STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185456	A. Building B. Wing	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Place	3526 Dutchmans Lane Louisville, KY 40205

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44486 Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs and preferences for two (2) of twenty-three (23) sampled residents, Resident #69 and Resident #78. The facility initiated a plan of care to keep a touch call light within Resident #69's reach, however observation revealed Resident #69 had a push-button call light. The facility initiated a plan of care to keep Resident #78's call light within reach; however, observation revealed the resident's call light was lying on his/her bedside table. The findings include: Review of the policy titled Call Lights: Accessibility and Timely Response, undated, revealed the policy's purpose was to assure the facility was adequately equipped with a call light at each resident's bedside, toilet, and bathing location to allow residents to call for assistance. Per policy review, each resident was evaluated for unique needs and preferences to determine any special accommodations that might be needed in order for the resident to utilize the call system. Continued review revealed special accommodations were to be identified on the resident's person-centered plan of care and provided accordingly. (Examples of special accommodations included touch pads, larger buttons, bright colors, etc.) Further review revealed staff were to ensure the resident's call light was within reach and secured, as needed. Review further revealed the call system was to be accessible to residents while in their bed or other sleeping accommodations within the resident's room. 1. Review of the Admission Record, for Resident #69, printed 02/09/2024, revealed the facility admitted the resident on 03/09/2021, with diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting his/her right dominant side; contracture of muscle, right hand; and generalized muscle weakness. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed Resident #69 to have no score on the Brief Interview for Mental Status (BIMS), indicating he/she was rarely/never understood. Continued review revealed the facility also assessed Resident #69 to have impairment on one (1) side of his/her upper extremity with functional limitation in range of motion of the shoulder, elbow, wrist, and hand. (continued on next page)

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #69's Comprehensive Care Plan, revealed the facility care planned the resident as at risk for falls related to balance problems due to cardiovascular accident (CVA) with right hemiplegia. Further review revealed interventions included a touch call light for Resident #69 initiated on 03/24/2021. Observation, on 02/07/2024 at 3:20 PM, revealed no visual evidence Resident #69 had a touch call light as care planned, he/she had a regular push-button type of call light. The State Survey Agency (SSA) Surveyor and Licensed Practical Nurse (LPN) #1 entered Resident #69's room, and the LPN handed the push-button type of call light to Resident #69 in his/her left hand. Continued observation revealed LPN #1 asked Resident #69 to push the call light; however, the resident wrapped his/her left fingers, thumb, and palm around the shaft of the call light device and squeezed the device with his/her left hand. Further observation revealed Resident #69 did not push the red button on the top of the call light device, and therefore the resident's call light did not activate. During an interview, on 2/07/2024 at 3:24 PM, LPN #1 stated he knew Resident #69 needed something if he/she was moaning. The LPN stated Resident #69 needed to have a touch-pad call light, which came from the facility's maintenance department. He further stated he would tell maintenance to put in an order for a touch-pad call light for Resident #69. During an interview, on 02/07/2024 at 3:42 PM the Maintenance Manager (MM) stated if someone needed a call light they could tell us, and we would get one (1) immediately. The MM searched the facility's electronic maintenance system records, and stated no one had told the maintenance department Resident #69 needed a touch-pad call light, and there was no work order for the resident to receive a touch pad call light. During further interview the MM stated the maintenance department did not make the call on who gets one (touch pad call light), nursing or management must tell us to supply a resident with a call light. The MM further stated he had just handed the last one out (touch pad call light). During an interview, on 02/09/2024 at 6:21 PM, the DON stated if a touch-pad type call light was on a resident's care plan, then a touch-pad call light should be in the resident's room. Per interview, the DON stated she had not been aware of Resident #69 having a push-button type call light, instead of a touch-pad type call as noted on his/her care plan. She further stated Resident #69 was at risk for everything, During an interview, on 02/09/2024 at 7:59 PM, the Administrator stated the care plan provided a care path for the residents. When asked what could happen if there was a touch-pad call light on a resident's care plan and the resident did not have access to a touch-pad call light, the Administrator stated it depended on the situation, but the resident might have been not able to call out for help. 2. Review of Resident #78's Admission Record, printed 02/09/2024, revealed the facility admitted the resident on 02/28/2023, with diagnoses which included: muscle weakness (generalized); type two (2) diabetes mellitus with hyperglycemia; and radiculopathy (pinching of the nerves at the root) of the lumbar region. Review of the Quarterly MDS assessment dated [DATE], revealed the facility assessed Resident #78 to have a BIMS score of thirteen (13) out of fifteen (15), indicating he/she was cognitively intact. Additional review revealed the facility also assessed Resident #78 to have impairment on both sides of upper body, with functional limitation in range of motion the shoulder, elbow, wrist, and hand. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #78's Comprehensive Care Plan, revealed the facility care planned the resident as at risk for falls related to decreased vision, medications in use, and fear of falling. Further review revealed the interventions included educating Resident #78 to ask for assistance and use hi/his/her call light before trying to transfer himself/herself, initiated on 05/15/2023. Observation, on 02/07/2024 at 10:58 AM, revealed Resident #78's call light was lying on his/her bedside table. During an interview, on 02/07/2024 at 10:59 AM, Resident #78 said his/her television in his/her room did not work, and the SSA Surveyor the television remote and asked him/her to push his/her television remote, which did not work. The SSA Surveyor then asked Resident #78 to push his/her call light to let staff know about the television not working, and he/she stated it's just so hard to reach. Observation at the time of interview, revealed the SSA Surveyor entered the hallway and saw the Director of Nursing (DON) and asked her to come into Resident #78's room and look at something. Further observation revealed State Registered Nurse Aide #12 was nearby and also entered the resident's room. In addition, observation further revealed as SRNA #12 approached Resident #78's bedside table, she moved the resident's call light from the bedside table and clipped it to the resident's bedsheets. During an interview, on 02/07/2024 at 11:10 AM, the DON stated housekeeping staff had just moved Resident #78's call light onto the bedside table while they were cleaning the resident's room. During an interview, on 02/07/2024 at 11:30 AM, Housekeeper #1 stated, using a language translator application on his phone, that he had been trained not to touch residents' call lights and to call the nurse about call lights issues. Housekeeper #1 and the SSA Surveyor walked to Resident #78's room and observed the resident's call light. Housekeeper #1 then stated he had not cleaned Resident #78's room yet. During an interview, on 02/09/2024 at 4:45 PM, the Housekeeping Manager stated the facility's housekeeping staff were trained to not move residents' call lights. Per interview, the Housekeeping Manager stated if housekeeping staff saw a resident's call light lying on the floor, they were to notify nursing staff. During an interview, on 02/09/2024 at 3:40 PM, SRNA #3 stated if a call light was not within reach of the resident, he/she might roll out of bed and hurt himself/herself. During an interview, on 02/01/2024 at 4:24 PM, Registered Nurse #1 stated the SRNA's and Nurses rounded on residents to make sure their call lights were within reach. The SSA Surveyor asked RN #1 if there was a potential that a resident could fall, or have other potential outcomes, if his/her call light was not within reach; however, the RN did not answer the question. During an interview, on 02/09/2024 at 7:36 PM, the Regional Resident Assessment Instrument (RAI) Coordinator stated lots of work went into developing the care plans, which were to provide guidance for residents' care needs and any problems the resident had. The Regional RAI Coordinator stated if a resident's care plan indicated the call light was to be kept within the resident's reach, the expectation was for the call light to be kept within the resident's reach. The Regional RAI Coordinator further stated an outcome for a resident whose care plan was not implemented would be the resident experiencing an unmet need. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 02/07/2024 at 3:42 PM, when asked how something broken in a resident's room was fixed, the Maintenance Assistant stated either the nurse, the aide or the unit manager could put an order in the electronic maintenance system. He further stated if he was just walking through the building he would just go in there (meaning a resident's room that needed maintenance service) and do it for them (fix the problem the resident had). During an interview, on 02/09/2024 at 6:21 PM, the DON stated it was the expectation call lights be within each resident's reach. The DON stated for residents who had weaknesses and were not able to push the call light button, they could benefit from touch-pad type call light which they just had to tap on. The DON stated the facility needed to have residents' call lights close to them and within reach.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44486 Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment for one (1) of twenty-three (23) sampled residents, Resident #69. The facility initiated a care plan intervention to keep a touch call light within Resident #69's reach; however, observation revealed the resident had a push-button call light. The findings include: Review of the policy titled, Comprehensive Care Plans, undated, revealed it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident which was consistent with resident rights. Continued review revealed residents' comprehensive person-centered care plans that included measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs as identified in the resident's comprehensive assessment. Further review revealed the comprehensive care plan was to describe, at a minimum, the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review of the policy titled, Call Lights: Accessibility and Timely Response, undated, revealed the policy's purpose was to assure the facility was adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Per review, each resident was to be evaluated for his/her unique needs and preferences to determine any special accommodations that might be needed in order for the resident to utilize the call system. Continued review revealed special accommodations were to be identified on the resident's person-centered plan of care and provided accordingly. (Examples included: touchpads, larger buttons, bright colors, etc.) Further interview revealed staff were to ensure the call light was within reach of the resident and secured, as needed. Review of the Admission Record, for Resident #69, printed 02/09/2024, revealed the facility admitted the resident on 03/09/2021, with diagnoses that included Hemiplegia (paralysis of one [1] side of the body) and Hemiparesis (partial weakness of one [1] side of the body) following a cerebral infarction affecting right dominant side, contracture of muscle in the right hand, and generalized muscle weakness. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 11/17/2023, revealed the facility assessed Resident #69 to have no score on the Brief Interview for Mental Status (BIMS) assessment, indicating the resident was rarely/never understood. Additionally, the facility assessed Resident #69 to have impairment on one (1) side of his/her body with functional limitation in range of motion of the upper extremity (shoulder, elbow, wrist, hand). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #69's Comprehensive Care Plan revealed the facility care planned the resident as at risk for falls related to balance problems due to the cardiovascular accident (CVA) which resulted in right Hemiplegia. Further review revealed an intervention the facility initiated on 03/24/2021, for Resident #69 to have a touch call light (a sensitive touchpad which gave residents with limited movement the ability to summon help). Observation, on 02/07/2024 at 3:20 PM, revealed Resident #69 had a regular push-button type of call light which Licensed Practical Nurse (LPN) #1 handed to the resident and asked him/her to push to alert staff. Continued observation revealed Resident #69 wrapped his/her left fingers, thumb, and palm around the shaft of the push button call light device and squeezed with his/her left hand. However, further observation revealed Resident #69 did not touch or push the red button on the end of the call light device, therefore the resident's call light did not activate. During an interview, on 2/07/2024 at 3:24 PM, LPN #1 stated if Resident #69 was moaning he knew the resident needed something. LPN #1 then stated Resident #69 needed a touchpad call light, which came from the maintenance department. He stated he would tell maintenance to put in an order for a touchpad call light for Resident #69. During an interview, on 02/09/2024 at 7:36 PM, the Regional Resident Assessment Instrument (RAI) Coordinator stated lots of work went into residents' care plans. Per the Regional RAI Coordinator, the care plan was to provide guidance for staff regarding the care needs and problems of the resident. The Regional RAI Coordinator further stated a possible outcome for a resident whose care plan was not implemented would be for the resident to have an unmet need. During an interview, on 02/07/2024 at 3:42 PM, the Maintenance Manager (MM) stated if someone needed a call light staff could tell us, and maintenance would get one (1) immediately. The MM searched the facility's electronic maintenance system records and stated no work order had been placed in the electronic maintenance system for Resident #69 to receive a touchpad call light. The MM stated no one had notified the maintenance department of Resident #69's need for a touchpad call light. During further interview the MM stated the maintenance department did not make the call on who gets a touchpad call light, nursing or management must tell us to supply a resident with a call light. The MM further stated, I did have one touchpad in stock, and just handed it out for Resident #69's use. In addition, the MM stated more touchpads were on order. During an interview, on 02/09/2024 at 6:21 PM, the DON stated it was the facility's expectation all call lights to be within a resident's reach. The DON stated for residents who had weaknesses and were not able to push the regular call light button, a touchpad type call light could be utilized which the resident could tap on to alert staff. She stated Resident #69 should have had a touchpad type call light. The DON stated if a touchpad type call light was on a resident's care plan, then a touchpad call light should be in that resident's room. Further interview revealed the DON stated she was not aware Resident #69 had a push-button type call light earlier that week, instead of the touchpad type call light noted on the resident's care plan. In addition, the DON stated Resident #69 was at risk for everything. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 02/09/2024 at 7:59 PM, the Administrator stated residents' care plans provided a care path for the residents' needs. The State Survey Agency (SSA) Surveyor asked the Administrator what could happen if there was an intervention for a touchpad call light on a resident's care plan, but the resident did not have the touchpad call light. The Administrator stated it depended on the situation, but the resident might not have been able to call out for help.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45914 Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, as based on the comprehensive assessment of the resident, the comprehensive person-centered care plan, and the resident's choices for one (1) of twenty-three (23) sampled residents (Resident #22). Review of Resident #22's Physician's Orders dated 01/20/2024 and the resident's Treatment Administration Record (TAR) dated 02/2024, revealed wound care orders for his/her wound on the right foot anterior first digit to be provided daily at bedtime. However, observation on 02/08/2024, revealed a gauze with tape noting the date of 02/03/2024, and the bottom of the gauze dressing on Resident #22's left foot was reddish-brown in color and was soiled with what resembled blood seeping through the gauze. The findings include: Review of the facility policy titled, Wound Treatment Management, undated, revealed the policy was to promote wound healing of various types of wounds and provide evidence-based treatments in accordance with current standards of practice and physician orders. Further review revealed wound treatments were to be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. Review of Resident #22's Electronic Health Record (EHR) revealed the facility admitted Resident #22, initially on 07/07/2023, with last readmitted on 11/30/2023, with diagnoses which included Cerebral Infarction due to Embolism of left middle cerebral artery, Diabetes Mellitus due to underlying condition with foot ulcer, Cellulitis of right lower limb, and other acute Osteomyelitis, right ankle, and foot. Review of Resident #22's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three (03) out of fifteen (15) indicating he/she was severely cognitively impaired and not interviewable. Review of Resident #22's physician order dated 01/20/2024, revealed an ongoing order to cleanse the wound to the resident's right anterior foot, first digit with wound cleanser, apply betadine (topical antiseptic used for infection protection) to the base of the wound, secure with an abdominal (ABD) pad and wrap with rolled gauze at bedtime and change as necessary (PRN). Review of Resident #22's Treatment Administration Record (TAR) dated 02/2024 revealed the resident's wound care was to be provided daily by nursing staff. Further review of the TAR revealed RN #2 had signed off Resident #22's wound care as having been completed on 02/03/2024 through 02/07/2024. Observation of Registered Nurse (RN) #2, on 02/03/2024 at 9:30 PM, revealed Resident #22's door was slightly ajar and RN #2 was observed performing wound care for Resident #22's feet, and dated the dressing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional observation of Resident #22, on 02/08/2024 at 1:45 PM, revealed State Registered Nurse Aide (SRNA) #4 and SRNA #10 were obtaining Resident #22's current weight via a Hoyer lift. Per observation, while Resident #22's protective boots were off, the State Survey Agency (SSA) Surveyor observed the tape holding the gauze on both the resident's right and left foot was dated 02/03/2024, and was initialed by RN #2. Further observation revealed the gauze on the bottom of Resident #22's left foot was reddish-brown in color and was soiled with what resembled blood seeping through the gauze. In an interview with RN #2, on 02/08/2024 at 3:34 PM, he stated he had made a mistake and marked the wrong date on the tape holding Resident #22's dressing in place. RN #2 stated he dated the dressing 02/03/2024, which was a mistake. He stated he was aware of who Resident #22 was and he stated he had provided wound care daily every night he had worked, 02/03/2024 through 02/07/2024. RN #2 stated he did the treatment for both the resident's feet; however, had just kept repeating the first date he had written on the tape he originally placed on it, which was 02/03/2024. In an interview with SRNA #4, on 02/08/2024 at 3:50 PM, she stated RN #5 and RN #1 completed Resident #22's wound care, after the observation by the State Survey Agency (SSA) Surveyor of the incorrect date noted on the dressing. She stated she was aware the nurses were to date the wound care treatment dressings; however, did not recall the past date on the tape holding the gauze covering Resident #22's feet. In an interview with the Nurse Practitioner (NP), on 02/09/2024 at 6:15 PM, she stated she was in the facility everyday; however, was not involved with the daily wound care for residents. She stated she only became involved if a resident's wound had become infected. Per the NP, Health Partners wound care usually handled everything else related to wounds. She stated her expectations for the facility's nursing staff was for would care to be provided as ordered. Additionally, she stated the Wound Care Practitioner checked on resident's wounds weekly. In an interview with the DON, on 02/09/2024 at 7:00 PM, she stated when a nurse provided wound care they were required to date the dressing, and sign off on the wound care on the resident's TAR. The DON stated nurses were to also enter any observed changes to the wound and document those changes in the resident's EHR. She stated if the date on a dressing was incorrect that would be a concern for residents with wounds. The DON stated providing proper wound care was a priority. Per the DON, if the nurse had not completed the wound care or noted the incorrect date of completion, the nurse was to be written up, reeducated, and made aware of the risk of not completing proper wound care as ordered. She stated the residents had the potential for harm as their wound could worsen, which could potentially be dangerous for the resident's health. The DON further stated her expectation for nursing staff providing wound care was for them to follow the provided guidance and physician's orders. In an interview with the Administrator, on 02/09/2024 at 8:15 PM, she stated expectations were for nursing staff to follow physician's orders when completing a resident's wound care. She stated she did not believe there was potential for harm to other residents; however, if the wound splashed onto the nurse there could be possible harm for the staff member. The Administrator stated it was her expectation for nursing staff to date wound care dressing changes to ensure other staff were aware of when the wound care had been completed and to prevent any further deterioration of the wound.

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F 0692 Level of Harm - Minimal harm or potential for 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** 45914 Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range unless the resident's clinical condition demonstrates that this was not possible or resident preferences indicated otherwise for one (1) of twenty-three (23) sampled residents, (Resident #22) who had exceeded a twelve (12) percent weight loss in sixty-seven (67) days. The findings include: Review of the facility policy titled, Nutritional Management, dated 2023, revealed the facility was to provide care and services to each resident to ensure the residents maintained acceptable parameters of nutritional status in the context of his or her overall condition. Continued review revealed a systematic approach was used to optimize each resident's nutritional status. Further review revealed optimizing the residents' nutritional status included: identifying and assessing each resident's nutritional status and risk factors; evaluating and analyzing the assessment information; developing and consistently implementing pertinent approaches; and monitoring the effectiveness of interventions and revising them as necessary. Review of Resident #22's Electronic Health Record (EHR) revealed the facility admitted the resident, initially on 07/07/2023, with a last readmitted [DATE], with diagnoses of: acute Osteomyelitis, right ankle and foot; Diabetes Mellitus; foot ulcer; Cellulitis of right lower limb; and Cerebral Infarction due to Embolism of left middle cerebral artery. Review of the Quarterly Minimum Data Set (MDS) Assessment for Resident #22, dated 12/06/2023, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three (03) out of fifteen (15) which indicated he/she was severely cognitively impaired and not interviewable. Review of the facility's weights and vitals summary for Resident #22, dated 12/03/2023, revealed the resident weighed 191.5 pounds (lbs) and on 02/08/2024, the resident was noted to weigh 168 lbs. (Which was calculated as a -12.27 percent weight loss). Review of the facility's documented nutrition intake for Resident #22, for the time period of 12/01/2024 through 02/06/2024, revealed the percentages of the resident's meals noted as eaten per occurrence: was 0-25% for eight (8) meals; 26-50% for twenty (20) meals; 51-75% for thirty-five (35) meal times; 76-100% occurred for one hundred and twenty (120) meals. In addition, review of the nutrition intake documented for Resident #22 revealed the resident noted to have refused meals two (2) times, and not applicable documented for three (3) meal times. (continued on next page)

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	185456	A. Building B. Wing	02/09/2024

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Seneca Place	3526 Dutchmans Lane Louisville, KY 40205

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #22's physician's orders initiated on 12/08/2023, with a start date of 12/08/2023, revealed orders for a Consistent Carbohydrate Diet (CCD) and 2 Gram sodium (salt) diet with Dysphagia pureed texture, regular (None/Thin) consistency, for his/her diet. Continued review revealed the orders included for Resident #22 to have double portions. Per review of the physician's orders, Resident #22 had orders initiated on 12/14/2023 with start date of 12/15/2023 for multi-vitamin/minerals supplement, one (1) tablet to be administered by mouth one (1)time a day. Further review revealed physician's orders dated 12/15/2023, with a start date on 12/16/2023, for Glucerna supplements twice a day at 240 cc. Continued review of Resident #22's physician's orders revealed an order dated 01/18/2024 with start date of 01/18/2024, for Mirtazapine (an antidepressant medication with a side effect of weight gain) oral tablet 7.5 mg, one (1) tablet by mouth at bedtime for weight. Review of Resident #22's comprehensive care plan revealed the facility care planned the resident for potential/actual weight loss with interventions. Continued review revealed Resident #22's care plan was updated to reflect the physician's orders for the dates of 12/08/2023, 12/14/2023, 12/15/2023, and 12/18/2023. Observation of Resident #22 on 02/04/2024 at 12:45 PM, revealed State Registered Nurse Aide (SRNA) #4 was talking to and feeding the resident. Continued observation revealed SRNA #4 continually asked Resident #22 if he/she was still hungry or was finished eating. Further observation revealed Resident #22 was drowsy and did not continue to eat. In an interview with SRNA #4, on 02/08/2024 at 1:30 PM, she stated Resident #22 needed feeding assistance, and she had to report the resident's food intake at every meal, and document the results in the Kardex (SRNA care plan). She stated when Resident #22 did not want anything to eat she reported that to the nurse. SRNA #4 stated whenever Resident #22 did not want to eat what was provided she offered the resident something else to eat. She stated Resident #22 loved to eat breakfast, sometimes skipped lunch; however, usually ate his/her dinner meal. SRNA #4 stated when she assisted Resident #22 with eating, the resident was able to express when he/she was full. She further stated Resident #22 was a weekly weight and resident's weights were conducted by two (2) SRNAs with the use of the mechanical lift. Observation of Resident #22, on 02/08/2024 at 1:45 PM, revealed SRNA #4 and SRNA #10 were operating the mechanical lift to obtain the resident's current weight. Continued observation revealed revealed SRNA #10 removed the resident's boots to obtain an accurate weight. Per observation, the first attempted weight was 168 lbs and SRNA #4 questioned Resident #22's weight loss from Tuesday to Thursday, so she performed second weight which was 168.1. Further observation revealed the SRNAs obtained a third weight for Resident #22 which was 167.1 lbs. In addition, SRNA #4 noted Resident #22's weight on 02/06/2024, had been 173 lbs per the SRNA's list of weekly weights. Review of Resident #22's EHR revealed the facility's Interdisciplinary Team (IDT) risk review dated 01/24/2024, noted the resident's orders for 7.5 mg Mirtazapine, and 240 ml Glucerna twice daily were in place, and the resident's intake averaged 50%. Continued review revealed Resident #22's double meal portions for his/her meal intakes appeared to usually be 51-100%. Per review, Resident #22 was to continue on the facility's Nutrition at Risk (NAR) program due to his/her previous weight loss with no recommendations; however,consultations with the Registered Dietician (RD) as necessary (PRN) was noted. Additionally, review of the IDT risk review, revealed the IDT members in attendance for the review were the RD and Assistant Director of Nursing (ADON). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional review of Resident #22's EHR revealed a progress note dated 01/24/2024, revealed the resident was discussed in the weekly NAR meeting and had experienced a one (1) pound weight loss. Further review of the progress note revealed no new RD recommendations were noted at that time; however, staff were to continue to assist Resident #22 with his/her meals. Observation of Resident #22 on 02/09/2024 at 1:21 PM, revealed SRNA #14 assisted the resident with eating his/her lunch meal, of pureed sweet potatoes, pureed meat with gravy, ice cream, and tea. Continued observation revealed SRNA #14 sat with Resident #22, feeding him/her the food, and asking between each bite if he/she was ready for more or was he/she still hungry. Further observation revealed Resident #22 ate all items on the plate and drank all of the tea and some water. In an interview with the Nurse Practitioner (NP) on 02/09/2024 at 6:15 PM, she stated the RD monitored residents' weight loss and added them to the IDT risk review list. She stated she did not recall if she had been notified of Resident 22's weight loss, but stated either the DON or RD made her aware when recommendations were made. She stated when she received the recommendations as orders she signed off on the orders. The NP further stated the RD sometimes recommended an appetite stimulant such as Mirtazapine that helped increase the resident's appetite. In an interview with DON, on 02/09/2024 at 7:00 PM, she stated Resident #22 was in the facility's NAR program. She stated the SRNAs were asked about residents' meal intakes and the RD tracked the residents' weights. The DON stated the SRNAs were to report any concerns with residents who had not eaten or consumed very little of their meals. She stated if Resident #22 had orders to receive a Glucerna supplement she expected staff to follow the physicians orders. The DON stated when Resident #22 received the Glucerna as per the physician's orders, that information was to be tracked in the resident's EHR on the date he/she received the supplement. She stated Resident #22 had a State Guardian who had been made aware of the weight concerns regarding the resident, and the interventions being implemented. The DON further stated the State Guardian was trying to initiate palliative care for Resident #22 because of his/her decreasing weight loss, severity of his/her wounds, and decreased mental status. In an interview with the Administrator, on 02/09/2024 at 8:15 PM, she stated the IDT met to discuss the residents on the NAR list. She stated they looked at residents' weights, and obtained the residents' weight for four (4) weeks, or longer if needed. The Administrator stated the IDT tried to determine what could be done to help a resident to gain weight, which could include protein supplements, vitamins, and/or increased food intake. She stated the Dietician helped tremendously by making recommendations such as when it would be appropriate to consider gastrostomy tube (g-tube) placement. The Administrator stated there was ongoing discussion with Resident #22's State Guardian, state nurses and doctors with the IDT team to determine if palliative care was the best option due to the resident's co-morbidities and wounds. She stated oversight to ensure interventions were put into place and carried out had been completed by conducting rounds. The Administrator further stated depending on what the concern was related to and what interventions had been implemented, administrative staff could better ensure those interventions were in place, and the processes were being followed by all staff.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44974 The facility failed to ensure all drugs and biologicals were labeled and stored in accordance with professional standards to include labels, the date opened and the securement of medication carts for two (2) of four (4) medication carts observed out of the facility's total of eight (8) medication carts. Observation of one (1) medication cart revealed it was left unlocked and unattended while the Registered Nurse (RN) passed medications to residents in their rooms. In addition, opened, undated medications were observed stored in medication carts. The findings include: Review of the facility policy titled, Storage of Medications revised 08/2020, revealed medications and biologicals were to be stored safely, securely, and properly, following the manufacturer's recommendations or recommendations of the supplier. Per policy review, the medication supply was to be accessible only to licensed nursing personnel, or staff members lawfully authorized to administer medications. Continued review revealed only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) were permitted to access medications. In addition, policy review further revealed medication rooms, carts, and medication supplies were to be locked when they were not attended by persons with authorized access. Observation on 02/03/2024 at 7:35 PM, of the medication cart on E Hall revealed it was left in the hallway with no attending staff. Observation at 7:37 PM, RN #9 came out of a resident's room and returned to the medication cart. Continued observation at 7:44 PM, revealed RN #9 went to another resident's room and leaving the medication cart unlocked and unattended. Further observation of the medication cart, from 7:44 PM through 7:49 PM, revealed the medication cart continued to sit in the hallway on the E Hall unlocked while RN passed medications to residents in their rooms. Additional observation revealed at 7:49 PM, RN #9 returned to the medication cart and locked it. During an interview on 02/09/2023 at 7:51 PM, with RN #9 he stated he was not supposed to leave the medication cart unlocked at anytime that he was not present at the cart. He further stated any resident or others could take medications from the cart. Observation on 02/09/2024 at 4:12 PM, revealed the facility had medication carts located on halls A, B, C (two [2]carts), D, E, F, G, for a total of eight (8) medication carts containing insulin vials and pens. Observation of a medication cart on the C-Hall revealed two (2) vials of insulin without an opened date. Continued observation of the C-Hall medication cart revealed one (1) insulin pen not labeled with opened date. Further observation revealed a container of Nitroglycerin 0.4 milligram (mg) for sublingual use, which had no opened date. In addition, Active Liquid Protein multidose bottle, Levetiracetam liquid multidose bottle, Milk of Magnesium liquid multidose bottle, Amantadine liquid multidose bottle, and Polyethylene Glycol multidose bottle which were all opened, and not expired; however had no opened dates noted.) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN #7 on 02/09/2024 at 4:30 PM, she stated they were supposed to put an open date on each medication once it was opened for multidose medications. RN#7 stated persons passing medications were to appropriately discard any medications left when a resident was discharged . The RN further stated insulin pens and bottles were to be refrigerated until opened; however, once opened the insulin pens were to be dated and could remain on the medication cart for twenty-eight (28) days before being discarding. Observation on 02/09/2024 at 4:45 PM, of the E-Hall medication cart revealed two (2) inhalers not labeled with an opened date. Further observation of the E-Hall medication cart revealed a Liquid Protein multidose bottle and Chlorhexidine liquid multidose vial opened with no opened date noted. In interview with RN #1 on 02/09/2024 at 4:50 PM, he stated medications should always be labeled with an opened date and any expired medications were to be discarded per the facility's protocol. RN#1 further stated the medication cart should always remain locked when unattended or not in use. During an interview on 02/09/2024 at 7:50 PM, with the Executive Director (ED) she stated her expectations were for staff administering medications to ensure all medications were secured as per policy. She stated she expected those staff were also to ensure medications were labeled, stored, and disposed of properly as per policy. The ED further stated oversight was provided by administrative and nursing managers through walking rounds performed daily. During an interview on 02/09/2024 at 9:15 PM, with the Director of Nursing (DON) revealed her expectations were for the medication carts to always be locked when not attended by staff. The DON stated she expected an opened date to be noted on medications as soon as they were opened to ensure resident safety. The DON further stated she would re-educate staff immediately. She stated she would ensure ongoing education was provided regarding administering medications, and on ensuring medications were secured and labeled properly, and reprimand staff as needed for not following the facility's policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45914 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for two (2) of twenty-three (23) sampled residents (Residents #22 and #69). Observation revealed Enhanced Barrier Precautions (EBP) signage outside Resident #22's room with guidance for staff; however, a Registered Nurse (RN) was observed to enter the resident's room without donning the appropriate Personal Protective Equipment (PPE) and provide wound care for him/her. Additionally, observation revealed no PPE located outside the resident's door as per the facility's policy. Observation revealed Resident #69 was on Enhanced Barrier Precautions (EBP) related to having an indwelling medical device (gastrostomy tube). However, on 02/07/2024, a facility staff member was observed providing personal hygiene care for Resident #69 without her Personal Protective Equipment fully donned, which allowed the staff member's clothing to come into contact with Resident #69's bed linens. The findings include: Review of the facility policy titled, Enhanced Barrier Precautions, dated 2023, revealed the policy was to implement EBP for the prevention of transmission of multidrug-resistant organisms (MDRO). Per review, Enhanced barrier precautions refer to the use of gown and gloves, or Personal Protective Equipment (PPE) for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Continued policy review revealed when EBP were implemented, gowns and gloves were to be available immediately outside of the resident's room. Additionally, further review revealed high-contact resident care activities included wound care of any skin opening requiring a dressing, providing hygiene, changing briefs, or assisting with toileting. 1. Review of Resident #22's Electronic Health Record (EHR) revealed the facility admitted the resident, initially on 07/07/2023, with last readmitted on 11/30/2023. Continued review of the EHR revealed the facility admitted Resident #22 with diagnoses which included: Osteomyelitis, right ankle, and foot; Cerebral Infarction due to Embolism; Diabetes Mellitus due to underlying condition with foot ulcer; and Cellulitis of right lower limb. Review of the Quarterly Minimum Data Set (MDS) Assessment for Resident #22 dated 12/06/2023, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15), which indicated he/she had severe cognitive impairment and was not interviewable. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/03/2024 at 9:30 PM, revealed signage outside Resident #22's room noting the resident was on Enhanced Barrier Precautions (EBP) due to wounds, with guidance for staff. Continued observation revealed Registered Nurse (RN) #2 was in Resident #22's room, with the door slightly ajar which allowed observation of RN #2 performing wound care for Resident #22's feet. Observation revealed however, RN #2 did not don a gown as required for EBP. Observation of B Hall, where Resident #22 resided, on 02/04/2024 and on 02/08/2024, at various times revealed no visual evidence of personal protective equipment (PPE) located outside of Resident #22's door. In addition, observation further revealed only one (1) bin had been placed in the B hallway. In interview with RN #2, on 02/03/2024 at 9:30 PM, he stated he was a new RN since 10/2023. He stated he had provided wound care for Resident #22 and had forgotten to wear a gown as required. RN #2 stated there could be potential for harm for Resident #22 if staff were not following the requirements for someone on EBP. Additionally, he stated possible outcomes from not following the EBP requirements could include the spread of germs to others or cause infections, or cause residents to get sick. 2. Review of the Admission Record, printed 02/09/2024, for Resident #69 revealed the facility admitted the resident on 03/09/2021, with diagnoses that included gastrostomy tube (indwelling medical device); Hemiplegia and Hemiparesis following cerebral infarction affecting the right dominant side; contracture of muscle of the right hand; and generalized muscle weakness. Review of the Quarterly MDS assessment dated [DATE], revealed the facility assessed Resident #69 to have impairment on one (1) side of of his/her upper extremity causing functional limitation in range of motion of shoulder, elbow, wrist, and hand. Further MDS review revealed the facility assessed Resident #69 as dependent on facility staff for personal hygiene. Review of Resident #69's Comprehensive Care Plan, revealed the facility care planned the resident as at risk for falls related to balance problems related to cardiovascular accident (CVA) with right Hemiplegia. Further review of the CCP revealed an intervention the facility initiated on 05/05/2023, for staff to assist Resident #22 with his/her toileting/incontinence care. Observation on 02/03/2024 at 8:33 PM, revealed EBP signage on the door of Resident #69's room. Continued observation revealed the resident was lying on his/her bed, with a tubefeeding pump and tubing connected to a bottle of tubefeeding and to the resident via his/her gastrostomy tube (g-tube). Further observation revealed the tubefeeding pump was running, Observation on 02/07/2024 at 10:09 AM, revealed State Registered Nurse Aide (SRNA) #12 donned PPE which included a gown and gloves in preparation to enter Resident #69's room to provide personal hygiene care for the resident. Continued observation revealed SRNA #12 knocked on the door and entered the resident's room. The State Survey Agency (SSA) Surveyor then, with permission from SRNA #12, also entered Resident #69's room. Further observation revealed SRNA #12's PPE gown was not tied in the back and her gown fell down over her shoulder in front exposing the right side of the SRNA's uniform top and pants. In addition, observation further revealed SRNA #12's uniform clothing touched Resident #69's bed while she was giving Resident #69 a bed bath. Observation further revealed SRNA #12's right side of her uniform top and pants continued to come into contact with the right side of Resident #69's bedsheets. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 02/07/2024 at 10:36 AM, SRNA #12 stated her gown should have been tied in back; however, she stated she had trouble reaching around behind her and that's why she had not tied the gown. SRNA #12 stated when using the green PPE gowns she had to tie it in back first and then put the gown over her head. Observation, on 02/07/2024 at 10:51 AM, revealed SRNA #1 exited a resident's room, walked down hallway past three (3) other residents' rooms to reach the bin containing PPE. Continued observation revealed SRNA #1 retrieved PPE from the bin, and returned to the resident's room where she had been providing care, which required her to walk back down the hallway and past the three (3) other residents' rooms. During an interview, on 02/07/2024 at 10:56 AM, SRNA #1 stated walking past three (3) residents' rooms twice to get the required PPE made her feel like it was a whole lot of extra work. In an interview with the DON, on 02/09/2024 at 7:00 PM, she stated her expectation was for nurses and SRNA's providing resident care to follow the facility's guidance and wear gloves and gowns when residents were on EBP. Additionally, she stated if nursing staff were not following the facility's guidance provided for EBP, residents could experience potential harm through staff carrying germs or other bacteria from other residents' rooms. In an interview with the Administrator, on 02/09/2024 at 8:15 PM, she stated her expectations were for nursing staff to follow physicians' orders and the facility's EBP guidelines when completing care for residents. She further stated EBP guidelines were provided for protection of staff as well as the safety of all residents. 47567