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	02/06/2025

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. 37074 Based on record review, facility investigative file review, resident and staff interviews, and policy review the facility failed to treat 1 of 3 residents (Resident #5) with dignity while assisting with cares and during transfers. The facility reported a census of 47 residents. Findings include: 1. According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 7/26/24 Resident #5 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested the resident had no cognitive impairment. Resident #5 did not display behaviors during the review period and was not resistive to cares. The MDS documented the following diagnoses for Resident #5: UTI, heart failure, Parkinson's disease, depression, osteoarthritis, overweight, insomnia, chronic pain. The Care Plan focus area with a revision date of 8/8/2022 documented Resident #5 had self-care deficit related to tremors with weakness. The Care Plan documented she required the assistance of one staff with personal cares. A Progress Note dated 10/15/2024 at 11:30 AM documented resident's eyes had greenish matter in them again this morning. After cleansing her eyes with a warm wash cloth, noted to have an old bruise on her upper eye lid going around the outside of her eye to under eye. The facility provided the following document titled Concern/Suggestion Form with Resident #5's name on it, dated 10/15/24 at 9:30 AM. The form contained the following information: this worker visited with resident about a concern she had. She stated that a black girl that has long braided hair was wiping her face. She stated that this happened a day or two ago. She stated that it hurt and she told her to stop but she did not. She stated she felt like she was going to push her eye back. She added her eye was mattery that morning. This writer asked the nurse to look at it. In the corrective actions taken staff documented this was addressed with a self-report and staff termination. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/2025 at 9:14 AM Resident #5 was sitting in a wheelchair in her room with her call light on the table in front of her. When asked if staff have ever been rough with her during cares, Resident #5 stated that's a tough question. When asked if staff have ever been rough while assisting with removing her make up or cleaning her eyes, she stated yes and it's still sore. Resident #5 stated she told the staff member to stop rubbing her eyes because it hurt, but she did not stop. She could not recall the staff member's name. Resident #5 feels safe here and has not had an issue like that since that one time. On 1/22/2025 at 5:11 PM Staff E Licensed Practical Nurse (LPN) acknowledged she documented the old bruise to Resident #5's upper eye lid, around the outside of her eye to under her eye. She indicated when she saw the bruising she asked what happened and the resident told her the CNA one evening wiped her eye really hard while taking her make up off. Resident #5 told the staff member she was hurting her but she kept cleaning her eyes too hard. Staff E stated throughout that day, the resident reported her eye hurt more and more, the bruise became more predominant as it became more painful. It was not dark purple, more light in color. On 1/23/2025 at 11:07 AM Staff F CNA stated she could not remember anything specific when asked about assisting Resident #5 with removing her make up. She denied the resident ever telling her to stop or that it hurt. She stated the facility never brought it to her attention there were concerns with Resident #5. Staff F indicated she did not work on Resident #5's hall the last weekend she worked at the facility and could not remember if she assisted her at any point that weekend. Staff F stated if she had assisted Resident #5 and she reported pain, she would have stopped and called for a nurse. Staff F stated she did not recall the resident ever reporting pain to her. On 1/23/2025 at 1:04 PM Staff J Director of Nursing (DON) stated on 10/15/2024 in the morning she was notified of Resident #5's complaint about a staff member with black hair with red braids had assisted with washing her face. The staff member that assisted her washed her face so hard the resident reported she thought she was going to push her eye out of the socket. When asked if she saw the bruising the DON stated she had pneumonia at the time, both of her eyes were purple in color but one was more discolored than the other above her eye. She could not remember which eye but wanted to say her left eye. The resident reported it happened a couple days prior but could not say for sure what day. She knew it happened during the night time as she was getting ready for bed. The DON stated at the time of the incident, Resident #5 was 100% reliable but did not mention a name. Based on the description Resident #5 gave, they only had one staff member that had black hair with red braids at that time; Staff F. They did not get a statement from Staff F before she was terminated because they were investigating another incident involving her at the same time. The DON was asked about the daily staffing sheets. It was noted when the overnight shift staff are listed on the sheets, they are not assigned on a specific hall. She stated the overnight girls are their regular staff members so they just work where they always work. They also help each other throughout their shifts, going from hall to hall. During a follow-up interview with Staff J, she stated when staff are assisting with washing a resident's eyes they are to gently start with the inner eye to the outer corner of the eye with a warm cloth. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/2025 at 1:45 PM the Social Worker stated a CNA came to her and stated Resident #5 wanted to talk to her. She went down to Resident #5's room and spoke her. The resident stated the CNA washed her face, scrubbed it too hard, hurt her eye. Resident #5 reported her eye was sore during their conversation. She indicated the resident told her it happened a day or two prior. She had told the staff member it hurt and to stop but she did not stop. Resident #5 could not recall the staff's member's name but stated she had braided hair. The Social Worker stated during the conversation she noticed her eye to be a little red but she's not a nurse so she reported it to the nurse then went to the Administrator. When asked what CNA reported to her initially, she was unable to recall but knew she spoke with Staff E. The facility provided a document titled Rights of Residents in Long-Term Care Facilities that indicated residents have the right to be treated with consideration, respect and dignity.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on interview, policy review and record review the facility failed to complete a comprehensive Minimum Data Set (MDS) as directed by the Centers for Medicaid and Medicare Services (CMS), Resident Assessment Instrument (RAI) Version 3.0 Manual assessment for 3 of 4 residents reviewed, (Residents #50, #51 and #149). The facility reported a census of 47 residents. Findings include: The Centers for Medicaid and Medicare Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual dated October 2023 defined an annual assessment as a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless the facility completed a significant change status assessment or a significant correction to the prior quarterly assessment since the previous comprehensive assessment. The Assessment Reference Dates (ARD) must be set within 366 days after the ARD of the previous comprehensive assessment and within 92 days of the quarterly or SCQA (ARD of previous Quarterly assessment plus 92 calendar days). 1) According to the Clinical-MDS page of the electronic chart, printed on 2/2/25 at 4:00 PM, Resident #51's admission assessment dated [DATE] had been accepted. From 7/17/23 until 12/27/24 all other assessments were found to be incomplete. The Admission assessment dated [DATE] was accepted on 2/1/25. 2) The Clinical-MDS page of electronic chart printed on 1/29/25 at 1:47 PM, showed that the annual assessment for Resident #149 was due on 12/20/24. At the time of survey, the document was still in progress. On 2/4/25 at 12:26 PM, the Administrator acknowledged that Resident #51 did not have a full MDS completed from 7/30/23 through 12/27/24. She said that for a period of time, she was initiating the MDS assessments while working in a different building with the understanding that there would be other staff completing them. But, due to many staff issues, the responsibility had fallen on her and it's been difficult to get caught up on the requirements. 44474 3. Review of Resident #50's Census tab revealed admitted [DATE] and discharge date of [DATE]. At the time of survey, review of the MDS assessment dated [DATE] labeled Admission/Medicare 5 day listed as in progress status.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on facility record review and staff interviews the facility failed to complete a significant change MDS within 14 days of the facility recognizing the resident had a significant change for 1 out of 22 residents reviewed, (Resident #33). The facility reported a census of 47. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #33 documented diagnoses of stroke, cancer and hypertension. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Review of Resident #33's Census status revealed 12/13/24 primary payer of hospice private. Review of residents Progress Notes revealed the following: a. On 12/13/24 at 1:46 p.m., resident admitted back to facility from hospitalization . Power of Attorney elected to move forward with hospice admission. Resident will be admitted to hospice today. b. On 12/16/24 at 9:39 a.m., hospice will manage anxiety medications. Review of the care plan with a revision date of 1/27/25 lacked documentation regarding information on which hospice company resident is using and any services being provided by hospice. Review of MDS listing revealed a significant change MDS started on 12/20/24 and was completed on 1/5/25 with 23 days lapsing from the admission to hospice. According to CMS's RAI Version 2.0 Chapter 2 page 2-3 revised on August 2003 revealed a significant change in status must be completed by the end of the 14th calendar day following determination that a significant change has occurred. Interview on 2/4/25 at 12:11 p.m., with the Administrator revealed significant change MDS are automatic when someone starts on hospice care.

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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. 37074 Based on interview, policy review and record review the facility failed to complete a Quarterly Minimum Data Set (MDS) as directed by the Centers for Medicaid and Medicare Services (CMS), Resident Assessment Instrument (RAI) Version 3.0 Manual assessment for 3 of 3 residents reviewed, (Resident #19, #39 and #49). The facility reported a census of 47 residents. 1. Review of Resident #19's Minimum Data Set (MDS) tab in her Electronic Health Record (EHR) revealed a Quarterly MDS assessment was completed on 6/28/2024. A second Quarterly MDS assessment was completed on 11/29/2024. The Quarterly MDS assessment completed on 11/29/2024 was completed five months after the 6/28/2024 Quarterly assessment was completed. 2. Review of Resident #39's MDS tab in his EHR revealed an Admission MDS assessment was completed on 7/10/2024. A Quarterly MDS assessment was completed on 12/6/2024. The Quarterly MDS assessment completed on 12/6/2024 was completed five months after the 7/10/2024 Admission MDS was completed. The facility failed to complete the Quarterly assessments every three months. On 2/4/2025 at 12:43 PM the Administrator verified Resident #19's and Resident #39's MDS assessments were completed more than 3 months apart, outside of the quarterly timeframe. She indicated when she took over as the Administer the MDS assessments were a hot mess and they were not getting completed. Staff would put in their information for their sections but never finished them. When she noticed this, she took the MDS assessments out because she did not want anyone to back date the information they were putting in. According to the MDS 3.0 Resident Assessment Instrument User's Manual dated October 2024 from the www.cms.gov website, a quarterly assessment must be completed at least every 92 days following the previous assessment of any type. Three quarterly assessments must be completed in each 12-month period. 44420 2. Resident #49's Clinical MDS record showed the resident's admission MDS completed on 8/9/23. The facility started but failed to complete documentation on quarterly assessments. The next accepted MDS occurred with a Significant Change on 1/21/25. The undated Resident Assessment Instrument Process (RAI/MDS) policy identified the facility will initiate, and code, transmit, modify/inactivate and store all required OBRA a PSS assessments as delineated in chapters 2, 3, 4, 5 and 6 of the current CMS RAI User's Manual. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CMS RAI Version 3 Manual dated October 2024 regarding the assessment schedule directed an Omnibus Budget Reconciliation Act of 1987 (OBRA) assessment (comprehensive or Quarterly) is due every quarter unless the resident is no longer in the facility. There must be no more than 92 days between OBRA assessments. An OBRA comprehensive assessment is due every year unless the resident is no longer in the facility. There must be no more than 366 days between comprehensive assessments. PPS assessments follow their own schedule. See Chapter 2 for details. In an interview on 2/3/25 at 3:32 PM, the Administrator reviewed the MDS record for Resident #49 then reported the facility failed to complete quarterly assessments. When asked why, the Administrator reported her position within the company and changes in the MDS position caused failure to complete MDS requirements including quarterly assessments. The Administrator reported she was aware of the issues and worked to make improvements.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37074 Based on record review, staff interview and the MDS 3.0 Resident Assessment Instrument User's Manual the facility failed to complete and/or submit MDS assessments in a timely manner for 4 of 37 residents reviewed, (Resident #23, #36, #39 and #96). The facility reported a census of 47 residents. Findings include: 1. On [DATE] at 10:56 AM a review of Resident #23's Minimum Data Set (MDS) tab in his Electronic Health Record (EHR) revealed the most recent MDS was completed on [DATE] with a listed description as Significant Change. A Progress Note dated [DATE] at 7:39 AM documented Resident #23 was sent to the emergency room (ER). At 10:32 AM a Progress Note documented he was being admitted to the hospital and his Power of Attorney (POA) was aware. The facility failed to complete a discharge assessment once he was transferred and admitted to the hospital on [DATE]. 2. On [DATE] at 11:12 AM a review of Resident #36's MDS tab in his EHR revealed his End of Prospective Payment System (PPS) Part A Stay dated [DATE] status was documented as in progress. The facility failed to submit his [DATE] End of PPS Part A Stay MDS assessments. 3. On [DATE] at 3:55 PM a review of Resident #39's MDS assessment tab in his EHR revealed his [DATE] Admission MDS status documented as in progress. The facility failed to submit his [DATE] Admission MDS as completed. 4. On [DATE] at 1:52 PM a review of Resident #96's assessment tab in her EHR revealed his last MDS was a Quarterly assessment that was completed on [DATE]. A Progress Note dated [DATE] at 2:37 AM documented Resident #96 was found to not be breathing. Resident was noted to not have breath sounds or heart tones. A call to hospice was made to notify them of his death. The facility failed to complete a death in the facility MDS. On [DATE] at 12:43 PM the Administrator verified Resident #96's MDS assessment after he expired was not completed. The Administrator stated she started auditing all MDS assessment in December of 2024. She verified Resident #23's discharge MDS was not completed and was unsure how she missed that one. She indicated Resident #36's in progress MDS was completed and submitted on [DATE] and Resident #39 in progress MDS was completed and submitted on [DATE]. She indicated when she took over as the Administer the MDS assessments were a hot mess and they were not getting completed. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the MDS 3.0 Resident Assessment Instrument User's Manual dated [DATE] from the www.cms.gov website, a death in facility refers to when the resident dies in the facility. The facility must complete a Death in Facility tracking record. A discharge refers to the date a resident leaves the facility. Any of the following situations warrant a Discharge assessment, regardless of facility policies regarding opening and closing clinical records and bed holds: resident is admitted to a hospital.

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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** 44474 Based on clinical record review, facility policy and staff interview the facility failed to provide accurate assessments on residents to reflect the residents current needs for 1 of 22 residents reviewed, (Resident #33). The facility reported a census of 47 residents. Findings include: 1.The Minimum Data Set (MDS) assessment dated [DATE] for Resident #33 documented diagnoses of stroke, cancer and hypertension. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Review of the MDS dated [DATE] revealed the following information: a. Resident had a pressure ulcer or injury, a scar over bony prominence, or a non-removable dressing device. b. Question of does this resident have one or more unhealed pressure ulcers or injury was answered yes. c. Number of stage 2 pressure ulcers was answered 1. Interview on 2/3/25 at 3:00 p.m., with Staff J, Director of Nursing (DON) revealed Resident #33 does not have a pressure ulcer and Staff U, DON revealed Resident #33 had a laceration but doesn't have a pressure ulcer. Staff J and Staff U are going to look into it. Interview on 2/4/25 at 8:45 a.m., with Staff J revealed Resident #33 does not have a pressure ulcer and there had to have been incorrect documentation for her. The facility does not have a policy on maintaining accurate resident records.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, facility policy and staff interview the facility failed to provide a written summary of the baseline care plan for 3 of 22 residents reviewed, (Resident #24, #28 and #41). The facility reported a census of 47 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #24 documented diagnoses of chronic obstructive pulmonary disease (COPD), respiratory failure and dependence on supplemental oxygen. The MDS showed the Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. Review of Resident #24's Census tab revealed an admitted [DATE]. Review of Resident #24's record lacked documentation that facility staff reviewed the initial care plan with the resident or her representative or provided a copy of the baseline care plan to the resident or her representative. 2. The MDS assessment dated [DATE] for Resident #28 documented diagnoses of hypertension, non-Alzheimer's Dementia and coronary artery disease. The MDS showed the BIMS score not completed due to resident rarely or never understood. Review of Resident #28's Census tab revealed an admitted [DATE]. Review of Resident #28's record lacked documentation that facility staff reviewed the initial care plan with the resident or her representative or provided a copy of the baseline care plan to the resident or her representative. 3. The MDS assessment dated [DATE] for Resident #41 documented diagnoses of hypertension, anxiety disorder and insomnia. The MDS Showed the BIMS score of 12, indicating moderate cognitive impairment. Review of Resident #41's Census tab revealed an admitted [DATE]. Review of Resident #41's record lacked documentation that facility staff reviewed the initial care plan with the resident or her representative or provided a copy of the baseline care plan to the resident or her representative. Review of facility provided policy titled Preliminary Care Plan undated revealed to ensure the resident's needs are are met and maintained, a preliminary care plan will be developed within twenty-four hours of the resident's admission. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/30/25 at 9:33 a.m., with Staff U, Director of Nursing revealed the facility does not keep the kardex sheet they put in the room and confirmed that is what is considered a baseline care plan. Staff U further revealed the facility has not offered to give that to the resident and or family and they do not keep the old kardex when it is updated, so they do not have the admission one.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on clinical observation, record review and staff interview the facility failed to develop comprehensive care plans for continuous positive airway pressure (CPAP), pain management, urinary tract infection, catheter, and hospice services for 4 out of 22 residents reviewed, (Residents #21, #24, #28 and #33). The facility reported a census of 47 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #21 documented the Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. The MDS showed diagnoses of anemia, coronary artery disease and heart failure. The MDS also showed Resident #21 experienced shortness of breath or trouble breathing when laying flat. The Physician Orders showed on 10/17/24 a CPAP ordered for at night and every evening. Review of the Care Plan for Resident #21 showed the facility failed to develop a comprehensive care plan for the need and usage of the CPAP. Observation on 1/18/25 at 9:49 AM showed Resident #21 asleep in his room without wearing a CPAP. In an interview on 1/19/25 at 1:34 PM, Resident #21 reported that he is supposed to use the CPAP machine but doesn't always like to use it. The Care Planning Interdisciplinary policy dated April 2016 identified: 1. A comprehensive care plan for each resident is developed within 14 days of admission. 2. The care plan is based on the residents comprehensive assessment and is developed by a care plan interdisciplinary team which may include facility staff, therapy staff, contracted care, hospice staff, physicians, etc. 3. Care plan meetings will be offered to accommodate the resident or responsible party. Meetings will be scheduled at intervals. Meetings may be conducted as needed. For the mechanics of how the interdisciplinary team meets its responsibilities in the development of the interdisciplinary care plan that is at the direction of the care plan team. In an interview on 2/5/25 at 2:06 PM, the Assistant Director of Nursing (ADON) reviewed Resident's #21 Care Plan and confirmed the facility failed to develop a comprehensive care plan regarding the CPAP. The ADON stated the CPAP should be on there. I will get it taken care of. 44474 (continued on next page)

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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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The MDS assessment dated [DATE] for Resident #24 documented diagnoses of chronic obstructive pulmonary disease (COPD), respiratory failure and dependence on supplemental oxygen. The MDS showed the BIMS score of 14, indicating no cognitive impairment. Observation on 1/27/25 at 11:06 a.m., revealed Resident #24 had a catheter and Resident #24 confirmed during the interview the catheter was placed during her recent hospitalization . Review of Resident 24's Care Plan revealed the resident has a catheter with a date created of 1/27/25 with an initiated date of 1/2/25. During interview on 2/3/25 at 12:39 p.m., Staff U, Director of Nursing (DON) revealed she needs education on how to complete the care plans. She was gone when resident admitted and she realized the resident did not have a care plan completed so she dated it back to the admission as she thought she was admitted with the catheter. 3. The MDS assessment dated [DATE] for Resident #28 documented diagnoses of hypertension, non-Alzheimer's Dementia and coronary artery disease. The MDS showed the BIMS score not completed due to resident rarely or never understood. Review of facility provided Incident Report dated 7/4/24 revealed resident had an unwitnessed fall. Immediate intervention initiated was a walker within reach with a note changed to reminder sign. Review of the Care Plan with a revision date of 9/16/24 revealed an intervention of reminder sign in room to wait for staff assist before getting up with a created date of 9/15/24 with date initiated 7/4/24. 4. The MDS assessment dated [DATE] for Resident #33 documented diagnoses of stroke, cancer and hypertension. The MDS showed the BIMS score of 15, indicating no cognitive impairment. Review of Resident #33's census status revealed 12/13/24 primary payer of hospice private. Review of residents Progress Notes revealed the following: a. On 12/13/24 at 1:46 p.m., resident admitted back to facility from hospitalization . Power of Attorney elected to move forward with hospice admission. Resident will be admitted to hospice today. a. On 12/16/24 at 9:39 a.m., hospice will manage anxiety medications. Review of the Care Plan with a revision date of 1/27/25 lacked documentation regarding information on which hospice company resident was using and any services being provided by hospice. Review of facility provided policy titled Care Planning- Interdisciplinary reviewed April 2016 revealed our facilities care planning interdisciplinary action team is responsible for the development of an individual comprehensive care plan for each resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 2/3/25 at 12:39 p.m., with Staff U, DON revealed she needed education on the care plans with dating specifically. Staff U stated she had been on leave and before she left she had everything up to date so when she came back and found that things were not done it has been frustrating. Staff U further revealed the nursing staff should be doing the care plan interventions after a fall but with the turnover it has been difficult to keep all the nurses trained.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 develop resident-specific care plans for 4 of 22 residents reviewed, (Resident #31, #11, #39 and #32). The facility reported a census of 47 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #31 had a Brief Interview for Mental Status (BIMS) score of 14 (intact cognitive ability). The resident required moderate assistance with toileting hygiene, lower body dressing, and toileting transfers. His diagnosis included; renal insufficiency, peripheral vascular disease, and hip fracture. Resident #31 did not have a pressure injury upon admission on 12/28/23 and staff were to provide a pressure reducing device for his chair and bed. The Care Plan last reviewed on 8/30/24, showed Resident #31 had insomnia and chronic fatigue. He did not participate in activities and preferred to stay in his room. The resident required 1-2 staff assistance with a walker for transfers and he was encouraged to use the call light. The care plan lacked any reference to skin conditions or interventions to prevent pressure sores. On 1/27/25 at 12:20 PM, Resident #31 was sitting in a recliner in his bedroom. His speech was soft, and he said that he had a sore on his bottom that was causing him some discomfort. An inspection of the recliner seat revealed that he was sitting directly on the vinyl seat and there was no pressure-reducing device. 2) According to the MDS dated [DATE], Resident #11 had a BIMS score of 15 (intact cognitive functioning.) She had limited functioning, and used a walker and a wheel chair for mobility. She required partial assistance for sit to stand and toileting transfers. She was frequently incontinent of urine and occasionally incontinent of bowel. Her diagnosis included coronary artery disease, diabetes mellitus, arthritis, sepsis and anxiety disorder. The Care Plan for Resident #11 was last revised on 10/2/24, and staff were to monitor for cognition decline. She required the assistance of one staff with a wheelchair for long distances mobility. An Incident Report dated 9/5/24 at 11:15 PM, showed that two Certified Nurse Aides (CNA) had transferred the resident with the use of a mechanical lift, Sit to Stand, and the resident slipped out of the sling and into the floor. On 1/27/25 at 3:45 PM, Resident #11 was in her wheel chair in her room. She had supplemental oxygen via nasal cannula and struggled to breath as she spoke. When asked if she'd had any falls, the resident said that she hadn't been feeling very well and was weak, so the staff used a Sit to Stand to transfer her to the bathroom. She said that she was so week she couldn't stand any longer, then slid from the machine onto the floor. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/6/25 at 8:02 AM Staff J, Director of Nursing said that Resident #11 was usually one assist, but when she was sick, they would use the Sit to Stand. She said that if the resident was not bearing weight enough to stand on the mechanical lift, she would have sent her out to be checked, because it was out of her normal. Staff J was not sure that the use of the mechanical lift should have been on the Care Plan, but something along the likes of monitoring for change of status and steps to take at that point would be appropriate. A facility policy titled: Care Planning-Interdisciplinary, dated April 2016 showed that care plans would be based on the resident's comprehensive assessment. The Care Planning/Interdisciplinary Team was responsible for the development of individualized care plans. 44420 3. The MDS assessment dated [DATE] for Resident #32 documented diagnoses of seizure disorder or epilepsy, anxiety disorder, depression, and bipolar disorder. The MDS revealed Resident #32 was taking antipsychotic, antianxiety and antidepressant medications in the review period. The Clinical Orders for Resident #32 showed: a. Buspirone started on 7/12/24 for anxiety. b. Sertaline started on 7/12/24 for depression. c. Seroquel started on 7/11/24 for bipolar disorder. The Medication Administration Record for February 2024 showed the following medications administered to Resident #32 as ordered: a. Buspirone 10 milligrams (mg) one time a day, b. Sertaline 25 mg one time a day, c. Seroquel 50 mg two times a day. The Care Plan for Resident #32 failed to include the behaviors resident displayed, non-pharmacological interventions when behaviors were displayed or what targeted behaviors staff were to monitor for. The undated Quarterly Review of Care Plans policy identified: 1. The care plan interdisciplinary team is responsible for maintaining care plans on a current status. 2. The care planning interdisciplinary team is responsible for the periodic review and updating of care plans: a. When there has been a significant change in the residence condition. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. When the desired outcome is not met. c. When the resident has not been readmitted to the facility from a hospital stay; and d. at least quarterly. In an interview on 2/5/25 at 2:06 PM, the Assistant Director of Nursing (ADON) reported she managed the care plans and was not aware that information on behaviors resident displayed, non-pharmacological interventions when behaviors were displayed or what targeted behaviors staff were to monitor for were required on care plans. 37074 4. The quarterly Minimum Data Set (MDS) with a reference date of 12/6/24 documented a Brief Interview of Mental Status (BIMS) score of 0. A BIMS score of 0 suggested severe cognitive impairment. Resident #39 displayed physical and verbal behavioral symptoms directed towards others occurred 1 to 3 days. The MDS documented he rejected care 1 to 3 days. The MDS documented he utilized a walker and wheelchair. The MDS documented he received an antipsychotic, antianxiety, antidepressant, and an opioid. The MDS documented he utilized an alarm daily. Resident #39 was always continent of urine and was frequently incontinent of bowel. The MDS listed the following diagnoses: atrial fibrillation, anemia, heart failure, hip fracture, stroke, dementia, anxiety, depression, insomnia, glaucoma, macular degeneration, and thrombocytopenia. A Care Plan focus area with a revision date of 8/30/2024 documented Resident #39 was dependent on staff for meeting emotional, intellectual, physical, and social need due to cognitive deficits, dementia, and behaviors. The Care Plan documented the follow interventions with an initiation date of 8/27/2024: for toilet use he required 1-2 staff assistance and for transfers he required 2 staff assistance for transfers with a gait belt. Staff were encouraged to use a walker when able, however he had a history of refusing. Resident #39 had a history of refusing gait belt at times, staff are to encourage the usage of the gait belt. A Progress Note dated 1/23/2025 at 9:24 AM documented an evaluation for safe transfers because resident was unable to follow verbal cues and becomes frustrated and agitated if over prompted. He is currently a 2 staff assistance but to prevent injury to his person and staff, an EZ Stand (mechanical lift) as needed. However, he is unsafe at times for the EZ Stand, not following verbal cues so this is the reason for the evaluation for safe transfers. On 1/21/2025 and 1/22/2025 during continuous observations, it was noted Resident #39 had an EZ Stand in his room. On 1/21/2025 at 11:15 AM Staff C CNA (Certified Nursing Assistant) stated she has assisted Resident #39 with transfers by using an EZ Stand. On 1/21/2024 at 2:29 PM Staff D CNA stated in the pasted Resident #39 would transfer without an EZ Stand. Currently they would use an EZ Stand to transfer him but at times the resident will push staff away while they assist with the transfer. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/21/2024 at 4:04 PM the Administrator stated on 1/5/2025 Staff C spoke with her about a transfer her and Staff D completed with Resident #39. She stated during the transfer Resident #39 would not hang on to the EZ Stand so they assisted him back to his wheelchair. On 1/22/2025 at 12:02 PM Staff A CNA stated when assisted with Resident #39 it can take two to three staff with a mechanical lift at times. On 1/23/2025 at 2:50 PM Staff B Physical Therapist Assistant (PTA) stated the therapy department completed an evaluation when he was first admitted to the facility for transfers. They completed an evaluation today and her boss recommended an EZ Stand for transfers. On 2/4/2025 at 12:25 Staff J Director of Nursing (DON) stated on 1/22/2024 they received an order for therapy to complete an elevation for safe transfers. Before the evaluation he was an assistance of 2 staff or EZ stand. She was informed when the survey started on 1/21/2025 the care plan documented he was an assisted of 1-2 staff but staff interviews and record review found they were using the EZ stand for transfers. The care plan did not include the use of an EZ stand for transfers. She stated their previous MDS coordinator also was in charge of care plans. The DON stated as of 1/22/2025 the care plan should have included the use of an EZ stand. The facility provided a policy titled Care Planning-Interdisciplinary, with a reviewed date of April 2016. The policy contained the following policy statement: our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team which may include facility staff, therapy staff, contracted care, hospice staff, physicians, etc.

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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, interview and record review the facility failed to ensure that staff followed physicians' orders for 2 of 22 residents reviewed, (Resident #31 and #39). Staff failed to contact the physician with high blood pressures for Resident #31. Resident #39 had an order for anti-anxiety medication, staff failed to utilize and document as ordered. The facility reported a census of 47 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #31 had a Brief Interview for Mental Status (BIMS) score of 14 (intact cognitive ability). The resident required moderate assistance with toileting hygiene, lower body dressing, and toileting transfers. His diagnosis included; renal insufficiency, peripheral vascular disease, and hypertension. The Care Plan last reviewed on 8/30/24, showed Resident #31 had insomnia and chronic fatigue. He did not participate in activities and preferred to stay in his room. The resident had hypertension, staff were to provide daily blood pressure assessments per physician orders. The Order tab in the electronic chart showed an order dated 6/13/24 at 3:30 PM, for staff to take Blood Pressure (BP) daily and contact the Primary Care Provider (PCP) if the BP was less than 100/60 or greater than 140/90. From 6/30/24 - 7/28/24 the BP was higher than 140/90, 10 times and the chart lacked documentation that the physician had been contacted. A hand-written order from the PCP dated 7/29/24 at 11:10 AM, indicated that the resident was in for a 3 month visit. Blood pressure was consistently greater than 140/90 and the provider was not notified. The hypertension medication was increased. According to the Vitals tab, the BP for Resident #31 was over 140/90 on 9/16, 9/17, 9/21, 9/22, 12/14 and 1/25/25 and the chart lacked documentation that the PCP had been contacted. On 2/6/25 at 8:02 AM, Staff J Director of Nursing acknowledged that staff needed to follow doctor's orders and document that they followed through. 37074 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The quarterly Minimum Data Set (MDS) with a reference date of 12/6/24 documented a Brief Interview of Mental Status (BIMS) score of 0. A BIMS score of 0 suggested severe cognitive impairment. Resident #39 displayed physical and verbal behavioral symptoms directed towards others occurred 1 to 3 days. The MDS documented he rejected care 1 to 3 days. The MDS documented he utilized a walker and wheelchair. The MDS documented he received an antipsychotic, antianxiety, antidepressant, and an opioid. The MDS documented he utilized an alarm daily. Resident #39 was always continent of urine and was frequently incontinent of bowel. The MDS listed the following diagnoses for Resident #39: atrial fibrillation, anemia, heart failure, hip fracture, stroke, dementia, anxiety, depression, insomnia, glaucoma, macular degeneration, and thrombocytopenia. The Care Plan focus area with a revision date of 1/21/2025 documented Resident #39 had the potential to be physically aggressive as staff attempt to provide cares or redirect him. He has become combative with Certified Nursing Assistants (CNAs) during transfers, toileting, and cares. The care plan directed staff to allow him to de-escalate by allowing him time by himself and redirecting him, assess and anticipate his needs such as food, thirst, toileting needs, comfort level, body positioning, pain, etc. Staff are encouraged to modify his environment such as adjusting the room temperature to a comfortable level, reduce noise, dim lights, place familiar objects in the room, or keep the door closed. Staff are to administer medications as ordered. The Care Plan focus area with a revision date of 8/27/2024 documented Resident #39 used anti-anxiety medications related to adjustment issues, dementia, and anxiety disorder. The care plan directed staff to administer his anti-anxiety medications as ordered by the physician, monitor for side effects and effectiveness every shift. The Care Plan focus area with a revision date of 8/27/2024 documented Resident #39 used psychotropic medications related to behavior management, disease process, dementia, and anxiety. The care plan directed staff to administer his psychotropic medications as ordered by the physician, monitor for side effects and effectiveness every shift. Review of Resident #39's August 2024 Medication Administration Record (MAR) revealed the following orders: a) Lorazepam (anti-anxiety) 0.5 milligrams (mg), give 1 tablet by mouth every 6 hours as needed (PRN) for anxiety, agitation for 30 days. This order had a start date of 7/29/2024 and a discontinued date of 8/15/2024, b) Lorazepam 0.5mg, give 1 tablet by mouth every 6 hours PRN for anxiety, agitation for six months. This order had a start date of 8/15/2024. The following Progress Notes and Orders-Administration Note were documented for Resident #39: a) On 8/1/2024 at 12:58 PM PRN lorazepam was given for agitation. There was no behavior note documented to include non-pharmacological interventions. b) On 8/1/2024 at 7:11 PM PRN lorazepam was given due to resident being restless, agitated, has set off personal alarms multiple times. There was no behavior note documented to include non-pharmacological interventions. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) On 8/2/2024 at 1:20 AM PRN lorazepam was given to due resident being restless and continued attempts to self-transfer. There was no behavior note documented to include non-pharmacological interventions. d) On 8/4/2024 at 12:03 AM PRN lorazepam was given for increased restlessness. There was no behavior note documented to include non-pharmacological interventions. e) On 8/5/2024 at 6:10 PM PRN lorazepam was given for restlessness, aggression, setting off his personal alarms multiple time. There was no behavior note documented to include non-pharmacological interventions. f) On 8/6/2024 at 3:40 PM PRN lorazepam was given for restlessness, aggression, setting off his personal alarms multiple time. There was no behavior note documented to include non-pharmacological interventions. g) On 8/7/2024 at 5:57 PM PRN lorazepam was given for agitation and anxiety. There was no behavior note documented to include non-pharmacological interventions. h) On 8/8/2024 at 8:05 AM PRN lorazepam was given for agitation and anxiety. There was no behavior note documented to include non-pharmacological interventions. i) On 8/8/2024 at 9:39 PM PRN lorazepam was given for agitation. There was no behavior note documented to include non-pharmacological interventions. j) On 8/11/2024 at 10:56 PM PRN lorazepam was given due to resident being restless and unable to sit still, provided PRN medication per order. There was no behavior note documented to include non-pharmacological interventions. k) On 8/13/2024 at 5:29 PM PRN lorazepam was given due to resident being restless. There was no behavior note documented to include non-pharmacological interventions. l) On 8/14/2024 at 4:40 PM PRN lorazepam given due to resident being restless. There was no behavior note documented to include non-pharmacological interventions. m) On 8/15/2024 at 5:43 PM PRN lorazepam given due to resident being restless and agitated. n) On 8/16/2024 at 5:59 PM PRN lorazepam was given. There was no behavior note documented to include non-pharmacological interventions. o) On 8/17/2024 at 9:44 PM PRN lorazepam was given due to the resident being restless. There was no behavior note documented to include non-pharmacological interventions. p) On 8/21/2024 at 10:00 PM PRN lorazepam was given for agitation. There was no behavior note documented to include non-pharmacological interventions. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	q) On 8/22/2024 at 3:21 AM PRN lorazepam was given due to resident being aggressive with staff, wrung the nurse's arm, swung fist repeatedly at staff. Resident was continuously trying to get out of bed, and being aggressive provided PRN medication per orders. There was no behavior note documented to include non-pharmacological interventions. r) On 8/22/2024 at 9:33 AM PRN lorazepam given due to resident being agitated. There was no behavior note documented to include non-pharmacological interventions. s) On 8/25/2024 at 5:02 PM PRN lorazepam given due to resident being agitated. There was no behavior note documented to include non-pharmacological interventions. t) On 8/25/2024 at 11:28 PM PRN lorazepam given due to resident being agitated. There was no behavior note documented to include non-pharmacological interventions. u) On 8/26/2024 at 4:49 PM PRN lorazepam given due to resident being aggressive and restless. There was no behavior note documented to include non-pharmacological interventions. v) On 9/1/2024 at 10:21 PM PRN lorazepam given due to resident's increased agitation and restlessness, provided PRN medication per orders. w) On 9/4/2024 at 9:54 PM PRN lorazepam given due to resident's agitation. There was no behavior note documented to include non-pharmacological interventions. x) On 9/7/2024 at 4:51 PM PRN lorazepam given due to resident's agitation. There was no behavior note documented to include non-pharmacological interventions. y) On 9/7/2024 at 11:27 PM PRN lorazepam given due to resident's agitation and restlessness that required the PRN medication. There was no behavior note documented to include non-pharmacological interventions. z) On 9/10/2024 at 10:53 AM PRN lorazepam given due to resident's agitation. There was no behavior note documented to include non-pharmacological interventions. aa) On 9/11/2024 at 11:51 AM PRN lorazepam given due to resident's increased anxiety. bb) On 9/14/2024 at 10:57 PM PRN lorazepam given due to resident's agitation. cc) On 9/17/2024 at 10:30 PM PRN lorazepam given due to resident's increasing restlessness and violent towards staff. dd) On 9/22/2024 at 7:45 PM PRN lorazepam given due to resident's agitation. ee) On 9/28/2024 at 1:30 AM PRN lorazepam given due to resident's agitation. ff) On 9/28/2024 at 4:09 PM PRN lorazepam given due to resident's increased agitation, setting off personal alarms multiple times. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gg) On 10/1/2024 at 4:59 PM PRN lorazepam given due to resident's agitation. There was no behavior note documented to include non-pharmacological interventions. hh) On 10/5/2024 at 12:06 AM PRN lorazepam given due to resident's agitation and kept trying to get out of bed. There was no behavior note documented to include non-pharmacological interventions. ii) On 10/5/2024 at 8:05 AM PRN lorazepam given due to resident's anxiety and being grumpy with staff. There was no behavior note documented to include non-pharmacological interventions. jj) On 10/6/2024 at 7:47 PM PRN lorazepam given due to resident's agitation. There was no behavior note documented to include non-pharmacological interventions. kk) On 10/8/2024 at 8:34 AM PRN lorazepam given due to resident grabbing staff during meal time. There was no behavior note documented to include non-pharmacological interventions. ll) On 10/15/2024 at 4:39 AM PRN lorazepam given due to resident's agitation. There was no behavior note documented to include non-pharmacological interventions. mm) On 10/25/2024 at 6:24 PM PRN lorazepam given due to resident's agitation. There was no behavior note documented to include non-pharmacological interventions. nn) On 10/26/2024 at 1:28 PM PRN lorazepam given due to resident's agitation. There was no behavior note documented to include non-pharmacological interventions. oo) On 10/29/2024 at 11:53 PM PRN lorazepam given due to resident continuing to be restless and increasingly agitated. There was no behavior note documented to include non-pharmacological interventions. pp) On 1/17/2024 at 1:38 AM PRN lorazepam given due to resident's anxiety and agitation. There was no behavior note documented to include non-pharmacological interventions. The Progress Notes lacked documentation of non-pharmacological interventions prior to administering the resident's PRN lorazepam. On 2/24/2025 at 11:12 AM Staff E Licensed Practical Nurse (LPN) stated when a resident needs a PRN medication, she would look at the orders and administer the medication as ordered. When asked what type of documentation is included when administering a PRN, Staff E stated if it's for behaviors they would put in a behavior note about what behaviors the resident was having, interventions tried and failed. She added at times they will put this information in the orders Progress Notes as well. On 2/4/2025 at 12:25 PM Staff J Director of Nursing (DON) stated staff are to attempt to do non-pharmacological interventions prior to giving a PRN. Resident #39 does have a hard time following commands, so staff will allow him time to calm down, attempt to reposition him. She added it all depends on where he is at mentally right then and there. When asked where staff are to chart the non-pharmacological interventions attempted, she stated they document a progress note before administering the medication. The DON was informed staff reported they also chart behavior notes with non-pharmacological interventions but during record review, that is not consistently being completed. She indicated that would be a big education piece for all staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on interviews with staff and Hospice Nursing, record and medication review, the facility failed to assess residents and ensure they had appropriate interventions for 3 of 22 residents reviewed, (Resident #152, #33 and #24). Resident #11 had an unwitnessed fall that resulted in a fracture, staff failed to send her to the hospital for observation until 6 hours later and failed to document neurological assessments. Residents #33 and #24 missed medication doses because they were not available at the facility. The facility reported a census of 47 residents. Findings include: 1) According to the MDS dated [DATE], Resident #152 had a BIMS score of 12 (moderate cognitive deficits.) She used a walker and wheelchair for mobility. Resident #152 required set up assistance for hygiene and eating and was independent with sit to stand, toileting, transfer and walking 10 feet. The resident had diagnoses that included; hip fracture, cerebrovascular accident. The resident did not have any pain in the 5 day look back period. The Care Plan updated on 9/12/24, for Resident #152 showed the resident was at risk for falls, staff were to ensure she was wearing appropriate footwear. A reminder sign was placed on the walker for her to ask for staff assistance for help. The resident had some pain and staff were instructed to assess and monitor for non-verbal signs of pain. An Incident Report dated 9/12/24 at 3:00 PM, showed that on 9/12/24, Resident #152 had her call light turned on and when the Aide went to check on her, they found that she was on the floor. The Incident Report indicated that neurological assessments were initiated immediately and the resident was assisted back to bed and given pain medication. At 10:00 PM, the resident still complained of leg pain and was sent to the hospital. On 9/13/24 at 4:10 AM, the facility was informed the resident was admitted to the hospital for a pelvic fracture. The chart showed that initial vital signs had been taken at the time of the fall and 5 minutes later. The chart lacked any further vitals or neurological assessments. The fax out to the doctor on 9/12/24 at 3:43 PM, and signed by the physician at 4:55 PM, indicated that the nurse communicated to the doctor that the resident had pain in the right leg, resident has no injuries. Staff requested a urinalysis because the resident had increased confusion. On 1/28/25 at 2:49 PM, Staff Z Licensed Practical Nurse (LPN) said that she was the charge nurse at 2:00 PM when Resident #152 had the fall with fracture. The Certified Nurse Aide (CNA) called for help and she and Staff AA, LPN went back to check on the resident. The resident was laying on the floor on her right side. She was complaining of pain on the right side, and they used the Mechanical Lift to get her off the floor and into bed. Before they moved her, they put her onto her back and did range of motion and the resident was able to lift and bend her legs. She did not see any shortening; the resident did grimace and indicate pain at that time. She said that the family came to visit later and that was the last interaction that Staff Z had with the resident that evening because she was no longer charge nurse. She didn't know what Staff AA may have done for assessment the rest of the night. She said that they did start neuro assessments and she contacted the doctor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 3:00 PM, Staff AA said that the fall was too long ago, she did not remember how they transferred the resident back to bed, if she had pain or if neurological assessments had been completed, but it would be documented in the chart. On 1/29/25 at 2:00 PM, Staff U, Director of Nursing (DON) looked through the charting for Resident #125 and did not find the assessment charting. Staff U indicated that they did not have a policy on conducting neurological assessments after a fall. On 2/6/25 at 8:02 AM, Staff J, DON said that the nurses told her they completed Neurological assessments after the fall but she was unable to find them. She said that she would have liked the nurses to have sent the resident out for observation sooner. If was unusual for Resident #152 to complain of pain, they should have asked for more direction from one of the DON's or the doctor. 44474 2) The MDS assessment dated [DATE] for Resident #24 documented diagnoses of chronic obstructive pulmonary disease (COPD), respiratory failure and dependence on supplemental oxygen. The MDS showed the BIMS score of 14, indicating no cognitive impairment. Review of Resident #24's January Medication Administration Record revealed the following orders: a. Fexofenadine tablet daily for allergic rhinitis b. Yupelri Inhalation Solution daily for acute respiratory failure Review of Resident #24's Progress Notes revealed the following: a. 1/3/25 at 10:26 a.m., Fexofenadine tablet daily, do not have, call pharmacy. b. 1/3/25 at 10:27 a.m., Yupelri Inhalation Solution, do not have will call pharmacy. c. 1/6/25 at 7:05 a.m., Fexofenadine tablet daily, do not have any yet. d. 1/6/25 at 11:59 a.m., Yupelri Inhalation Solution, resident explained we do not have the right piece of equipment for this inhaler. Will reach out to her son because she thinks he has the piece. e. 1/7/25 at 7:36 a.m., Fexofenadine tablet daily, we do not have this stocked. f. 1/7/25 at 10:01 a.m., Yupelri Inhalation Solution, no note added. g. 1/8/25 at 7:40 a.m., Fexofenadine tablet daily, do not have. h. 1/10/25 at 7:49 a.m., Fexofenadine tablet daily, do not have. i. 1/11/15 at 7:57 a.m., Fexofenadine tablet daily, do not have. j. 1/12/25 at 7:37 a.m., Fexofenadine tablet daily, do not have stocked. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	k. 1/13/25 at 7:32 a.m., Fexofenadine tablet daily, do not have stocked. Review of Resident #24's Electronic Health Record (EHR) failed to indicate physician notification for omitted administrations of fexofenadine tablet and Yupelri Inhalation Solution. 3. The MDS assessment dated [DATE] for Resident #33 documented diagnoses of stroke, cancer and hypertension. The MDS showed the BIMS score of 15, indicating no cognitive impairment. Review of Resident #33's Progress Notes revealed the following: a. 1/28/25 at 11:25 a.m., hospice nurse here to see resident today. New orders to discontinue fish oil, vitamin D3 and preservision. Family notified. b. 1/28/25 at 11:37 a.m., Resident's family did not agree with discontinuation of preservision. Called hospice nurse and talked to her and we are just going to continue resident taking preservision for now. c. 1/28/25 at 8:45 p.m., received signed verbal order to discontinue fish oil, vitamin D3 and preservision. Review of Resident #33's January Medication Administration Record revealed preservision tablet take 1 tablet twice daily with a start date of 3/1/24 and discontinued date of 1/28/25. Review of Resident #33's EHR failed to indicate physician notification family wanted Resident #33 to stay on preservision. Interview on 2/3/25 at 2:44 p.m., with Staff X, Hospice Nurse revealed she had given orders to the facility to discontinue the medications for Resident #33. Staff X stated the facility called her back and said they family did not want to discontinue the preservision and she said not discontinuing the medication was ok with the physician and not to discontinue the preservision. Staff X revealed she was going to call and talk to the family but had not done that yet and the facility was to have kept Resident #33 on preservision per family request. Interview on 2/6/25 at 9:17 a.m., with the Director of Nursing (DON) revealed she would expect the nursing staff to be notifying the physician if there are missed medications and if the family wanted the resident to stay on the medication their wishes should have been followed.

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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 0686 Level of Harm - 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, interview and record review the facility failed to implement interventions to prevent pressure ulcers for 1 of 3 residents reviewed, (Resident #31). At the time of survey, Resident #31 was found to be sitting in the recliner in his room for long periods of time with no pressure-reducing device on the seat. The resident had two open sores on his buttocks. The facility reported a census of 47 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #31 had a Brief Interview for Mental Status (BIMS) score of 14 (intact cognitive ability). He required moderate assistance with toileting hygiene, lower body dressing, and toileting transfers. His diagnoses included; renal insufficiency, peripheral vascular disease, and hip fracture. Resident #31 did not have a pressure injury upon admission on 12/28/23, and staff were to provide a pressure reducing device for his chair and bed. The Care Plan last reviewed on 8/30/24, showed Resident #31 had insomnia and chronic fatigue. He did not participate in activities and preferred to stay in his room. The resident required 1-2 staff assistance with a walker for transfers and he was encouraged to use the call light. The care plan lacked any reference to skin conditions or interventions to prevent pressure sores. A Weekly Skin Observation Tool (WSOT) dated 1/21/25 at 9:29 PM, showed that Resident #31 had a reddened area on his bottom and staff were to apply cream. On 1/27/25 at 12:20 PM, Resident #31 was sitting in a recliner in his bedroom. His speech was soft and said that he had a sore on his bottom that was causing him some discomfort. He said that there was a cream that staff used, but they didn't apply it every day. Resident #31 said that he was not able to shift his weight in the chair without help, and at times, the call light response could take up to an hour. An inspection of the recliner seat revealed that he was sitting directly on the seat wearing a hospital gown that was open in the back and just a brief. There was no pressure-reducing device on the seat. On 1/28/25 at 9:15 AM, Resident #31 was wearing a hospital gown and sitting in the recliner in his room. The seat did not have a pressure-reducing device. On 1/28/25 at 11:00 AM, the resident was leaning to the right in his recliner, his body had slid down to where his head was resting on the arm of the chair. Staff K, Certified Nurse Aide (CNA) and Staff S, Certified Medication Aide (CMA) walked past his room and saw that he was sliding down. Staff K asked the resident if he needed help getting boosted back up in the chair. The resident nodded yes and she said that she would get a second person to help. Staff K and Staff S stood on each side and boosted him up in the recliner. They inspected the seat and saw that there wasn't any protective padding for pressure prevention, the aides acknowledged that he probably should have one under him. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/29/25 at 6:00 AM, Resident #31 was in the recliner sleeping. There was a urinal hanging on the walker next to his chair with urine in it. At 8:00 AM, Staff V, Certified Medication Aide (CMA) and Staff T, Certified Nurse Aide (CNA) went into the residents' room to get him ready for the day. Staff T put a gait belt around him and told him they would get him up to the toilet. Resident #31 had difficulty scooting his bottom to the edge of the chair to stand. His brief was soaked and the seat of the recliner was soiled with wet and brown stains. The chair did not have a protective pad or a pressure-reducing cushion. Staff V and Staff T used the gait belt to assist the resident to stand, directed him to pivot to the wheel chair and sit. He was wheeled to the bathroom, and pushed toward the wall where there was a handle bar for him to grab and pull himself to stand. Staff T removed his heavily soiled brief, and directed him to sit on the toilet. The resident indicated that he had pain on his bottom and she asked him if he wanted some cream applied and he said yes. When the resident was done on the toilet, the aide had him grab the handle bar to stand as she wiped his bottom. The residents' buttocks were red with darker blotched areas on the left side, with two open spots. The resident struggled to breath and had audible wheezing. The aide quickly wiped his bottom and applied a heavy cream and he indicated he needed to sit. He sat in the wheel chair. The CNA put an absorbent padding in the recliner, but no pressure reducing pad. Staff T said that the resident had become weaker and it was getting more difficult to transfer him. She directed him to move feet and gave much encouragement as he settled back into the wheel chair. On 1/29/25 at 11:00 AM, the resident was awake and sitting in his recliner with the foot feet extended. He had his legs bent at the knees and was frowning. When asked if he had pain on his bottom and he shook his head yes. On 1/29/25 at 2:46 PM, Staff P, Licensed Practical Nurse (LPN) had just come in for the 2:00 PM shift. When asked if she had gotten any information from the Aides or the off-going nurse that Resident #31 had some open spots on his bottom, she said that she did not. She agreed that a pressure-reducing matt in his recliner would probably be helpful. She said that the CNA's were expected to tell the nurses when there are new skin issues. A WSOT dated 1/29/25 at 7:17 PM, showed that the resident had two open areas on the left buttocks, both measured 0.5 centimeters (cm). The document lacked description in color or texture. On 1/30/25 at 1:20 PM, Resident #31 was in his recliner. He indicated that the staff put cream on his bottom today, but he still did not have a pressure reduction cushion in the chair. A Health Status Note dated 1/30/25 at 2:35 PM, showed that a wound care provider had been in to see the resident and directed staff to apply pressure relieve cushion to the recliner and wheel chair. A Braden Scale for Predicting Pressure Sore Risk (BSPPSR) dated 6/7/24 at 10:39 AM, showed that Resident #31 was at moderate risk for pressure ulcers. The following documentation was found in Nursing Notes: a. On 6/1/24 the resident had a fall with fracture to his hip. b. On 6/10/24 at 4:37 PM, the resident was notified of his wife's passing. c. On 6/28/24 at 1:54 PM, the resident was declining therapy services. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	d. On 7/30/24 at 1:02 PM WSOT showed that the resident had an open area on left buttocks that measured 1-centimeter (cm) x 1 cm. d. On 9/30/24 at 9:50, a new order for treatment to open area on buttocks. e. On 9/12/24 at 12:23 PM after orthodontist appointment the resident was noted to have increased weakness to right upper and lower extremities. f. On 9/12/24 at 5:32 PM, new medication added for Major Depressive Disorder. g. On 10/28/24 at 12:15 PM complaints of weakness and fatigue, refusing restorative therapy services, constipation and depression continued, increased antidepressant medication. h. On 11/21/24 at 12:32 PM, Care Conference and resident reported to have depressed mood. i. On 11/20/24 at 12:32 PM depression worsening. j. On 12/25/24 at 11:09 AM area is no longer open on buttocks, (A BSPPSR assessment dated [DATE] at 12:44 showed that Resident #31 was not at risk for pressure sores.) k. On 12/12/24 at 10:59 AM the resident had audible wheezing. l. On 1/30/25 at 11:14 AM, Care Conference, resident noted to have a decline in status and Hospice was contacted for evaluation. A review of the Weights & Vitals tab in the electronic chart showed that from 7/17/24 to 1/30/25, Resident #31 had a 14-pound weight loss. On 2/3/25 at 1:30 PM the nurse with the mobile wound clinic said she came into the facility on ce a week to treat skin breakdown. She did see Resident #31 and acknowledged that he had two small open areas on his bottom. She prescribed an air cushion to be used in his wheel chair and recliner and a cream. On 2/6/25 at 8:02 AM, Staff J, Director of Nursing (DON) said that she wouldn't necessarily expect a pressure reduction matt in the chair for Resident #31 because he had been up and around in his room. She acknowledged that he'd had a decline in status but it wasn't that he couldn't move around, he chose not to. She said that the Care Plan should have a focus area for skin breakdown and she was not aware that the MDS indicated that he would have pressure reduction mat in the chair and wheelchair. According to the undated Facility Assessment, between 60-70% of the residents were at risk for skin breakdown. The facility provided resident-specific preventive measure for the risk areas, based on an individualized assessment and in accordance with residents' treatment goals and preferences. An interdisciplinary approach was used to develop a resident centered care plan with input from the resident, nursing department, medical providers the therapy department the registered dietician and the social worker. The licensed nurses provided care and treatment to resident based on their medical needs. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Facility policy titled: Skin Care Guidelines from Nursing Manual dated 2010, it was the policy of the facility that a resident who entered the facility without pressure sores would not develop pressure sores unless the individual clinical condition demonstrated that they were unavoidable. The needs of the resident would be assessed individually and developed into the plan of care to promote the prevention of skin trauma and prompt healing of the residents entering the facility with break down.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on observations, record review, facility investigative file review, resident and staff interviews and policy review, the facility failed to ensure 2 of 3 residents (Resident #11 and #96) reviewed were free of accidents/hazards with transfers. The facility reported a census of 47 residents. Findings include: 1) The quarterly Minimum Data Set (MDS) assessment tool with a reference date of 8/2/24, documented Resident #96 had a Brief Interview of Mental Status (BIMS) score of 9. A BIMS score of 9 suggested Resident #96 had mild cognitive impairment. Resident #96 did not exhibit behaviors during the review period nor did he reject care during the review period. He has impairments on both sides to bilateral upper and lower extremities and utilized a wheelchair. The MDS documented the following diagnoses: Parkinson's Disease, anemia, hip fracture, dementia, encephalopathy. The Care Plan focus area with an initiation date of 7/24/2023 and a revision date of 11/1/2023 documented Resident #96 was totally dependent on two staff for transferring with a hoyer lift. The following Progress Notes were documented for Resident #96: a) On 10/14/2024 at 8:10 AM the resident arrives to the dining hall. The Registered Nurse (RN) attempted to take his pulse and oxygen level with a pulse ox. Resident #96 refused to pull his fingers apart. Once able to get his fingers apart, discoloration and swelling noted to right thumb. After contacting his Primary Care Provider (PCP) an appointment was made for 1:30 PM at their office. Pain relief provided. b) On 10/14/2024 at 6:39 PM resident returned to the facility from his appointment with the PCP with orders to use ice to fractured right thumb for 10 minutes, three times a day (TID) along with pain control medication. A Weekly Skin Observation dated 10/14/2024 documented Resident #96's right thumb to be swollen and discoloration of multiple types. The facility provided an incident timeline dated 10/14/2024: a) On 10/13/2024 at 2:00 PM Staff F assumed responsibility of Resident #96. b) On 10/13/2024 at approximately 8:00 PM Staff F assisted the resident in EZ stand with 1 assist (against company policy of two assistance with mechanical lift) to bed. c) From 10/13/2024 at 8:00 PM until 10/14/2024 at 6:00 AM Staff F was responsible for Resident #96 with all cares. d) On 10/14/2024 at 6:00 AM shift report was completed with Staff F and Staff D. No report given about any injuries or incidents with Resident #96. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	e) On 10/14/2024 at 8:10 AM Resident #96 entered the dining room for breakfast, nurse attempted to get his oxygen saturation. Resident was unable to release his left hand from his right hand. Once he was able to release, the nurse noted a very swollen and purple bruising to right thumb on top and bottom of thumb. f) On 10/14/2024 at 8:15 AM Resident #96 stated that while using the machine last night, he was unable to get his hand to let go of the EZ stand, so staff took his hand off. g) On 10/14/2024 at 1:57 PM following his appointment with his PCP, fracture noted to right thumb. h) Investigation reveals: a. Staff F was responsible for Resident #96 from 10/13/2024 at 2:00 PM until 10/14/2024 at 6:00 AM. She did not follow policy and assisted resident #96 with an EZ stand transfer with 1 assistance resulting in an injury to the resident's right thumb. b. Staff F did not report any incidents or injury to the nurse or oncoming shift. c. After getting statements from all other staff that worked, no other staff assumed cares of Resident #96. Staff F provided the following verbal statement to the facility on [DATE]: she reported that she was working on Resident #96's hall on 10/13/2024 from 2:00 PM until 10/14/2024 at 6:00 AM. The EZ stand was used to transfer the resident. Staff reported no difficulties during transfers but did the transfer herself (1 assistance). She did not have a second person. Staff did not notice any concerns with the transfer, no swelling or bruising to his thumb. Staff F denied any noted concerns during her shifts with Resident #96. This statement was received via telephone call on 10/14/2024 at 12:47 PM. Staff D provided the following written statement to the facility on [DATE]: he went into Resident #96's room to get him ready for the day and out for breakfast. He did seem extra hard to realize (release) his hand from is nightgown. He did not notice his thumb until the nurse had said something about it. He had also got a skin tear on his left forearm. The statement was signed by Staff D. Staff G RN provided the following written statement to the facility on [DATE]: Resident #96 was brought to the dining hall around 8:00 AM. He refused to pull hands apart to check his oxygen level. Once she was able to get his hands apart, she noticed his right thumb was bruised and swollen with limited movement. She provided pain relief and notified his son, the DON and hospice staff. The statement was signed by Staff G. The facility provided an x-ray report with an order date of 10/14/2024 at 1:30 PM documented the following results: fracture at base of right thumb noted on x-rays. On 1/23/2025 at 9:14 AM Resident #5 stated they used two staff while using the hoyer this morning, they usually have two staff. She added they have used the lift with one staff, this happens during the day time. She added it does not happen a lot though. On 1/23/2025 at 9:30 AM Resident #35 stated there is generally two staff when they are using the EZ stand to assist him. At times they do only use one staff but it does not happen a lot. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/23/2025 at 2:59 PM Resident #36 stated they usually have 1-2 staff assist with the hoyer lift during transfers. He stated the majority of the time its 2 staff because he is so big. On 1/22/2025 at 4:54 PM Staff G stated on 10/14/2024 once they were able to pull his fingers apart to see what was going on she noticed some discoloration and swelling to his right thumb. She could tell with his facial expressions that he was in pain that day. His thumb also looked painful, so she gave him his as needed (PRN) morphine to help. As soon as she saw the injury she called the PCP and set up an appointment at the clinic to be seen. She worked on the 12th and his thumb was not like that. She asked Resident #96 if this happened the night before and he said yes, during the night. She also asked who did this to him and he gave different answers but she could not attest to who. Staff G stated she had heard that staff will use the mechanical lifts alone and if she saw it she would intervene. She stated they were to have two staff when using mechanical lifts on residents. On 1/22/2025 at 3:33PM Staff N CNA stated they are to have 2 staff present when using the EZ stand. When asked if that is happening at the facility she stated almost everyone uses the EZ stand with one staff unless it's for a specific resident on Hall 3. She indicated how many staff they use for the mechanical lifts all depends on how many staff they have that day. Staff N stated for the most part EZ stands are used with 1 staff. She added when they use the hoyer lift they are also mostly done with 1 staff. If the resident is hard to roll or required extensive help they will try to use two but that does not happen a lot because they are short staffed or busy. On 1/22/2025 at 5:11 PM Staff E Licensed Practical Nurse (LPN) stated when staff would use the mechanical lifts she would see staff using them alone without the second staff member. She would have to remind staff that the have to have a second person. If staff called for help and no one responded she would assist with the transfer. On 1/23/2025 at 9:24 AM Staff I CNA was asked if she had ever heard of or saw staff using an EZ stand with 1 staff, she indicated it happens. She added it does not happen often, maybe once in a blue moon. On 1/23/2025 at 10:55 AM Staff H previous Administrator stated if he remembered correctly a CNA was using a lift and he believed the Resident's thumb or hand got caught. He could not recall how it happened or if the CNA noticed if it got pinched. He remembered Resident #96's thumb was black and blue, swollen. Indicated the staff member involved was Staff F. He stated staff are always to have 2 present when using the mechanical lifts, it's their company policy. When asked if staff used the lifts with only 1 staff member he stated he was sure it happened when they could not find a second person. He added he was not going to say it did not happen but they always preached to have two staff for resident transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/23/2025 at 11:07 AM Staff F stated on 10/13/2024 she worked 2:00 PM until 6:00 AM on 10/14/2024. She stated the facility called her in to the office, said something about Resident #96's thumb was swollen. She indicated when she left work that morning he was ok. The day they found an injury to his thumb she acknowledged she worked with him that night and morning. She transferred him to bed using the EZ stand. When asked if anyone was in the room with her during the transfer she stated no. She added they terminated her for improper use of equipment. Staff F stated staff normally would only have one staff for transfers using the mechanical lifts but then started telling everyone they needed two staff. She acknowledged that evening, she could not find anyone to help her so she did the transfer herself. She denied the resident had any pain during the transfer nor did he make any complaints. She indicated Resident #96 did not have issues with his hands not wanting to let go or hold on to the lift during the transfer. She added there were no issues when she transferred him that day. She added Resident #96 goes to bed after dinner, so she put him to bed between 6:00-6:30 PM. Resident #96 does not get up at night, they do check and change with him throughout the night. On 1/23/2025 at 1:04 PM Staff J Director of Nursing (DON) stated on 10/14/2024 she was notified by Staff G that while trying to use the [NAME]/oximeter on Resident #96 he would not put his hands apart. Once she was able to get his hands apart, she noticed it to be very bruised. He was given pain medication and the PCP was notified and wanted to see him. Through their investigation they learned only one staff had worked with the resident for 16 hours, the day prior. When they spoke with other staff members they did not have contact with him the night prior. That staff member was Staff F. The resident does have Parkinson's disease so he has a hard time getting his body to move with him. The resident told her staff took his hand off the lift. When she spoke to Resident #96 he stated it happened the night prior he was in the EZ stand and he could not get his hand to let go when he sat down. When asked what she meant by would not let go, she stated the resident in the EZ stand has to hold on to the grab bars to stand up and that day he could not let go after he was sat down in the chair, to release the lift. Resident #96 did not tell her what happened after he sat down, just that staff helped get his hands off the lift, but did not mention a name. He did not say if he had pain that night but did say he had pain that morning. She indicated Resident #96 was reliable at the time of the incident. Once they determined it was Staff F that had assisted him they called her in to terminate her for improper use of the lift and not reporting an injury. She admitted to using the EZ stand with Resident #96, alone that night prior. At the time of the incident Resident #96 was an assist of two because he required an EZ stand for transfers. She added any use of a mechanical lift requires 2 staff members. When asked if that is being followed at the facility she indicated to the best of her knowledge it is. On 2/4/2025 at 12:25 PM during a follow-up interview Staff J stated it is unacceptable to one staff when using the EZ stand. She added all mechanical lift to have two staff present when being used. On 1/23/2025 at 2:02 PM Staff D stated on the morning of 10/14/2024 Resident #96 was grippy that morning. He did not see any injuries until the nurse had said something. The resident was in the dining room when the injury was found. Staff D stated his thumb was 2-3 times bigger than his other thumb. When asked what he did to help get the resident ready for the day he stated he provided cares, put a new brief on him, got him dressed, put his teeth in, put on his socks and shoes, sprayed cologne, then put is hat and glasses on. He denied observation any injuries during morning cares. He accompanied Resident #96 to his appointment for an x-ray and did not display any pain. The clinic said he had a hairline fracture to the middle part of his thumb. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility provided a document titled 8/28/2024 Nursing, that provided the following information: EZ stands are a two person assist in the State of Iowa, and hoyer lifts. Do not transfer a resident with an EZ stand with one staff member, especially Resident #96. Disciplinary actions will be made. The facility provided a document titled Nurse Aide Skills, Skills Checklist #9, Mechanical Residents Lifts. 1. Secure assistance needed (at minimum, have at least two people). 41785 2) According to the MDS dated [DATE], Resident #11 had a BIMS score of 15 (intact cognitive functioning.) She had limited functioning, and used a walker and a wheel chair for mobility. Resident #11 required partial assistance for sit to stand and toileting transfers. She was frequently incontinent of urine and occasionally incontinent of bowel. Her diagnoses included coronary artery disease, diabetes mellitus, arthritis, sepsis and anxiety disorder. The Care Plan for Resident #11 was last revised on 10/2/24, and staff were to monitor for cognition decline. She required the assistance of one staff with a wheelchair for long distance mobility. An Incident Report dated 9/5/24 at 11:15 PM, showed that 2 CNA's had transferred Resident #11 with the use of a mechanical lift, Sit To Stand (STS) to the bathroom and the resident slipped out of the sling and onto the floor. On 1/27/25 at 3:45 PM, Resident #11 was in her wheel chair in her room. She had supplemental oxygen via nasal cannula and struggled to breath as she spoke. When asked if she'd had any falls, the resident said that a while ago, she hadn't been feeling very well and was weak, so the staff used a Sit to Stand to transfer her to the bathroom. She said that she was so week she couldn't stand any longer, then slid from the machine onto the floor. On 1/28/25 at 9:46 AM, Staff L, CNA said that she was working when Resident #11 fell from the Sit to Stand, (STS) mechanical lift. She said that the resident needed to use the bathroom so she and Staff W, CNA got her hooked up and transferred her to the toilet but the resident put her arms up and slid to the floor. Normally, the resident would pivot transfer with one staff but she was weaker than normal and was having a hard time standing and was confused. The nurse was aware that the resident was weak and they weren't able to transfer her as usual so she told them to use STS. On 1/28/25 at 9:54 AM, Staff P, Licensed Practical Nurse (LPN) said that Staff L called her back to the room to help with Resident #11, and when she came into the room, the resident was on the floor with her back up against the recliner. She said the staff lowered the resident to the floor when she slid from the lift. The STS was next to the recliner and they used the total mechanical lift to get her off the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/29/25 at 6:00 AM, Staff W, CNA said that she was with Resident #11 when she fell from the mechanical lift. She said that Staff L had been in with the resident and tried to get her up to the bathroom and the resident would normally transfer with just one assist but had gotten weaker. The two of them tried to get her up to pivot transfer to the wheel chair, which was just in front of the recliner but she couldn't stand. Staff W said that the recliner was inclined, tilted up, so the resident could get to standing position easier. The resident had a gait belt on, they were not able to get her into a standing position so they went to the nurse, Staff P, and explained they were having trouble transferring. The nurse went and tried, when they still couldn't get her up, so the nurse told them to go ahead and use the STS. They got her to the bathroom, but the resident was not standing up very well on the machine. When she was done on the toilet, they started to transfer her back to the recliner, and Staff W reached for the remote on the recliner to decrease the incline while Staff L had control of the STS. They did not have time to get the recliner down before the resident slid from the sling and onto the floor. Staff W said that the resident's arms had been parallel to the floor chicken winged. They could tell she was getting tired, her arms slid up and out of the sling. She was in front to the recliner, and as she came down, the recliner slide across the floor a little bit and the resident ended up on her bottom, on the floor. She did not remember what size of sling they used, there was usually one on the machine so they probably just used that. She said it was buckled, but she did not remember tightening the buckle. Staff W said that they aren't necessarily taught to tighten the buckle once the residents are standing, but it would make sense. On 1/29/25 at 6:15 AM Staff L, CNA, said that they had used to STS with Resident #11 one other time. The resident was very weak, she wasn't standing well enough and they were trying to hurry because she was wiggling, and chicken winged. She did not remember if they tightened the belt on the sling when she was standing. The nurses would let the CNA's know if/when a resident was safe for mechanical lift transfers. On 2/6/25 at 8:02 AM Staff J, Director of Nursing said that Resident #11 was usually one assist, but when she was ill, they would use the lift. If the resident was not bearing weight, she would ask to send her out for evaluation because that was out of her normal and they later found out she was septic with a urinary tract infection. According to the staff, they did tighten the belt. According to the User Manual for Stand Up Patient Lift, revised on 1/2010, Using the Sling; the Belt must be snug, but comfortable on the patient, otherwise the patient could slide out of the sling during transfer, possibly causing injury. Individuals that use the standing patient sling must be able to support the majority of their own weight, otherwise injury may occur.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on observations, record review, staff interviews and policy reviews, the facility failed to change and label oxygen tubing for 1 of 2 residents reviewed, (Resident #24). The facility reported a census of 47. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #24 documented diagnoses of chronic obstructive pulmonary disease (COPD), respiratory failure and dependence on supplemental oxygen. The MDS showed the Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. Observation on 1/27/25 at 11:04 a.m., revealed Resident #24 wearing oxygen tubing with supplemental oxygen running. Observation further revealed the oxygen tubing lacked a date of application. Interview on 1/27/25 at 11:04 a.m., with Resident #24 revealed she has a CPAP machine that she is to be wearing when she is sleeping and napping and she has had to argue with the staff to put it on. Resident #24 further revealed that on 1/26/25 she had to argue with the staff to apply it while she was napping during the day. Observation on 1/29/25 at 9:47 a.m., revealed Resident #24 wearing oxygen tubing with supplemental oxygen running. Observation further revealed the oxygen tubing lacked a date of application. Observation on 1/29/25 at 1:00 p.m., revealed Resident #24 wearing oxygen tubing with supplemental oxygen running. Observation further revealed the oxygen tubing lacked a date of application. Observation on 1/29/25 at 1:15 p.m., revealed Resident #24 wearing oxygen tubing with supplemental oxygen running. Observation further revealed the oxygen tubing lacked a date of application. Observation on 2/3/25 at 10:25 a.m., revealed Resident #24 wearing oxygen tubing with supplemental oxygen running. Observation further revealed the oxygen tubing lacked a date of application. Interview on 2/3/25 at 10:47 a.m., with Staff Q, Licensed Practical Nurse (LPN) revealed the night nurses change the oxygen tubing and record it on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). Review of the January MAR and TAR revealed no orders for changing oxygen tubing. Interview on 2/3/25 at 10:56 a.m., with Staff U, Director of Nursing revealed the night nurse changes the oxygen tubing monthly and they record on the TAR. The facility did not provide a policy regarding changing and documentation of changing oxygen tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/3/25 at 11:14 a.m., with Staff U revealed she had misspoke earlier and the oxygen tubing is changed weekly on Sunday nights and the nurse records on the TAR. Staff U confirmed the TAR should have the orders listed for changing oxygen tubing.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41785 Based on observation, interview and record review facility failed to monitor for expired medications, and failed to document open dates on insulin medications for 6 of 6 resident reviewed, (Resident #31, #32, #47, #54, #30 and #27). The facility reported a census of 47 residents. Findings include: On 1/29/25 at 6:02 AM the oncoming nurse Staff R Registered Nurse (RN) just started her shift for the day and looked through the bubble pack cards of narcotics in the medication cart. Staff R said that the pharmacy would document the dates on the back when the medications should be destroyed. She said that if there were no dates documented, the rule of thumb was 6 months from delivery. Hydrocodone for Resident #31 delivered on 6/7/24 expired 12/7/2024. Hydrocodone for Resident #32 delivered on 7/15/24 expired 1/15/2025. On 1/28/25 at 7:45 AM the following insulin pens were found in the medication cart without documentation of the dates that they were opened: a. Resident #47 Lantus delivery on 1/8/25. b. Resident #54 Xultophy insulin delivery date of 12/31/24 c. Resident #30 Gargine insulin delivery date 1/16/25 d. Resident #27 Toujeo, insulin delivery dated 11/29/24. On 1/28/25 at 6:02 AM Staff O, Licensed Practical Nurse (LPN) went through the documentation of Scheduled II (high risk for abuse) medications with Staff R. As Staff R looked through the packages of medications in the drawer, Staff O quickly paged though the sheets and called out the number of remaining pills documented on the sheet. She did not look at the medications, call out the name of the resident or the name of the narcotic. On 2/3/25 at 11:35 AM, Staff U, Director of Nursing (DON) said that she and another nurse destroyed the outdated medications but she was not aware of the insulin pens that did not have open dates on them. On 2/6/25 at 8:02 AM Staff J, DON said that she addressed the insulin pens that did not have open dates and told the nurse to destroy them and start with new pens. She said that when the nurses are counting medications at shift change, she expected that they would verify the name of the resident and the name of the medication along with the total number remaining. On Page 7 of the Medication Administration policy, staff were to record the open date on the bottle or container. They were to return expired or outdated medications promptly to the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy titled: Administration of Insulin Pen, indicated that staff must label with the date opened.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on record review and staff interview, the facility failed to assure residents were free from significant medication errors for 1 of 22 residents reviewed, (Resident #30). The facility reported a census of 47 residents. Findings Include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #30 documented a diagnoses of Diabetes Mellitus (DM), renal insufficiency and hypertension. The MDS indicated the resident required the high risk drug class of insulin injections for DM management. The MDS showed a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The Care Plan for Resident #30 showed the following related to DM: a. Diabetes medication of glucose tabs, glipizide and insulin ordered by the physician. b. Monitor and document side effects and effectiveness. The Physician Orders for Resident #30 showed the following: a. Blood sugar check four times a day. Call the medical doctor (MD) if <70 or >250. b. NovoLOG Injection Solution 100 units/milliliter (ml). Inject 8 units subcutaneously (sq) before meals. c. Insulin Glargine Subcutaneous Solution 100 until/ml. Inject 34 units sq two times a day. d. Glucagon subcutaneous solution 1 mg per 2 ml. Inject 1 mg sq as needed for symptomatic hypoglycemia 1 gram intramuscular /sq as needed for blood sugar less than 60 and resident unconscious or unable to take oral. Recheck blood sugar in 15 minutes. May repeat if blood sugar is less than 60 mg/dl. Call MD when used. The January 2025 Medication Administration Record for Resident #30 showed the following medications were administered by Staff Q, Licensed Practical Nurse (LPN) on 1/3/25 during the morning medication administration: a. Novolog FlexPen Subcutaneous Solution Pen-injector 100 unit/ml. Injected 3 units subcutaneously. b. Insulin Glargine Subcutaneous Solution 100 until/ml. Injected 34 units subcutaneously. c. Glucagon subcutaneous solution 1 mg per 2 ml. Inject 1 mg sq given at 9:44 AM. The Weights and Vitals record for Resident #30 on 1/3/25 showed the following blood sugar results: a. 52 milligrams per deciliter mg/dl at 2:51 AM (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	b. 122 mg/dl at 3:22 AM c. 69 mg/dl at 6:37 AM The Progress Note for Resident #30 dated 1/3/25 documented the following: At 9:38 AM, the Certified Nurse's Aide (CNA) called the nurse into the room and the patient was unresponsive but breathing. The resident was not answering any questions, checked blood sugar and it was 34 mg/dl. This nurse gave the patient 1 dose of glucagon and called the primary care physician (PCP) to get okay to send the patient to the emergency room (ER). 911 was called at 9:24 and they arrived and took the patient to ER. At 9:44 AM, the resident was sent to the ER. In an interview on 2/3/24 at 9:53 AM, Staff Q stated, I received a report from the night nurse that Resident #30's blood sugar check was low that night (1/3/25), she gave the resident snacks and the recheck was normal. He was fine. The blood sugar I took that morning was normal. No signs. Staff Q confirmed 69 mg/dl was the blood sugar she was referring to. Staff Q continued, after breakfast was served, the other nurse called out and told me the resident was not responding. When I got to his room the resident was moaning and groaning when we tried to talk with him but wouldn't respond with words. The breakfast tray was sitting beside him and not in front of him, he didn't touch it. The other nurse and the CNA stayed in the room while I left to get glucagon. After I gave that, I called the doctor immediately, then called for an ambulance. When we rechecked the blood sugar it was lower. Staff Q confirmed the blood sugar was 34 mg/dl. Staff Q reported Resident #30 received all the scheduled morning medications including long and short acting insulin after the blood sugar check of 69 mg/dl. When asked if there were high or low perimeters for blood sugar checks that required PCP notification. Staff Q replied, I didn't normally call if the resident was going to eat and it's like 90 mg/ml or higher, but the Administrator talked to me after this and told me that she doesn't normally give insulin unless the residents are above 100 ml/dl and eating. When asked if all residents had the same parameters that required PCP notification, Staff Q replied, no they are all different. Staff Q then retrieved a computer and checked the electronic health record. Staff Q verified the PCP should have been notified for blood sugars lower than 70 mg/dl. Staff Q stated, I should have called the primary physician. When asked if she should have held the insulin until after consulting with the physician, the nurse replied, yes. Staff Q stated, the Administrator went over that with me. Staff Q explained due to being a newer nurse, she wasn't used to handling abnormal blood sugar levels. Staff Q stated, I was in the wrong, I learned from it. When asked if the short acting insulin caused the blood sugar of 69 mg/dl to decline to 34 mg/dl. Staff Q replied yes, the short acting, Aspart (Novolog), would have caused that. The ER Record on 1/3/25 for Resident #30 recorded the resident was seen in ER with chief complaint as low blood sugar. The Physician's Note documented the following: He was found unresponsive this am. Noted to be hypoglycemic (low blood glucose) of 47 mg/dl. Transferred to the facility via emergency services. Intravenous dextrose given enroute. Upon arrival he was responsive and answered questions appropriately. During my examination he was unresponsive with hypoxia. He was given another dose of IV dextrose. He is currently responsive and eating lunch. Resident #30 subsequently admitted to the hospital for cellulitis and urinary tract infection. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The Employee Counseling Form dated 1/3/25 for Staff Q LPN documented the following for the background and discussion information completed by the Administrator: Discussed insulin administration timing and using judgement with blood sugar checks. Talked about ensuring a resident is able to eat when the blood sugar is low to them. Also discussed parameters for calling the MD prior to administering insulin. The corrective actions to be taken by the employee documented Staff Q stated, I know I messed up. Staff Q stated to the Administrator that she understood and will be more mindful in the future. The American Diabetes Association, Insulin Basic Education, given with the employee counseling form to Staff Q LPN, indicated Novolog as a rapid-acting insulin that begins to work about 15 minutes after injection and peaks in about one to two hours after injections and lasts between two to four hours. The undated blood Glucose Monitoring policy failed to provide direction as to treatment of diabetes. In an interview on 2/3/24 at 12:48 PM, the Director of Nursing (DON) confirmed Staff Q was the only staff that received counseling and education related to the incident. In an interview on 2/5/25 at 2:15 PM, when asked if Staff Q in the morning of 1/3/25 should have contacted the physician, according to the physician's order, to call if blood sugar was less than 70 ml/dl before administering the insulin, the Administrator replied yes. When asked if the administration of insulin caused the resident to go unresponsive and resulted in the need for the ER visit, the Administrator stated, the insulin should have been held and the doctor notified of Resident #30's blood sugar. I gave the nurse education. She has been disciplined.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview and record review the facility failed to ensure that resident records reflected accurate care provided for 2 of 22 residents reviewed, (Resident #149 and #31). The facility reported a census of 47 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE] Resident #149 had a Brief Interview for Mental Status (BIMS) score of 15. She used a feeding tube for medications and nutrition. The Care Plan updated on 8/30/24, showed that she was at risk for aspiration and altered nutritional status related to enteral feeding. Staff were to evaluate and report significant changes to the physician as needed. On 1/27/25 at 4:55 AM, Staff O, Licensed Practical Nurse (LPN.) prepared and administered medications and nutritional supplement for Resident #149 and said that she did not take anything in by mouth. A review of the clinical record revealed a fax sent to the doctor on 12/24/24 at 12:05 PM, where staff reported that the resident had a significant weight loss. The physician responded with a new order for weekly weights for 4 weeks. The Census Tab in the electronic record showed that Resident #149 was hospitalized from 1/5/25- 1/9/25. The Weight Record showed that on 12/24/24 at 10:48 AM, the resident weighed 216.4. The chart lacked any follow up weights. The Medication Administration Record (MAR) indicated that the weights had been taken and documented on 1/13/25 and 1/20/25. 2) According to the MDS dated [DATE], Resident #31 had a BIMS score of 14 (intact cognitive ability). The resident required moderate assistance with toileting hygiene, lower body dressing, and toileting transfers. His diagnoses included; renal insufficiency, peripheral vascular disease, and hypertension. The Care Plan last reviewed on 8/30/24, showed that Resident #31 had insomnia and chronic fatigue. He did not participate in activities and preferred to stay in his room. The resident had hypertension, staff were to provide daily blood pressure assessments per physician orders. The Order tab in the electronic chart showed an order dated 6/13/24 at 3:30 PM, for staff to take Blood Pressure (BP) daily and contact the Primary Care Provider (PCP) if the BP was less than 100/60 or greater than 140/90. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	From 6/30/24 - 7/28/24 the BP was higher than 140/90, 10 times and the chart lacked documentation that the physician had been contacted. The Medication Administration Record (MAR) for July showed that on each one of the days that the BP was high, the nurses checked the box to indicate that they had contacted the provider. On 2/6/25 at 8:02 AM Staff J, Director of Nursing (DON) acknowledged that when the nurses checked the box, they were confirming that they understand and had followed through with the orders as written. She said that if they had contacted the provider, there should have been documentation in the clinical record.

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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. 44420 Based on previous CMS-2567 review, staff interview and facility policy review the facility failed to ensure a comprehensive, effective Quality Assessment and Performance Improvement (QAPI) program. The facility reported a census of 47 residents. Findings include: Review of the Department of Inspections, Appeals and Licensing (DIAL) website under the facility's visit history revealed repeated deficient practices identified during the facility's annual survey and complaint investigation on 2/15/24 and the facility's annual survey, complaint and facility reported incident investigation on 1/21/25. The repeat deficiencies cited included: 1. F636- Comprehensive Assessments and Timing 2. F637- Comprehensive Assessment After a Significant Change 3. F638- Quarterly Assessment at least Every 3 Months 4. F640- Encoding/Transmitting Resident Assessment 5. F656- Develop and Implement Comprehensive Care Plan 6. F658- Services Provided Meet Professional Standards 7. F684- Quality of Care 8. F865- QAPI Program and Plan 9. F880- Infection Prevention and Control The QAPI Facility Plan dated December 2024 identified the governing body and\or the facility administration shall provide general oversight for QAPI activities related to resident care and services throughout the facility. The governing body is responsible and accountable for ensuring that: 1. An ongoing QAPI program is defined, intimate, maintained and addressed identified priorities. 2. Policies are established to ensure the QAPI program is sustained during transitions and leadership and staff turnover. 3. The QAPI program is adequately resourced, including ensuring staff, time, equipment and technical training as needed to conduct its work. 4. The QAPI program identifies and prioritizes problems and opportunities that reflect organizational processes, functions, and services to residents based on performance indicator data, resident and staff input, and other information. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Corrective actions adjust gaps in systems in our evaluation for effectiveness. 6. Clear expectations are set around safety, quality, rights, choice and respect. 7. One or more persons are designated to be accountable for QAPI. 8. Leadership and facility wide training is conducted on QAPI. 9. An atmosphere exists in which staff members are encouraged to identify and report quality problems, as well as opportunities for improvement. In an interview on 2/6/25 at 8:57 AM, the Administrator stated, we are working on MDS (Minimum Data Set) and resident falls with a performance improvement plan (PIP). They both started in December. When asked about repeated deficiencies the Administrator explained last year the facility hired two different staff that no longer work for the facility. For MDS needs the facility hired a third party to manage MDS and care plans.

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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** 41785 Based on observation, interview and record review the facility failed to implement infection control practices for 2 of 22 residents reviewed, (Resident #149 and #24). While staff provided nutrition and medications through a feeding tube, she failed to wear all of the required Personal Protective Equipment (PPE). The nurse stood on the resident's oxygen tubing while providing care to Resident #149. The urinary catheter bag for Resident #24 was laying on the floor. The facility reported a census of 47 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE] Resident #149 had a Brief Interview for Mental Status (BIMS) score of 15. She had an abdominal feeding tube and was on medications that included antipsychotic, antidepressant, diuretic, antiplatelet and continuous oxygen. The Care Plan updated on 8/30/24, showed that Resident #149 had orders for nothing by mouth (NPO). She was at risk for aspirations, staff were to monitor for signs and symptoms of aspiration, assess evaluate report significant changes to physician as needed. On 1/27/25 at 4:55 AM, Staff O, Licensed Practical Nurse (LPN) explained that a cup of dark fluid that was sitting on the medication cart, was the medication for Resident #149 that she had mixed earlier that morning. Staff O donned disposable gloves but failed to put on a gown. She prepared the Glucerna nutritional supplement, poured it in the bag on the pole next to the resident's bed and held the tubing while the fluid flowed down the tubing. Once the fluid reached the end of the tubing, she took the tip of the tubing and hung it inside the bag of fluid while she prepared and administered the medications via feeding tube. The resident was lying in bed with supplemental oxygen via nasal cannula and the oxygen tubing was laying across the floor beside the bed. Staff O stepped on and off the oxygen tubing twice while administering the medications. On 2/6/25 at 8:02 AM, Staff J, Director of Nursing said that Staff O realized that she should have had a gown on when she did the tube feeding. Staff J agreed that placing the tip of the tubing in the bag of nutritional supplement and stepping on the oxygen tubing were infection control concerns. According to the undated facility policy titled: Enhanced Barrier Precautions Enhanced Barrier Precautions (EBP) the facility would expand the use of Personal Protective Equipment (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 (central line, urinary catheter, feeding tube, tracheostomy) 44474 2. Observation on 2/3/25 at 10:50 a.m, included observation of Resident #24's catheter bag laying directly on the floor. The catheter bag lacked a privacy cover. Facility did not provide a policy on catheter bags not touching the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/6/25 at 9:11 a.m., with the Director of Nursing revealed the catheter bag should not ever be on the floor.