STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175172	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Healthcare and Rehab Topeka	2515 SW Wanamaker Road Topeka, KS 66614

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 88 residents. The sample included 26 residents with three residents reviewed for dignity. Based on observation, record review, and interviews, the facility failed to ensure a dignified dining experience for Resident (R) 27 when staff stood over him instead of sitting beside him while assisting him with eating. This placed R27 at risk for impaired dignity. Findings included: - R27's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of altered mental status, major depressive disorder (major mood disorder that causes persistent feelings of sadness), aphasia (a condition with disordered or absent language function), and muscle weakness. The Significant Change Minimum Data Set (MDS) dated [DATE] documented per staff interview, R27 had impaired cognition. The MDS documented R27 had functional limitation on one side for both upper and lower extremities. The MDS documented R27 required supervision or touch assistance with meals. The Quarterly MDS dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R27 had functional limitation on one side of both upper and lower extremities. The MDS documented R27 required supervision or touch assistance with meals. R27's Nutritional Status Care Area Assessment (CAA) dated 05/13/24 lacked analysis documentation. R27's Care Plan dated 01/21/22 documented he required supervision with eating. On 11/18/24 at 08:32 AM, R27 sat reclined at the dining room table in his Broda chair (specialized wheelchair with the ability to tilt and recline). Certified Nurse Aide (CNA) P stood beside R27 as she assisted him with breakfast. Administrative Nurse D retrieved a chair for CNA P to sit down next to R27 at eye level to finish assisting him with breakfast. On 11/20/24 at 02:54 PM, CNA O stated staff should be next to the person at eye level to assist them with eating. On 11/20/24 at 03:01 PM, Licensed Nurse (LN) I stated staff should be seated next to the resident while the staff assist the resident with meals. (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 11/20/24 at 04:31 PM, Administrative Nurse D stated she expected staff to be seated during the meal next to the resident as they assisted the resident with their meal. The facility's Dignity policy last revised 02/2021 documented each resident would be cared for in a manner that promoted and enhanced his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents would be treated with dignity and respect at all times. The facility failed to ensure R27 was treated with dignity during dining. This deficient practice placed R27 at risk for impaired dignity.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 88 residents. The sample included 26 residents with two reviewed for reasonable accommodation of needs related to call lights and wheelchair foot pedals. Based on observation, record review, and interviews, the facility failed to ensure Resident (R)57 had a call light he could functionally activate for staff assistance. The facility additionally failed to ensure R66 had foot pedals on her wheelchair while being pushed. This deficient practice placed both residents at risk for preventable accidents and injuries related to unmet care needs. Findings Included: - R57'sMedical Diagnosis section within the Electronic Medical Record (EMR) noted diagnoses of insomnia (difficulty sleeping), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), polyneuropathy (multiple areas of weakness, numbness, and pain from nerve damage, usually in the hands and feet), muscle weakness, and dysphagia (difficulty swallowing). R57's Quarterly Minimum Data Set (MDS) completed 10/10/24 revealed a Brief Interview for Mental Status (BIMS) score of seven indicating severe cognitive impairment. The MDS indicated he required set-up and clean-up assistance during meals. The MDS indicated he was totally dependent on staff assistance for bed mobility and transfers. The MDs noted no swallowing disorders. R57's Functional Abilities Care Area Assessment (CAA) completed 10/10/24 was triggered but lacked analysis or recommendations. R57's Care Plan initiated 05/11/22 indicated he required assistance from staff for his activities of daily living (ADLs). The plan noted R57 required extensive assistance from one staff for bed mobility and transfers. The plan indicated he required a meal set and supervision for meals. The plan instructed staff to encourage the use of his call light. On 11/17/24 R57's Care Plan was updated to reflect a soft-touch call light replaced his push-button call light. R57's EMR under Evaluations revealed a screening for dysphagia completed on 09/21/24. The screening revealed he had difficulty swallowing on demand and encouraged prolonged mastication (chewing of food). R57's EMR under Progress notes indicated he was sent out to an acute medical facility on 11/08/24 for an acute gastrointestinal (digestive /stomach) disorder. The notes indicated he returned on 11/16/24. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/17/24 at 01:05 PM, R57 lay in his bed. The head of his bed was elevated between 30 to 40 degrees with him resting on his back. R57 had a spoon in his left hand while he attempted to eat his chili. R57 had spilled down his shirt from attempting to eat in a flat position. R57 struggled to answer questions due to his mouth being dry but he could not reach for his water. R57 pulled his call light up to his chest but could not activate the push button. R57 started coughing and struggled to talk as he attempted to activate his call light. At 01:08 PM staff were alerted that R57 needed assistance. Certified Nurse's Aide (CNA) Q entered R57's room. CNA Q acknowledged that R57 was supposed to be in a higher position during his meals and said R57 should be able to use his call light. CNA Q stated that R57's CNA would reposition him to make him more comfortable and change his clothing. At 01:12 PM staff entered the room and repositioned R57. Administrative Nurse D then entered the room and talked with R57. Upon request, Administrative Nurse D assessed R57's ability to use his call light. R57 was unable to use his call light independently or with nursing assistance. Administrative Nurse D stated that R57 just returned from an acute medical facility but could use his call light before he left. On 11/17/24 at 01:42 PM Administrative Nurse D stated R57's push-button call light was changed to a soft-touch call light. On 11/20/24 at 10:15 AM Certified Nurse's Aide (CNA) M stated all call lights should be placed within reach of the residents and staff should monitor each resident's ability to use their call buttons. On 11/20/24 at 04:30 PM Administrative Nurse D stated all residents are assessed upon admission, readmission, or when significant changes occurred to ensure their functional abilities had not declined. She stated the call lights should always be within reach and staff were expected to report any changes in a resident's abilities to nursing. The facility's Call System, Resident policy dated 09/2022 indicated the facility would ensure all residents had the means to call staff for assistance through a communication system. The policy indicated the facility would provide alternate means of communication if the resident was unable to activate the call system. The facility failed to ensure R57 had a call light he could functionally activate for staff assistance. This deficient practice placed both residents at risk for preventable accidents and injuries due to unmet care needs. 49634 - R66's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) with cerebrovascular accident (CVA -stroke - the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting the right dominant side, hypertension (HTN - elevated blood pressure, involuntary movements, diabetes mellitus (DM -when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), cardiomyopathy (heart disease), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), aphasia (a condition with disordered or absent language function), muscle weakness, and unsteadiness. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R66 had an impairment of the extremities on one side of her body. The MDS documented R66 needed substantial to maximum assistance for bathing, dressing, and toileting. The MDS documented R66 was dependent on staff for putting on or taking off footwear. R66's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 11/06/24 lacked analysis. R66's Care Plan revised 02/08/24 documented R66 had an activity of daily living (ADL) self-care performance deficit related to a history of a stroke. R66 communicated with picture sheets. R66 was independent with bed mobility and was able to wheel herself for short distances. R66 was able to self-propel her wheelchair, and if staff were assisting R66, staff were to ensure that her foot pedals were in place on her wheelchair. On 11/18/24 at 07:33 AM Certified Nurse's Aide (CNA) N pushed R66 into the dining area for breakfast without foot pedals. CNA N asked R66 to pick up her feet. On 11/18/24 at 08:21 AM, CNA N pushed R66 from the dining area to R66's room. R66 did not have foot pedals and staff asked R66 to pick up her feet. On 11/20/24 at 02:17 PM CNA M stated if the staff were pushing a resident, the foot pedal should be put on the resident's wheelchair. On 11/20/24 at 02:31 PM, Licensed Nurse (LN) G stated the residents should not be pushed in a wheelchair without foot pedals. LN G stated most of the residents who do not have foot pedals can propel their wheelchair. On 11/20/24 at 12:29 PM in an interview, Administrative Nurse D stated residents should have foot pedals if being pushed by a staff member. The facility did not provide an accommodations of needs policy. The facility failed to ensure R66's footrests were placed on her wheelchair when staff pushed her into the dining room, and then pushed her into her room. This deficient practice placed the residents at risk for impaired care due to unmet care needs.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 88 residents. The sample included 26 residents with two residents reviewed for self-determination. Based on observation, record review, and interview, the facility failed to ensure staff allowed Resident (R) 80, who had a smoking agreement in place at the facility, to remain at the facility and continue to smoke after the facility changed its policy to prohibit smoking. The facility further failed to allow R51 to choose his bathing times and preferences. This placed R80 and R51 at risk for decreased autonomy and impaired psychosocial well-being. Findings included: - R80's Electronic Medical Record (EMR) documented a diagnosis of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R80's Annual Minimum Data Set (MDS) dated [DATE], documented she had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. R80 required supervision to touching assistance with her activities of daily living (ADLs). R80 used tobacco. R80's Quarterly MDS dated [DATE], documented a BIMS score of 13, which indicated intact cognition. R80 required set-up assistance for ADLs. R80's triggered Care Area Assessment (CAA) , dated 05/03/24, lacked an analysis of findings. R80's Care Plan last revised 08/15/24 directed staff that R80 was a smoker. Staff were to educate R80 on the smoking rules and policy, designated smoking areas, and that she would be regularly assessed for safety. Staff were to have all smoking material individually labeled and kept in a secure location. Staff were to instruct R80 about the facility policy on smoking including the locations, times, and safety concerns. Staff were directed to provide staff supervision during designated smoking times. Staff were directed to reeducate R80 as needed to the facility smoking rules and policy. R80's Smoking Safety Screen, dated 04/26/24 at 01:23 PM, documented she smoked five to 10 cigarettes daily. R80 was able to light her own cigarette but she needed supervision to safely smoke. The undated Scheduled Smoking Times form documented all smoking for residents would be supervised by staff in the south unit courtyard. Smoking times were 09:30 AM, 01:30 PM, 04:00 PM, 06:30 PM, and 08:30 PM. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Memorandum for Residents of [NAME] Post Acute, dated 09/16/24, from Administrative Staff A documented that effective 30 calendar days from the date of the letter (10/16/24), the facility would no longer be a smoking facility. This meant that smoking would no longer be permitted anywhere on the premises, including all indoor and outdoor areas. The memorandum noted the facility understood that the change may require adjustments for some of the residents, and the facility wanted to offer support during the transition. The memorandum recorded that if the resident was a smoker and would like assistance in quitting or reducing their smoking, they were encouraged to contact the administration, social services, and or the nursing teams. The memorandum indicated the facility was happy to provide resources, information, and referrals to help the residents through the process. A Social Services Note dated 10/03/24 at 04:32 PM, documented R80 had been accepted to another facility. R80 was eager to transfer to the facility. A Nurse's Note dated 10/11/24 at 02:39 PM, documented that R80 approached the nurse stating that she was not sure that she wanted to move from the facility. R80 verbalized that she understood that the facility would be non-smoking. R80 stated she would just quit smoking and would not need a patch. The social worker was aware that R80 was not sure about moving at that point. A Social Service Note dated 10/22/24 at 04:13 PM documented R80 would be discharged on [DATE] at 12:00 PM when the new facility would pick her and her belongings up. The new facility would bring a wheelchair and oxygen as the items she currently used belonged to the facility. R80's current medication list was sent to the new facility. The signed orders would be sent upon physician review and signature the following day. R80's care was to be transferred to the medical director at the new facility. R80 and her representative were aware of the transfer plans. All current questions and concerns were addressed at that time. A Nurse Note dated 10/23/24 at 09:14 AM, documented R80 discharged , and the facility called a nursing report to the receiving facility. The nurse went over the discharge plan with R80 who voiced understanding and stated she loved the staff at the facility but just really wanted to smoke. On 11/19/24 at 01:15 PM Administrative Staff A stated that he and the interdisciplinary team (IDT) did some research on how much time staff spent going outside with residents to supervise their smoking. Administrative Staff A then devised the 30-day notice of the facility becoming a non-smoking facility and the facility notified all of the residents and their representatives of the new policy. Administrative Staff A stated all residents who smoked were offered the option of the nicotine patch (nicotine replacement therapy) or the facility would assist the resident with relocation to another facility that allowed smoking. Administrative Staff A stated he realized after the new policy took effect on 10/16/24, that there was a grandfather provision in the regulations and he had to abide by the grandfather provision. He stated all residents who smoked at the time of the policy change notification on 09/16/24 and those residents were grandfathered in, were allowed to smoke. Administrative Staff A stated that R80 was offered the nicotine patch and declined and was offered an alternate placement at another facility, which R80 chose to do. Administrative Staff A stated that R80 had been discharged to the new facility before he made the grandfathered provisions. Administrative Staff A stated he grandfathered 13 or 14 residents who did smoke to smoke twice daily at 09:30 AM and 04:00 PM. Administrative Staff A stated that all new residents admitted to the facility were made aware of the new non-smoking facility policy. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated Smoking Policy- Residents policy documented: This facility had established and maintains safe resident smoking practices. Prior to, and upon admission, residents were informed of the facility smoking policy. If the facility policy changed to one that prohibits smoking, residents who were currently allowed to smoke would be provided an area to smoke which maintained the quality of life and safety for smoking residents while considering the health and well-being of non-smoking residents. The current Smoking times (subject to change) were 09:30 AM and 04:00 PM. The facility failed to ensure staff allowed R80, who had a smoking agreement in place at the facility, to remain at the facility and continue to smoke after the facility changed its policy to prohibit smoking. This placed R80 at risk for decreased autonomy and impaired psychosocial well-being.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 45668 The facility reported a census of 88 residents. The sample included 26 residents. The facility failed to have a surety bond that covered the facility's resident trust funds. This deficient practice placed 52 residents at risk for complications related to financial loss. Findings Included: - A review of the facility's Trust Account statement indicated a current balance of $32,310.15. The statement indicated that 52 residents had active accounts managed by the facility. The facility's surety bond, effective 06/17/24, indicated the bond covered $30,000.00. On 11/21/24 at 10:00 AM, Administrative Staff B stated she was not aware that the surety bond only covered $30,000.00 and would make sure the bond amount was raised to $40,000.00. On 11/21/24 at 10:12 AM, Administrative Staff A was not aware the resident fund accounts exceeded the amount the surety bond covered. The facility's Resident Funds policy, not dated, directed the facility ensured a protective bond was in place to cover the amounts deposited in the funds account. The facility failed to have a surety bond that covered the facility's resident trust funds. deficient practice placed 52 residents at risk for complications related to financial loss.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 41713 The facility identified a census of 88 residents. The sample included 26 residents. Based on observation, record review, and interview, the facility failed to ensure staff secured and protected the privacy and confidentiality of Resident (R) 34's medical record. This placed R34 at risk for impaired right to confidentiality. Findings included: - On 11/18/24 at 07:53 AM, a laptop with an unsecured and visible screen that showed R34's Medication Administration Record (MAR) was left unattended on medication cart number (#) eight. On 11/18/24 at 08:00 AM Certified Medication Aide (CMA) R stated she was an agency CMA and had not worked a shift for a while. CMA R stated the laptop screen should be locked when she was away from the medication cart. On 11/21/24 at 11:19 AM Administrative Nurse D stated she expected any staff that passed medications to lock the medication cart and the laptop screen any time they walked away from their medication cart. Administrative Nurse D stated a resident's personal information should never be left visible on a laptop screen. The Protected Health Information (PHI), Management and Protection policy, last revised April 2014, directed PHI shall not be used or disclosed except as permitted by current federal and state laws. The policy directed it was the responsibility of all personnel who had access to resident and facility information to ensure that such information was managed and protected to prevent unauthorized release or exposure. The facility failed to ensure that staff secured and protected the privacy and confidentiality of R34's medical record. This placed R34 at risk for impaired right to confidentiality.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 88 residents. The sample included 26 residents. Based on observation, record review, and interview, the facility failed to identify a fracture of unknown origin for Resident (R) 65 as potential abuse or neglect and report to the State Agency as required. This placed R65 at risk for unidentified and ongoing abuse, neglect, or mistreatment. Findings included: - The Diagnoses tab of R65's Electronic Medical Record (EMR) documented diagnoses of restlessness and agitation, altered mental status, lack of coordination, diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), osteoarthrosis (chronic arthritis without inflammation) mood disturbance, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), muscle weakness, communication deficit, hypertension (HTN - elevated blood pressure), unsteadiness on feet, insomnia (inability to sleep), abnormal posture, aphasia, and dysphagia (swallowing difficulty). The Diagnoses section of R65's EMR recorded a diagnosis entered on 11/14/24 for age-related osteoporosis (a medical condition in which the bones become brittle and fragile from loss of tissue), with a current pathological fracture (a broken bone that occurs in an area of bone that been weakened by disease). The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R65 had unclear speech with mumbled words. The MDS documented R65 was independent with eating, dressing her lower and upper body, putting on and taking off footwear, and oral hygiene. The MDS documented R65 needed partial to moderate assistance with bathing, and supervision or touching assistance with toileting hygiene. The MDS documented R65 had occasional urinary incontinence and frequent bowel incontinence. R65's MDS lacked indication R65 had osteoporosis. The Falls Care Area assessment dated [DATE], documented R65 triggered for delirium (sudden severe confusion, disorientation, and restlessness) related to a report of her inability to focus. R65 had severe cognitive decline based on her dementia (a progressive mental disorder characterized by failing memory and confusion) R65 had not demonstrated a significant change indicating a need for a delirium care plan at this time. R65 triggered for cognition due to her diagnosis of dementia. She does have poor cognition and was unable to verbalize her needs or concerns. R65 can communicate some via whiteboard but this was becoming less effective as her overall decline in cognition continues. R65 would have a care plan to address her cognition. R65 triggered for communications due to dementia. R65 triggered for incontinence due to the periods of both bowel and bladder incontinence during the lookback period. R65 was not only incontinent but was now requiring assistance with incontinence care due to the inability to clean up her bowel movements appropriately and get bowel movements on her hands, clothing, and walls. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R65's Care Plan would address those concerns. R65 triggered for falls based on the use of psychotropic (alters mood or thought) medication. She takes Remeron (an antidepressant) for appetite as well as depression and the drug would increase R65's risk of falls. R65 had an unsteady gait and an inability to remember to ask for assistance. R65 triggered for pressure injury based on incontinence. R65 triggered for psychotropic drug use related to the use of Remeron. She was on this medication to address both her weight loss risk and her depression. R65's Care Plan documented she had a cognitive communication deficit and dementia, and she required assistance with activities of daily living (ADLs). R65's plan of care dated 04/17/24 documented R65 was independent with bed mobility, walking, dressing, and transferring. She required moderate assistance of one for hygiene and set up for eating. R65's plan of care dated 04/17/24 documented R65 had difficulty communicating with others related to aphasia. R65 communicated with a notepad and pen. R65's Care Plan dated 11/25/22 and revised on 04/18/24 documented R65 had limited physical mobility related to dementia (a progressive mental disorder characterized by failing memory and confusion). Staff were to monitor, document, and report any signs or symptoms of immobility. R65's Care Plan dated 09/16/24 documented R65 was at risk for falls and had an actual fall related to confusion, gait and balance, incontinence, and poor communication. An intervention dated 11/25/22 directed staff to anticipate and meet the resident's needs. The plan documented a non-injury fall (NIF) on 03/03/24 and an intervention dated 03/04/24 which directed staff to encourage R65 to remain seated in the shower. The plan documented a NIF on 05/25/24 with an intervention dated 05/28/24 for non-skid strips in front of the toilet in R65's room. The plan documented a NIF on 09/15/24 (revised on 11/18/24) with an intervention dated 09/16/24 that directed staff to apply nonskid strips beside R65's bed. R65's plan of care dated 09/27/24 documented R65 had a fall on 09/26/24 and the nurse practitioner (NP) was to complete a medication review. R65's EMR under Nurses Notes dated 09/26/24 at 03:56 documented the Certified Nurse's Aide (CNA) assigned to R65 was assisting R65 with cleaning up bowel movement, R65 had a bowel movement all over her body, the floor, and toilet. When the CNA stepped out of the room briefly to put R65's dirty laundry in a bag and get a second CNA to help with R65. R65 was observed sitting on the floor next to the toilet stool. R65 had bowel movements on her fingers, hands, and hips, and R65 was trying to pull her panties and jeans off her. R65 had nonskid socks on her feet. The Nurse assigned to R65 did a head-to-toe assessment. R65's EMR under Nurses Notes dated 09/27/24 at 05:52 PM documented R65 presented with a decline in cognition, and R65's behaviors continued to increase. R65 was observed not being able to provide self-care after toileting, and toileting was a task she was able to do. Additionally, R65 continued to play in bowel movements, such as washing her hands in her water pitcher and then placing bowel movements inside of her water pitcher. The nurse communicated the above documentation with NP and discussed a review of R65's medications. The following order was provided: increase donepezil (a medication to treat dementia) to 10 milligrams (mg) daily. The NP stated he would review medications and see R65 on 09/30/24. R65's guardian was notified of the increase in medication. R65's EMR under Nurses Note dated 09/27/24 at 11:22 PM (late entry made on 09/29/24) documented R65 was alert and oriented per her baseline. R65 displayed no signs and symptoms of pain or discomfort. R65's skin was assessed for injury, and no injury was noted. R65's skin was without alteration. The note documented R65 was ambulating independently. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R65's EMR under Nurses Note dated 9/28/24 at 12:27 AM (late entry made on 09/29/24) documented R65 continued follow-up fall monitoring. R65 was alert and oriented per baseline and the resident displayed no signs and symptoms of pain or discomfort. R65's skin was assessed for injury; no injury was noted, and the skin was without alteration. R65 was in her bed asleep, in a position of comfort. The bed was in the lowest locked position with the call light in reach. R65's EMR under an Interdisciplinary team (IDT) Note at 02:59 PM dated 10/01/24 documented a note for therapy intervention. R65 was having a decline in her level of function, and the focus was to improve the toileting task. R65's EMR under Nurses Note dated 10/2/24 at 11:42 AM documented the NP saw R65 related to falls and cognition decline and reviewed R65's medication. The NP ordered nursing to assess orthostatic (laying, sitting then standing) blood pressure for three days. R65's EMR under Nurse Practitioner Note dated 10/02/24 at 11:42 AM documented R65's medication list and vital signs were reviewed post-fall. R65 had a recent increase in Aricept (a medication to treat dementia), and orthostatic vital signs were ordered twice daily for three days to provide more data. R65's EMR under weekly IDT Note dated 10/8/24 at 02:28 PM for therapy intervention noted a decline in R65's level of function, related to toileting and self-care. The note documented occupational therapies worked with toileting improving for R65. Speech therapy staff and resident communication tools had improved when staff gave visual and tactile cues for putting condiments on food, eating, sitting down, hand-over-hand assistance for toileting and self-care, and gait in the hallway. R65 was getting feces on herself and the bathroom. R65's EMR under IDT-Behavior dated 10/17/24 at 10:17 AM documented an increase in behaviors related to dementia progression. R65 had an increase in wandering and a recent fall. R65 was undressing and walking in the hallway, playing with her bowel movement, and storing used toilet paper. The NP assessed R65 in the facility, reviewed and adjusted her medication, and ordered staff to continue the current plan of care. R65's EMR under IDT Weekly Therapy Note dated 11/05/24 at 02:57 PM documented for therapy interventions, R65 had a decline in level of function, disc generation (a chronic condition that occurs when the spinal disc wears down) without pain, abnormal posture, muscle weakness, and was unsteady on her feet. Physical therapy documented a decrease in balance and activity tolerance. Occupational therapies were working on toileting and ADLs, with sequencing with ADLs. The note documented R65 was not making any improvement with occupational therapies as R65 had continued with bowel movements in the sink, poor hygiene, and was not progressing. R65 was forgetting the process of initiating tasks. R65's EMR under IDT Note dated 11/07/24 at 11:02 AM documented that R65 was being followed by IDT for behaviors, a change of condition, and weight loss. R65 was still demonstrating playing in bowel movements and having a bowel movement in the sink. R65's current weight was 102.4 pounds which had decreased from 106 pounds the week of 11/01/24, R65 continued a regular thin liquid diet, received double portions at meals, and house shakes three times a day with ice cream. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R65's EMR under Alert Note dated 11/11/24 at 10:43 AM documented the nurse entered R65's room to administer the morning medication. The nurse observed R65 in bed with her eyes open and she was incontinent of bowel. R65 had a bowel movement on her legs and her hands, R65 also had bowel movement in her hair. R65 had her brief half off and wrapped in her sheets. The nurse asked a CNA to assist R65 to the shower. R65 was noted with facial grimacing and limping on her right leg. Upon assessment, R65's right knee had abnormal swelling, the right knee was internally rotated and R65 was unable to raise her leg. R65 was unable to do range of motion (ROM); R65 grimaced and guarded the right knee. The note recorded this was unusual for R65 The NP was at R65's bedside and an assessment was completed. Staff received new orders for an X-ray of R65's right knee, two views, and for Tramadol 50 milligrams (mg) twice a day for seven days for R65's Pain. R65's EMR under Nurses Note dated 11/11/24 at 06:32 PM documented the right knee X-ray results were received. The findings indicated there was no evidence of acute fracture, dislocation, or osseous lesion (no visible bone damage) to the right knee. The joint spaces were unremarkable, there was mild peripatellar (the area around the kneecap) soft tissue swelling with small suprapatellar (area above the kneecap) effusion (build-up of excess fluid) noted. R65's EMR under Nurses Note dated 11/12/24 at 10:50 AM documented R65 was resting in her bed with her eyes open. She appeared relaxed with no facial grimacing. R65 continued to have very limited mobility in her right knee. R65 guarded her extremities during care. R65 was incontinent of bowel and bladder. R65 consumed less than 25 percent of her breakfast and lunch. Staff were in the room routinely to check on R65. R65's call light was placed on the right side of her at the bedside. R65's EMR under Nurses Note dated 11/13/24 at 02:02 PM documented The NP reviewed R65's right knee X-ray and requested an X-ray of R65's right hip related to limited mobility with intense pain. The note recorded the X-ray was ordered and would be performed on 11/14/24. R65's EMR under Nurses Note dated 11/14/24 at 11:34 PM documented the nurse contacted the X-ray department to fax the X-ray results of R65's right hip X-ray. R65's right hip X-ray results indicate a fracture of the right femoral neck. Staff notified the NP who ordered R65 to be sent to the emergency department. The nurse explained to the doctor that hospice would be notified. R65 exited the facility via ambulance on a stretcher. R65's EMR under Admission/Readmission Summary Note dated 11/18/24 at 06:50 PM documented that R65 was readmitted to a skilled nursing facility (SNF) for skilled services. R65 returned to the facility via a transportation van. R65 entered the facility through the front entrance via a gurney with transportation aid and R65's daughter at her side. R65 was oriented to her room, call light, bed controls, TV remote, restroom, light fixtures as well as facility. R65's height, weight, vitals, and assessment were obtained upon admission. R65 was assisted to her bed by two staff assistants and placed in a position of comfort. R65's call light was within her reach and her bed was in the lowest locked position. R65 was admitted with an 18-fr Foley catheter (a tube inserted into the bladder to drain urine into a collection bag) in place. R65 was admitted post-surgery to her right hip. R65 had a right hip hemiarthroplasty (half of the joint was replaced). R65 had an immobilizer in place and denied signs or symptoms of pain at that time. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Nurse (LN) I's undated Witness Statement documented the last time LN I worked with R65 was on 11/09/24 on the 07:00 AM to 07:00 PM shift. LN I stated R65 was at her baseline at that time. R65 was ambulating independently to and from the toilet, walking around in her room, and up to the nurse's station to refill her cup with ice chips. The statement documented R65 was nonverbal confused. R65 had no signs or symptoms of pain or discomfort. LN I documented she worked with R65 on 11/11/24 on the 07:00 AM to 07:00 PM shift and at that time she noticed a change in R65's condition. The statement documented R65's change of condition was noted in nurses' notes and was followed up by the NP on the same day. CNA SS's Incident Statement dated with an illegible date marked as either 10/11/24 or 11/11/24, CNA SS documented he was told in nursing report that R65's knee had been hurting. CNA SS described that whenever he went in to help R65 she had an uneasy look on her face and was in a lot of pain. The statement documented the last time CNA SS worked with R65 prior to the statement date was on 10/07/24 CNA RR's Incident Statement dated 11/07/24 documented he heard about the incident for R65 when he came back to work. The statement included a handwritten note at the bottom which documented CNA RR saw R65 on 11/07/24. R65 was walking around and going to the nursing station to get ice and ice water; R65 appeared normal and at her baseline. Administrative Nurse E's undated Witness Statement documented on 11/10/24, Administrative Nurse E walked with R65 to the resident's room after R65 brought her meal tray to the nurse's station. The statement documented Administrative Nurse E assisted R65 with hand washing and R65 ambulated at her baseline, with no signs and symptoms of pain. R65's Rapid Radiology Patient Report dated 11/14/24 documented significant findings of the right hip. The report documented there was no dislocation, and overall osseous (bone) mineralization was decreased, which could reflect osteopenia or osteoporosis in the correct clinical context. The report documented a displaced fracture of the right femoral neck with angulation at the fracture site. On 11/19/24 at 07:05 AM R65 laid in her bed with her hip pillows in place, and a call light at the resident's side. R65 had communication sheets and a whiteboard at the bedside. R65 was not able to communicate with visitors by communication sheets or whiteboard. On 11/20/24 at 09:05 AM LN I stated she talked to Consultant GG about R65's decline, and Consultant GG saw R65 during facility rounds. LN I stated R65's decline was due to dementia. LN I stated after the fall on 09/26/24, R65 was able to walk and was able to make her bed. LN I stated R65's downfall was that she had no idea what to do after she had gone to the bathroom and had a bowel movement. LN I stated R65 needed more assistance from nursing. LN I stated she did not know if the care plan reflected the assistance R65 needed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 10:57 AM Administrative Nurse D stated immediately after she received the call from the nurse on duty stating R65's right knee had swelling, Administrative Nurse D called Administrative Staff A. She stated the facility did not feel there was abuse or neglect. She stated R65 had no reported falls after 09/26/24. Administrative Nurse D stated R65 was up and walking until the point staff reported R65 was limping. She stated R65 was able to get in and out of her bed, and staff were checking on her more frequently. She said R65 had started occupational therapy and physical therapy, and her care plan had been updated. Administrative Nurse D stated all nursing staff have access to the care plan, she stated she was unsure if the staff were following R65's care plan. She stated R65 had no marks, no bruising, and no discoloration on her body. Administrative Nurse D stated the facility did investigate the fracture, the facility talked to and got witness statements from multiple nurses and aides working with R65 from 11/09/24-11/11/24 and all statements stated R65 was walking before nursing found her in her bed with her brief half off, and grimacing when nursing performed cares. Administrative Nurse D was unsure the last time R65 was checked on, or what time before finding her with her brief half off. Administrative Nurse D stated immediately after finding R65 grimacing the nurse on duty called the NP to come to the facility and assess R65. Administrative Nurse D stated NP called her personally after reviewing R65's X-rays and gave her the diagnosis of pathological fracture and osteoporosis. Administrative Nurse D Stated Administrative Staff A was the person who decided what needed to be reported. She said Administrative Staff A had a program he puts the resident information in and determined what was reportable. On 11/20/24 at 11:43 AM Administrative Staff A stated he was the abuse coordinator. He stated if he had suspected abuse or neglect, he would have called Administrative Nurse D and the State Agency (SA) within two hours. He stated nothing he read about the incident made him suspect abuse or neglect, and said he did an investigation of every incident. Administrative Staff A said risk management looked at every incident and all underdefined assessments (UDAs) were triggered. Administrative Staff A stated he had a sheet from the SA that he goes by when reporting. He stated he did not feel a resident's BIMS would make a difference with what he would report to the SA. He stated that no falls for R65 were reported, and Consultant GG did an assessment and ordered an X-ray. Administrative Staff A stated he was unsure what the root cause and analysis was but said Consultant GG had determined the fracture was pathological, so no investigation was required. Administrative Nurse D stated at the end of the day, R65 was taken care of, and if he had suspected abuse or neglect, he would have reported it, even if it was late. The facility's Abuse, Neglect, exploitation or Misappropriation policy dated 09/2022 documented all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft and misappropriation for residents' property are reported to local, state, and federal agencies and thoroughly investigated by the facility management. Findings of all investigations are documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property, or injury of unknown source was suspected the suspicion must be reported immediately to the administrator and to other officials according to the law. The physician and staff will help identify risk factors for abuse within the facility. The facility failed to identify a fracture of unknown origin for R65 as potential abuse or neglect and report to the State Agency as required. This placed R65 at risk for unidentified and ongoing abuse, neglect, or mistreatment.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 88 residents. The sample included 26 residents, with five residents reviewed for abuse. Based on observations, record review, and interviews, the facility failed to ensure Resident (R) 65 received the necessary protective oversight to prevent potential abuse and/or neglect when the facility staff failed to identify and investigate a fracture (broken bone) of unknown origin as potential abuse or neglect. R65 was cognitively impaired, had a diagnosis of aphasia (a condition with disordered or absent language function), and had wandering behaviors. R65's clinical record documented a non-injury fall on 09/26/24 with multiple assessments following which reported R65 ambulated and wandered in the facility with no apparent injury. On 11/11/24 staff noted R65 lying in bed, with her incontinence brief half off. The staff took R65 to the shower and observed she was limping, and her right knee appeared swollen. Staff notified the provider and obtained orders for an X-ray of R65's right knee. On 11/12/24 the right knee X-ray was completed with no remarkable findings. On 11/13/24, R65's pain became intense, and staff obtained an order for a right hip X-ray, which indicated a fracture. R65 went to the hospital where she was diagnosed with a broken hip where the bone at the sub-capital region (the junction of the femoral head and neck) comminuted (was shattered into multiple pieces). Upon learning of the fracture, the facility failed to identify the serious injury of unknown origin as a potential abuse or neglect situation and failed to initiate an investigation to determine the cause of the fracture. The facility failed to implement protective measures to prevent ongoing abuse while an investigation was conducted. This deficient practice placed R65 in immediate jeopardy. Findings included: - The Diagnoses tab of R65's Electronic Medical Record (EMR) documented diagnoses of restlessness and agitation, altered mental status, lack of coordination, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), osteoarthrosis (chronic arthritis without inflammation) mood disturbance, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), muscle weakness, communication deficit, hypertension (HTN-elevated blood pressure), unsteadiness on feet, insomnia (inability to sleep), abnormal posture, aphasia, and dysphagia (swallowing difficulty). The Diagnoses section of R65's EMR recorded a diagnosis entered on 11/14/24 for age-related osteoporosis (a medical condition in which the bones become brittle and fragile from loss of tissue), with a current pathological fracture (a broken bone that occurs in an area of bone that been weakened by disease). The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R65 had unclear speech with mumbled words. The MDS documented R65 was independent with eating, dressing her lower and upper body, putting on and taking off footwear, and oral hygiene. The MDS documented R65 needed partial to moderate assistance with bathing, and supervision or touching assistance with toileting hygiene. The MDS documented R65 had occasional urinary incontinence and frequent bowel incontinence. R65's MDS lacked indication R65 had osteoporosis. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The Falls Care Area assessment dated [DATE], documented R65 triggered for delirium (sudden severe confusion, disorientation, and restlessness) related to a report of her inability to focus. R65 had severe cognitive decline based on her dementia (a progressive mental disorder characterized by failing memory and confusion) R65 had not demonstrated a significant change indicating a need for a delirium care plan at this time. R65 triggered for cognition due to her diagnosis of dementia. She does have poor cognition and was unable to verbalize her needs or concerns. R65 can communicate some via white but this was becoming less effective as her overall decline in cognition continues. R65 would have a care plan to address her cognition. R65 triggered for communications due to dementia. R65 triggered for incontinence due to the periods of both bowel and bladder incontinence during the lookback period. R65 was not only incontinent but was now requiring assistance with incontinence care due to the inability to clean up her bowel movements appropriately and get bowel movements on her hands, clothing, and walls. R65's Care Plan would address those concerns. R65 triggered for falls based on the use of psychotropic (alters mood or thought) medication. She takes Remeron (an antidepressant) for appetite as well as depression and the drug would increase R65's risk of falls. R65 had an unsteady gait and an inability to remember to ask for assistance. R65 triggered for pressure injury based on incontinence. R65 triggered for psychotropic drug use related to the use of Remeron. She was on this medication to address both her weight loss risk and her depression. R65's Care Plan documented she had a cognitive communication deficit and dementia, and she required assistance with activities of daily living (ADL). R65's plan of care dated 04/17/24 documented R65 was independent with bed mobility, walking, dressing, and transferring. She required moderate assistance of one for hygiene and set up for eating. R65's plan of care dated 04/17/24 documented R65 had difficulty communicating with others related to aphasia. R65 communicated with a notepad and pen. R65's Care Plan dated 11/25/22 and revised on 04/18/24 documented R65 had limited physical mobility related to dementia (a progressive mental disorder characterized by failing memory and confusion). Staff were to monitor, document, and report any signs or symptoms of immobility. R65's Care Plan dated 09/16/24 documented R65 was at risk for falls and had an actual fall related to confusion, gait and balance, incontinence, and poor communication. An intervention dated 11/25/22 directed staff to anticipate and meet the resident's needs. The plan documented a non-injury fall (NIF) on 03/03/24 and an intervention dated 03/04/24 which directed staff to encourage R65 to remain seated in the shower. The plan documented an NIF on 05/25/24 with an intervention dated 05/28/24 for non-skid strips in front of the toilet in R65"sroom. The plan documented a NIF on 09/15/24 (revised on 11/18/24) with an intervention dated 09/16/24 that directed staff to apply nonskid strips beside R65's bed. R65's plan of care dated 09/27/24 documented R65 had a fall on 09/26/24 and the nurse practitioner (NP) was to complete a medication review. R65's EMR under Nurses Notes dated 09/26/24 at 03:56 documented the Certified Nurse Aide (CNA) assigned to R65 was assisting R65 with cleaning up bowel movement, R65 had a bowel movement all over her body, the floor, and toilet. When the CNA stepped out of the room briefly to put R65's dirty laundry in a bag and get a second CNA to help with R65. R65 was observed sitting on the floor next to the toilet stool. R65 had bowel movements on her fingers, hands, and hips, and R65 was trying to pull her panties and jeans off her. R65 had nonskid socks on her feet. The Nurse assigned to R65 did a head-to-toe assessment. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R65's EMR under Nurses Notes dated 09/27/24 at 05:52 PM documented R65 presented with a decline in cognition, and R65's behaviors continued to increase. R65 was observed not being able to provide self-care after toileting, and toileting was a task she was able to do. Additionally, R65 continued to play in bowel movements, such as washing her hands in her water pitcher and then placing bowel movements inside of her water pitcher. The nurse communicated the above documentation with the NP and discussed a review of R65's medications. The following order was provided: increase donepezil (a medication to treat dementia) to 10 milligrams (mg)daily. The NP stated he would review medications and see R65 on 09/30/24. R65's guardian was notified of the increase in medication. R65's EMR under Nurses Note dated 09/27/24 at 11:22 PM (late entry made on 09/29/24), R65 was alert and oriented per her baseline. R65 displayed no signs and symptoms of pain or discomfort. R65's skin was assessed for injury, and no injury was noted. R65's skin was without alteration. The note documented R65 was ambulating independently. R65's EMR under Nurses Note dated 9/28/24 at 12:27 AM (late entry made on 09/29/24) R65 continued follow-up fall monitoring. R65 was alert and oriented per baseline and the resident displayed no signs and symptoms of pain or discomfort. R65's skin was assessed for injury; no injury was noted, and the skin was without alteration. R65 was in her bed asleep, in a position of comfort. The bed was in the lowest locked position with the call light in reach. R65's EMR under an Interdisciplinary team (IDT) Note at 02:59 PM dated 10/01/24 documented a note for therapy intervention. R65 was experiencing a decline in her level of function, and the focus was on improving the toileting task. R65's EMR under Nurses Note dated 10/2/24 at 11:42 AM documented the NP saw R65 related to falls and cognition decline and reviewed R65's medication, The NP ordered nursing to assess orthostatic (laying, sitting then standing) blood pressure for three days. R65's EMR under Nurse Practitioner Note dated 10/02/24 at 11:42 AM documented R65's medication list and vital signs were reviewed post-fall. R65 had a recent increase in Aricept (a medication to treat dementia), and orthostatic vital signs were ordered twice daily for three days to provide more data. R65's EMR under weekly IDT Note dated 10/08/24 at 02:28 PM for therapy intervention noted a decline in R65's level of decline of function, related to toileting and self-care. The note documented occupational therapies worked with toileting improvement for R65. Speech therapy staff and resident communication tools had improved when staff gave visual and tactile cues for putting condiments on food, eating, sitting down, hand-over-hand assistance for toileting and self-care, and gait in the hallway. R65 was getting feces on herself and the bathroom. R65's EMR under IDT-Behavior dated 10/17/24 at 10:17 AM documented an increase in behaviors related to dementia progression. R65 had an increase in wandering and a recent fall. R65 was undressing and walking in the hallway, playing with her bowel movements, and storing used toilet paper. The NP assessed R65 in the facility, reviewed and adjusted her medication, and ordered staff to continue the current plan of care. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Healthcare and Rehab Topeka	2515 SW Wanamaker Road Topeka, KS 66614

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R65's EMR under IDT Weekly Therapy Note dated 11/05/24 at 02:57 PM documented for therapy interventions, R65 had a decline in level of function, disc generation (a chronic condition that occurs when the spinal disc wears down), without pain, abnormal posture, muscle weakness, and was unsteady on her feet. Physical therapy documented a decrease in balance and activity tolerance. Occupational therapies were working on toileting and ADLs, with sequencing with ADLs. The note documented R65 was not making any improvement with occupational therapies as R65 had continued with bowel movements in the sink, poor hygiene, and was not progressing. R65 was forgetting the process of initiating tasks. R65's EMR under IDT Note dated 11/07/24 at 11:02 AM documented that R65 was being followed by IDT for behaviors, a change of condition, and weight loss. R65 was still demonstrating playing in bowel movements and having a bowel movement in the sink. R65's current weight was 102.4 pounds which had increased from 106 pounds the week of 11/01/24, R65 continued a regular thin liquid diet and was receiving double portions at meals, and house shakes three times a day with ice cream. R65's EMR under Alert Noted dated 11/11/24 at 10:43 AM documented the nurse entered R65's room to administer the morning medication. The nurse observed R65 in bed with her eyes open and she was incontinent of bowel. R65 had a bowel movement on her legs and her hands, and R65 also had feces in her hair. R65 had her brief half off and wrapped in her sheets. The nurse asked a CNA to assist R65 to the shower. R65 was noted to have facial grimacing and limping on her right leg. Upon assessment, R65's right knee had abnormal swelling, the right knee was internally rotated and R65 was unable to raise her leg. R65 was unable to do range of motion (ROM); R65 grimaced and guarded the right knee. The note recorded this was unusual for R65. The NP was at R65's bedside and an assessment was completed. Staff received new orders for an X-ray of R65's right knee, two views, and for Tramadol 50 milligrams (mg) twice a day for seven days for R65's Pain. R65's EMR under Nurses Note dated 11/11/24 at 06:32 PM documented the right knee X-ray results were received. The findings indicated there was no evidence of acute fracture, dislocation, or osseous lesion (no visible bone damage) to the right knee. The joint spaces were unremarkable, there was mild peripatellar (the area around the kneecap) soft tissue swelling with small suprapatellar (area above the kneecap) effusion (build-up of excess fluid) noted. R65's EMR under Nurses Note dated 11/12/24 at 10:50 AM documented R65 was resting in her bed with her eyes open. She appeared relaxed with no facial grimacing. R65 continued to have very limited mobility in her right knee. R65 guarded her extremities during care. R65 was incontinent of bowel and bladder. R65 consumed less than 25 percent of her breakfast and lunch. Staff were in the room routinely to check on R65. R65's call light was placed on the right side of her at the bedside. R65's EMR under Nurses Note dated 11/13/24 at 02:02 PM documented the NP reviewed R65's right knee X-ray and requested an X-ray of R65's right hip related to limited mobility with intense pain. The note recorded the X-ray was ordered and would be performed on 11/14/24. R65's EMR under Nurses Note dated 11/14/24 at 11:34 PM documented the nurse contacted the X-ray department to fax the X-ray results of R65's right hip X-ray. R65's right hip X-ray results indicated a fracture of the right femoral neck. Staff notified the NP who ordered R65 to be sent to the emergency department. The nurse explained to the doctor that hospice would be notified. R65 exited the facility via ambulance on a stretcher. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R65's EMR under Admission/Readmission Summary Note dated 11/18/24 at 06:50 PM documented that R65 was readmitted to a skilled nursing facility (SNF) for skilled services. R65 returned to the facility via a transportation van. R65 entered the facility through the front entrance via a gurney with transportation aid and R65's daughter at her side. R65 was oriented to her room, call light, bed controls, TV remote, restroom, light fixtures, as well as facility. R65's height, weight, vitals, and assessment were obtained upon admission. R65 was assisted to her bed with assistance from two staff and placed in a position of comfort. R65's call light was within her reach and her bed was in the lowest locked position. R65 was admitted with a Foley catheter (a tube inserted into the bladder to drain urine into a collection bag) in place. R65 was admitted post-surgery to her right hip. R65 had a right hip hemiarthroplasty (half of the joint was replaced). R65 had an immobilizer in place and denied signs or symptoms of pain at that time. R65's Rapid Radiology Patient Report dated 11/14/24 documented significant findings of the right hip. The report documented there was no dislocation, and overall osseous (bone) mineralization was decreased, which could reflect osteopenia or osteoporosis in the correct clinical context. The report documented a displaced fracture of the right femoral neck with angulation at the fracture site. Licensed Nurse (LN) I's undated Witness Statement documented the last time LN I worked with R65 was on 11/09/24 on the 07:00 AM to 07:00 PM shift. LN I stated R65 was at her baseline at that time. R65 was ambulating independently to and from the toilet, walking around in her room, and up to the nurse's station to refill her cup with ice chips. The statement documented R65 was nonverbal and was confused. R65 had no signs or symptoms of pain or discomfort. LN I documented she worked with R65 on 11/11/24 on the 07:00 AM to 07:00 PM shift and at that time she noticed a change in R65's condition. The statement documented R65's change of condition was noted in nurses' notes and was followed up by the NP on the same day. CNA SS's Incident Statement dated with an illegible date marked as either 10/11/24 or 11/11/24, documented he was told in nursing report that R65's knee had been hurting. CNA SS described that whenever he went in to help R65 she had an uneasy look on her face and was in a lot of pain. The statement documented the last time CNA SS worked with R65 prior to the statement date was on 10/07/24. CNA RR's Incident Statement dated 11/07/24 documented he heard about the incident for R65 when he came back to work. The statement included a handwritten note at the bottom which documented that CNA RR saw R65 on 11/07/24. R65 was walking around and going to the nursing station to get ice and ice water; R65 appeared normal and at her baseline. Administrative Nurse E's undated Witness Statement documented that on 11/10/24, Administrative Nurse E walked with R65 to the resident's room after R65 brought her meal tray to the nurse's station. The statement documented Administrative Nurse E assisted R65 with hand washing and R65 ambulated at her baseline, with no signs and symptoms of pain. During an observation on 11/19/24 at 07:05 AM, R65 laid in her bed with her hip pillows in place, and a call light at the resident's side. R65 had communication sheets and a whiteboard at the bedside. R65 was not able to communicate with visitors by communication sheets or whiteboard. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/20/24 at 09:05 AM LN I stated she talked to Consultant GG about R65's decline, and Consultant GG saw R65 during facility rounds. LN I stated that R65's decline was due to dementia. LN I stated after the fall on 09/26/24, R65 was able to walk and was able to make her bed. LN I stated R65's downfall was that she had no idea what to do after she had gone to the bathroom and had a bowel movement. LN I stated R65 needed more assistance from nursing. LN I stated she did not know if the care plan reflected the assistance R65 needed. On 11/20/24 at 10:57 AM Administrative Nurse D stated immediately after she received the call from the nurse on duty stating R65's right knee had swelling, Administrative Nurse D called Administrative Staff A. She stated the facility did not feel there was abuse or neglect. She stated that R65 had no reported falls after 09/26/24. Administrative Nurse D stated R65 was up and walking until the point staff reported R65 was limping. She stated R65 was able to get in and out of her bed, and staff were checking on her more frequently. She said R65 had started occupational therapy and physical therapy, and her care plan had been updated. Administrative Nurse D stated all nursing staff have access to the care plan, she stated she was unsure if the staff were following R65's care plan. She stated R65 had no marks, no bruising, and no discoloration on her body. Administrative Nurse D stated the facility did investigate the fracture, the facility talked to and got witness statements from multiple nurses and aides working with R65 from 11/09/24-11/11/24 and all statements stated R65 was walking before nursing found her in her bed with her brief half off, and grimacing when nursing performed cares. Administrative Nurse D was unsure the last time R65 was checked on, or what time before finding her with her brief half off. Administrative Nurse D stated immediately after finding R65 grimacing the nurse on duty called the NP to come to the facility and assess R65. Administrative Nurse D stated the NP called her personally after reviewing R65's X-rays and gave her the diagnosis of pathological fracture and osteoporosis. Administrative Nurse D stated Administrative Staff A was the person who decided what needed to be reported. She said Administrative Staff A had a program he put the resident information in and determined what was reportable. On 11/20/24 at 11:43 AM Administrative Staff A stated he was the abuse coordinator. He stated if he had suspected abuse or neglect, he would have called Administrative Nurse D and the State Agency (SA) within two hours. He stated nothing he read about the incident made him suspect abuse or neglect, and said he did an investigation of every incident. Administrative Staff A said risk management looked at every incident and all underdefined assessments (UDAs) were triggered. Administrative Staff A stated he had a sheet from the SA that he goes by when reporting. He stated he did not feel a resident's BIMS would make a difference with what he would report to the SA. He stated that no falls for R65 were reported, and Consultant GG did an assessment and ordered an X-ray. Administrative Staff A stated he was unsure what the root cause and analysis was but said Consultant GG had determined the fracture was pathological, so no investigation was required. Administrative Staff A stated at the end of the day, R65 was taken care of, and if he had suspected abuse or neglect, he would have reported it, even if it was late. On 11/21/24 at 12:02 PM, Consultant GG stated he had reviewed the radiologist's report to determine the diagnosis of pathological osteopenia and the lack of trauma. He had assessed her on Monday and ordered a knee X-ray due to swelling and R65's right leg was rotated inward. The X-ray was completed the next day, and the X-ray was negative. Consultant GG stated he did a follow-up visit on the following day and ordered a hip X-ray. Consultant GG stated he did not see the X-ray. Consultant GG stated because there was no trauma to R65, he diagnosed pathological osteopenia. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The facility's Abuse, Neglect, exploitation or Misappropriation policy dated 09/22 documented all allegations are thoroughly investigated, and the administrator initiates the investigation. The investigations may be assigned to an individual trained in reviewing, investigating, and reporting such allegations. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation, any evidence that may be needed for criminal investigation is sealed, labeled, and protected from tampering or destruction. The administrator was responsible for keeping the resident and his or her representative informed of the progress of the investigation. The administrator ensures that the resident and the person reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator or by anyone associated with the faculty. Any employee who had been accused of resident abuse was placed on leave with no resident contact until the investigation was complete. The investigator observes the alleged victim, including his or her interaction with staff and other residents. Each interview was conducted separately and in a private location. The witness may write his or her statement or the investigator may obtain a statement. On 11/20/24 at 02:08 PM Administrative Staff A received a copy of the 'Immediate jeopardy [IJ] Template and was informed of the facility's failure to identify the serious injury of unknown origin as a potential abuse or neglect situation and initiate an investigation to determine the cause of the fracture as well failure to implement protective measures to prevent ongoing abuse while an investigation was conducted placed R65 in immediate jeopardy. The facility submitted an acceptable removal plan to address the immediacy on 11/20/24 at 06:28 PM which listed the following corrective actions: R65 is being monitored every shift using the appropriate pain scale. Staff conducted an immediate observation of R65 for identification of any current injuries as appropriate, and ongoing monitoring of R65 and other residents at risk, including conducting unannounced management visits at different times and shifts. Additionally, the Administrator will notify any alleged violations to the appropriate agency or law enforcement authority as applicable. An immediate assessment would be conducted on any resident with cognitive deficit issues if any signs of pain, discomfort, or alteration in the skin such as bruising, or discoloration are identified. If any of the above is identified, then a formal investigation will be initiated by the DON/ and or designee. Conduct interviews with cognitively intact residents to ensure residents are free of abuse, neglect, and exploitation. The facility enhanced its internal incident reporting and escalation program, by creating a real-time notification system for staff, visitors, or residents to utilize. Enhanced reporting program includes a focus for falls, abuse, and unusual occurrences/injuries of unknown source. Upon immediate completion of the incident report, automated notification will be provided to facility leadership including but not limited to the Administrator and DON. The facility created an informational flyer displaying the internal incident reporting program and provides a QR code that can be scanned for immediate reporting/escalation. The above actions were verified onsite on 11/21/24. The deficient practice remained at a scope and severity of a D.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 45668 The facility identified a census of 88 residents. The sample included 26 residents with five residents reviewed for hospitalization . Based on observation, interview, and record review, the facility failed to provide written notification of transfer to Resident (R)57 and/or their representative, with a written notice specifying the location and reason for R57's facility-initiated transfer. This deficient practice placed R57 at risk for miscommunication between the facility and resident/representative and impaired rights. Findings included: - R57's Medical Diagnosis section within the Electronic Medical Record (EMR) noted diagnoses of insomnia (difficulty sleeping), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), polyneuropathy (multiple areas of weakness, numbness, and pain from nerve damage, usually in the hands and feet), muscle weakness, and dysphagia (difficulty swallowing). R57's Quarterly Minimum Data Set (MDS) completed 10/10/24 revealed a Brief Interview for Mental Status (BIMS) score of seven indicating severe cognitive impairment. The MDS indicated he required set-up and clean-up assistance during meals. The MDS indicated he was totally dependent on staff assistance for bed mobility and transfers. The MDS noted no swallowing disorders. R57's Functional Abilities Care Area Assessment (CAA) completed 10/10/24 was triggered but lacked analysis or recommendations. R57's Nutritional CAA completed 10/10/24 was triggered but lacked analysis or recommendations. R57's Care Plan initiated 05/11/22 indicated he required assistance from staff for his activities of daily living (ADLs). The plan documented he required extensive assistance from one staff for bed mobility, dressing, personal hygiene, and bathing. The plan documented he required a Hoyer lift (total body mechanical lift) and two staff for all transfers. The plan documented R57 began hospice services (end-of-life comfort care) on 11/17/24. R57's EMR under Progress notes indicated he was sent out to an acute medical facility on 11/08/24 for an acute gastrointestinal (digestive /stomach) disorder. The notes indicated he returned on 11/16/24. R57's EMR under Miscellaneous noted a written notification of transfer form was completed on 11/08/24 but lacked the reason or location of his transfer for hospitalization . On 11/20/24 at 04:00 PM, Administrative Staff A stated the facility sent a transfer notice to the resident or representative. He stated the notice should include the location and reason for transfer or discharge. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Transfer or Discharge Notice policy revised 09/2012 indicated the facility will notify the resident or responsible party of transfer or discharge to include the reason, location, and information related to the return. The facility failed to send a written notification of a facility-initiated transfer for R57 which included the reason for the transfer and the location of the transfer. This deficient practice placed R57 at risk for miscommunication between the facility and resident/representative and impaired rights.

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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** 41037 The facility identified a census of 88 residents. The sample included 26 residents. Based on observation, record review, and interviews, the facility failed to complete the Care Area Assessment (CAA) analysis of findings, related to a Comprehensive Minimum Data Set (MDS), for Residents (R) 57 and R56, in order to address the underlying cause, risk factors, and other contributing factors to ensure the resident received care based on their individual needs. This placed the residents at risk for impaired care and decreased quality of life due to unidentified care needs. Findings included: - R57's Significant Change MDS dated [DATE] triggered CAA for functional abilities, urinary incontinence, indwelling catheter, falls, nutritional status, dental care, pressure ulcer, and psychotropic medications. All triggered CAA lacked completion with analysis of findings. R66's Significant Change MDS dated [DATE] triggered CAA for psychotropic drug use, cognitive loss/dementia, urinary incontinence, indwelling catheter, falls, dental care, communication, and pressure ulcer injury. All triggered CAA lacked completion with analysis of findings. On 11/20/24 at 04:31 PM Administrative Nurse D stated she was unaware the triggered CAA assessments lacked analysis. She stated there should be analysis for each CAA identified because the triggered CAA assessments help build the individual comprehensive care plan. The facility's Resident Assessments policy last revised 03/2022 documented a comprehensive assessment of every resident's needs was made at intervals designated by Omnibus Budget Reconciliation Act (OBRA) and Performance Scale (PPS) requirements. A Comprehensive Assessment included the completion of the Minimum Data Set (MDS); the completion of the care area assessment (CAA) process; and the development of the comprehensive care plan. The facility failed to fully complete the Comprehensive MDS including the CAAs for R57 and R56 as required. This placed the residents at risk for impaired care and decreased quality of life due to unidentified care needs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 88 residents. The sample included 26 residents with 26 residents reviewed for comprehensive care plans. Based on observation, record review, and interviews, the facility failed to develop a comprehensive care plan for Resident (R) 76 which included individualized person-centered interventions for her Trilogy ventilator (a positive pressure ventilation device that treats a variety of respiratory issues through non-invasive or invasive ventilation therapy). This deficient practice placed R76 at risk for impaired care due to uncommunicated care needs. Findings included: - R76's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of chronic respiratory failure, emphysema (lung disease that causes breathlessness), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and hypoxia (inadequate supply of oxygen). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R76 had received an invasive and non-invasive mechanical ventilator and oxygen therapy during the observation period. R76's Care Plan dated 11/11/24 documented staff would administer oxygen at two liters (L) per (P) minute (M) via nasal cannula at rest and four LPM via nasal cannula during exertion. The plan of care directed the staff to change humidification and oxygen tubing as directed. The plan of care directed the staff to elevate the head of R76's bed to a level of comfort to promote oxygenation. The plan of care dated 11/15/24 documented the nursing staff would monitor R76's oxygen saturation level every shift. The care plan lacked direction to the nursing staff for the care and application of her Trilogy mask. R76's EMR under the Orders tab revealed the following physician orders: Continue Trilogy therapy at night, nurse to ensure proper mask placement and assist as needed. Trilogy setting as ordered for COPD at bedtime dated 07/14/24. Azithromycin(antibiotic) oral tablet 500 milligrams (mg) give one tablet by mouth one time a day every Monday, Wednesday, and Friday related to COPD dated 07/15/24. Oxygen at two LPM at rest and four LPM with activity via nasal cannula continuous every shift for COPD dated 11/15/24. On 11/19/24 at 09:13 AM R76 sat upright on her bed and ate her breakfast. R76's unbagged Trilogy mask rested directly on her refrigerator. There was no bag visible for storing the ventilator mask. R76 stated the mask was usually not stored in a bag and was not sure how often her mask was changed or cleaned. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 02:54 PM, Certified Nurse Aide (CNA) O stated she had a code that would access the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CNA O stated she would usually ask the other staff or the nurse if she had a question about the residents she provided care to. On 11/20/24 at 03:01 PM, Licensed Nurse (LN) I stated everyone had access to the resident's care plan. LN I stated that R76's respiratory care should be addressed on R76's Care Plan. On 11/20/24 at 04:21 PM, Administrative Nurse D stated she expected a resident's care plan to be individualized to address each resident's needs. Administrative Nurse D stated she expected the nursing staff to review the residents' care plan daily for any changes in their care needs. The facility's Comprehensive Person-Centered Care Plans policy last revised 03/2022 documented a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was developed. The facility failed to develop a comprehensive care plan for R76 which included individualized person-centered interventions for her Trilogy ventilator. This deficient practice placed R76 at risk for impaired care due to uncommunicated care needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 88 residents. The sample included 26 residents. Based on observation, interview, and record review, the facility failed to ensure Resident (R)15's Care Plan was updated with revised interventions to direct staff on care related to her Stage 1 pressure wound. This placed R15 at risk for delayed healing and increased risk for pressure ulcers due to uncommunicated care needs. Findings included: - R15's Electronic Medical Record (EMR) documented diagnosis of type 2 diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), dependence on renal dialysis (a procedure where impurities or wastes are removed from the blood), and venous insufficiency (poor circulation). R15's Annual Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R15 had impairment of both lower extremities and required substantial assistance to being dependent on staff for her activities of daily living (ADLs). R15 required the use of a wheelchair for mobility. R15 was always incontinent of bowel and bladder. The MDS documented R15 was at risk of developing pressure ulcers but had no unhealed pressure ulcers. R15 had a pressure-reducing device for her chair, her bed, and was on a turning and repositioning program. R15 was on dialysis. R15's Functional Abilities Care Area Assessment (CAA) dated 10/07/24 documented she was being evaluated for her annual review. R15 was alert and oriented and was able to make her needs known. R15 was able to request assistance as appropriate. R15 was always incontinent of bowel and bladder and required staff assistance with personal hygiene following incontinence episodes. R15 was also on dialysis three times weekly. R15 would have a care plan to address these concerns. R15 triggered for functional abilities due to requiring substantial to full dependency for all ADLs. R15 would have an ADL care plan to address the areas where assistance was needed as well as to assist staff in knowledge of cares. R15 triggered for pressure injury due to decreased mobility and always being incontinent. She was at risk for skin breakdown and would have a care plan for the risks involved. R15 triggered for pain due to personal reports of pain as well as the need for as-needed pain medication. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's Care Plan last revised on 05/22/24 documented she had a history of impaired skin integrity. R15 was at risk for pressure ulcer development. Staff were directed to apply moisturizer as needed to her skin. Staff was directed that R15 had a low-air loss mattress (a specialized mattress designed to prevent and treat pressure wounds) per setting for pressure reduction. Staff was directed to monitor, document, and report to the physician any changes in skin status. Staff were directed to minimize extended exposure of skin to moisture by providing frequent incontinence care and prompt removal of wet clothing or sheets as needed. Staff was to provide R15 with a pressure relieving device in her chair. The care plan lacked staff direction for R15's current Stage 1 pressure ulcer (pressure wound which appears reddened, does not blanche, and may be painful but is not open). R15's Orders tab of the EMR documented an order dated 11/14/22 for a low-air loss mattress. Check the setting closest to the resident's current weight and mattress functionality every shift for monitoring. R15's Orders tab of the EMR documented an order dated 10/23/24 for zinc oxide cream to be applied to her left posterior leg and buttock topically two times a day for Stage 1 pressure ulcer. R15's Orders tab of the EMR documented an order dated 10/23/24 for a low-air loss mattress. Check the setting closest to the resident's current weight and mattress functionality every shift for monitoring. R15's Nursing- Comprehensive Skin Evaluation/Assessment in the EMR dated 10/18/24 at 05:36 PM documented: skin appeared dry, intact, and warm. No new skin issues were noted. R15 has additional cares of a cushion and a mattress with a pump. A Nurse's Note dated 10/22/24 at 08:29 PM documented the Certified Nurse Aide (CNA) informed this writer that R15 had some open areas to her skin. R15 was noted to have an open area to her left posterior thigh, an open area to her buttocks with redness, and a rash under her pannus (extra skin and fat deposits hang from the stomach or belly area on the abdomen). A treatment was currently in place for the pannus. However, appeared to be ineffective at this time as the CNA reported the redness had worsened since last rounds were done two hours ago when the resident was changed. The physician was notified and would see R15 on next rounds. A barrier cream was applied to the open areas. The assessment of the open areas lacked staff measurements of the wounds. R15's Nursing - Comprehensive Skin Evaluation/Assessment in the EMR dated 10/23/24 at 02:47 AM documented the resident had one or more newly identified or existing wound or skin integrity concerns. The assessment noted a rash to the left and right iliac crest (a curved bony ridge on the top of the ilium bone, which is the largest pelvic bone), unspecified wound to the right buttock, left posterior thigh, and sacrum (large triangular bone/area between the two hip bones). Cares included: heel protectors, a mattress with a pump, a moisture barrier, and moisture control. The skin assessment lacked documentation of the wound measurements. A Nurse Practitioner Note dated 10/23/24 at 11:09 AM documented that R15 was seen for pain in her hips and legs. R15 has a new wound on her posterior left leg and buttocks area. The left posterior leg has a circular area that is non-blanchable (to press on a person's skin to push blood away and wait for the return to determine blood circulation), and tender to palpation. There was some flaky skin present in a circle, but no open area. The buttock folds are very erythematous (redness or inflammation of the skin) with flat diffuse erythematous rash. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's Nursing- Comprehensive Skin Evaluation/assessment dated [DATE] at 07:25 PM, documented that skin was dry, intact, reddened, and warm. The resident did not have any newly identified wounds or skin integrity concerns. The skin assessment lacked documentation of any current open wound areas. R15's Nursing- Comprehensive Skin Evaluation/assessment dated [DATE] at 04:22 PM, documented that the skin was warm and dry. The resident has reddened areas under her breast, arms, and abdomen, and the folds of her knees. R15 had an opened area to the buttocks. Treatment was in place on all areas. The skin assessment lacked wound measurements of the opened areas. R15's Nursing- Comprehensive Skin Evaluation/assessment dated [DATE] at 06:42 PM documented R15 had existing reddened areas. The skin assessment lacked documentation of any current open wounds to the buttocks or any active treatments in place. R15's clinical record lacked evidence staff assessed, measured, and recorded the wound status for the Stage 1 pressure ulcer. On 11/18/24 at 08:51 AM R15 laid on her low-air loss bolstered mattress. On 11/19/24 at 09:11 AM R15 was lying on her low-air loss bolstered mattress. R15 had just turned her call light on and stated she was waiting for staff to come get her up out of bed so she could go to her dialysis appointment. On 11/21/24 at 11:19 AM Administrative Nurse F stated she had access to the resident's care plan and would update the care plan when new interventions had been put in place. Administrative Nurse F stated R15's care plan should have been updated with the newest treatments and any other interventions that had been put into place. On 11/21/24 at 11:25 AM Administrative Nurse D stated she the charge nurse, herself or the MDS coordinator was responsible for ensuring that a resident's care plan was updated with any new interventions. Administrative Nurse D could not state for certain why R15's Care Plan had not been updated with all the information about R15's current Stage 1 pressure wound. The Care Plan, Comprehensive Person-Centered policy last revised on March 2022, documented that the care plan intervention was derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Care plan interventions were chosen after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision-making. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. Assessments of residents was ongoing and care plans were revised as information about the resident and resident's condition changed. The facility failed to ensure R15's Care Plan was updated with interventions to direct staff on care related to her Stage 1 pressure wound. This placed R15 at risk for delayed healing and increased risk for pressure ulcers due to uncommunicated care needs.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 88 residents. The sample included 26 residents with four sampled for activities of daily living (ADL). Based on observations, interviews, and record review, the facility failed to ensure Resident (R) 66 received supportive care and services to promote and maintain her quality of life when the facility did not use the communication cards per the plan of care to allow R66, who had aphasia (a condition with disordered or absent language function), to communicate her wants, needs, or feelings. This deficient practice placed the resident at risk for decreased quality of life, isolation, and impaired dignity. Findings Included: - R66's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) with cerebrovascular accident (CVA -stroke - the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain, affecting the right dominant side, hypertension (HTN - elevated blood pressure, involuntary movements, diabetes mellitus (DM -when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), cardiomyopathy (heart disease), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), aphasia (a condition with disordered or absent language function), muscle weakness, and unsteadiness. The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R66 had an impairment of the extremities on one side of her body. The MDS documented R66 needed substantial to maximum assistance for bathing, dressing, and toileting. The MDS documented R66 had unclear speech and sometimes understood. R66's Communication Care Area Assessment (CAA) dated 11/06/24 lacked analysis. R66's Care Plan dated 11/03/23 documented R66 had a communication problem related to expressive aphasia. The care plan directed staff to anticipate and meet R66's needs, Staff were to allow adequate time for R66 to respond and to repeat as needed, and staff were not to rush R66. R66's plan of care revised on 10/28/24 documented R66 required picture sheets to communicate. R66's EMR under the Treatment Administration Record (TAR) documented the following physician's order: Use picture sheets for improved communication, every shift for aphasia dated 11/05/23. On 11/18/24 at 08:24 AM R66 sat in her wheelchair in her room, R66 was reaching out her hand, attempting to communicate with staff. The staff did not use a communication sheet or pictures. R66's picture sheets were under containers of cereal, jelly, and water flavor-pakets, on the bedside table. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/24 at 12:46 PM, R66 was in the dining room sitting in her wheelchair watching TV. R66 was trying to communicate with nursing by holding out her hand and reaching for staff. R66 was trying to say words, R66's words were not understood. Nursing asked yes or no questions, but the staff did not use communication sheets. On 11/20/24 at 02:17 PM Certified Nurse Aide (CNA) M stated she had worked with R66 long enough that she understood what R66 wanted. CNA M stated she did not know the communication cards should be used for interaction. On 11/20/24 at 02:44 PM Licensed Nurse (LN) H stated she had worked at the facility a long time, and she knew what R66 usually asked for. LN H stated she did not realize she was signing off on the TAR stating she had used the communication sheets. LN H said she was under the impression she was signing the TAR to ensure R66 had communications available. On 11/20/24 at 04:31 PM, Administrative Nurse D stated staff should use the communication sheets to communicate with R66, due to R66's aphasia. The facility's Functional Impairment policy revised on 09/12 documented upon admission to the facility, at any time a significant change of condition occurs, and periodically during the resident's stay the physician would assess the resident's physical condition and function status, the physician would help identify individuals who have had a recent history of functional decline and those who are at risk for addition functional decline. The physician would order consultations and professional evaluations that were appropriate for the resident's condition. The facility failed to ensure R66 received supportive care and services to promote and maintain her quality of life when the facility did not use communication cards to allow R66 to communicate her wants, needs, or feelings. This deficient practice placed the resident at risk for decreased quality of life, isolation, and impaired dignity.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility reported a census of 88 residents. The sample included 26 residents with four reviewed for activities of daily living (ADLs). Based on records review, interviews, and observations, the facility failed to provide ADL care and services necessary for Resident (R) 57 for eating. The facility additionally failed to provide personal hygiene or bathing for R25, R54, and R65. This deficient practice placed the residents at risk for a decline in their ADLs. Findings included: - R57's Medical Diagnosis section within the Electronic Medical Record (EMR) noted diagnoses of insomnia (difficulty sleeping), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), polyneuropathy (multiple areas of weakness, numbness, and pain from nerve damage, usually in the hands and feet), muscle weakness, and dysphagia (difficulty swallowing). R57's Quarterly Minimum Data Set (MDS) completed 10/10/24 revealed a Brief Interview for Mental Status (BIMS) score of seven indicating severe cognitive impairment. The MDS indicated he required set-up and clean-up assistance during meals. The MDS indicated he was totally dependent on staff assistance for bed mobility and transfers. The MDS noted no swallowing disorders. R57's Functional Abilities Care Area Assessment (CAA) completed 10/10/24 was triggered but lacked analysis. R57's Nutritional CAA completed 10/10/24 was triggered but lacked analysis. R57's Care Plan initiated 05/11/22 indicated he required assistance from staff for his activities of daily living (ADLs). The plan documented he required extensive assistance from one staff for bed mobility and transfers. The plan indicated he required a meal set and supervision for meals. R57's EMR under Evaluations revealed a screening for dysphagia completed on 09/21/24. The screening revealed he had difficulty swallowing on demand and encouraged prolonged mastication (chewing of food). R57's EMR under Progress notes indicated he was sent out to an acute medical facility on 11/08/24 for an acute gastrointestinal (digestive /stomach) disorder. The notes indicated he returned on 11/16/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 11/17/24 at 01:05 PM, R57 lay in his bed. The head of his bed was elevated between 30 to 40 degrees with him resting on his back. R57 had a spoon in his left hand while he attempted to eat his chili. R57 had spilled chili down his shirt from attempting to eat in a flat position. R57 struggled to answer questions due to his mouth being dry but he could not reach for his water. R57 pulled his call light up to his chest but could not activate the push button. R57 started coughing and struggled to talk as he attempted to activate his call light. At 01:08 PM staff were alerted R57 needed assistance. Certified Nurse's Aide (CNA) Q entered R57's room. CNA Q acknowledged that R57 was supposed to be in a higher, more upright position during his meals and said R57 should be able to use his call light. CNA Q stated that the staff would reposition the resident to make him more comfortable and change his clothing. At 01:12 PM staff entered the room and repositioned R57. Administrative Nurse D then entered the room and talked with R57. Upon request, Administrative Nurse D assessed his ability to use his call light. R57 was unable to use his call light independently or with nursing assistance. Administrative Nurse D stated that R57 just returned from an acute medical facility but could use his call light before he left. On 11/20/24 at 02:21 PM, Licensed Nurse (LN) G stated staff should ensure each resident was able to safely eat their meals. She stated staff should position the resident in an upright position and move the plates close to them. She stated staff should ensure each resident could eat their meals before leaving them. She stated food and drinks should always be left within reach. She stated the resident ideally would eat in the dining room but may choose to eat in their rooms. She stated staff should ensure the resident could effectively eat their meals or provide assistance to them. She stated clothing protectors may also be offered to prevent stains on their clothing during meals. On 11/20/24 at 04:30 PM Administrative Nurse D stated staff were expected to ensure each resident was in an upright position during meal service. She stated staff should ensure the food was within easy reach of the resident and the resident could call for assistance if needed. The facility's Activities of Daily Living policy revised 03/2018 indicated all residents will be assessed related to their abilities to carry out their ADLs. The policy noted the facility would ensure appropriate care and services were provided to assist residents who were unable to complete their daily care needs and prevent a decline of abilities. The facility failed to ADL care and services to R57 related to eating. This deficient practice placed R57 at risk for impaired nutrition, aspiration (an inflammatory condition of the lungs caused by inhaling foreign material or vomit), and a general decrease in ADL ability. 41037 - R25's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of other symptoms and signs involving cognitive functions and awareness, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R25 had limited function in bilateral extremities. The MDS documented R25 was dependent on staff assistance for dressing and positioning. R25 required substantial to maximum assistance from staff for personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	The Quarterly MDS dated [DATE] documented a BIMS score of five which indicated severely impaired cognition. The MDS documented that R25 was dependent on staff assistance for dressing, personal hygiene, positioning, and bathing. R25's Functional/Rehabilitation Abilities Care Area Assessment (CAA) dated 01/10/24 lacked analysis documentation. R25's Care Plan dated 05/22/24 documented her preference for bathing was on Monday and Thursday during the day shift. R25's EMR under the Reports tab and Bathing task was reviewed for the following dates 10/01/24 to 11/20/24 (51 days). The EMR documented five Showers (SH) or Baths (B) on 10/07/24, 10/10/24, 10/17/24, 11/04/24, and 11/14/24, one Resident Refused (RR) on 10/28/24, three Resident Not Available (RU) on 10/03/24, 10/17/24, and 10/31/24, and two Not Applicable (NA) documented on the following dates 10/24/24 and 11/12/24. R25's clinical record lacked evidence she was unavailable for care during the 51 days reviewed. R25's notes lacked documentation regarding bathing refusals or attempts to offer alternatives. On 11/19/24 at 09:12 AM R25 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) in front of the north nurse's station. R25's hair was matted on the back of her head. R25 stated she was not feeling well and was nauseated. On 11/20/24 at 02:54 PM, Certified Nurse Aide (CNA) O stated she had not had R25 refuse her bath or shower. CNA O stated she would offer R25 a bed bath or shower. On 11/20/24 at 03:01 PM, Licensed Nurse (LN) I stated the night shift made out bath sheets for the residents on their bath days. LN I stated if a resident refused their bath or shower, the nurse would make a note in their EMR, and staff would document the refusal under the tasks charting. On 11/20/24 at 04:31 PM, Administrative Nurse D stated the interdisciplinary team (IDT) would review the bathing documentation. Administrative Nurse D said it was everyone's duty to ensure the residents were kept clean. The facility's Functional Impairment policy revised on 09/12 documented upon admission to the facility, at any time a significant change of condition occurs, and periodically during the resident's stay the physician and staff would assess the resident's physical condition and function status, the physician would help identify individuals who have had a recent history of functional decline and those who are at risk for addition functional decline. The physician would order consultations and professional evaluations that were appropriate for the resident's condition. The facility failed to provide consistent bathing for R25. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity. 49634 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	- R54's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), hydrocephalus (a condition in which fluid accumulates in the brain, typically in young children, enlarging the head and sometimes causing brain damage), thrombocytopenia (abnormally low number of platelets, the parts of the blood that help the blood to clot, sometimes associated with abnormal bleeding), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), history of falling, muscle weakness, lack of coordination, and neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying). The Significant Change Minimum Data Set (MDS) for R54 dated 10/17/24 recorded a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented R54 had not had falls since admission or prior assessment. The MDS documented R54 was impaired on both sides of her body. The MDS documented R54 needed supervision or touching assistance for eating, and was dependent on staff for toileting, dressing, showering, and personal hygiene. R54's The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 10/17/24 did not accurately reflect R54 (Refer to F641). R54's Care Plan dated 03/22/24 documented R54's bathing preferences were Wednesday and Saturday. R54's plan of care documented R54 required extensive assistance of one staff for bathing. R54's EMR under Tasks for Bathing documented R54 was dependent on staff. The task documented R54 had received bathing last on 11/16/24. On 11/17/24 at 08:33 AM R54 sat at the breakfast table visiting with staff. R54's fingernails had purple nail polish on part of her fingernail, and the polish on the top part of her nail was chipped off. R54 had dark brown substance visible underneath her fingernails. On 11/18/24 at 09:12 AM R54 sat at the breakfast table. R54 still had a dark brown substance under her fingernails. On 11/19/24 at 09:01 AM R54 visited with staff at the dining table, R54 continued to have dirty fingernails with a dark brown substance visible under the nails. On 11/20/24 at 02:17 PM Certified Nurse Aide (CNA) M stated the CNAs or bath aide were supposed to trim fingernails and to ensure the resident's nails were kept clean. On 11/20/24 at 02:31 PM, Licensed Nurse (LN) G stated that normally the bath aide or the CNAs trimmed residents' fingernails and ensured they were clean, but all nursing staff could help ensure the nails were kept clean. On 11/20/24 at 04:31 PM Administrative Nurse D stated the CNAs were responsible for the resident's nail care. Administrative Nurse D said it was everyone's duty to ensure the residents were kept clean. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	The facility's Activities for Daily Living dated 03/18 documented that residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. The facility failed to ensure R54 had proper nail care to maintain cleanliness. This deficient practice placed the resident at risk for decreased quality of life, and impaired dignity. - R65'sMedical Diagnosis section within the Electronic Medical Record (EMR) noted diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), cognitive-communication deficit, aphasia (condition with disordered or absent language function), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and muscle weakness. R65's Annual Minimum Data Set (MDS) dated [DATE] noted a Brief Interview of Mental Status (BIMS) score of zero which indicated severe cognitive impairment. The MDS indicated she was independent in meals, dressing, and oral hygiene. The MDS noted she had unclear speech. The MDS noted she required partial to moderate assistance with bathing. The MDS noted she required supervision or touch assistance with toileting. The MDS noted she had occasional urinary incontinence and frequent bowel incontinence but had no toileting program in place. R65's Dementia Care Area Assessment (CAA) completed 10/19/24 indicated noted she had a severe cognitive decline and an inability to focus her attention. The CAA noted she had poor cognition and was unable to verbalize her needs or concerns. The CAA noted she could communicate via a whiteboard. The CAA noted her communication became less effective with her whiteboard due to her recent cognitive decline. R65's Urinary Incontinence CAA completed 10/19/24 indicated she had bowel and bladder incontinence and declined in her ability to complete toileting hygiene. The CAA noted she required staff assistance to clean her bowel movements appropriately and prevent soiling her hands. R65's Care Plan initiated on 11/25/22 indicated she was at risk for a decline in her communication, activities of daily living (ADLs), mobility, and cognition. The plan noted she was at risk for falls related to her limited mobility, cognitive impairment, and medical diagnoses. The plan noted she was independent with bed mobility, toileting, walking, dressing, and transfers. The plan noted she required supervision and set-up assistance with bathing. R65's Care Plan dated 09/16/24 documented that R65 was at risk for falls and had an actual fall related to confusion, gait and balance, incontinence, and poor communication. An intervention dated 11/25/22 directed staff to anticipate and meet the resident's needs. The plan documented a non-injury fall (NIF) on 03/03/24 and an intervention dated 03/04/24 which directed staff to encourage R65 to remain seated in the shower. The plan documented an NIF on 05/25/24 with an intervention dated 05/28/24 for non-skid strips in front of the toilet in R65"sroom. The plan documented a NIF on 09/15/24 (revised on 11/18/24) with an intervention dated 09/16/24 that directed staff to apply nonskid strips beside R65's bed. R65's plan of care dated 09/27/24 documented that R65 had a fall on 09/26/24 and the nurse practitioner (NP) was to complete a medication review. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	R65's EMR under Interdisciplinary Team (IDT)-Behavior dated 10/17/24 at 10:17 AM documented an increase in behaviors related to dementia progression. R65 had an increase in wandering and a recent fall. R65 was undressing and walking in the hallway, playing with her bowel movements, and storing used toilet paper. The NP assessed R65 in the facility, reviewed and adjusted her medication, and ordered staff to continue the current plan of care. On 11/19/24 at 07:05 AM R65 laid in her bed with her hip pillows in place, and a call light at the resident's side. R65 had communication sheets and a whiteboard at the bedside. R65 was not able to communicate with visitors by communication sheets or whiteboard. On 11/20/24 at 02:31 PM, Licensed Nurse (LN) G stated the R65 was being checked on more often due to not being able to toilet herself. On 11/20/24 at 04:31 PM Administrative Nurse D stated the IDT team had been following her, nursing was checking on her more often and therapies were following her. The facility's Activities of Daily Living policy revised 03/2018 indicated all residents will be assessed related to their abilities to carry out their ADLs. The policy noted the facility will ensure appropriate care and services will be provided to assist residents that were unable to complete their daily care needs and prevent a decline of abilities. The facility failed to identify and implement interventions to ensure R65 received the required staff assisatnce for toileting. This deficient practice placed R65 at risk of impaired ADLs and unmet care needs.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 45668 The facility identified a census of 88 residents. The sample included 26 residents. Based on observation, record review, and interviews, the facility failed to provide directed, interactive activities based on resident preferences for the residents on weekends. This deficient practice placed the affected residents at risk for decreased psychosocial well-being, boredom, and isolation. Findings Included: - A review of the facility's Activity Calendars for September, October, and November 2024, was completed. The calendars stated the facility scheduled nail care, noodle ball, and social hour on Saturdays. The calendars stated the facility scheduled patio chit-chat, movies, and church service for Sunday. The calendars also revealed that activity packets were also available for residents. On 11/18/24 at 09:22 AM the Resident Counsel reported that staff-led activities did not occur as scheduled every weekend. The council reported an activities aid went back to school and some of the listed activities did not occur. The council reported Activity Staff Z tried her best to cover the weekends but can't be there seven days a week. The council reported some of the residents would hold the groups in place of staff to try to keep the activities going. On 11/20/24 at 08:54 AM Licensed Nurse (LN) I stated recently the residents started holding activities groups on the weekends. She stated direct care staff would try and help but often had their hands full with resident cares. She stated sometimes Activity Staff Z would come in to hold weekend groups. She stated the facility also provided activity packets for residents to complete by themselves if no activity was available. On 11/20/24 at 11:00 AM Activities Staff Z stated she tried to cover some of the weekends but had no one to cover on the weekends she could not cover herself. She stated the residents would hold self-ran groups on weekends like Bingo and social hour. The facility's Activities Evaluation policy (undated) indicated the facility will provide ongoing individualized and group activities that promoted goals, strengths, social, and emotional support for each resident. The facility failed to provide consistent activities on the weekends which reflected the residents' interests, and preferences. This placed the affected residents at risk for boredom, isolation, and decreased quality of life.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 88 residents. The sample included 26 residents with five residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interview the facility failed to provide ongoing wound assessment for Resident (R) 15's pressure injury and failed to ensure R39's offloading boots were applied. This placed R15 and R39 at risk for delayed healing and increased risk for pressure ulcers. Findings included: - R15's Electronic Medical Record (EMR) documented diagnosis of type 2 diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), dependence on renal dialysis (a procedure where impurities or wastes are removed from the blood), and venous insufficiency (poor circulation). R15's Annual Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R15 had impairment of both lower extremities and required substantial assistance to being dependent on staff for her activities of daily living (ADLs). R15 required the use of a wheelchair for mobility. R15 was always incontinent of bowel and bladder. The MDS documented R15 was at risk of developing pressure ulcers but had no unhealed pressure ulcers. R15 had a pressure-reducing device for her chair, and bed, and was on a turning and repositioning program. R15 was on dialysis. R15's Functional Abilities Care Area Assessment (CAA) dated 10/07/24 documented she was being evaluated for her annual review. R15 was alert and oriented and was able to make her needs known. R15 was able to request assistance as appropriate. R15 was always incontinent of bowel and bladder and required staff assistance with personal hygiene following incontinence episodes. R15 was also on dialysis three times weekly. R15 would have a care plan to address these concerns. R15 triggered for functional abilities due to requiring substantial to full dependency for all ADLs. R15 would have an ADL care plan to address the areas where assistance was needed as well as to assist staff in knowledge of cares. R15 triggered for pressure injury due to decreased mobility and always being incontinent. She was at risk for skin breakdown and would have a care plan for the risks involved. R15 triggered for pain due to personal reports of pain as well as the need for as-needed pain medication. R15's Care Plan last revised on 05/22/24 documented she had a history of impaired skin integrity. R15 was at risk for pressure ulcer development. Staff were directed to apply moisturizer as needed to her skin. Staff were directed that R15 had a low-air loss mattress (a specialized mattress designed to prevent and treat pressure wounds) per setting for pressure reduction. Staff was directed to monitor, document, and report to the physician any changes in skin status. Staff were directed to minimize extended exposure of skin to moisture by providing frequent incontinence care and prompt removal of wet clothing or sheets as needed. Staff were to provide R15 with a pressure relieving device in her chair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's Orders tab of the EMR documented an order dated 11/14/22 for a low-air loss mattress. Check the setting closest to the resident's current weight and mattress functionality every shift for monitoring. R15's Orders tab of the EMR documented an order dated 10/23/24 for zinc oxide cream to be applied to her left posterior leg and buttock topically two times a day for a Stage 1 pressure ulcer (pressure wound which appears reddened, does not blanche, and may be painful but is not open). R15's Orders tab of the EMR documented an order dated 10/23/24 for a low-air loss mattress. Check the setting closest to the resident's current weight and mattress functionality every shift for monitoring. R15's Nursing- Comprehensive Skin Evaluation/Assessment in the EMR dated 10/18/24 at 05:36 PM documented: the skin appeared dry, intact, and warm. No new skin issues were noted. R15 has additional cares of a cushion and a mattress with a pump. A Nurse's Note dated 10/22/24 at 08:29 PM documented the Certified Nurse Aide (CNA) informed the nurse that R15 had some open areas to her skin. R15 was noted to have an open area to her left posterior thigh, an open area to her buttocks with redness, and a rash under her pannus (extra skin and fat deposits hang from the stomach or belly area on the abdomen). A treatment was currently in place for the pannus, however, appeared to be ineffective at this time as the CNA reported the redness had worsened since the last rounds were done two hours ago when the resident was changed. The physician was notified and would see R15 on the next rounds. A barrier cream was applied to the open areas. The assessment of the open areas lacked staff measurements of the wounds. R15's Nursing- Comprehensive Skin Evaluation/Assessment in the EMR dated 10/23/24 at 02:47 AM documented the resident had one or more newly identified or existing wound or skin integrity concerns. The assessment noted a rash to the left and right iliac crest (a curved bony ridge on the top of the ilium bone, which is the largest pelvic bone), unspecified wound to the right buttock, left posterior thigh, and sacrum (large triangular bone/area between the two hip bones). Cares included: heel protectors, a mattress with a pump, a moisture barrier, and moisture control. The skin assessment lacked documentation of the wound measurements. A Nurse Practitioner Note dated 10/23/24 at 11:09 AM documented that R15 was seen for pain in her hips and legs. R15 has a new wound on her posterior left leg and buttocks area. The left posterior leg has a circular area that is non-blanchable (to press on a person's skin to push blood away and wait for the return to determine blood circulation), and tender to palpation. There was some flaky skin present in a circle, but no open area. The buttock folds are very erythematous (redness or inflammation of the skin) with flat diffuse erythematous rash. R15's Nursing - Comprehensive Skin Evaluation/assessment dated [DATE] at 07:25 PM, documented that skin was dry, intact, reddened, and warm. The resident did not have any newly identified wounds or skin integrity concerns. The skin assessment lacked documentation of any current open wound areas. R15's Nursing - Comprehensive Skin Evaluation/assessment dated [DATE] at 04:22 PM, documented that the skin was warm and dry. The resident has reddened areas under her breast, arms, and abdomen, and the folds of her knees. R15 had an opened area to the buttocks. Treatment was in place on all areas. The skin assessment lacked wound measurements of the opened areas. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's Nursing- Comprehensive Skin Evaluation/assessment dated [DATE] at 06:42 PM documented R15 had existing reddened areas. The skin assessment lacked documentation of any current open wounds to the buttocks or any active treatments in place. R15's clinical record lacked evidence staff assessed, measured, and recorded the wound status for the Stage 1 pressure ulcer at least weekly. On 11/18/24 at 08:51 AM R15 laid on her low-air loss mattress. On 11/19/24 at 09:11 AM R15 was lying on her low-air loss perimeter mattress. R15 had just turned her call light on and stated she was waiting for staff to come get her up out of bed so she could go to her dialysis appointment. On 11/21/24 at 11:19 AM Administrative Nurse F stated a nurse does weekly skin checks on each resident and they would notify her and the physician if a new skin area had been identified. Administrative Nurse F stated after the physician was notified, she would expect a treatment to be put in place. Administrative Nurse F stated any open wounds should be documented with the size, the stage, and such. On 11/21/24 at 11:25 AM Administrative Nurse D stated she expected nursing staff to assess and document any new skin or wound findings and notify the physician and the provider. Administrative Nurse D stated all wounds should have documentation that included the size, the stage, if there was any discharge from the wound, and any treatments that were in place. Administrative Nurse D stated the wound nurse was responsible for following up on any wounds and documenting the findings each week. The Pressure Ulcers/Skin Breakdown - Clinical Protocol policy revised March 2014, documented that the nursing staff and attending physician would assess and document an individual's significant risk factors for developing pressure sores. In addition, the nurse shall describe, document, and report the following- a full assessment of the pressure sore including the location, stage, length, width, depth, the presence of exudates or necrotic tissue (pertaining to the death of tissue in response to disease or injury); a pain assessment; the resident's mobility status; the current treatments; and all active diagnoses. The physician would authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings, and application of topical agents if indicated for the type of skin alteration. During the resident visits, the physician would evaluate and document the progress of the wound healing. The facility failed to ensure R15's Stage 1 pressure wounds were assessed and measured at least weekly. This placed R15 at risk for delayed healing and increased risk for pressure ulcers. 49634 - R39's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of lymphedema (swelling caused by accumulation of lymph), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), pain, muscle weakness, transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hearing loss in the left ear, and lack of coordination. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R39 had impairment of one side of her upper body and both sides of her lower body. R39's MDS documented R39 was at risk for developing pressure ulcers. R39's Pressure Ulcer/ Injury Care Area assessment dated [DATE] lacked analysis. R39's Care Plan dated 06/23/2024 documented R39 was at risk for skin breakdown related to contracture (abnormal permanent fixation of a joint or muscle), incontinence of bowel and bladder, and immobility. Staff were to apply barrier creams and encourage adequate intake. The plan recorded R39 used a low-air loss mattress. R39's Braden Scale for Prediction Pressure Sore Risk dated 11/06/24 documented a score of 13 indicating a moderate risk for pressure ulcers. R39's Weekly Wound assessment dated [DATE] documented R39 had no skin issues and redness to the groin. R39's physician's orders under the Orders tab revealed the following orders: heel boots as tolerated, check skin integrity on application and removal, every shift for heel protection, dated 06/08/24. On 11/18/24 at 08:25 AM, R39 sat in her room, in her Broda (special wheelchair with the ability to tilt and recline) chair and talked to a visitor after reading from her whiteboard. R39 was not wearing her boots. On 11/19/24 at 03:30 PM, R39 sat in her Broda chair watching TV. R35 did not have her boots on her heels. On 11/20/24 at 03:30 R39 wrote on the whiteboard that her boots were not put on often. R39 wrote that she did not refuse to let staff put the boots on her. On 11/20/24 at 02:17 PM Certified Nurse's Aide (CNA)M stated if a resident needed pressure relieving boots, staff would know by looking at the plan of care. CNA M stated she did not put R39's boots on. She stated if the CNAs were responsible for R39's boots, that information would be communicated in nursing rounds. On 11/20/24 at 02:31 PM Licensed Nurse (LN) G stated if a resident needed to wear pressure-reducing boots, it would come up on the Treatment Administration Record (TAR). She stated the nurse was the one responsible for any treatments on the TAR. She stated the nurses would ensure the boots were on the residents' heels. LN G stated that R39 would not refuse to wear her boots. On 11/20/24 at 04:31 PM Administrative Nurse D stated if the residents' boots were an order, they should be applied to the residents' heels, or at the least the resident should be asked if she wanted to put the boots on. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Pressure Ulcers and Skin Breakdown dated 03/2014 documented that the nursing staff and attending physician would assess and document individual significant risk factors for developing pressure sores. The nurse would describe and document and report the full assessment of the pressure sore including location, state, length, width and depth, presence of exudates or necrotic tissue and pain, resident mobility, and treatment process. The facility failed to ensure R39's offloading boots were applied to both heels to prevent the pressure ulcers. This placed R39 at increased risk for worsening pressure ulcers and developing pressure ulcers.

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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** 41713 The facility identified a census of 88 residents. The sample included 26 residents with ten residents reviewed for accidents. Based on observation, record review, and interview the facility failed to ensure Resident (R) 185 was monitored and provided a safe environment free from accident hazards when her bed was left in a high upright position which contributed to a fall that resulted in a fracture (broken bone). The facility failed to ensure a safe care environment related to R57's positioning during meals. The facility failed to provide a safe care environment related to the appropriate usage of wheelchair foot pedals during transport for R11. The facility failed to ensure R54's call light was within her reach and further failed to ensure R54's bed was in a low position and her fall mat was in place beside her bed. The facility failed to identify and respond to R65's increased need for assistance and failed to ensure staff were present to ensure safety during toileting and ADL care for R65. The facility failed to investigate R65's falls on 09/16/24 and 09/26/24 to determine causative factors and implement relevant interventions to prevent falls. The facility failed to ensure a safe environment free from accident hazards when R27's bed was left in a high position. These deficient practices placed R185, R57, R11, R54, R65, and R27 at risk for falls and related injuries. Findings included: - R185's Electronic Medical Record (EMR) documented diagnoses of falls, muscle weakness, and a fracture of the neck of the left femur (thigh bone). R185's Admission Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R185 was independent with eating but required substantial to maximal assistance with her activities of daily living (ADLs) including going from sitting to standing. R185 used a manual wheelchair for mobility. R185 had an impairment and functional limitation in the range of motion on one side of her lower extremities. R185 was always incontinent of bladder and had a colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body) for bowel elimination. R185 had a history of a fall with a fracture in the two to six months before admission. R185 had a recent orthopedic (pertaining to the bones) surgery that required skilled nursing care. R185's Care Plan initiated 10/25/24 directed staff that R185 was to have a fall mat at her bedside. The staff were directed to keep her call light within reach when she was in her room. An intervention initiated on 11/01/24 after a fall directed staff to ensure R185's bed was in the lowest, locked position while she was in bed. An admission Nursing - Fall Risk Observation/assessment dated [DATE] documented R185 had a high risk for fall score of 20. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/01/24 at 03:38 AM a Nurse's Note documented R185 was hollering out to help her that she was having pain. The nurse went down to R185's room and R185 reported that she was having pain in her left hip and wanted pain medication. R185 rated her pain at an eight out of 10 on the pain scale. The nurse left R185's room and went to the medication cart to obtain some as-needed (PRN) oxycodone (an opioid medication used to alleviate pain). Upon return to R185's room, R185 was found lying on her right side with her upper half on the fall mat and her lower half on the floor between the fall mat and the bed. R185 was wearing nothing but her incontinence brief and had pulled her nightgown off and thrown it on the floor on the opposite side of the bed. R185 was assessed for injury, with no apparent injury noted. Active range of motion was within normal limits. No new skin issues were observed. Vital signs were obtained; neurological checks were initiated and were within normal limits. R185 was assisted back to bed with the assistance of the nurse and two CNAs utilizing the Hoyer lift (total body mechanical lift) due to her recent left hip replacement. R185 agreed to allow the nurse to put a clean nightgown on and cover her with a comforter. R185 was tearful and stated she didn't understand why she kept doing that. R185's physician, the director of nursing (DON), assistant DON (ADON), and R185's emergency contact were notified. R185's daughter requested grab bars on both sides of the bed to help R185 reposition herself when she was restless. The nurse notified R185's representative that therapy must evaluate for the grab rails then the physician would order if deemed appropriate. A perimeter mattress was discussed with R185's daughter as well. R185's Nursing - Fall Risk Observation/assessment dated [DATE] documented she had a high-risk score of 25. R185's Nursing - Post-Fall Review dated 11/02/24 documented R185 had a recent fall and had a history of falls within the last six months. R182 had incontinence daily in the last 14 days. R185 was not able to walk on her own and was unable to independently come to a standing position on her own. R185's Un-witnessed Fall Report dated 11/02/24 at 04:37 PM by LN L documented R185 was observed on the floor beside her bed. R182 was unable to describe the incident. The resident had been in bed, the head of the bed was in the highest position, bed was not in the lowest position as her family had been in her room visiting with the resident prior to her fall. R185's bed was not placed back in a safe position before the family left the resident's room. An assessment was performed, vital signs were taken, and neurological checks started. The nurse stayed with R185 until emergency medical services (EMS) arrived. An Interdisciplinary Team (IDT) Fall Progress Note dated 11/02/24 at 05:16 PM documented R185 fall on 11/02/24 around 04:37 PM. The resident was observed on the ground. R185 was unable to report what occurred. R185 had increased pain in her leg and was unable to report if she hit her head or not. Risk factors included weakness, poor safety awareness, forgetfulness, and needing assistance with ADLs. Prior interventions in place were a fall mat, the call light within reach, and her bed in the lowest, locked position. The new intervention was to send R185 to the emergency department for evaluation and treatment. R185's Rehab - Status Post- Fall Screen dated 11/02/24 at 07:00 PM by LN L documented R185 was in her room and fell out of bed. This was an unwitnessed fall. The resident could not explain what happened. The resident appeared to have hit her head. An assessment was completed, and the ambulance was called. EMS arrived at the facility at 05:33 PM to take R185 to the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Facility Reported Incident dated 11/02/24 documented R185's incident that occurred on 11/02/24. On 11/02/24 at approximately 04:37 PM R185 was observed on the ground by nursing staff. A facility witness and incident documentation indicated R185 was heard yelling for assistance and nursing team members quickly proceeded to her room to investigate. R185 was observed on the floor on her right side with her head near the bedside table leg. R182 was unable to report what had occurred but reported pain in her leg and was unable to report if she had a head injury. The facility fall protocol was then initiated which includes but was not limited to the following evaluate R185 for possible head, neck, spine, and extremity injuries; obtain and record her vital signs; provide immediate first aid/medical treatments, as needed; assist the resident to a comfortable position and document the details; notification of the physician, the resident's representative, the Director of Nursing, and the administrator as soon as practically possible; observe for delayed complications of fall and complete the appropriate post-fall evaluations and assessments; document signs or symptoms of pain, swelling, bruising, and other changes of condition; and complete incident reporting and all facility follow-up documentation. Per the EMR documentation, nursing staff indicated that the resident's family had just visited with the resident, and the head of the bed was in the highest position and was not placed back to a safe position upon the family leaving the room, potentially further contributing to R185's injury. The facility nursing staff initiated contact with the facility provider and he recommended R185 be sent to the emergency department for further evaluation and treatment. On 11/03/24, at approximately 09:16 AM hours LN H spoke with a nurse at the hospital regarding R185's status. The hospital nurse verbally indicated that R185 had a right femur fracture and was set to have surgery that same day. LN H updated Administrative Nurse D and she advised the Administrative Staff A of the injury. On 11/12/2024, R185's daughter came to the facility to collect R185's belongings as she had been discharged from the hospital and sent home on hospice services. An Incident Statement from Certified Medication Aide (CMA) UU dated 11/02/24 documented she heard hollering down the extensive hall around 04:35 PM when she and several nurse aides went down the hall to find R185 on the floor on top of her fall mat. Staff notified the charge nurse immediately. CMA UU stated the charge nurse stayed with R185 until EMS arrived. An Accident/Incident Statement form and witness statement completed by CMA T dated 11/02/24 documented she heard R185 yelling. CMA T stated that R185 had been put to bed around 03:30 PM and the fall mat was down on the floor. R185 was checked on again at 04:00 PM and was still in bed at that time. CMA T stated about 04:30 R185 was heard yelling so staff all went down to her room to check on her when they observed she had fallen off her bed onto the fall mat. An Accident/Incident Statement form and witness statement completed by CMA TT dated 11/02/24 documented he had found R185 on the floor around 04:30 PM while rounding and heard her hollering and went down to her room. CMA TT stated he stayed with R185 while one of the other aides immediately went and got the nurse. An Accident/Incident Statement form and witness statement completed by LN L dated 11/02/24 documented she was charting at the nurse's station when a CNA came down the hall and said R185 was on the floor. LN L went down to R185's room and she was lying beside the bed on her right side with her head on the side table leg. R182 appeared to have hit her head. LN L stated R182 complained of right face pain and bilateral shoulder pain. Vital signs were obtained. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An Accident/Incident Statement form and witness statement completed by LN H dated 11/02/24 documented she heard R185 yelling but was unable to understand what she said. LN H stated a CNA went to find where the yelling was coming from and alerted LN L that R185 was on the floor next to her bed. R185 was unable to state what had happened. R185 was last seen by the nurse aide neat the edge of her bed and repositioned to the center of the bed. R185 was calm and resting when the staff left the room, and her call light was within reach. LN H stated R185 was observed on the floor mat on the right side of her body on the right side of the bed. LN H stated R185 had facial grimacing with active range of motion to both shoulders. No skin alterations were observed but staff did not fully turn R185 side to side due to her pain and possible injuries. LN H notified the provider and called 911 and was sent to the hospital for evaluation and treatment to rule out injuries related to the fall. Hospital documentation from R185's hospital visit was not provided by the facility as requested. On 11/20/24 at 03:30 PM LN L reported she responded to R185's fall. She stated R185's family had been in the room visiting most of the day. She stated that R185's family must have raised the head of the bed up and left it in a high position. She stated R185's family left the facility with the bed still in the high position. She stated R185's family did not tell staff their visit was over and left. LN L stated that R185 fell right after the family left. On 11/20/24 at 04:30 PM, LN H stated by the time she got to R185's room the bed was in the lowest position and the fall mat was present on the floor. On 11/20/24 at 04:35 PM Administrative Nurse D stated that R185's bed should have been on the lowest position if she had been in bed. Administrative Nurse D stated staff had not been made aware that R185's family had left and was not able to go check on her before her fall occurred. On 11/20/24 at 04:15 PM Administrative Staff A stated he called the fall incident in to the State Agency after he was notified that R185's fall had resulted in a fracture injury. Administrative Staff A stated his nursing staff followed the fall protocol and completed witness statements regarding the incident. Administrative Staff A stated staff were unaware that R185's family had left so they were unable to ensure her bed was in the lowest position due to staff not knowing the family had left. The Accidents and Incidents - Investigating and Reporting policy last revised February 2023 documented: All accidents or incidents involving residents, employees, visitors, and vendors, occurring on facility premises shall be investigated and reported to the administrator. The nurse supervisor, charge nurse, or department director shall complete a Report of Incident/Accident form and submit the original to the director of nursing services within 24 hours of the incident or accident. The facility failed to ensure R185 was monitored and provided a safe environment free from accident hazards when her bed was left in a high position, and she had a fall that resulted in a fracture. This deficient practice placed R185 at risk for increased pain and preventable injuries. 45668 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- R57's Medical Diagnosis section within the Electronic Medical Record (EMR) documented diagnoses of insomnia (difficulty sleeping), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), polyneuropathy (multiple areas of weakness, numbness, and pain from nerve damage, usually in the hands and feet), muscle weakness, and dysphagia (difficulty swallowing). R57's Quarterly Minimum Data Set (MDS) completed 10/10/24 revealed a Brief Interview for Mental Status (BIMS) score of seven indicating severe cognitive impairment. The MDS indicated he required set-up and clean-up assistance during meals. The MDS indicated he was totally dependent on staff assistance for bed mobility and transfers. The MDS documented no swallowing disorders. R57's Functional Abilities Care Area Assessment (CAA) completed 10/10/24 was triggered but lacked analysis. R57's Nutritional CAA completed 10/10/24 was triggered but lacked analysis. R57's Care Plan initiated 05/11/22 indicated he required assistance from staff for his activities of daily living (ADLs). The plan documented he required extensive assistance from one staff for bed mobility and transfers. The plan indicated he required a meal set and supervision for meals. The plan instructed staff to encourage the use of his call light. On 11/17/24, during the survey, R57's Care Plan was updated to reflect a soft-touch call light replaced by his push-button call light. R57's EMR under Evaluations revealed a screening for dysphagia completed on 09/21/24. The screening revealed he had difficulty swallowing on demand and encouraged prolonged mastication (chewing of food). R57's EMR under Progress notes indicated he was sent out to an acute medical facility on 11/08/24 for an acute gastrointestinal (digestive /stomach) disorder. The notes indicated he returned on 11/16/24. On 11/17/24 at 01:05 PM, R57 lay in his bed. The head of his bed was elevated between 30 to 40 degrees with him resting on his back. R57 had a spoon in his left hand while he attempted to eat his chili. R57 had spilled chili down his shirt from attempting to eat in a flat position. R57 struggled to answer questions due to his mouth being dry but he could not reach for his water. R57 pulled his call light up to his chest but could not activate the push button. R57 started coughing and struggled to talk as he attempted to activate his call light. At 01:08 PM staff were alerted R57 needed assistance. Certified Nurse's Aide (CNA) Q entered R57's room. CNA Q acknowledged that R57 was supposed to be in a higher, more upright position during his meals and said R57 should be able to use his call light. CNA Q stated that staff would reposition the resident to make him more comfortable and change his clothing. At 01:12 PM staff entered the room and repositioned R57. Administrative Nurse D then entered the room and talked with R57. Upon request, Administrative Nurse D assessed his ability to use his call light. R57 was unable to use his call light independently or with nursing assistance. Administrative Nurse D stated that R57 just returned from an acute medical facility but could use his call light before he left. On 11/21/24 at 01:42 PM Administrative Nurse D stated R57's push-button call light was changed to a soft-touch call light. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/20/24 at 02:21 PM, Licensed Nurse (LN) G stated residents with dysphagia and swallowing concerns needed to be supervised during meals to prevent aspiration. She stated the facility did not encourage eating in bed, but residents should be positioned in an upright position to prevent choking. She stated the call light should always be within reach and the resident should be able to appropriately use it. On 11/20/24 at 04:30 PM Administrative Nurse D stated staff should not leave residents with swallowing difficulties unsupervised during mealtime and R57's was to be positioned at least at 90 degrees during mealtimes. She stated staff should also ensure he can access his meals and drink safely. The facility's Accident and Incident- Investigating and Reporting revised 02/2023 indicated the facility would ensure preventative measures were in place to prevent potential accidents and injuries. The facility failed to ensure a safe care environment related to R57's positioning during meals. This deficient practice placed R57 at risk for choking or complications related to aspiration (inhaling liquid or food into the lungs). - R11'sMedical Diagnosis section within the Electronic Medical Record (EMR) documented diagnoses of muscle weakness, communication deficit, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), lack of coordination, and osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk). R11's Quarterly Minimum Data Set (MDS), completed on 08/22/24, revealed a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. The MDS indicated bilateral lower extremity impairments. The MDS indicated she required substantial to maximal assistance with bed mobility, transfers, dressing, bathing, personal hygiene, and toileting. The MDS indicated no falls since her last assessment. R11's Functional Abilities Care Area Assessment (CAA) completed 08/29/24 indicated she required moderate to maximal assistance with all of her activities of daily living (ADLs). The CAA documented she was at risk for a decline in her ADLs and falls related to her impaired cognition, poor vision, and difficulty with communication. R11's Care Plan initiated 05/11/22 indicated she was at risk for falls related to her medical diagnoses. The plan documented she required extensive assistance from one staff for transfers, hygiene, toileting, dressing, bed mobility, and bathing. The plan indicated R11 used her wheelchair for mobility. The plan instructed staff to use her wheelchair's foot pedals while assisting. On 11/19/24 at 01:20 PM, R11 sat in the dining room and watched television. Her foot pedals were attached to her wheelchair but in the up position. At 01:25 PM, staff wheeled R11 out of the dining room and down the 200 Hall to her room. Her foot pedals remained in the up position, and her feet dangled as staff pushed her down the hall. Her feet contacted the ground several times while being pushed by staff. On 11/20/24 at 10:23 AM Certified Nurse Aide (CNA) N stated staff were supposed to use the foot pedals while pushing residents in their wheelchairs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/20/24 at 10:41 AM Licensed Nurse (LN) I stated all wheelchairs should have foot pedals in place and staff should ensure the pedals were used while transporting residents around the facility. On 11/20/24 at 04:30 PM Administrative Nurse D stated she expected staff to utilize the foot pedals to prevent falls and injuries while pushing the residents. The facility's Accident and Incident - Investigating and Reporting revised 02/2023 indicated the facility would ensure preventative measures were in place to prevent potential accidents and injuries. The facility failed to provide a safe care environment related to the appropriate usage of wheelchair foot pedals during transport for R11. This deficient practice placed R11 at risk for preventable falls and injuries. 49634 - R54's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), hydrocephalus (a condition in which fluid accumulates in the brain, typically in young children, enlarging the head and sometimes causing brain damage, thrombocytopenia (abnormally low number of platelets, the parts of the blood that help the blood to clot, sometimes associated with abnormal bleeding), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), history of falling, muscle weakness, lack of coordination, and neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying). The Significant Change Minimum Data Set (MDS) for R54 dated 10/17/24 recorded a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented R54 had not had falls since admission or prior assessment. The MDS documented R54 was impaired on both sides of her body. The MDS documented R54 needed supervision or touching assistance for eating, and was dependent on staff for toileting, dressing, and showering. R54's Falls Care Area Assessment (CAA) dated 10/17/24 documented R54 was evaluated for a significant change following a urology (a part of health care that deals with diseases of the male and female urinary tract) consult that resulted in a new diagnosis of neurogenic bladder and Foley catheter (a tube inserted into the bladder to drain urine into a collection bag) insertion. R54 was also currently treated with antibiotics for pneumonia (lung infection). R54 triggered for risk of falls related to the use of multiple psychotropic (alters mood or thought) drugs as well as her need for assistance with all activities of daily living (ADLs). R54 had not fallen recently but remained at risk. R54 would have a care plan to address the risks as well as interventions to decrease her risk of falls with injuries. R54's Care Plan dated 02/23/22 documented R54 was at risk for falls and has had an actual fall related to immobility, and cerebral palsy. R54's plan of care documented staff were to ensure R54's call light was within reach and would encourage her to use it for assistance as needed. R54's plan of care dated 05/16/22 documented R54's bed would be a hi-low bed, and her floor mats would be in place. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/18/24 at 11:30 AM R54 laid in her bed asleep. R54's floor mat was rolled up by her nightstand, and her bed was not in the lowest position. On 11/19/24 at 10:17 AM R54 sat in her wheelchair, watching TV. R54's pancake call light lay at the bottom of her bed, out of R54's reach. On 11/20/24 at 02:17 PM, Certified Nurse's Aide (CNA) M stated all call lights should be within the resident's reach, and fall mats should always be in place, even if the resident was just napping. CNA M stated she could see the resident's care plan. She stated she would know what needs to be done for the resident in nursing rounds and by the resident's care plan. On 11/20/24 at 02:17 PM Licensed Nurse (LN) G stated call lights should be within reach of the resident. LN G said if the care plan stated the bed should be in the lowest position and a fall mat in place, that was what should happen. LN G stated the CNAs are responsible for ensuring the care plan was followed. On 11/20/24 at 04:31 PM Administrative Nurse D stated staff were expected to ensure all interventions were in place. Administrative Nurse D stated all nurses were responsible for ensuring all interventions were in place. The facility's Accidents and Incidents policy which lacked a date documented that all accidents or incidents involving residents, employees, visitors, and vendors occurring on our premises shall be investigated and reported to the administrator. The supervisor shall promptly initiate and document an investigation of the accident or incident. The facility failed to ensure R54's call light was within her reach and further failed to ensure R54's bed was in a low position and her fall mat was in place beside her bed. This deficient practice placed R54 at risk for falls and related injuries. - The Diagnoses tab of R65's Electronic Medical Record (EMR) documented diagnoses of restlessness and agitation, altered mental status, lack of coordination, diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), osteoarthrosis (chronic arthritis without inflammation) mood disturbance, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), muscle weakness, communication deficit, hypertension (HTN - elevated blood pressure), unsteadiness on feet, insomnia (inability to sleep), abnormal posture, aphasia, dysphagia (swallowing difficulty), and osteoporosis (medical condition in which the bones become brittle and fragile from loss of tissue) with current pathological fracture (a broken bone that occurs in an area of bone that been weakened by a disease). The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R65 had unclear speech with mumbled words. The MDS documented R65 was independent with eating, dressing her lower and upper body, putting on and taking off footwear, and oral hygiene. The MDS documented R65 needed partial to moderate assistance with bathing, and supervision or touching assistance with toileting hygiene. The MDS documented R65 had occasional urinary incontinence and frequent bowel incontinence. R65's MDS lacked indication R65 had osteoporosis. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Falls Care Area assessment dated [DATE], documented R65 triggered for delirium (sudden severe confusion, disorientation, and restlessness) related to a report of her inability to focus. R65 had severe cognitive decline based on her dementia (a progressive mental disorder characterized by failing memory and confusion). R65 had not demonstrated a significant change indicating a need for a delirium care plan at this time. R65 triggered for cognition due to her diagnosis of dementia. She does have poor cognition and was unable to verbalize her needs or concerns. R65 can communicate some via whiteboard but this was becoming less effective as her overall decline in cognition continues. R65 would have a care plan to address her cognition. R65 triggered for communications due to dementia. R65 triggered for incontinence due to the periods of both bowel and bladder incontinence during the lookback period. R65 was not only incontinent but was now requiring assistance with incontinence care due to the inability to clean up her bowel movements appropriately and would get bowel movements on her hands, clothing, and walls. R65's Care Plan would address those concerns. R65 triggered for falls based on the use of psychotropic (alters mood or thought) medication. She takes Remeron (an antidepressant) for appetite as well as depression and the drug would increase R65's risk of falls. R65 had an unsteady gait and an inability to remember to ask for assistance. R65 triggered for pressure injury based on incontinence. R65 triggered for psychotropic drug use related to the use of Remeron. She was on this medication to address both her weight loss risk and her depression. R65's Care Plan documented she had a cognitive communication deficit and dementia, and she required assistance with activities of daily living (ADLs). R65's plan of care dated 04/17/24 documented R65 was Independent with bed mobility, walking, dressing, and transferring. She required moderate assistance of one for hygiene and set up for eating. R65's plan of care dated 04/17/24 documented R65 had difficulty communicating with others related to aphasia. R65 communicated with a notepad and pen. R65's Care Plan dated 11/25/22 and revised on 04/18/24 documented R65 had limited physical mobility related to dementia. Staff were to monitor, document, and report any signs or symptoms of immobility. R65's Care Plan dated 09/16/24 documented R65 was at risk for falls and had an actual fall related to confusion, gait and balance, incontinence, and poor communication. An intervention dated 11/25/22 directed staff to anticipate and meet the resident's needs. The plan documented a non-injury fall (NIF) on 03/03/24 and an intervention dated 03/04/24 which directed staff to encourage R65 to remain seated in the shower. The plan documented a NIF on 05/25/24 with an intervention dated 05/28/24 for non-skid strips in front of the toilet in R65's room. The plan documented a NIF on 09/15/24 (revised on 11/18/24) with an intervention dated 09/16/24 that directed staff to apply nonskid strips beside R65's bed. R65's plan of care dated 09/27/24 documented R65 had a fall on 09/26/24 and the nurse practitioner (NP) was to complete a medication review. R65's EMR under Nursing Note date 09/16/24 documented R65 had diarrheas on the evening and night shift. The NP was notified by message. R65's vital signs were obtained and were within normal limits. R65 was nonverbal and unable to express discomfort or confusion. R65 sat on the toilet, cleaning her underwear and pants in the sink. R65 had loose stool on her clothing. R65 had her shoes on, and her shoes were on the wrong feet. Staff cleaned R65, put her call light within her reach, and provided her with fresh water. R65's EMR under IDT Fall Note on 09/16/24 documented R65 was observed on the ground beside her bed attempting to get her shoe on. R65's call light was within her reach. The Intervention placed for R65's fall was non-skid strips in front of her bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R65's EMR under Practitioner Note dated 09/16/24 documented the resident had a recent fall. R65 was found by staff after a fall but had no injury at that time. The facility failed to provide evidence of an investigation of R65's fall on 09/16/24. R65's clinical record lacked evidence of staff-identified potential contributing factors related to R65's fall. R65's EMR recorded a Behavior Note dated 9/19/24 at 07:25 AM that documented R65 continued to have incontinent episodes of diarrhea through the night shift. R65 refused to use her call light. The note recorded the resident walking through the bowel movement (BM) tracking it all over the room and bathroom and smearing it with her hands. Staff cleaned the resident and continued to encourage R65 to use her call light. R65's EMR recorded a Nurses Note dated 09/24/24 at 06:22 AM that documented staff made several attempts to collect urine for urinalysis (lab analysis of urine). According to the CNA, R65 poured the urine back into the

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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** 41037 The facility identified a census of 88 residents. The sample included 26 residents with one resident reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 76's Trilogy ventilator (a positive pressure ventilation device that treat a variety of respiratory issues through non-invasive or invasive ventilation therapy) mask was stored in a sanitary manner to decrease exposure and contamination. R76 was on antibiotic therapy for chronic respiratory failure. This deficient practice placed R76 at increased risk of developing a respiratory infection or other respiratory complications. Findings included: - R76's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of chronic respiratory failure, emphysema (lung disease that causes breathlessness), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and hypoxia (inadequate supply of oxygen). The Quarterly MDS dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R76 had received an invasive and non-invasive mechanical ventilator and oxygen therapy during the observation period. R76's Care Plan dated 11/11/24 documented staff would administer oxygen at two liters (L) per (P) minute (M) via nasal cannula at rest and four LPM via nasal cannula during exertion. The plan of care directed the staff to change humidification and oxygen tubing as directed. The plan of care directed the staff to elevate the head of R76's bed to a level of comfort to promote oxygenation. The plan of care dated 11/15/24 documented the nursing staff would monitor R76's oxygen saturation level every shift. The care plan lacked direction to the nursing staff for the care and application of her Trilogy mask. R76's EMR under the Orders tab revealed the following physician orders: Continue Trilogy therapy at night, nurse to ensure proper mask placement and assist as needed. Trilogy setting as ordered for COPD at bedtime dated 07/14/24. Azithromycin(antibiotic) oral tablet 500 milligrams (mg) give one tablet by mouth one time a day every Monday, Wednesday, and Friday related to COPD dated 07/15/24. Oxygen at two LPM at rest and four LPM with activity via nasal cannula continuous every shift for COPD dated 11/15/24. On 11/19/24 at 09:13 AM R76 sat upright on her bed and ate her breakfast. R76's unbagged Trilogy mask rested directly on her refrigerator. There was no bag visible for storing the ventilator mask. R76 stated the mask was usually not stored in a bag and was not sure how often her mask was changed or cleaned. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 02:54 PM, Certified Nurse Aide (CNA) O stated respiratory equipment should be stored in a clean bag when not in use. On 11/20/24 at 03:01 PM, Licensed Nurse (LN) I stated R76's respiratory mask should be stored in a clean plastic bag when not in use. On 11/20/24 at 04:21 PM, Administrative Nurse D stated she expected respiratory equipment to be stored in a plastic bag when not in use. The facility's Departmental (Respiratory Therapy) -Prevention of Infection policy dated 11/2011 documented the purpose of this procedure was to guide the prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Staff would review the resident's care plan to assess for any special circumstances or precautions related to the resident. The facility failed to ensure R76's, Trilogy mask was stored in a sanitary manner. This placed R76 at increased risk for further respiratory infections and complications.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 88 residents. The sample included 26 residents with two residents reviewed for hemodialysis (a procedure using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observation, record review, and interviews, the facility failed to monitor Resident (R) 25's access site for complications at least daily. This deficient practice placed R25 at risk of adverse outcomes and physical complications related to dialysis. Findings included: - R25's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of other symptoms and signs involving cognitive functions and awareness, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R25 received dialysis services during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of five which indicated severely impaired cognition. The MDS documented that R25 received dialysis services during the observation period. R25's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 01/10/24 lacked analysis documentation. R25's Care Plan dated 10/07/24 directed staff to check and change the dressing daily at the access site. The plan of care directed staff to document the condition and any complications of the access site. The plan of care documented that staff would change the dressing only if ordered by the physician. R25's EMR under the Orders tab revealed the following physician orders: Dialysis on Tuesday, Thursday, and Saturday. Pick up time at 10:45 AM dated 09/10/24. Central venous catheter to upper right chest dated 09/10/24. Complete pre and post-dialysis under defined assessment (UDA) and dialysis communication sheet. Enter a nurses note for dialysis. Check for completed communication paperwork, labs, and new orders. Please call the dialysis center if the paperwork did not come back with R25. Two times a day every Tuesday, Thursday, and Saturday for Dialysis related to CKD dated 09/18/24. On 11/19/24 at 09:12 AM R25 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) in front of the north nurse's station. R25 stated she was not feeling well and was nauseated. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 03:01 PM, Licensed Nurse (LN) I stated R25's access site was not checked on a daily basis. LN I stated R25's access site was checked and monitored on the days she had dialysis. LN, I stated the evaluation of the access site was documented on the pre & post UDA form under the evaluation tab. On 11/20/24 at 04:31 PM, Administrative Nurse D stated that R25's access site should be checked at least daily and documented in her EMR. The facility's Access and Care of Hemodialysis Catheters policy last revised 02/2023 documented that hemodialysis catheters would only be accessed by medical staff who have received training and demonstrated clinical competency regarding the use of this catheter. The nurse would document in the resident's medical record every shift as follows: location of the catheter, condition of dressing (interventions if needed), if dialysis was done during that shift, any part of a report from the dialysis nurse post-dialysis being given, and observations post-dialysis. The facility failed to monitor R25's dialysis access site for signs of infection, bleeding, and the status of the dressing in place. This deficient practice placed R25 at risk of potential adverse outcomes and physical complications related to dialysis.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 41713 The facility identified a census of 88 residents. Based on observation, record review, and interview, the facility failed to ensure nursing staff demonstrated the appropriate competencies and skill sets to provide nursing services to care for resident's needs when staff failed to transcribe the correct dosage amount from the hospital discharge order to the Medication Administration Record (MAR) for the intravenous (IV - administered directly into the bloodstream via a vein) daptomycin (an antibiotic medication used to treat infections) for Resident (R) 182 and then failed to check the order in the MAR against the actual medication dose being administered. This deficient practice placed R182 at risk for medication errors and potential adverse side effects. Findings included: - R182's hospital discharge summary dated 11/11/24 documented an order to continue IV daptomycin in 0. 9% sodium chloride solution 500 milligrams (mg)/50 milliliters (ml), Give 650 mg intravenous every 24 hours. R182's November 2024 MAR documented an order dated 11/12/24 for daptomycin in sodium chloride intravenous solution 500 - 0.9 mg/50 ml. Give 500 mg intravenously one time a day for bacteremia (presence of bacteria in the blood) for 23 administrations. R182's November 2024 MAR documented the 500 mg dose was signed as administered on 11/12/24, 11/13/24, 11/4/24, 11/15/24, 11/16/26, and 11/17/24. On 11/18/24 at 10:02 AM Licensed Nurse (LN) G had the supplies to administer R182's IV medication on her medication cart including the sealed bag with the IV medication daptomycin. LN G verified the order in R182's MAR with the medication label and noticed that the order on the MAR differed from the label on the medication. LN G had Administrative Nurse E, who was at the medication cart, double-check the MAR and the label on the medication. LN G secured the screen on her laptop and locked her medication cart and LN G and Administrative Nurse E walked down the hallway to the nurse's station to look for the admission orders for R182. Upon review of the admission order and the order on the medication label, the two nurses verified that the order on the medication label was correct at 650 mg, but the order typed into the MAR was not correct. Consultant GG was at the nurse's station at the same time LN G and Administrative Nurse E came up to the nurse's station and Consultant GG verified the correct dosage amount from the admission order was the same as what was on the label of the daptomycin for R182. On 11/18/24 at 10:10 AM LN G stated she could not say who entered R182's order dosage for the daptomycin into the MAR but had the order verified by Administrative Nurse E that the order had been transcribed incorrectly. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/24 at 10:10 AM Administrative Nurse E stated that the pharmacy had sent the correct dosage of 650 mg for the IV daptomycin for R182. Administrative Nurse E stated that looking at the MAR the dosage of 500mg to be given was entered into R182's MAR incorrectly, but R182's IV medication label had the correct ordered dosage of 650 mg on the medication. Administrative Nurse E stated staff are trained to enter physician orders as given and should verify with the provider or herself if there was a question regarding an order. Administrative Nurse E stated prior staff had not noticed the incorrect dosage amount on R182's MAR prior to today. On 11/18/24 at 10:11 AM Consultant GG stated he verified the order for R182 to be the correct dosage on the IV medication bag as what the original order was for the 650 mg dosage. Consultant GG verified that R182's MAR did have the incorrect dosage of 500 mg to be given for the daptomycin medication. The Staffing, Sufficient and Competent Nursing policy revised on August 2022, documented: all nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. Staff must demonstrate the skills and techniques necessary to care for resident needs including (but not limited to) the following areas: resident rights; behavioral health; psychosocial care; dementia care; person-centered care; communication; basic nursing skills; basic restorative services; skin and wound care; medication management; pain management; infection control; identification of change in condition; and cultural competency. The Medication and Treatment Orders policy revised in July 2016, documented: Orders for medications and treatments will be consistent with the principles of safe and effective order writing. Orders for medications must include the name and strength of the drug; the number of doses, start and stop date, and or specific duration of therapy; the dosage and frequency of administration; the route of administration; clinical conditions for which the medication was prescribed; and any interim follow-up requirements. The facility failed to ensure staff were competent when staff failed to check the order in the MAR against the actual medication dose being administered and failed to transcribe the correct dosage amount from the hospital discharge order to the MAR for R182's daptomycin. This deficient practice placed R182 at risk of unnecessary medication administration and possible adverse side effects.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 45668 The facility identified a census of 88 residents. The sample included 26 residents. Based on record review and interview the facility lacked a census on its daily posted nurse staffing hours. Findings included: - On 11/17/24 at 10:00 AM an inspection of the front lobby revealed the Daily Posted Staffing sheet. The sheet was dated and displayed staffing but lacked a census. On 11/18/24 at 07:10 AM an inspection of the front lobby revealed the Daily Posted Staffing sheet. The sheet was dated and displayed staffing but lacked a census. On 11/17/24 at 10:10 AM Licensed Nurse (LN) H stated the sheets were completed by the night shift and posted each morning. She stated it should include the number of residents and staffing for the day. On 11/21/24 at 04:30 AM Administrative Nurse stated the staffing records were held for 18 months and should include the daily staffing requirements and census. A review of the facility's Staffing policy revised 08/2022 indicated that staffing hours must be maintained for facility records for a minimum of 18 months. The policy indicated the records must be made available upon request. The facility's posted daily nurse hours lacked a census on its daily posted nurse staffing hours.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 88 residents. The sample included 26 residents. Based on observation, record review, and interviews, the facility failed to provide adequate pharmaceutical services to ensure Resident (R) 69 had her prescribed medications available in a timely manner for administration. This deficient practice placed R69 at risk of delayed treatment which could have adverse consequences. Findings included: - R69's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), epilepsy (brain disorder characterized by repeated seizures), schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R69 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medications and antidepressant (a class of medications used to treat mood disorders) medication during the observation period. The MDS documented R96 had hallucinations and no behavioral symptoms during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R69 received antipsychotic medications, antidepressant medications, and antianxiety (a class of medications that calm and relax people) medication. The MDS documented no gradual dose reduction was completed or there was any physician document that a gradual dose reduction was clinically contraindicated for R69. R69's Psychotropic Drug Use Care Area Assessment (CAA) dated 02/28/24 lacked analysis documentation. R69's Care Plan dated 11/17/24 documented nursing staff would administer medication as ordered, monitor for side effects, and notify the physician as needed. R69's EMR under the Orders tab revealed the following physician orders: Buspirone Hcl (Buspar-antianxiety) tablet five milligrams (mg), give one tablet by mouth three times a day for anxiety dated 09/16/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R69's Medication Administration Record (MAR) for September 2024 revealed R69's antianxiety medication Buspar which was ordered on 09/16/24 was documented as a 9 (not administered) two times on 09/22/24, one time on 09/23/24, three times on 09/24/24, two times on 09/25/24, three times on 09/26/24 and two times on 09/27/24 and was documented 2 one time on 09/25/24. On 09/28/24 at 01:36 PM a Nurse's Note documented the Buspar was delivered, the physician was notified, and started to administer the medication as it was ordered. On 11/18/24 at 04:16 PM, R69 sat in her wheelchair out in the front lobby. On 11/19/24 at 02:32 PM, Administrative Nurse D stated she did not know what was the reason R69's antianxiety medication was not available to be administered as ordered. Administrative Nurse D stated she would have to look into it and find out why the medication was not delivered from the pharmacy. On 11/20/24 at 03:01 PM, Licensed Nurse (LN) I stated she thought R69's Buspar was not delivered from the pharmacy due to R69's insurance would not pay for the medication. LN I stated the facility finally agreed to pay for a 30-day supply of the antianxiety medication until the pharmacy was able to straighten out the insurance concern. LN I said the assistant director of nursing would know more about R69's medications. On 22/20/24 at 03:30 PM, Administrative Nurse E stated she could not remember what the reason was why R69's antianxiety medication was not delivered from the pharmacy. The facility's Pharmacy Services policy dated 04/19 documented the consultant pharmacist shall provide consultation on all aspects of pharmacy services in the facility and collaborate with the facility and medical director to develop, implement, evaluate, and revise the procedures for the provision of all aspects of pharmacy services, including procedures to support resident quality of life such as safe, individualized medication administration programs. The Consultant Pharmacist would provide specific activities related to medication regimen review including a document review of the medication regimen of each resident at least monthly. or providing or more frequently. The facility failed to provide adequate pharmaceutical services to ensure R69 received her prescribed medication. This deficient practice placed R69 at risk of delayed treatment which could have adverse consequences.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 88 residents. The sample included 26 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities for Resident (R) 69 related to antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication and antianxiety (a class of medications that calm and relax people) medication not administered as ordered by the physician. These deficient practices placed R69 at risk for unnecessary medication use, side effects, and physical complications. Findings included: - R69's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), epilepsy (brain disorder characterized by repeated seizures), schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R69 received antipsychotic medications and antidepressant (a class of medications used to treat mood disorders) medications during the observation period. The MDS documented R96 had hallucinations and no behavioral symptoms during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R69 received antipsychotic medications, antidepressant medications, and antianxiety (a class of medications that calm and relax people) medication. The MDS documented no gradual dose reduction was completed or there was any physician document that a gradual dose reduction was clinically contraindicated for R69. R69's Psychotropic Drug Use Care Area Assessment (CAA) dated 02/28/24 lacked analysis documentation. R69's Care Plan dated 11/17/24 documented nursing staff would administer medication as ordered, monitor for side effects, and notify the physician as needed. R69's EMR under the Orders tab revealed the following physician orders: Invega sustenna (antipsychotic) intramuscular suspension prefilled syringe 234 milligrams (mg)/1.5 milliliters (ml) (paliperidone palmitate) inject 1.5ml intramuscularly one time a day every 21 days for antipsychotic dated 10/08/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Buspirone Hcl (Buspar-antianxiety) tablet five mg give one tablet by mouth three times a day for anxiety dated 09/16/24. Review of R69's Medication Administration Record (MAR) for August 2024 documented Invega was administered on 08/01/24 as ordered. The August 2024 MAR documented the medication was not able to be administered on 08/22/24 represented by 9 on the MAR. R69's clinical record lacked evidence the 08/22/24 dose of Invega was ever administered or rescheduled and lacked evidence the physician was notified that the medication was not administered as ordered on 08/22/24. Review of R69's September 2024 MAR documented the Invega was administered on 09/14/24 which was 44 days since the last administration of the Invega on 08/01/24. R69's September 2024 MAR revealed R96's antianxiety medication Buspar which was ordered on 09/16/24 was documented as a 9 (not administered) two times on 09/22/24, one time on 09/23/24, three times on 09/24/24, two times on 09/25/24, three times on 09/26/24 and two times on 09/27/24, and was documented 2 one time on 09/25/24. Review of R69's Monthly Medication Review (MMR) from August 2024 through October 2024 lacked evidence the CP identified and reported R69's antipsychotic medication Invega and her antianxiety medication Buspar was not administered per physician orders. On 11/18/24 at 04:16 PM, R69 sat in her wheelchair out in the front lobby. On 11/20/24 at 03:01 PM, Licensed Nurse (LN) I stated the unit managers, or the assistant director of nursing, took care of the monthly pharmacy reviews. On 11/20/24 at 04:31 PM, Administrative Nurse D stated the CP completed a MMR on all the residents in the facility. Administrative Nurse D stated she was not aware the CP had not addressed R69's medications not being administered as ordered. The facility's Pharmacy Services policy dated 04/19 documented the facility would have the services of a consultant pharmacist, who would provide evidence of current licensure and appropriate training to provide the services. The facility would give the consultant pharmacist a current roster and would inform the consultant pharmacist of all new admission and readmission to the facility. The consultant pharmacist would provide consultation on all aspects of pharmacy services in the facility and collaborate with the faculty and medical director. The facility failed to ensure the CP had identified and reported irregularities with R69's antipsychotic and antianxiety medication not administered per the physician's orders. This deficient practice placed R69 at risk for unnecessary medication administration, ineffective benefits of the medication, and possible adverse side effects.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 88 residents. The sample included 26 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure a documented physician rationale, nonpharmacological attempts, and risk versus benefits with informed consent prior to starting an antidepressant (a class of medications used to treat mood disorders) for Resident (R)66. The facility further failed to ensure an appropriate indication of use or a documented physician rationale and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat a mental disorder characterized by gross impairment in reality testing) for R25, and further failed to ensure R69 had a signed consent for Caplyta (antipsychotic medication) and fluphenazine (antipsychotic medication). These deficient practices placed the residents at risk for adverse medication effects and unnecessary medications. Findings Included: - R66's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) with cerebrovascular accident (CVA - stroke - the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), affecting the right dominant side, hypertension (HTN - elevated blood pressure, involuntary movements, diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), cardiomyopathy (heart disease), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), aphasia (a condition with disordered or absent language function), muscle weakness, and unsteadiness. R66's Significant Change Minimum Data Set (MDS) dated [DATE] recorded R66's mood score was zero, indicating no signs of depression. R66's Quarterly MDS dated [DATE] recorded a mood score of zero, indicating no depression. R66's Quarterly MDS dated [DATE] documented that a mood interview should be conducted but the resident did not respond. The MDS lacked a staff assessment of the resident's mood. R66's Quarterly MDS dated [DATE] documented that a mood interview should be conducted but the resident did not respond. The MDS lacked a staff assessment of the resident's mood. The Significant Change MDS dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R66 had an impairment of the extremities on one side of her body. The MDS documented R66 needed substantial to maximum assistance for bathing, dressing, and toileting. The MDS documented R66 was dependent on staff for putting on or taking off footwear. The MDS documented R66 received antidepressants during the observation period. The MDS mood and behavior assessment documented the resident was unable to respond and lacked evidence the staff interview for mood and behavior was completed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R66's Psychotropic Drug Use Care Area Assessment (CAA) dated 11/06/24 lacked analysis. R66's Care Plan dated 10/28/24 documented R66 had a potential for psychosocial well-being related to end-stage disease, lack of motivation, and social isolation. R66 would be able to cope with her feelings of isolation unhappiness, anger, and loss. Staff were to give R66 time to answer questions, and verbalize feelings perceptions, and fears as needed. R66's EMR under the Orders tab revealed the following physician orders: Zoloft Oral Tablet 50 milligrams (mg) give one tablet by mouth in the morning for depression dated 08/15/24. R66's EMR under Nursing Notes dated 10/23/24 documented R66 graduated from hospice on 10/23/24. Review of R66's EMR lacked evidence of physician documented rationale including the risk versus benefits for R66's depression medication. The EMR lacked evidence of a signed consent for the use of the psychotropic medication. On 11/18/24 at 07:33 AM, unidentified staff pushed R66 in her wheelchair to the dining room. On 11/19/24 at 09:24 AM R66 sat in her wheelchair watching TV in her room with her roommate. On 11/20/24 at 02:31 PM, Licensed Nurse (LN) G stated she was unsure what medication would need documentation prior to starting the medication. On 11/20/24 at 04:21 PM Administrative Nurse D stated R66 was put on the medication by her hospice provider. Administrative Nurse D stated she did not know if there was any documentation by the hospice provider prior to starting the antidepressant. The facility did not provide an unnecessary medication policy. The facility failed to ensure a documented physician rationale, risk versus benefits including informed consent and non-pharmacological interventions prior to starting a psychotropic medication for R66. This placed the resident at risk for unnecessary medication effects. 41037 - R25's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of other symptoms and signs involving cognitive functions and awareness, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R25 received antidepressant (a class of medications used to treat mood disorders) medication, antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, diuretic (a medication to promote the formation and excretion of urine) medication, and opioid (a class of controlled drugs used to treat pain) medication during the observation period. The MDS documented no gradual dose reduction was completed and there was no physician documentation that a gradual dose reduction was clinically contraindicated. The Quarterly MDS dated [DATE] documented a BIMS score of five which indicated severely impaired cognition. The MDS documented that R25 received antidepressant medication, antipsychotic medication, diuretic medication, and opioid medication during the observation period. The MDS documented the last gradual dose reduction was completed on 10/07/23 and there was no physician documented that a gradual dose reduction was clinically contraindicated. R25's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/10/24 lacked analysis documentation. R25's Care Plan dated 05/24/22 documented nursing staff would administer psychotropic medications as ordered. R25's EMR under the Orders tab revealed the following physician orders: Haloperidol (antipsychotic) five milligrams (mg) tablet, give 2.5 mg by mouth two times a day related to psychosis, dated 11/08/24. R25's EMR lacked evidence of a physician documented rationale including the risk versus benefits and informed consent for R25's antipsychotic medication Haldol. The facility was unable to provide documentation upon request. On 11/19/24 at 09:12 AM R25 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) in front of the north nurse's station. R25 stated she was not feeling well and was nauseated. On 11/20/24 at 03:01 PM Licensed Nurse (LN) I stated she was unsure what medications would need documentation prior to starting the medication. LN I stated she did not know where the non-pharmacological inventions would be documented and where to find what non-pharmacological interventions had been effective. LN I stated the unit manager would obtain the consent for use of any antipsychotic medication. On 11/20/24 at 04:21 PM Administrative Nurse D stated R25's non-pharmacological interventions had been to reduce stimuli and remove from the situation. Administrative Nurse D stated the floor nursing staff would obtain the informed consent for the administration of antipsychotic medication. The facility did not provide an unnecessary medication policy. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility failed to ensure a documented physician rationale, risk versus benefits including informed consent for antipsychotic medication for R25. This placed R25 at risk for unnecessary medication side effects. - R69's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), epilepsy (brain disorder characterized by repeated seizures), schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R69 received antipsychotic medications and antidepressant (a class of medications used to treat mood disorders) during the observation period. The MDS documented R96 had hallucinations and no behavioral symptoms during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R69 received antipsychotic medications, antidepressant medications, and antianxiety (a class of medications that calm and relax people) medication. The MDS documented no gradual dose reduction was completed or there was any physician document that a gradual dose reduction was clinically contraindicated for R69. R69's Psychotropic Drug Use Care Area Assessment (CAA) dated 02/28/24 lacked analysis documentation. R69's Care Plan dated 11/17/24 documented nursing staff would administer medication as ordered, monitor for side-effects, and notify the physician as needed. R69's EMR under the Orders tab revealed the following physician orders: Invega sustenna (antipsychotic) intramuscular suspension prefilled syringe 234 milligrams (mg)/1.5 milliliters (ml) (paliperidone palmitate) inject 1.5ml intramuscularly one time a day every 21 days for antipsychotic dated 10/08/24. Buspirone hci (Buspar-antianxiety) tablet five mg give one tablet by mouth three times a day for anxiety dated 09/16/24. Caplyta (antipsychotic) oral capsule 42mg (lumateperone tosylate), give one capsule by mouth at bedtime for bipolar dated 10/04/24. Fluphenazine hci (antipsychotic) oral tablet 2.5mg give five mg by mouth two times a day for schizoaffective disorder dated 11/08/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of R69's EMR lacked evidence of an informed consent for her Caplyta and fluphenazine antipsychotic medications. The facility was unable to provide consent signed by the resident or her representative upon request. On 11/18/24 at 04:16 PM R69 sat in her wheelchair out in the front lobby. On 11/20/24 at 03:01 PM Licensed Nurse (LN) I stated she was unsure what medication would need documentation prior to starting the medication. LN I stated she did not know where the non-pharmacological inventions would be documented and where to find what non-pharmacological interventions had been effect. LN I stated the unit manager would obtain the consent for use any antipsychotic medication. On 11/20/24 at 04:21 PM Administrative Nurse D stated the nursing staff would obtain the informed consent for administration of antipsychotic medication. The facility did not provide an unnecessary medication policy. The facility failed to ensure a documented risk versus benefits including informed consent for psychotropic medications for R69. This placed R69 at risk for unnecessary medication side effects.

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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** 41037 The facility identified a census of 88 residents. The sample included 26 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 69 remained free of significant medication errors when staff failed to administer her antipsychotic medication (used to treat major mental conditions that cause a break from reality) as ordered. This deficient practice resulted in increased auditory and visual hallucinations (sensing things while awake that appear to be real, but the mind created) for R69, which caused her significant psychosocial distress, and additional psychotropic medications were prescribed which placed her at increased risk for adverse medication effects. Findings included: - R69's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), epilepsy (brain disorder characterized by repeated seizures), schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R69 received antipsychotic medications and an antidepressant (a class of medications used to treat mood disorders) during the observation period. The MDS documented R96 hallucinated and no behavioral symptoms during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R69 received antipsychotic medications, antidepressant medications, and antianxiety (a class of medications that calm and relax people) medication. The MDS documented no gradual dose reduction was completed or there was any physician document that a gradual dose reduction was clinically contraindicated for R69. R69's Psychotropic Drug Use Care Area Assessment (CAA) dated 02/28/24 lacked analysis documentation. R69's Care Plan dated 11/17/24 documented that nursing staff would administer medication as ordered, monitor for side effects, and notify the physician as needed. R69's EMR under the Orders tab revealed the following physician orders: Invega sustenna (antipsychotic) intramuscular suspension prefilled syringe 234 milligrams (mg)/1.5 milliliters (ml) (paliperidone palmitate) inject 1.5ml intramuscularly one time a day every 21 days for antipsychotic dated 10/08/24. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	R69's Medication Administration Record (MAR) for August 2024 documented staff administered Invega on 08/01/24 as ordered. The August 2024 MAR documented the medication as not able to be administered on 08/22/24, which was represented by a 9 on the MAR. R69's clinical record lacked evidence the 08/22/24 dose of Invega was ever administered or rescheduled and lacked evidence the physician was notified that the medication was not administered as ordered on 08/22/24. On 08/28/24 at 10:01 AM a Nurse Practitioner Note documented R69 was seen for her weight gain and shortness of breath. On 09/03/24 at 03:50 PM a Social Service Note documented R69 accused her roommate of touching her things. R69 had symptoms of paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking). The interdisciplinary team (IDT) would formulate a plan to address R69's behaviors. On 09/08/24 at 10:29 AM a Behavior Note documented R69 had increased auditory hallucinations. R69 had screamed and yelled out loudly, cussing at unknown and unseen persons. The nurse practitioner was notified to follow up with R69 on the next rounds. On 09/08/24 at 03:22 PM a Behavior Note documented R69 continued to have verbal outbursts. R69 was heard screaming and yelling at unknown persons. R69 remained in her room and did not participate in activities outside her room. On 09/09/24 at 08:56 AM a Behavior Note documented a referral was made for R69 for counseling services related to her mental health and the increase in hallucinations. On 09/09/24 at 08:58 AM a Nurse Practitioner Note documented R69 was seen for increased hallucinations The note documented the assessment and plan for lab work and a new order for trazodone hci (antidepressant) oral tablet 100 mg give one tablet by mouth at bedtime for depression dated 09/09/24. On 09/10/24 at 01:40 AM a Nurse's Note documented it had been reported R69 could be heard screaming and yelling. R69 had received the first dose of trazodone. R69's September 2024 MAR lacked evidence Invega was administered on 09/12/24 as ordered on the 21-day schedule (21 days from the missed dose scheduled for 08/22/24). R69's clinical record lacked evidence the physician was notified the medication was not administered as ordered. On 09/13/ at 01:48 PM a Behavior Note documented R69 was unable to be seen by the counseling services related to her current insurance provider and the writer would make another referral to a different counseling service. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 9/14/24 at 09:40 AM a Nurse's Note documented the nurse had called the pharmacy a second time for R69's Invega medication. On 09/13/24 the nurse was told the Invega could not be filled at that time because the request was too soon to be filled. The pharmacy reported the order they had on file directed the Invega to be given every 28 days instead of every 21 days. The pharmacy would deliver the medication on that date. The nurse practitioner was aware and directed staff to administer the medication when delivered from the pharmacy on that date. R69's September 2024 MAR documented the Invega was administered on 09/14/24, which was 44 days since the last administration of the Invega on 08/01/24. On 09/15/24 at 10:17 AM a Nurse's Note documented R69 was heard yelling in her room. R69 was aware at that time she was hallucinating and felt her medication was not working. A message was left for the physician. On 09/16/24 at 02:34 AM a Nurse's Note documented R69 was heard yelling in her room. R69 had reported the people in her head were being mean to her at that time. A message was left to notify the physician of R69's behavior. On 09/16/24 at 10:13 AM a Nurse's Note documented the following new physician order for: Buspirone hci (antianxiety) tablet five mg give one tablet by mouth three times a day for anxiety. On 09/17/24 at 02:41 PM a Social Service Note documented a referral was sent for a psychiatry consult for R69. On 09/18/24 at 03:13 PM a Nurse's Note documented staff had noted R69 had declined in her overall function related to self-isolation because of her increased reported hallucinations. The note documented R69 had required more staff assistance with activities of daily living (ADLs). R69 had increased complaints of back pain at that time. On 09/20/24 at 02:07 PM a Behavior Note documented R69 could be heard yelling in her room. On 09/21/24 at 02:22 PM a Behavior Note documented R69 was heard yelling out in her room. On 09/21/24 at 11:52 PM a Behavior Note documented R69 could be heard yelling out in her room. R69 reported to the nurse she had outbursts and would yell out but would never scream out. R69 stated the nurse had given her an Invega injection in her hip and not in her arm, which made her hip hurt. R69 reported she thought that might have triggered her outburst. On 09/22/24 at 03:32 PM a Behavior Note documented R69 could be heard yelling out in her room. R69 reported to the nurse her outburst was related to the voices in her head and her hallucinations. R69 had reported the nurse had given her an Invega injection in her buttocks and not in her arm. R69 reported she did not get her injection in her buttocks and felt the injection had not been effective. On 09/23/24 at 08:39 AM a Behavior Note documented the nurse practitioner was notified of R69's increased reported hallucinations. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 09/25/24 at 08:48 AM an Alert Note documented the nurse would check R69's plan of care to address a possible change in condition. Consultant GG's Communication Sheet provided by the facility documented on 09/26/24, R69 had increased hallucinations noted though Consultant GG was not R69's provider. On 09/27/24 at 03:19 PM a Nurse's Note documented R69 had been self-isolating herself in the room at that time. On 09/27/24 at 04:03 PM a Nurse's Note documented a follow-up call was placed to the pharmacy related to the delivery of the antianxiety medication Buspar that had been ordered on 09/16/24. The pharmacy reported the medication would be delivered on that date. On 09/28/24 at 01:36 PM a Nurse's Note documented the Buspar was delivered, and the physician was notified and stated to administer the medication as it was ordered. On 09/30/24 at 03:49 PM a Nurse Practitioner Note documented R69 was seen for the report of increased hallucinations. R69 had reported that her hallucinations were not just audible, she felt she was being attacked during her hallucinations. Staff have reported that R69 had been isolating herself in her room. The note documented the plan was to make medication changes. On 10/06/24 at 02:50 PM a Nurse's Note documented R69 had a loud verbal outburst in her room. R69's October 2024 MAR revealed her antipsychotic medication Invega was administered on 10/08/24 which was 23 days from the previous injection on 09/14/24. On 11/18/24 at 04:16 PM, R69 sat in her wheelchair out in the front lobby. On 11/19/24 at 02:15 PM, Licensed Nurse (LN) LL stated R69's antipsychotic medication Invega was not available for administration on 09/12/24. LN LL stated she had notified the assistant director of nursing of the unavailability for administration. LN LL stated she had not notified the physician. On 11/19/24 at 02:32 PM, Administrative Nurse D stated she was aware R69's antipsychotic medication Invega had not been available for administration. Administrative Nurse D stated that R69's Invega was difficult to get filled by the pharmacy related to her insurance coverage. Administrative Nurse D stated the physician was notified and had informed the facility they could administer R69's Invega between 21 to 28 days. The facility's Medication Error policy (undated) indicated medication must be administered per the attending provider's instructions and within accepted professional standards of practice. The policy instructed staff to verify orders with the prescribing medical provider's guidance. The policy indicates the facility will complete medication monitoring on high-risk medication, monthly reviews from the pharmacy, and tracking of administration to reduce the risks of medication errors. The policy noted the facility will monitor each resident for adverse reactions related to high-risk medication. The facility failed to ensure R69 remained free of significant medication errors. This deficient practice caused R69 significant psychosocial harm as evidenced by R69 having increased auditory and visual hallucinations that caused her significant distress and risk of unnecessary medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45668 The facility reported a census of 88 residents. The facility reported they had two medication rooms, five medication arts, and two treatment carts. Based on observations, record reviews, and interviews, the facility failed to ensure appropriate storage of medications and/or biologicals. This deficient practice placed the residents at risk for unnecessary medication and administration errors and medication diversions. Findings Included: - On 11/17/24 an initial walk-through of the facility was completed with the following: At 10:05 AM an inspection of the North Unit revealed an unlocked and unsupervised medication cart (Cart #1) in the 200 Hall. An inspection of the cart revealed unsecured prescription medications, diabetic treatment supplies, and medicated ointments within the drawers. The cart's controlled substance drawer remained locked. The cart was secured by Licensed Nurse (LN) H at 10:10 AM. She stated the cart was accidentally left unlocked and should be locked when not in use. At 10:05 AM an inspection of the North Unit revealed an unlocked treatment cart (Cart #7) in the alcove of the hallway. The cart contained medicated ointments and lotions with the poison control warning of Keep out of reach of children. At 10:08 AM LN G secured the treatment cart and stated the cart was to be locked when not in use. At 10:15 AM a small medicine cup with Resident (R)1's name labeled on it was left unsupervised on top of the medication cart at the North Hall. Certified Medication Aide (CMA) UU approached the cart, secured the pill in the medication cart, and stated it should not have been left on top of the cart unsupervised. On 11/20/24 at 04:30 PM Administrative Nurse D stated the medication and treatment carts were to be locked at all times when staff walked away from them. She stated staff should never leave medication out unsupervised and within reach of the residents. The facility's Medication Labeling and Storage undated policy indicated the facility would ensure all medications and biologicals remain supervised and locked in compartments. The policy documented all medications would only be accessible to authorized personnel. The facility failed to ensure appropriate storage of medications and/or biologicals. This deficient practice placed the residents at risk for unnecessary medication and administration errors and medication diversions.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 88 residents. The sample included 26 residents. Based on observations, interviews, and record reviews, the facility failed to conduct a thorough facility wide assessment to determine the resources necessary to care for residents competently during both day-to-day operations and emergencies. This failure affected all 88 residents residing in the facility. Findings Included: - On 11/25/24 the Administrative Nurse D provided a Facility assessment dated [DATE]. A review of the assessment revealed the following: The assessment failed to identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse's Aide (CNA) needed for each unit, patient acuity, and census. The assessment lacked staffing levels required for each shift to include evenings and weekends. The assessment lacked informed contingency plans for events that do not require activation of the facility's emergency plan but have the potential to impact resident care. The Facility Assessment Addendum dated 07/31/24 indicated nursing leadership will reallocate staffing ratios and review the individual resident needs to meet the staffing requirements. The addendum also indicated the facility had a contingency plan in place for events that did not require activation of the facility's emergency plan but did not specify the plan. On 11/20/24 at 04:00 PM Administrative Nurse D stated the facility assessment was recently updated by Administrative Staff A. She stated the facility assessment should include specific staffing requirements to help identify the facility's staffing and care needs. On 11/20/24 at 04:30 PM Administrative Staff A stated the facility was updated on 11/07/24. The facility's Facility Assessment policy revised 12/2023 indicated the facility assessment will be reviewed and updated yearly and ass needed to identify the resources needed to meet the resident care needs. The policy indicated the facility assessment was to identify specific staffing needs to include contract staff, managers, directors, regular employees, and volunteers. The facility failed to conduct a thorough, updated facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. This failure affected all 88 residents residing in the facility.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41713 The facility identified a census of 88 residents. Based on observations, record reviews, and interviews, the facility failed to maintain an effective quality assessment and assurance (QAA) program to develop actions plans and monitor them to correct quality deficiencies prior to survey. This deficient practice placed the residents at risk for inadequate care. Findings Included: - The facility failed to ensure Resident (R)57 had a call light he could functionally activate for staff assistance. The facility additionally failed to ensure R66 had foot pedals on her wheelchair while being pushed. This deficient practice placed both residents at risk for preventable accidents and injuries related to unmet care needs. (Refer to F558) The facility failed to have a surety bond that covered the facility's resident trust funds. This deficient practice placed 52 residents at risk for complications related to financial loss. (Refer to F570) The facility failed to identify a fracture of unknown origin for R65 as potential abuse or neglect and report to the State Agency as required. This placed R65 at risk for unidentified and ongoing abuse, neglect, or mistreatment. (Refer to F609) The facility failed to identify R65's serious injury of unknown origin as a potential abuse or neglect situation and failed to initiate an investigation to determine the cause of the fracture. The facility failed to implement protective measures to prevent ongoing abuse while an investigation was conducted. (Refer to F610) The facility failed to provide written notification of transfer to R57 and/or their representative, with a written notice specifying the location and reason for R57's facility-initiated transfer. This deficient practice placed R57 at risk for miscommunication between the facility and resident/representative and impaired rights. (Refer to F623) The facility failed to fully complete the Comprehensive Minimum Data Set including the CAAs for R57 and R56 as required. This placed the residents at risk for impaired care and decreased quality of life due to unidentified care needs. (Refer to F636) The facility failed to ensure R66 received supportive care and services to promote and maintain her quality of life when the facility did not use communication cards to allow R66 to communicate her wants, needs, or feelings. This deficient practice placed the resident at risk for decreased quality of life, isolation, and impaired dignity. (Refer to F676) The facility failed to provide activities of daily living (ADL) care and services necessary for R57, R25, R54, and R65. This deficient practice placed the residents at risk for a decline in their ADLs. (Refer to F677) (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	The facility failed to provide consistent activities on the weekends which reflected the residents' interests, and preferences. This placed the affected residents at risk for boredom, isolation, and decreased quality of life. (Refer to F679) The facility failed to provide ongoing wound assessment for R15's pressure injury and failed to ensure R39's offloading boots were applied. This placed R15 and R39 at risk for delayed healing and increased risk for pressure ulcers. (Refer to F686) The facility failed to ensure a safe environment free from accident hazards for R185, R57, R11, R65 and R27 placing them at risk for falls and related injuries. (Refer to F689) The facility failed to ensure staff were competent when staff failed to check the order in the MAR against the actual medication dose being administered and failed to transcribe the correct dosage amount from the hospital discharge order to the MAR for R182's daptomycin. This deficient practice placed R182 at risk of unnecessary medication administration and possible adverse side effects. (Refer to F726) The facility failed to provide adequate pharmaceutical services to ensure R69 received her prescribed medication. This deficient practice placed R69 at risk of delayed treatment which could have adverse consequences. (Refer to F755) The facility failed to ensure a documented physician rationale, nonpharmacological attempts, and risk versus benefits with informed consent prior to starting an antidepressant (a class of medications used to treat mood disorders) for R66. The facility further failed to ensure an appropriate indication of use or a documented physician rationale and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat a mental disorder characterized by gross impairment in reality testing) for R25 and failed to ensure R69 had a signed consent for Caplyta (antipsychotic medication) and fluphenazine (antipsychotic medication). These deficient practices placed the residents at risk for adverse medication effects and unnecessary medications. (Refer to F758) The facility failed to ensure R69 remained free of significant medication errors. This deficient practice caused R69 significant psychosocial harm as evidenced by R69 having increased auditory and visual hallucinations that caused her significant distress and risk of unnecessary medications. (Refer to F760) The facility failed to ensure appropriate storage of medications and/or biologicals. This deficient practice placed the residents at risk for unnecessary medication and administration errors and medication diversions. (Refer to F761) The facility failed to ensure the completion of the required training for staff who provided care in the facility. This deficient practice placed the residents at risk for impaired care and decreased quality of life. (Refer to F941, F942 and F945) (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	A Memorandum to the Quality Assurance and Performance Improvement (QAPI) committee dated 10/30/24 documented that after thorough analysis and review the September data tracking would be closed. The data collected had been invaluable in identifying areas for improvement and had provided critical insights into the operational performance. In the continuous effort to enhance our quality improvement process the facility was excited to announce the revamp and rollout of a new consolidated data metrics system starting in November 2024. This new system aimed to streamline data collection and analysis processes, making it more efficient and comprehensive. On 11/21/24 at 12:45 PM Administrative Staff A stated that QAPI committee met once a month and would review the previous month(s) data. Each department head would go over any significant issues that had occurred in the last month. Administrative Staff A stated some of the ongoing issues the facility was working on was falls, wounds, medications, activities of daily living (ADLs), and care plans. Administrative Staff A stated that the facility has made many cosmetic improvements to the facility including painting of the rooms and new floors was in progress. Administrative Staff A stated the facility had made many improvements in the past four months and would continue to make improvements as warranted. The Quality Assurance Performance Improvement (QAPI) policy (undated) noted that the facility would develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI Program that was focused on indicators of the outcomes of care and quality of life for our residents. The objectives of the QAPI Program were to provide a means to measure current and potential indicators for outcomes of care and quality of life; provide a means to establish and implement performance improvement projects (PIPs) to correct identified negative or problematic indicators; reinforce and build upon effects systems and processes related to the delivery of quality care and services; and establish systems through which to monitor and evaluate corrective actions. The facility failed to identify and develop corrective action plans for potential quality deficiencies through the QAPI plan to correct identified quality issues. This deficient practice placed the residents at risk for inadequate care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41713 The facility identified a census of 88 residents. The facility identified 20 residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) and one resident on contact precautions (safeguards designed to reduce the risk of transmission of microorganisms by direct or indirect contact). Based on record review, observations, and interviews, the facility failed to ensure Resident (R)76's ventilator mask was stored in a sanitary manner, failed to implement adequate hand hygiene, and further failed to ensure the sit-to-stand lift was sanitized after resident use. These deficient practices placed the residents at risk for infectious diseases. Findings included: - On 11/19/24 at 09:13 AM R76 sat upright on her bed and ate her breakfast. R76's unbagged Trilogy mask rested directly on her refrigerator. There was no bag visible for storing the ventilator mask. R76 stated the mask was usually not stored in a bag and was not sure how often her mask was changed or cleaned. On 11/19/24 at 11:09 AM Administrative Nurse F gathered the supplies needed to do R45's wound treatments. She had two clear medication pill cups that she put Santyl (prescription ointment is used to remove damaged tissue from skin ulcers) and two more pill cups that had pre-cut pieces of calcium alginate (highly absorbent dressing) in them. Administrative Nurse F knocked on R45's door announced herself and said that she was there to do the wound treatments. Administrative Nurse F set the pill cups down on the bedside table, obtained a Chux pad (a disposable pad used as a barrier), and placed it on the bedside table. Administrative Nurse F went to the bathroom and washed her hands, obtained a gown and gloves, and donned the gown and then the gloves. Administrative Nurse F placed the four pill cups for the treatment onto the Chux pad with the other wound supplies -dressings, A & D ointment (an ointment used to protect the skin), and wound cleanser that were in R45's room. Administrative Nurse F asked R45 to turn to his right side. Administrative Nurse F placed a clean pad under R45, removed the old dressing from R45's wounds to his bottom, and threw it away in the trash. She doffed the dirty gloves, did hand hygiene with sanitizer gel then donned clean gloves. Administrative Nurse F grabbed some gauze pads and the wound cleanser, moistened the gauze pads with the wound cleanser, wiped R45's wound, and disposed of the gauze in the trash. Administrative Nurse F doffed the gloves and placed them in the trash. Administrative Nurse F performed hand hygiene and donned clean gloves. Administrative Nurse F opened a sealed swab package then obtained some Santyl onto the swab and placed it into R45 wounds. Once completed Administrative Nurse F disposed of the swab and then obtained the calcium alginate and placed it onto the wound beds. Administrative Nurse F then opened an ABD pad (large pad to absorb drainage) package applied A & D ointment onto the pad and placed the pad on top of R45's wounds. Administrative Nurse F doffed the gloves and disposed of the gloves into the trash. Administrative Nurse F failed to perform hand hygiene before she donned clean gloves to wipe R45's groin area clean. On 11/20/24 at 02:11 PM Certified Medication Aide (CMA) UU pushed the sit-to-stand into the hall. CMA UU sanitized her hands and walked away from the sit-to-stand without cleaning it. On 11/20/24 at 02:17 PM therapy personnel took the sit-to-stand to the therapy room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at 02:17 PM Certified Nurse Aide (CNA) M stated all staff were to clean equipment between residents. CNA M stated she was unsure how the Trilogy should be cleaned or stored. On 11/20/24 at 02:44 PM, Licensed Nurse (LN) H stated that shared equipment was cleaned between residents. LN H stated all respiratory equipment should have a bag, to keep masks sanitary. On 11/20/24 at 04:31 PM, Administrative Nurse D stated staff were educated to clean all equipment between residents. Administrative Nurse D stated all respiratory masks are bagged and dated. On 11/21/24 at 11:45 AM Administrative Nurse F stated hand hygiene should be performed after each glove change or when gloves were dirty or soiled. She was just in the moment and nervous and must have forgotten to do hand hygiene in between doffing and donning. The Infection Prevention and Control policy dated 12/23 documented the facility adopted infection prevention and control policies and procedures intended to help maintain a safe, sanitary, comfortable environment and to help prevent and manage transmission of diseases and infections. All personnel are trained on infection prevention and control and procedures upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The facility failed to ensure R76's ventilator mask was stored in a sanitary manner, failed to implement adequate hand hygiene, and further failed to ensure the sit-to-stand lift was sanitized after resident use. These deficient practices placed the residents at risk for infectious diseases.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 45668 The facility identified a census of 88 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required communication training. This placed the residents at risk for impaired care and decreased quality of life. Findings included: - On 11/20/24 at 10:01 AM the facility was unable to provide proof of training records for agency staff. The staff reviewed were Certified Nurse's Aides (CNA) MM, NN, OO, PP, and QQ. On 11/20/24 at 04:30 PM Administrative Nurse D stated it was difficult to get the training records from the contracted nursing agency. She stated the facility trained its employees, but it was the agency's responsibility to ensure the contracted staff had the appropriate training. The facility's Nurse Aide Qualifications and Training Requirements policy revised 08/2022 indicated the facility will ensure all staff are appropriately certified and provided education to ensure competencies are met related to knowledge of abuse prevention, infection control, resident rights, dementia care, communication, and mental health services. The facility failed to ensure the completion of the required communication training for staff who provided care in the facility. This deficient practice placed the residents at risk for impaired care and decreased quality of life.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 45668 The facility identified a census of 88 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required resident rights training. This placed the residents at risk for impaired care and decreased quality of life. Findings included: - On 11/20/24 at 10:01 AM the facility was unable to provide proof of training records for agency staff. The staff reviewed were Certified Nurse's Aides (CNA) MM, NN, OO, PP, and QQ. On 11/20/24 at 04:30 PM Administrative Nurse D stated it was difficult to get the training records from the contracted nursing agency. She stated the facility trained its employees, but it was the agency's responsibility to ensure the contracted staff had the appropriate training. The facility's Nurse Aide Qualifications and Training Requirements policy revised 08/2022 indicated the facility will ensure all staff are appropriately certified and provided education to ensure competencies are met related to knowledge of abuse prevention, infection control, resident rights, dementia care, communication, and mental health services. The facility failed to ensure the completion of the required resident rights training for staff who provided care in the facility. This deficient practice placed the residents at risk for impaired care and decreased quality of life.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 45668 The facility identified a census of 88 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required infection control training. This placed the residents at risk for impaired care and decreased quality of life. Findings included: - On 11/20/24 at 10:01 AM the facility was unable to provide proof of training or in-service records for agency staff. The staff reviewed were Certified Nurse's Aides (CNA) MM, NN, OO, PP, and QQ. On 11/20/24 at 04:30 PM, Administrative Nurse D stated that it was difficult to get the training records from the contracted nursing agency. She stated that the facility trained its employees, but it was the agency's responsibility to ensure that the contracted staff had the appropriate training. The facility's Nurse Aide Qualifications and Training Requirements policy revised 08/2022 indicated the facility will ensure all staff are appropriately certified and provided education to ensure competencies are met related to knowledge of abuse prevention, infection control, resident rights, dementia care, communication, and mental health services. The facility failed to ensure the completion of the required infection control training for staff who provided care in the facility. This deficient practice placed the residents at risk for impaired care and decreased quality of life.