STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175175	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Valley Retirement Village	1505 E Spruce Street Garden City, KS 67846

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. The facility reported a census of 45 residents. The sample included 12 residents, with two residents reviewed for discharge. Based on observation, interview, and record review the facility failed to ensure that the discharge needs were identified, and an appropriate discharge plan was created for Resident (R) 39. This placed the resident at risk for unmet care needs and inappropriate discharge. Findings included: - R39's Electronic Health Records (EHR) documented diagnoses which included surgical amputation (surgical removal of a body part), acute osteomyelitis left ankle and foot (local or generalized infection of the bone and bone marrow), cellulitis (skin infection caused by bacteria) left lower limb, morbid obesity, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), muscle weakness, unsteadiness, lack of coordination, Stage 4 pressure ulcer (a deep pressure wound that reaches the muscles, ligaments, or even bone) of the left ankle, venous insufficiency (poor circulation), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), and hypertension (HTN-elevated blood pressure). R39's 04/15/25 Modified admission Minimum Data Set (MDS) documented the resident entered the facility on 04/09/25 and the Brief Interview for Mental Status (BIMS) score was 15, indicating cognitively intact. She exhibited no behaviors and did not exhibit social isolation. R39 reported being around animals and pets, going outside when the weather was nice, participating in religious activities, and having snacks available between meals was very important to her. She required substantial/maximum assistance for toileting hygiene, dressing, applying footwear, toileting, and transfers. R39 had an indwelling catheter (a tube inserted into the bladder to drain the urine into a collection bag) and was always continent of bowel. She received scheduled pain medication and reported almost constant pain rated an eight on a 0-10 scale (zero indicating no pain and 10 the worst pain imaginable) that almost constantly interfered with day-to-day activities. She fell in the 2-6 months prior to her admission and had recent surgery requiring skilled nursing facility care which included orthopedic (bone) surgery. Her formal skin assessment revealed she was at risk for pressure ulcers/injury and the MDS noted she received pressure-reducing devices as well as a turning and repositioning schedule. She had a surgical wound, applications of ointments/medications other than to her feet, and received opioids (narcotic pain medication), antibiotics, and antiplatelet (medications used to prevent blood clotting) medications. The resident participated in her assessment and expressed a desire to be discharged from the facility with the overall goal of returning to the community. The MDS noted referrals were not made to the local contact agency due to a discharge date three or fewer months away. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Cognitive Loss/Dementia Care Area Assessment and Referral to the Community Care Area Assessments (CAA) dated 04/21/25 did not trigger. The Functional Abilities/Mobility CAA dated 04/21/25 documented the resident required varying levels of assistance with her activities of daily living (ADLs) following a recent hospitalization. She was working with therapies for strengthening and endurance and staff would continue to assist the resident with her daily care. R39's Care Plan dated 04/23/25 with an initial care plan entry of 04/09/25, directed staff to initiate discharge planning after skilled rehabilitation care. The plan noted R39's desire was to be discharged to her prior living setting. The plan directed staff to provide the resident with community resources and assess the placement setting to ensure her needs could be met. The plan directed staff to confer with the care team and her physician to determine the resident's discharge needs. R39's Care Plan lacked any updates related to her discharge plan and or progress toward discharge to the community. R39's EHR reviewed from 04/09/25 through 06/12/25 lacked Social Service admission Notes, Social Service Progress Notes, and/or Discharge Plan or other evidence of discharge planning. On 06/10/25 at 01:24 PM, R39 sat in her recliner with her feet elevated. Her wound dressings were intact extending from below her left knee to her toes. She reported she was going to leave the facility even if it was against medical advice. She reported she had not agreed to stay in the facility for long-term care and no one would give her information about when Medicare would stop paying for her care. R39 stated she only received a thousand dollars a month and she could hardly live on that amount in the community, where she lived in a recreational vehicle (RV) park, which included her utilities. The resident stated she had to get out the minute Medicare stopped paying for her care because she could not afford to lose her Medicaid payment to the facility. She stated she had a support dog for panic attacks and the dog was staying with her friend in Nebraska while she received care in the facility. Upon inquiry, she stated no one was assisting with helping her make arrangements to be discharged from the facility. She reported her RV needed repair and that she needed to have the expanded part moved into the RV, and the blocks removed so she could hook her truck to the RV and pull it to Nebraska to live where her friend lives. She stated she did not necessarily want to move to Nebraska and would like to stay in Kansas. R39 reported she would not qualify for public housing because she was a felon with a drug record from 20 years ago and public housing would not allow her service animal. R39 said staff kept telling her she could stay at the facility, but that was not something she would agree to. The resident reported she could not have her dog at the facility, and she was going to leave against medical advice (AMA) if needed. R39 said the facility would not give her a discharge date in order to plan for help. She stated she feared losing everything. She said she felt the facility was like a prison and reported she had been in prison from 2001 through 2003, so she knew what she was talking about. She repeatedly stated she would not stay one day longer than Medicare would pay and she had informed the facility of that from day one. R39 reported her foot and leg would take a long time to heal, but she has changed the dressing herself prior to hospitalization and she would again. She reported she had home health come out and change dressings and it was the home health nurse who sent her to the hospital. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/25 at 11:43 AM, Social Service X confirmed R39 had informed the facility staff she wanted to be discharged back to the community upon her admission. Social Service X reported she was responsible for discharge planning, social service progress notes, and updating care planning related to discharge planning. She confirmed R39's clinical record lacked Social Service admission Notes, Social Service Progress Notes, and/or Discharge Plan. Social Service X reported she should have completed her documentation regarding the resident's discharge plan and the challenges she faced trying to successfully discharge R39 back to the community. She reported the resident was not making progress with therapy so the facility would issue her a beneficiary notice regarding the end of skilled services due to the resident no longer meeting skilled criteria. Social Service X reported she was not aware the resident was a felon and would not qualify for public housing. On 06/12/25 at 09:03 AM, Administrative Staff A confirmed the above findings and reported he was not aware that social services notes and/or a discharge plan for R39 had not been completed. He stated discharge planning should be initiated on the day of admission and documentation updated to keep up with the resident's progress and goals. Administrative Staff A stated he expected the social service staff to keep the residents informed of timelines in their care and assist the residents with setting up necessary services for a successful discharge home. He stated he was aware that R39 wanted to be discharged to Nebraska. The facility policy Discharging the Resident, dated 01/2025, documented the purpose of the procedure is to provide guidelines for the discharge process. The resident should be consulted about the discharge Discharges can be frightening to a resident. The policy did not address the discharge planning process.

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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. The facility reported a census of 45 residents with 12 residents sampled. Based on observation, interview, and record review, the facility failed to ensure that Resident (R) 43 received services to maintain his abilities of activities of daily living (ADL). This deficient practice placed the resident at risk for a decrease in functional abilities and decreased independence. Findings included: - R43's Electronic Health Record (EHR) included diagnoses of unspecified dislocation of the right shoulder, muscle weakness, and unsteady gait. R43's 07/11/24 Annual Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R43 had impairment of the upper extremity on one side. R43 was dependent on staff for toileting, transfers, showering, dressing, footwear, personal hygiene, and bed mobility. The MDS documented R43 was independent with wheelchair mobility. R43's 07/18/24 Functional Abilities Self-Care and Mobility Care Area Assessment (CAA) documented R43 had impaired mobility and weakness, and required staff assistance to complete ADL; staff would assist as needed with all ADL. R43's 03/28/25 Quarterly MDS documented a BIMS score of 15. The MDS documented R43 had impairment of the upper extremity on one side. R43 was dependent on staff for toileting, transfers, showering, dressing, footwear, personal hygiene, and bed mobility. The MDS documented R43 was independent with wheelchair mobility. R38's Care Plan documented on 07/21/23 refer to therapy as needed. The care plan dated 06/10/25 lacked any instructions for the staff to ambulate the resident. R43's 01/10/25 Physical Therapy Encounter Note documented R43's received gait training with a front wheeled walker and minimal assist of two. R43 was able to advance his right lower extremity with some circumduction (a body movement where the distal end of a limb or body part describes a circle while the proximal end remains relatively fixed) for 15 feet one time, without a loss of balance. R43's 01/13/25 Physical Therapy Encounter Note documented R43 received gait training with a front-wheeled walker and minimal assistance from the therapist for 25 feet, one time. R43's 01/16/25 Physical Therapy Encounter Note documented R43 received gait training with a front-wheeled walker and minimal assistance from two therapists; R43 ambulated 10 feet three times. R43's 01/16/25 Physical Therapy Note documented R43's new goal was to safely ambulate on a level surface for 100 feet using a front wheeled walker and a right ankle and foot orthoses (AFO- an external device fitted to the body, used to prevent a physical deformity, stabilize a joint or joints, reduce pain. improve mobility or performance) with minimal assist. The note recorded R43's baseline was 20 feet. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R43's 02/07/25 Physical Therapy Encounter Note documented R43 performed gait training with a front-wheeled walker and minimal assistance of two for 18 steps with the wheelchair following him. R43's 02/10/25 Physical Therapy Discharge Summary documented R43 ambulated 20 feet with minimal assistance 90 percent of the time. R43's prognosis to maintain his current level of function was good with consistent staff follow-through. The summary documented R43's discharge recommendation was to remain a long-term resident. The discharge summary lacked any recommendations to nursing to continue the current level of ambulation. R43's EHR lacked evidence of a formal or informal walking program or restorative activity. During an observation on 06/09/25 at 03:04 PM, R43 was in the lounge working on a cycle machine and requested to converse later. During an observation on 06/11/25 at 08:15 AM, R43 propelled himself backward in his wheelchair to the 300 hallway from the dining room. On 06/10/25 at 08:20 AM, R43 reported that he should be receiving therapy but he was not, and he wanted to know why. He reported that when he asked staff why not, he never received a reason. He reported that he had been walking in therapy in February and had walked since therapy was discontinued. On 06/10/25 at 03:16 PM, Certified Nurse Aide (CNA) N reported the facility had a Restorative Aide but was not sure who it was. CNA N reported that she would only complete exercises or ambulation for a resident if she was asked to do it, and the resident's care plan had the directions for what was required. CNA N reported that she did not know if R43 ever ambulated. On 06/10/25 at 03:19 PM, Certified Medication Aide (CMA) T reported that the facility did have a restorative aide, and all the CNA/ CMAs were responsible for completing any ambulation, or range of motion for the residents. CMA T verified the information should be on the care plan. CMA T reported that R43 could not ambulate. On 06/10/25 at 03:25 PM, Licensed Nurse (LN) H reported that CNA/CMAs were responsible for completing any range of motion exercises including ambulation for the residents that required this if it was care planned. LN H reported that R43 could not ambulate and stated he required a sit-to-stand lift. On 06/11/25 at 07:59 AM, Therapy Staff JJ reported the facility did not have an exercise program for the residents once they were discharged from therapy services. Therapy Staff JJ reported the nursing staff was required to apply splints, perform exercises, range of motion, and ambulate the residents. Therapy Staff HH reported the Physical Therapist wrote recommendations to nursing for what the staff would need to complete to maintain the resident's level of function. Therapy Staff JJ reported if a resident had a decline in ADL, the therapy department was notified by nursing and an evaluation was ordered. Therapy Staff JJ said the therapist would not know if the resident had a decline if nursing did not let them know. On 06/11/25 at 01:01 PM, Therapy Staff HH reported that R43 had asked for therapy recently and she reported that R43 had not declined so he would not qualify for therapy. Therapy Staff HH reported that R43's discharge therapy notes were not accurate. Therapy Staff HH reported R43 really did not ambulate in therapy in January and February 2025. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/25 at 09:53 AM, Administrative Nurse D reported R43 received skilled services including therapy from November 2024 through February 2025. Administrative Nurse D reported nursing received a recommendation from therapy when a resident was discharged . She reported she was not aware that R43 could ambulate in therapy and did not receive any recommendations from therapy after R43 was discontinued from therapy. Administrative Nurse D reported that nursing did receive the discharge note from therapy. The facility's policy Activities of Daily Living (ADLS) Supporting dated March 2018 documented residents would be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. Including appropriate support and assistance with mobility (transfer, ambulation, including walking), Interventions to improve or minimize a resident's functional abilities would be in accordance with the resident's assessed needs, preferences, stated goals, and recognized standards of practice.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. The facility reported a census of 45 residents. The sample included 12 residents with one dependent resident reviewed for activities of daily living (ADLs). Based on observation, interviews, and record review the facility failed to provide ADL care including grooming of facial hair for Resident (R) 45. This placed the resident at risk for impaired dignity and poor hygiene. Findings included: - R45's Electronic Health Record (EHR) revealed diagnoses of a need for assistance with personal care, muscle weakness, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) R45's 12/24/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R45 had no depression and no behaviors. The MDS documented R45 had lower extremity impairment on one side. The MDS documented R45 was dependent on staff for dressing, footwear, and transfers and required maximal assistance for bed mobility, sit-to-stand, personal hygiene, and bathing. R45's 01/07/25 Functional Abilities Self-Care and Mobility Care Area Assessment (CAA) documented R45 triggered related to the residents need for assistance with his daily cares. Staff would continue to provide care and support in residents daily needs encouraging independence as appropriate while maintaining safety with cares. R45's 04/25/25 Quarterly MDS documented a BIMS score of 15. The MDS documented R45 had no depression or behaviors. The MDS documented R45 had lower extremity impairment on one side and was dependent on staff for dressing, footwear, and transfers; he required maximal assistance for bed mobility, sit-to-stand, personal hygiene, and bathing. R45's Care Plan documented on 01/05/24 directed staff to shave R45 on bath days and as needed. R45's Personal Hygiene Tasks documented that R45 required maximal assistance or was dependent on staff for hygiene tasks. R45's Bathing Task documented R45 received bathing on 06/03/25 and 06/06/25. On 06/09/25 at 02:09 PM, R45 reported that he should be shaved at least once a week. R45 had prominent beard growth on his face with irregular borders and a mustache. R45 reported the staff would have to shave him because he could not do it himself. R45 said he liked to be clean shaven but he could not recall the last time he was shaved. On 06/10/25 at 05:05 PM, R45 sat in the dining room for supper. Observation revealed prominent beard growth on his face with irregular borders and a mustache. On 06/12/25 at 08:01 AM R45 was in dining room finishing breakfast. His facial hair remained. R45 reported again that he preferred to be clean shaven. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/25 at 10:55 AM, R45 sat in the lobby. His facial hair was removed. R45 smiled and said it felt good. On 06/11/25 at 03:04 PM, Certified Nurse Aide (CNA) M reported that the staff followed the shower list and provided bathing to residents on the list. CNA M said sR45 was on the shower list for Tuesday and Fridays during the day shift. On 06/11/25 at 03:25 PM, CNA M reported if a resident asked to be shaved, she would shave them. CNA M reported staff would shave residents on their shower days or when the resident asked. On 06/11/25 at 03:27 PM, Licensed Nurse (LN) G reported after the CNA gave a bath, the LN checked to see if the residents were shaved and if they were not, the LN staff would shave the residents because the CNA staff were quite busy. During an interview on 06/12/25 at 09:20 AM, Administrative Nurse D reported if the residents had no cognitive issues, they could request a shave on their scheduled shower days, and she expected staff would shave any of the residents including residents that were confused. Administrative Nurse D reported she expected staff to shave a resident daily and as needed if they requested that as part of their care. Administrative Nurse D reported that R45 generally would not talk a lot and did not complain. The facility's policy Activities of Daily Living (ADLS) Supporting dated March 2018 documented residents would be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs including appropriate support and assistance for hygiene (bathing, and grooming).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The facility reported a census of 45 residents, with 12 residents sampled. Based on observation, interview, and record review, the facility failed to ensure an environment free from accident hazards when the facility failed to identify and change ineffective fall interventions and failed to fully implement all interventions aimed at preventing falls for Resident (R) 38, who had multiple falls. This deficient practice placed R38 at risk for further falls and related injuries. Findings included: - R38's Electronic Health Record (EHR) included diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) and hemiparesis/hemiplegia (weakness and paralysis on one side of the body). R38's 09/06/24 Annual Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The MDS documented R38 utilized a wheelchair for locomotion and required moderate assistance for the application of footwear, dressing, bathing, and toileting. The MDS documented R38 required supervision for standing. The MDS documented R38 was occasionally incontinent of the bladder. The MDS documented R38 had one non-injury fall since the previous assessment. R38's 09/10/24 Fall Care Area Assessment (CAA) documented R38 had impaired mobility, weakness, use of an antidepressant (a medication used to treat mood disorders), a history of falls, and was at risk for falling. The CAA noted staff assisted R38 with all activities of daily living (ADL) as needed. R38's 03/03/25 Quarterly MDS documented a BIMS score of 10, which indicated moderately impaired cognition. R38's 04/26/25 Quarterly MDS documented a BIMS score of five, which indicated severely impaired cognition. The MDS documented R38 had inattention, was easily distractible, or had difficulty keeping track of what was said, continuously. R38 had one non-injury fall, one fall with injury, and one fall with major injury since the previous assessment. R38's Care Plan dated 09/30/22 documented R38 was at risk for falls related to poor safety awareness, and unsteady balance and gait and included the following interventions: 09/30/22: The staff would ensure R38's environment was clutter-free and free from spills and/or clutter. The staff were to ensure adequate lighting and ensure the resident's personal items were within reach. Staff would ensure the call light was within reach and encourage use. Staff would provide appropriate footwear when transferring and ambulating R38. R38 required the assistance of one staff for dressing. 08/24/23: The staff placed Dycem (a non-slip mat used for stabilization and gripping to prevent slipping) in R38's wheelchair under the cushion to prevent the cushion from sliding. 08/27/23: The staff provided gripper socks to R38 to use when she was in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/13/23: The staff educated R38 to keep appropriate footwear on at all times while transferring. 12/10/24: The staff encouraged R38 to utilize non-skid socks and/or appropriate footwear when transferring. 03/21/25: R38 went to the hospital for evaluation, with an Ace wrap and splint applied to her left forearm. The plan documented R38 stated she would call for help with all transfers from then on. R38's Fall Risk Tool on 08/27/23, 10/13/23, 12/20/23, 06/08/24, 07/28/24, 12/20/24, and 01/13/25 recorded R38 was at moderate risk for falls. R38's Fall Risk Tool on 12/22/23 and 03/20/25 recorded she was at high risk for falls. The Fall Note dated 10/13/23 at 05:40 PM, documented R38 sat on the floor next to her bed and wheelchair. R38 reported that she was changed into her pajamas and nonskid socks. The note said R38 told staff she slipped and landed on her bottom while she looked for her hat. The note documented R38's wheelchair was locked, and the resident did not have on nonskid socks. R38 was educated on the importance of keeping non-skid socks or proper footwear when transferring or ambulating. The note documented R38 was encouraged to use the call button for assistance. The Fall Note dated 12/20/23 at 01:30 AM, documented staff heard R38 yelling and found R38 next to her bed sitting on the floor. R38 had no shoes or socks on, the wheelchair was next to her and locked, and the call light was on at the time of the fall. Staff had just left the area of the resident's room. The note documented R38 reported she slid and sat on the floor. The note recorded a fall intervention as staff reminded R38 to wear shoes or nonskid socks. The Fall Note dated 06/08/24 at 01:19 PM, documented R38 sat up on the floor, near the restroom doorway with her legs outstretched in front of her; she had bare feet. R38 reported she needed to go to the bathroom and the wheelchair was too far away from her bed. The note recorded the fall intervention was staff encouraged R38 to use her call button and wear slippers or nonskid socks during ambulation or transfers; the wheelchair was to be placed within reach of the resident, as she has a history of not using her call button. The Fall Note dated 07/27/24 at 09:52 PM, documented R38 sat up against her bed with her legs stretched out towards the television; R38 reported her wheelchair started to move so she placed herself on the floor. The note documented staff removed R38's wheelchair and provided her with a working wheelchair. The Fall Investigation Report dated 07/29/24 documented R38 sat on the floor when her wheelchair slipped during a transfer. The report documented the root cause analysis was the wheelchair was not locked before R38 attempted to transfer. The report noted wheelchair brake extenders were ordered to add to R38's wheelchair and her plan of care was updated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Fall Note dated 12/10/24 at 10:45 AM, documented R38 sat on the floor in front of her bed, her wheelchair was locked, and her call light was not on. R38 had regular cotton socks on. The note recorded R38 said she was getting out of bed and into her wheelchair to go to the restroom and she said she did not wear her slippers because she did not think she would slip. The note recorded the fall intervention was staff encouraged R38 to use her call button for assistance with toileting and staff applied nonskid socks. Staff encouraged R38 to always use nonskid socks or slippers when transferring or ambulating. The Progress Note dated 12/11/24 at 11:17 AM documented R38 expressed a desire to participate and receive therapy services; she wanted to walk again. The note documented R38 had a recent fall without injury, and she was agreeable to receive therapy services and agreeable to commit to therapy schedule. The Progress Note dated 12/11/24 at 11:35 AM documented the facility submitted for authorization with the resident's insurance company for therapy services. The Physician Orders dated 12/12/24 at 10:13 AM, directed physical therapy to evaluate and treat. R38's EHR lacked evidence the above PT evaluation was completed for R38. The Fall Note dated 01/13/25 at 03:28 PM, documented R38 screaming from her room. R38 was in a praying position on her knees in front of her bed and reported she was trying to put her clothes on. The note documented an intervention in which staff applied nonskid socks and educated R38 on the importance of wearing them. Staff encouraged R38 to always call for help when changing clothes or getting ready. The Fall Note dated 03/20/25 at 10:06 PM, documented R38 yelled from her room and was observed seated upright on the floor with her face covered in blood. R38 reported she transferred herself from her wheelchair to her bed and thought she could make it without assistance. R38 went to the hospital. The Progress Note dated 03/21/25 at 01:10 AM, documented R38 returned from the hospital with sutures for a right forehead laceration (cut) and a fracture of the fourth metacarpal (bone of the hand) of her left hand; she had a splint and ace wrap on her left forearm. The Fall Investigation Report dated 03/21/25 documented R38 reported she transferred herself from her wheelchair to her bed and thought she could make it without assistance. The report noted R38 removed her shoes and nonskid socks before transferring herself. R38 denied harm and reported she was the only one in the room when she fell. The intervention documented R38 went to the hospital for an evaluation and received an ace wrap and splint for her left forearm. R38 reported she would now call for help with all transfers. During an observation on 06/09/25 at 02:49 PM, R38 started to cry and reported that she had a funny feeling the facility was going to keep her permanently and said she had an apartment she wanted to go back to. R38 reported she wore a splint on her left hand and had four broken bones but she could not recall what happened. Further observation revealed R38's wheelchair lacked a Dycem pad, wheelchair brake extenders, or anti-roll back appliances. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/11/25 at 12:20 PM, R38 remained in bed. She reported she just did not feel well. Further observation revealed a wheelchair with the brakes locked sat next to her bed but there was no Dycem, or brake extenders noted on the wheelchair. During an observation on 06/12/25 at 10:35 AM, R38 sat in her wheelchair. Further observation revealed the wheelchair lacked brake extenders. On 06/09/25 at 04:52 PM, R38's representative reported that R38 had been very confused for about a year. On 06/11/25 at 02:13 PM, Certified Nurse Aide (CNA) M reported she was not sure if R38 should have Dycem on her wheelchair but said it would be on the care plan if she needed if. CNA M then reported the Dycem must have gone to laundry. On 06/12/25 at 10:40 AM Administrative Nurse D reported if there was a concern with R38's wheelchair, the concern may have been placed in the Technology, Solutions, and Services for Building Management system (TELS- a technology-based system focused on optimizing building operations by offering solutions for life safety, asset management, maintenance, and repair services to building management professionals) for maintenance staff to address. On 06/12/25 at 10:24 AM, Maintenance Supervisor U reported he completed quarterly maintenance checks of the facility's wheelchairs, and said TELS would send him an alert to have the task completed in March, June, September, and December. On 06/12/25 at 10:50 AM, Certified Medication Aide (CMA) S reported R38 had never had brake extenders on her wheelchair. CMA S reported all staff had access to TELS to report concerns. On 06/11/25 at 02:13 PM, CNA M reported that R38 would not be able to remember to use the call light or not get up by herself since she started here about four months ago. CNA M said R38's confusion had gotten worse. On 06/11/25 03:34 PM, CMA S reported that R38 had increased confusion for over a year and that the resident would not remember to call staff for assistance. On 06/12/25 at 11:13 AM, Administrative Nurse D reported she was not the Director of Nursing in July 2024 but said the brake extenders should have been placed on R38's wheelchair and on the care plan. On 06/12/25 at 11:17 AM, Maintenance Supervisor U reported he did not have a report to show wheelchair maintenance was completed and said he did not have time to look at every wheelchair in the facility as he was the only maintenance personnel. He reported he could not recall placing brake extenders on R38's wheelchair and he could not locate that request in TELS. On 06/12/25 at 08:30 AM, Therapy Staff HH reported she was not able to locate any documentation for a therapy evaluation for R38. Therapy Staff HH reported she would receive an order from nursing for an evaluation, then the business manager would check for insurance and then the evaluation would be completed. Therapy Staff HH reported she had no evaluation or any notes for R38 in the computer or papers filed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/25 at 08:35 AM, Therapy Staff JJ reported if R38 refused therapy, a form would be filed in the business office. On 06/12/25 at 08:45 AM, Business Office Manager (BOM) KK reported she had no documentation in R38's EHR or a paper file for a therapy evaluation in December 2024. BOM KK reported R38 had different insurance in December 2024 and R38 would have had a co-pay for insurance. BOM KK reported that R38 refused to pay the co-pay and recalled that R38's family member who assisted in decision making would follow R38's decision and not pay for therapy. BOM KK reported she did not document this conversation. On 06/12/25 at 09:28 AM, Administrative Nurse D reported she expected staff to document when a resident refused any treatment, therapy, or medication order prescribed by a physician in the EHR or the therapy form that R38 refused to pay her co-pay for therapy. On 06/11/25 at 04:06 PM, Licensed Nurse (LN) G reported that R38 would not always remember to call staff for assistance. LN G said all residents should always have their fall interventions in place. On 06/12/25 at 09:28 AM, Administrative Nurse D reported R38 had attention-seeking behavior when first admitted . Administrative Nurse D reported R38's cognition became more impaired and confirmed R38's fall interventions could have been different to prevent falls because the resident would not remember the education provided and she expected staff to implement all fall interventions. The facility's policy Fall Guidelines - Assessing Falls and Their Causes dated October 2010 documented the purpose of this procedure are to provide guidelines for assessing a resident after a fall to assist staff in identifying caused of the fall. The facility's policy Assistive Devices and Equipment dated January 2020 documented the facility maintains and supervised the use of assistive devices and equipment for residents. Devices are documented in the residents' care plan.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 45 residents, with 12 residents sampled. Based on observation, interview, and record review, the facility failed to provide adequate care and services for Resident (R) 41's peripherally inserted central catheter (PICC-a thin, flexible tube that is inserted into a vein in the upper arm and threaded into a large vein above the heart) when staff failed to perform the PICC dressing change every five days and failed to label the antibiotic medication that was administered. These deficient practices placed R41 at risk for complications related to the PICC line and medication administration via the PICC. Findings included: - R41's Electronic Health Record (EHR) included diagnoses of cellulitis (skin infection caused by bacteria) of the buttock, paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), and pressure ulcer (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) Stage 4 (a deep pressure wound that reaches the muscles, ligaments, or even bone). R41's 04/26/25 Annual Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R41was dependent on staff for toileting, lower body dressing, footwear, and transfers. The MDS documented R41 required maximal assistance with showers and bed mobility. The MDS documented R41 had one pressure ulcer Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) not present on admission. R41's 04/30/25 Functional Abilities Self-Care and Mobility Care Area Assessment (CAA) documented R41 required varying levels of assistance with his activities of daily living (ADL) related of paraplegia. Staff would continue to assist resident with his daily care. R41's EHR documented Entry Tracking Record MDS which documented R41 readmitted to the facility from the hospital on [DATE]. R41's Care Plan dated 06/05/25 instructed the Licensed Nurse (LN) to change the PICC line dressing every five days. The plan instructed staff to observe and report concerns of infection or changes in length (of the PICC) to the physician. The plan instructed staff to administer medications as ordered and educate the resident regarding infection prevention as indicated. Staff were to monitor for signs and symptoms of infection, including fever, chills, nausea, vomiting, and pain every shift and notify the physician of adverse effects from the antibiotics. R41's Physician Orders ordered Vancomycin (antibiotic) intravenous (IV-administered directly into the bloodstream via a vein) solution reconstituted 1.5 grams, give 1.5 grams intravenously two times a day for wound abscess (cavity containing pus and surrounded by inflamed tissue) until 07/18/25, date ordered 06/10/25. R41's Physician Orders ordered PICC line dressing. Change sterile dressing every five days and as needed. May use sterile dressing kit, date ordered 06/06/25. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R41's 06/05/25 at 03:35 PM Progress Note documented R41 had a PICC line to his left arm and received Vancomycin IV twice a day for 42 days. Last administration was on 06/05/25 at 11:24 AM. R41's EHR, Medication Administration Record, and Treatment Administration lacked any documentation that R41's PICC line dressing was changed. During an observation on 06/09/25 at 02:30 PM, R41 reported he was on an antibiotic but was not sure why; he was in the hospital recently for kidney stones and had surgery. Observation revealed R41's PICC line dressing on his left arm was intact and dated 06/03/25. During an observation on 06/10/25 at 10:30 AM, R41 had IV Vancomycin 1.5 grams infusing into his PICC line. The IV bag had no label containing the resident's name, amount and route to be administered, date and time prepared, or expiration date. During an observation on 06/10/25 at 03:36 PM. Administrative Nurse D completed R41's PICC line dressing. She verified the date on old dressing was 06/03/25. Administrative Nurse D said she expected staff to change the dressing per the physician orders and reported the PICC line dressing should have been completed on 06/08/25, and said it was two days late. On 06/10/25 at 10:32 AM, LN H reported that she had just hung the bag of Vancomycin and confirmed she did not label the bag as there was no label for it when she prepared the bag. LN H reported she would go back down to R41's room and label the bag with a marker. LN H reported that a Registered Nurse would complete the PICC line dressing as it was out of her scope of practice. The facility's policy Central Venous Catheter Care and Dressing Changes dated March 2022 documented the purpose of this procedure is to prevent complications associated with IV therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. A physician's order is not needed for this procedure.

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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. The facility reported a census of 45 residents. The sample included 12 residents with five residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to implement provider orders based on the Consultant Pharmacist's (CP) monthly medication review (MRR) and ensure an MRR review system that mitigated duplication or omissions for Resident (R) 38. The deficient practice placed the resident at risk of receiving unnecessary medications. Findings included: - R38's Electronic Health Record (EHR) included diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) and major depressive disorder (a major mood disorder that causes persistent feelings of sadness). R38's 09/06/24 Annual Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of nine, which indicated moderately impaired cognition, and noted R38 had no behaviors. The MDS documented R38 utilized a wheelchair for locomotion and required moderate assistance for the application of footwear, dressing, bathing, and toileting. The MDS documented R38 received an antidepressant (a class of medications used to treat mood disorders). R38's 09/10/24 Cognitive Loss Care Area Assessment (CAA) documented R38 had moderate vascular dementia with other behavioral disturbances. The CAA lacked the analysis and care plan decisions. R38's 09/10/24 Psychotropic Drug Use CAA documented R38's use of an antidepressant and risk for adverse effects. R38's 04/26/25 Quarterly MDS documented a BIMS score of five, which indicated severely impaired cognition. The MDS documented R38 had inattention, was continuously easily distractible, or had difficulty keeping track of what was said. The MDS documented R38 received an antidepressant, an opioid (a class of controlled drugs used to treat pain), and an antibiotic (medication used to treat bacterial infection). R38's Care Plan dated 12/15/22 directed staff to administer medications as ordered and review black box warnings located under the orders tab next to the medications on the medication administration record. The plan directed staff to monitor for antidepressant medication side effects such as dry mouth, nausea, blurred vision, drowsiness, constipation, urinary retention, hypotension (low blood pressure), appetite changes, headache, insomnia (inability to sleep), and sedation. The plan instructed staff to monitor routinely for possible dose reduction. An update dated 05/19/25 documented a gradual dose reduction (GDR) of R38's antidepressant was not successful. R38's Physician Orders dated 05/02/25 documented venlafaxine HCl oral tablet (antidepressant) 100 milligrams (mg), give 100 mg by mouth, one time a day related to major depressive disorder. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 03/23/25 CP MRR documented R38 had been taking venlafaxine 150 mg daily for about a year and a half. Federal guidelines required periodic reviews to find the lowest effective dose. The CP asked if it was appropriate to try a reduction to 75 mg when R38's current supply ran out. R38's Progress Notes on 3/24/25 at 10:02 AM, documented a fax was sent to R38's physician reporting R38 had been taking venlafaxine 150 mg daily for about a year and a half and indicated the guidelines and recommendation from the 03/23/25 MRR. The note documented staff awaited a response. On 03/25/25 R38's physician extender responded, on the 03/23/25 MRR, in writing to decrease the venlafaxine to 75 mg daily due to the federal guideline requirement; a prescription was sent to pharmacy. R38's EHR lacked evidence staff acknowledged and acted on this order on 03/25/25. R38's Medication Administration Record documented the venlafaxine order was reduced to 75 mg daily on 04/12/25. The EHR lacked a progress note for the medication change. On 04/16/25 R38's physician responded on the 03/23/25 MRR in writing and checked the box indicating the physician disagreed with the recommendation. The physician documented on the MRR and wrote previous attempts to GDR R38's antidepressant were unsuccessful and made the resident more despondent. R38's Progress Note on 05/02/25 at 02:09 PM, documented staff faxed the physician to clarify the dose of venlafaxine following gradual dose reduction recommendations form pharmacy. R38's Progress Note on 05/02/25 at 04:17 PM, documented that staff received a new order from the physician to increase the venlafaxine to 100 mg by mouth daily for depression. R38's Progress Note on 05/07/2025 at 04:27 PM, documented R38 hollered for help; staff assisted the resident and in 20-30 minutes, R38 hollered out again. The note documented the behavior was repetitive that afternoon. During an observation on 06/09/25 at 02:49 PM, R38 cried and reported that she had a funny feeling the facility was going to keep her permanently and said she had an apartment she wanted to go back to. R38 reported she wore a splint on her left hand and had four broken bones, but she could not recall what happened. During an observation on 06/11/25 at 12:20 PM, R38 remained in bed. She reported she just did not feel well. On 06/11/25 at 02:13 PM, Certified Nurse Aide (CNA) M reported that R38's confusion had gotten worse. On 06/11/25 at 04:06 PM, Licensed Nurse (LN) G reported that she did not complete the MRR, and said that Administrative Nurse D would complete the MRR reports. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/25 at 09:28 AM, Administrative Nurse D reported that the nurse faxed the MRR to the physicians. Administrative Nurse D stated she did not understand why R38 had two separate MRR forms from two different providers regarding the GDR for venlafaxine. Administrative Nurse D reported that R38 should not have had a GDR completed as the resident had a failed GDR in the past and reported that R38 had increased behaviors recently. Administrative Nurse D said that R38 should be on the 150 mg dose of venlafaxine. The facility's Drug Regimen Review dated April 2013 documented the consultant pharmacist would monitor the ordering, storage, distribution, and use of medications in the facility. The policy lacked what nursing would complete with in regard to the MRR.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. The facility reported a census of 45, which included four residents that had physician orders for pureed diets. Based on observation, interview, and record review the facility failed to provide food prepared in accordance with recipes to ensure conservation of nutritive value, flavor, palatability, and appearance for four residents that received pureed diets. This placed the affected residents at risk for impaired nutrition and diminished enjoyment of their meals. Findings included: - On 06/10/25 at 10:39 AM observation of Dietary Staff BB preparation to pureed lunch menu items revealed the lack of recipes to provide guidance to the dietary staff to ensure the nutritional value and palatability of the food items. On inquiry, Dietary Staff BB and Dietary Staff EE confirmed they could not find recipes to instruct the cook on the preparation of pureed menu food items which included Orange Chicken, Lo Mein noodles, and apple pie. Dietary Staff BB stated she expected the staff to follow the recipes for food preparation and service to ensure the residents received the proper nutritional value of the ordered diets. She verified the facility had four residents who received pureed diets (mechanically altered food). She confirmed the current menu cycle as week four and the first day of the weekly cycle as Sunday (06/08/25, two days prior). Dietary Staff BB verified the 06/10/25 lunch menu included Orange chicken, broccoli, Lo Mein noodles, and apple pie. On 06/10/25 at 11:00 AM, during Dietary Staff FF's preparation to puree apple pie, observation revealed he lacked a recipe to provide guidance for appropriate measurements and preparation to ensure nutritional value and palatability. On inquiry, Dietary Staff FF confirmed he was not able to find the recipe for apple pie and reported he did not always use the recipes for puree food. Dietary Staff BB instructed Dietary Staff FF to remove the crust from the apple pie before pureeing. On 06/10/25 at 11:10 AM, observation revealed Dietary Staff DD pureed the apple pie using the recipe provided for apple crisp. She poured apple juice into the blender directly from the juice container without following the measurements recipe for apple crisp. Dietary Staff BB stated pie was served at room temperature. The temperature of the pureed apple pie was 80 degrees. On 06/10/25 at 11:10 AM, when asked how he knew how much he was serving in each bowl, Dietary Staff FF asked Dietary Staff DD, who responded the dessert bowls were four ounces. Dietary Staff FF stated the dessert bowls were only three-quarters full, so the serving size was probably three ounces. When asked why only three portions of apple pie were plated when the facility had reported four residents with pureed diets, Dietary Staff FF stated the fourth resident was transitioning to a regular diet and they were starting with regular dessert. On 06/10/25 at 10:49 AM, Dietary Staff EE stated she cooked Sunday (06/08/25) and could not find the pureed recipes for the menu items. She reported she did not always use the recipes to prepare the residents' meals to ensure portion sizes or nutritional value. Dietary EE stated she knew how much she usually served the residents. In an interview on 06/10/25 at 11:00 AM, Dietary Staff FF confirmed he was not able to find the recipe for apple pie and reported he did not always use the recipes for puree food. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The undated policy Standardized Recipes, documented standardized recipes will be used for all menu items, including pureed and therapeutic diets. Each recipe will include the name of the product, number of servings, ingredients, measurement and/or weight of ingredients, the procedure for assembling/method of production serving sizes, modifications for therapeutic diets if applicable, and the registered dietician will approve recipe changes or new recipes utilized for a menu item.