STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165546	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tabor Manor Care Center	209 Main Street Tabor, IA 51653

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47582 Based on clinical record review, staff interview, and facility policy review, the facility failed to treat residents with dignity and respect throughout cares provided for 1 of 7 residents reviewed (Resident #15).The facility reported a census of 43 residents. Findings include: Record Review of Resident #15 Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 06 indicating severe cognitive decline. The MDS reflected Resident #15 diagnoses of non-Alzheimer's dementia, hemiplegia (paralysis on one side of the body), seizure disorder, and ataxia following cerebral infarction (poor muscle coordination and balance after a stroke). The MDS further documented Resident #15 required total dependence on staff for performing activities of daily living. Clinical record review of Resident #15 documented a nurse's Progress Note dated 1/10/25 at 8:49 am a concern about a staff member holding resident's hands down and forcing medications. During an interview on 2/4/25 at 3:13 pm Staff A, Licenced Practical Nurse (LPN) with 9 years of experience in the role, recalled administering medications to Resident #15 and confirmed she did it to prevent residents from flinging her arms. She also stated the resident had a history of refusing medications but typically not for her and the right step would be to wait until the resident was willing to take them. During an interview on 2/06/25 at 2:34 pm the Director of Nursing (DON) stated that her expectations are for staff to document residents' medications refusal. The facility policy titled Protocol for medication administration updated 9/13/14 did not provide directions for staff to follow in case a resident refused to take prescribed medications.

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

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 47582 Based on observation and staff interviews, the facility failed to post required notifications of State Survey Agencies and other support for advocacy in a form or manner accessible and understandable to residents or representatives. The facility reported a census of 43 residents. Findings include: Surveyor's observations throughout the survey dates 2/3/25 - 2/6/25 revealed information posted in the common area by the nurses station on how to contact state agencies was above eye level and in small print flyers. Information on Residents Rights was not posted. A framed flyer that read current state survey, fire marshall's report, medicaid and medicare information located in lobby bookcase did not have all listed information in the lobby's bookcase. Another flyer read nondiscrimination policy and at the bottom of the flyer the contact for the facility was outdated. During a facility tour on 2/4/25 at 3:00 pm with the Administrator Assistant, it was observed that the required postings with list of names, mailing and email addresses, and telephone numbers of all pertinent State regulatory and informational agencies and advocacy groups were not all displayed in the area easily visible or accessible to residents and some of the postings were outdated. In an interview with the Administrator on 2/6/25 at 2:34 pm he stated that he will have to look at the area by the nurses desk to check for the information and ensure it is correct and present.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47582 Based on document review, record review, and staff interviews the facility failed to have correct documentation of residents' choice related to advance directives for 3 of 7 residents reviewed (Resident #24, Resident #194 and Resident #9). The facility reported a census of 43 residents. Finding include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #24 entered the facility on 1/6/25. The MDS documented resident entered with Hospice services. Review of the current Medication Administration Record (MAR) revealed Advance Directive as Do Not Resuscitate (DNR). The EHR lacked Resident Advance Directives form signed on admission to reflect the DNR wishes and signed by the resident or representative and the physician. On 2/4/24 at 3:00 pm, the Director of Nursing (DON) stated that advance directives are verified at the time of admission and confirmed the EHR and the physical chart did not have the Resident Advanced Directives form. During the follow up review of the physical record for Resident #24, the Resident Advance Directives form was located and signed by the DON, and verbally verified with the Power of Attorney (POA) for the resident on 2/3/25 to reflect the DNR wishes but not signed by the physician. The facility provided policy titled Advance Directives revised 10/19/23 documented the procedure for obtaining a signed advance directive form upon admission and DNRs statuses required physician's signatures. In an interview on 2/6/25 at 2:34 pm, the Administrator stated his expectation was for the code status to be verified during an admission and for the paperwork to be faxed in a timely manner. 47673 2. The Minimum Data Set (MDS) dated [DATE] for Resident #9 documented a Brief Interview of Mental Status (BIMS) score of 9 indicating moderate cognitive impairment. Review of a document titled, Resident Advance Directive dated 12/21/24 revealed a selection of do not attempt resuscitation (DNR). This document further revealed signatures by DON and Resident #9 but not signed by the physician. 3. The MDS dated [DATE] for Resident #194 documented a BIMS score of 11 indicating moderate cognitive impairment. Review of a document titled, Resident Advance Directive revealed a selection of do not attempt resuscitation (DNR). This document further revealed undated signatures by DON and Resident #194 but not signed by the physician. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A request for documentation from the DON of any physician signed copies of Resident Advance Directive for Resident #9 and Resident #194 revealed no signed copies provided. Review of policy titled, Advanced Directives revised 10/19/23 documented DNR's require a physician's signature to be faxed back to the facility.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on clinical document review, staff interview, and policy review the facility failed to provide residents and families with 48 hour notification of financial responsibility when Medicare Part A services were scheduled to be discontinued for 2 of 3 residents reviewed (Resident #11, and #15). The facility reported a census of 43 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #11 had a Brief Interview for Mental Status (BIMS) score that should not be completed by the resident and needed to be completed by the staff. Cognitive patterns identified by the staff included memory problems for short and long term memory, inability to normally recall the season, location of bedroom, staff names and faces, and residing in a nursing home. The document further revealed severely impaired cognitive skills for daily decision making, inattention and disorganized thinking that was continuously present and did not fluctuate. The MDS revealed the resident had diagnoses that included: coronary artery disease, cerebrovascular accident, and multiple sclerosis. The Care Plan updated 12/22/24, showed Resident #11 had self care performance deficits related to activity intolerance, fatigue and limited mobility. The resident required 1 staff assistance for toileting, dressing, and transfers, According to the Census Tab in the Electronic Medical Record (EMR) on 11/26/24 Resident #11 qualified for Medicare A services and on 12/10/24, the resident was Private Pay. The facility Discharge Notification from therapy dated 12/5/24 indicated the last date of treatment was 12/9/24 and the discharge date was 12/10/24. The facility provided a Notice of Medicare Non-Coverage (NOMNC) Form CMS-10123 with a date of termination of services 12/9/24 with a signature date of 12/29/24 by the resident. The facility failed to provide the document and obtain a signature 48 hours in advance of the discharge from therapy services. 2. According to the MDS dated [DATE], Resident #15 had a BIMS score of 6/15 indicating severe cognitive impairment. The MDS revealed the resident had diagnoses that included: other fracture, Cerebrovascular Accident, Non-Alzheimer's Dementia, and hemiplegia or hemiparesis. The Care Plan updated 12/22/24, showed Resident #15 had self care performance deficits related to activity intolerance, fatigue and limited dementia, hemiplegia, and limited mobility. The resident required 1 staff assistance for dressing tasks, and was dependent upon staff for transfers using a mechanical non weight bearing lift. According to the Census Tab in the EMR on 8/22/24 Resident #15 qualified for Medicare A services and on 9/1/24, the resident was Medicaid. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided a Skilled Nursing Facility Beneficiary Protection Notification Review Form CMS-20052 (2/2017) with a last covered day of Part A Service of 8/31/24. The document revealed a Skilled Nursing Facility (SNF) Advanced Beneficiary Notice (ABN), Form CMS-10044 was not provided to the resident without an explanation. The document did not reveal whether a NOMNC Form CMS 10123 was issued and signed by the resident or power of attorney. The facility failed to provide written documentation with a signature by the resident or power of attorney of Form CMS-10123 or Form CMS-10044. On 2/10/25 at 9:55 AM the Assistant Administrator (AA) stated the Beneficiary Notice - Residents discharged Within the Last Six Months document completed upon entry did not have the correct resident names on it. The document contained Medicare B residents, Medicaid Residents, Managed Care Residents, as well as Medicare A residents. The AA indicated the Social Services Director completed the ABN notifications and he completed the pre-authorizations. On 2/10/24 at 10:45 AM the AA indicated the documentation that was completed was submitted for review. On 2/10/24 at 11:40 AM the Administrator acknowledged he had become aware of concerns regarding ABN completion. The facility did not provide an Advanced Beneficiary Notice Policy.

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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** 47673 Based on Electronic Health Records (EHR) review, observations, resident interview and staff interview the facility failed to provide the residents with a comfortable homelike environment by leaving feces and urine in a commode without being emptied for at least 8 hours for 1 of 19 residents (Resident #20) reviewed. The facility reported a census of 43 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #20 documented a Brief Interview of Mental Status (BIMS) score of 9 indicating moderate cognitive impairment. Review of Resident #20's EHR documented Resident #20 resided in room [ROOM NUMBER]-A by herself. On 2/3/25 at 4:02 PM entered room [ROOM NUMBER] and observed a commode full of urine and toilet paper with the toilet taped shut. Strong odor of urine noted when entered room [ROOM NUMBER]. On 2/5/25 at 11:05 AM entered room [ROOM NUMBER] and noted a strong smell of urine and feces. A commode in the bathroom was about 1/4 full of urine, feces and toilet paper. On 2/5/25 at 11:07 AM the resident stated she had a bowel movement before breakfast. She stated staff usually come once a day to empty her commode. The resident stated she does not have an issue with the toilet being taped shut becasue she wanted a commode in her room to use anyway. On 2/5/25 at 12:51 PM entered room [ROOM NUMBER] and noted a strong smell of urine and feces. A commode in the bathroom was about 1/2 full of urine with the same feces and toilet paper from earlier observation. On 2/5/25 at 1:38 PM entered room [ROOM NUMBER] and noted a strong smell of urine and feces. A commode in the bathroom was about 1/2 full of urine with the same feces and toilet paper from earlier observation. Current observation also included more feces and more toilet paper. On 2/5/25 at 1:55 PM Staff E, Assistant Administrator stated he was unaware the toilet in room [ROOM NUMBER] had been taped shut. Staff E stated he did not know why there was a commode in room [ROOM NUMBER] either. On 2/5/25 at 1:57 PM Staff A, Licensed Practical Nurse (LPN) stated the toilet in room [ROOM NUMBER] had been taped shut by the administration. Staff A stated she did not know why room [ROOM NUMBER] had a commode but knew Resident #20 had flushed rolls of toilet paper down the toilet and kept clogging it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25 at 2:01 PM Staff N, Certified Nurse Assistant (CNA)/Restorative Aide stated Resident #20 had thrown wash cloths in the toilet and flushed them. Staff N stated she had not witnessed that but was told Resident #20 had done that. Staff N stated she did not know who taped the toilet in room [ROOM NUMBER]'s toilet shut. Staff N acknowledged that Resident #20 had a commode in her room that she had to use for toileting. Staff N stated the CNA's on the hallway were expected to empty the commode. Staff N stated when she arrived at the facility at 6 am she checked the commode before breakfast, after breakfast, before lunch, and after lunch. Staff N stated she had worked the morning shift and had not checked or emptied the toilet. Staff N stated she was working in the restorative department at time of interview. Staff N stated would expect the commode to be emptied about 6 times a shift. On 2/5/25 at 2:06 PM Staff D Certified Nurse Assistant (CNA)/Certified Medication Assistant (CMA) stated the toilet in room [ROOM NUMBER] was taped shut because Resident #20 flushed random things like washcloths, paper towels and other things. Staff D stated the Administrator taped the toilet shut. Staff D acknowledged Resident #20 used a commode for toileting. Staff D stated the CNA's emptied Resident #20's commode. Staff D stated Resident #20 would come out and tell the staff when the commode needs to be emptied. Staff D stated would usually check around lunch time to see if the commode needed to be emptied. Staff D stated she usually checked the commode before and after meals. Staff D stated she arrived at work around 11:00 am and had not emptied the commode in room [ROOM NUMBER] all day. Staff D stated the facility had never trained any expectation on care for the commode. On 2/5/25 at 2:06 PM Staff O, CNA stated the toilet in room [ROOM NUMBER] was taped shut because Resident #20 flushed random things like washcloths, paper towels and other things. Staff O stated the Administrator taped the toilet shut. Staff O acknowledged Resident #20 used a commode for toileting. Staff O stated the CNA's emptied Resident #20's commode. Staff O stated Resident #20 would come out and tell the staff when the commode needs to be emptied. Staff O stated would usually check around lunch time to see if the commode needed to be emptied. Staff O stated she usually checked the commode before and after meals. Staff O stated she arrived at work around 11:00 am and had not emptied the commode in room [ROOM NUMBER] all day. Staff O stated the facility had never trained any expectation on care for the commode. On 2/5/25 at 2:38 PM the Administrator acknowledged the toilet in room [ROOM NUMBER] was taped shut. The Administrator stated there were multiple issues with her flushing washcloths and wipes The Administrator stated when Resident #20 was in the west hall Resident #20 had backed up the toilet 4 times. The Administrator stated the facility had a plumber remove issues. The Administrator stated a company from Omaha came down with a camera and had to jet the whole wing to open it up to get everything up and clear it. The Administrator stated Resident #20 had moved to the south wing and there were washcloths and wipes and little bits of dolls in the plumbing. The Administrator stated the first time cost $2500 and 2nd time cost $1200. The Administrator stated he decided to have a commode put in Resident #20's room and had not had any problems since. The Administrator acknowledged he did not know whether that was wrong or right. The Administrator stated he would expect that the commode should be emptied several times a day. The Administrator stated he expected the commode should be emptied after each use. The Administrator stated he did not want the odor lingering. The Administrator stated checks should have been completed every 2 hours and would expect it would be emptied or addressed at that time. On 2/5/25 at 2:45 PM the DON stated she would expect that the commode would be emptied and would check it every 2 hours.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 47582 Based on staff interview, record review and facility policy review, the facility failed to make information on how to file a grievance available to the residents and make efforts to resolve complaints for 1 resident out of 8 residents reviewed. The facility reported a census of 43 residents. Findings include: During an observation on 2/3/25 at 10:24 am of the common areas, no information was posted on how to file a complaint or a grievance, including a name of the grievance official. In an interview with the Administrator on 2/3/25 at 3:00 pm he revealed the grievances forms and records were located in his office. During the review of the Grievances records, only 1 record was located in the binder filed on 1/2/25 and the section 3 for follow up comments was left blank. The Administrator confirmed the grievance was not followed up for a resolution. In a follow up interview with the Administrator on 2/6/25 at 2:34 pm he stated his expectations was that the residents had access to file grievances and he was responsible to complete and follow up on grievances. The Administrator provided a policy titled Grievance Policy revised 12/27/23 documented the following: It is the policy of this facility that resident or family concerns/grievances occurring during the resident's stay in the facility shall, whenever possible, be responded to by the designated Grievance officer or responsible Department Head closest to the cause of the concern/grievance. Regardless of which supervisor/department head responds, the Administrator or his/her authorized representative shall review all complaints and agree with the actions taken towards resolution. Actions taken to resolve the complaint shall be made within 72 hours from the time the Concern/Grievance was received.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 47673 Based on facility document review, staff interviews and clinical record review, the facility failed to implement the abuse and neglect policy by not completing background checks prior to staff employment and failing to provide annual abuse training. The facility reported a census of 43 residents. Findings include: 1. Review of the document dated 2/4/25 titled, Employee Contact List documented Staff I, Certified Nurse Assistant (CNA) was hired 7/29/24. Review of the document for Staff I titled, Single Contact License and Background Check documented background check was completed 7/25/22. On 2/6/25 at 9:44 AM Staff E, Assistant Administrator acknowledged Staff I's background check was last completed 7/25/22. Staff E stated he would expect that a background check would have been completed prior to being hired 7/29/24. On 2/6/25 at 12:21 PM the Administrator stated the facility's expectation was that a background check would have been completed prior to Staff I's employment at the facility. 47582 2. A review of the Resident #15 Electronic Health Record (EHR) titled Progress Notes documented on 1/10/25 at 8:49 am a concern was brought to the Administrator and the Director of Nursing (DON) about a staff member holding resident's hands down and forcing medications. In an interview on 2/4/25 at 3:13 pm with the alleged Staff A, Licensed Practical Nurse (LPN) confirmed putting her hands on top of Resident #15 hands during the medication administration and giving meds to the resident while the resident was refusing them. Staff A, LPN stated the Administrator did not give her any written disciplinary actions after he was notified of the incident and he did not provide any additional training on Abuse Preventions. She stated the Administrator kept her off work for 1 week and then she returned to work again and was actively providing cares to Resident #16 and to other residents. A review of Staff A, LPN, personnel file documented a hire date of 10/26/16. The file lacked documentation of annual abuse prevention training. A review of the facility provided policy titled Abuse Prevention, Identification, Investigation, and Reporting Policy revised on 11-16 documented all employees shall receive annual training related to the reporting requirements of the Elder Justice Act. In an interview with the Administrator on 2/6/25 at 2:34 pm confirmed the facility did not follow the policy to ensure all staff received annual abuse prevention training.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 47582 Based on clinical record review, staff interview, facility document review and the facility policy review, the facility failed to thoroughly investigate, prevent further potential abuse or mistreatment and report all results of allegations of abuse to the State Survey Agency within 5 working days of the incident for 1 of 6 residents reviewed (Resident #15). The facility reported a census of 43 residents. Findings include: The Minimum Data Set (MDS) for Resident #15 dated 1/16/25 documented a Brief Interview of Mental Status (BIMS) score of 06 indicating severe cognitive decline. The MDS reflected Resident #15 diagnoses of non-Alzheimer's dementia, hemiplegia (paralysis on one side of the body), seizure disorder, and ataxia following cerebral infarction (poor muscle coordination and balance after a stroke). The MDS further documented Resident #15 required total dependence on staff for performing activities of daily living. The Progress Note for Resident #15 documented on 1/10/24 at 8:49 am a concern about a staff member holding resident's hands down and forcing medications. A review of the facility reported incident (FRI) submitted to the State Survey Agency (SSA) on 1/8/25 documented an allegation of abuse witnessed by a visitor of the facility was brought to the Administrator's attention. In the FRI a corrective action described Staff A, LPN, was notified she was put on administrative leave pending abuse investigation. The Administrator failed to submit a thorough investigation of the alleged abuse to the SSA within 5 working days. The facility provided a current nursing staff schedule and Staff A, LPN, was on the schedule to work as a nurse. During an interview with the Administrator on 2/4/25 at 9:00 am he stated all information from the investigation was submitted to the SSA. Upon request to provide in-house file of the internal investigation, he provided two written witness statements of the allegations of abuse for Resident #15 and a written statement from the alleged perpetrator, Staff A, Licensed Practical Nurse (LPN). He confirmed he did not interview or screen other residents for possible abuse, he did not interview other staff and did not initiate training on Abuse prevention, to include Residents Rights to the alleged perpetrator, Staff A, (LPN) after the incident, only undocumented verbal conversation. The Administrator further revealed Staff A, LPN, was notified a week later she was able to return to work in the same role as prior to the investigation but he told her not to work with the Resident #15. He also stated Staff A, LPN, was due for a mandatory refresher course on Mandatory Reported Training but did not complete it prior to returning to work. During an interview on 2/4/25 at 3:13 pm Staff A, Licensed Practical Nurse (LPN) with 9 years of experience in the role, confirmed the Administrator put her on leave to investigate the allegation but one week later notified her verbally he completed the investigation and she was cleared to work again. Staff A, LPN, did not have verbal or written notices in regard to not providing cares to Resident #15 and was providing nursing cares to Resident #15 since returning to work. Staff A, LPN confirmed the facility did not require her to complete any training, only reminded to take Dependent adult abuse training again since she was due for it. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The review of the document titled Time Cards for Staff A, LPN, revealed she returned to work on 1/16/25. Review of the facility provided policy titled Abuse Prevention, Identification, Investigation, and Reporting Policy revised 11-16, documented the procedure: Following completion of the facility investigation, if the facility concludes that the allegations of resident abuse are unfounded, the employee will be allowed to return to job duties involving resident contact, but the employee must maintain a separation and have no contact with the resident alleged to have been abused, by reassigning the accused employee to an area of the facility where no contact will be made between the accused employee and the resident alleged to have been abused. This separation must be maintained until the Department concludes its investigation and issues the written results of its investigation. Following investigation, the Administrator or designated agent will be responsible for forwarding the results of the investigation to the Department of Inspections & Appeals. This written report shall be forwarded to the Department within five days of the initial report.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on clinical record review, policy review, and staff interviews the facility failed to represent an accurate assessment of the resident's status during the observation period of the MDS by not accurately assessing the use of insulin and antianxiety medication for 1 of 10 residents reviewed (Resident #2). The facility reported a census of 43 residents. Finding include: The Minimum Data Set (MDS) dated [DATE] for Resident #2 documented a Brief Interview for Mental Status (BIMS) score of 13 indicating no cognitive impairment. Review of Resident #2's MDS dated [DATE] documented use of insulin therapy by Resident #2. Review of Resident #2's Medication Administration Record (MAR) documented a physician's order for Ozempic 0.25 mg once a day every 7 days. Review of Resident #2's MAR documented no physician order for insulin. On 2/4/25 at 9:11 AM Staff P, Licensed Practical Nurse (LPN)/MDS Coordinator stated she had worked at the facility. Staff P acknowledged the Ozempic was identified as an insulin on Resident #2's MDS and this was a coding error. On 2/4/25 at 10:48 AM the DON acknowledged that Resident #2 was not on insulin. The DON acknowledged Ozempic coded as insulin was a coding error. The DON stated the facility's expectation was that the MDS would reflect an accurate assessment and would be coded correctly. Review of policy dated 3/23/24 titled, MDS Policy documented the MDS is a data collection system that was a correlation of data painting an accurate picture of a resident's needs, care, goals, diagnosis and plan of care.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on clinical record review, staff interview, and policy review the facility failed to complete a Pre-Admission Screening and Resident Review (PASRR) for 1 of 1 residents (Resident #3), who was diagnosed with new mental disorder diagnoses since admission to the facility. The facility reported a census of 43 residents. Findings include: Review of Resident #3's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating no cognitive deficit. The MDS further revealed diagnoses of Anxiety Disorder, Depression, and Psychotic Disorder, and Post Traumatic Stress Disorder (PTSD). The document indicated the resident took antipsychotic and antidepressant medications. Review of a facility provided document titled, The Preadmission Screening and Resident Review (PASRR) Level I Screen Outcome, dated 6/14/22 revealed a summary of findings indicating that Resident #3 that did not show evidence of a serious mental illness or an intellectual or developmental disability (IDD) that appears to require PASRR intervention. The document provided the resident had a diagnosis of anxiety disorder (current). The document revealed the resident was taking Amitriplyline 75 mg/day, Klonopin 1 mg/day, Klonopin 4 mg/day, Prozac 20 mg/day, and Trazadone 150 mg/day all for depressive disorder. The document further revealed that should there be a discrepancy in the reported information, a status change should be submitted for further evaluation. The electronic health record (EHR) revealed Resident #3 had medical diagnoses of a.) Anxiety Disorder (F41.9) 5/10/23 during stay b.) Unspecified Psychosis not due to a substance or known physiological condition (F29) 2/7/23 history c.) Other Malaise 2/7/23 (R56.9) history d.) Dizziness and Giddiness 2/7/23 (R42) history e.) Hallucinations 2/7/23 (R44.3) history f.) Alcohol Abuse, uncomplicated 5/3/21 during stay. The EHR Clinical Physician Orders documented the following orders: a.) Sinemet 10-100 mg 1 tab TID unspecified psychosis not due to substance or known physiological condition - 12/2/24 b.) Trintellix Oral Tablet 20 mg - 1 tablet bedtime Generalized Anxiety Disorder (F41.1); other specific depressive episodes (F32.89) - 8/30/24 (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c.) Clonazepam Oral 1 mg BID - restless legs d.) Seroquel Oral 25 mg (Quetiapine Fumarate) 1 tab - PTSD, primary insomnia, anxiety disorder (F41.9) -5/22/24 f.) Seroquel Oral 50 mg (Quetiapine Fumarate) 50 mg bedtime - Generalized anxiety disorder (F41.1) - 3/18/24 On 2/4/25 at 2:21 PM the Director of Nursing (DON) reviewed the documentation of the PASRR and diagnoses in the EMR for Resident #3, and acknowledged there should have been a PASRR completed with the new diagnoses added in 2023. On 2/10/25 at 11:40 AM the Administrator stated he had become aware of the PASRR concern during the survey and needed to put a process in place to ensure a PASRR was completed when new diagnoses were added by a physician. The facility policy, PASRR Policy dated 1/23/23 revealed when there is a change in mental status or behaviors the resident will be assessed for submitting a Level II PASRR. It further revealed the MDS/Care Plan Team will monitor and the DON will submit concerns.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47673 Based on clinical record review, policy review and staff interviews the facility failed to provide a comprehensive care plan that included goals, desired outcomes and interventions for use of psychotropic medication use, use of antianxiety medication, use of opioid, anticoagulant therapy and use of a diuretic for 7 of 12 residents reviewed (Resident #1, #2, #16 #23, #33, and #194). The facility reported a census of 43 residents. Finding include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #1 documented a Brief Interview for Mental Status (BIMS) score of 8 indicating moderate cognitive impairment. The MDS also documented utilization of urostomy. Review of Resident #1's Medication Administration Records-Treatment Administration Record (MAR-TAR) dated January 2025 documented a physician's order to change urostomy as needed. Review of Resident #1's Care Plan dated 12/9/23 revealed no focus, desired outcome, or intervention/task in place related to use/care of urostomy. On 2/6/25 at 2:44 PM Staff P, Licensed Practical Nurse (LPN)/MDS Coordinator acknowledged Resident #1 had no Care Plan for use or care of urostomy. Staff P stated the Care Plan should reflect a focus, desired outcome, or intervention/task in place for the use and care of the urostomy. 2. The MDS dated [DATE] for Resident #2 documented a BIMS of 13 indicating no cognitive impairment. The MDS also documented diagnoses of urine retention, essential hypertension, unspecified depression and congestive heart failure. Review of Resident #2's MAR-TAR for February 2025 documented a physician's orders for Rexulti 1mg by mouth in the morning, Furosemide 40mg by mouth daily, Escitalopram 20mg by mouth daily, and Buspirone 10mg by mouth 3 times daily. Review of Resident #2's Care Plan dated 3/22/24 revealed no focus, desired outcome, or intervention/task for use of psychotropic, antipsychotic or diuretic. On 2/4/25 at 2:55 PM Staff P acknowledged Resident #2's Care Plan did not have a focus, desired outcome, or intervention/task for use of psychotropic, antipsychotic or diuretic use. Staff P stated use of psychotropic medications and use of diuretics should have been included on the Care Plan with goals, desired outcomes and interventions. On 2/4/25 at 3:50 PM the DON stated the facility's expectation was Care Plans would have been developed with goals, desired outcomes, and interventions in place for use of psychotropic drugs and use of a diuretic. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The MDS dated [DATE] for Resident #194 documented a BIMS score of 11 indicating moderate cognitive impairment. Review of Resident #194's Care Plan dated 1/16/25 revealed no focus, desired outcome, or intervention/task for use of psychotropic/antipsychotic and use of opioid. Review of Resident #194's MAR-TAR for February 2025 documented a physician's orders for tramadol 50mg by mouth every 8 hours as needed for pain. Temazepam 7.5mg by mouth at bedtime, and escitalopram 10 by mouth daily, and buspirone 5mg three times per day. On 2/4/25 at 2:55 PM Staff P acknowledged Resident #194's Care Plan did not have a focus, desired outcome, or intervention/task for use of psychotropic, antipsychotic or opioid use. Staff P stated use of psychotropic medications and use of opioids should have been included on the Care Plan with goals, desired outcomes and interventions. On 2/4/25 at 3:50 PM the DON stated the facility's expectation was Care Plans would have been developed with goals, desired outcomes, and interventions in place for use of psychotropic drugs and use of opioids. 47582 4. The MDS for Resident #16 dated 1/16/25 identified a BIMS score of 11 indicating moderate cognitive impairment. The MDS indicated the following high-risk drug classes: antidepressant, diuretic, opioid, antiplatelet, hypoglycemic, and anticonvulsant. The MDS identified verbal behavioral symptoms directed toward others occurring at a frequency of every 1 to 3 days. Resident #16's Care Plan revised 12/8/23 documented the resident had the potential to be verbally aggressive towards staff related to poor impulse control. A desired outcome identified the resident will demonstrate effective coping skills through the review date. However, the interventions/tasks did not include the resident's target behaviors or which coping skills to implement. It also lacked non-pharmacological interventions, ordered medications or other treatments available. Review of Resident #16's Physician Orders dated 10/11/2024 identified the resident was prescribed Fluoxetine HCl Capsule 30 mg 1 capsule by mouth daily for depressive disorder. The Progress Notes revealed on 12/26/24 Resident #16 had verbal behavior towards staff, using profanity and no interventions or coping skills were offered or implemented. An Electronic Medical Record (EMR) Progress Note for Resident #16 dated 1/14/25 through 2/10/25 monitoring of Behavior Symptoms did not identify any behaviors in the past 30 days. 49628 5. The MDS for Resident #23 dated 11/25/24 identified a BIMS score of 12/15 indicating a moderative cognitive impairment. The MDS included diagnoses of hypertension, cerebrovascular accident, paraplegia, and personal history of other venous thrombosis and embolism. It revealed the resident was provided antiplatelet medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Electronic Medical Record (EMR) Physician Orders dated 1/23/25 revealed the resident was prescribed Aspirin EC Low Dose oral tablet delayed release 81 mg 1 time daily related to personal history of pulmonary embolism with a start date of 9/26/24. Resident #23's Care Plan revised 2/3/25 revealed a focus for antiplatelet therapy related to history of pulmonary embolism with an initiation date of 12/8/23. The goal for the focus area revealed the resident would be free from adverse reactions to anticoagulant medication. The interventions/tasks referenced anticoagulant medication. The facility failed to develop a Care Plan with goals and interventions related to antiplatelet medication. On 2/10/25 the MDS Coordinator stated that both she and the Director of Nursing (DON) completed the nursing portions of the Care Plan. The MDS Coordinator indicated that the goals and interventions should relate back to the focus area, and in the case of an antiplatelet medication the goal and intervention(s) should relate to antiplatelet medication not anticoagulant. 6. The MDS for Resident #33 dated 12/26/24 identified a BIMS score of 8/15 indicating moderate cognitive impairment. The MDS included diagnoses of Non-Alzheimer's Dementia and depression. It identified a lack of pleasure/interest in doing things for 2-6 days of the reporting period. It did not identify indicators of psychosis. It revealed the resident exhibited behavioral symptoms towards others occurring 1-3 days, verbal behaviors towards others 4-6 days, and other behavioral symptoms not directed towards others for 1-3 days. The document revealed the resident refused cares for 4-6 days. The MDS identified Resident #33 took antipsychotic and antidepressant medications during the last 7 days of the assessment period. The Electronic Medical Record (EMR) Physician Orders dated 2/4/25 identified the resident was prescribed a.) Zyprexa (Olanzapine) 5 mg 1 tablet daily for mood stabilizer related to Vascular Dementia, unspecified severity with other behavioral disturbance. b.) Namenda (Memantine HCl) 10 mg 2 times daily related to Vascular Dementia, unspecified severity with other behavioral disturbance. c.) Donepezil HCl 10 mg 1 time daily related to Vascular Dementia, unspecified severity with other behavior disturbance. d.) Lexapro (Escalitopram Oxalate) 10 mg 1 time daily related to Major Depressive Disorder, recurrent, unspecified. The EMR Progress Notes dated 4/24/24 - 2/9/25 revealed behaviors including refusal of care, yelling, and hitting at staff members and family. Resident #33's Care Plan revised 2/3/25 included psychotropic medications related to major depressive disorder. A goal identified remaining free of drug related interactions. The interventions/tasks did not include the resident's individualized target behaviors of depression. The Care Plan failed to identify a focus area related to the resident taking antidepressant medications related to Major Depressive Disorder, as well as psychotropic medications prescribed for the diagnosis of Vascular Dementia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/25 at 1:57 PM the MDS Coordinator stated the medications should be on the Care Plan, and what the interventions and side effects were. The staff stated the target behaviors for a resident should be identified. On 2/4/25 at 2:15 PM the DON stated the facility utilized the pharmacist for completion of Care Plans related to which individual was on psychotropic medications, the audit tools needed, and completion of the Assurance and Improvement in Medication Safety (AIMS). The DON indicated some Care Plans may identify behaviors for residents, but it was not consistent. Additionally the DON stated there would not be target behaviors within each medication focus area. The facility policy, Resident Information to be Used for Care Plan, dated 1/24/23 revealed that all pertinent information was considered for the development of the Care Plan. The document revealed sources to develop the Care Plan including medications with the proper diagnosis and side effects. The document neither included the use of target behaviors related to psychotropic medications, or ensuring the goal and interventions directly related to the identified focus area.

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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** 47582 Based on clinical document review, staff interview, and facility policy review the facility failed to update care plans in a timely manner to reflect the resident's condition for 3 of 5 residents (Resident #19, #23, and #33) reviewed. The facility reported a census of 43 residents. Finding include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #19 documented a significant change in status and hospice care program. Review of Resident #19's Care Plan lacked significant change to include hospice care or end of life care and interventions. In an interview on 2/6/25 at 3:05 pm the Director of Nursing (DON) stated her expectation was that Resident #19's Care Plan would have been updated at the time to reflect hospice services. 49628 2. The MDS for Resident #23 dated 11/25/24 identified a BIMS score of 12/15 indicating a moderate cognitive impairment. The MDS included diagnoses of hypertension, cerebrovascular accident, paraplegia, diabetes mellitus, and personal history of other venous thrombosis and embolism. It revealed the resident had an open lesion(s) on the foot, and other open lesion(s) other than ulcers, rashes or cuts. It also revealed the application of dressings to the feet. The document revealed the resident utilized a motorized scooter with independence for 150 feet. Resident #23's Electronic Medical Record (EMR) Clinical Medical Diagnoses included acquired absence of the left leg below the knee, Resident #23's Clinical Physician Orders dated 1/23/25 revealed an order dated 1/23/25 for the resident's dressing to remain in place for 1 week, and covered for showers. The order also included the resident was to wear an off-loading boot at all times. An order dated 1/9/25 indicated the resident would wear an off-loading boot to the right foot. An order dated 12/4/24 revealed no whirlpool or tub baths until the foot wound heals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #23's Care Plan revised 2/3/25 revealed a focus area of wound management initiated and revised on 12/8/23. The interventions initiated on 12/8/23 revealed use of antibiotics, monitoring the ulcer for signs of infection, progression or declination, and providing wound care per order. The ADL self-care focus area initiated and revised 12/8/23 revealed interventions for staff including total dependence for bath/shower dated 12/8/23, dressing assistance for staff to pull up pants and brief revised 2/3/25, and transfers with total assistance using a mechanical non weight bearing lift revised 2/3/25. The document contained a focus area of having acute/chronic pain related to diabetic neuropathy, left leg amputation below the knee, and wound infection on back initiated and revised 12/8/23. The fall risk focus related to the left below the knee amputation and contracture of the right lower extremity revised 12/8/23 had an intervention related to the use of the scooter and an extended call light revised 12/8/23, and reminder to turn the scooter off before transfers revised 12/8/23. The document also revealed a focus area related to impaired cognitive loss revised 12/5/23. The facility failed to document in the Care Plan the physician orders to not remove the right foot dressing, and to cover the bandages for showers. The facility did not include the intervention of the resident being seen by the wound clinic for management of the right foot. The failure of Care Plan revision to interventions extended to wearing an off-loading boot to the right foot at all times. The facility failed to include the order for no whirlpool or tub baths in the self care/ADL interventions. Additionally the Care Plan failed to include a focus area related to scooter mobility and the interventions the facility had completed after an incident involving another resident. On 2/5/25 at 11:36 AM and on 2/10/25 at 10:00 AM the MDS Coordinator stated she and the Director of Nursing (DON) completed the nursing portions of the Care Plans. The staff stated the resident had a history of not always aware of safety in the environment. The MDS Coordinator acknowledged that if there were specific interventions regarding the powered mobility it should be on the Care Plan. The staff stated she was not aware of what specific modifications were done to the scooter, but that the Administrator and Maintenance had completed them. On 2/5/25 at 3:05 PM the Administrator stated the resident had been driving his scooter quickly in the halls and had not responded to verbal redirection. The Administrator stated a governor had been placed on the scooter to control the speed. The Administrator stated he did not know the interventions to monitor the speed and safety of the resident's safe use of the scooter. On 2/10/25 at 10:00 AM the MDS Coordinator stated if a resident had orders for a specific treatment regarding wounds then it should be reflected on the Care Plan. The MDS coordinator stated in the example of a wound care boot if it was ordered then it should be on the Care Plan. 3. The MDS for Resident #33 dated 12/26/24 identified a BIMS score of 8/15 indicating moderate cognitive impairment. The MDS included diagnoses of Non-Alzheimer's Dementia and depression. The document revealed the resident was dependent for toileting hygiene, and lower body dressing. The resident required partial to moderate assistance for sit to stands, chair/bed to chair transfers, toilet transfers, and walking distances up to 10 feet. The document revealed the use of bed and chair alarms used daily. The MDS revealed the resident had 2 or more falls without injury, 1 fall with injury (except major), and no falls with major injury. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #33's Care Plan revised 2/3/25 revealed a focus area for risk of falls related to confusion, gait/balance problems, psychoactive drug use and vision/hearing problems revised 12/23/23. The interventions for staff included pressure pad alarm at all times revised 12/18/23, and the use of bed/chair alarm in place as needed revised 11/2/23. A focus area related to actual fall with injury initiated 5/2/24 and revised 9/19/24 revealed interventions for staff including ghost alarm added to recliner and alarm to stay in dining chair initiated 6/10/24 and revised 12/13/24, nurses to check alarms every shift and staff education on alarm placement initiated 9/9/24. The facility failed to revise the Care Plan interventions to include instructions for staff to follow when the alarm fails or if there was a failure of the call light system. On 2/4/25 at 8:26 AM the Administrator acknowledged there were concerns with the call light system since mid December and it did not function properly all the time. The Administrator stated sometimes it is random rooms that do not work and other times it is an archive situation and all the call lights were affected. The Administrator stated they became aware of the system not working when the residents reported to staff their call lights had been on, and staff would report that the alerts were not going across the radios. On 2/4/25 at 3:00 PM the DON stated if the call system went down the resident would be switched from a ghost alarm to a pressure pad alarm. On 2/5/25 at 11:15 AM Staff G, Certified Nursing Assistant (CNA), acknowledged the ghost alarm was attached to the call light system and probably would not work if the call lights didn't. On 2/6/25 at 2:32 PM the DON concurred the ghost alarm was attached to the call light system, and if the call lights were not working the ghost alarm would not function properly. The facility's policy, Resident Information to be Used for Care Plan, dated 1/24/23 revealed pertinent information to be utilized to generate the Care Plan. Information to be utilized included fall history with interventions, access to incident report, resident information book, and behaviors. The policy did not include procedures for when to update the Care Plan.

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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** 47673 Based on clinical record review, family interview and staff interviews, the facility failed to enter physician's orders into the electronic health record (EHR) and follow physician orders for a resident with an order to wear a mitt/glove for 1 of 8 residents (Resident #22) reviewed. The facility reported a census of 43 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #22 documented a Brief Interview for Mental Status score as rarely/never understood indicating severe cognitive impairment. The MDS also documented use of a gastrostomy tube. On 2/3/25 at 1:20 PM Resident #22's mother stated she brought Resident #22 mitts but the facility told her that the mitt was seen as a restraint. Resident #22's mother stated Resident #22 never had the mitt on when she came to the facility. Resident #22's mother stated she bought Resident #22 three pairs of mitts. Review of the document dated 10/30/24 titled Physician's Order documented to place a mitt/glove on the right hand daily. Remove for hygiene and range of motion at least twice daily. Noted by Staff Q, Registered Nurse (RN) on 11/4/24 at 10:35 AM. Review of the Treatment Administration Record for February 2025 revealed no physician's order entered for mitt/glove use. Review of Resident #22's EHR titled, Progress Notes dated 11/4/24 at 10:33 AM by Staff Q, documented a signed order from Resident #22's primary care physician to place a mitt/glove on right hand daily. Remove for hygiene and range of motion at least twice daily. Mitts are to be supplied by the family. Order entered into EHR, POA notified, and Director of Nursing (DON) updated. Review of Resident #22's EHR titled, Progress Notes dated 11/4/24 at 10:33 AM by Nurse Staff R, Licensed Practical Nurse (LPN) documented Resident #22 does not like the mitt on his hand. On 2/6/25 at 8:15 AM Staff P, MDS Coordinator stated the staff had put the mitt on him once that she could recall. On 2/6/25 at 8:43 AM the DON acknowledged Resident #22 had worn the mitt/glove at least once. The DON acknowledged the order for a mitt/glove for Resident #22 was not entered into the EHR. The DON stated she would have expected the order to be entered into the EHR. The DON acknowledged an assessment should have been completed twice a day and was not when Resident #22 had the glove on. The DON stated that Resident #22's mother wanted him to have a glove to prevent him from pulling out his peg tube. The DON stated Resident #22 hates the glove and will refuse the glove frequently.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tabor Manor Care Center	209 Main Street Tabor, IA 51653

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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 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** 47673 Based on observation, clinical record review, family interview, staff interviews and facility protocol review the facility failed to provide quality of nursing care by not completing an assessment related to the use of a restraint that was ordered by the physician for 1 of 3 residents reviewed (resident #22). The facility reported a census of 43 residents. Finding include: The Minimum Data Set (MDS) dated [DATE] for Resident #22 documented a Brief Interview for Mental Status score as rarely/never understood indicating severe cognitive impairment. The MDS also documented use of a gastrostomy tube. On 2/3/25 at 1:20 PM Resident #22's mother stated she brought Resident #22 mitts but the facility told her that the mitt was seen as a restraint. Resident #22's mother stated Resident #22 never had the mitt on when she came to the facility. Resident #22's mother stated she bought Resident #22 three pairs of mitts. Review of the document dated 10/30/24 titled Physician's Order documented to place a mitt/glove on the right hand daily. Remove for hygiene and range of motion at least twice daily. Noted by Staff Q, Registered Nurse (RN) on 11/4/24 at 10:35 AM. Review of Resident #22's EHR titled, Progress Notes dated 11/4/24 at 10:33 AM by Staff Q, documented a signed order from Resident #22's primary care physician to place a mitt/glove on right hand daily. Remove for hygiene and range of motion at least twice daily. Mitts are to be supplied by the family. Order entered into EHR, POA notified, and Director of Nursing (DON) updated. On 2/6/25 at 8:15 AM Staff P, Licensed Practical Nurse (LPN) MDS Coordinator stated she completely forgot to have the mitt evaluated with Resident #22's order and the assessment was not completed. Staff P acknowledged that a restraint assessment should have been completed because Resident #22 could not take the mitt off on his own. On 2/6/25 at 8:43 AM the DON acknowledged Resident #22 had worn the mitt/glove at least once. The DON acknowledged the order for a mitt/glove for Resident #22 was not entered into the EHR. The DON stated she would have expected the order to be entered into the EHR. The DON acknowledged an assessment should have been completed twice a day and was not when Resident #22 had the glove on. The DON stated that Resident #22's mother wanted him to have a glove to prevent him from pulling out his peg tube. The DON stated Resident #22 hates the glove and will refuse the glove frequently. The DON acknowledged that an evaluation/assessment should have been completed by an occupational therapist. On 2/6/25 at 3:15 PM Staff S, Contract Occupational Therapist stated he had never seen Resident #22 for an assessment/evaluation. Staff S stated if Resident #22 was unable to remove the mitt on his own then an evaluation/assessment should have been completed because the mitt would have been seen as a restraint. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of protocol updated 2/10/16 titled, Protocol For Use of Physical Restraints And Assessment For Least Restrictive Devices By Therapist documented in the case in which a resident was a high risk for a fall or safety was a concern because all other interventions had been utilized and failed, and / or the facility feels a fall is imminent, the facility may implement the use of a restrictive device while requesting an order from the physician for the use and evaluation of the device. The facility will contact the Power Of Attorney (POA) of the resident prior to initiation of a restrictive device. Whenever the safety of a resident is determined to be at risk a screening shall be completed quarterly by a licensed therapist or care plan team to determine the least restrictive device to be used. A CNA will electronically sign that the resident's restraint had been released and the resident repositioned approximately every 2 hours while using the restraint.

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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** 49628 Based on observations, clinical record review, staff interviews, and policy review the facility failed to protect residents from accidents and injuries for 2 of 2 residents (Resident #33, and #193) reviewed for falls. Resident #33 fell on [DATE] and sustained a right greater tuberosity of humerus fracture (right upper arm) when his alarm failed to go off alerting staff that he had gotten up without staff assistance. Resident #193 fell on [DATE] when he got up out of bed and walked across his room without staff assistance, fell , and sustained a left intertrochanteric fracture (left hip fracture). The facility reported a census of 43. Findings include: 1. The Minimum Data Set (MDS) for Resident #33 dated 7/29/24 identified a Brief Interview of Mental Status (BIMS) score of 7/15 indicating severe cognitive impairment. The MDS included diagnoses of Non-Alzheimer's Dementia and depression. The document revealed the resident was substantial assistance for toileting hygiene and lower body dressing. The resident required partial to moderate assistance for sit to stands, chair/bed to chair transfers, toilet transfers, and walking distances up to 50 feet. The document revealed the use of bed and chair alarms used daily. The MDS revealed the resident had 1 fall without injury, and no falls with injury or major injury. Resident #33's Care Plan revised 2/3/25 revealed focus areas for risk for falls and actual falls with injury. The document revealed the interventions at the time of the fall on 9/18/24 included pressure pad alarm at all times (12/13/23), call light within reach at all times and prompt response (11/2/23), ghost alarm to be added to the recliner and alarm to stay in the dining chair (6/10/24), and nurses to check alarms every shift and staff re-education on alarm placement (9/9/24). The Care Plan identified an ADL self-care performance focus with interventions at the time of the fall with transfers requiring the assistance of 2 staff and a walker (11/1/23), toileting with the assistance of staff and staff to perform peri care as needed (11/1/23), and dressing with minimal assistance for the upper body and staff to assist with the lower body (11/1/23). The Morse Fall Scale assessment dated [DATE] revealed a score of 80. A score above 45 indicated a high risk for falls. The Electronic Medical Record (EMR) revealed there was no documentation of the alarms being checked every shift by the nurses to ensure they were functioning from 9/9/24 to 2/5/25. The Risk assessment dated [DATE] revealed the resident sustained an unwitnessed fall in his bedroom. The document revealed the chair alarm did not go off. Intervention from the fall was nurses to check the alarm system and placement every shift, and staff re-education. The Emergency Department (ED) Summary dated 9/18/24 revealed the resident seen for an unwitnessed fall with chief complaint of right hip pain, right shoulder pain, resident holding his head and in a c-collar, and has a skin tear to his left wrist. The discharge diagnosis from the ED was charted as greater tuberosity of humerus fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Orthopedic Note dated 9/20/24 revealed the resident is no weight bearing to his right upper extremity, may remove the sling for elbow, wrist and hand range of motion and hygiene. Observations of Resident #33 revealed the following: -On 2/4/25 at 10:00 AM the resident lying in bed with an alarm cord visible, and 1 alarm on the dining chair. No alarm on the recliner. -On 2/4/25 at 1:56 PM an alarm present on the dining chair, no alarm on the recliner. -On 2/5/25 at 11:15 AM a ghost alarm on the dining chair and no alarm on the recliner. -On 2/6/25 at 10:45 AM a ghost alarm on the dining chair and no alarm on the recliner. -On 2/6/25 at 2:35 PM with the Director of Nursing (DON) a ghost alarm on the dining chair and no alarm on the recliner. On 2/4/25 at 3:00 PM the DON stated the resident's alarm did not go off on 9/18/24. The DON stated the resident had both audible and ghost alarms. The staff stated the resident had a ghost alarm in his recliner, a pressure pad alarm in his dining chair, and a pressure pad alarm in his bed. The DON stated the alarms were checked twice weekly by the restorative nurse and maintenance. The staff stated it was everyone's responsibility to make sure the alarms were working, and to notify nursing if they were not. The DON stated the ghost alarm is attached to the call light system, and if the system were to go down the resident would be switched to a pressure pad alarm. On 2/5/25 at 1:25 PM the DON stated the Care Plan did not have interventions related to the failure of an alarm as it was part of the policy and everyone knew what to do. The DON stated there was never an instance on overnights or weekends when there was not at least 1 regular staff on duty who would know what to do. On 2/5/25 at 3:00 PM the DON acknowledged she was not aware of an intervention on the Care Plan related to nursing completing alarm checks every shift and did not know about the documentation. On 2/6/25 at 10:53 AM the MDS Coordinator acknowledged that documentation had not been completed for the alarm checks, and the checks were not completed. The staff stated there wasn't a link developed to place it in the EMR for documentation. The MDS Coordinator concurred that according to an intervention on the Care Plan the resident should have 2 separate alarms for his chairs - 1 ghost alarm for the recliner and an alarm for the dining chair. On 2/6/25 at 2:32 PM the DON reviewed the Care Plan and indicated there should be a ghost alarm on the recliner and an alarm on the dining room chair. The DON observed the Resident #33's room and chair alarms, and concurred there were not 2 separate alarms as per the Care Plan intervention; there was a ghost alarm on the dining chair and no alarm present on the recliner. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. The MDS for Resident #193 dated 1/24/25 identified a BIMS score of 8/15 indicating moderate cognitive impairment. The document revealed diagnoses that included: urinary tract infection, white matter disease, unspecified, and mild cognitive impairment of uncertain or unknown etiology. It further disclosed the resident required partial/moderate assistance for dressing, and supervision or touching assistance for toileting hygiene, toilet transfers, and walking distances up to 150 feet. The document indicated the resident utilized a walker during the previous 7 days. The MDS also documented the resident had fallen in the last month. The Baseline Care Plan dated 1/22/25 in the Assessment tab of the EMR was not completed and did not contain interventions or assistance levels related to self care, mobility or mobility devices. The Baseline Care Plan also lacked any safety risks or interventions related to his history of falls. The Morse Fall Scale assessment dated [DATE] revealed a score of 80. Any score above 45 indicated a high risk for falls. The Care Plan dated 2/5/25 revealed a focus related to ADL self-care performance deficit was initiated on 2/2/25 and had a revision of 2/5/25. The interventions did not provide instructions for direct care staff for assistance for toileting, transfers, or use of side rails until 2/5/25. The document contained a focus area related to impaired cognitive function or impaired thought process initiated 1/23/25 with interventions of supervision with all decision making, and task segmentation to support short term memory deficits. The Care Plan revealed a moderate risk for falls focus with interventions including call light within reach at all times with prompt response, and use of appropriate footwear initiated on 1/23/25. The Physical Therapy (PT) Evaluation dated 1/24/25 identified decreased safety with ambulation demonstrated by forgetting to use a walker and bringing his catheter, increasing his risk for falls. The PT Notes dated 1/24/25 to 2/4/25 revealed focus of therapy included strengthening, dynamic balance, endurance, safety education and ambulation. The entry on 2/3/25 indicated the resident required the use of a front wheeled walker and close standby assistance (SBA), the resident was within arm's reach. The 2/3/25 entry further revealed the resident transferred with contact guard assistance (CGA), hands on assistance, with cues required for use of the front wheeled walker (FWW) and safety. Occupational Therapy (OT) Evaluation dated 1/23/25 identified the resident required CGA for toileting, hygiene/grooming, and functional mobility (ambulation) during ADLs. It further revealed decreased standing dynamic balance and safety. OT Notes dated 1/23/25 to 2/4/25 revealed focus of therapy included safety training during transitional movements, dynamic reaching activities in standing position, and ADLs. The note dated 1/31/25 indicated Resident #193 required CGA assistance during dynamic standing activities. A PT Note provided by the facility dated 1/29/25 revealed during the Medicare Meeting the Clinical Team discussed a trial of removing the bed and chair alarms for the resident as he was demonstrating increased agitation and decreased non-compliance with all transfers and mobility. It revealed the staff was in agreement. A recommendation was made for Speech Therapy order to address memory and cognition. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the EMR revealed an order dated 1/29/25 for Speech Therapy to evaluate and treat. The record lacked any documentation of Speech Therapy starting and lacked any other interventions being put into place when the alarms were removed. The EMR Progress Notes dated 1/22/25 to 2/5/25 revealed the resident ambulated with a walker and SBA. The Risk assessment dated [DATE] at 11:00 PM revealed Resident #193 sustained an unwitnessed fall in the resident's bedroom. The document revealed the resident did have gripper socks on his feet and his walker nearby. It indicated the resident had stated he was using his walker to get up and turn a light on over his sink. The document identified poor lighting with the resident exhibiting predisposing confusion and gait imbalance. The EMR Point of Care documented care provided by staff on 2/4/25 at 8:37 PM for limited assistance of transfers. The record lacked any documentation of care provided after 8:37 PM. On 2/5/25 at 11:25 AM the Administrator stated Resident #193 sustained a nonwitnessed fall the previous night and sustained a hip fracture. The Administrator stated therapy had wanted the resident independent in his room. The Progress Notes for Resident #193 documented the following: On 2/5/25 at 3:40 AM this nurse notified of resident unwitnessed fall with hip pain on 2/4/25 at 11:14 AM. On call doctor notified and obtained order to send the resident to the hospital. On 2/5/25 at 5:52 AM notified by hospital that the resident was admitted with left hip fracture and ortho was to evaluate. On 2/6/25 at 8:13 AM Staff Y, Certified Occupational Therapy Assistant (COTA), revealed he was a contract therapist for the facility. The staff stated the focus of OT included safety, balance, weight shifting, and functional mobility. The staff stated on 2/4/25 during treatment the resident required CGA for dynamic balance tasks with reaching outside away from the body. On 2/6/25 at 9:46 AM Staff Z, Certified Nurse Assistant (CNA), stated Resident #193 required SBA for ambulation. The staff stated the resident would stand up and move around his room whether he had an alarm or not. On 2/6/25 at 9:51 AM Staff N, CNA/Restorative Aide (RA), stated the resident required SBA for ambulation to the dining room using a walker, the distance is approximately 350 feet. The staff stated the resident would stand with or without the alarm present. Staff N stated that upon standing the resident would take off and walk using the walker. On 2/6/25 at 2:41 PM the DON stated the Baseline Care Plan was utilized until the actual Care Plan was developed. The DON concurred the Care Plan was opened on 1/23/25, and neither the Baseline Care Plan nor the Care Plan provided interventions for staff regarding the resident's transfer abilities until 2/5/25. The DON further concurred the assistance level placed on the Care Plan on 2/5/25 indicated the resident was independent by therapy recommendation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/6/25 at 3:15 PM Staff S, Occupational Therapist Registered (OTR), revealed was a contract therapist for the facility. Staff S stated during his treatment with the resident on 1/28/25 the resident had staggering balance in standing when challenged. The staff stated the resident required CGA>SBA for standing and mobility using the FWW. On 2/6/25 at 4:07 PM Staff AA, Physical Therapist Assistant (PTA)/Program Coordinator (PC), revealed she was a contract therapist for the facility. The staff stated the resident was admitted to the facility for skilled therapy services. The staff stated treatment emphasized strengthening, leg exercises, walking, safety, balance, endurance. Staff AA stated the resident was discussed at the weekly Medicare Meeting on 1/29/25. The staff stated the Medicare Team, which is the clinical team, meets weekly to discuss the residents. The staff stated during the Medicare Meeting on 1/29/25 the clinical team decided to discontinue the bed and chair alarms as they were not effective in preventing the resident from standing and moving around in the room. Additionally Staff AA stated she had observed the resident exhibit signs of agitation with the alarms during therapy by punching the bed when the alarm sounded. Staff AA stated CNAs were part of the team decision to trial no alarms in the room. The staff stated the decision by the team was a 48 hour trial beginning on Wednesday the 29th, and there were no concerns raised during the 48 hour trial. The staff stated the therapy department did not recommend the resident be independent in his room, but discontinue the alarm. On 2/10/25 at 10:10 AM the MDS Coordinator stated the Baseline Care Plan should reflect the resident's ability to transfer within the ADLs portion of the Care Plan. The staff stated the Care Plan should provide information for staff on the resident's assistance needs. The MDS Coordinator stated during the Medicare Meeting it was discussed discontinuing the use of the alarms due to therapy stating it caused increased agitation, and the alarms did not stop the resident from standing or moving around in his room. The MDS Coordinator stated the resident was considered contact guard at a minimum for transfers and ambulation. The staff stated the resident had not been made independent for mobility and transfers. On 2/10/25 at 10:12 AM the Certified Dietary Manager (CDM) stated the alarms for Resident #193 had been discontinued but the resident continued to require assistance for transfers and ambulation. The facility's policy, Resident Information to be Used for Care Plan, dated 1/24/23 revealed sources for generating the Care Plan. The document did not contain information regarding the updating the Care Plan, development of the Baseline Care Plan within 48 hours, or use of the MDS/Resident Assessment Instrument.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on employee file review, staff interviews, State Agency website, and facility policy review the facility failed to ensure that a hired nurse aide that had worked longer than 4 months had completed a training and competency evaluation program approved by the state. The facility reported a census of 43 residents. Findings include: Review of the document dated 2/4/25 titled, Employee Contact List documented Staff I, Certified Nurse Assistant (CNA) was hired 7/29/24. Review of Staff I's employee files revealed no CNA certificate. No proof that Staff I had completed a training and competency evaluation program, a competency evaluation program approved by the State or that Staff I had been deemed or determined competent as a CNA by an approved source. A review of the State Agency (SA) website titled, Direct Care Worker Registry and Health Facility Database documented Staff I's status with CNA certification as no test, currently employed as no, and certification date/expiration date as blank. On 2/6/25 at 9:38 AM Staff J Administrative Assistance stated the facility should report that a CNA was employed at the facility to the SA website and ensure that CNA was certified. Staff J stated if the forms are provided that both the skills test and the written test are provided and they have passed can keep these copies and ask the skills program to report the completion to the SA. Staff J stated she had worked at the facility since July 31, 2024 and trained for all of August 2024. Staff J stated she realized that Staff I was not in the CNA registry last month. On 2/6/25 at 9:44 AM Staff E, Assistant Administrator stated someone at the facility should have reached out to the SA to send the forms and informed the instructor the staff had tested with at the college. Staff E stated Staff I currently worked on the floor as a CNA. Staff E stated in June when Staff I returned to the facility her license had lapsed because she had not worked in 2 years. Staff E stated the facility had a time clock that said she worked about a year and a half ago. Staff E stated in 2023 Staff K, Previous Administrative Assistant noticed Staff I did not have a CNA certificate and started an email to send with the report of work for Staff I in the last 24 months. Staff E stated the concern was passed on after Staff K stopped working at the facility to Staff L, Previous Administrative Assistant. Staff E explained that the concern was never followed up with by Staff L. Staff E stated Staff I tested on ,d+[DATE] and 8/24. Staff E stated at 11:07 am 8/6/25 a message was sent to the college inquiring when the written and skills test was completed. Staff E stated Staff I was now documented on the SA website as certified as of 8/8/24. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/6/25 at 12:21 PM the Administrator acknowledged Staff I's certification was a previously identified concern. The Administrator stated the facility should have checked within the first 4 months of employment to ensure Staff I was certified. The Administrator stated the facility should have checked with the college to ensure the test was uploaded to the SA website. The Administrator acknowledged the facility did not have a competency test or written test for Staff I, and should have had these tests to prove she was certified. Review of the policy titled, Verification of Licensed Personnel dated 6/2/22 documented CNA's would be used as environmental aides until staff can complete the course and successfully pass the course and the written and skills test. Upon verification of licensed CNA's upon hiring process and verification of successfully passing the course and testing, the CNA will be utilized on the floor. The facility would give the college 5 days to upload this data to the Nurse Aide Registry. In the event it is not showing up on the registry, the college would be contacted on the completion of this action.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on clinical record reviews, staff interviews, and policy review, the facility failed to identify target behaviors for psychotropic medication use for 5 of 5 residents reviewed (Resident #33, #16, #2, #22 and #194). The facility reported a census of 43 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #33 dated 12/26/24 identified a BIMS score of 8/15 which indicated moderate cognitive impairment. The MDS included diagnoses of Non-Alzheimer's Dementia and depression. It identified a lack of pleasure/interest in doing things for 2-6 days of the reporting period. It did not identify indicators of psychosis. It revealed the resident exhibited behavioral symptoms towards others occurring 1-3 days, verbal behaviors towards others 4-6 days, and other behavioral symptoms not directed towards others for 1-3 days. The document revealed the resident refused cares for 4-6 days. The MDS identified Resident #33 took antipsychotic and antidepressant medications during the last 7 days of the assessment period. Review of Resident #33's Electronic Medical Record (EMR) Physician Orders dated 2/4/25 identified the resident was prescribed a.) Zyprexa (Olanzapine) 5 mg 1 tablet daily for mood stabilizer related to Vascular Dementia, unspecified severity with other behavioral disturbance. b.) Namenda (Memantine HCl) 10 mg 2 times daily related to Vascular Dementia, unspecified severity with other behavioral disturbance. c.) Donepezil HCl 10 mg 1 time daily related to Vascular Dementia, unspecified severity with other behavior disturbance. d.) Lexapro (Escalitopram Oxalate) 10 mg 1 time daily related to Major Depressive Disorder, recurrent, unspecified. The Physician Orders failed to include target behaviors for each psychotropic medication order. The Progress Notes dated 4/24/24 - 2/9/25 identified behaviors of care refusal, and yelling and hitting at staff members and family. Resident #33's Care Plan revised 2/3/25 included psychotropic medications related to major depressive disorder. A goal identified remaining free of drug related interactions. However, the interventions/tasks did not include the resident's target behaviors of depression. The Care Plan failed to identify a focus area related to the resident taking antidepressant medications related to Major Depressive Disorder, as well as psychotropic medications prescribed for the diagnosis of Vascular Dementia. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/25 at 2:15 PM the Director of Nursing (DON) stated the target behaviors for medications were not included in the orders but diagnoses were identified. The facility did not provide a policy related to orders, medications, and target behavior identification. 47582 2. The MDS for Resident #16 dated 1/16/25 identified a BIMS score of 11 indicating moderate cognitive impairment. The MDS indicated high-risk drug class: antidepressant. The MDS did not list a diagnoses depressive disorder. The MDS identified verbal behavioral symptoms directed toward others occurring at a frequency of every 1 to 3 days. Review of Resident #16's Physician Orders dated 10/11/2024 identified the resident was prescribed Fluoxetine HCl Capsule 30 mg 1 capsule by mouth daily for depressive disorder. Resident #16's Care Plan revised 12/8/23 documented the resident had the potential to be verbally aggressive towards staff related to poor impulse control. A desired outcome identified the resident will demonstrate effective coping skills through the review date. However, the interventions/tasks did not include the resident's target behaviors or which coping skills to implement. It also lacked non-pharmacological interventions, ordered medications or other treatments available. The Care Plan did not list a diagnosis of Depressive disorder, prescribed antidepressant or side effects management. The Progress Notes revealed on 12/26/24 Resident #16 had verbal behavior towards staff, using profanity and no interventions or coping skills were offered or implemented. An Electronic Medical Record (EMR) Progress Note for Resident #16 dated 1/14/25 through 2/10/25 monitoring of Behavior Symptoms did not identify any behaviors in the past 30 days. 47673 3. The MDS dated [DATE] for Resident #2 documented a Brief Interview for Mental Status (BIMS) score of 13 indicating no cognitive impairment. Review of Resident #2's MAR-TAR documented a physician's orders for Rexulti 1mg by mouth in the morning for mood related to depression, Escitalopram 20mg by mouth daily for depression, and Buspirone 10mg by mouth 3 times daily for anxiety. Review of Resident #2's Care Plan revealed no focus, desired outcome, or intervention/task for use of psychotropic, antipsychotic and antianxiety medications and their respective target behaviors. The Physician Orders failed to include target behaviors for each psychotropic medication order. 4. The MDS dated [DATE] for Resident #22 documented a BIMS score as rarely/never understood indicating severe cognitive impairment. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #22's MAR-TAR documented a physician's orders for quetiapine fumarate 12.5mg daily via enteral tube and 25mg twice daily via enteral tube for vascular dementia with other behavioral disturbances. Review of Resident #22's Care Plan revealed no target behaviors for use of psychotropic and antipsychotic. The Physician Orders failed to include target behaviors for each psychotropic medication order. 5. The MDS dated [DATE] for Resident #194 documented a BIMS of 11 indicating moderate cognitive impairment. Review of Resident #194's MAR-TAR documented a physician's orders for Temazepam 7.5mg by mouth at bedtime for sleep, and escitalopram 10 by mouth daily for other specified anxiety disorders, and buspirone 5mg three times per day for other specified anxiety disorders. Review of Resident #194's Care Plan revealed no focus, desired outcome, target behaviors or intervention / task for use of psychotropic / antipsychotic medications. The Physician Orders failed to include target behaviors for each psychotropic medication order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47582 Based on observations, staff interviews, pharmacy documentation review and facility policy review, the facility failed to ensure all drugs and biologicals used in the facility are labeled in accordance with professional standards, including expiration dates and with appropriate accessory and cautionary instructions. The facility reported a census of 43 residents. Findings include: 1. During a medication administration observation on 2/5/25 at 7:21 am, Staff B, Registered Nurse (RN) verified a medication against the Medication Administration Record (MAR) for a resident on hall 100. The MAR order directed the medication of insulin injection of 20 units. The insulin pen labeled with the resident's name and read 12 units of insulin to be injected. When asked to verify if the MAR and the insulin pen labels matched, Staff B, RN, stated they don't look at the labels, only in the MAR and she was surprised the label was still attached to the insulin pen because they often just fall off. She didn't read the label prior to using the insulin pen and wasn't aware the dose on the label had a different dosage ordered. During an interview with the Director of Nursing (DON) on 2/5/25 at 7:39 AM she stated the pharmacy does not reprint new order labels for the medications already on hand. A facility provided document titled Pharmacy Labeling of Medication dated 2/10/25 with a communication about pharmacy will be sending the facility stickers when current medication had a change in dosage and to refer to the MAR until that medication is used up. The facility provided policy titled Protocol for medication administration updated 9/3/14 documented the following: The nurse, medication aide administering medications must remain alert to these seven factors. Noting the resident's allergies Giving the right medication Giving the medication to the right resident Giving the medication int he right dosage Giving the medication at the right time Giving the medication by the right route Respecting the resident's right to privacy when administering medications and treatments. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 2/6/25 at 2:34 pm, he stated he didn't know what the rules of the pharmacy were in regard to the medications and labeling if an order for a resident's current medications was changed. 47673 2. The Minimum Data Set (MDS) dated [DATE] for Resident #1 documented a Brief Interview for Mental Status (BIMS) of 8 indicating moderate cognitive impairment. Review of Resident #1's MAR documented a physician's order for MS Contin oral tablet extended release 15 mg give one tablet every 8 hours for pain with a start date of 12/13/24 and discontinue date of 1/20/25. A physician's order for MS Contin oral tablet extended release 15 mg give two tablets every 8 hours for pain with a start date of 1/20/24 and discontinue date of 1/21/25. A physician's order for MS Contin oral tablet extended release 15 mg give two tablets every 8 hours for pain with a start date of 1/22/24 and discontinue date of 1/30/25. A physician's order for MS Contin oral tablet extended release 30 mg give one tablet every 12 hours for pain with a start date of 1/30/24 and no discontinuation date. On 2/4/25 at 9:31 AM Staff T, Licensed Practical Nurse (LPN) stated she had taken the order for MS Contin from the hospice nurse over the phone. Staff T stated the order had changed from MS Contin 15 mg to MS Contin 30 mg but the times had not changed. Staff T stated Resident #1's hospice physician wanted the medication to be every 12 hours. Staff T stated the hospice nurse and the physician did not specify that the MS Contin 30 mg was supposed to be every 12 hours not every 8 hours. Staff T stated the hospice nurse wanted the facility to use two of the 15 mg tablets because insurance would not cover another prescription and once finished the 15 mg tablets were gone the pharmacy would send the 30 mg tablets. Staff T stated the nurses wrote on the bubble pack the use of two 15 mg tablets until more were sent out. On 2/4/25 at 10:12 AM the Director of Nursing (DON) stated the facility did not have Resident #1's written order for 30 mg MS Contin at the facility. The DON stated the pharmacy was supposed to send new labels but that had not happened for a while. The DON stated she did not know if the staff at the facility could write on the pharmacy labels. On 2/5/25 at 12:54 PM Staff A, LPN stated she had worked at the facility for the last 9 years. Staff A stated if there was a change to an insulin order she would request new labels from the pharmacy or new pens so that it would reflect the same dose on the insulin pen, box it came in, and order in PCC. Staff A stated the order change was in the form of a tablet the medication would be sent back to the pharmacy to be relabeled. Staff A stated she would not write on the label because it was against regulations to write on the label. Staff A stated she had never seen any stickers that stated see MAR for any order changes. On 2/5/25 at 1:07 PM Staff B RN stated when a resident had a change in insulin order the old pens got sent back to the pharmacy to be relabeled. Staff B stated she had worked at the facility almost 2 years. Staff B stated she had never seen any stickers that read see MAR for order change. Staff B stated she would not write on the label because nurses are not supposed to write on pharmacy labels. Staff B stated at other facilities she had worked at she had seen stickers that stated order change see MAR. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25 at 4:01 PM the DON stated when a medication was changed the nurses are expected to look at the 24 hour report and to read the MAR. The DON stated the issue occurs when the package and the MAR did not match. The DON acknowledged the facility did not have stickers to mark the medication bubble pack. The DON stated when she spoke to the pharmacy the pharmacy stated they had stickers to apply to the medication label. The DON also stated the pharmacy stated a CMA could not pass medication with the sticker on this label because it was not in their scope of practice to administer with the sticker on the label. The DON acknowledged that the facility did not have the stickers and are currently being ordered. The DON stated the facility had no policy or procedure that had to do with labels or the procedure for an order change. On 2/5/25 at 12:24 PM the Consultant Pharmacist stated she works with the facility as a consultant. She stated the pharmacy was not able to provide new labels to the facility for medication changes per regulations. She stated when the medication was changed the label should have a sticker that stated directions changed see MAR. She stated a CMA would not be able to complete the 5 rights on their own if that sicker is on the medication label. She stated the pharmacy did provide those stickers upon request. The Consultant Pharmacist stated facility staff changing the label would not be acceptable practice. She stated if the narcotic order was not a signed valid script from the provider and the medication would not be sent out until they had a signed valid script from the physician. She stated she does see the continued use of narcotics with changes related to insurance purposes but would expect the facility to use the sticker that states direction change see MAR.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observations, staff interviews, and policy review the facility failed to store food in accordance with professional standards by not dating food items removed from boxes or disposing of expired food items. The facility reported a census of 43 residents. Findings include: On [DATE] at 11:15 am an observation in the dry storage room revealed a sealed bag of pretzels with expiration date of [DATE], a bag of dry gravy mix with expiration date of [DATE] sealed cans of chicken noodle soup with expiration date of [DATE], and a cardboard flat of 24 cans of tomato soup with expiration date of [DATE]. The dry storage room also revealed 12 sleeves of sealed saltine crackers removed from boxes stored in a large plastic tote without receiving date or expiration date and 8 large bags of cereal sealed removed from boxes without receiving date or expiration date. On [DATE] at 11:20 am an observation of the walk-in freezer revealed 10 frozen bags of fried rice removed from the box without a receiving date or expiration date. On [DATE] at 11:30 Staff F, Certified Dietary Manager (CDM) stated dry storage is cleaned out and checked for expiration dates two times a year. Staff F stated the freezer is cleaned out and remaining food is moved to yellow milk crates and used for alternate food for the new menu. Staff F stated it was her assumption that all of the previous menu food is used then. Staff F stated she did not know when the bags of cereal or the plastic sleeves of saltine crackers were received or when they expired. Staff F stated the facility did not have a policy on maintaining expiration dates for food removed from boxes. Staff F acknowledged the bag of pretzels, bag of dry gravy mix, cans of chicken noodle soup and cans of tomato soup were expired. Staff F removed the expired items and threw items away. Staff F stated it was the facility's expectation that expired food would not be served and those items would have been thrown away. On [DATE] at 8:26 AM the Administrator stated he spoke with Staff F about the expired food in the dry storage. The Administrator stated items in dry storage should be looked at once a month or once a quarter. The Administrator stated the facility's expectation was that the expired food would have been thrown away before it expired. Review of undated policy titled Storage Policy documented that any items out of their original packaging could only be kept for 3 days after opening. Frozen foods and produce are left in the original package. Items remaining in their original packaging may be kept for 30 days after. All items must have an open date after opening. If an item has no open date or improperly stored items must be discarded. Items will be inspected daily by dietary staff, twice weekly on Mondays and Thursday by the CDM and the CDM assistant. Additionally monthly by the Registered Dietitian.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47582 Based on observations, and staff interviews the facility failed to safeguard medical record information against loss, destruction, or unauthorized use. The facility reported a census of 43 residents. Findings include: Observation on 100 hallway on 2/4/25 from 7:50 am until 8:00 am revealed an unattended medication cart located near the exit door of the hallway. The medication cart equipped with a built-in computer monitor on top of it displayed an Electronic Health Record of a current resident. It revealed personal identifiable information, including full name, room number, birthday, code status, and several medication/treatment orders. One resident walked past the unlocked computer monitor. Subsequent observations of the unlocked, unattended computer monitor with the EHR displaying residents' medical records: 1. 02/05/25 07:32 AM computer screen unlocked 2. 02/05/25 08:36 AM medication labels for refills stuck on the pill crusher 3. 02/05/25 08:37 AM facility visitor in the hallway walked by 4. 02/05/25 08:45 AM computer screen unlocked 5. 02/05/25 09:19 AM computer screen unlocked, housekeeping staff present nearby An anonymous staff member who walked past the medication cart confirmed the computer screen monitor was displaying resident identifiable information and it had to be locked. This staff further stated when they are tasked with administering medications, they lock the monitor screen to protect residents' confidential information. In an interview 2/6/25 at 02:34 pm, the Administrator confirmed that the computer monitor where EHR contained residents information had to be locked if the staff member in charge of the computer was not present.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47673 Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (July 1-September 30, 2024) review, facility staffing reports review, and staff interviews, the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 43 residents. Findings include: The PBJ Staffing Data Report run date 1/29/25 for quarter four 2024 triggered for excessively low weekend staffing and failed to have licensed nursing coverage 24 hours a day. Review of weekend staffing schedules for quarter 4 months of July, August, and September 2024 revealed equal staffing during the week and the weekend. On 2/6/25 at 12:06 PM Staff E, Assistant Administrator acknowledged time sheets were not turned in for a traveling nurse in particular and was not appropriately being sent to the billing email. Staff E acknowledged this was the reason for the inaccuracy in reporting staffing data. On 2/6/25 at 12:02 PM the Administrator stated he had inaccuracies probably related to agency staff hours being reported. Stated the facility's accountant takes all the staffing data information and submits it to CMS. The Administrator acknowledged time sheets were not turned in appropriately for an agency nurse in particular and this was the reason for the inaccuracy when reporting staffing data. The Administrator stated the facility's expectation was for accurate data to be sent when the facility reported the Payroll Based Journal (PBJ) report to CMS.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 49628 Based on facility record review, staff interview, and policy review the facility failed to have an effective Quality Assurance and Performance Improvement (QAPI) program in place to provide quality care for residents. The facility failed to make good faith attempts to correct quality deficiencies, and maintain and implement a comprehensive QAPI program and plan. The facility identified a census of 43 residents. Findings include: The Centers for Medicare and Medicaid Services (CMS) document CASPER Report 0003D dated 1/29/25 revealed the facility had repeated deficient practices in the years 2019, 2021, 2022, 2024, and 2025 as exhibited by the following: F582 Medicaid/Medicare Coverage/Liability Notice (2021, 2025) F623 Notice Requirements Before Transfer/Discharge (2021, 2022) F625 Notice of Bed Hold Policy Before/Upon Transfer (2019, 2021, 2022) F641 Accuracy of Assessments (2021, 2024, 2025) F644 Coordination of Pre-Admission Screening and Resident Review (PASRR) and Assessments (2019, 2022, 2024, 2025) F655 Baseline Care Plan (2019, 2025) F656 Development/Implement Comprehensive Care Plan (2022, 2025) F657 Care Plan Timing and Revision (2021, 2022, 2024, 2025) F689 Free of Accident Hazards/Supervision/Devices (2019, 2021, 2022, 2025) F693 Tube Feeding Management/Restore Eating Skills (2019, 2024) F758 Free from Unnecessary Psychotropic Medications/PRN Use (2019, 2021, 2022, 2025) F760 Residents are Free of Significant Med Error (2024, 2025) F761 Label/Store Drugs and Biologicals (2021, 2025) F812 Food Procurement, Store/Prepare/Serve Sanitary (2019, 2021, 2022, 2025) F880 Infection Prevention and Control (2021, 2022, 2024) F883 Influenza and Pneumococcal Immunizations (2021, 2024) (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/10/25 at 11:40 AM the Administrator stated the facility was not able to provide any current Performance Improvement Plans (PIPs), tracking mechanisms for PIPs, or what staff developed the PIP and took responsibility for it. The Administrator stated the last PIP the facility addressed was Enhanced Barrier Precautions (EBP) when it came out in 4/2024. The Administrator stated going to be honest trying to take something like Infection Control, do all the paperwork and root cause analysis through the assistance of a subsidiary of CMS was difficult. The Administrator stated he was aware of repeat deficiencies including PASRR, Advanced Directives, Minimum Data Set (MDS) accurate completions, and Care Plans. The Administrator stated he would not expect repeat deficiencies but with a small facility and staff turnover there might be some. When asked about concerns with repeat deficiencies the Administrator replied if we get tagged, it's a tag. The Administrator stated the facility did complete Plans of Corrections (POCs), but did not necessarily create a PIP to mitigate repeat deficiencies. The staff stated the POC would shore up the deficiency via personnel changes or audits, but expected the staff to stand on their own 2 feet and do their jobs correctly. The Administrator stated the QAPI team discussed the same concerns that were raised in the Standup Meetings regarding infection control, falls, insufficient intakes and fluids. The Administrator revealed during the past year the facility reorganization of Chapter 11 Section 5 took a toll on himself and Assistant Administrator, and some areas may not have been a high focus as if the facility did not reorganize the facility would have to close. The Administrator acknowledged the facility was not using QAPI to its fullest extent. The facility policy, QAPI Policy and Protocol not dated, revealed PIPs would be used to identify problems and concerns within the facility. The document revealed through the Quality Assurance process data based concerns would be identified and would use staff huddles to collaborate on interventions and root cause analysis.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 49628 Based on staff interview, and policy review the facility failed to properly establish and implement written policies and procedures for the Quality Assurance and Performance Improvement (QAPI) plan. The facility reported a census of 43 residents. Findings include: The facility policy, QAPI Policy and Protocol, revealed no effective procedures to identify, collect, use and monitor data for all departments, and utilize the Facility's Assessment. The document did not identify how the facility would report, track, investigate and analyze adverse events and/or problem prone concerns. The facility policy did not describe how the facility developed corrective actions to effect change at the systems level to prevent quality of care, quality of life and safety problems. The document did not contain how the facility monitored the effectiveness of its Performance Improvement Plans (PIPs) to ensure improvements were sustained. The facility did not contain the required committee members. On 2/10/25 at 11:40 AM the Administrator stated the facility was unable to provide any on-going QAPI programs, implementations, and activities in either paper or electronic format for review. The Administrator indicated he would have to look for that, but did not provide further details. The Administrator stated the last PIP was related to Enhanced Barrier Precautions (EBP) in April 2024, and how the facility customized it to meet its needs. The Administrator stated the committee would use concerns brought up during the Standup Meeting including infection control, falls, upper respiratory infections, urinary tract infections and insufficient intakes. The Administrator stated everyone submits paperwork on falls, infection control, and intakes but was unable to provide the documentation or details of PIPs developed from the paperwork submitted. The Administrator stated the QAPI is managed in the same manner as the daily Standup Meeting. The Administrator acknowledged the policy should be updated yearly. The Administrator stated the facility did not utilize QAPI to its highest potential and abilities.

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 49628 Based on facility record review, staff interview, and policy review the facility failed to maintain records of Quality Assurance and Performance Improvement (QAPI) committee meetings 1 of the 3 quarters reviewed and the required attendees. The facility reported a census of 43 residents. Findings include: The facility provided documents titled, Q.A. Meeting, dated 7/10/24 and 12/5/24 revealed all the required members were in attendance. No further quarterly documentation was provided for the previous 3 quarters. The facility policy, QAPI Policy and Protocol undated, revealed the members did not include the Infection Preventionist and Medical Director as required. The document further revealed the team would meet monthly and as needed. The facility document, QAA Committee, revealed the members included the Administrator, Director of Nursing (DON), Minimum Data Set (MDS) Coordinator, Dietary Manager, Activities Director, Social Services, Medical Director, and Pharmacy. The document did not include Infection Preventionist. On 2/10/25 at 11:40 PM the Administrator stated the core members of the QAPI committee were the Administrator, DON, MDS/Care Plan Coordinator, Social Services/Housekeeping/Laundry, and Dietary Supervisor as per policy. When asked about the difference between the QAPI Policy and Protocol, and the QAA Committee document, the Administrator stated the documents should match and the policy must be old. The Administrator acknowledged the policy should be updated yearly. The Administrator stated he expected social services, nursing, MDS Coordinator, Administrator, Assistant Administrator, and the Medical Director present, as well as a floor nurse and Certified Nurse Assistant (CNA) depending upon the concern in the building at the meetings. The Administrator stated in general the Medical Director should be present, and the facility attempts to have QAPI meetings when he is present for rounds. The Administrator stated meetings were held once a quarter, but may have them more frequently if needed and may be without the Medical Director. The Administrator stated there should be 4 attendance sheets since the previous survey. The Administrator stated he could not provide any additional documentation as the Social Services personnel manages that. The Administrator expected as many team members to be present for QAPI meetings, and there was no excuse for not having people at the meetings. The Administrator stated there had been QAPI plans developed related to meeting frequencies or attendance. The Administrator stated the facility did not utilize QAPI to its highest potential and abilities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165546	A. Building B. Wing	02/10/2025

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on clinical record review, resident interview, and staff interview the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or centralized work area by the system having a known issue that prevents the entire call light system from working. The facility reported a census of 43 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #194 documented a Brief Interview for Mental Status (BIMS) of 11 indicating no cognitive impairment. The MDS documented diagnoses of acute respiratory failure with hypoxia and unspecified asthma with acute exacerbation. On 2/3/25 at 12:55 PM Resident #194 stated every staff member knows that her call light does not work appropriately. Resident #194 stated she used to live in a room on the west side and it did not work appropriately. Resident #194 stated she had just had her call light on for the last 30 minutes a couple minutes ago and it was not working. Resident #194 stated the staff had to unplug the call light at the wall to reset the call light. On 2/3/25 at 1:00 PM Staff G, Certified Nurse Assistant (CNA) stated Resident #194 had mentioned to her that the call light was not working appropriately once before. On 2/3/25 at 1:07 PM Staff H, CNA Stated Resident #194's light did not work appropriately when she was in room [ROOM NUMBER]. Staff H stated the call light system goes down at times and needs to be reset. Staff H stated when that happens none of the call lights work. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/25 at 8:26 AM the Administrator stated the call light system had to archive, and was something the facility has had to deal with since 12/12/24 or 12/15/24. The Administrator stated that the company that made the call light came to the facility and spoke about fixing it, but the software was determined to be outdated. The Administrator stated residents had to tell the staff the call light system was not working. The Administrator revealed when the staff entered a room the resident said the call light had been on for a while. The Administrator further revealed this is when the staff told the resident that the call lights were not coming across the radio. The Administrator stated the call lights not working appropriately happened more on the south wing and there were 2 rooms on south hall that had lost the link to the wireless call light system. The Administrator stated the call light company would remote in and fix that or they would have to reboot the system. The Administrator stated the facility had to archive the call lights and/or the call light system would become overwhelmed. The Administrator acknowledged occasionally he had to ask the staff to check rooms. The Administrator stated there are bells for the residents that were purchased, but they were currently in storage and not handed out to the residents. The Administrator stated there are 40 bells that would be utilized if the system crashed. The Administrator acknowledged there had been complaints from residents and family members about the time it takes to answer the call lights related to the system failure. The Administrator stated it was random rooms and that sometimes when it is an archive situation it is all the call lights. The Administrator stated there were isolated incidents where the IP address was lost. The Administrator stated currently there were no residents that had bells in their room.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 47673 Based on facility document review, staff interviews and policy review the facility failed to provide training to their staff that at a minimum educates staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property and procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property. The facility reported a census of 43 residents. Findings include: A request for documentation from the Administrator and Staff E, Assistant Administrator of training for Staff I, Certified Nurse Assistant (CNA) in Dependent Adult Abuse / Mandatory Reporter revealed no documentation of completion or certificate of completion. A request for documentation from the Administrator and Staff E of training for Staff M, CNA in Dependent Adult Abuse/Mandatory Reporter revealed no documentation of completion or certificate of completion. On 2/6/25 at 9:44 AM Staff E, Assistant Administrator stated he just sent an email to Staff M that requested a copy of her Dependent Adult Abuse/Mandatory Reporter certificate. Staff E stated Staff M was not on the list the facility had that needed a Dependent Adult Abuse/Mandatory Reporter update. Staff E stated Staff I was on the list and had asked her to complete the Dependent Adult Abuse training and should have completed the training. Staff E acknowledged no documentation of completed training or certificate of completion for either staff. On 2/6/25 at 12:21 PM the Administrator stated the facility's expectation was that Dependent Adult Abuse/Mandatory Reporter training would be completed in the first 6 months of employment at the facility for each staff member. Review of undated policy titled, Abuse Prevention, Identification, Investigation, and Reporting Policy documented each employee shall be required to complete 2 hours of training related to the identification and reporting of dependent adult abuse within six months of initial employment and at least 2 hours of additional dependent adult abuse identification and reporting training every 5 years.

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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. 47673 Based on employee file review and staff interview the facility failed to complete required in-service training for nurse aides to ensure continued competence no less than 12 hours per year. The facility reported a census of 43 residents. Findings include: On 2/5/25 at 3:34 PM Staff D, Certified Nurse Assistant (CNA) stated she had worked at the facility for about a year and a half. Staff D stated the facility provided online in-services for mandatory reporters. Staff D stated she had not gotten regular in-service training related to resident rights, dementia care, infection control or behavioral health. Review of Staff D's employee file revealed no documents of yearly in-service training related to resident rights, dementia care, infection control or behavioral health. On 2/5/25 at 3:47 PM the Director of Nursing (DON) stated there was not currently any training being conducted as the annual training. The DON acknowledged there was no yearly in-services related to resident rights, dementia care, infection control or behavioral health that had been completed. The DON stated not having an CNA yearly training has been identified as a concern and brought to the Administrator's attention. On 2/6/25 at 10:55 AM the Administrator acknowledged that the yearly training/in-services related to resident rights, dementia care, infection control or behavioral health that was required was not completed for CNA's per the regulation.