STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225294	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Andover Manor Rehab and Nursing	89 Morton Street Andover, MA 01810

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43846 Based on observation and interviews the facility failed to provide a dignified dining experience for several residents on one resident care unit (The dementia care unit), out of three resident units. Findings include: Review of the facility's policy and procedure, titled Dining Room Rounds, dated as revised November 5, 2024, indicated the following: Our facility audits the food services department regularly to ensure that resident needs are being met and that dining is a safe and pleasant experience for residents. Policy Interpretation and Implementation 2. The auditor will assess: d. If residents at each table are served together, f. If adequate staff are available to assist with passing trays, meal set-up, and feeding. During an observation during the breakfast meal service on the dementia care unit the following was observed: On 1/6/25 at 8:38 A.M., table one's first resident received their meal at 8:38 A.M., the next resident did not receive their tray until 8:51 A.M., thirteen minutes later. On 1/6/25 at 8:40 A.M., table three's first resident received their meal at 8:40 A.M., the next resident did not receive their tray until 8:48 A.M., eight minutes later. On 1/6/25 at 8:46 A.M., table four's first resident received their meal at 8:46 A.M., the next resident did not receive their tray until 8:52 A.M., six minutes later. On 1/6/25 at 8:43 A.M., table five's first resident received their meal at 8:43 A.M., the last resident did not receive their tray until 8:49 A.M., six minutes later. The first resident was observed trying to feed his/her table mate. During the lunch meal service on 1/6/24 on the Dementia Care Unit, the following was observed: (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/6/25 at 12:42 P.M., table two's first resident received their meal at 12:42 P.M., the next resident did not receive their tray until 12:52 P.M. ten minutes later. On 1/6/25 at 12:38 P.M., table three's first resident received their meal at 12:38 P.M., the last resident did not receive their tray until 12:55 P.M. seventeen minutes later. During an interview on 1/6/25 at 9:08 A.M., Nurse #9 said mealtime tray pass is chaotic and the staff do not get help from other floors or other departments. Nurse #9 said that each table should be served in order so the residents at the table do not have to wait to receive their meal.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review and interview, the facility failed to ensure Advance Directives (written documents that instructs health care providers of the decisions for specific medical treatment if a person was unable to speak or lacked the capacity to make decisions for themselves) were consistently documented in the medical record for one Resident (#94), out of a total sample of 29 residents. Findings include: Review of the facility policy titled Advanced Directives, dated 11/5/24, indicated The Advanced Directive shall be reviewed and updated upon resident request, with the comprehensive care plan, and with significant changes in resident. The Facility will implement the instructions outlined in the Advanced Directive. Resident #94 was admitted to the facility in February 2024 with diagnoses that included dementia, adult failure to thrive, and anxiety. Review of Resident #94's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a zero out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident has severe cognitive impairments. The MDS further indicated the Resident's code status is DNR (Do Not Resuscitate) and DNI (Do Not Intubate). Review of Resident #94's physician order, dated 5/21/24, indicated FULL CODE, Do not Intubate and Ventilate, No artifial [sic] Nutrition. Review of Resident #94's MOLST (Medical Orders for Life Sustaining Treatment), dated 8/29/24, indicated the Resident is a DNR, DNI, no dialysis, no artificial nutrition. During an interview on 1/8/25 at 1:43 P.M., Nurse #3 said the MOLST should match the physician order so the nurses are clear on what the code status is for that Resident. Nurse #3 reviewed Resident #94's MOLST with the surveyor and said it does not match the physician order. During an interview on 1/8/25 at 1:49 P.M., the Director of Nurses (DON) said the MOLST should match the physician order.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 43807 Based on observations, interviews and record review, the facility failed to maintain privacy and confidentiality of personal and medical records on one out of three resident units. Findings include: A review of the facility policy titled 'Patient Confidentiality' revised November 2024 indicated the following: -Patient confidentiality is keeping information about a patient's healthcare private. -Protect all records-keep all resident information covered. Don't leave it where unauthorized people can see it. On 1/6/25 at 8:02 A.M., the surveyor observed Nurse #10 at the medication cart. Nurse #10 walked away from the medication cart down the hall, left the computer screen unlocked revealing residents' medical and private information. Nurse #10 returned to the medication cart, did not lock the computer screen, walked away from the medication cart again, and walked down the hall. On 1/7/25 at 12:50 P.M., the surveyor observed Nurse # 11 at the medication cart. Nurse #11 walked away from the medication cart to the medication room leaving the computer screen unlocked revealing residents' medical and private information. Nurse #11 returned to the medication cart, left the computer screen unlocked, went into a resident's room, then walked back to the medication room. During an interview on 1/7/25 at 1:43 P.M., Nurse #11 said she is supposed to lock the computer screen to maintain privacy of the medical record when she walks away from the medication cart. During an interview on 1/7/25 at 2:58 P.M., Nurse #10 said the medication cart computer should always be locked to protect resident medical records if the Nurse is not at the medication cart. During an interview on 1/9/25 at 1:04 P.M., the Director of Nurses said she expects the Nurses working on the medication carts to lock their computer screen prior to walking away from the medication cart. She said this ensures that the residents' medical information is kept private and confidential.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on record review and interviews, the facility failed to prevent a resident-to-resident altercation between two Residents (#56 and #23) out of a sample to 29 residents. Specifically, the facility failed to prevent Resident #23 from pinching Resident #56's left cheek. Findings include: A review of the facility's policy titled 'Resident Right to Freedom from Abuse, Neglect and Exploitation' with a revision date of October 2024 indicated the following: -The Facility's residents have the right to be free from abuse as defined in this policy. This policy applies to any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the facility. -The Facility shall review altercations from resident to resident as a potential situation of abuse. -Staff shall monitor for any behaviors that may provoke a reaction by residents or others, which include but are not limited to, physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures and throwing objects. -When the Facility has identified abuse, the Facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The Facility will increase enforcement action, including, but not limited to: -Taking steps to prevent further potential abuse. -Reporting the alleged violation and investigation within required timeframes pursuant to Federal and State statutes and regulations. -Conducting a thorough investigation of the alleged violation. -Taking appropriate corrective action. A review of a Facility flyer titled 'Abuse Reporting' dated 6/19/23 indicated the following: -Things that need to be reported immediately to the supervisor: -Any bruise, redness or other injury to a resident that you do know how it occurred. -Any resident-to-resident altercation. -Many of these concerns must be addressed and reported to the Department of Public Health within two hours. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #56 was admitted to the facility in October 2024 with diagnoses including dementia with behavioral disturbance. A review of the most recent Minimum Data Assessment (MDS) dated [DATE] did not indicate a Brief Interview for Mental Status (BIMS) score because the Resident is rarely and never understood. Resident #23 was admitted to the facility in June 2024 with diagnoses including dementia with psychotic features and behavioral disturbance. A review of the most recent Minimum Data Set, dated dated dated [DATE] indicated a Brief Interview for Mental Status score of 3 out of a possible 15 indicating severe cognitive impairment. A review of Nursing progress notes dated 12/6/24 indicated the following: -Resident #56 approached a male/female resident and was talking to him/her close in his/her face, male/female resident became aggressive and pinched resident on his/her lower left cheek. He/she was escorted out of the room and taken in the supervise room. Administrator, UM (Unit Manager), on call NP (Nurse Practitioner), HCP (Health Care Proxy) notified and explained plan of care and he agreed. He said, My spouse is a very friendly person. During assessment was noted a redness on his/her left lower cheek. NP (Nurse Practitioner) said to monitor residents. A review of Nursing progress notes dated 12/7/24 indicated the following: -Resident redness subsides by the end of the shift. A review of the facility event report titled 'physical aggression received' dated 12/6/24 indicated the following: - Resident approached a male/female resident and was talking to him/her close in his face, male/female resident became aggressive and pinched resident on his/her lower left cheek. He/she was escorted out of the room and taken in the supervise room. During assessment it was initially noted redness on his/her left lower cheek, but it quickly resolved. [sic] A review of Resident #56's care plan initiated 10/3024 and 12/10/24 respectively indicated the following: -Focus: Resident #56's current risk of wandering/elopement and safety will be monitored every shift by all staff. -Focus: Resident #56 has alteration in behavior status related to restlessness, physical aggression and is resistive to care. Intervention: Approach in a calm manner, divert attention when encroaching on others' personal space, remove from situation and take to alternate location as needed. A review of Resident #23's care plan initiated 7/3/24 and intervention initiated 12/10/24 indicated the following: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #23 has an alteration in behavior status related to anxiety, depression and agitation. Intervention-Assist Resident #23 to develop more appropriate methods of coping and interacting, encourage Resident #23 to express feelings appropriately. During a telephone interview on 1/9/25 at 8:51 A.M., Activity Assistant #3 said on 12/6/24, she was running an activity alone. Activity Assistant #3 said Resident #56 and Resident #23 were in attendance. Activity Assistant #3 said she was seated at a table with two other residents completing a puzzle. Activity Assistant #3 said she was not paying attention to Resident #56 who was wandering around the room and Resident #23 who was seated at a different table watching television. She said Resident #56 approached Resident #23, Resident #56 moved in close to Resident #23's face and started to talk to him/her. Resident #23 became aggressive and pinched Resident #56's left lower cheek. The Activity Assistant said she had to run across the room to separate both Residents. Activity Assistant #3 said she escorted Resident #23 out of the room into the sensory room. She said, as she escorted Resident #56 out of the room, the Resident had his/her hand on his/her left cheek and said it hurt. Activity Assistant #3 said Resident #56 should always be closely supervised if he/she is up, she said the Resident has a history of wandering, getting close in other resident's personal spaces. Activity Assistant #3 said there is not always enough staff to help supervise residents during activities. She said it would be beneficial to have more than one staff during activities with residents with a behavior history. Activity Assistant #3 said the incident between Resident # 23 and #56 was physical abuse because Resident #23 inflicted physical pain on Resident #56. During a telephone interview on 1/9/25 at 9:06 A.M., Nurse #12 said on 12/6/24, Resident #23 was watching television in the Activity room. She said Resident #56 was in the same Activity room, wandering around the room. She said Resident #56 has a history of getting close to other residents, she said he/she got close to Resident #23's face, he/she did not like it, he/she pinched Resident #56's lower left cheek. Nurse #12 said the Activity Assistant brought Resident #56 to her after the incident. She said the Resident was covering the left cheek with his/her hand, saying it hurt. She said the cheek was red for several hours. She said staff should be aware when Resident #56 is up and about, they should closely supervise him/her and be ready to separate him/her when he/she enters other residents' personal spaces. Nurse #12 said the incident between Resident #56 and #23 was physical abuse because it was a physical altercation between two residents. During an interview on 1/9/25 at 9:47 A.M., Unit Manager #1 said she was not in the facility when the incident happened between Resident #56 and #23. She reviewed the progress notes and said when incidents such as these happen, the expectation is for staff to redirect the residents involved, assess for injuries, start an investigation and notify the Director of Nurses immediately. She said abuse can be defined as the willful inflicting of harm on another person, she said abuse can happen between residents or staff and residents. She said the incident that happened between Resident #23 and #56 was physical abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/25 at 10:14 A.M., the Director of Nurses said on 12/6/24, Resident #56 and #23 were both in an unsupervised common area, she said after the incident occurred, the Residents were redirected to a supervised common area. She said based on Resident #56's behavior history of wandering and getting in other resident's personal spaces, she expects staff to supervise him/her on the unit. The DON said an event report was completed after the incident occurred. She said it was determined that Resident #23's intentions were not to harm Resident #56 even though he/she retaliated aggressively by pinching Resident #56 causing pain on his/her left cheek. The DON said after using the [NAME] navigation tool, (This tool was built to help Massachusetts health care providers navigate key state and federal requirements for reporting adverse and other events that affect patient safety). As a facility, they determined that the incident was not abusive. During an interview on 1/9/25 at 12:14 P.M., both the DON and the Administrator defined abuse as causing physical, mental and emotional harm to another person. They both defined physical abuse as striking or unwanted contact between residents, or residents and staff with purposeful infliction with intent to harm.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on record review and interviews, the facility failed to report an allegation of abuse to the state agency within the mandated timeframes for two Residents (56 and #23) out of a sample of 29 residents after a resident to resident altercation. Specifically, the facility failed to file a report to the state agency after Resident #23 pinched Resident #56. Findings include: A review of the facility's policy titled 'Resident Right to Freedom from Abuse, Neglect and Exploitation' with a revision date of October 2024 indicated the following: -The Facility's residents have the right to be free from abuse as defined in this policy. This policy applies to any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the facility. -The Facility shall review altercations from resident to resident as a potential situation of abuse. -Staff shall monitor for any behaviors that may provoke a reaction by residents or others, which include but are not limited to, physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures and throwing objects. -When the Facility has identified abuse, the Facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The Facility will increase enforcement action, including, but not limited to: -Taking steps to prevent further potential abuse. -Reporting the alleged violation and investigation within required timeframes pursuant to Federal and State statutes and regulations. -Conducting a thorough investigation of the alleged violation. -Taking appropriate corrective action. A review of a Facility flyer titled 'Abuse Reporting' dated 6/19/23 indicated the following: -Things that need to be reported immediately to the supervisor: -Any bruise, redness or other injury to a resident that you do know how it occurred. -Any resident-to-resident altercation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Many of these concerns must be addressed and reported to the Department of Public Health within two hours. Resident #56 was admitted to the facility in October 2024 with diagnoses including dementia with behavioral disturbance. A review of the most recent Minimum Data Assessment (MDS) dated [DATE] did not indicate a Brief Interview for Mental Status (BIMS) score because the Resident is rarely and never understood. Resident #23 was admitted to the facility in June 2024 with diagnoses including dementia with psychotic features and behavioral disturbance. A review of the most recent Minimum Data Set, dated dated dated [DATE] indicated a Brief Interview for Mental Status score of 3 out of a possible 15 indicating severe cognitive impairment. A review of Nursing progress notes dated 12/6/24 indicated the following: -Resident approached a male/female resident and was talking to him/her close in his face, male/female resident became aggressive and pinched resident on his/her lower left cheek. He/she was escorted out of the room and taken in the supervise room. Administrator, UM (Unit Manager), on call NP(Nurse Practitioner), HCP (Health Care Proxy) notified and explained plan of care and he agreed. He said, My spouse is a very friendly person. During assessment was noted a redness on his/her left lower cheek. NP (Nurse Practitioner) said to monitor residents. [sic] A review of Nursing progress notes dated 12/7/24 indicated the following: -Resident redness subsides by the end of the shift. [sic] A review of the facility event report titled 'physical aggression received' dated 12/6/24 indicated the following: - Resident #56 approached a male/female resident and was talking to him/her close in his/her face, male/female resident became aggressive and pinched resident on his/her lower left cheek. He/she was escorted out of the room and taken in the supervise room. During assessment it was initially noted redness on his/her left lower cheek, but it quickly resolved. [sic] A review of Resident #56's care plan initiated 10/3024 and 12/10/24 respectively indicated the following: -Focus: Resident #56's current risk of wandering/elopement and safety will be monitored every shift by all staff. -Focus: Resident #56 has alteration in behavior status related to restlessness, physical aggression and is resistive to care. Intervention: Approach in a calm manner, divert attention when encroaching on others' personal space, remove from situation and take to alternate location as needed. A review of Resident #23's care plan initiated 7/3/24 and intervention initiated 12/10/24 indicated the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #23 has an alteration in behavior status related to anxiety, depression and agitation. Intervention-Assist Resident #23 to develop more appropriate methods of coping and interacting, encourage Resident #23 to express feelings appropriately. During a telephone interview on 1/9/25 at 8:51 A.M., Activity Assistant #3 said on 12/6/24, she was running an activity alone. Activity Assistant #3 said Resident #56 and Resident #23 were in attendance. Activity Assistant #3 said she was seated at a table with two other residents completing a puzzle. Activity Assistant #3 said she was not paying attention to Resident #56 who was wandering around the room and Resident #23 who was seated at a different table watching television. She said Resident #56 approached Resident #23, Resident #56 moved in close to Resident #23's face and started to talk to him/her. Resident #23 became aggressive and pinched Resident #56's left lower cheek. The Activity Assistant said she had to run across the room to separate both Residents. Activity Assistant #3 said she escorted Resident #23 out of the room into the sensory room. She said, as she escorted Resident #56 out of the room, the Resident had his/her hand on his/her left cheek and said it hurt. Activity Assistant #3 said Resident #56 should always be closely supervised if he/she is up, she said the Resident has a history of wandering, getting close in other resident's personal spaces. Activity Assistant #3 said there is not always enough staff to help supervise residents during activities. She said it would be beneficial to have more than one staff during activities with residents with a behavior history. During a telephone interview on 1/9/25 at 9:06 A.M., Nurse #12 said on 12/6/24, Resident #23 was watching television in the Activity room. She said Resident #56 was in the same Activity room, wandering around the room. She said Resident #56 has a history of getting close to other residents, she said he/she got close to Resident #23's face, he/she did not like it, he/she pinched Resident #56's lower left cheek. Nurse #12 said the Activity Assistant brought Resident #56 to her after the incident. She said the Resident was covering the left cheek with his/her hand, saying it hurt. She said the cheek was red for several hours. She said staff should be aware when Resident #56 is up and about, they should closely supervise him/her and be ready to separate him/her when he/she enters other residents' personal spaces. She said based on the flyer hanging on the unit tilted 'Abuse Reporting' the incident should have been reported to the state agency within two hours. During an interview on 1/9/25 at 9:47 A.M., Unit Manager #1 said she was not in the facility when the incident happened between Resident #56 and #23. She reviewed the progress notes and said when incidents such as these happen, the expectation is for staff to redirect the residents involved, assess for injuries, start an investigation and notify the Director of Nurses immediately. She said abuse can be defined as the willful inflicting of harm on another person, she said abuse can happen between residents or staff and residents. She said this type of resident-to-resident altercation should be reported to the state agency within two hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/25 at 10:14 A.M., the Director of Nurses said on 12/6/24, Resident #56 and #23 were both in an unsupervised common area, she said after the incident occurred, the Residents were redirected to a supervised common area. She said based on Resident #56's behavior history of wandering and getting in other resident's personal spaces, she expects staff to supervise him/her on the unit. The DON said an event report was completed after the incident occurred. She said it was determined that Resident #23's intentions were not to harm Resident #56 even though he/she retaliated aggressively by pinching Resident #56 causing pain on his/her left cheek. The DON said after using the [NAME] navigation tool(This tool was built to help Massachusetts health care providers navigate key state and federal requirements for reporting adverse and other events that affect patient safety). As a facility, they determined that the incident did not need to be reported to the state agency. The DON said reportable abuse events should be reported within two hours to the state agency. A review of the Health Care Facility Reporting System (HCFRS) failed to indicate that the resident to resident altercation was reported.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 50338 Based on record review and interviews, the facility failed to identify and complete a Significant Change in Status (SCSA) Minimum Data Set assessment (MDS) timely for one Resident (#19), out of a total sample of 29 residents, when the Resident was admitted to hospice services. Findings include: Review of the MDS 3.0 Resident Assessment Instrument (RAI) Manual, dated October 2024, indicated: - A Significant Change in Status Assessment (SCSA) is required to be performed when a resident enrolls in a hospice program. A Significant Change in Status MDS is considered timely when the RN Assessment Coordinator signs the MDS as complete by the 14th calendar day after the assessment reference date (ARD). The ARD must be no later than 14 days after the Resident has enrolled on hospice service. Resident #19 was admitted to the facility in March 2024 with diagnoses that include traumatic subdural hemorrhage, diabetes, dysphagia requiring tube feedings. Review of the most recent Minimum Data Set Assessment, (MDS) assessment, dated 12/16/24 indicated that the Resident could not participate in a Brief Interview for Mental Status exam, and was assessed by staff to have severe cognitive impairment. The MDS further indicated that the resident was receiving hospice services. Review of Resident #19's medical record indicated a form for admission to hospice services dated,12/2/24. Review of the medical record failed to indicate a Significant Change in Status Assessment was completed within 14 days of the ARD, which would have been 12/30/24. The MDS was still not complete as of 1/7/25. During an interview on 1/8/25 at 12:39 P.M., the MDS coordinator said that for a change in status, such as admission to hospice services, a Significant Change in Status Assessment should have been completed within 14 days of the ARD, but it was not. During an interview on 1/8/25 at 1:35 P.M. with the Director of Nurses said a Significant Change in Status Assessment should have been completed for Resident #19.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview, the facility failed to ensure for one Resident (#66), out of a total sample of 29 residents, that the Minimum Data Set (MDS) was accurate. Specifically, the MDS failed to accurately assess Resident #66's limited range of motion in his/her left upper extremity. Findings include: Resident #66 was admitted to the facility in October 2022 and has diagnoses that include Alzheimer's disease, muscle weakness and multiple sclerosis. Review of the Minimum Data Set assessment dated [DATE] indicated the staff assessment for mental status indicated Resident #66 as having severely impaired cognition. Further, the MDS indicated Resident #66 is dependent on staff for all daily care activities and did not have functional limitation in ROM in his/her extremities. On 1/6/25 at 8:07 A.M., Resident #66 was observed sitting in a wheelchair in the dining room. Resident #66 was repetitively vocalizing, and did not respond to the surveyors greeting. Resident #66 left arm was pulled across his/her chest with his/her fingers bent at the knuckle joint into a fist. On 1/7/25 at 8:15 A.M., Resident #66 was observed in bed. His/her left arm was pulled across his/her chest and his/her fingers were folded into a fist. Certified Nursing Assistant (CNA) #5 said the Resident was unable to use his/her left arm and hand. CNA #5 said the Resident's hand/fingers were more contracted in the last few weeks and more difficult to open. CNA #5 extended Resident #66's fingers slowly. Resident #66 was vocalizing/moaning continuously throughout the observation. CNA #5 said she cleans his/her hand, that the Resident did not have any device and that she did not do any other care for his/her hand. During an interview on 1/7/25 at 12:21 P.M., Resident #66's family member said he/she has no movement on his/her left side and has been this way for a while. During an interview on 1/7/25 at 3:40 P.M., CNA #6 said Resident #66 is dependent on care, and is unable to move his/her left arm and hand because it is contracted. During an interview on 1/7/25 at 3:46 P.M., Nurse #6 said Resident #66 has impaired mobility in his/her left arm and hand and that it has been that way for a while but could not specify how long. Nurse #6 said she is able to passively move Resident #66's arm and hand during skin checks. During an interview on 1/7/25 at 3:48 P.M., Nurse #12 said Resident #66 has impaired mobility on his/her left side and is unable to use his/her left arm or hand at all and it has been that way for quite a while. Review of Resident #66's MDS assessments dated 9/12/24 and 12/11/24 did not indicate that Resident #66 had impairment in functional limitation in mobility in his/her upper extremity (shoulder, elbow, wrist, hand). This conflicts with staff and family member interviews. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/25 at 3:51 P.M., the MDS nurse said she did not complete the most recent MDS dated [DATE] and that based on her review and discussion with staff the impaired ROM was present at the time the 12/11/24 MDS was completed and should have been accurate.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 45343 Based on record review and interview the facility failed to develop a baseline care plan that includes the instructions needed to provide effective and person-centered care for one Resident (#91) out of a total sample of 29 residents. Specifically, the facility failed to develop a baseline care plan including resident specific interventions for a Resident who requires psychotropic medications. Findings include: Review of the facility policy titled Comprehensive Care Plan, last revised 10/24, indicated the following: Policy Statement: Individual comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Resident #91 was admitted to the facility in January 2024 and has diagnoses that include anxiety disorder, adjustment disorder, and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/16/24, indicated that on the Brief Interview for Mental Status exam Resident #91 scored a 3 out of a possible 15, indicating severely impaired cognition. Further review of the MDS indicated Resident #91 is dependent for self-care activities and demonstrates behaviors impacting the delivery of care. Review of the Resident #91's Physician orders indicated the following: -Olanzapine Tablet 5 MG, Give 1 tablet by mouth two times a day for psychotic disorder. - Diazepam Oral Tablet 5 MG (Diazepam) *Controlled Drug*, Give 1 tablet by mouth two times a day for Anxiety. Review of the medical record failed to indicate a baseline care plan for psychotropic medications was created for Resident #91. During an interview on 1/9/25 at 8:10 A.M., with the Director of Nursing said that a baseline care plan for psychotropic medications should have been developed by nursing on admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36431 Based on observations, interviews and record review, the facility failed to develop and implement person-centered care plans for five Residents (#6, #16, #25, #210 and #23) out of a sample of 29 residents. Specifically, 1. For Resident #6, the facility failed to implement his/her compression socks. 2. For Resident #16, the facility failed implement offloading his/her heels as per the plan of care. 3. For Resident #25, the facility failed to develop a comprehensive pacemaker care plan. 4. For Resident #210, the facility failed to develop personalized behavior care plans. 5. For Resident #23, facility failed to develop a personalized history of substance abuse care plan. Findings include: A review of the facility policy titled 'Comprehensive Care Plan' with a revision date of October 2024 indicated the following: -An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. A review of the facility policy titled 'Behavioral Health Services-Including Substance Abuse' with a revision date February 2024 indicated the following: -It is this facilities policy that all residents receive the necessary behavioral health care and services, including substance abuse services, to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1. Resident #6 was admitted to the facility in July 2022 and has diagnoses that include but are not limited to chronic obstructive pulmonary disease, edema, and chronic systolic (congestive) heart disease. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #6 scored an 8 out of 15 on the Brief Interview for Mental Status (BIMS) exam, indicating he/she as having moderately impaired cognition. Further, the MDS indicated that Resident #6 was dependent on staff for lower body dressing. On 1/6/25 at 8:00 A.M., Resident #6 was observed in the dining room. He/she was observed to be breathing heavy. Resident #6 said he/she gets short of breath and needs to eat and drink slowly. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #6's medical record indicated the following: -A physician's order dated 12/5/24 compression socks on in morning, off night every day and evening shift for prevention. During an observation and interview on 1/7/25 at 8:21 A.M., Resident #6 was in the dining room. He/she was not wearing compression socks. Resident #6 said he/she needs help putting them on. On 1/7/25 at 11:38 A.M., Resident #6 was sitting in his/her wheelchair in the dining room. His/her left leg was observed with a slipper sock and no compression sock. On 1/7/25 at 12:36 P.M., Resident #6 said he/she only had ankle socks on. Resident #6's feet were observed with slipper socks and no compression socks. On 1/7/25 at 3:30 P.M., Resident #6 was in the dining/living room and observed not to be wearing compression stocks, and his/her feet were observed as puffy. On 1/8/25 at 4:22 P.M., Resident #6 said she did not have her compression socks on. Observation of his/her legs revealed the compression socks were not on. Resident #6 said she had a bruise or something on her right foot. On 1/9/25 at 8:36 A.M. Resident #6 was observed being assisted by staff out of the bathroom located across from the elevators. Resident #6 was observed back in the dining room and observed to not be wearing his/her compression socks. Resident #6 was breathing heavily and said she just came from the bathroom. During an interview on 1/9/25 at 8:39 A.M., Certified Nursing Assistant (CNA) #12 said Resident #6 accepts daily care and does not refuse. CNA #12 said Resident #6 wears special stockings. CNA #12 said she did not put them on this morning because Resident #6 was already up when she came in at 7:00 A.M. The surveyor and CNA #12 went to Resident #6's room and found one compression sock. CNA #12 said that Resident #6 has something on his/her heel and maybe cannot wear the compression sock on that foot. CNA #12 said either the CNA or the nurse can put on the compression stocks. During an interview on 1/09/25 at 10:31 A.M., Nurse #14 said Resident #6 has a blister on his/her right heel and may have refused to wear the compression socks. During an interview on 1/9/25 at 10:44 A.M. Unit Manager #1 said the compression socks should be on as ordered. Unit Manager #1 said if the compression socks are not put on per the order the nurse should document why in the medical record. Review of the documentation in Resident #6's medical record failed to indicate any entries regarding Resident #6 not wearing the compression socks. 43846 2. Resident #16 was admitted to the facility in August 2015 with diagnoses that included dementia, dysphagia, adult failure to thrive, and anxiety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #16's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she was assessed by nursing staff to have severe cognitive impairment. The MDS further indicated the Resident was dependent on staff for eating and all other Activities of Daily Living (ADLs). The MDS further indicated Resident #16 is at risk for pressure ulcers. On 1/6/25 at 7:57 A.M., the surveyor observed Resident #16 in bed with his/her heels flat on the mattress. On 1/7/25 at 6:59 A.M., the surveyor observed Resident #16 in bed with his/her heels flat on the mattress. On 1/9/25 from 7:19 A.M. to 8:06 A.M., the surveyor observed Resident #16 in bed with his/her heels flat on the mattress. During an interview on 1/9/25 at 8:06 A.M., Certified Nurse Aide (CNA) #7 said each resident has a care plan and kardex and staff are expected to follow them. Review of Resident #16's skin breakdown care plan dated, 10/16/23, indicated Off Load/Float heels while in bed. Review of Resident #16's CNA Kardex, dated 1/7/25, indicated Off Load/Float heels while in bed. Review of Resident #16's Braden Scale for Predicting Pressure Sore Risk, dated 10/19/24, indicated he/she scored an 11 indicating he/she is at high risk for developing a pressure ulcer. During an interview on 1/9/25 at 8:03 A.M., Nurse #8 and Nurse #4 said he/she is at risk for skin breakdown and his/her heels should be offloaded while in bed. Nurse #8 and Nurse #4 said nursing staff are expected to follow the Resident care plan and Kardex. 3. Review of the facility policy titled Pacemaker Function and Testing, dated 11/5/24, indicated To ensure pacemaker is functioning properly through nursing assessment resident education and physician notification of abnormalities. The physician shall provide the facility with the specific maximum heart rate above the pacemaker rate that is acceptable. The physician shall provide the programmed lower and upper rate for the pacemaker. Resident #25 was admitted to the facility in December 2023 with diagnoses that included dementia, presence of a cardiac pacemaker, and adult failure to thrive. Review of Resident #25's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 6 out of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairments. Review of Resident #25's readmission assessment, dated 3/13/24, indicated the Resident has a pacemaker. Review of Resident #25's physician order, dated 3/14/24, indicated Pacemaker Apical Pulse Check: Check apical pulse for one minute daily. Pulse rate should be the same as pacemaker rate or faster. Notify physician if pulse is more than 5-10 beats lower than pacemaker's setting. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #25's care plan, alteration to my Cardiac System d/t (due to) sick sinus syndrome due to SA node dysfunction for which I recently had a pacemaker placed care plan, dated 3/14/24, indicated has a Pacemaker: Manufacturer: (SPECIFY) Model: (SPECIFY) Serial #: (SPECIFY) Date implanted: (SPECIFY, if known) Name of cardiologist: (SPECIFY). Monitor pulses as ordered and PRN. Report abnormalities to MD (medical doctor). My pacemaker will be check per cardiologist orders. Review of Resident #25's Physician Assistant progress note, dated 3/19/24, indicated Permanent pacemaker placed on 3/11/2024. Recommend follow-up with cardiology. During an interview on 1/8/25 at 1:44 P.M., Nurse #5 said Resident #25 does have a pacemaker and said she does not know the pacemaker settings or any other pacemaker information. During an interview on 1/8/25 at 1:48 P.M., the Director of Nurses (DON) said there should be a complete comprehensive care plan for Resident #25's pacemaker. The DON said she would expect the nurses to know the pacer settings to monitor the Resident. 43807 4. Resident #210 was admitted to the facility December 2024 with diagnoses including major depressive disorder, generalized anxiety disorder, delusions and hallucinations. A review of the most recent Minimum Data Set (MDS) dated [DATE] did not indicate a Brief Interview for Mental Status Score. A review of the Psychiatric Nurse Practitioner's progress note dated 1/6/25 indicated that the Resident is AOx2 (alert and oriented to person and place only). On 1/6/25 at 8:25 A.M., the surveyor observed Resident #210 in bed, his/her right upper arm had bruises and scars. Resident #210 said she picks and digs at the scabbed bruises and opens them up. A review of the discharging hospital shift notes dated 10/30/24 indicated the following: -Skin with multiple scabbed areas in various stages of healing, patient continued to pick and scratch at skin. Review of Resident #210's medical record indicated the following: A review of the skin review dated 12/27/24 indicated the following: -Multiple scabbed areas all over due to bedbugs. A review of the skin review dated 12/31/24 indicated the following: -Scars on the abdomen and limbs from picking per patient. A review of the skin review dated 1/7/25 indicated the following: -Scars on abdomen and limbs from picking' per patient. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #210's care plans failed to indicate that the Resident's behavior of skin picking, history of hallucinations and delusions was care planned. During an interview on 1/8/25 at 1:30 P.M., Certified Nurse's Assistant (CNA) #11 said she provided head to toe care to Resident #210 today, she said she saw scars, scabbed areas and open areas on the Resident's body. She said Resident #210 told her he/she picks on his/her skin when he/she gets angry. During an interview on 1/8/25 at 2:23 P.M., Nurse # 13 said Resident #210 was admitted with scabbed areas on his/her body due to a history of bedbugs prior to admission. During a telephone interview on 1/9/25 at 7:50 A.M., the Social Worker said she was not aware of Resident #210's behavior of picking his/her skin, she said his/her history of hallucinations and delusions should be further explored to determine whether the skin picking is a tactile hallucination. The Social Worker said his/her behavior care plans should be developed and individualized. 5. Resident #23 was admitted to the facility in June 2024 with diagnoses including Dementia with psychotic features and behavioral disturbance. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15 indicating severe cognitive impairment. A review of Resident #23's Psychiatric Nurse's progress notes dated 12/30/24 indicated the following: -Substance Use/Abuse based symptoms: history of alcohol abuse. A review of Resident #23's care plan failed to indicate a substance abuse care plan. During a telephone interview on 1/9/25 at 7:42 A.M., The Social worker said Resident #23's cognition might present a barrier for participation in the facility's substance abuse services, but the facility Nursing staff should also be aware that most residents with a history of alcohol use disorder perceive pain more intensely. She said Resident #23's substance abuse care plans should be developed and personalized.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 50338 Based on observation, record review and staff interview, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team for two Residents (#19 and #52) out of a total sample of 29 residents. Specifically: 1. For Resident #19, the facility failed ensure the entire comprehensive care plan was reviewed and revised by an interdisciplinary team following the completion of a comprehensive assessment for a significant change in status after Resident #19 was admitted to hospice services and 2. For Resident #52 the facility failed to review and update the care plan for the discontinuation of hospice care services. Specifically, Resident #52 was discharged from hospice care services on 4/27/24 and a hospice care plan remained in place for over eight months and after two quarterly Minimum Data Set (MDS) assessments dated 8/8/24, and 11/7/24. Findings include: Resident #19 was admitted to the facility in March 2024 with diagnoses including traumatic subdural hemorrhage, diabetes, and dysphagia. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/16/24, indicated that Resident #19 was severely cognitively impaired as evidenced by staff assessment of Brief Interview for Mental Status. The MDS further indicated that Resident #19 was receiving hospice services. Review of Resident #19's medical record indicated start of hospice services was 12/2/24. Review of Resident #19's active plan of care, failed to include a Hospice plan of care until 1/7/24, after the surveyor had asked about the date hospice services had started. During an interview on 1/8/25 at 12:39 P.M., the MDS nurse she said he would expect a Resident receiving Hospice services to have a plan of care to include hospice services. During an interview on 1/8/25 at 1:35 P.M., the Director of Nursing said she would expect a Resident receiving hospice services would have a plan of care to include hospice services. 36431 2. Resident #52 was admitted to the facility in October 2021 and has diagnoses that include epilepsy, chronic obstructive pulmonary disease, and Alzheimer's disease. Review of the most recent MDS indicated that Resident #52 scored a 4 out of 15 on the Brief Interview for Mental Status (BIMS) exam, indicating he/she as having severe cognitive impairment and is dependent in most activities of daily living. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #52's medical record indicated the following: A care plan: I am currently on Hospice Care r/t (due to) Alzheimer (sic), dated as created on 1/9/2024 revision on 8/15/24 and a goal target date of 2/22/25. Review of Resident #52's current physician's orders did not indicate an order for hospice care services. During an interview on 1/7/25 at 11:16 A.M., Nurse #6 said Resident #52 was discharged from hospice services sometime last year, maybe around August 2024. Nurse #6 said she does not go to care plan meetings and that the Unit Manager participates in the care plan meetings. During an interview on 1/9/25 at 8:00 A.M., Unit Manager #1 said the care planning process includes the interdisciplinary team reviewing, updating, revising and discontinuing care plans, with the MDS schedule and as needed. Unit Manager #1 said Resident #52 has been off hospice services for some time now and she would need to verify the date of when he/she came off services. Unit Manager #1 reviewed the medical record which indicated a significant change in status MDS was completed in May 2024, a quarterly MDS was completed 8/8/24 and a quarterly MDS was completed 11/7/24. Unit Manager #1 said Resident #52 should not have a current care plan stating he/she is currently receiving hospice services. During an interview on 1/9/25 at 8:45 A.M., Unit Manager #1 said Resident # 52 came off hospice care services on 4/27/24.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50338 Based on observation, record review and interview, the facility failed to meet professional standards of practice for 3 Residents (#19, #69 and #106) out of a total of 29 sampled residents. Specifically: 1. For Resident #19 the facility failed to obtain a physician's order for the use of an air mattress, 2. For Resident #69 the facility failed to discontinue a treatment for a healed right ankle, and 3. For Resident #106 the facility failed to ensure an antibiotic used to treat an infection was administered timely for one of two closed records reviewed. Findings include: Resident #19 was admitted to the facility in March 2024 with diagnoses including traumatic subdural hemorrhage, diabetes, and dysphagia. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/16/24, indicated that Resident #19 was severely cognitively impaired as evidenced by staff assessment of Brief Interview for Mental Status. The MDS further indicated that Resident #19 had a pressure relieving device to his/her bed. Review of Resident #19's physician's orders, dated 1/7/25, failed to indicate an order for an air mattress to his/her bed. Review of Resident #19's active plan of care, failed to include the interventions of an air mattress to his/her bed. On 1/8/25 at 1:21 P.M. Nurse #1 and the surveyor observed Resident #19 on an air mattress in his/her bed. During an interview on 1/7/25 at 9:04 A.M., Nurse #1 said she would expect a Resident with an air mattress to have a physician's order. During an interview on 1/8/25 at 1:35 P.M., the Director of Nursing said she would expect a Resident with an air mattress to have a physician's order. 36431 2. For Resident #69 the facility failed to adhere to professional standards of practice, when nursing staff provided a treatment two times a day to an ankle wound that was not present on the Resident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #69 was admitted to the facility in August 2021 and has diagnoses that include but are not limited to unspecified dementia, adult failure to thrive, bipolar disorder and chronic obstructive pulmonary disease. Review of the most recent Minimum Data Set assessment dated [DATE] indicated Resident #69 scored a zero out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having severe cognitive impairment. Further, the MDS indicated the Resident is dependent on staff for all aspects of care, is at risk for developing pressure ulcers and does not have any unhealed pressure ulcers. On 1/6/25 at 8:27 A.M., Resident #69 was observed in his/her bed, equipped with a pressure-relieving air mattress. The air mattress setting affixed to the foot board was illuminated and blinking at the top light, under the word 'firm'. Review of Resident #69's medical record indicated the following: -Braden Scale for Predicting Pressure Sore Risk dated, 3/6/24, 4/30/24, 5/21/24, 8/21/24 and 11/22/24 all with a score of 10 indicating Resident #69 as having a high risk for developing pressure sores. -A physician's order, Right ankle: Assess wound and apply skin prep every shift and ensure pressure is off loaded. Every day and evening shift for wound examination, order date 2/2/24. Review of Resident #69's care plans failed to indicate a care plan for any actual open areas, including the right ankle. Review of the weekly skin check dated 1/7/24 indicated no open skin areas and documented a callous hammer toe. During an interview on 1/9/25 at 7:25 A.M., Nurse #7 said Resident #69 had a pressure area on his/her coccyx a while ago and she was not aware of any other wounds. Nurse #7 checked the orders and then asked Certified Nursing Assistant (CNA) #4 if the Resident had a wound. CNA #4 said Resident #69 did not have any wound or skin issues on his/her feet. During an observation and interview on 1/9/25 at 7:33 A.M., Nurse #7, with the surveyor present, examined/observed Resident #69's feet which revealed no wound on his/her right ankle. Nurse #7 said she did not know why a treatment twice a day with skin prep for a wound was on the physician's orders. Nurse #7 said maybe it was pink at one time. During an interview on 1/9/25 at 7:38 A.M., Unit Manager #1 said if a resident is identified with a new skin injury, skin tear, open area or pressure area the Nurse Practitioner/Doctor is notified, a treatment order is obtained, and a skin incident report is completed. Unit Manger #1 said for Resident #69, she did not see a skin area incident report. Unit Manager #1 reviewed the order for the right ankle wound for Resident #69 and said if there is no wound present, she would expect the nurses who are providing the twice daily treatment to report the wound as healed and to have the wound order discontinued. Unit Manager #1 said she would need to investigate the origin of the order more. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/25 at 12:51 P.M., Unit Manager #1 said the right ankle treatment was ordered on 2/20/24, said there was no identified area on the weekly skin check, nor note regarding the right ankle wound. 3. Review of the facility's policy entitled, MISCELLANEOUS SPECIAL SITUATION, UNAVAILABLE MEDICATIONS, dated November 2021 indicated: medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to ensure medications are available to meet the needs of each resident. Procedures B. Nursing staff shall: 1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available. Resident #106 was admitted to the facility in September 2024 and had diagnoses that included but were not limited to unspecified dementia and urinary tract infection. Review of the Nursing Admission Screening V15, with an effective date of 9/20/24 for Resident #106 indicated the following: reason for admission: Rehab/UTI (urinary tract infection), cognition confused with short-term and long-term memory problem. Review of Resident #106's medical record indicated the following: A physician's order dated 9/20/24 with a start date 9/21/24, Cefdinir (an antibiotic medication) Capsule 300 mg (milligrams), Give 1 capsule by mouth two times a day for infection for 5 days. Review of the Medication Administration Record (MAR) dated for September 2024 indicated the administration of the Cefdinir 300 mg was signed off as a 9 (other/see progress note) dated 9/21/24 2000 (8:00 P.M.) dose, 9/22/24 0800 (8:00 A.M.) dose and 9/22/24 2000 (8:00 P.M.) dose. Further review of the MAR indicated Resident #106 had been administered his/her first dose of the antibiotic cefdinir, on 9/22/24 at 2139 (9:39 P.M.) Review of the progress note dated 9/21/24 at 06:44 (6:44 A.M.) note text: Abx (antibiotic) for patient not delivered, f/u (follow up) with pharmacy and said it will be on the run tonight. Review of the progress note dated 9/22/24 at 14:40 (2:40 P.M.) note text: Abx (antibiotic) for patient not delivered, f/u with pharmacy and said it will be on the run tonight. The progress notes failed to indicate that the physician or nurse practitioner were notified that the antibiotic was not administered as ordered. During an interview on 1/7/25 at 11:45 A.M., Nurse #6 said when a new medication is ordered for a resident, including an antibiotic when they return from the hospital, the nurse verifies the order with the Nurse Practitioner (NP)/Medical Doctor (MD) and then the nurse can obtain the medication from the Cubex (an automated pharmacy system) located on the B1 unit. Nurse #6 said if the medication is not available the pharmacy and the NP or MD need to be called, and the NP/MD would review and decide on how to proceed. Nurse #6 said the NP/MD need to be made aware when a medication is not administered as ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/7/25 at 3:33 P.M., Physician #1 said the NP/MD should be notified if an antibiotic is not started for any reason. During an interview on 1/9/25 at 12:39 P.M., the Director of Nursing (DON) said although the nurses documented that the pharmacy was called and the first dose was administered on 9/22/24 when the antibiotic arrived at the facility, the nursing staff should have notified the NP/MD that the antibiotic for Resident #106 was not started as ordered.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on record review and interviews, the facility failed to ensure for one Resident (#107), out of 2 closed records that the interdisciplinary team participated in the discharge planning process. Review of the facility's Policy and Procedure dated as initiated November 1, 2015, indicated the following: Policy Interpretation and Implementation, 1. When the facility anticipates a resident's discharge to a private residence or to another nursing facility (i.e., skilled, intermediate care ICF, etc.) a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment. 2. The post-discharge plan will be developed by the care plan team with the assistance of the resident or his or her family. 4. As a minimum, the post discharge plan will include: a. A description of the resident's and family's preference for care; b. A description of how the residents and family will access and pay for such services; c. A description of how the care should be coordinated if continuing treatment involves multiple care givers; d. The identity of specific resident needs after discharge (i.e., personal care, (ADLS, self-administration of medications, diet, etc.) sterile dressings, physical therapy, etc.) Appropriate referrals, when necessary, are made my (sic) social services and documented in the medical record; and: e. A description of how the resident and family need to prepare for discharge. 5. Social Services will review the plan with the resident and family before the discharge is to take place. Resident #107 was admitted to the facility in October 2023 and has diagnoses that include memory deficit following cerebral infarction, type 2 diabetes mellitus with diabetic neuropathy, and dipolar disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #107 scored a 6 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having severe cognitive impairment and requires partial to moderate assistance with care including bathing/showering and dressing. Review of the MDS dated [DATE] indicated a discharge (from the facility) assessment return not anticipated was completed. Review of Resident #107 care plans indicated the following: I am long term care placement and have no plans for discharge, date initiated 11/6/2023, the goal indicated review my placement status quarterly and as needed, with a revision date on 5/2/24 and target date of 11/11/24. During an interview on 1/6/25 at 5:14 P.M., the Administrator said Resident #107 had a planned discharge which she believed to be with the Pace program (a Medicare, Medicaid program that helps people who are eligible meet their health care needs in the community) . Review of the physician's orders indicated an active order dated 11/13/24, may discharge home with services and meds. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review indicated under the miscellaneous tab in Resident #107's medical record a patient care referral dated 11/15/24 that failed to indicate what agency or contact information Resident #107 was referred to for services. Review of Resident #107's medical record progress notes indicated the following: -Progress notes dated from 11/3/24 through 11/15/24 failed to indicate any discipline from the care plan team that documented any information regarding discharge planning for Resident #107 and failed to indicate the Resident or responsible parties' input in the discharge planning process or information on what the discharge plan was going to include. During an interview on 1/7/25 at 4:22 P.M., Nurse #15 said a patient care referral is completed as part of the discharge plan along with review of the discharge medications. Nurse #15 said nursing staff would also complete a discharge assessment and discharge summary and write a note under progress notes the day of discharge. Nurse #15 looked in the medical record for Resident #107 and said there was no nursing discharge assessment, not a progress note written that indicated Resident #107 was discharged . During an interview on 1/7/24 at 5:18 P.M., and on 1/8/24 at 1:12 P.M., the Director of Nursing (DON) said the Pace program social worker set up the discharge plan. The DON said the Pace program social worker is an outside agency and that she would have expected the facility social worker to document in Resident #107's medical record the planning for discharge from the facility and would expect the nurse who discharged staff to write a note the day of discharge

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observations, record review and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs), for two Residents (#94 and #26) out of a total sample of 29 residents. Specifically, the facility failed to provide assistance with meals as per the plan of care for Resident #94 and for Resident #26. Findings include: Review of facility policy titled Activities of Daily Living (ADLs), dated 1/23/24, indicated Resident who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene; d. Dining (meals and snacks). 1. Resident #94 was admitted to the facility in February 2024 with diagnoses that included dementia, adult failure to thrive, and anxiety. Review of Resident #94's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a zero out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident has severe cognitive impairments. The MDS further indicated the Resident required substantial/maximal assistance for eating. On 1/6/25 from 9:13 A.M. to 9:22 A.M., Resident #94 was observed in bed with his/her breakfast tray left within reach and not set up. No staff were present in the room, On 1/6/25 from 12:39 P.M. to 12:52 P.M., Resident #94 was observed in the dining room using his/her hands trying to feed themselves. No staff were present assisting the Resident. During an interview on 1/6/25 at 12:44 P.M., Nurse #9 said Resident #94 will feed him/herself if he/she is hungry. Review of Resident #94's activity daily living care plan, dated 6/26/24, indicated EATING: requires (Limited / Extensive Assistance or Total Dependence) on (1) staff for eating. Review of Resident #94's Certified Nurse Aide (CNA) Kardex (a form that explains each resident needs), dated 1/7/25, indicated EATING: requires (Limited / Extensive Assistance or Total Dependence) on (1) staff for eating. During an interview on 1/9/25 at 8:00 A.M., Nurse #4 and Nurse #8 said Resident #94 needs assist with meals so a staff member should be with his/her during meal time. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/25 at 9:00 A.M., CNA #14 said Resident #94 needs assistance with meals because he/she is unable to feed themselves. 50338 2. Resident #26 was admitted to the facility in August 2023 with diagnoses that included dementia, heart failure, and diabetes. Review of Resident #26's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a six out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident has severe cognitive impairments. The MDS further indicated the Resident required partial/moderate assistance for eating and he/she has a mechanically altered diet. On 1/6/25 from 8:41 A.M. to 8:55 A.M., Resident #26 was observed in bed with his/her breakfast tray left within reach and set up, the Resident was not eating. The Speech Language Pathologist (SLP) was on other side of room working with Resident #26's roommate but was not supervising or assisting Resident #26. On 1/6/25 from 12:33 P.M. to 12:45 P.M., Resident #26 was observed in bed with his/her lunch tray left within reach and set up, the Resident was sleeping. No staff were present assisting the Resident. On 1/7/25 from 12:52 P.M. to 1:14 P.M., Resident #26 was observed in bed with his/her lunch tray covered and out of Resident #26's reach. On 1/7/25 from 1:14 P.M. to 1:34 P.M., Resident #26 was observed in bed with his/her lunch tray left within reach and set up. No staff were present assisting the Resident. On 1/8/25 at 12:49 P.M., Resident #26 was observed in bed with his/her lunch tray left within reach and set up. No staff were present assisting the Resident. During an interview on 1/7/25 at 8:38 A.M., the SLP said Resident #26 should have supervision and assist sometimes to initiate and compete his/her meal. During an interview on 1/8/25 at 12:55 P.M., Certified Nursing Assistant (CNA) #1 said Resident #26 requires meals to be set up and may need assist eating at times. During an interview on 1/8/25 at 1:04 P.M., Nurse #2 said Resident #26 requires meals to be set up and then usually eats independently, but staff will check in on him/her and assist as needed to complete the meal. During an interview 1/8/25 at 1:35 P.M., the Director of Nursing said if Resident #26's plan of care indicates he/she requires assist for eating, then Resident #26 should receive assist with eating.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to adhere to professional standards of care for the prevention of pressure ulcers for 1 Resident (#69), out of a total sample of 29 residents. Specifically, for Resident #69, who was assessed as being high risk for developing pressure ulcers, and has a history of pressure wounds, the facility failed to ensure the air mattress was functioning and set in accordance with the medical plan of care. Resident #69 was admitted to the facility in August 2021 and has diagnoses that include but are not limited to unspecified dementia, adult failure to thrive, bipolar disorder and chronic obstructive pulmonary disease. Review of the most recent Minimum Data Set assessment dated [DATE] indicated Resident #69 scored a zero out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having severe cognitive impairment. Further, the MDS indicated Resident #69 is dependent on staff for all aspects of care, is at risk for developing pressure ulcers and does not have any unhealed pressure ulcers. Review of Resident #69's medical record indicated the following: -The Braden Scale for Predicting Pressure Sore Risk assessments, dated, 3/6/24, 4/30/24, 5/21/24, 8/21/24 and 11/22/24 all with a score of 10 indicating Resident #69 as having a high risk for developing pressure sores. -The comprehensive MDS dated [DATE] indicated Resident #69 had one stage 3 pressure ulcer. -A care plan My [NAME] (sic) assessments shows that I am at risk or no risk Moisture (sic) due to incontinence, previous skin breakdown, dated as created on 9/12/24. Interventions include Genexair SL5 Air Mattress with perimeter edges at 4. Created on 9/12/24. Review of Resident #69's physician's orders indicated the following: -Pressure-redistribution mattress to bed set at 4 (from ideal to firm setting) check every shift for placement and function, every shift for monitor mattress setting, order date 11/15/2024. On 1/6/25 at 8:27 A.M., Resident #69 was observed in his/her bed, equipped with a pressure-relieving air mattress. The air mattress setting affixed to the foot board was illuminated and blinking at the top light, under the word 'firm'. Resident #69 did not respond to the surveyors greeting. On 1/7/24 at 8:17 A.M., Resident #69 was observed in a recliner chair. Resident #69 was just now out of bed and pushed to the dining room by staff. Resident #69's air mattress was illuminated and blinking at the top setting, under the word firm. On 1/7/24 at 12:20 P.M., Resident #69 was not in his/her bed. The air mattress setting affixed to the foot board was illuminated and blinking at the top, under the word firm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 4:20 P.M. Resident #69 was observed resting in bed. The air mattress setting affixed to the foot board and easily visible was illuminated and blinking on the highest point, under the word firm. On 1/9/25 at 7:24 A.M., Resident #69 was observed resting in his/her bed. The air mattress setting affixed to the footboard was illuminated and blinking at the highest setting. During an interview on 1/9/25 at 7:25 A.M. Nurse #7 said Resident #69 had a pressure wound on his/her coccyx that healed a while ago and that he/she remained at risk for developing pressure ulcers. During an interview on 1/9/25 at 7:34 A.M., Nurse #7 said Resident #69's air mattress should be set to 4 which would be the fourth light from the bottom. During an interview on 1/9/25 at 7:38 A.M. Unit Manager #1 said the air mattress on Resident #69's bed should be set to what is in the physician's order. During an interview and observation on 1/9/25 at 7:48 A.M., Unit Manager #1, with the surveyor present, observed the air mattress affixed to Resident #69's footboard illuminated and blinking at the highest light on top, under the word firm. Unit Manager #1 touched the setting on the air mattress and could not get it set to 4, which she said is fourth from the bottom. Unit Manager #1 said when it is set, it does not blink. Unit Manager #1 tried to set it at 4 and the mattress remained blinking and set at the highest level. Unit Manager #1 said she would expect the nursing staff to be aware and monitor the air mattress function and setting and report that it is not working as it should.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50338 Based on observations, record reviews and interviews, the facility failed to ensure for one Resident (#26), out of a total sample of 29 residents, that the Resident admitted with an indwelling catheter was assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates continued catheter use is necessary. Findings include: According to the Resident Assessment Instrument (RAI): (A manual used to for the guidance for the Minimum Data Set assessment, which is required by the Centers for Medicare and Medicaid recipients in skilled nursing facilities) -Indwelling catheters should not be used unless there is valid medical justification. Assessment should include consideration of the risk and benefits of an indwelling catheter, the anticipated duration of use, and consideration of complications resulting from the use of an indwelling catheter. Complications can include an increased risk of urinary tract infection, blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort, and bleeding. Resident #26 was admitted to the facility in August 2023 with diagnoses that included dementia, heart failure, and diabetes. Review of Resident #26's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 6 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident has severe cognitive impairments. The MDS further indicated that the Resident had an indwelling catheter. Review of the Physician's order dated 12/18/23 indicated: Foley catheter #16 with 10 ml balloon. Review of resident's care plan updated 1/6/25 indicated: Has an Indwelling Foley Catheter for history of unstageable sacrum region pressure and urinary retention. Review of the resident's medical history and diagnosis lists failed to indicate a diagnosis that indicates the continued need/use of a catheter. Review of Resident #26's record indicated that he/she was hospitalized from 8/2/23-8/14/23. The hospital paperwork indicated the following: -the Resident had catheter inserted due to urinary retention. -the hospital recommended a urology consult. Further review of Resident #26's medical record failed to indicate that he/she had a urology consult and that sacral ulcer had healed in June 2024. (continued on next page)

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	225294	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/25 at 1:04 P.M., Nurse #2 said a resident that has an indwelling catheter without an approved diagnosis should have a voiding trial. During an interview on 1/8/25 at 1:35 P.M., the Director of Nursing said the reason for having an indwelling foley catheter would be an approved diagnoses of neurogenic bladder or obstructive uropathy. A resident that has an indwelling catheter without an approved diagnosis should have a voiding trial.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 36431 Based on observation record review and interview, the facility failed to ensure that one Unit (A3) out of three units observed, had sufficient staff to meet the needs of the residents. Specifically, the facility failed to ensure sufficient staff were available to assist residents during the breakfast meal. Findings include: On 1/6/24 beginning at 9:00 A.M., the following observations were made during the breakfast meal at the A-3 resident care unit. Florida room: Staff including the maintenance director assisted with passing trays. There were 12 residents present for the breakfast meal and 2 staff present in the dining room. The 2 staff present were each seated with a resident assisting them to eat. Four other residents had not started eating and their breakfast was left on the table near them. At 9:10 A.M., one resident received his/her breakfast meal and after it was set up the resident used a fork, moved it around the plate and at no time ate the meal, and at no time did staff prompt or assist the resident to eat his/her meal until nearly 9:50 A.M. At 9:13 A.M., another resident was brought into the dining room and placed at a table with a meal on the table. The staff left the room and then returned, making it three staff present. Four residents were not being assisted, and no staff were observed verbally cueing or prompting other residents to eat. At 9:19 A.M., a staff member briefly left the resident she was assisting and the resident put a napkin in his/her mouth. The staff said he/she needs 1:1 during meals and quickly got back to the resident. At 9:20 A.M., three residents remained with their breakfast meals on the table in front of them or near them and were not being assisted. At this time there were two staff in the room. One of the two staff, who was identified as a nurse, stayed with one resident the entire time and did not direct or make any effort to assist others until nearly 9:50 A.M. At 9:25 A.M., two residents were not being assisted with their breakfast meal which was in front of or nearby them on the table. At 9:29 A.M. there were three staff in the room. One of the staff began to assist two residents. At 9:36 A.M., one resident was sitting at the table with his/her breakfast meal in front of him/her without assistance. The resident was rubbing his/her hands together. At 9:43 A.M., one staff member went to the last resident and started to assist him/her with his/her breakfast. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/7/25 at 11:26 A.M., Certified Nursing Assistant (CNA) # 5 and CNA #3 said when they work with just three CNAs, they are unable to get all the people who need assistance to be fed in the Florida dining room. CNA #5 said yesterday (1/6/25) one resident who is blind got his/her meal very late because they did not have enough staff to assist all the residents that need to be fed. Both CNA #5 and CNA #3 said all the residents in the Florida room need some type of assistance and many need to be fed. Both CNA #5 and CNA #3 said having only three CNAs does not happen all the time but happens. During an interview on 1/7/25 at 11:39 A.M., Nurse #7 said the residents who eat in the Florida room require assistance or are dependent on staff to eat. During an interview on 1/8/25 at 4:50 P.M., Nurse #6 said on Monday morning (1/6/24) the breakfast meal did not go well, it was bad. When asked what that meant Nurse #6 said they did not have enough staff to make sure residents were up out of bed to have their breakfast meal. Nurse #6 said the residents who eat in the Florida room all require to be fed, supervised or assisted. Nurse #6 said they did not have enough staff to make sure residents were fed timely and that it took too long to assist them all, and it was nearly 10:00 A.M., before some were assisted with their breakfast meal. Nurse #6 said they only had three CNAs on that morning. Nurse #6 said she and one CNA were in the dining room assisting residents who are dependent and that the other residents in the room were not being assisted with their meals. Nurse #6 said not having enough staff for a meal has happened before. Review of the actual working schedule indicated the following: Sunday December 8, 2024, Sunday December 22, 2024, Sunday December 29, 2024, and Tuesday December 31, 2024, had three CNAs on the 7:00 A.M. -3:00 P.M. shift. During an interview during the Quality Assurance and Performance Improvement review on 1/9/25 at 1:22 P. M., the Administrator said A3 had many dependent residents and is scheduled to be staffed with four CNAs on the 7:00 A.M.-3:00 P.M. shift.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record reviews, policy reviews and interviews, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable mental, and psychosocial well-being for one Resident (#70) out of a total sample of 29 residents. Specifically, for Resident #70, the facility failed to ensure a psychiatric consult was completed. Resident #70 was admitted to the facility in September 2024 with diagnoses that included dementia with behaviors, restlessness and agitation, delirium, and insomnia. Review of Resident #70's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 5 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairments. Further review of the MDS indicated the Resident is receiving antidepressant and antianxiety medications. Review of Resident #70's physician order, dated 9/7/24, indicated Counseling and Psychology Services PRN (as needed). Review of Resident #70's physician progress note, dated 12/12/24, indicated Dementia with anxiety: Continue with lorazepam (benzodiazepine medication) and trazodone (anti-depressant medication). He/she may benefit from an SSRI (selective serotonin reuptake inhibitors- treats depression), and a referral to psychiatry will be made. Review of Resident #70's nursing progress note, dated 1/1/25, indicated Increase in anxiety noted this morning difficulty concentrating to eat 1:1 with slight effect. During an interview on 1/8/25 at 1:42 P.M., Nurse #5 said nursing staff will send an email to the psych provider that a resident needs to be seen. Nurse #5 said psych services come in weekly and said Resident #70 should have been seen since 12/12/24 and if he/she was seen the note would be available in the medical record. Review of Resident #70's medical record failed to indicate that he/she had been seen by psych services. During an interview on 1/8/25 at 1:49 P.M., the Director of Nurses (DON) said if the Physician wanted the Resident to be seen by psych around 12/12/24 then he/she should have been seen by psych services by now.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation and interview, the facility failed to provide a meals that were palatable and served at an appetizing temperature. Findings include: Review of the facility's policy and procedure, titled Dining Room Rounds, dated as revised November 5, 2024, indicated the following: Our facility audits the food services department regularly to ensure that resident needs are being met and that dining is a safe and pleasant experience for residents. Policy Interpretation and Implementation 2. The auditor will assess: b. Food temperatures on delivery and at end of service; e. Palatable presentation of food; During an observation of the breakfast meal on the A 3 unit, on 1/6/25 at 9:10 A.M., twelve residents were present in the Florida room. At 9:10 A.M., one of the first residents received his/her breakfast meal, the last resident was served his/her breakfast meal at 9:43 A.M., Forty-three minutes following the first breakfast meal delivered. During an interview on 1/7/25 at 11:26 A.M., Certified Nursing Assistants (CNA) #3 and #4 said residents who eat in the Florida dining room all require assistance or are dependent on staff to eat. CNA #5 said the last resident was served very late and the food was not warmed up. During a Resident Council Meeting on 1/7/25 at 11:00 A.M., 10 out of 10 Residents reported food being cold with all meals upon delivery. On 1/9/25 at 8:57 A.M., the second food truck arrived at the A3 unit for the Florida room. On 1/9/25 at 9:15 A. M., the surveyor received the test tray and recorded the following: The pancakes registered at 90 degrees Fahrenheit and tasted barely warm and not warm all the way through. The sausage patty temperature registered at 80 degrees Fahrenheit and tasted barely warm and had a small hard piece of [NAME]. During an interview on 1/9/25 at 11:20 A.M., the Food Service Director said she would expect food to be hot and palatable for residents and to be delivered in a timely manner. 45343

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 45343 Based on observation, interview and record review, the facility failed to provide or offer adequate snacks between meals. Findings include: Review of the policy titled Nutritional Snacks and Supplements, revised 12/24, indicated the following: Policy: Nutritional supplements are available and will be provided for all appropriate residents by the nursing staff. -Bedtime snacks will be offered daily. During the resident group meeting on 1/7/25 at 11:00 A.M., 5 out of 10 residents who are unable to independently obtain snacks from the kitchenette said they are not offered snacks after dinner and were not aware there were snacks available to them. During an observation on 1/8/25 at approximately 4:00 P.M., the kitchenettes on all units had a variety of snacks available for resident consumption. During an interview on 1/8/25 at 4:23 P.M., Certified Nursing Assistant (CNA) #9 said snacks are given upon request from the residents. CNA #9 was asked if snacks are offered in the evening. She said we provide snacks to the residents that ask for them. During an interview on 1/9/25 at 8:11 A.M., the Director of Nursing and Administrator said residents on all units should be offered snacks between meals and there should be a snack pass in the evening on the 3:00 P.M. to 11:00 P.M. shift. The Administrator said she was not aware that residents were not being offered snacks in the evening after dinner.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50338 Based on observations, record review and interviews, the facility failed to ensure the nursing staff documented accurately in the medical record for two Residents (#2 and #19) out of a total sample of 29 Residents. Specifically, for Resident #2 and Resident #19 the facility failed to ensure nursing staff accurately documented which arm a blood pressure was taken. Findings include: 1. Resident #2 admitted to the facility in October 2021 with diagnoses that included chronic heart failure, chronic respiratory failure, diabetes, and hypertension. Review of Resident #2's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had moderate cognitive impairment. The MDS further indicated that the Resident was receiving a diuretic (a medication that can be used to lower blood pressure). Review of Resident #2's physician order, dated 9/9/21, indicated no blood pressure on left arm (every shift for left mastectomy). Review of Resident #2's blood pressures indicated: - 11/15/24 143 / 79 mmHg Sitting l (left)/arm - 11/14/24 135 / 73 mmHg Sitting l/arm - 11/13/24 169 / 95 mmHg Sitting l/arm - 10/9/24 132/ 75 mmHg Sitting l/arm - 10/3/24 142 / 75 mmHg Lying l/arm - 7/1/24 149 / 80 mmHg Sitting l/arm - 2/14/24 133 / 64 mmHg Sitting l/arm Review of Resident #2's active care plan failed to include that the Resident's blood pressure should not be taken in his/her left arm. During an interview on 1/7/25 at 9:03 A.M., Nurse #1 said the Resident's blood pressure should not be taken in the left arm as the Resident had a mastectomy on the left side. Nurse #1 said it should be documented as being taken in the right arm. During an interview on 1/8/2 at 1:35 P.M., the Director of Nurses said the nurses should not be documenting that they are taking Resident #2's blood pressure in the left arm. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #19 admitted to facility March 2024 with diagnoses that included traumatic subdural hemorrhage, diabetes, hypertension. Review of Resident #19's most recent MDS, dated [DATE], indicated he/she was rarely/never understood and had severe cognitive impairment as evidenced by a staff assessment for BIMS. Review of Resident #19's physician order, dated 3/25/24, indicated No blood pressure on Left arm. Right arm only due to history of left mastectomy. Review of Resident #19's blood pressures indicated: -9/1/24 135 / 80 mmHg Lying l/arm -7/3/24 142 / 99 mmHg Lying l/arm -6/27/24 118 / 66 mmHg Lying l/arm -5/1/24 106 / 72 mmHg Lying l/arm -4/10/24 110 / 78 mmHg Lying l/arm -3/28/24 112 / 74 mmHg Lying l/arm -3/28/24 110 / 78 mmHg Lying l/arm -3/28/24 124 / 76 mmHg Lying l/arm -3/25/24 118 / 84 mmHg Lying l/arm Review of Resident #19's active care plan, failed to include that Resident's blood pressure should not be taken in left arm. During an interview on 1/7/25 at 9:03 A.M., Nurse #1 said the Resident's blood pressure should not be taken in the left arm as the Resident had a mastectomy on the left side and said it should be documented as being taken in the right arm. During an interview on 1/8/2 at 1:35 P.M., the Director of Nurses said the nurses should not be documenting that they are taking Resident #19's blood pressure in the left arm.