STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185166	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harlan Health and Rehabilitation Center	200 Medical Center Drive Harlan, KY 40831

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47852 51174 Based on observation, interview, record review, and review of the facility's policy, the facility failed to provide Notice of Medicare Non-Coverage (NOMNC) to residents before their coverage ended. Two of 10 residents reviewed (Residents (R) 282 and 279) revealed the NOMNC's were issued after the residents' benefits ended. The findings include: Review of the facility's policy titled, Notice Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS [Centers for Medicare and Medicaid Services]-10123, undated, revealed The NOMNC must be delivered to all Medicare beneficiaries at least two calendar days before Medicare covered services ended or the second to last day of service if care was not being provided daily. 1. Review of R282's NOMNC revealed the resident's Medicare coverage ended on 12/07/2024. Further review revealed Family Member (FM) 10 signed the NOMNC on 12/09/2024 which was two days after the resident's coverage ended. During an interview with the Business Office Manager 1 (BOM1) on 03/21/2025 at 9:19 AM, she stated she called FM10 and informed her of R282's coverage ending the week before. BOM1 stated she had also mailed a copy of the NOMNC out, but FM10 came into the office and signed it that day. The State Survey Agency (SSA) requested documentation that FM10 had been contacted regarding the Medicare coverage ending, and BOM1 stated she did not have any documentation. During an interview with FM10 on 03/21/2025 at 9:27 AM, she stated she did not know anything about R282's Medicare coverage ending and she did not remember receiving the NOMNC in the mail. 2. Review of R279's NOMNC revealed Medicare coverage would end on 03/07/2025. Further review revealed R279's NOMNC was unsigned by the resident or the resident's representative as of 03/21/2025. During an interview, on 03/21/2025 at 12:15 PM, BOM1 stated the NOMNC was mailed to R279's representative on 03/04/2025. She further stated she had verbally informed R279's representative she was mailing the NOMNC on 03/04/2025 and he should sign it and bring it back to the facility when he next visited R279. (continued on next page)

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 03/21/2025 at 12:51 PM, R279's representative stated he was not notified prior to R279's Medicare coverage ending and was not informed of the right to appeal for Medicare coverage to continue. He stated he did receive paperwork in the mail several days after 03/07/2025 but was unsure which box to check and how to fill it out. He stated no one from the facility had informed him how to complete the form and had only told him he would need to check one of the boxes.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51174 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to develop and/or implement a comprehensive person-centered care plan related to dental needs to ensure that medical, nursing, mental and psychosocial needs related to weight loss were met for one (Resident (R) 99) of seven residents reviewed for nutrition out of a sample of 49 residents. R99 sustained pain and a severe weight loss of 20% in the six months between 09/17/2024 and 03/10/2025. The findings include: Review of the facility's policy Care Plan Policy and Protocol, revision 09/2024, revealed the care plan would be updated as indicated with changes in condition, physician orders, fall interventions, etc. Review of R99's clinical record revealed the facility admitted R99 on 07/05/2023, with diagnoses which included Huntington's disease and cognitive communication deficit. Review of R99's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/14/2023, revealed the resident had obvious cavities or broken teeth. 1. Review of R99's Comprehensive Care Plan (CCP), initiated on 07/16/2023 with a target date of 03/25/2025, revealed the facility assessed the resident to have broken or carious (decayed) teeth. Further review revealed R99's teeth were discolored and missing, as well as broken. Interventions included R99 would have consults with the dentist as indicated. a. Review of R99's CCP revealed no evidence that the facility care planned the resident to receive the facility's in-house 360 Care Dental Program (which provides routine care.) b. In addition, review of R99's clinical record revealed that on 05/29/2024, the resident saw an external dentist to have three teeth extracted. Review of R99's dental note, dated 05/29/2024, revealed that the dentist could not do the extractions and noted the need to refer to an oral surgeon for extraction of all of his remaining teeth. Review of a Progress Note, dated 06/11/2024, revealed the dental office sent R88's information to the referred dentist/oral surgeon, and the facility was informed that if they had not received a call back by 06/14/2024, they were to call the dental office. Further record review revealed there was no evidence in R99's record that the facility's staff contacted the dental office or the oral surgery regarding the referral, from the time of the 06/11/2024 note through 03/17/2025. Review of a Word Document provided by a regional corporate representative on 03/19/2025 at approximately 9:00 AM, revealed the facility documented they had left messages. However, the facility did not actually talk with staff at the oral surgery clinic about R99's referral for needed dental care, per the care plan, until 03/19/2025, after surveyor intervention. (Refer to F790.) (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of R99's clinical record revealed the Annual MDS, dated [DATE], documented that the resident continued to have obvious cavities/broken teeth. There was no evidence that the facility identified that they had failed to include the need for the routine Dental Care program on the care plan or that they had implemented successful actions to ensure the resident received the dental services he needed, per the care plan. Observation, of R99's mouth, on 03/21/2025 at 2:04 PM with Registered Nurse 6 (RN6) revealed the resident had missing multiple teeth in both the front and the back of his mouth, as well as on both the top and bottom. In addition, the resident had multiple discolored teeth, with some that were partially black in appearance. An interview conducted by RN6 revealed R99's teeth were hurting him at a level of 10/10 on a pain scale of 10. (Refer to F790) Review of MDS assessments dated 06/21/2024, 09/17/2024, and 12/10/2024 and a weight record dated 03/10/2025, and observation on 03/20/2025 at 5:47 PM, revealed R99 sustained a weight loss of 20% (32 pounds) in the six months between 09/17/2024 -03/10/2025. Further review revealed a weight loss of 42 pounds (24.4%) between 06/21/024- 03/20/2025, both of which constituted a severe (more extreme than significant) weight loss. (Refer to F692) However, the facility failed to implement a person centered plan to address the resident's dental care needs and his weight loss. 2. Review of R99's CCP, initiated on 07/16/2023 with a current target date of 03/25/2025, revealed the facility also identified the resident with the potential for alteration in nutrition/hydration status based on factors including poor dental status. Per the care plan, interventions included for staff to obtain speech therapy/occupational therapy (OT/ST) as indicated. Although the care plan called for ST/OT as indicated, an order for Speech Therapy was not obtained until 03/19/2025, after surveyor intervention. During an interview with the Speech-Language Pathologist (SLP) 1 on 03/19/2025 at 2:24 PM, SLP1 stated until 03/19/2025, R99 had not been assessed by speech therapy. SLP1 stated that upon assessment, R99's teeth were bad, they're terrible, and that could be the reason R99 had lost weight. During an interview with the Minimum Data Set Coordinator (MDSC) 1 on 03/20/2025 at 12:05 PM, MDSC1 stated CCP's should be followed to ensure the residents were safe, the residents received the care they needed, and that each CCP was individualized to meet each resident's care needs. MDSC1 stated All Supervisors just pop in randomly and check [for implementation of care plans]. Clinical Coordinators do, too. MDSC1 indicated that if staff were not following the care plan, Nursing staff should go with them to the Kardex (care plan system used by direct care staff), and ask What happened for you to not follow it? MDSC1 indicated that the failure should then be investigated with staff education in response. During an interview with the Administrator and Director of Nursing (DON) on 03/21/2025 at 11:23 AM, the Administrator stated that R99 should have been in the facility's 360 Dental Program, and this failure was an oversight on the facility's part.

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51174 Based on observation, interview, record review, and review of the facility's policy, the facility failed to maintain acceptable parameters of nutritional status such as body weight for one (Resident (R) 99) of seven residents reviewed for nutrition, out of a total sample of 49 residents. R99, who had significant dental breakdown, experienced pain and sustained a severe/significant unplanned weight loss that continued for at least six months after the facility was notified that the resident needed dental care. In addition, the facility failed to timely address the consistency of the resident's food and the need for dental care. The findings include: Review of the facility's Nutrition Policy, dated 08/2024, revealed the facility was to implement interventions to prevent unintentional weight loss. Per the policy, the facility will include the IDT [interdisciplinary team], provider, resident and/or representative, as well as the registered dietician in determining appropriate interventions/strategies to maximize nutritional status. The policy noted that interventions that may be considered included assessing for the potential need for food consistency change, as well as assessing for methods of increasing nutritional intake, such as nutritional supplements, and supplemental med pass. Review of the policy revealed it did not address weights, including who was responsible for obtaining weights, the time frames/how often in which a resident was to be weighed, who was to review the weights, and what action was to be taken in response to various parameters. Review of R99's medical record revealed the facility admitted the resident on 07/05/2023, with diagnoses which included Huntington's disease and cognitive communication deficit. Further review of the resident's record revealed the resident was not currently on hospice (end of life care) and had not been given an end-stage diagnosis. Review of the Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/14/2023, revealed R99 weighed 153 pounds and was 63 inches tall (5 feet, 3 inches). Further review revealed R99 was not on a physician-prescribed weight loss diet. Per the MDS, R99 had obvious cavities or broken natural teeth, and no nutritional approaches (including but not limited to a mechanically altered diet) were provided. Both areas Nutrition and Dental Needs were triggered for Care Area Assessments, based on the MDS data. Review of a Progress Note dated 06/11/2024, revealed the facility received a phone call from a dental office regarding a referral to an oral surgeon because the resident needed to have multiple teeth extracted. The referring dental office informed the facility that R99's information was sent over and if the facility had not received a call by 06/14/2024, they were to call the referring dental office. Further record review revealed there was no evidence in R99's record that the facility's staff had actually contacted the dental office or the oral surgery regarding the referral, from the time of the 06/11/2024 note until 03/19/2025. Although the facility documented they had left messages, the facility did not speak with staff at the oral surgery clinic about R99's referral until 03/19/2025, after surveyor intervention. (Refer to F790.) (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the Annual MDS, with an ARD of 06/21/2024, revealed R99 weighed 172 pounds, The resident continued to have obvious broken teeth or cavities with no nutritional approaches, such as a mechanically altered diet. R99 was not on a prescribed weight loss diet. Per the MDS, the resident was moderately cognitively impaired, based on a Brief Interview for Mental Status (BIMS) score of 12/15. R99 had unclear speech, with slurred or mumbled words, no refusal of care, and required set up assistance with eating. Review of a Nutrition/Dietary Note, dated 08/01/2024, revealed R99 had a 1% weight loss in one month and 6% in six months. At this time, the resident was consuming 77% of meals. Per the note, resident has high energy needs and will need to observe intakes and weights for decline. Review of the Quarterly MDS assessment with an ARD of 09/17/2024, revealed R99 now weighed 160 pounds, and had a weight loss of 5% or more in the last month or 10% or more in the last six months and was not on a prescribed weight loss diet. Per the MDS, the resident continued to not have nutritional approaches in place, needed set up assistance, and had unclear speech. The section of the assessment regarding the resident's dental status was not completed. Review of R99's 09/17/2024 Dietary Profile, completed by the Dietary Manager (DM), revealed the resident was now averaging 67% of his meals, which was down 20% since the previous review. However, the Dietary Profile did not address the resident's weight loss, which was noted on the MDS documented the same day. In addition, the Dietary Profile failed to address the resident's continued dental issues, and R99's regular consistency diet, which had the ability to impact the resident's food consumption/intake. Review of R99's 12/09/2024 Dietary Profile, also completed by the DM, revealed the resident now had lost 10% in six months and 8% in one month. Again, the Dietary Profile failed to address the resident's dental issues and/or the regular-consistency diet orders. Review of R99's Quarterly MDS, with an ARD of 12/10/2024, revealed the facility assessed the resident to have moderately impaired cognition, based on a BIMS of 8/15. The MDS documented the resident had a weight loss of 5% or more in the last month or 10% or more in the last six months. Per the MDS, the resident, who was not on a prescribed weight-loss diet, now weighed 139 pounds. This weight reflected a 33-pound weight loss of 19.18% since the 06/21/2024 MDS, and a 21-pound weight loss of 13.12% since the 09/17/2024 MDS. During an interview with Registered Dietician (RD)1, on 03/20/2025 at 3:04 PM, she stated R99 received large portions. However, review of the Quarterly MDS dated [DATE], revealed the facility failed to address R99's dental issues. The section of the assessment regarding the resident's dental status was not completed. Review of the weight records after the 12/10/2024 MDS revealed the resident's weight on 03/10/2025 was 128.4 lbs. Review of the 03/10/2025 Dietary Profile, completed by the DM, revealed R99's intake was now down to an average of 56% of his meals and snacks throughout the day. The Profile again noted the resident had more than a 10% weight loss in six months (severe weight loss.) The Dietary Profile again failed to address the resident's dental issues and/or regular-consistency diet, which had the ability to affect the resident's consumption/intake. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of R99's Comprehensive Care Plan (CCP), initiated on 07/16/2023, with a current target date of 03/25/2025, revealed the facility identified the resident with the potential for alteration in nutrition/hydration status due to a regular diet and poor dental status. Review of the care plan revealed no evidence that it was revised with approaches to address the resident's dental issues when the weight loss was identified on both the 09/2024 and 12/2024 MDS assessments, Per the care plan, interventions included for staff to administer medications and supplements as ordered, observe for any difficulties in chewing food and notify the physician. Review of the R99's current dietary profile dated 03/10/2025, revealed that as of the initiation of the recertification survey on 03/17/2024, the resident remained on a regular, no mechanically altered consistency diet. Observation of the dinner meal on 03/17/2025 at 4:46 PM, revealed R99 sitting at a table in the dining room. Staff assisted R99 with opening his milk, silverware, and straw. Further observation revealed while feeding himself, R99 had involuntary spastic movements, indicative of Huntington's disease. However, staff did not assist R99 with eating. Observation on 03/17/2025 at 5:17 PM, revealed staff wheeled R99 to his room from the dining room in his wheelchair. R99's shirt and pants were wet with spilled liquid and pieces of food down the front of them. Observation of R99 on 03/20/2025 at 8:46 AM revealed the resident was in the bed. R99 was neat, clean, and dressed. The resident appeared thin, and his jeans were loose around his waist and in the legs. An interview was conducted with R99 during this observation. Because of his communication deficits, the State Survey Agency (SSA) team asked R9 single questions at a time, to which he would respond by answering 'yes' or 'no' and moving his head. During the interview, R99 indicated his teeth hurt all the time, and had been hurting about a year, nodding his head up-and-down and stating, yep to both of these questions. R99 indicated that the tooth pain made it difficult to eat at times, again nodding his head up-and-down and stating, yep. R99 indicated that there were times that he was hungry due to his inability to eat because of the tooth pain, as he nodded his head up-and-down stating, yep. Observation, on 03/20/2025 at 5:47 PM, revealed Certified Nursing Assistant (CNA) 10 weigh the resident in his wheelchair. The scale indicated a weight of 185.2 lbs. CNA10 then subtracted the wheelchair weight of 55.2 pounds, verifying the resident's current weight was 130 pounds. This weight indicated the resident had lost over 40 pounds since the 172-pound weight recorded on his annual MDS dated [DATE]. Observation on 03/21/2025 at 2:04 PM with Registered Nurse (RN) 6 of R99's mouth revealed the resident was missing multiple teeth in both the front and the back of his mouth, as well as on both the top and bottom. In addition, the resident had multiple discolored teeth, with some that were partially black in appearance. An interview conducted by RN6 revealed R99's teeth were hurting him at a level of 10/10 on a pain scale. (Refer to F790) During an interview with CNA8 on 03/20/2025 at 9:34 AM, CNA8 stated that during R99's oral care, R99 would wince in pain, like someone touching a nerve. CNA8 stated he thought that was why R99 had a hard time eating. CNA8 stated that he had previously informed nursing staff about the resident's dental pain but could not remember the specifics of when or who he told. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview with CNA7 on 03/20/2025 at 9:20 AM, revealed she was one of the staff who did routine weights for the residents on the hall where R99 resided. CNA7 stated that the aides were not aware of weight loss as they did not see the previous weight when they recorded the current weight in the CNA book to give to the Care Coordinator. Although the care plan called for ST/OT (Speech Therapy/Occupational Therapy) to evaluate as indicated, an order for Speech Therapy was not obtained until 03/19/2025, after surveyor intervention. During an interview with the Speech-Language Pathologist 1 (SLP1) on 03/19/2025 at 2:24 PM, SLP1 stated until 03/19/2025, R99 had not been assessed by speech therapy. SLP1 stated that upon assessment, R99's teeth were bad, they're terrible, and that could be the reason R99 had lost weight. SLP1 stated that after assessing R99 on 03/19/2025, she changed R99's diet from regular with large portions, to mechanical soft meats and feeding assistance. Further interview with SLP1 on 03/20/2025 at 3:02 PM, revealed that once the resident's diet consistency was changed, R99 consumed 90 percent of his meal. Interview with Registered Dietician (RD) 1 on 03/20/2025 at 3:04 PM, revealed that she was a corporate regional dietitian and was answering questions for the facility's RD, who was out of the country and unavailable for interview. She stated that assessments were completed annually, on change in condition, or upon request. RD1 stated R99's last RD Assessment was in 06/2024, and at that time, R99 weighed 171.6 pounds. Per RD1, the facility's RD documented that at that time, the resident's usual weight was 165, with a Body Mass Index (BMI) of 30.4 (mild obesity.) Continued interview with RD1 revealed that as of 03/10/2025, R99 now weighed 128.4 pounds, adding, Wow, what happened? RD1 verified that the resident's average intake had declined. Although RD1 indicated that the facility's RD had made interventions such as an appetite supplement, a dietary supplement, and large servings. However, no information was provided to indicate that R99's ongoing issues with multiple missing/painful teeth and a regular diet, had either been considered as a possible cause of the resident's continued weight loss nor addressed the issue. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a joint interview with the Administrator and Director of Nursing (DON) on 03/21/2025 at 11:23 AM, the DON stated that the supervisor recorded the weights that the direct care staff obtained into the system, which then triggers it in the 24-hour report. Per the DON, this report was then reviewed in morning meeting. However, no evidence was provided by the DON prior to the exit from the survey to verify that this occurred each time R99's weight loss was identified. The DON stated that the RD came to the facility weekly, and the Quality Assurance and Performance Improvement Committee (QAPI) met quarterly to discuss the findings of the 24-hour reports, and sometimes more frequently. During the interview with the Administrator, she stated that R99's teeth were in the same condition as upon admission and she did not believe that this was the cause of the resident's weight loss. She stated that the resident should have been in the facility's 360 Dental Program (which provides routine dental care), and that was an oversight on their part. The Administrator stated R99 used to attend activities quite frequently with 75% of the activities involving food, and he would eat like a horse; however, he's not been going to activities much. The Administrator and DON expressed the opinion that R99's weight loss was due to the resident's diagnosis of Huntington's disease, with the Administrator describing it as end-stage. However, there was no documented evidence of this in the R99's clinical record. The Administrator stated R99 had stayed within a 10-pound range since 12/02/2024, adding that, I consider that stable. However, R99 had a 12-pound (7.9%) pound weight loss between the 12/10/2024 MDS and 03/10/2025 assessments, which occurred while the resident was not on a physician-ordered weight loss program. This weight loss constituted a severe (more extreme than significant) weight loss. In addition, the weight loss of 20% (32 pounds) in the six months between 09/17/2024 and 03/10/2025, and weight loss of 42 pounds (24.4%) between 06/21/024 and 03/20/2025 also both constituted a severe weight loss.

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F 0790 Level of Harm - Actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51174 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to provide/obtain needed dental care for one of 49 sampled residents (Resident (R) 99) who was reviewed for dental services. The facility failed to obtain needed dental services over a nine-month period for the resident who had multiple broken teeth which needed extraction. During this time, the resident sustained pain, as well as, a severe weight loss over a six and nine-month period. The findings include: Review of the facility's policy titled, Protocol for Oral Status Assessment, revision date 08/2017, revealed An assessment of the oral cavity of each resident will be completed annually by a nurse. This assessment will be documented on the Comprehensive MDS [Minimum Data Set] in Section L, as well as in the CAAs [Care Area Assessments]. Each resident will have an Oral Status Care Plan which will be reviewed and updated quarterly with each MDS and prn [as needed]. The documentation of the assessment in the CAA should address the resident's gums, edentulous/dentures (upper/lower), partial, broken or carious teeth, pain, difficulty chewing, etc. The CAA should also address any consults or referrals that have occurred since last comprehensive assessment and if the resident/family decline consult or further referral. The Oral Status Care Plan will be updated annually and prn with any changes in condition. The resident will have consult with Dentist on annual basis as indicated, unless the resident or resident representative declines dental consults. It will be documented in the medical record if the consult is not obtained. The undated Protocol for Oral Hygiene policy revealed that, Staff will notify nurse of any changes noted in oral cavity during oral care, residents' ability to chew, teeth, etc. Review of R99's record revealed the facility admitted R99 on 07/05/2023, with diagnoses which included Huntington's Disease and cognitive communication deficit. Further review of the resident's record revealed that the resident was not currently on hospice and had not been given an end-stage diagnosis. The Admission MDS, with an Assessment Reference Date (ARD) of 07/14/2023, revealed the resident had obvious cavities or broken natural teeth. Per the MDS, the resident weighed 153 pounds and was 63 inches tall (5 feet, 3 inches), was not on a physician-prescribed weight loss plan, and had no nutritional approaches (such as mechanically altered diet). In response, the Dental Needs were triggered for CAA review, based on the MDS data. Review of the Comprehensive Care Plan (CCP), initiated on 07/16/2023 for R99 and still current as of 03/17/2025 (the date the Recertification survey was initiated), revealed the resident was care planned for alteration in nutrition/hydration status, in part due to poor dental status. Approaches included obtaining speech therapy/occupational therapy (OT/ST) as indicated. Further review of the care plan revealed that R99's teeth were discolored, missing, and broken, and interventions included that R99 would have consults with the dentist as needed. a. Review of the clinical record revealed R99 had a tooth extracted in 08/2023. The resident then went back to the external dental office on 05/29/2024, to have three more teeth extracted. (continued on next page)

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F 0790 Level of Harm - Actual harm Residents Affected - Few	Record review of R99's dental note dated 05/29/2024, revealed Patient [Resident] was very difficult to work on. He had trouble keeping his mouth open and he shakes. He tried really hard, but he was very uncomfortable, and he was very difficult to work on. He kept biting me. Will need to talk to his nurse at the nursing home and refer to an oral surgeon for extraction of all of his remaining teeth. Review of a Progress Note, dated 06/11/2024, revealed the facility received a phone call from the dental office regarding their referral to another provider for the extraction of the remaining teeth. The referring primary dental office informed the facility that R99's information was sent over and if the facility had not received a call back by 06/14/2024, they were to call the dental office. Further review of R99's clinical record revealed no evidence that the facility contacted either the dentist/oral surgeon to whom the referral was made or with the primary referring dentist between the 06/11/2024 note and the initiation of the Recertification survey on 03/17/2025. Further review of R99's medical record revealed no evidence that any other dentist saw R99 for the needed extractions. Review of the annual MDS, with an ARD of 06/21/2024, revealed the resident continued to have obvious broken teeth or cavities. Per the MDS, the resident was moderately cognitively impaired, based on a Brief Interview for Mental Status (BIMS) score of 12/15, and had unclear speech, with slurred or mumbled words, and no refusal of care. Review of the next two MDS, a quarterly assessment with an ARD of 09/17/2024 and a quarterly MDS with an ARD of 12/10/2024 revealed the section of the assessment regarding the resident's dental status was not completed. b. Record review revealed that, in addition to the outside dentist that R99 saw on 05/29/2024, the facility had an agreement with a dental provider who came to the facility for routine care. Review of the facility's agreement with 360 Care (the mobile dental provider), effective 11/01/2018, revealed 360 Care offered dental services to the facility that included dental examination and oral cancer screening, diagnostic x-ray examination, prophylaxis and denture cleaning, tooth surface restorations, simple extractions, and removable prosthetic fabrication, relines and repairs. Record review of 360 Care's visits to the facility revealed 360 Care had been to the facility on [DATE], 05/09/2024, 07/02/2024, 08/13/2024, 09/11/2024, 10/03/2024, 10/22/2024, and 01/02/2025. Review of R99's medical record revealed no evidence that R99 was seen or treated by this dental service during any of these visits. Review of facility records and observation revealed that, during the time that R99 failed to receive needed dental care, the resident (who was not on a physician-ordered weight loss plan) sustained unplanned weight loss. Review of MDS assessments dated 06/21/2024, 09/17/2024, and 12/10/2024, a weight record dated 03/10/2025, and observation on 03/20/2025 at 5:47 PM, revealed R99 sustained a weight loss of 20% (32 pounds) in the six months between 09/17/2024 - 03/10/2025, and weight loss of 42 pounds (24.4%) between 06/21/2024 - 03/20/2025, both of which constituted a severe (more extreme than significant) weight loss. (Refer to F692.) Although the care plan, date initiated 07/16/2023, called for ST/OT to evaluate as indicated, an order for Speech Therapy was not obtained until 03/19/2025, after surveyor intervention. (continued on next page)

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F 0790 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Speech-Language Pathologist (SLP) 1 on 03/19/2025 at 2:24 PM, she stated R99 had not been assessed by speech therapy until 03/19/2025. SLP1 stated that upon assessment, R99's teeth were bad, they're terrible, and that could be the reason R99 had lost weight. An interview was conducted with R99 on 03/20/2025 at 8:46 AM. The resident was observed to have communication deficits, and as a result, the State Survey Agency (SSA) team asked R99 single questions at a time, to which he would respond by answering 'yes' or 'no' and moving his head. During the interview, R99 indicated his teeth hurt all the time, and had been hurting for about one year, nodding his head up-and-down and stating, yep to both of these questions (which were asked separately). R99 also indicated that teeth pain made it difficult to eat at times, again nodding his head up-and-down and stating, yep. R99 also indicated that there were times that he was hungry due to inability to eat because of the tooth pain, as he nodded his head up-and-down stating, yep. Observation on 03/21/2025 at 2:04 PM revealed Registered Nurse (RN)6 assessed R99, who was in bed, for pain. RN6 asked R99 if he could sit up and the resident followed the instruction, sitting on the side of the bed. RN6 asked R99 if he was having any pain and R99 nodded his head up-and-down stating yep, teeth. RN6 then asked R99 Your teeth are hurting right now? R99 nodded his head up-and-down, stating yep. RN6 asked R99 Scale of 1-10, how bad? R99 replied yep, and proceeded to hold his hand up. When RN6 asked R99 if his pain was a '5', R99 motioned his left thumb up. RN6 then asked Is it a 10? to which R99 stated yep. Observation at this time revealed RN6 examined R99's mouth which revealed that the resident was missing multiple teeth in both the front and the back of the mouth, as well as, on both the top and bottom. In addition, the resident had multiple discolored teeth, with some that were partially black in appearance. Interview with Certified Nursing Assistant (CNA) 8, on 03/20/2025 at 9:34 AM, revealed that during R99's oral care, the resident would wince in pain, like someone touching a nerve. CNA8 added that he thought that was why R99 had a hard time eating. CNA8 added that he had previously informed nursing staff about the resident's dental pain, but was informed the facility was waiting on a dentist. Further interview revealed CNA8 could not remember the specifics of when or who he told about R99's dental pain. During an interview with Licensed Practical Nurse (LPN)8 on 03/20/2025 at 3:05 PM, LPN 8 stated R99's teeth looked bad, noting that some teeth were missing. LPN8 stated there was no assigned staff responsible for dealing with referrals and making appointments, saying, No one handles the appointments specifically; we do our best to make sure they're followed up on. Further interview with LPN8 revealed when a resident complains of tooth/oral pain, nursing staff were required to notify the physician and document in the Health Status Note/Progress Note. Review of R99's chart for 2025 revealed no documentation regarding teeth/oral pain or notification to the physician about such an issue. On 03/19/2025 at approximately 9:00 AM, a Regional Corporate representative brought in a typed Word Document, which she stated was a list of the times that the facility had attempted to contact the oral surgeon to whom R99 was referred. (continued on next page)

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F 0790 Level of Harm - Actual harm Residents Affected - Few	Review of this compiled document revealed it listed attempts on 07/09/2024, 08/06/2024, 09/02/2024 (Labor Day), 10/07/2024, 11/11/2024, 12/09/2024, 12/10/20/24, 12/16/2024, 01/06/2024 [sic], and 02/03/02025. For each of these 10 attempts, there was a note that the facility had called and left a message and was awaiting a call back. There were no further attempts to contact the dental provider after 02/03/2025 until 03/19/2025, after initiation of the Recertification survey. Review of the Word document revealed that during the 03/19/2025 call (which was made after surveyor intervention regarding R99's dental needs}, the facility was able to make actual contact with the provider and speak with them for the first time since the referral was made nine months earlier. Further review of the Word Document provided by the Regional Corporate representative revealed that on 11/11/2024 and 11/12/2024, the facility contacted three additional dental office (two dentists and one oral surgeon). However, the dentist declined because they were not an oral surgeon, and the oral surgeon declined to see R99, as they preferred not to take Nursing Home or residents with the resident's payor source. Review of this Word Document revealed no further attempts after 11/12/2024 to locate an any other available oral surgeons to remove R99's teeth as needed. Interview with Unit Manager (UM)1 on 03/20/2025 at 11:15 AM, revealed she took charge of the dental referral for R99. Further interview with UM1 on 03/21/2025 at 11:58 AM, confirmed that there was nothing in R99's medical record about the follow up for needed dental care. Instead, UM1 stated, she kept a spiral notebook with the calls made to the dental office at her desk because It was easier to work on in a notebook. UM1 stated she had made calls to the oral surgeon's office; however, they were not returned. She added that she had also tried outside providers, but they declined to take the resident because of his nursing home and/or payor source. Interview with R99's physician, on 03/20/2025 at 3:22 PM, revealed he had not been notified of R99 having any dental pain. The physician stated the facility had told him that they had been trying to contact a dentist but were awaiting a call back. During a joint interview with the Director of Nursing (DON) and Administrator on 03/21/2025 at 11:23 AM, the Administrator stated R99 should have been in the facility's 360 Dental Program, and that was an oversight on their part. The Administrator stated it was her expectation that staff document dental pain or oral care in the progress notes or on the Medication Administration Record (MAR) to ensure it was on the 24-hour change in condition report. The DON also stated she expected to see pain documented in the progress notes or on the Medication Administration Review (MAR). Both the Administrator and DON indicated that the resident should have been seen for the broken teeth, saying that the facility had tried, but it was difficult to find someone who would take Nursing Home residents

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47852 Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure each resident received food and drinks which were palatable, attractive, and at a safe and appetizing temperature for five of 35 sampled residents reviewed for food temperatures (Residents (R)19, R67, R86, R98, and R111). During resident council, residents expressed concerns of their food being served cold when the aides passed their trays. Observation of the breakfast meal, on 03/19/2025, revealed the sausage, eggs, biscuits, oatmeal, milk, and cranberry juice were not at an appetizing and acceptable temperature. Observation of the breakfast meal, on 03/20/2025, revealed the sausage, eggs, oatmeal, and grape juice were not at an appetizing and acceptable temperature. The findings include: Review of the facility's policy titled, Dietary Infection Control, undated, revealed temperatures must be maintained at 41 degrees (41) Fahrenheit (F) or below for cold or refrigerated food. Further review revealed temperatures must be maintained at the following Fahrenheit settings: all potentially hazardous food must be kept below 41 F and above 140 F during transportation. Continued review revealed temperatures must be maintained at 150 degrees F for pork (sausage). Observation of a test tray on 03/19/2025 at 8:55 AM, with Dietary Manager (DM) 1 and DM2 the following food temperatures were recorded: sausage: 114.0 F, scrambled eggs: 116.5 F, biscuit: 84.3 F, oatmeal, 136 F, milk: 43.0 F, and cranberry juice: 44.0 F. Observation of a second test tray on 03/20/2025 at 8:20 AM, with DM 2 and DM 3, revealed the following temperatures: sausage: 111.0 F; scrambled eggs: 111.0 F; oatmeal:138 F; and grape juice: 46 F. During the Resident Group meeting, held on 03/18/2025 at 2:00 PM, with 13 residents in attendance, three residents complained about cold food. R98 stated food often sat in the hallway and the kitchen sends it out on the carts and it sometimes sits there 20 minutes before the aides serve the food. R86 and R111 agreed the food was often cold. During an interview, on 03/17/2025 at 3:20 PM, R67 stated food was only warm about one-half the time and the food was no good. During an interview, on 03/17/2025 at 3:50 PM, R19 stated meals were not warm several times a week. During an interview, on 03/17/2025 at 6:00 PM, R98 stated food was often not warm and the food was not always pleasant tasting. During interview, on 03/19/2025 at 9:05 AM, DM1 stated the tray line was on schedule and that food service did not exceed expected preparation or delivery timeframes. DM1 stated that food temperature compliance was critical both for resident safety and palatability. DM1 stated that staff were expected to monitor food temperatures regularly during service. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 03/19/2025 at 11:40 AM, R67 stated the food was so salty you can't eat it. R67 further stated the facility would not give any eggs that were not scrambled and the texture of the eggs was rubbery. During an interview, on 03/19/2025 at 2:45 PM, the Administrator stated the plate warmer was not working correctly and was not warming the middle row of plates. Additionally, the Administrator stated that serving foods within the safe handling zone was important to prevent foodborne illnesses. During interview on 03/20/2025 at 8:27 AM, DM2 stated the trays had been delivered without delay and that the service was consistent with internal protocols. DM 2 emphasized that delivering food at safe temperatures was essential not only for infection control but also for maintaining resident satisfaction and ensuring meals were served in a palatable state. 51157

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51157 Based on observation, interview, and review of the facility's policy, the facility failed to serve food in accordance with professional standards for food service safety. The census was 132. The findings include: Review of the facility's policy titled, Tray Line and Meal Delivery Service, undated, revealed staff were to not touch the food surface areas of plates, bowls, cups, or saucers. Staff were to pick the items up by the outer rim only. Continued review revealed staff were to use tongs, spoons, scoops, etc. to serve all food including bread. Additionally, staff should wash their hands and change gloves between each task. Review of the facility's policy titled, Hand Washing, undated, revealed staff were to wash their hands after handling soiled equipment or utensils and during food preparation, as often as necessary to remove soil or contamination and to prevent cross contamination when changing tasks. Observation on 03/17/2025 at 4:15 PM revealed Cook1 touched the surface area of plates as she removed them from the plate warmer. Further observation revealed she rested her gloved hands on the surface of the plates once they were sat on the tray line. Observation revealed Cook1 used her gloved hand to move the pot roast on the plate to make it look better. Cook1 then the proceeded to use the same gloved hand to place a roll on the plate. Continued observation of the tray line revealed Dietary Aide (DA)1 answered the telephone and did not wash her hands or change gloves. DA1 continued to work the tray line touching the bowl (inside) of the spoons and the fork prongs. During an interview, on 03/17/2025 at 6:35 PM, Cook1 stated that touching the surface area of plates could lead to the contamination of food and make the residents sick. During an interview, on 03/17/2025 at 6:45 PM, DA1 stated that touching the bowl of a spoon or the prongs of a fork could pass germs to the residents, and they could get sick. DA1 stated that she was unsure of the last time training on proper hand hygiene was conducted. During an interview, on 03/17/2025 at 6:52 PM, the Corporate Registered Dietician stated that touching the surface area of plates and silverware was not good practice and food safety was the utmost concern. Continued interview with the Corporate Registered Dietician revealed that not following proper hand hygiene could lead to cross contamination of foods and make residents sick. The Corporate Registered Dietician stated that it was her expectation that all staff follow proper hand hygiene policies. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 03/17/2025 at 7:08 PM, the Dietary Manager (DM) stated that the [NAME] should not have touched the pot roast, roll, or the surface area of plates. She stated the DA should not have touched the surface area of silverware and not changed their gloves after answering the telephone. Continued interview with the DM revealed that touching the surface area of the plates and silverware, and not following proper hand hygiene could cause residents to get sick. Additionally, the DM stated that it was her expectation for all staff to follow all policies and procedures to prevent illness.

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F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough backup water supply for essential areas of the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51157 Based on observation, interview, and record review, the facility failed to ensure it had safe drinking water available when there was a loss of normal water supply for all residents. This had the ability to affect all 132 residents. The findings include: In an interview with the Administrator, on [DATE] at 11:10 AM, she stated the facility did not have a policy to address the availability of water when there was a loss of normal water supply. Further, she stated it was her expectation that the facility would have drinkable water available each day for a period of three days, for the residents consumption. Review of the facility's Water Utility Agreement, dated [DATE], revealed the city's Municipal Water Works assisted the facility with emergency water access. Review of the facility's Emergency Preparedness Plan document, dated [DATE], from the Food Service Vendor, revealed the industry standard was to have 1.5 gallons of water per person, per day, available in the event of an emergency. Observation on [DATE] at 2:15 PM revealed the facility had a total of 1,368 gallons of water stored in a temperature-controlled building. Further observation revealed 1,248 gallons of the water had expired with expiration dates ranging from ,d+[DATE]. This left a total of 120 gallons of drinkable water reserved for the residents in the event of an emergency. Review of the facility's Emergency Preparedness Plan, however, revealed the industry standard was to have 1.5 gallons of water, per person, per day, which left the facility short of available water to support the residents for three days should the facility have a loss of normal water supply. In an interview with the Maintenance Director, on [DATE] at 2:27 PM, he stated he did not check the expiration dates on the potable (drinkable) water. Per interview, the Maintenance Director stated he thought it was the responsibility of the Dietary Manager to check the expiration dates of the water. Further, he stated it never occurred to him to check the dates of the water. In an interview the Dietary Manager, on [DATE] at 3:42 PM, she stated that she did not check the expiration dates and thought it was the responsibility of the Maintenance Director. The Dietary Manager stated that she was responsible for ordering the potable water but the Maintenance Director was responsible for storing the water and should have checked the dates. In an interview with the Corporate Registered Dietician, on [DATE] at 11:06 AM, she stated that the Registered Dietician (RD) had advised the Dietary Manager to check the potable water every August. The Corporate Registered Dietician stated that she had monthly phone meetings with the Dietary Managers and reminded them all to check their expiration dates. She stated that it was her expectation that the facility had enough potable water to provide to the residents, in the event of an emergency. (continued on next page)

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F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the Administrator, on [DATE] at 11:10 AM, she stated the facility did not have a policy for potable water but stated her expectation was to have one gallon of water a day for three days for each resident, to ensure the facility could safely care for the residents, if there was a shortage of water. Additionally, the Administrator stated that it was the responsibility of the Dietary Manager to check the dates of the potable water supply.