STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175273	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Care and Rehab	4007 E Lincoln Street Wichita, KS 67218

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 50659 The facility reported a census of 37 residents, with 12 residents sampled. Based on interviews and record review, the facility failed to ensure residents received the opportunity to participate in the care planning process when staff failed to invite Residents (R) 31, R22, R4, R6, R32, and R1 or their responsible party to care plan meetings. The deficient practice placed the residents at risk for impaired resident rights and decreased autonomy. Findings included: - During an interview on 05/12/25 at 09:00 AM, R31 reported she did not know what a care plan meeting was and had never been invited. R31's Electronic Health Record (EHR) revealed the EHR lacked any documentation of a care plan meeting conducted in the past six months. During an interview on 05/12/25 at 09:14 AM, R22 reported he had not received any care plan invites. R22's EHR lacked documentation of a care plan meeting conducted in the past six months. During an interview on 05/12/25 at 10:17 AM, R4 reported she was not invited to care plan meetings. R4's EHR lacked any documentation of a care plan meeting conducted in the past six months. During an interview on 05/12/25 at 10:42 AM, R6 reported she had never been invited to or attended a care plan meeting. R6's EHR lacked any documentation of a care plan meeting conducted in the past six months. During an interview on 05/12/25 at 11:01 AM, R32 reported he has never been to a care plan meeting. R32's EHR lacked any documentation of a care plan meeting conducted in the past six months. During an interview on 05/12/25 at 03:39 PM, R1 reported he had never been invited to a care plan meeting. R1's EHR lacked any documentation of a care plan meeting conducted in the past six months. (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/13/25 at 02:32 PM, Social Service Designee (SSD) X reported that he would send an invitation for care plan meetings. SSD X reported unfortunately the facility had no Clinical Reimbursement Coordinator (CRC) employed at the facility since October of 2024, and the CRC would be the person responsible for scheduling care plan meetings. SSD X reported he had not sent out any care plan meeting invitation to residents and or their responsible party since October of 2024. During an interview on 05/13/25 at 02:42 PM, Administrative Nurse D reported she expected the care plan meetings to be held per facility policy. The facility's policy Resident/Family Participation - Assessment Care Plans dated 10/2024 documented that each resident and his/her family members are encouraged to participate in the development of the resident's comprehensive assessment and person-centered care plan. The resident and or his/her representative, are invited to attend and participate in the resident's assessment and care planning conference.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 50659 The facility reported a census of 37 residents, with 12 residents sampled for advanced directives (a written document, which indicates the medical decisions for health care professionals when the person cannot make their own decisions). Based on interview and record review, the facility failed to ensure one resident's advanced directives were thoroughly completed when Resident (R)7 had a do not resuscitate (DNR- or no code, a legal document or order that means the person does not desire resuscitative measures) which was only signed by a physician rendering it invalid. This placed the resident at risk for an impaired right to have advance directives honored. Findings included: - R7 's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion) depression (excessive sadness), and anxiety. The 09/19/24 Quarterly Minimum Data Set (MDS) documented the resident had a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. R7 required total dependence to complete activities of daily living (ADL) including toileting, footwear, & personal hygiene. The MDS recorded R7 required maximal assistance with bathing, and moderate with assistance dressing, and transfers. The 03/10/25 Significant Change Minimum Data Set (MDS) documented the resident had a BIMS score of four, which indicated severely impaired cognition. R7 required total dependence with ADLs including toileting, footwear, & personal hygiene. The MDS recorded R7 required maximal assistance with bathing, and moderate with assistance dressing, and transfers. The MDS noted R7 received hospice services. The 04/04/25 Cognitive Loss/ Dementia Care Area Assessment (CAA) triggered due to R7 refused care at times with contributing factors of depression. The CAA recorded risk factors included self-care deficits, falls, incontinence, and decreased socialization. The CAA indicated the care plan would be reviewed to maintain ADLs, encourage activity participation, decrease falls, and maintain dietary intake and hydration. R7's Care Plan documented a DNR date revised 10/23/19. R7's Physician Orders documented a DNR order, date ordered 03/18/20. Review of R7's EHR revealed a hospice-based DNR form signed 08/15/19 by the physician. The form lacked a signature from the resident or resident's representative. During an interview on 05/13/25 at 11:16 AM, Social Service Designee (SSD) X confirmed that R7's DNR which was loaded in R7's EHR was incorrect, having only the physician's signature. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/13/25 at 05:01 PM, Administrative Nurse D reported that a resident should have a DNR form signed by the resident or durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to), and it should be witnessed. Administrative Nurse D verified the DNR should not just contain a physician's signature. The facility did not provide a policy for advance directives.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 37 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to promote a sanitary, homelike environment. This deficient practice had the potential for decreased psychosocial well-being and impaired safety and comfort for the affected residents. Findings include: - During an observation on the initial tour of the facility at around 07:50 AM, several patches of white plaster spots were observed on several walls and doors of the hallway walls and entrance doors to the residents' rooms. There were several chipped floor tiles noted on the floors in the residents' hallway as well. During an observation on 05/12/25 at 08:51 AM, Resident (R) 5's bathroom floor had some holes in the flooring where the concrete floor could be seen through the holes. R5's grab bar next to the toilet had frayed worn duct tape on the handle. During an observation on 05/12/25 at 03:39 PM, R1's room had a vent cover off the ceiling that was supposed to cover the air conditioning vent; the cover sat on R1's nightstand under a book. Additionally, R1 had three beds in his room. Two of the beds were not made and had a rolled-up air mattress on them. During an interview on 05/13/25 at 09:38 AM, Housekeeping Staff QQ reported that R1's vent cover had been off for about a month now and she had reported that to Maintenance Staff U. Housekeeping Staff QQ reported that the beds were not in R1's room three days ago. During an interview on 05/13/25 at 09:38 AM, R1 reported that Maintenance Staff U had put the beds in his room to store them there a few days ago. During an interview on 05/13/25 at 03:12 PM, Certified Medication Aide (CMA) S reported that Maintenance Staff U placed the beds in R1's room on 05/12/25. CMA S did not realize the vent cover laid on the nightstand stating she was not in R1's room a lot. CMA S reported the staff used to let Maintenance Staff U know of needed repairs by notifying him via an online program on the computer when a repair was needed During an interview/observation tour on 05/15/25 at 11:28 AM, Maintenance Staff U reported that he knew about the bathroom flooring in R5's room and reported that another bathroom floor in room [ROOM NUMBER] had the same concern though no resident was currently admitted to that room. Maintenance Staff U reported that he would start a job and then be told to stop and start a different job, so it was difficult to complete tasks. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview observation tour on 05/15/25 at 11:28 AM, Maintenance Staff U observed the beauty shop to have tiles missing off the wall. The baseboard was coming off the wall in the hallway by the beauty shop door. room [ROOM NUMBER] had baseboard missing and door trim for the entrance. room [ROOM NUMBER] the bathroom floor was partially painted white. Maintenance Staff U reported that he needed to wait to hear what flooring was needed for the bathroom. Maintenance Staff U reported that he placed the beds in R1's room as he had no other place to store the beds when rooms [ROOM NUMBERS] were being repaired. During an interview on 05/15/24 at 11:50 AM Administrative Staff A and Consultant Staff HH reported that they were working on a master plan to complete the environmental concerns at the facility. The facility did not provide a policy for homelike environment.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. 50659 The facility reported a census of 37 residents with 12 residents sampled. Five residents were reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure that Resident (R) 7's as-needed (PRN) antianxiety (a class of medications that calm and relax people) medication had a 14-day stop date or a specified duration which included the physician's rationale for extended use. This deficient practice placed the R7 at risk for adverse effects associated with the use of psychotropic (alters mood or thoughts) medications. Findings included: - R7 's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion) depression (excessive sadness), and anxiety. The 09/19/24 Quarterly Minimum Data Set (MDS) documented the resident had a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. R7 required total dependence to complete activities of daily living (ADL) including toileting, footwear, and personal hygiene. The MDS recorded R7 required maximal assistance with bathing, and moderate with assistance dressing, and transfers. The MDS recorded R7's behavior fluctuated and R7 had disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject) thinking. The MDS noted R7 was easily distracted and had difficulty keeping track of what was said. The MDS recorded R7 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an antianxiety, and an antidepressant (a class of medications used to treat mood disorders) medications on a routine basis. The 03/10/25 Significant Change Minimum Data Set (MDS) documented the resident had a BIMS score of four, which indicated severely impaired cognition. R7 required total dependence with ADLs including toileting, footwear, & personal hygiene. The MDS recorded R7 required maximal assistance with bathing, and moderate with assistance dressing, and transfers. The MDS recorded R7 rejected care one to three days during the look-back period. The MDS recorded R7 received an antipsychotic, antianxiety, and antidepressant medication on a routine basis. The 04/05/25 Psychotropic Drug Use Care Area Assessment (CAA) triggered due to R7's use of antidepressant, antianxiety, and antipsychotic medications to help manage psychiatric illness. The CAA noted risk factors included impaired balance, increased falls, and adverse effects of medication. The CAA indicated the care plan would be reviewed to monitor the effectiveness of psychotropic medications and any adverse effects of medication. The 04/04/25 Cognitive Loss/ Dementia Care Area Assessment (CAA) triggered due to R7 refused care at times with contributing factors of depression. The CAA recorded risk factors included self-care deficits, falls, incontinence, and decreased socialization. The CAA indicated the care plan would be reviewed to maintain ADLs, encourage activity participation, decrease falls, and maintain dietary intake and hydration. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's Care Plan documented interventions on 02/22/17 which directed staff to administer medications as ordered and monitor and document side effects and effectiveness. The plan directed staff to reassure R7 that medications were safe and were not tranquilizers (a drug used to make a person calmer); staff were directed to monitor behavior episodes and attempt to determine the underlying cause. The plan noted an intervention dated 11/01/18 which directed to consult with the pharmacy and physician to consider dosage reduction when clinically appropriate. The plan directed staff to administer antianxiety medications as ordered by physician and monitor and document side effects, dated 09/21/24. R7s Physician's Orders documented an order for Ativan (antianxiety medication) 0.5 milligram (mg), give 0.5mg/0.1 milliliter (ml) topically every 4 hours PRN for anxiety, date ordered 04/07/25. The order lacked a stop date. R7's Physician's Orders documented an order for lorazepam topical cream. Give 1mg/0.1ml, apply topically to the wrist, three times a day for anxiety or restlessness, date ordered 04/07/25. R7's Medication Regimen Review (MRR) dated 04/07/25 documented no irregularities noted. R7's Medication Regimen Review (MRR) dated 05/06/25 identified there was no stop date for the PRN Ativan. R7's Medication Administration Record reviewed from 04/07/25 through 05/15/25, R7 received the PRN Ativan 21 times. R7's EHR lacked evidence of a specified duration which included a physician's rationale for the PRN Ativan . During an interview on 05/13/25 at 08:29 AM, Licensed Nurse (LN) G reported that some PRN medications required a stop date but said they could not recall which medications required a stop date. During an interview on 05/15/25 at 08:15 AM Administrative Nurse D reported that she expected the nurses to obtain a stop date for as needed psychotropic medications when the order was obtained from the physician. Administrative Nurse D reported that R7 had a MRR completed on 05/06/25 and she sent the MRR to the provider, however, she needed to send it back to the provider for clarification of a stop date, which she received 05/15/25. The facility's policy Free from Chemical Restraints, Unnecessary Psychotropic Medications dated 04/2025 documented chemical restraints shall only be used for the safety and well-being of the resident and only after other alternatives have been tried unsuccessfully. The facility's policy Medication Regimen Reviews dated 02/2025 documented a review of residents with as needed psychotropic medications are limited to 14 days and if greater than 14 days the rationale for such listed in EHR.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. 50659 The facility had a census of 37 residents. The sample included 12 residents with three residents reviewed for hospitalization . Based on observation, interview, and record review, the facility failed to provide a written bed hold policy and failed to issue written notification as soon as practicable for transfers for Resident (R) 31, R32, and R1. This placed the residents at risk for impaired rights related to returning to the facility. Findings included: - R31's Electronic Health Record (EHR) documented R31 was transferred to the hospital on 12/01/24. R31's EHR lacked evidence the facility provided a bed hold notice or written notification of the transfer to R31 and/or her representative. R32's EHR documented R32 was transferred to the hospital on 11/22/24, 01/22/25, 02/10/25, 02/25/25, and 05/05/25. R32's EHR lacked evidence the facility provided a bed hold notice or written notification of the transfer to R32 and/or his representative. R1's EHR documented R1 was transferred to the hospital on 11/01/24, 11/18/24, and 12/21/24. R1's EHR lacked evidence the facility provided written notification of the transfer to R1 and/or his representative. During an interview on 05/13/25 at 03:21 PM, Licensed Nurse (LN) G reported when a resident was transferred to the hospital, the nurse would notify Social Service Designee (SSD) X. LN G reported the nurse would have the resident sign a bed hold policy form and send it with the resident. LN G reported this is not done during an emergency staff just send a blank bed hold form and SSD X took care of the residents who did not sign. LN G reported that he would send copies of the information that the hospital would need to take care of the resident, a face sheet, current orders, labs, vital signs, code status, and call a report to the hospital. During an interview on 05/13/25 at 04:24 PM, SSD X reported that if a resident had an emergent transfer, a bed hold would be completed the next business day. He stated he would call or contact by email the resident and/or responsible party and would receive a verbal bed hold. SSD X reported he would send the bed hold to get it signed and requested the form back. SSD X reported that the bed hold form does not get uploaded in the EHR, he kept the forms in a folder. During an interview on 05/13/25 at 04:34 PM, SSD X demonstrated he had a bed hold form that R31 signed on 12/01/24. During an interview on 05/13/25 at 04:38 PM, SSD had a signed bed hold form for 11/01/24 and 11/18/24 from R1's guardian. SSD X reported he could not locate a signed bed hold for the hospital visit on 12/21/24. SSD X reported that the bed hold policy was the only form that was used when a resident was transferred out to the hospital and reported he did not have to write a cost for a bed hold on the form. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/25 at 10:47 AM Administrative Nurse D stated she expected the bed holds to be completed the same day or the next business day for all residents that were transferred to the hospital. Administrative Nurse D reviewed the facility's bed hold form and reported that it was the correct form. She said that she expected the nurses to complete the transfer e-interact in the EHR every time a resident was transferred as it contained the required information per the regulations. The facility's policy Bed Hold dated 04/2025 documented the community staff shall inform the residents upon admission and prior to transfer for hospitalization (unless for an emergency) or therapeutic leave of the bed hold policy. The bed hold information will include any charges that the resident may incur as well as the time limit established by Medicaid. Bed hold days in excess of Medicaid are considered non-covered services. A resident would be required to pay for additional days. The facility's Transfer and/ or Discharge, Including Against Medical Advice, Discharge Notification dated 04/2025 documented the community has established transfer and discharge criteria based upon federal requirements.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40801 The facility reported a census of 37. The sample included 12 residents. Based on interviews and record review, the facility failed to accurately complete the Minimum Data Set (MDS) for Resident (R)22, R6 and R31. This placed the residents at risk for unidentified care needs and inadequate plan of care. Findings included: - R22's Electronic Medical Record (EMR) recorded a diagnosis dated 02/09/22 of obstructive sleep apnea (a sleep disorder characterized by periods without respirations). The Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Section O of the MDS lacked indication of the use of a continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep). The Quarterly MDS dated [DATE] under Section O lacked indication of use of the CPAP. The Physician Orders dated 07/15/23 documented R22 was to wear the CPAP at bedtime and during naps R22's Care Plan dated 05/23/24 documented R22 had altered respiratory status related to sleep apnea. The plan noted R22 used a CPAP at bedtime. On 05/13/25 at 02:30 PM Certified Nurse Aide (CNA) T verified R22 used a CPAP machine at night. On 05/14/24 at 04:53 PM Administrative Nurse D stated she expected the MDS to accurately reflect the resident's status The facility did not provide a policy on accurate MDS assessment. 50659 - R31's Electronic Health Record (EHR) revealed diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness) and cerebrovascular accident (CVA-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). The 11/01/24 Annual Minimum Data Set (MDS) documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R31 was dependent on staff for toileting activities of daily living (ADL). The MDS recorded R31 required maximal assistance with showering, lower body dressing, and transfers. The MDS recorded R31 required set up assistance for oral care. The MDS recorded R31 had adequate vision and wore eyeglasses. The MDS recorded R31 had no issues with her teeth. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 11/22/24 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R31 required staff assistance to complete ADLs. The Dental Care CAA was not triggered. The 03/26/25 Quarterly MDS documented a BIMS of 15. The MDS recorded no changes in ADLs from the previous MDS. The MDS recorded R31 had no issues with her mouth; she had adequate vision and required no device. R31's Care Plan dated 11/30/23 documented R31 had oral and dental health problems related to poor nutrition and a history of drug use. The plan directed staff to coordinate arrangements for dental care including transportation as needed and as ordered. The plan directed staff to provide R31 mouth care assistance. An intervention dated 12/01/23 documented R31 had impaired visual function related to a CVA and a left-sided visual deficit. R31's Admission assessment dated [DATE] documented R31 did not have her own teeth and no other documentation was checked on the assessment. R31 was moderately impaired with vision could only see half of visual field no device was checked off that she had any. During an interview/observation on 05/12/25 at 09:01 AM, R31 reported that no staff had asked her about being assessed by a dentist since she admitted on [DATE]. R31 reported she had a lot of bits and pieces of teeth in her mouth. Observation revealed R31 had several broken teeth on both the top and bottom. R31 reported that she requested to have an eye exam. She reported that she could not read without reading glasses and that she had never had eyeglasses at the facility. On 05/14/24 at 04:53 PM Administrative Nurse D stated she expected the MDS to accurately reflect the resident's status. The facility did not provide a policy on accurate MDS assessment. - R6's Electronic Health Record (EHR) revealed diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) and anxiety. The 02/22/25 Annual Minimum Data Set (MDS) documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS recorded R6 had received six of the seven days of insulin injections and received a hypoglycemic (a medication to control blood sugar) and used a non-invasive mechanical ventilator (breathing support delivered without inserting a tube into the windpipe). The 03/27/25 Nutritional Status Care Area Assessment (CAA) triggered due to body mass index (BMI-a calculation used to estimate body fat percentage based on height and weight) of 48. Risk factors included weight instability, impaired fluid balance, abnormal lab values, and impaired skin integrity. The CAA recorded a care plan would be maintained to address dietary and hydration status. The 11/26/24 Quarterly MDS documented a BIMS of 14, which indicated intact cognition. R6 did not receive injections, hypoglycemic medication, or use a non-invasive mechanical ventilator. R6's Care Plan dated 05/13/25 current and resolved lacked any documentation for insulin, or a non-invasive mechanical ventilator. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's Physician Orders current and discontinued lacked any documentation for insulin, or a non-invasive mechanical ventilator. During an interview/observation on 05/12/25 10:35 AM R6 was in bed and had oxygen on via her nasal cannula. She reported that she had never used anything but oxygen through a nasal cannula to help her breath. R6 also reported that she had never received insulin and was not a diabetic. On 05/14/24 at 04:53 PM Administrative Nurse D stated she expected the MDS to accurately reflect the resident's status. Administrative Nurse D reported that R6 had no diagnosis of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and had never required a non-invasive mechanical ventilator. The facility did not provide a policy on accurate MDS assessment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40801 The facility reported a census of 37. The sample included 12 residents with five residents reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to provide professional standards of care for Resident (R) 22 when staff failed to contact the physician for blood sugars greater than 400 milligrams (mg) per deciliter (dL) or lower than 60 mg/dL. This placed the resident at risk for impaired care and complications related to high or low blood sugar. Findings include: - R22's Electronic Medical Record (EMR) revealed a diagnosis dated 02/09/22 of type two 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] recorded a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS noted R22 received insulin (a medication used to treat high blood glucose)for seven days during the observation period. The Quarterly MDS dated [DATE] recorded no changes from the 12/25/24 MDS. R22's Care Plan dated 05/08/23 directed staff to monitor blood sugars as ordered, and give insulin as ordered R22's Physician Orders dated 04/20/25 ordered to notify the physician for blood sugars greater than 400 mg/dL or less than 60 mg/dl. Review of the blood sugars on 03/14/25 R22's revealed blood sugar was 418 mg/dl. The nurse's notes lacked evidence staff notified the physician. On 04/20/25 R22 had a blood glucose of 409 mg/dL. The note lacked evidence staff notified the physician. On 05/15/25 at 08:27 AM Licensed Nurse (LN) I stated the standard of practice was to document and notify the physician if the blood sugar was above 400 mg/dl. On 05/15/25 at 08:32 AM LN J said the protocol was to contact the physician for blood sugars above 400 mg/dl. On 05/15/25 at 08:20 AM Administrative Nurse D stated she expected the nurses to contact the physician for blood sugars above 400 mg/dl as per the orders. The facility policy Guidelines for Notifying Physicians of Clinical Problems guidelines are to help ensure that 1) medical care problems are communicated to the medical staff in a timely, efficient, and effective manner and 2) all significant changes in resident status are assessed and documented in the medical record.

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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. 50659 The facility reported a census of 37 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 in accordance with the resident's preferences for Resident (R) 2. This placed the resident at risk for impaired dignity and poor hygiene. Findings included: - R2's Electronic Health Record (EHR) revealed diagnoses of blindness of the right and left eye, paranoid schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and a need for assistance with personal care. The 06/20/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS recorded R2 had severely impaired vision and required no devices. The MDS noted R2 required moderate assistance for personal hygiene and maximal assistance for bathing. The 06/24/24 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) triggered for impaired functional and cognitive ability related to history of schizophrenia. The CAA noted R2 was blind and required assistance with ADLs, eating, set-up and clean-up assistance for meals, oral hygiene, personal cares, and bathing. The 02/26/25 Quarterly MDS documented a BIMS of 15, which indicated intact cognition. The MDS documented R2 required moderate assist with personal hygiene. R2's Care Plan revised on 01/12/23 directed staff to provide cueing and set up assistance with personal hygiene and oral care. R2's Personal Hygiene Task was not documented on the EHR. During an interview and observation on 05/12/25 at 11:30 AM R2 reported she required help getting around the facility at times as she had been blind since birth. Observation revealed R2 had prominent beard stubble on her chin with irregular borders. R2 reported that staff would need to take the facial hair off when they got a chance. Further observation revealed both R2's eyes had yellow crusty drainage; R2 reported staff clean her face when she gets a shower. During an observation on 05/13/25 at 10:11 AM, R2 had the same facial hair on her chin. During an observation on 05/14/25 at 07:59 AM R2 sat in the lounge. Further observation revealed R2's facial hair had been removed. R2 reported that her face felt better, and she smiled. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/14/25 at 01:24 PM, Certified Nurse Aide (CNA) KK reported that facial hair should be removed on residents' shower days or when they request it. CNA KK reported that R2 would generally not ask for her facial hair to be removed but if staff asked her if they could remove the facial hair, R2 would allow the staff. CNA KK reported some staff will shave residents and other would not. During an interview on 05/14/25 at 03:51 PM Licensed Nurse (LN) H reported that residents should be offered to have their facial hair removed on shower days and as needed or requested. He reported that R2 was blind and would not be able to see in order to remove her own facial hair. During an interview on 05/15/25 at 01:15 PM, Administrative Nurse D reported she expected staff to remove facial hair on residents during shower day, as needed, or when requested for any resident. Administrative Nurse D stated if the resident had a preference, it should be on the care plan. The facility did not provide a policy on ADL assistance for a dependent resident.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 37 residents, with 12 residents sampled. Based on observation, interview, and record review, the facility failed to develop and implement a system to ensure the presence of at least one staff certified in cardiopulmonary resuscitation (CPR- an emergency lifesaving procedure performed when the heart stops beating) for residents who desired a Full Code status (full resuscitative measures). This deficient practice placed the residents at risk for decreased quality of care and inadequate resuscitative measures. Findings included: - Review of three current staff members' CPR certificates revealed Licensed Nurse (LN) PP had a current certification from an online CPR provider, named on the card, which did not have an instructor-led hands-on skills component. Review of the transportation schedule revealed that Certified Nurse Aide (CNA) AA transported Resident (R) 32, who was a Full Code status to and from his appointments three times a week from [DATE] through [DATE]. During an observation on [DATE] at 09:45 AM, R32 returned from dialysis (a procedure where impurities or wastes are removed from the blood) with CNA AA, the transportation aide. CNA AA propelled R32 into the facility in his wheelchair from the facility van. During an interview on [DATE] at 03:23 PM, CNA AA reported she was currently CPR certified. CNA AA reported she had completed the CPR class at another facility but could not remember the exact date. During an interview on [DATE] at 10:00 AM, CNA AA reported that Administrative Staff AA would locate her CPR card. CNA AA reported that she conducted all the facility's transportation trips. During an interview on [DATE] at 12:10 PM, Administrative Staff A reported that CNA AA's CPR card had expired in [DATE]. During an interview on [DATE] at 03:53 PM, Administrative Staff A reported that he would like to provide a more complete list of staff who are CPR certified the following day. Administrative Staff A reported that most of the staff received CPR training at the facility in [DATE] and said those staff would have current CPR cards, and that information would be available on [DATE]. Administrative Staff A reported he expected at least one facility staff member on each shift would be CPR-certified and believed that the staff schedule did not have the CPR-certified staff for each shift identified on that form. During an interview on [DATE] at 10:30 AM, Administrative Staff A stated he expected staff to have a hands-on skills component when a CPR course was completed. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Cardiopulmonary Resuscitation (CPR) and Basic Life Support (BLS) dated ,d+[DATE] documented staff must maintain current CPR certifications for Healthcare Providers through a CPR provider whose training includes a hands-on session. Staff CPR certified are available 24 hours a day. This is posted in the community.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 37 residents. The sample included 12 residents with one reviewed for visual services. Based on interview and record review, the facility failed to provide visual services or facilitate access to visual services for Resident (R) 31 who had impaired visual function. This placed the resident at risk for further deterioration of vision. Findings included: - R31's Electronic Health Record (EHR) revealed diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness) and cerebrovascular accident (CVA-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). The 11/01/24 Annual Minimum Data Set (MDS) documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R31 was dependent on staff for toileting activities of daily living (ADL). The MDS recorded R31 required maximal assistance with showering, lower body dressing, and transfers. The MDS recorded R31 required set-up assistance for oral care. The MDS recorded R31 had adequate vision and wore eyeglasses. The MDS recorded R31 had no issues with her teeth. The 11/22/24 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R31 required staff assistance to complete ADLs. The Visual Function CAA was not triggered. The 03/26/25 Quarterly MDS documented a BIMS of 15. The MDS recorded no changes in ADLs from the previous MDS. The MDS recorded R31 had no issues with her mouth; she had adequate vision and required no device. R31's Care Plan dated 11/30/23 documented R31 had oral and dental health problems related to poor nutrition and a history of drug use. The plan directed staff to coordinate arrangements for dental care including transportation as needed and as ordered. The plan directed staff to provide R31 mouth care assistance. An intervention dated 12/01/23 documented R31 had impaired visual function related to a CVA and a left-sided visual deficit. R31's Admission assessment dated [DATE] documented R31 did not have her own teeth and no other documentation was checked on the assessment. R31s Physician's Orders documented an order may be seen by specialists as needed including an eye doctor of choice care as needed, date ordered 11/17/2023. R31's EHR lacked evidence the facility had offered or facilitated visual services for R31 and lacked evidence R31 had declined visual services. During an interview/observation on 05/12/25 at 09:01 AM, R31 reported that she requested to have an eye exam. She reported that she could not read without reading glasses and that she had never had eyeglasses at the facility. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/13/25 at 03:21 PM, Licensed Nurse (LN) G reported when a resident requested to see an eye doctor or a dentist, and it was not an emergency, the nurse wrote a progress note in the EHR or informed Social Services Designee (SSD) X verbally. During an interview on 05/13/25 at 03:23 PM, Certified Nurse Aide (CNA) KK, a transportation aid, reported she had not taken R31 to any appointments for dental or vision care. During an interview on 05/13/25 at 03:27 PM, SSD X reported when a resident requested to have a dental or eye appointment the facility would receive a consent form sent from the outside provider that comes into the facility to complete appointments. SSD X said residents had to sign a consent or declination, and all residents had standing orders. SSD X reported that R31 had declined services. SSD X verified they could not locate a declined consent or a progress note in R31's EHR. During an interview on 05/14/25 04:53 PM, Administrative Nurse D reported she expected all residents should have an eye exam once admitted as a baseline and as required or requested. The facility's policy Ancillary Services: Vision, Hearing, and Foot Care dated 10/2024 documented the residents would be provided the necessary care and services based on their comprehensive care plan. The SSD or Designee would assist with making vision appointments.

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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** 40801 The facility reported a census of 37 residents. There were 12 residents in the sample including two residents reviewed for respiratory care. Based on observation, interviews and record review the facility failed to provide sanitary respiratory care and services when staff failed to clean the nebulizer (a device for administering inhaled medication) after each use for Resident (R) 14 and also failed to store the continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask in a sanitary manner for R22. This placed the residents at risk for infection and increased respiratory complications. Findings included: - R14's Electronic Medical Record (EMR) dated 08/11/22 revealed a diagnosis of pneumonia (inflammation of the lungs). The Significant Change Minimum Data Set, dated dated dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate impaired cognition. The MDS noted R14 required substantial to maximal assistance with activities of daily living (ADL). The Quarterly MDS dated [DATE] noted R14 had BIMS score of 12 which indicated moderately impaired cognition. R14's Care Plan indicated R14 is at risk for delirium related to manic episodes monitor/record and report to medical physician any new onset or signs of delirium. The care plan lacked information regarding the nebulizer is not available on the care plan. R14's Physician Orders dated 04/30/25 ordered ipratropium-albuterol solution (a medication used in a nebulizer to open airways) 0.5 -2.5 milligrams/3 milliliters three times a day. During an observation on 05/12/25 at 12:05 PM R14's nebulizer was attached to the tubing on the bedside table with clear liquid in the bottom of the chamber. During a observation on 05/13/25 at 10:17 AM R14's nebulizer was still attached to the tubing the device and had not been separated and rinsed after treatment. On 05/13/25 at 02:25 PM Certified Nurses Aide (CNA) T verified R14 had nebulizer treatments and staff were to rinse the nebulizer out after each treatment. On 05/13/25 at 02:50 PM Administrative Nurse D stated she expected the nurses to makes sure the nebulizer was cleaned and stored after each use. The facilities policy on Administering Medication through a Small Volume (Handheld) Nebulizer) dated 10/24 rinse and disinfect the nebulizer equipment according to facility protocol of wash pieces with warm soapy water, rinse with hot water, place all pieces in a bowl and cover with isopropyl alcohol soak for five minutes. Wash and dry hands when equipment is completely dry store in a plastic bag with resident's name and date on it. Change the equipment and tubing every seven days. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R22's Electronic Medical Record (EMR) recorded a diagnosis dated 02/09/22 of obstructive sleep apnea (a sleep disorder characterized by periods without respirations). The Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Section O of the MDS lacked indication of the use of a CPAP. R22's Care Plan dated 05/08/23 documented R22 had altered respiratory status related to sleep apnea and used a CPAP at bedtime and during naps. During observations on 05/13/25 at 10:15 AM R22's CPAP mask was still latched to the hose and sitting on the bedside table, open to air. During observation on 05/14/25 at 09:38 AM R22's CPAP mask was attached to the tubing and hung off the bedside table open to air. On 05/13/25 at 03:30 PM Administrative Nurse D stated she expected the staff to make sure they cleaned and placed the CPAP mask in a storage bag after each use. The facility's policy CPAP/BIPAP Support dated 05/2024 did not address the procedure for cleaning and storage of the CPAP mask when not in use.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. 50659 The facility reported a census of 37 residents. Five Certified Nurse Aides (CNA) were reviewed for current certified nurse aide certifications. Based on interview and record review, the facility failed to ensure one CNA had a current and valid certificate. This placed the residents at risk for decreased quality of care. Findings included: - Review of CNA LL's files revealed CNA LL was hired on 05/16/22. CNA LL's file lacked evidence of a current certified nurse aide certificate. Review of CNA LL on the Nurse Aide Registry on 05/15/25 revealed CNA LL had an inactive CNA status as of 06/07/23. During an interview on 05/15/25 at 12:00 PM, Administrative Staff A reported he expected all the CNA staff to have a current certified nurse aide certificate. The facility did not provide a policy for the renewal of certified nurse aide certificate.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 50659 The facility reported a census of 37 residents. Five Certified Nurse Aides (CNA) were reviewed for annual performance evaluations. Based on interview and record review, the facility failed to complete an annual performance review at least once every 12 months for CNA NN and CNA LL. This placed the residents at risk for decreased quality of care. Findings included: - Review of CNA NN's files revealed CNA NN was hired on 05/16/22. CNA NN's file lacked evidence a performance evaluation was done in the last 12 months. Review of CNA LL's files revealed CNA LL was hired on 02/29/20. CNA LL's file lacked evidence a performance evaluation was done in the last 12 months. During an interview on 05/15/25 at 12:00 PM, Administrative Staff A reported he expected all the can staff to have annual performance evaluations completed annually. The facility's Performance Management in the employee handbook dated 09/2024, documented the community believes that performance evaluations are a constructive means of improving the performance of both the employee and the community. An employee assessment is a continuous process which normally culminates the formal performance review.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 37 residents. The sample included 12 residents sampled with one resident reviewed for dementia (progressive mental disorder characterized by failing memory, and confusion) care services. Based on observation, record review, and interviews, the facility failed to provide nonpharmacological dementia care and services to promote Resident (R) 7's highest practicable level of function and well-being. This placed the resident at risk for decreased quality of life. Findings included: - R7 's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion) depression (excessive sadness), and anxiety. The 09/19/24 Quarterly Minimum Data Set (MDS) documented the resident had a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. R7 required total dependence to complete activities of daily living (ADL) including toileting, footwear, & personal hygiene. The MDS recorded R7 required maximal assistance with bathing, and moderate with assistance dressing, and transfers. The MDS recorded R7's behavior fluctuated and R7 had disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject) thinking. The MDS noted R7 was easily distracted and had difficulty keeping track of what was said. The MDS recorded R7 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an antianxiety, and antidepressant (class of medications used to treat mood disorders) medications on a routine basis. The 03/10/25 Significant Change Minimum Data Set (MDS) documented the resident had a BIMS score of four, which indicated severely impaired cognition. R7 required total dependence with ADLs including toileting, footwear, & personal hygiene. The MDS recorded R7 required maximal assistance with bathing, and moderate with assistance dressing, and transfers. The MDS recorded R7 rejected care one to three days of during the look-back period. The MDS recorded R7 received antipsychotic, antianxiety, and antidepressants on a routine basis. The 04/05/25 Psychotropic Drug Use Care Area Assessment (CAA) triggered due to R7's use of antidepressant, antianxiety, and antipsychotic medications to help manage psychiatric illness. The CAA noted risk factors included impaired balance, increased falls, and adverse effects of medication. The CAA indicated the care plan would be reviewed to monitor the effectiveness of psychotropic medications and any adverse effects of medication. The 04/04/25 Cognitive Loss/ Dementia Care Area Assessment (CAA) triggered due to R7 refused care at times with contributing factors of depression. The CAA recorded risk factors included self-care deficits, falls, incontinence, and decreased socialization. The CAA indicated the care plan would be reviewed to maintain ADLs, encourage activity participation, decrease falls, and maintain dietary intake and hydration. R7's Care Plan lacked interventions to address dementia care needs. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's Physician's Orders documented an order for Seroquel (an antipsychotic) oral tablet 25 milligram (mg), give 25 mg by mouth, three times a day for schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), date ordered 02/27/25. R7's Physician's Orders documented an order for Sertraline (an antidepressant) 50 mg tablet, give 50 mg by mouth, two times a day for anxiety, date ordered 02/27/25. R7's Physician's Orders documented an order for rivastigmine transdermal patch (a medication used to manage and treat dementia) apply one patch 4.6 mg/24 hour one time a day for R7 refusing oral medications, remove patch and apply a new patch and remove per schedule, date ordered 02/27/25. R7's Physician's Orders documented an order for Haldol (antipsychotic) 50 mg/ milliliter (ml), inject 0.5 ml intramuscularly monthly every 28 days related to schizoaffective disorder, date ordered 03/20/25. R7s Physician's Orders documented an order for Ativan (antianxiety medication) 0.5 milligram (mg), give 0. 5mg/0.1 milliliter (ml) topically every 4 hours as needed for anxiety, date ordered 04/07/25. R7's Physician's Orders documented an order for lorazepam topical cream. Give 1mg/0.1ml, apply topically to the wrist, three times a day for anxiety or restlessness, date ordered 04/07/25. R7's April 2025 and May 2025 Medication Administration Record (MAR) revealed staff monitored and recorded occurrences of target behavior symptoms as follows: Ativan: behavior codes: 0. None 1. Verbal aggression: cursing, threatening, yelling 2. Physical aggression: hitting 3. Delusions 4. Paranoia-obsession of negative event/health concerns 5. Sexual aggression 6. Refusal of meds and cares. Record non-pharmacological behavioral interventions. Intervention codes: 0. None 1. Called daughter 2. Talk to in calm voice 3. Provided reassurance 4. Offer drink-likes Mountain Dew as needed for behavior monitoring. R7's April and May 2025 MAR lacked documentation of behavioral occurrences. R7's May 2025 Monitoring Behavior Symptoms in the Tasks in R7's EHR, documented on 05/08/25 at 05:35 AM, R7 had the following behaviors frequent crying, repetitive movement, yelling, screaming, kicking or hitting, pushing, grabbing, pinching, scratching, and spitting. R7's 'Progress Note on 12/31/24 at 06:42 AM documented R7 sometimes had difficulty starting and staying involved in recreational activities as evidenced by a short attention span. The note recorded R7 enjoyed nail spa and activities with food/drink, and she also enjoyed one-on-one visits which let her be more relaxed and vent or just chat about her day/nights. The note documented R7 would get very confused sometimes and was not easily redirected and noted that staff can offer a snack, sit with R7, and hold her hand. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's 'Progress Note on 01/12/25 at 12:36 PM documented R7 refused to allow Certified Nurse Aides (CNAs) to give personal cares including peri-care. The note recorded the nurse, and two CNAs were able to assist R7 into the shower to clean up bowel movement from R7's buttocks, vaginal area and legs and in the process, R7 pinched staff, scratched staff, and struck out to anyone within reach. Staff notified the on-call provider and received a one time order for lorazepam 0.5mg. Staff pulled the lorazepam from R7's routine card of lorazepam. Staff gave R7 a shower, cleaned her up, and kept her away from peers until her mood was less aggressive. R7's Physician Visit Note on 01/12/25 documented that clinical staff were concerned with increased aggressive behaviors; R7 was combative with staff, kicking and hitting them while they were providing care for her. The note documented the nurse reported this was a common behavior for the resident but more so that day. The note documented R7 also received an Invega (an antipsychotic medicine) injection the previous day for the first time. The noted documented staff were advised to give R7 an additional dose of lorazepam 0.5mg by mouth to help calm her. But the resident refused to take her medication including the additional dose of lorazepam. The note documented R7's family got involved and tried to encourage the resident; staff were advised to try to reapproach the resident at a later time to see if she could be redirected. The note recorded an acute care follow up would be coordinated since staff felt adjusting R7's medications would be helpful in caring for patient. R7's Progress Note on 02/12/25 at 04:31 PM documented R7 threw a cup of water at another resident. R7 was taken away from the resident she threw the water at. The note documented R7 was unable to be understood with things she said and was frequently yelling out and grabbing the staff that walk by; R7 was resistant to care, grabbing staff's arms and clothing. R7's 04/09/25 Physician Progress Note documented general: [AGE] year old female with fall and some increased behaviors this weekend, R7 remained on hospice, and they reached out for med changes discussion with staff and hospice today about underlying schizophrenia and need for continued psych follow up. During an observation on 05/12/25 at 09:20 AM, R7 tried to slap the surveyor during initial interview. During an observation on 05/13/25 at 10:53 AM CNA JJ assisted R7 out of her recliner and into her wheelchair. Administrative Nurse D followed R7 around in her wheelchair for a few moments and R7 wanted to go back into her recliner and called out loudly. Social Service Designee (SSD) X transferred R7 to her recliner. During an observation on 05/14/25 at 01:38 PM, R7 parked her wheelchair in front of the loveseat where R15 was seated. R7 grabbed at R15's walker after she hit it a few times, R7 then stood up in a semi-crouched position and sat on the loveseat next to R15. R15 had a frown on her face and sat on the loveseat for approximately a minute and R15 stood up and moved to a chair away from R7. Activity Director Z walked past R7 and R15 while R7 had a hold of R15's walker. During an observation on 05/14/25 at 01:51 PM Administrative Nurse D assisted R7 from the love seat to her wheelchair and asked Licensed Nurse (LN) H if R7 had received any pain medications lately. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/12/25 at 11:27 AM, R7's representative reported that there was one resident that R7 did not like so staff keep them separated. R7's representative stated they did not know the other resident and said that no recent altercations had been reported to them. During an interview on 05/14/25 at 01:21 PM, CNA KK reported that R7 would self-transfer at times and staff would intervene. CNA KK reported that residents' care plans would have directions to the staff on interventions and approaches to address the resident's needs. During an interview on 05/14/25 at 02:03 PM, CNA O reported that R7 attempted to transfer herself and staff would need to intervene. CNA O reported she noticed earlier that R7 had lifted her hand towards R15 but R15 did not notice it and staff intervened. CNA O stated R7 kept staff busy at times because she liked to move around in her wheelchair and sometimes she liked her baby doll and other times she did not. CNA O reported the staff just needed to redirect R7 a lot. During an interview on 05/14/25 at 02:21 PM, Activity Director Z reported she did not notice R7 holding onto a walker in front of R15. Activity Director Z reported the lounge was a common area and said she did not believe that R15 would have a problem with R7. During an interview on 05/14/25 at 04:53 PM, Administrative Nurse D reported that she and Administrative Nurse E were responsible to update and review the care plans. Administrative Nurse D reported she was shocked that R7 did not have dementia addressed on her care plan. The facility did not provide a policy for dementia care.

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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. 50659 The facility reported a census of 37 residents, with 12 residents sampled, with five residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to act upon the pharmacist's monthly medication review (MRR) for Resident (R) 32. The deficient practice had the potential to lead to the residents receiving unnecessary medications. Findings included: - Review of the Electronic Health Record (EHR) for R32 included diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), end-stage renal disease (ESRD-a terminal disease of the kidneys) and anxiety. The 07/24/24 Significant Change Minimum Data Set (MDS) documented R32 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R32 required maximal assist from staff for bathing, standing, and wheelchair mobility activities of daily living (ADL). The MDS recorded R32 required moderate assistance with toileting, transfer, and lower body dressing. The MDS recorded no behaviors and R32 required dialysis (a procedure where impurities or wastes are removed from the blood). R32 received no psychotropic medications. The 08/02/24 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R32 triggered for functional abilities due to increased self-care deficit, and cognitive skills for daily decision-making abilities. The 08/02/24 Psychosocial Well-Being CAA documented R32 triggered for psychosocial well-being due to little interest in activities. R32 indicated that occasional loss of interest in activities due to decreased energy, therefore placing him at risk of decreased social involvement and self-isolation. The 03/25/25 Quarterly MDS documented a BIMS score of 15, and he had no depression or behaviors. The MDS recorded R32 received an antidepressant (a class of medications used to treat mood disorders) and an antianxiety (a class of medications that calm and relax people). R32'S Care Plan dated 04/15/25 documented R32 used anti-anxiety medications related to anxiety disorder, staff instructed to provide education to R32 about risks, benefits, and the side effects and/or toxic symptoms of medication. Staff instructed to administer anti-anxiety medications ordered by physician. Monitor and document side effects and effectiveness. Staff instructed to monitor/record occurrence of target behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. R32's Care Plan dated 05/13/25 lacked any non-pharmacological interventions. R32's Physician Orders documented an order for hemoglobin A1c (HbA1c-blood test used to evaluate the level of glucose control over the past 90 days) laboratory draw one time every six months for diabetes, date ordered 07/14/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R32's Physician Orders documented an order for citalopram hydrobromide tablet (antidepressant) 20 milligrams (mg), give one tablet by mouth, one time a day for depression date ordered 03/07/25. R32's Physician Orders documented an order for buspirone (antianxiety) HCl Oral tablet 5mg, give two tablets by mouth, two times a day for anxiety, date ordered 04/03/25. R32's Medication Regimen Review (MRR) dated 07/26/24 documented there were irregularities noted, see report. Review of EHR lacked the actual report and response from physician or nurse. R32's Medication Regimen Review dated 09/26/24 documented there were irregularities noted, see report. Review of EHR lacked the actual report and response from physician or nurse. R32's Medication Regimen Review dated 01/08/25, documented the pharmacist requested a HbA1c lab draw next lab day and every six months. R32's Laboratory Results in EHR documented a HbA1c 7.5 dated on 07/26/24 that was obtained at dialysis facility. No other HbA1c was noted in EHR. During an interview on 05/15/25 at 07:43 AM, Administrative Nurse D reported that R32 refused his lab to be drawn at the facility as R32 reported his labs would be drawn at dialysis. Administrative Nurse D reported that unfortunately, dialysis did not draw the HbA1c and the last one obtained was 07/26/24. During an interview on 05/15/25 at 09:05 AM Administrative Nurse D reported that she could not locate the missing MRR for R32. She reported she was not employed at that time and she epcted the MRR to be followed up in a timely manner. The facility's Medication Regimen Reviews dated 02/2025 documented the consultant pharmacist shall review medication regimen per state and federal guidelines. The irregularity reports on a separate written form would include the resident's name, relevant drug, and the irregularity that had been identified. Provide the physician with access to report to review irregularity and document reviewed, if any action had been required, and or rationale for no change based on the reported irregularity.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 37 residents. The sample included 12 residents with one reviewed for dental services. Based on interview and record review, the facility failed to provide dental services or facilitate access to dental services for Resident (R) 31 who had widespread dental decay. This placed the resident at risk for further deterioration of dentition (of or having to do with teeth) and related complications. Findings included: - R31's Electronic Health Record (EHR) revealed diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness) and cerebrovascular accident (CVA-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). The 11/01/24 Annual Minimum Data Set (MDS) documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R31 was dependent on staff for toileting activities of daily living (ADL). The MDS recorded R31 required maximal assistance with showering, lower body dressing, and transfers. The MDS recorded R31 required set up assistance for oral care. The MDS recorded R31 had adequate vision and wore eyeglasses. The MDS recorded R31 had no issues with her teeth. The 11/22/24 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R31 required staff assistance to complete ADLs. The Dental Care CAA was not triggered. The 03/26/25 Quarterly MDS documented a BIMS of 15. The MDS recorded no changes in ADLs from the previous MDS. The MDS recorded R31 had no issues with her mouth; she had adequate vision and required no device. R31's Care Plan dated 11/30/23 documented R31 had oral and dental health problems related to poor nutrition and a history of drug use. The plan directed staff to coordinate arrangements for dental care including transportation as needed and as ordered. The plan directed staff to provide R31 mouth care assistance. R31's Physician's Orders documented an order may be seen by specialists as needed including a dentist of choice care as needed, dated ordered 11/17/2023. R31's Admission assessment dated [DATE] documented R31 did not have her own teeth and no other documentation was checked on the assessment. R31's EHR lacked evidence the facility had offered or facilitated dental services for R31 and lacked evidence R31 had declined dental services. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview/observation on 05/12/25 at 09:01 AM, R31 reported that no staff had asked her about being assessed by a dentist since she admitted on [DATE]. R31 reported she had a lot of bits and pieces of teeth in her mouth. Observation revealed R31 had several broken teeth on both upper and lower. R31 reported she was able to eat well. During an interview on 05/13/25 at 03:21 PM, Licensed Nurse (LN) G reported when a resident requested to see an eye doctor or a dentist, and it is not an emergency, the nurse wrote a progress note in the EHR or informed Social Services Designee (SSD) X verbally. During an interview on 05/13/25 at 03:23 PM, Certified Nurse Aide (CNA) KK, a transportation aid, reported she had not taken R31 to any appointments for dental or vision cares. During an interview on 05/13/25 at 03:27 PM, SSD X reported when a resident requested to have a dental or eye appointment the facility would receive a consent form sent from the outside provider that comes into the facility to complete appointments. SSD X said residents had to sign a consent or declination, and all residents had standing orders. SSD X reported that R31 had declined services. Though SSD X verified they could not locate a declined consent, or a progress note in R31's EHR. During an interview on 05/14/25 04:53 PM, Administrative Nurse D reported she expected all residents should have a dental exam once admitted as a baseline. The facility's policy 'Routine Dental Care dated 10/2024 documented each resident would receive routine dental care, an initial evaluation of the resident's dental needs and preventative care and treatment.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40801 The facility reported a census of 37 residents. The facility had one main kitchen where dietary staff prepare all the food. Based on observation, interview and record review the facility failed to store food items in a sanitary manner when staff failed to date food items in the refrigerator and freezer. This placed the residents at risk of food-borne illness. Findings included: - Observation on 05/12/25 at 09:40 AM revealed one bag of beef patties were placed in the freezer without closure of the plastic bag. Further observation revealed two bags of chicken in a store bag sat on the floor in the refrigerator . The freezer floor had food debris visible. There were numerous bags of vegetables and sandwich meat which lacked a date received. In the kitchen there were nine loafs of bread found with expiration date of 02/22/25 and there was mold growing on the bread. Interviewed on 05/14/25 at 12:0 PM, Dietary Manager BB stated they expected the staff to make sure that all raw meat was on the bottom shelf, and that everything was dated with the open date and expiration date and when received. Dietary Manager BB said the staff was supposed to rotate stock first in first out. Dietary Manger Bb stated they had provided education to the staff regarding the process. The policy Food Safety Requirements dated 10/24 food shall be received and stored in a manner that complies with safe food handling practices, uncooked and raw animal products and fish will be stored separately in drip- proof containers below fruits, vegetables and other ready to eat food.

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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. 40801 The facility reported a census of 37 residents. The sample included 12 residents. Based on observation, interview and record review, the facility failed to maintain an effective infection control program related to the enhanced barrier precaution (EBP-a set of infection control measures that use goggles, gown and gloves to reduce the spread of multidrug-resistant organisms [MDROs] in nursing homes) when providing tube feeding care (a specialized medical flexible tube made of either silicone or plastic to deliver liquid nutrition directly int the stomach) or providing a shower to the resident with the tube feeding. Additionally, staff failed to disinfect the Hoyer lift (full body mechanical lift) after use and failed to utilize adequate hand hygiene. This placed the residents at risk for infections. Findings included: - Observation on 05/12/25 at 12:05 PM revealed Licensed Nurse (LN) K in R14's room reattaching the feeding tube the resident had pulled out. LN K did not utilize a gown during the care provided. Observation on 05/13/25 at 10:43 AM revealed Certified Nurse Aide (CNA) Q and CNA JJ transferred R14 from his bed using a lift into the shower chair, Neither CNA implemented a gown for EBP before providing care. Further observation revealed the staff pushed the Hoyer out into the hall after use but did not disinfect it. Observation on 05/12/25 at 04:44 PM revealed CNA N provided peri-care to R6. CNA N assisted R6 off of the bed pan, removed the resident's wet brief, washed the residents' buttocks, and placed a new brief with the same soiled gloves. CNA N then took the bed pan to the bathroom and emptied into the toilet. CNA N removed her gloves but did not wash her hands before applying new gloves. CNA N then washed the residents front genital area. CNA N removed one glove, picked up the garbage and went to the soiled room then came out and washed her hands. On 05/14/25 at 04:11 PM CNA N reported that she should have washed her hands when she removed her gloves before cleaning the resident's peri-area. On 05/14/25 at 02:50 PM Administrated Nurse D stated she expected that all staff implement the adequate hand hygiene and EBP and said they had received education on EBP. The facility policy Multidrug-Resistant Organisms (MDRO) and Enhanced Barrier Precautions (EBP) dated 04/25 appropriate precautions will be taken when caring for individuals known or suspected to have infection or colonization with multidrug-resistant organisms (MDRO) and require Enhanced Barrier Precautions note the infection means the organism is present and causing illness. Additional guidance recommend by the CC will be reviewed and adopted as it becomes available for the prevention of spread of Muli- resistant organism. Enhanced Barrier Precautions Guidance for Cares refers to practices such as brushing teeth, combing hair and shaving are commonly bundled as part of morning and evening cares.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 50659 The facility reported a census of 37 residents. Five Certified Nurse Aide (CNA) staff, who worked in the facility were reviewed for required in-service training. Based on interview and record review, the facility failed to develop, implement, and permanently maintain an in-service training program for CNAs with the required topics and no less than 12 hours per year. This placed the residents at risk for decreased quality of care. Findings included: - On 05/15/25 at 08:30 AM, review of training records for five CNAs revealed that CNA P, who was hired on 12/30/24 lacked dementia (progressive mental disorder characterized by failing memory, confusion) training. Review of CNA NN's employee file lacked evidence the CNA received dementia training and lacked the total number of in-service hours that were completed. During an interview on 05/15/25 at 12:00 PM, Administrative Staff A reported he expected the staff to have the required education and the required 12 hours annually. The facility's policy Staff Competency dated 06/2023 documented all nurse aides shall participate in regularly scheduled in-service training classes. Each nursing assistant must attend, as a minimum, 12 hours of continuing education annually which included dementia management.