STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165615	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer Valley Living and Rehab	400 Sergeant Square Drive Sergeant Bluff, IA 51054

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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. 49628 Based on observations, interviews, and facility policy the facility failed to provide dignity to 1of 5 residents reviewed (Resident #6). The facility failed to provide dignity to the resident as demonstrated by the resident waiting to return to her room from the dining room while sitting in soiled garments. The facility reported a census of 45 residents. Findings Include: The Minimum Data Set (MDS) in progress for Resident #6, dated 3/31/25, identified a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognitive functioning. The resident had diagnoses of hemiplegia or hemiparesis (stroke with an affected extremity(ies)), depression, and muscular dystrophy, unspecified. Resident #6's Care Plan dated 3/24/25 revealed a focus area of Activities of Daily Living (ADL) self-care performance deficit with interventions including 1 staff assistance for toileting and the resident was dependent, dependent for transfers requiring 2 staff with the use of hoyer lift (non-weight bearing mechanical lift), and staff assistance for wheelchair (w/c) location in and outside of the facility. The Electronic Medical Record (EMR) Progress Notes from 3/1/24 to 2/19/25 revealed the 3 incidents of behavior including inappropriate toileting involving a Certified Nurse Assistant (CNA), accusations involving staff, and impatience regarding needing to wait for staff assistance for toileting. The EMR for bowel elimination revealed 11 of 29 entries for bowel incontinence. The EMR for bladder elimination revealed 17of 20 entries for incontinence and toileting, and 2 of 20 entries for incontinence. On 3/31/25 at 12:00 PM Resident #6 stated on 3/30/25 while in the dining room she had an incontinence episode. The resident stated she was told that the staff could not take her back to her room as they were feeding other residents. Resident #6 stated she felt bad that she needed assistance and was incontinent, but wanted to be changed. On 4/2/25 at 9:09 AM Resident #6 stated she waited approximately 30 minutes on 3/30/25 to be taken to her room to be changed. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165615	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Pioneer Valley Living and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Sergeant Square Drive Sergeant Bluff, IA 51054	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 1:50 PM Staff GG, Certified Nursing Assistant (CNA)/Certified Medication Aide (CMA) stated if a resident stated they had an accident in the dining room and needed to leave to be changed, they would assist the resident back to their room to provide care or get assistance. Staff GG stated during meals the CNAs assist in the dining room except for 1-2 CNAs that were floats who would continue to get any residents up, pass room trays, or answer call lights. On 4/2/25 at 10:40 AM Staff J, Director of Nursing, expected if a resident requested to go back to their room due to incontinence, then the staff should take the resident back and assist them. The facility's policy, Rights of Residents in Long-Term Care Facilities by the Office of the State Long-Term Care Ombudsman, revealed residents have the right to receive adequate and appropriate care. It further revealed the residents should be treated with consideration, respect, dignity and have control of their life.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 41785 Based on facility record review and staff interviews the facility failed to complete a Significant Change Minimum Data Set (SCMDS) within 14 days of the facility recognizing the resident had a significant change for 1 of 1 resident reviewed (Resident #1.) The facility reported a census of 45 residents. Findings include: The MDS date 2/14/25, showed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 0 (severe cognitive deficit.) He was totally dependent on staff for toileting and transfers and he was on Hospice care services. The Care Plan for Resident #1, updated on 2/19/25, showed that he had a decline in cognition and in physical condition. He was admitted to Hospice services on 1/25/25. A hand-written, Hospice admission form showed that services started on 1/25/25. The Clinical - MDS page of the electronic chart showed a quarterly MDS was completed on 12/6/24 and on 2/14/25. The chart lacked a SCMDS. On 4/3/25 at 11:30 AM, the Administrator acknowledged that Resident #1 had been admitted to Hospice in January and that they failed to complete a SCMDS. According to the Center for Medicare and Medicaid Services (CMS), Resident Assessment Instrument (RAI) Version 2.0 Chapter 2 page 2-3 revised on August 2003, a significant change in status must be completed by the end of the 14th calendar day following determination that a significant change has occurred.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on medical health record review (MHR) and staff interviews the facility failed to submit a comprehensive Minimum Data Set (MDS) as directed by the Centers for Medicaid and Medicare Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.19.1 October 2024, within the required timeframe for 2 out of 15 residents reviewed (Residents #3, and #10). The facility census was 45. Findings include: 1. The review of Resident #3's MDS Quarterly assessment data indicated assessment dated [DATE], was accepted on 3/11/25. 2. The review of Resident #10's MDS Quarterly assessment data indicated assessments dated 1/31/25 were completed on 3/17/25 (late), and accepted on 3/17/25. On 4/2/25 at 10:33 AM Staff J, Director of Nursing (DON), and Staff U, DON, stated they did not have a response related to the completion and submission of the MDS documents as they did not complete them. The facility provided document, RAI/MDS Policy from Clinical Procedures for Long-Term Care, revealed the facility will initiate, encode, and transmit, assessments as delineated in Chapters 2, 3, 4, 5, and 6 of the current CMS RAI User's Manual.

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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 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** 41785 Based on observation, interview and record review the facility failed to update and provide resident specific care plan for 3 of 13 residents reviewed, (Resident #4, #7 and #10). Resident #4, #7 and #10 had long-standing conditions and the care plans lacked a focus area and intervention related to these conditions. The facility reported a census of 45 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #4 had a Brief Interview for Mental Status (BIMS) score of 11 (moderate cognitive deficit.) He was totally dependent on staff for toileting hygiene, lower body dressing, and transfers. The resident had Moisture Associated Skin Damage (MASD). The Care Plan last updated on 9/27/24, showed that Resident #4 had Activities of Daily Living Self-care performance deficits and he was being seen by an outside agency wound clinic. Rounds would be completed weekly and as needed. The resident required the assistance of 2 staff to the toilet and the use of the mechanical lift sit to stand for transfers. His diagnoses included diabetes mellitus, chronic kidney disease stage 3, edema, benign prostatic hyperplasia and diabetic neuropathy. The care plan lacked focus areas and interventions for edema or skin breakdown. On 4/1/25 at 9:31AM, Resident #4 was in a wheel chair, in his room. He was wearing a pair of sweat pants that fit tightly around his lower extremities. He was not wearing shoes and his feet were swollen, with the right foot much larger than the left. The resident said that he'd had a lot of trouble with fluid retention and for a while it had gotten better. The resident had two, fluid filled blisters on the front of his right leg, the entire area was red with extensive dry, pealing skin throughout both lower extremities. There was a small soiled, undated pad stuck to an open sore on the inside of the right leg. On 4/3/25 at 11:30 AM, the Administrator acknowledged that Resident #4 had extensive skin and edema issues and these concerns should have been included in the care plan. A facility policy titled: Care Planning - Interdisciplinary, reviewed in April 2016, showed that the Care Planning/Interdisciplinary Team was responsible for the development of an individualized comprehensive care plan for each resident. 49628 2. Resident #7's MDS assessment dated [DATE] revealed the resident had impairments in short term and long term memory, moderate impairment for daily decision making, inattention, and disorganized thinking as indicated by the staff. The document revealed diagnoses of Alzheimer's, Non-Alzheimer's Dementia, anxiety, and depression. The resident required substantial/maximal assistance for rolling in bed, and was dependent on staff for transfers. The document disclosed the resident was at risk for development of pressure ulcers and injuries, and treatments included pressure reducing devices for chair and bed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/25 at 11:37 AM observed an unidentified staff member push Resident #7 to the dining room in a Broda Reclining Wheelchair (w/c) wearing Prafo boots. On 3/31/25 at 12:43 PM observed Resident #7 in the living area in the Broda Reclining w/c wearing Prafo boots. On 3/31/25 at 1:13 PM observed Resident #7 lying in bed on her back with Prafo boots. On 4/1/25 at 7:55 AM observed Resident #7 sleeping in the living area in the Broda Reclining w/c wearing Prafo boots. On 4/1/25 at 10:06 AM observed Resident #7 sleeping in the Broda Reclining w/c in the living area. On 4/1/25 at 1:22 PM Staff EE, Certified Nursing Assistant (CNA), and Staff GG, CNA/Certified Medication Aide (CMA), transferred Resident #7 to bed, removed the Prafo boots, completed care, and re-applied the Prafo boots prior to leaving the room. On 4/2/25 at 10:20 AM observed Resident #7 sleeping in the Broda Reclining w/c in the living area with the Prafo boots on. The Electronic Medical Record (EMR) revealed Weekly Skin Assessment completed on 3/27/25. Resident #7 had a pressure area on the right inner ankle that measured 1.7 centimeters (cm) long by .2 cm wide. The EMR Clinical Physician Orders dated 3/27/25 revealed an order for the right medial ankle wound treatment to be completed on Mondays and Thursdays. Resident #7 's Care Plan, dated 3/5/25, identified a focus area indicating a risk for skin impairment related to advanced dementia, decreased mobility, and incontinence. Interventions included heel lift boots on the resident when in bed (initiated on 8/22/24), pressure relieving pad in bed, pressure relieving mattress when in bed, tilt in space wheelchair with pressure reduction cushion, and monitoring/documenting location and size of skin injury. The facility failed to update the Care Plan to identify the resident's treatments for the pressure area on the right medial ankle. The facility failed to update the Care Plan to reflect the use of Prafo boots when out of bed. 3. Resident #10's MDS assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13/15 indicating normal cognition. The document revealed diagnoses of cerebrovascular accident (stroke), hemiplegia (paralysis of 1 side of the body), and depression. The resident required substantial/maximal assistance for rolling in bed, and was dependent on staff for transfers. The document disclosed the resident was at risk for development of pressure ulcers and injuries, had a diabetic foot ulcer, and had pressure reducing devices for chair, bed, applications of ointments/medications other than to feet, and dressings to feet. On 3/31/25 at 11:37 AM observed an unidentified staff member push Resident #10 to the dining room in a tilt in space w/c wearing Prafo boots. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/25 at 1:15 PM observed Resident #10 engaged with other residents seated in a tilt in space w/c wearing Prafo boots. On 4/1/25 at 12:10 PM observed Resident #10 seated in the dining room wearing Prafo boots for the noon meal. On 4/1/25 at 12:56 PM observed Resient #10 seated in the tilt in space w/c wearing Prafo boots in the living area. The EMR revealed Weekly Skin Assessment completed on 3/12/25 noted Resident #10 had no redness to buttocks or boggy heels. The EMR Clinical Physician Orders dated 12/18/25 revealed an order for Prafo boots for pressure avoidance, every shift for intervention to pressure dated 12/10/24. Resident #10's Care Plan, dated 3/3/25, revealed the resident was at moderate risk for pressure ulcers. The document provided interventions for staff including pressure relieving cushion to the recliner, pressure relieving device to w/c, and an air mattress. The facility failed to update the Care Plan to identify use of Prafo boots for pressure avoidance as per physician orders. 4. Resident #15's MDS assessment dated [DATE] revealed the resident had a BIMS score of 15/15 indicating normal cognition. The document revealed diagnoses of diabetes, anxiety, and hypertension (high blood pressure). Resident #15's Care Plan, dated 8/26/24, revealed the resident had 16 focus areas with target dates, and interventions. The target date identified on all focus areas was 12/23/24. The facility failed to review the Care Plan and update the target dates for all focus areas. On 4/2/25 at 10:37 AM Staff J, Director of Nursing (DON), and Staff U, DON, did not have a response to the Care Plans required to be updated. The staff did indicate both Resident #7 and Resident #10 did wear Prafo boots. The facility's policy Quarterly Review of Care Plans revealed the care planning/interdisciplinary team was responsible for the periodic review and updating of the care plans.

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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** 41785 Based on observation, interviews and record review the facility failed to follow physician's orders for blood pressure parameters and daily weights for 2 of 6 residents reviewed (Resident #2 and #3.) The facility reported a census of 45 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13 (moderate cognitive deficit). She required set up assistance for dressing and tub transfers, and was independent with transfers and toileting. The Care Plan for Resident #2, updated on 3/12/25, showed that she had bariatric surgery, she was diabetic and on anticoagulant therapy. Staff were directed to monitor for medication side effects such as significant or sudden changes in vital signs. The resident had diagnoses that included chronic kidney disease, weakness and adult failure to thrive. On 3/31/25 at 11:07 AM, Resident #2 was in her recliner with her feet elevated. She had supplemental oxygen running but the nasal cannula tubing was sitting next to her and not on her nose. Resident #2 said she would take it off herself. She said that she didn't have much energy lately and the oxygen helped but sometimes she forgot to put it back on. An Order Audit Report showed that Resident #2 had a medication order dated 3/22/25 at 4:08 PM, for Midodrine 10 milligrams (mg) give every 8 hours for hypotension. Staff were to hold the medication if the systolic Blood Pressure (BP) was over 100. The Medication Administration Report showed that the midodrine had been given on following dates after blood pressures were taken: a. 3/18/25 BP: 114/64 b. 3/20/25 BP: 112/67 c. 3/21/25 BP: 122/64 d. 3/22/25 BP: 107/63 e. 3/29/25 BP: 124/64 f. 3/30/25 BP: 130/72 2) According to the MDS dated [DATE], Resident #3 had a BIMS score 15 (intake cognitive ability). She required partial assistance with dressing, toileting, hygiene and transfers. The resident had frequent pain and shortness of breath. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan for Resident #3, revised on 10/2/24, showed that she had Activities of Daily Living (ADL) performance deficits. The resident had hypertension, staff were to monitor for edema and use ted hose/ ace wraps as needed, and record daily blood pressure. Resident #3 used diuretic medication, staff would monitor for side effects and provide weights per schedule. Her diagnoses include diabetes mellitus, morbid obesity, edema and heart disease. An Order Audit report dated 9/9/24 at 1:50 PM, showed that the facility was to provide daily weights and to notify the primary care physician if the resident had a weight gain of 2-3 pounds overnight, or 4-5 pounds in 5 days. The Weight Summary report for Resident #2, showed that her weight had not been taken on 3/10, 3/17, 3/20, 3/22 or 3/26. From 3/24-3/25 the resident had a 13-pound weight gain and the chart lacked documentation that the doctor had been notified. On 4/3/25 at 11:30 AM the Administrator thought that staff may have started using a different scale when Resident #2 showed a 13-pound gain in one day. She said that they had started adding the blood pressures and weights directly on the MAR/TAR to help remind the nurses to address these areas. The Administrator said that they did not have policies on edema or blood pressure management.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on record and policy review and interviews the facility failed to implement restorative services for 1 of 2 residents reviewed (Resident #1). The facility reported a census of 45 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #1 had a Brief Interview for Mental Status (BIMS) score of 0 (severe cognitive deficit.) The resident was totally dependent on staff for toileting and transfers, and required substantial assistance with putting on and taking off footwear and lower body dressing. The resident had a stage 2 pressure injury and treatments included pressure ulcer care, application of ointments/medications and application of dressings to feet. The resident was on Hospice care. The Care Plan updated on 2/19/25, showed that Resident #1 had impairment to skin integrity related to fragile skin and a decline in his cognition and physical condition. The resident required a program to maintain strength and mobility. Staff were to monitor for ability to complete the restorative plan including use of the Nustep 15 minutes a day as tolerated and Range of Motion (ROM) all extremities as tolerated. If the resident refused the Nustep, attempt to use the arm bike. Adjust the program as indicated. According to the Point of Care Response History from 3/5/25 - 3/31/25, in the 26 days, staff had 52 opportunities to assist the resident with exercises. The document was marked 26 times as not applicable, 13 times as resident refused and 6 times as having exercised for 15 minutes. On 4/2/25 at 10:57 AM, Staff B, Director of Rehabilitation, said that she provided annual training for staff on the use of the equipment but did not train the staff on restorative services or ROM exercises to use with residents. On 4/2/25 at 7:06 AM, Staff Q, Licensed Practical Nurse (LPN) said that the restorative services were done by one aide scheduled to complete it for all of the residents. If they didn't have enough staff scheduled, the aides in the halls would try to get it done. On 4/2/25 at 8:07 AM, the Director of Nursing (DON) said they didn't have a special person to do restorative and the CNA's that are in the specific hallways are expected to offer restorative exercises. There's a list of the residents on restorative in the schedule book and they can look down the list for who gets what. She gave me a copy of the list. On 4/2/25 at 10:30 AM, Staff FF, CNA said that she was not aware of a restorative program and hadn't been trained on those expectations to exercise with the residents. On 4/3/25 at 10:00 AM, Staff P, LPN said that the restorative program wasn't getting completed very often because they didn't have enough staff. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/25 at 11:30 AM the Administrator acknowledged that the restorative program was not what should be and they have hired a couple new staff to implement the program. She indicated that they did not have a policy on restorative services. The undated Facility Assessment showed under the heading: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies, would include the Administrator, QAPI, Infection Control and Prevention, Environmental Services, Social Services, Discharge Planning, Business Office, Finance, Human Resources. Nursing Services - DON, ADON, RN, LPN, CNA, CMA, MDS Nurse, Resident Care Coordinator, Restorative Aid, Bath Aid Food and Nutrition Services - Dietary Manager, Dietitian, Dietary Aid, Cook.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on the observation, staff interviews, and policy review the facility failed to reposition 1 of 3 reviewed (Resident #7). The facility reported a census of 45 residents. Findings include: Resident #7's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impairments in short term and long term memory, moderate impairment for daily decision making, inattention, and disorganized thinking as indicated by the staff. The document revealed diagnoses of Alzheimer's, Non-Alzheimer's Dementia, anxiety, and depression. The resident required substantial/maximal assistance for rolling in bed, and was dependent on staff for transfers. The document revealed the resident had a catheter, and was always incontinent of bowel. The document disclosed the resident was at risk for development of pressure ulcers and injuries, and treatments included pressure reducing devices for chair and bed. Resident #7's Care Plan, dated 3/5/25, identified a focus area indicating a risk for skin impairment related to advanced dementia, decreased mobility, and incontinence. Interventions included heel lift boots on the resident when in bed (initiated on 8/22/24), pressure relieving pad in bed, pressure relieving mattress when in bed, tilt in space wheelchair with pressure reduction cushion, and monitoring/documenting location and size of skin injury. An additional focus area, activities of daily living (ADLs) self care performance deficit, revealed the resident required 2 staff assist with dependent mechanical non-weight bearing lift transfers, 1-2 staff for bed mobility, dressing, and hygiene. The document revealed the resident was totally dependent with toileting, wore incontinence products, and occasionally used the bed pan. The Electronic Medical Record (EMR) Skin Nurse - Weekly Skin Observation Tool completed weekly 2/27/25 through 3/27/25 revealed the resident had a pressure area on the right inner ankle. Observed on 4/1/25 at 7:55 AM Resident #7 seated in a Broda Reclining Wheelchair (w/c) in the living area sleeping. Observed on 4/1/25 at 8:10 AM an unidentified staff take Resident #7 to the dining room. Continuous observation on 4/1/25 began at 9:10 AM of Resident #7 in front of the television in the living room with other residents. The Broda Reclining w/c was slightly reclined (approximately 30 degrees from upright). Observed numerous staff (Certified Nursing Assistants (CNAs), nurses, housekeeping, therapy) walk past Resident #7 in the living room with some staff glancing at the resident, others not looking at the resident. During the continuous observation Resident #7 slept in the Broda Reclining w/c with her head leaning against the right lateral wing of the chair, and the resident's position was not changed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pioneer Valley Living and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Sergeant Square Drive Sergeant Bluff, IA 51054	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observed at 11:58 AM a staff member took Resident #7 to the dining room. Staff positioned the resident more upright during the meal. Observed at 12:43 PM staff placing the resident back in the living room area with the Broda Reclining w/c slightly reclined (less than 30 degrees from upright position). Observed at 1:22 PM Staff EE, CNA, and Staff GG, CNA/Certified Medication Aide (CMA) take Resident #7 to her room for care and repositioning. During the continuous observation Resident #7 was positioned in a Broda Reclining w/c without being repositioned from the chair or checked for personal needs for 5 hours 27 minutes. On 4/1/25 at 1:46 PM Staff EE stated residents were to be repositioned every 2 hours or as needed if they had pain or needed to be changed. The staff stated Resident #7 was repositioned before lunch by reclining the back of the w/c. The staff stated training had been provided that changing the position of a wheelchair was repositioning. On 4/1/25 at 1:50 PM Staff GG stated residents were repositioned every 2 hours. The staff stated change of position included not lying on a certain side, rolling for the prevention of pressure sores. The staff stated if a resident was in a wheelchair, the preferred reposition would be to lay the resident down. The staff stated a wheelchair that moves the resident back and brings the legs up could be done for repositioning. The staff did not know if Resident #7 was repositioned in the morning as she was not assigned to the hall. On 4/1/25 at 9:12 AM Staff CC, CNA, stated residents needed to be repositioned every 2 hours and checked. On 4/2/25 at 10:57 AM Staff B, Physical Therapist Assistant (PTA)/Director of Rehabilitation (DOR), contract therapy, did not know the specifics of the Broda Reclining w/c, but stated best practice was repositioning residents every 2 hours from their current position, including seated surfaces. The staff stated tilt in space seating systems changed the focus of gravity, changing pressure points, but the seating systems needed to be tilted in space, not reclined. On 4/2/25 at 10:40 AM Staff U, Director of Nursing (DON), stated she would have to look at the facility's policy regarding positioning requirements and the use of reclining w/c's. The facility's Wheelchair Use of Policy from the [NAME] Healthcare Clinical Procedures for Long-Term Care revealed staff were to assist the resident to toilet and reposition frequently. The facility's Positioning the Resident Policy from the [NAME] Healthcare Clinical Procedures for Long-Term Care did not indicate the frequency for repositioning residents.

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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** 41785 Based on observation, interview and record review the facility failed to adequately monitor skin issues and intervene with ordered treatments for 2 of 3 residents reviewed, (Residents #4 and #10). Staff failed to ensure that wound treatments were in place, and detailed skin assessments were completed for Res #4. The clinical record lacked weekly skin assessments for Resident #10. The facility reported a census of 45 residents. Findings included: 1. According to the Minimum Data Set (MDS) date 1/13/25, Resident #4 had a Brief Interview for Mental Status (BIMS) score of 11 (moderate cognitive deficit.) He was totally dependent on staff for toileting hygiene, lower body dressing, and transfers. The resident had Moisture Associated Skin Damage (MASD). The Care Plan last updated on 9/27/24, showed that Resident #4 had Activities of Daily Living (ADL) self-care performance deficits. The resident was being seen by an outside agency wound clinic and rounds would be completed weekly. Resident #4 required the assistance of 2 staff to the toilet and the use of the mechanical lift sit to stand for transfers. His diagnoses included diabetes mellitus, chronic kidney disease stage 3, edema, benign prostatic hyperplasia and diabetic neuropathy. The care plan lacked focus areas and interventions for skin breakdown and edema. On 4/1/25 at 9:31 AM, Resident #4 was in a wheel chair, in his room. He was wearing a pair of sweat pants that fit tightly around his lower extremities. He was not wearing shoes and his feet were swollen, with the right foot much larger than the left. The resident said that he'd had a lot of trouble with fluid retention and for a while it had gotten better. He said that he had some treatments to his legs, but he wasn't sure if there was a dressing on his right leg or not. The resident was waiting for staff to come in and transfer him to the recliner so he could put his feet up. At 9:56 AM, Staff EE, Certified Nurse Aide (CNA) and Staff Q, Licensed Practical Nurse (LPN) had transferred the resident to the toilet and back to the recliner where they prepared to complete the treatments on the right leg. The left leg has Kerlix (bandage roll of gauze) wrapped around it but the right leg did not. The resident had two, fluid filled blisters on the front of his right leg, the entire area was red with extensive dry, pealing skin throughout both lower extremities. There was a small soiled, undated pad stuck to an open sore on the inside of the right leg. Staff Q cleaned the open sore, applied a new, dated, non-adhesive pad, then wrapped the lower leg with Kerlix. Resident #4 commented that sometimes at night, he had to remind staff to wrap his leg. Progress Notes from the Wound Clinic (WC) dated 2/19/25, showed that Resident #4 had venous wounds on the right lower leg. The two, partial thickness wounds limited measurements due to exposed epidermis (outermost layer of skin) and dermis (below the epidermis.) The wound beds were macerated (occurs when skin is exposed to excessive moisture; soft, soggy and light color). Progress Notes from WC dated 3/12/25, showed an order to apply Plurogel to 3 open areas on right lower leg after cleansing with wound wash every 3 days. Apply non-adherent dressing to right lower leg to be changed daily and as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration Record and Treatment Administration Record (MAR/TAR) showed that the order entered on 3/13/25, included the Plurogel application and wound cleaning every 72 hours. The order entries lacked reference to the daily dressing changes. The Skin-Nurse Weekly Skin Observation Tool (SNWSO) showed the following: a. 3/12/25 at 12:01 PM Resident had flaky discolored skin on bilateral legs. Treatment on legs done per doctor's order. The form lacked measurements and detailed description. b. 3/19/25 at 11:04 AM Discoloration on bilateral legs, treatment completed. The form lacked measurements or description. c. 3/26/25 at 2:01 PM, Discoloration on bilateral legs, treatment completed. The form lacked measurements or description. A Nursing Note dated 3/24/25 at 1:38 AM, showed that the resident had edema to bilateral lower extremities, the skin was red with 2 fluid filled blisters to right shin, one measured 10 cm. around and the second blister was 7 cm. x 3 cm. The SNWSOT, dated 4/2/25 at 11:01 AM, lacked measurements, descriptions or mention of the new blisters. Discoloration on bilateral lower extremity. Order Audit Report for Resident #4 showed an order dated 8/1/24 at 1:33 PM, that staff were to include any measurements and progress note with description of skin issues every Wednesday for skin care and to notify the doctor of any new skin issues. On 4/2/25 at 10:50 AM, Staff J, Director of Nursing (DON) agreed that it would be difficult to determine progress or regression of skin condition if the assessments did not include measurements or detailed descriptions. A facility policy from a Nursing Manual dated 2010, titled Skin Care Policy, the needs of each resident would be assessed individually and developed into their plan of care to promote the prevention of skin trauma and prompt healing of the residents entering the facility with break down. Each resident would be assessed individually if a resident was at high risk for skin breakdown, result would be implemented into the plan of care. Nursing staff would measure the ulcers each week, documenting and evaluating a need to change treatment. With any skin breakdown the nursing staff would do an assessment no less than weekly. 49628 2. Resident #10's MDS assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13/15 indicating normal cognition. The document revealed diagnoses of cerebrovascular accident (stroke), hemiplegia (paralysis of 1 side of the body), and depression. The resident required substantial/maximal assistance for rolling in bed, and was dependent on staff for transfers. The document disclosed the resident was at risk for development of pressure ulcers and injuries, had a diabetic foot ulcer, and had pressure reducing devices for chair, bed, applications of ointments/medications other than to feet, and dressings to feet. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #10's Care Plan, dated 3/3/25, revealed the resident was at moderate risk for pressure ulcers. The document provided interventions for staff including pressure relieving cushion to the recliner, pressure relieving device to w/c, and an air mattress. The Electronic Medical Record (EMR) Clinical Physician Orders dated 12/18/25 had an order for completion of the Weekly Skin Observation Tool, including measurements and progress notes with description of skin issues, every evening shift every Wednesday for skin care and notify the physician of any new skin issues dated 11/6/24. The Assessments tab of the EMR on 4/2/25 revealed the last Skin Nurse - Weekly Skin Observation Tool was completed on 3/12/25 and was 14 days overdue with a due date of 3/19/25. The facility failed to complete the Skin Nurse - Weekly Skin Observation Tool as per physician orders to be completed weekly. On 4/2/25 at 10:35 AM when asked about the expectation of completing the Weekly Skin Observation Tool, Staff J, Director of Nursing (DON), and Staff U, DON, did not have a response, but Staff J was observed shaking her head. The facility's Physician Medication Orders Policy from the [NAME] Healthcare Clinical Procedures for Long-Term Care did not address following physician orders that were non medication involved.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interviews and record review the facility failed to provide interventions for pressure ulcer prevention for 1 of 3 residents reviewed, (Resident #1). Resident #1 had a pressure ulcer to the right heel and was found to be without his protective boots and without the ordered treatment dressing. The facility reported a census of 45 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. According to the Minimum Data Set (MDS) dated [DATE], Resident #1 had a Brief Interview for Mental Status (BIMS) score of 0 (severe cognitive deficit.) The resident was totally dependent on staff for toileting and transfers, and required substantial assistance with putting on and taking off footwear and lower body dressing. The resident had a stage 2 pressure injury and treatments included pressure ulcer care, application of ointments/medications and application of dressings to feet. The resident was on Hospice care. The Care Plan updated on 2/19/25, showed that Resident #1 had impairment to skin integrity related to fragile skin and a decline in his cognition and physical condition. He was admitted to Hospice services on 1/25/25. He had padded, protective boots that he was to wear as allowed. A wound specialist, Nurse Practitioner (NP) was seeing the resident for wound care. A Skin Nurse - Weekly Skin Observation Tool dated 1/6/25 at 1:34 PM, showed that a pressure ulcer was discovered on the right heel, measuring 5 centimeters (cm) x 4 cm. The right inner heel was black and mushy and painful. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The summary from the NP wound specialist, dated 1/22/25 showed that the wound was a Stage II and staff were to ensure that Profo (protective) boot was on the right foot at all times. The Hospice Interdisciplinary Group (IDG) Comprehensive Assessment and Plan of Care Update Report showed that on 1/27/25 the right heel was a Stage IV wound. A treatment order, dated 3/10/25 at 8:28 PM, showed that staff were to clean the right heel with Dakins solution, apply small amount of Therahoney to the wound bed, and to cover with foam dressing every 3 days. On 3/31/25 at 9:15 AM, Resident #1 was in his wheel chair in the commons area, in front of the television. His head was hanging, and he was sleeping with a blanket in his lap. His feet rested on the foot pedal and he was wearing gripper socks on his feet. At 10:16 AM, and at 10:46 AM, the resident was in the same position in front of TV. At 11:20 AM, Staff BB, Certified Nurse Aide (CNA) pushed him down the hallway and said she was going to take him in for a bath. Staff BB and another CNA tried to transfer him with the use of the mechanical lift, Sit to Stand, but he was too agitated and they decided to try again later. At 11:48 AM, Resident #1 was at the table in the dining room and was wearing the protective boots on both feet. At 12:47 AM Staff BB and Staff Y CNA used the total mechanical lift with full body sling to transfer him to the bed, where they undressed him. Staff DD, Registered Nurse (RN) came in as they removed his socks and his right foot did not have a treatment dressing. They transferred him to the shower chair and wheeled him into the shower room. At 1:22 PM, after his bath was completed, the CNA's transferred Resident #1 back to the bed and Staff DD, measured the area of the wound on the right heel. She completed the treatment and covered it was a dated dressing. The open area was round, yellow and deep. On 3/31/25 at 2:51 PM, Staff DD, said that she recognized the resident did not have any dressing on his foot and that the CNA's would usually let the nurses know if it had come off so they could put on another one. Staff DD said she thought the depth of the wound was about 0.2 cm. but she didn't have anything to measure it with. On 4/3/25 at 11:30 AM the Administrator said that Resident #1 should have had his protective boots on while in the wheel chair. A facility policy titled: Pressure Ulcer/Injury, Prevention showed that staff would develop a care plan to eliminate or minimize risk factor including pressure relief measures. Residents would be positioned with appropriate surfaces to protect bony prominences. Repositioning would be at least every 2 hours or as designated in the plan of care. If a pressure ulcer was present, the Licensed Nurse was responsible to record condition of the skin, including stage, size, site, depth, color, drainage and odor as well as the treatment provided.

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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** 49628 Based on observation, clinical record review, and staff interviews, the facility failed to protect a resident from a possible accident and injury by pushing the resident in a wheelchair without foot rests for 1 of 5 residents (Resident #12). The facility reported a census of 45 residents. Findings include: Resident #12's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated moderate cognitive impairment. The MDS included diagnoses of non-Alzheimer's Dementia, and Depression. It revealed the resident required partial or moderate assistance for sit to/from stand positions, and transfers to/from bed, wheelchair and toilet. It further indicated the resident utilized a manual wheelchair and required partial/moderate assistance for 50 ' with 2 turns, and partial/moderate assistance for 150 ' in a hallway. Resident #12's Care Plan revealed a focus area of Activities of Daily Living (ADLS) self care performance deficit with interventions included transfers with 1-2 staff assistance, able to self propel w/c. Observed on 3/31/25 at 9:40 AM Resident #12 self propel w/c down the hall towards the nursing station/living room area using bilateral arms and feet slightly off the floor, there were no foot rests. The resident stated she was going to the trailer court. Observed on 3/31/25 at 9:50 AM Staff GG, Certified Nursing Assistant (CNA)/Certified Medication Aide (CMA), push the resident from the end of the hallway to her bedroom without foot pedals; the distance was at least 50 ' . On 4/1/25 at 1:50 PM Staff GG stated if pushing a resident in a wheelchair the staff need to make sure feet are on foot pedals, clothing was not dragging, and Hoyer straps needed to be tucked in. On 4/1/25 at 2:38 PM Staff EE, CNA, stated foot pedals needed to be in place to push a resident in a wheelchair. On 4/1/25 at 9:12 AM Staff CC, CNA, stated residents needed to have foot pedals on their w/c ' s to be pushed by staff. On 4/2/25 at 10:47 AM Staff B, Physical Therapist Assistant (PTA)/Director of Rehabilitation (DOR), contract therapy, stated residents should have foot pedals when being pushed in their w/c ' s. On 4/2/25 at 10:41 AM Staff J, Director of Nursing (DON), expected that residents would have foot pedals when being pushed in their w/c ' s. The facility's Wheelchair Use of Policy from the [NAME] Healthcare Clinical Procedures for Long-Term Care revealed foot rests were to be lowered and the resident's feet placed on the foot rests prior to assisting the resident to the area of the facility desired.

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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. 41785 Based on the previous Centers for Medicare and Medicaid Services (CMS) form 2567 review, staff interviews and facility policy review, the facility failed to ensure they provided a comprehensive, effective Quality Assessment and Performance Improvement (QAPI) program. The facility reported a census of 45 residents. Findings include: A review of the Department of Inspections Appeals and Licensing website revealed that the facility had repeated deficient practices identified during the annual surveys and complaint investigations from 2/15/24, and 2/6/25. The repeated deficiencies cited include: 658 Services Provided Meet Professional Standards 684 Quality of Care 865 QAPI Program and Plan, Disclosure/Good Faith Attempt 880 Infection Prevention and Control A review of the facility Plan of Correction (POC) dated 3/6/25 revealed the following: a. POC for F658 indicated that 4 files a week would be audited. Just 2 files a week had been audited for the first 4 weeks. b. POC for F684 indicated that 4 files a week would be audited. Just 2 files a week had been done. c. POC for F689 indicated that 4 charts a week would be audited for accidents and hazards, safe transfers. Just 2 files a week had been audited for 7 weeks. On 4/3/25 at 11:30 AM the Administrator indicated that they had made progress in many areas and they continued to monitor successes along with the areas that still need work. She acknowledged that there was a misunderstanding on the POC and the number of files that would be audited weekly. The QAPI Facility Plan dated December 2024, identified the governing body and/or the facility administration would provide general oversight for QAPI activities related to resident care and services throughout the facility. The governing body was responsible and accountable for ensuring that: The QAPI program identified and prioritized problems and opportunities that reflect organizational processes, functions and services to residents based on performance indicator data, resident and staff input and other information.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41785 Based on observation, interview and record review the facility failed to ensure that staff followed Enhanced Barrier Precautions (EBP) while providing wound treatments for 1 of 1 resident reviewed (Resident #1). The facility reported a census of 45 residents. Findings include: According to the Minimum Data Set (MDS) date 2/14/25, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 0 (severe cognitive deficit.) The resident was totally dependent on staff for toileting and transfers, and required substantial assistance with putting on and taking off footwear and lower body dressing. The resident had a stage 2 pressure injury and treatments included pressure ulcer care, application of ointments/medications and application of dressings to feet. The resident was on Hospice care. The Care Plan updated on 2/19/25, showed that Resident #1 had impairment to skin integrity related to fragile skin and a decline in his cognition and physical condition. He was admitted to Hospice services on 1/25/25. He had padded, protective boots that he was to wear as allowed. A wound specialist, Nurse Practitioner (NP) was seeing the resident for wound care. On 3/31/25 at 12:51 PM, Staff BB, Certified Nurse Aide (CNA) and Staff Y, CNA, assisted Staff DD, Registered Nurse (RN) with a wound treatment dressing change to the right foot of Resident #1. The three staff members failed to wear gowns during the cares. On 4/3/25 at 6:55 AM, Resident #1 did not have EBP signs on his door to alert staff to wear full Personal Protective Equipment (PPE.) On 4/3/25 at 11:30 AM the Administrator said that they had just posted the signage on the door for Resident #1. She acknowledged that they failed to implement EBP while caring for the residents open wound. According to the undated facility policy titled: Enhanced Barrier Precautions (EBP), the facility would expand the use of PPE beyond situations in which exposure to blood and body fluids were anticipated and refer to the use of the gown and gloves during high-contact resident care activities that provide opportunities for transfer of pathogens to staff hands and clothing. EBP apply to: wounds and or indwelling medical devices.