STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165575	A. Building B. Wing	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Utica Ridge	3800 Commerce Blvd Davenport, IA 52807

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on clinical record review, facility policy review and staff interviews, the facility failed to notify the provider of a weight change of 3 pounds or more in one day as ordered for 1 of 1 resident (Resident #67) in sample reviewed. The facility reported a census of 88 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #67 scored an 8 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated moderately impaired cognition. The MDS listed diagnoses included: chronic systolic (congestive) heart failure; renal insufficiency, renal failure, ESRD (end stage renal disease), and non-Alzheimer's dementia. The MDS indicated the resident took a diuretic. Review of the Care Plan revealed a Focus area dated 5/6/24, for Resident #67 required the use of diuretic medication related to systolic CHF (congestive heart failure). The interventions dated 5/6/24 indicated to monitor for signs and symptoms of fluid defect and report to practitioner abnormal findings. The Care Plan revealed a Focus area dated 5/8/24, for Resident #67 had the potential/actual risk for altered nutritional status related to NAS (no salt added) therapeutic diet with 1800 ml (milliliter) FR (fluid restriction) for CHF, CAD (Coronary Artery Disease). The interventions dated 5/8/24 indicated to monitor weights; and notification to MD/RD (medical provider/registered dietician) of significant weight change. Review of Physician Orders revealed in part: Daily weights notify provider of weight gain of 3 lb (pounds) in one day or 5 lbs in one week, or a loss of 3 lbs in one day. State Date: 9/10/24. Review of the document titled Weight Summary, dated 4/16/25 revealed Resident #67 had a weight change of 3 pounds in one day on the following dates: The Review of the Weights revealed the following dates the resident had a weight change of 3 pounds for more in one day: a. 3/3/25 at 6:39 AM: 286.0 lbs to 3/4/25 at 11:14 AM: 291.2 lbs, gain of 5.2 lbs (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. 3/16/25 at 7:03 AM: 287.4 lbs to 3/17/25 at 6:14 AM: 284.0 lbs, loss of 3.4 lbs c. 3/19/25 at 6:56 AM: 282.8 lbs to 3/20/25 at 9:33 AM: 288.8 lbs, gain of 6 lbs d. 4/3/25 at 6:48 AM: 288.0 lbs to 4/4/25 at 1:21 PM: 292.0 lbs, gain of 4 lbs e. 4/5/25 at 1:59 PM: 292.0 lbs to 4/6/25 at 6:14 AM: 287.8 lbs, loss of 4.2 lbs f. 4/7/25 at 6:23 AM: 286.8 lbs to 4/8/25 at 6:17 AM: 283.8 lbs, loss of 3 lbs g. 4/8/25 at 6:17 AM: 283.8 lbs to 4/9/25 at 7:32 AM: 287.0 lbs, gain of 3.2 lbs h. 4/13/25 at 7:04 AM: 284.6 lbs to 4/14/25 at 10:40 AM: 288.8 lbs, gain of 4.2 lbs Review of the electronic health record revealed a lack of provider notification for the weight fluctuation which resulted in a gain of 3 pounds in one day, and a loss of 3 lbs in one day. During an interview on 4/17/25 at 10:17 AM, Staff L, LPN (Licensed Practical Nurse) queried on Resident #67 weight change order, stated she text the doctor when Resident #67 had a weight loss of more than 3 pounds. Staff L stated she didn't document in the progress notes when she notified the provider because she ran all the time checking on the residents and she may of failed in that aspect. When asked to provide the text messages, Staff L stated she deleted the messages after the provider responded back to her. During an interview on 4/17/25 at 10:39 AM, Staff M, LPN queried about the order to notify the provider if Resident #67 had a 3 pound weight change, stated she notified the provider and documented a progress note in Resident #67 file. During an interview on 4/17/25 at 12:33 PM, Staff O, RN (Registered Nurse) Unit Manager queried where notification to the provider was located and Staff O stated in a progress note or on paperwork submitted to the provider. During an interview on 4/17/25 at 2:34 PM, the Director of Nursing stated if there is a weight change over 3 pounds stated staff should be notifying the doctor after first reweighing the resident. The DON stated the Unit Manager should be auditing and educating staff. The DON stated she educated using the same scale and notification to the provider in the daily meetings. Review of the facility policy titled Physician Orders/Transcription of Orders, dated 7/2023 revealed Procedure section: #9. Active Orders should be followed and carried out as written/transcribed Review of the facility policy titled Notification for Change of Condition, dated 6/2023 revealed Procedure section: #1. The facility must immediately inform the resident, consult with the resident's physician .when there is: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions, or clinical complications). c. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment).

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 45338 Based on clinical record review and staff interview, the facility failed to ensure timely completion of quarterly Minimum Data Set (MDS) assessments for 4 of 4 residents reviewed for quarterly MDS timeliness (Resident #1, Resident #10, Resident #34, Resident #61). The facility reported a census of 88 residents. Findings include: 1. Review of the quarterly MDS assessment for Resident #1, Assessment Reference Date (ARD) 3/5/25, revealed the assessment completed on 3/31/25. 2. Review of the quarterly MDS assessment for Resident #10, ARD 3/5/25, revealed the assessment completed on 3/27/25. 3. Review of the quarterly MDS assessment for Resident #34, ARD 1/22/25, revealed the assessment completed on 2/6/25. 4. Review of the quarterly MDS assessment for Resident #61, ARD 2/19/25, revealed the assessment completed on 3/6/25. On 4/17/25 at 3:31 PM, Staff J, MDS Coordinator explained infection control responsibilities had taken quite a bit of their time, and explained they should have asked for help. On 4/17/25 at 3:58 PM, the facility's Director of Nursing (DON) acknowledged timeliness of the quarterlies had been recognized as a concern, and further explained assessments should be getting done within that week. A facility policy to address MDS requested, and the facility explained they did not have a policy.

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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** 45338 Based on staff interview and clinical record review, the facility failed to ensure accuracy of Section N, Medications, on the Minimum Data Set (MDS) assessment for 2 of 5 residents reviewed for unnecessary medications (Resident #26, Resident #34). The facility reported a census of 88 residents. Findings include: 1. Review of the MDS assessment dated [DATE], revealed Resident #34 scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) which indicated intact cognition, and revealed the resident took antiplatelet medication. Review of the resident's January 2025 Medication Administration Record (MAR) lacked administration of antiplatelet medication. During an interview on 4/17/25 at 3:35 PM, Staff J, MDS Coordinator shown Resident #34's MAR, queried if resident on antiplatelets, and Staff J confirmed no. 47336 2. The MDS assessment dated [DATE], revealed Resident #26 scored a 5 out of 15 on the BIMS exam, which indicated cognition severely impaired. The MDS indicated the resident took a diuretic. Review of the Physician Orders did not list a diuretic order for Resident #26. During an interview on 4/17/25 at 10:51 AM, Staff J, MDS Coordinator queried if Resident #26 accurately coded for use of a diuretic. Staff J reviewed the medical record and stated she didn't know why she coded it because Resident #26 didn't take a diuretic. During an interview on 4/17/25 at 2:36 PM, the Director of Nursing stated she didn't see Resident #26 prescribed a diuretic. The DON stated Staff J probably made a coding mistake. The DON stated she expected the MDS to be on time, correct, and coded correctly. Per email from the Administrator on 4/21/25 at 8:42 AM, the facility does not have a policy for MDS accuracy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45775 Based on clinical record review, facility policy review, and staff interviews, the facility failed to include dialysis services and use of an anticoagulant in the Care Plan for 2 of 3 (Resident #3 and Resident # 83). The facility reported a census of 88 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #3 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 13 out of 15. The MDS list of diagnoses included: fluid overload, coronary artery disease, and renal insufficiency requiring dialysis. Section O, Special Treatments, Procedures and Programs identified Resident #3 received dialysis services while a resident. Review of the Admission Record revealed Resident #3 admitted to the facility on [DATE]. Review of Progress Notes revealed an Alert Note entered on 3/18/25 at 3:53 AM, which documented Resident #3 readmitted to the facility on [DATE] after a hospitalization . Review of the Order Summary Report dated 4/17/25, revealed an order for [Dialysis provider name and phone number redacted] M-F-W (Monday-Wednesday-Friday) @ 12:00pm, arrival @ 11:40 am, pick up 11:20 am, every day and evening shift every Mon, Wed, Fri for monitoring. Start Date: 3/17/25. Review of the Care Plan revealed a lack of Focus areas and Interventions related to address Resident #3's dialysis services. During an interview on 4/17/25 at 10:24 AM, Staff C, Registered Nurse (RN) reported Resident #3 goes to dialysis three times a week. Staff C stated dialysis services should be in the residents Care Plan. During an interview on 4/17/25 at 2:43 PM, the Director of Nursing (DON) reported Resident #3 received dialysis three times a week. The DON stated this service should be included in the Care Plan. 2. The MDS dated [DATE], identified Resident #83 as cognitively intact with a BIMS of 15 out of 15. The MDS list of diagnoses included: atrial fibrillation (an abnormal heart rhythm), heart failure and hip fracture. The MDS identified Resident #83 prescribed an anticoagulant (a blood thinner). Review of the Admission Record revealed Resident #83 admitted to the facility on [DATE]. Review of Order Summary Report dated 4/15/25, revealed an order for Rivaroxaban (medication classified as an anticoagulant or blood thinner) Oral Tablet 20 MG .Give 1 tablet by mouth at bedtime and did not have orders for any antibiotics. Start Date: 1/25/25 Review of the Care Plan revealed a lack of a Focus area and related Interventions to address the use of an anticoagulant. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/25 at 11:32 AM, Staff C, RN reported any nurse can update the Care Plans. Staff C stated residents prescribed an anticoagulant should have them included in the Care Plan. During an interview on 4/17/25 at 2:43 PM, the DON reported Resident #83 should have the orders for the anticoagulant ordered addressed in her Care Plan. Review of the facility policy titled Care Plan Policy, revised March 2025 included a Purpose statement, which declared To ensure that all care plans including baseline care plans are in conjunction with the federal regulations including a baseline care plan to be completed within 48 hours of admission and a comprehensive care plan developed after the comprehensive assessment of a resident. The Procedure section directed, in part: #4. After the comprehensive assessment (state/federal-required MDS) is completed, the facility will put in place person-centered care plans outlining care for the resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on observation, staff and resident interview, clinical record review, and facility policy review, the facility failed to follow physician orders for treatment of left lower leg surgical site for 1 of 3 residents (Resident #87) reviewed for non-pressure injuries, when staff used an alternate treatment application to wound site during observation of wound care. The facility reported a census of 88 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition. The MDS identified surgical wounds and diagnosis of encounter for orthopedic aftercare. Resident #87 required surgical wound care, application of ointment or medication and application of non-sterile dressings. The Care Plan, dated 3/22/25, revealed Resident #87 had been at risk for alterations in skin integrity due to recent surgeries, resulting in open surgical wounds of left below the knee amputation with intervention to administer treatment per physician orders. The Treatment Administration Record (TAR), dated April 2025, revealed the following treatment orders: 1. Vashe Wound Cleanser External Solution 0.033%, with instructions to apply to left below the knee amputation topically every day and evening shift for skin care. Order initiated 3/27/25 and directed to be held between 4/17/25 and 4/19/25. 2. Cleanse left below the knee amputation site with normal saline, apply Vashe moistened gauze to wound bed, cover with padded dressing and secure with gauze wrap (Kerlix) and tape, initiated 3/27/25, with instructions to change dressing twice daily and as needed (PRN). 3. Cleanse left below the knee amputation site with normal saline, cover wound with gauze moistened with normal saline, apply padded dressing and secure with gauze wrap (Kerlix) and tape, with instructions to change dressing twice daily for wound care. Order initiated 4/17/25 and discontinued 4/17/25. 4. Cleanse left below the knee amputation site with with normal saline, cover wound with gauze moistened with Vashe, apply padded dressing and secure with gauze wrap (Kerlix) and tape, with instructions to change dressing two times a day for wound care. Order start date 4/18/25. On 4/17/25 at 11:16 AM, Staff Q, Registered Nurse (RN), performed wound cares to Resident #87's left lower extremity amputation site. Staff Q removed old dressing and cleansed wound site with normal saline. Resident #87 reported that the Vashe treatment had not been used for the past 3 days and stated Xeroform (gauze dressing impregnated with petrolatum and often contains 3% bismuth tribromo phenate) was utilized instead. Staff Q applied Xeroform to left lower leg amputation site, covered with padded dressing and secured with gauze wrap and tape. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/25 at 2:33 PM, Staff Q, Registered Nurse (RN), revealed the process for treatment order change included documentation of Vashe treatment refused by Resident #87 and Provider notification of refusal, with request for a new order of the Xeroform from Provider. Staff Q reported nursing staff should document treatment changes in the Nursing Progress Notes. On 4/17/25 at 3:58 PM, Director of Nursing (DON) informed that nursing staff had been unable to find Vashe treatment prior to Resident #87's left lower extremity amputation site dressing change. DON revealed expectation of nursing staff to follow physician treatment orders and notify physician if treatment is refused. A review of the facility policy titled: Physician Orders/Transcription of Orders dated as last reviewed on July 2023 had documentation of the following procedure: a. Physician orders will be received by a licensed nurse, therapist or dietitian. b. Orders may be received through written communication in the resident ' s chart, verbally, or per phone, via fax or electronically entered in PCC (Point Click Care, the electronic medical record software). c. When receiving a verbal or telephone order, the order should be repeated back to the Physician/Nurse Practitioner/Physician Assistant to assure accuracy. d. The order should be entered into the resident ' s medical record exactly as it was stated/written by the MD/NP/PA. e. If for any reason, the physician is not available or cannot be reached by the nurse, the facility appointed Medical Director may be contacted for orders. f. Medication and treatment orders will be entered into the electronic medical administration record or electronic treatment administration record accordingly. g. Active orders should be followed and carried out as written/transcribed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observation, interview, and record review the facility failed to ensure foot pedals were utilized when residents transported in a wheelchair, and failed to ensure fall interventions were consistently implemented for 3 of 4 residents reviewed for accidents (Resident #16, Resident #66, Resident #310). The facility reported a census of 88 residents. Findings include: 1. Review of Resident #16's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 scored 3 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per the assessment, the resident utilized a wheelchair. Review of Resident #16's Care Plan dated 8/16/24, revealed Resident is at risk for falls related to right hemiparesis related to CVA (cerebrovascular accident) and decreased mobility. Interventions dated 8/16/24 included the following: Assist resident with ambulation and transfers as needed, bed is in a low position, and call light within reach. Additional interventions included the following: Dycem (a brand name that has become a generic trademark used for a non-slip material commonly placed on a wheelchair seat, or under a dinner plate to enhance stability) a to wheelchair added to the resident's Care Plan on 1/15/25, sling to be taken out from under patient after transferring added to the resident's Care Plan on 3/27/25, and Non skid footwear added to the resident's Care Plan on 4/15/25. Review of the Incident Note dated 1/14/25 at 11:33 PM revealed, in part, Call to resident's room by CNA (Certified Nursing Assistant) @ (at) 2035 (8:35 PM). Resident lying in the middle of his room faced down on the floor. Resident was lying on his stomach. His head was lying in a pool of blood. Resident's hand were under his body. Resident did have non-skid socks on. Resident's call light was on. I asked resident if he fell out of his wheelchair and he shook his head yes. Me and CNA gently turned him onto his back to assess him and see where the blood was coming from. Resident's head cleaned with wound cleansed. The Alert Note dated 1/15/25 at 4:23 AM revealed, resident return from [Hospital Name Redacted] ER (emergency room) at 0340 (3:40 AM) by transportation team. At the hospital Ct (computed tomography) head or brain wo (without) contrast, negative. Laceration repair (2.0 cm (centimeters) with glue. No N/O (new orders). The CAA (Care Area Assessment) Summary Note dated 1/15/25 at 1:32 PM revealed, in part, Plan of care updated to include placing Dycem in wheelchair. The CAA Summary dated 3/27/25 at 1:47 PM revealed, in part, on 3/26/25 @ 16:15 (4:15 PM) patient was observed lying on his right side, patient slipped out of his chair .Patient slid out from his chair, and patient had sling under him during the time of the fall, care plan was updated for sling to be taken out after transfers, to prevent sliding and Dycem is in place. During an observation on 4/14/25 at 11:52 AM, near the nursing station revealed Staff A, Certified Nursing Assistant (CNA) pushed the resident in his wheelchair without pedals. Staff was heard to say, lets go get you cleaned up and find some pedals for your chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/14/25 at 3:07 PM, staff assisted resident to pull the resident back in the chair. The Incident Note dated 4/15/25 at 7:27 PM authored by Staff I, Licensed Practical Nurse (LPN) revealed, Resident observed in doorway on the floor of his room in supine position. W/c (wheelchair) on the right side of the resident up against the door frame. Resident did not have on gripper socks w/c was in use. Head to toe assessment completed no injuries noted at this time. Resident assisted from the floor by two staff members. NP (Nurse Practitioner) made aware, guardian made aware. During an interview on 4/17/25 at 9:32 AM, Staff I, LPN queried about the resident's fall and explained resident was sitting in his room doorway and waited for someone to put him (resident) to bed. Per Staff I, staff passing trays, Staff I at the nursing station, and a resident said a resident was on the floor. Staff I explained Resident #16 had backed his chair to corner of doorway, was laying flat, the resident's body was laying straight in the doorway with their head facing into the hall. When queried if the resident was on his abdomen or back, Staff A explained resident was on his back. Per Staff I, Resident #16 did not have injuries. When queried if the resident had Dycem, Staff A explained Resident #16 didn't have it in there, explained she asked someone if they used it (Dycem) because it would be an intervention, and someone said tried it on him (resident) and wouldn't work. During an interview on 4/17/25 at 10:54 AM, Staff A, CNA explained Dycem wasn't in there till put in yesterday. Staff A further explained resident used a hoyer (often used generic trademark for a mechanical lift), and were trying to figure out what worked best. Per Staff A, did put it (Dye) there yesterday. When queried if Dye present on Monday, Staff A responded they were not sure. During an observation on 4/17/25 at 10:56 AM, Resident #16 in their wheelchair in the hallway. Resident #16 wore regular gray socks, not gripper socks. 2. Review of Resident #66's quarterly MD'S dated 2/19/25, revealed the resident scored 15 out of 15 on a BINS exam, which indicated intact cognition. Per the assessment, the resident utilized a wheelchair. Review of Resident #66's Care Plan dated 8/23/24, revealed Resident #16 is at risk for falls. The Intervention dated 8/23/24, directed Assist resident with ambulation and transfers as needed. During an observation on 4/15/25 at 7:33 AM, Staff B, Registered Nurse (RN) pushed Resident #66 in their wheelchair into the dining room. The wheelchair did not have foot pedals in place when staff pushed the resident in the wheelchair. During an interview on 4/17/25 at 4:03 PM, the Director of Nursing (DON) explained one of the top five things recently covered the last three months with staff was no pedals, no push. When queried if had been informed with the lack of Dye availability, the DON responded no. Per the DON, Dye was replaced in wheelchairs this week because it had been resized. When queried how staff aware of interventions, the DON explained should be in the Care Plan and abrade (a quick reference system used to summarize resident information/needs. The DON stated interventions such as use of Dye or [NAME] socks should be implemented at all times. 47336 (continued on next page)

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	165575	A. Building B. Wing	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Utica Ridge	3800 Commerce Blvd Davenport, IA 52807

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an observation on 4/15/25 at 7:57 AM, a CAN pulled Resident #16's wheelchair back in the dining room to allow another resident in a wheelchair by and then pushed Resident #16 wheelchair out into the hallway. Resident #16 did not have foot pedals on his wheelchair. Resident #16 held his legs up slightly above the floor while being pushed in his wheelchair by the staff. During an interview on 4/17/25 at 9:53 AM, Staff AK, CAN queried if Resident #16 had foot pedals and Staff AK stated yes, he did. Staff AK asked if he could be pushed with no foot pedals and Staff AK stated no pedals, no push. Staff AK queried if she had ever observed Resident #16 pushed without foot pedals and she stated yes, sometimes with the new staff. During an interview on 4/17/25 at 2:32 PM, the DON stated she just had a meeting yesterday for education on no pedal, no push. The DON stated they went over no pedal, no push numerous times and also reviewed it in the education binder. 48888 4. The MD'S dated 4/15/25, revealed Resident #310 required partial to moderate amount of staff assistance with transferring. Resident #310 unable to ambulate at time of assessment. Diagnoses included myocardial infarction (a heart attack), schizophrenia, other symptoms involving the muscles system, and recent surgery involving heart/arteries. The Care Plan dated 4/07/25, identified Resident #310 at risk for falls and instructed staff to assist Resident #310 with ambulation and transfers as needed. During an observation on 4/14/25 at 10:30 AM, a staff member pushed Resident #310 through the [NAME] hallway to her room without foot pedals attached to the wheelchair. Resident #310 wore gripper socks to feet, crossed her legs at ankles, and held feet up approximately one to two inches above the floor while being transported.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observations, clinical record review and staff interviews, the facility failed to ensure a indwelling catheter bag and tubing maintained in a position minimize the risk of a urinary tract infection for 1 of 1 residents (Resident #43) reviewed. The facility reported a census of 88 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #43 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 14 out of 15. The MDS list of diagnoses included: neurogenic bladder (a condition where damage to the brain, spinal cord, or nerves affects bladder control), scoliosis (a condition where the spine curves abnormally, often appearing as an S or C shape), intestinal-genital tract fistulae (abnormal connections between the intestines and the genital tract). The MDS identified Resident #43 utilized an indwelling catheter. Review of the Care Plan, Date Initiated: 11/21/23 included a Focus area to address Suprapubic Catheter related to chronic urinary retention and colovaginal fistula. Interventions included, I would like staff to check my catheter for kinks and leaks, and Provide catheter care. Observations of Resident #43 revealed the following: a. On 4/14/25 at 2:57 PM, resident sitting in her wheelchair while in her room, catheter bag and tubing rested on floor. b. On 4/15/25 at 6:10 AM, resident asleep in her bed , catheter bag and tubing rested on floor. c. On 4/15/25 at 10:15 AM, Resident #43 sitting in her wheelchair while in her room, catheter bag and tubing rested on floor. At 10:17 AM, Resident #43 self propelled wheelchair to the doorway with catheter bag and tubing dragging on the floor. Staff L, Licensed Practical Nurse (LPN) positioned at a medication cart outside of residents room. Staff L did not note position of catheter bar and tubing, which remained on the floor. During an interview on 4/17/25 at 10:24 AM, Staff C, Registered Nurse (RN) stated when a nursing staff member finds a resident with an indwelling catheter bag and/or tubing on the floor, they should replace it. The bag and tubing should be kept off the floor. During an interview on 4/16/25 at 12:47 PM, Staff D, Certified Nursing Assistant (CNA) reported if she saw a catheter bag and/or the tubing of a resident on the floor, she would pick it up immediately and change the bag. During an interview on 4/17/25 at 2:43 PM, the Director of Nursing reported if the nursing staff saw an indwelling catheter bag or tubing on the floor, she would expect them to pick it up, wipe it off with alcohol based products and return it to the appropriate place. She would expect the aides to complete walking rounds between shifts. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled: Catheter Care: Indwelling Catheter, revised December 2023 directed; a. Check that the tubing is not kinked, looped, clamped, or positioned above the level of the bladder. b. Validate the drainage bag is off the floor and in a dignity bag.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on clinical record review, staff interviews, and facility policy review, the facility failed to ensure availability of scheduled medications for a new administration and timely availability of an as needed pain medication for 1 of 3 residents (Resident #104) reviewed for pain management. The facility reported a census of 88 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], revealed Resident #104 admitted to the facility on [DATE]. The MDS list of diagnoses included: displaced tri-malleolar fracture (fracture involving 3 bones around the ankle) of right lower leg, malignant carcinoid tumors of other sites, and adjustment disorder with depressed mood. The MDS indicated Resident #104 prescribed an opioid (class of medications used to treat pain) during the last seven (7) days of the assessment. Review of hospital Discharge Summary Medications section, dated 1/24/25, revealed: a. New order for acetaminophen-hydrocodone (Norco 5-325 mg (milligrams) oral tablet. 1 tab Oral every 4 hours as needed for moderate pain. b. Pregabalin (medication commonly used to treat nerve pain) 75 mg oral capsule, 1 cap oral three times daily Review of the Admission Assessment, dated 1/24/25 at 7:41 PM, Pain Presence section indicated Resident #104 had pain. When asked if have you had pain or hurting at any time in the last 5 days, Resident #104 answered yes. Resident #104 answered had pain frequently .Verbal Description Scale assessed as a Moderate. The pain scale indicated Moderate is a pain rated 7-9 on a scale of 0-10 . The Medication Administration Record (MAR), dated January 2025, revealed the following order: a. Norco Oral Tablet 5-325 MG (milligrams) (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for pain. Start Date: 1/24/25. D/C Date: 1/25/25. 1. Administered on 1/25/25 for a pain of 8 at 0044 (12:44 AM); 2. Administered on 1/25/25 for a pain of 9 at 0517 (5:17 AM). b. Pregabalin Oral Capsule 75 mg Give 1 capsule by mouth three times a day for pain. Start Date: 1/24/25 1800 (6:00 PM). D/C Date: 1/25/25. 1. HS (bedtime) medication pass lacked documentation 2. Administered on 1/25/25 during AM medication pass. Review of Nursing Progress Notes revealed: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Admission Summary, entered on 1/24/25 at 11:54 PM: Patient admitted today at 5:30 pm via medic. Patient has diagnosis of tri-malleolar fracture of right ankle .Patient is having pain due to that ankle fracture . b. General Progress Note, entered on 1/25/25 at 4:00 AM .resident continuously rating her pain at a 8-9 PRN pain medication given with no relief reported . c. General Progress Note, entered on 1/25/25 at 8:09 AM: Called Pharmacy and spoke to [Name redacted] r/g (regarding) only hydrocodone and no other medication meds came with AM med run. All other Meds will be coming STAT (immediately, without delay) on next medication run per pharmacy. Patient aware. d. General Progress Note, entered on 1/25/25 at 8:34 AM: Spoke to patient d/t (due to) wanting to leave AMA (Against Medical Advice) .Explained to patent all medications are coming STAT From pharmacy and will be administered to her as soon as they arrive . e. General Progress Note, entered on 1/25/25 at 8:47 AM: Called pharmascript and spoke to [name redacted], order for Lyrica (brand name of pregabalin) will be coming STAT from local pharmacy. Patient and family aware. f. General Progress Note: Lyrica arrived from pharmacy and this nurse administered to patient .Patient stated facility is not good fit for her and still wants to leave AMA . The facility provided an untitled, undated document list of medications present in the facilities e-kit (A locked supply of commonly prescribed medications, supplied by contracted pharmacy, that can be accessed quickly without delay). Review of the list indicated the facility had a standard supply of eight (8) tablets of Hydrocodone-Acetaminophen (Norco) 5-325 mg tablets in the e-kit. During an interview on 4/17/25 at 2:50 PM, Staff R, Licensed Practical Nurse (LPN), confirmed she worked the overnight shift on 1/24/25 to 1/25/25. Staff R stated she recalled Resident #104 had propelled self from room to nurse's desk, via wheelchair, due to being upset with lack of pain medications. Staff R reported a script was then obtained to remove Norco from the e-kit and administered to Resident #104, unable to recall the time this occurred. During an interview on 4/17/25 at 3:58 PM, the Director of Nursing (DON), stated the when pain medications are prescribed, an electronic prescription from the hospital physician should be sent electronically to the facilities pharmacy. The DON explained this allows nursing to access the e-kit and administer medication in a timely manner if a pharmacy has yet to make the delivery. The DON stated the expectation is prescriptions are obtained within a few hours of admission. The facility policy, titled Admission Policy, dated 9/2023, revealed that an individual who needs services that are not readily available in a particular facility, shall not be admitted to or kept in that facility. Policy revealed that the facility would follow guidelines to notify physician of admission and verify orders.

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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** 48888 Based on observations, staff interviews, and facility policy review, the facility failed to discard expired lettuce from refrigerator storage and failed to record evening meal temperatures for 3 of 7 days reviewed. The facility reported a census of 88 residents. Findings include: On [DATE] 10:15 AM, the walk in refrigerator contained trays with multiple pre-filled side salads, covered with plastic wrap, dated [DATE]. The walk-in refrigerator also contained a large plastic storage container, filled with shredded lettuce, dated [DATE], and labeled use by [DATE]. On [DATE] at 1:00 PM, the Dietary Manager entered walk-in refrigerator and confirmed the container of lettuce had expired on [DATE]. When queried if lettuce from expired container had been used for [DATE] lunch side salads, Dietary Manager stated, she did not know. Review of facility's meal temperature log, dated between [DATE] and [DATE], lacked record of temperatures for the food items served for evening meals on [DATE], [DATE], and [DATE]. On [DATE] at 1:05 PM, Dietary Manager revealed expectation of all dietary staff to record the food temperatures for each meal in the facility's meal temperature log. The Facility lacked policies related to food storage and expiration or monitoring food temperatures.

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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. 45338 Based on Payroll Based Journal (PBJ) review and staff interview, the facility failed to ensure accurate reporting of weekend staffing hours, resulting in a excessively low weekend staffing trigger for Quarter 1 2025 (October 1-December 31). The facility reported a census of 88 residents. Findings include: Review of the facility's PBJ report for Quarter 1 2025 (reported data from October 1-December 31 2024) revealed the facility triggered for excessively low weekend staffing for the time period. During an interview on 4/17/25 at 2:13 PM, the Administrator acknowledged they had not put agency hours in correctly. A facility policy to related to PBJ reporting requested. The facility reported they do not have such a policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review and staff interview, the facility failed to implement Enhanced Barrier Precautions for one of one residents reviewed with an indwelling catheter (Resident #43). The facility reported a census of 88 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #43 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 14 and had the following diagnoses: neurogenic bladder (a condition where damage to the brain, spinal cord, or nerves affects bladder control), and intestinal-genital tract fistulae (abnormal connections between the intestines and the genital tract). The MDS identified Resident #43 utilized a suprapubic catheter. Review of the Care Plan, dated 4/1/24 identified Resident #43 with the problem of Enhanced Barrier Precautions and directed staff to wear a gown and gloves for high contact activities (such as emptying the catheter bag) During an observation on 4/15/25 at 7:23 AM, Resident #43 room equipped with a caddy hanging on the bathroom door with an adequate supply of Personal Protective Equipment and a sign posted on door Enhanced Barrier Precautions. During an observation of catheter care on 4/15/25 at 1:08 PM, Staff N, Certified Nursing Assistant (CNA) donned mask and gloves, however, did not don an isolation gown, prior to emptying out Resident #43's catheter bag. During an interview interview on 4/16/25 at 12:47 PM, Staff D, CNA stated that EBP are in place for any resident using a catheter. Staff D stated when emptying a catheter bag gloves, a masks, and a gown should be worn. During an interview on 4/17/25 at 2:43 PM, the Director of Nursing reported a resident with an indwelling catheter should be placed in Enhanced Barrier Precautions. She stated when staff are emptying a catheter bag they should don an isolation gown and gloves. A review of the facility policy titled: Enhanced Barrier Precautions dated as last revised March 2024 had documentation of the following: a. Enhanced Barrier Precautions will be used in conjunction with standard precautions with residents with indwelling medical devices (such as indwelling urinary catheters). b. Gowns and gloves should be worn during high contact resident care activities.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on clinical record review, staff interviews, and the facility policy, the facility failed to provide documentation residents refused/accepted pneumococcal vaccine to 3 of 5 residents reviewed (Resident #16, #10, and #33). The facility reported a census of 88 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 scored a 3 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition severely impaired. The Review of the Immunization in the EMR (Electronic Medical Record) lacked documentation Resident #16 refused the pneumococcal vaccine. The Facility Unit Immunization Tracking Form revealed Resident #16 declined the pneumococcal vaccine. No date indicated when refused. The Facility lacked documentation of a declination/education provided to the resident/resident representative for the vaccine. 2. The MDS assessment dated [DATE] revealed Resident #10 scored a 4 out of 15 on the BIMS exam, which indicated cognition severely impaired. The Review of the Immunization in the EMR lacked documentation Resident #10 refused the pneumococcal vaccine. The Facility Unit Immunization Tracking Form revealed Resident #10 declined the pneumococcal vaccine, with no date indicated when refused. The Facility lacked documentation of a declination/education provided to the resident/resident representative for the vaccine. 3. The MDS assessment dated [DATE] revealed Resident #33 scored a 14 out of 15 on the BIMS exam, which indicated cognition intact. The Review of the Immunization in the EMR revealed Resident refused the PCV13 (pneumococcal conjugate vaccine) (no date indicated when refused). The Facility Unit Immunization Tracking Form revealed Resident #33 declined on the pneumococcal vaccine, with no date noted on the form. The Facility lacked documentation of a declination/education provided to the resident for the vaccine. During an interview on 4/16/25 at 4:05 PM, Staff J, RN (Registered Nurse) queried on Resident #33, #16, and #10 pneumococcal vaccine status and she stated Resident #33 on hospice for awhile, and Resident #10 and #16 had low BIMS and they reached out to the family. Staff J asked if she documented the call to family and she stated she turned in a piece of paper to the office with the date and time she tried to reach out to family. Staff J stated she guessed they were not able to get a hold of the family. Staff J queried if the pneumococcal vaccine offered every year to the residents when they refused previously and Staff J stated yes. During an interview on 4/17/25 at 10:57 AM, Staff J stated she got a hold of Resident #16 family and he will receive the pneumococcal. Staff J stated Resident #16 been at the facility since 2019 and she didn't have any information why he didn't receive the pneumonia vaccine previously and had no declination for Resident #16 either. Staff J stated Resident #10 didn't have a declination form and Resident #33 declined the vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/25 at 2:19 PM, the DON (Director of Nursing) queried on the pneumococcal vaccines and shown the Unit Immunization Tracking form and the DON stated she requested the Infection Preventionist fill out the form with the help of the unit managers. The DON stated the staff put in the EMR if the resident refused verbally. The DON informed the pneumococcal vaccine not documented and the DON stated then something was missed. The DON stated if they were not documented in the EMR, it should be documented on paper. The Facility Infection Control Manual Vaccination and Screening Policy dated 1/25 revealed the following: a. Determining which pneumoccal vaccine to give and when: 1. Pneumococcal vaccines are offered upon admission to patients who have never been vaccinated with a pneumonia vaccine or who have refused to be vaccinated in the past.