier precautions would be obtained for residents with any of the following; wound and or indwelling medical devices, (feeding tube).

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41785 Based on staff interview, personnel record review and Facility Assessment review, the facility failed to ensure that Certified Nurse Aides (CNA) completed the required 12 hours of in-service training annually, for 3 of 3 personnel reviewed. The facility reported a census of 48 residents. Findings include: According to an untitled facility spreadsheet, Staff A, CNA was hired on 10/20/23, Staff B, CNA was hired on 11/12/23, and Staff C, CNA was hired on 12/21/22. When asked to provide documentation of CNA continuing education on 3/12/25 at 10:19 AM, Staff D, Nurse Manager, said the previous Business Manager (BM) was not keeping track of the CNA education needs in Relias, and Staff B hadn't even been signed up for the Relias access. Staff D said that going forward, the new BM would be running a monthly list of required education for CNA in Relias and monitoring/tracking that it was getting completed. The Facility Assessment section titled: Information About Our Staff Training/Education and Competencies, showed that the facilities training program would include an orientation process and ongoing training for all new and existing staff including managers, nursing and other direct care staff. The facility would complete an educational needs assessment and develop a curriculum and training plan based on staff need and resident characteristics.