STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235016	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegra Nursing and Rehab	434 W North St Jackson, MI 49202

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 32064 Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from verbal abuse by staff for one (Resident #359) of three reviewed. Findings include: Review of the medical record revealed Resident #359 (R359) admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, depression, history of wedge compression fracture of thoracic vertebra, anxiety, and cerebral palsy. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/8/24 revealed R359 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). On 5/14/24 at 9:32 AM, R359 was observed lying in bed. R359 reported yesterday, she was in her chair from 2:00 PM to 5:00 PM and had to go to the bathroom. R359 reported she took herself to the bathroom because her call light was not in reach. R359 reported afterwards, she transferred herself into her bed which was not made with a sheet or blanket. R359 reported Certified Nursing Assistant (CNA) V came into her room and wanted her to transfer back out of bed since the bed was not made. R359 reported CNA V said Why the f*ck can't you get up and go to the bathroom? R359 stated she said the f word, she was literally cussing at me. R359 reported CNA V told her she was not going to change her bed if she could not get up and go to the bathroom. R359 stated I just don't like to be treated like that. That's why I'm here is because I need help with certain things. It's downgrading when someone literally swears at you and treats you like crap. R359 was tearful when recalling the incident. R359 reported her roommate (R37) was in the room at the time of the incident. R359 reported she reported the incident to Director of Nursing (DON) B this morning and DON B filled out a grievance form. On 5/16/24 at 9:56 AM, R359 reported she felt CNA V was inappropriate and that she was verbally abused. Review of R359's Complaint/Grievance Report dated 5/14/24 and completed by DON B revealed Last night I was not happy with my CNA. She was rude and used inappropriate language. The findings of investigation revealed Resident is upset. I reassured her that I would follow up with concern. The Plan to resolve complaint/grievance was Interview CNA involved today. CNA educated on asking for assist. CNA educated on approach. The Complaint/Grievance Report revealed the incident was not reportable to the State Agency. The resolution was CNA will not be assigned to care for [R359]. [R359] agrees this will resolve concern. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	On 5/15/24 at 1:55 PM, NHA A and DON B reported R359 had one grievance from 5/14/24 that they were investigating. NHA A and DON B reported R359 was not happy with the CNA and reported CNA V was rude and used inappropriate language with R359. DON B reported they spoke with CNA V and reassured R359 that CNA V would not take care of her. When asked what was reported, DON B reported R359 reported CNA V used the f word. DON B reported R359's roommate, R37, reported R359 and CNA V were arguing about getting out of bed. NHA A and DON B reported CNA V was educated on her approach and that it's okay to step away and reapproach. NHA A reported the allegation was not reported to the State Agency because R359 did not say she perceived the incident as abusive. NHA A reported when they followed up again today, R359 did not feel like it was anything intentional. NHA A reported the facility was investigating this incident as a resident concern. In an interview on 5/16/24 at 9:54 AM, R37 (R359's roommate) was observed lying in bed. According to the MDS with an ARD of 4/9/24, R37 scored 11 out of 15 (moderate cognitive impairment) on the BIMS. R37 had a history of stroke and had difficulty expressing speech. As questions were asked, R37 pointed to her right side indicating she had a stroke and that she would have trouble with speech. Yes and no questions were asked. R37 reported she overheard the argument between CNA V and R359. R37 reported CNA V did swear and use the f word. R37 felt CNA V was inappropriate. In an interview on 5/16/24 at 10:42 AM, NHA A and DON B reported R359 reported CNA V used the f word and said why the f*ck didn't you get up to go. NHA A reported they considered it as more of a customer service and etiquette issue. When asked if CNA V did swear and say that to R359, would that be considered abuse, NHA A and DON B did not answer the question. In a telephone interview on 5/16/24 at 12:43 PM, CNA V reported when her shift started at 3:00 PM on 5/14/24, it was very hectic with a lot of call lights on. CNA V reported it was the first time she cared for R359. CNA V reported the previous shift left R359's bed unmade and R359 was lying on a bare mattress. CNA V reported she wanted to make R359's bed and it took approximately 20 minutes to coerce R359 out of bed. When asked if there was any arguing, CNA V stated I guess you could call it arguing because I was like we have to get up and she would say no and start crying about her husband. When asked if raised voices were used, CNA V stated it was all kind of really loud because she was emotional and crying about her husband. CNA V denied swearing at R359. CNA V reported she was interviewed by NHA A and DON B and was told R359 reported she was mean towards her and that R359 was very upset. Review of the Grievance Summary provided by NHA A on 5/16/24 at 4:02 PM revealed On Tuesday, 5/14/24 am nurse notified Director of Nursing that community member was upset and she needed to go see her. DON met with member and completed complaint/grievance report. Resident stated that she was not happy with her CNA the afternoon previous and that she was rude and used inappropriate language. At no time did the resident allege abuse. She stated that she felt safe and thought the CNA was a good CNA but that she did not use proper etiquette and is ok with her providing care in the future. All residents within the set were questioned with no other identified concerns. Resident remains at her baseline and is exhibiting no catastrophic reaction that would signify abuse occurred. Customer service training and proper language etiquette have been provided. This was completed within 2 hours of notification and there were no allegations of abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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** 32064 Based on observation, interview, and record review, the facility failed to report an allegation of abuse to the State Agency for one (Resident #359) of three reviewed. Findings include: Review of the medical record revealed Resident #359 (R359) admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, depression, history of wedge compression fracture of thoracic vertebra, anxiety, and cerebral palsy. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/8/24 revealed R359 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). On 5/14/24 at 9:32 AM, R359 was observed lying in bed. R359 reported yesterday, she was in her chair from 2:00 PM to 5:00 PM and had to go to the bathroom. R359 reported she took herself to the bathroom because her call light was not in reach. R359 reported afterwards, she transferred herself into her bed which was not made with a sheet or blanket. R359 reported Certified Nursing Assistant (CNA) V came into her room and wanted her to transfer back out of bed since the bed was not made. R359 reported CNA V said Why the f*ck* can't you get up and go to the bathroom? R359 stated she said the f word, she was literally cussing at me. R359 reported CNA V told her she was not going to change her bed if she could not get up and go to the bathroom. R359 stated I just don't like to be treated like that. That's why I'm here is because I need help with certain things. It's downgrading when someone literally swears at you and treats you like crap. R359 was tearful when recalling the incident. R359 reported her roommate (R37) was in the room at the time of the incident. R359 reported she reported the incident to Director of Nursing (DON) B this morning and DON B filled out a grievance form. On 5/16/24 at 9:56 AM, R359 reported she felt CNA V was inappropriate and that she was verbally abused. On 5/14/24 at 9:40 AM, DON B entered R359's room with a grievance form in her hand. DON B reported she spoke with R359 earlier that morning, has a concern form, discussed the incident with Nursing Home Administrator (NHA) A, and they have a call out to CNA V. Review of R359's Complaint/Grievance Report dated 5/14/24 and completed by DON B revealed Last night I was not happy with my CNA. She was rude and used inappropriate language. The findings of investigation revealed Resident is upset. I reassured her that I would follow up with concern. The Plan to resolve complaint/grievance was Interview CNA involved today. CNA educated on asking for assist. CNA educated on approach. The Complaint/Grievance Report revealed the incident was not reportable to the State Agency. The resolution was CNA will not be assigned to care for [R359]. [R359] agrees this will resolve concern. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 1:55 PM, NHA A and DON B reported R359 had one grievance from 5/14/24 that they were investigating. NHA A and DON B reported R359 was not happy with the CNA and reported CNA V was rude and used inappropriate language with R359. DON B reported they spoke with CNA V and reassured R359 that CNA V would not take care of her. When asked what was reported, DON B reported R359 reported CNA V used the f word. DON B reported R359's roommate, R37, reported R359 and CNA V were arguing about getting out of bed. NHA A and DON B reported CNA V was educated on her approach and that it's okay to step away and reapproach. NHA A reported the allegation was not reported to the State Agency because R359 did not say she perceived the incident as abusive. NHA A reported when they followed up again today, R359 did not feel like it was anything intentional. NHA A reported the facility was investigating this incident as a resident concern. In an interview on 5/16/24 at 9:54 AM, R37 (R359's roommate) was observed lying in bed. According to the MDS with an ARD of 4/9/24, R37 scored 11 out of 15 (moderate cognitive impairment) on the BIMS. R37 had a history of stroke and had difficulty expressing speech. As questions were asked, R37 pointed to her right side indicating she had a stroke and that she would have trouble with speech. Yes and no questions were asked. R37 reported she overheard the argument between CNA V and R359. R37 reported CNA V did swear and use the f word. R37 felt CNA V was inappropriate. In an interview on 5/16/24 at 10:42 AM, NHA A and DON B reported R359 reported CNA V used the f word and said why the f*ck didn't you get up to go. NHA A reported they considered it as more of a customer service and etiquette issue. When asked if CNA V did say that to R359, would that be considered abuse, NHA A and DON B did not answer the question. In a telephone interview on 5/16/24 at 12:43 PM, CNA V reported when her shift started at 3:00 PM on 5/14/24, it was very hectic with a lot of call lights on. CNA V reported it was the first time she cared for R359. CNA V reported the previous shift left R359's bed unmade and R359 was lying on a bare mattress. CNA V reported she wanted to make R359's bed and it took approximately 20 minutes to coerce R359 out of bed. When asked if there was any arguing, CNA V stated I guess you could call it arguing because I was like we have to get up and she would say no and start crying about her husband. When asked if raised voices were used, CNA V stated it was all kind of really loud because she was emotional and crying about her husband. CNA V denied swearing at R359. CNA V reported she was interviewed by NHA A and DON B and was told R359 reported she was mean towards her and that R359 was very upset. Review of the Grievance Summary provided by NHA A on 5/16/24 at 4:02 PM revealed On Tuesday, 5/14/24 am nurse notified Director of Nursing that community member was upset and she needed to go see her. DON met with member and completed complaint/grievance report. Resident stated that she was not happy with her CNA the afternoon previous and that she was rude and used inappropriate language. At no time did the resident allege abuse. She stated that she felt safe and thought the CNA was a good CNA but that she did not use proper etiquette and is ok with her providing care in the future. All residents within the set were questioned with no other identified concerns. Resident remains at her baseline and is exhibiting no catastrophic reaction that would signify abuse occurred. Customer service training and proper language etiquette have been provided. This was completed within 2 hours of notification and there were no allegations of abuse.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on observation, interview, and record review, the facility failed to prevent further potential abuse for one (Resident #359) of three reviewed. Findings include: Review of the medical record revealed Resident #359 (R359) admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, depression, history of wedge compression fracture of thoracic vertebra, anxiety, and cerebral palsy. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/8/24 revealed R359 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). On 5/14/24 at 9:32 AM, R359 was observed lying in bed. R359 reported yesterday, she was in her chair from 2:00 PM to 5:00 PM and had to go to the bathroom. R359 reported she took herself to the bathroom because her call light was not in reach. R359 reported afterwards, she transferred herself into her bed which was not made with a sheet or blanket. R359 reported Certified Nursing Assistant (CNA) V came into her room and wanted her to transfer back out of bed since the bed was not made. R359 reported CNA V said Why the f*ck* can't you get up and go to the bathroom? R359 stated she said the f word, she was literally cussing at me. R359 reported CNA V told her she was not going to change her bed if she could not get up and go to the bathroom. R359 stated I just don't like to be treated like that. That's why I'm here is because I need help with certain things. It's downgrading when someone literally swears at you and treats you like crap. R359 was tearful when recalling the incident. R359 reported her roommate (R37) was in the room at the time of the incident. R359 reported she reported the incident to Director of Nursing (DON) B this morning and DON B filled out a grievance form. On 5/16/24 at 9:56 AM, R359 reported she felt CNA V was inappropriate and that she was verbally abused. On 5/14/24 at 9:40 AM, DON B entered R359's room with a grievance form in her hand. DON B reported she spoke with R359 earlier that morning, has a concern form, discussed the incident with Nursing Home Administrator (NHA) A, and they have a call out to CNA V. Review of R359's Complaint/Grievance Report dated 5/14/24 and completed by DON B revealed Last night I was not happy with my CNA. She was rude and used inappropriate language. The findings of investigation revealed Resident is upset. I reassured her that I would follow up with concern. The Plan to resolve complaint/grievance was Interview CNA involved today. CNA educated on asking for assist. CNA educated on approach. The Complaint/Grievance Report revealed the incident was not reportable to the State Agency. The resolution was CNA will not be assigned to care for [R359]. [R359] agrees this will resolve concern. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 1:55 PM, NHA A and DON B reported R359 had one grievance from 5/14/24 that they were investigating. NHA A and DON B reported R359 was not happy with the CNA and reported CNA V was rude and used inappropriate language with R359. DON B reported they spoke with CNA V and reassured R359 that CNA V would not take care of her. When asked what was reported, DON B reported R359 reported CNA V used the f word. DON B reported R359's roommate, R37, reported R359 and CNA V were arguing about getting out of bed. NHA A and DON B reported CNA V was educated on her approach and that it's okay to step away and reapproach. NHA A reported the allegation was not reported to the State Agency because R359 did not say she perceived the incident as abusive. NHA A reported when they followed up again today, R359 did not feel like it was anything intentional. NHA A reported the facility was investigating this incident as a resident concern. In an interview on 5/16/24 at 9:54 AM, R37 (R359's roommate) was observed lying in bed. According to the MDS with an ARD of 4/9/24, R37 scored 11 out of 15 (moderate cognitive impairment) on the BIMS. R37 had a history of stroke and had difficulty expressing speech. As questions were asked, R37 pointed to her right side indicating she had a stroke and that she would have trouble with speech. Yes and no questions were asked. R37 reported she overheard the argument between CNA V and R359. R37 reported CNA V did swear and use the f word. R37 felt CNA V was inappropriate. In an interview on 5/16/24 at 10:42 AM, NHA A and DON B reported R359 reported CNA V used the f word and said why the f*ck didn't you get up to go. NHA A reported they considered it as more of a customer service and etiquette issue. When asked if CNA V did swear and say that to R359, would that be considered abuse, NHA A and DON B did not answer the question. In a telephone interview on 5/16/24 at 12:43 PM, CNA V reported when her shift started at 3:00 PM on 5/14/24, it was very hectic with a lot of call lights on. CNA V reported it was the first time she cared for R359. CNA V reported the previous shift left R359's bed unmade and R359 was lying on a bare mattress. CNA V reported she wanted to make R359's bed and it took approximately 20 minutes to coerce R359 out of bed. When asked if there was any arguing, CNA V stated I guess you could call it arguing because I was like we have to get up and she would say no and start crying about her husband. When asked if raised voices were used, CNA V stated it was all kind of really loud because she was emotional and crying about her husband. CNA V denied swearing at R359. CNA V reported she was interviewed by NHA A and DON B and was told R359 reported she was mean towards her and that R359 was very upset. Review of the Grievance Summary provided by NHA A on 5/16/24 at 4:02 PM revealed On Tuesday, 5/14/24 am nurse notified Director of Nursing that community member was upset and she needed to go see her. DON met with member and completed complaint/grievance report. Resident stated that she was not happy with her CNA the afternoon previous and that she was rude and used inappropriate language. At no time did the resident allege abuse. She stated that she felt safe and thought the CNA was a good CNA but that she did not use proper etiquette and is ok with her providing care in the future. All residents within the set were questioned with no other identified concerns. Resident remains at her baseline and is exhibiting no catastrophic reaction that would signify abuse occurred. Customer service training and proper language etiquette have been provided. This was completed within 2 hours of notification and there were no allegations of abuse. Review of CNA V's timecard revealed they worked 5/14/24 from 3:00 PM to 11:00 PM. Timecard comments revealed went right to meet with [NHA A and DON B]. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Abuse and Neglect Procedural Guidelines (undated) revealed the facility will immediately remove any alleged perpetrator from any further contact with any resident .When an employee is the alleged perpetrator of abuse or neglect, that employee shall immediately be suspended from his/her position pending investigation and outcome.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46955 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plans for 1 (Resident #14) of 14 reviewed resulting in the potential for decreased safety, increased injury risk, and unmet care needs. Review of the medical record revealed that Resident #14 (R14) was readmitted to facility 1/10/24 with diagnoses including vascular dementia, catatonic schizophrenia, specified disorder of bone density and structure, muscle weakness, and abnormalities of gait and mobility. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/18/24 revealed that R14 had a Brief Interview for Mental Status (BIMS-a cognitive screening tool) score of 6 (severe cognitive impairment). Review of R14's ADL (Activities of Daily Living) Care Plan reflected that R14 required assist of one for bed mobility and bathing and assist of 2 for toilet use and transfers. In an observation and interview on 5/14/24 at 8:47 AM, R14 was observed lying in bed, on back, with body positioned toward right edge of mattress and head of bed at an approximate 60-degree angle. R14's entire bed was noted to be elevated between knee and hip level, left side of bed was positioned against the wall, and a black, cushioned mat was on the floor to the right of the bed. R14's over the bed table was positioned parallel to bed, on top of floor mat with R14 noted to lean to right side, reach over body with left arm to feed self from breakfast tray positioned on over the bed table. R14 stated that she could not walk, required a mechanical lift for transfer, and remembered falling a couple of times but couldn't recall details regarding the falls. In an observation on 5/14/24 at 10:11 AM, R14 was observed to remain positioned on back toward right edge of bed with head of bed remaining at an approximate 60-degree angle. Entire bed observed to remain elevated between knee and hip level with black, cushioned floor mat on floor to right of bed. In an observation on 5/15/24 at 8:19 AM, R14 was observed lying in bed, on back, feeding self-breakfast from tray positioned directly in front of her on over the bed table. The head of R14's bed was positioned at an approximate 60-degree angle with entire bed noted to be elevated to just above knee height level. Black cushioned floor mat noted at floor to right of bed. In an interview on 05/15/24 at 2:30 PM, Certified Nurse Aide (CNA) S confirmed familiarity with R14 and that she was her assigned aide that date. Per CNA S, R14 was alert, was generally able to make needs known, but had episodes of confusion. CNA S further stated that R14 required assist of 2 for transfer with use of mechanical lift but otherwise required assist of 1 for grooming, bathing, dressing, and bed mobility. CNA S stated that, to her knowledge, R14 had no recent falls but due to her confusion and dependence on staff for transfer, was at risk for and had the potential to fall or roll out of bed and therefore should have her bed lowered all the way to the floor and the mat placed at the bedside whenever she was in bed. CNA S stated that when she started her shift at 7:00 AM that date, R14's bed had been at knee height level, acknowledged that at that level it was higher than it should have been but maintained it at that level as knew that she would be eating breakfast soon. CNA S stated that R14's bed remained at knee height level until approximately 9:30 AM at which time she assisted her with care and out of bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R14's medical record completed with the following findings noted: Fall assessment dated [DATE] reflected that R14 had diminished safety awareness, predisposing medical conditions (dementia, hypertension, anemia), and medications (antihypertensive, antiseizure, diuretic, hypoglycemic, psychotropic medications) which contributed to fall risk. ADL Care Plan Focus with a revised date of 10/18/23 included Care Plan Interventions that stated, For my safety I need my room door open with an 8/13/2021 date of initiation and Resident moves in bed frequently, please check call light placement to be sure it is in reach with a 7/21/2021 date of initiation. Fall Care Plan Focus with a revised date of 4/12/24 stated, I am at risk for falls related to HX [history] of falling, encephalopathy, catatonic schizophrenia .hx fall with fracture . with associated interventions which included, Maintain bed in low position with a 7/17/21 date of initiation. Kardex (tool used by the Certified Nurse Aide to guide them as to the care needs of a specific resident) section titled Safety reflected, Maintain bed in low position. In an interview on 5/15/24 at 4:39 PM, Director of Nursing (DON) B stated that safety interventions for a resident with a fall from bed could include floor mats, low bed, and a specialized mattress. DON B further stated that an intervention for a low bed would be reflected on both the resident care plan and Kardex with the expectation that the indicated bed be maintained in the lowest position to the floor possible when the resident was in bed. DON B confirmed familiarity with R14, stated that she had dementia with some confusion and that, to her knowledge, had no recent falls. Nursing Home Administrator (NHA) A who was present during interview stated that R14's last documented fall was in 2022. Upon review of R14's fall care plan, DON B confirmed an active care plan intervention to Maintain bed in low position, stated that intervention was likely no longer warranted as did not believe that R14 would be considered a current fall risk and would be reviewing the care plan with the interdisciplinary team (IDT) for likely revision. Review of R14's progress notes post 5/15/24 interview with DON B was noted to include an IDT Note which stated, .IDT note r/t [related to] fall care plan. Fall care plan was reviewed and deemed appropriate. No changes needed at this time indicating ongoing need for the low bed for safety.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview and record review, the facility failed to 1) ensure blood glucose values were documented in the medical record for one (R22) and failed to implement assessment/intervention for bowel constipation for one resident (R408) of 14 reviewed for quality of care. Findings include: Resident #22 Review of the Face Sheet revealed Resident #22 (R22) was admitted to the facility on [DATE] with diagnoses that included muscle weakness, unspecified severe protein calorie malnutrition, delirium due to known physiological source, Alzheimer's disease, and metabolic encephalopathy. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/19/24 revealed R22 scored 3 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Care Plan revealed R22 required assistance of one staff member for toileting. Review of the MDS revealed R22 was coded always incontinent for bowels. On 05/14/24 at 3:56 PM, R22 was observed self propelling in the hallway. R22 was not easily conversant and preferred to independently propel through the hallway. Review of the Bowel Movement Task revealed R22 had not had a bowel movement from 5/8/24 to 5/12/24. In an interview on 5/16/24 at 12:12 PM, Unit Manager (UM) M reported that the nursing staff monitors for bowel movements and if the resident has not had a bowel movement in three days, the nurses are notified by an alert listing. UM M stated that the Interdisciplinary Team (IDT) also monitors all alert listings, complies a list, and informs the floor nurse when intervention is need. When the nurses are notified of the absence of a bowel movement, they should administer the as needed order for milk of magnesia which states Give 30 ml (milliliters) by mouth every 24 hours as needed for constipation/no bm (bowel movement) in 3 days. If the milk of magnesia is not effective, the nurse would refer to the next as needed order which reads Bisacodyl Suppository 10 MG; Insert 1 suppository rectally as needed for constipation or if no bowel movement in 24 hours after administration of milk of magnesia. If that is not effective, the nurse is to refer to the next as needed order which states Fleet Naturals Cleansing Enema Enema (Rectal Cleansers); Insert 1 application rectally every 24 hours as needed for constipation if no results from administration of Dulcolax/Bisacodyl suppository in 24 hours. UM Mreviewed the bowel movement documentation and verified that R22 had not had a bowel movement for a total of five days. UM M said the expectation would have been to implement the Bowel Protocol on day three. Review of the Medication Administration Record for R22 revealed that the as needed medication for constipation was not administered as required. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/16/24 at 2:41 PM, Director of Nursing (DON) B reported that the IDT team monitors the alert listing report for resident that had not had a bowel movement in three days. DON B stated that she will inform the corresponding nurse that the resident has not had a bowel movement in three days and ensure that staff had not missed documenting a bowel movement or that the resident had refused the as needed medication for constipation. DON B verified that the bowel protocol should have been implemented when R22 had not experienced a bowel movement for 5 days. Resident #408 Review of the Face Sheet revealed Resident #408 (R408) was admitted to the facility on [DATE] with diagnoses that included lower back pain, Alzheimer's disease, type two diabetes with hyperglycemia, and spinal stenosis. Review of a Skilled Note dated 5/15/24 at 12:48 PM revealed R408 was alert and oriented to person, place, date, time . [R408] can be understood all of the time and able to understand others all of the time . On 05/14/24 at 10:38 AM, R408 was observed in her room, dressed and seated in her recliner. R408 was easily conversant and understood questions. R408 stated that she had recently admitted to the facility for rehabilitation and lived at an assisted living facility prior to her admission. R408 reported a concern with her blood sugar checks. R408 stated they said my blood sugar was low yesterday and brought me crackers. Review of R408's Physician Order's revealed R408 had an order for Glipizide ER Oral Tablet Extended Release 24 Hour 10 MG (milligrams) . Give 1 tablet by mouth one time a day for Diabetes with a start date of 5/14/24 and an order for Lantus SoloStar Solution Pen-injector 100 UNIT/ML (Insulin Glargine) .Inject 15 unit subcutaneously one time a day . with a start date of 5/13/24. Review of the Physician's Orders revealed R408 had an order for Accuchecks (Blood Glucose checks) in the morning and in the evening with a start date of 5/13/24. Review of the Medical Record revealed a blood glucose reading on 5/13/2024 at 7:06 AM of 120.0 mg/dL (milligrams per deciliter), a reading on 5/15/2024 at 8:05 AM of 126.0 mg/dL, and a reading on 5/16/2024 at 7:48 AM of 168.0 mg/dL. Review of a Nutrition assessment dated [DATE] at 9:13 AM revealed R408 diet order was changed from a regular diet to a CCD (Consistent Carbohydrate) diet due to the elevated blood sugar. In an interview on 5/16/23 at 1:47 PM, Dietician W reported that she completed a nutritional assessment on R408 today and explained that the change in diet order was due to the increased blood sugar. Dietician W stated that she typically reviews blood sugar values when she conducts her assessment however, only had three values for the past four days. In an interview on 05/16/24 at 12:25 PM, Unit Manager M verified that R408 received twice daily for blood glucose checks. When queried if the blood sugar values should be documented in the medical record, UM M stated that they should be documented in the medical record. UM M reviewed the Physician Order's for R408 and stated that when the twice daily blood glucose check order was created, the option to include supplemental documentation did not trigger on the Physician Order. Due to this, the Medication Administration Record did not prompt a space to document blood glucose values and the blood glucose values did not get documented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/16/24 at 2:37 PM, Director of Nursing (DON) B stated that the expectation for blood glucose monitoring would be to ensure the blood glucose values were documented in the medical record.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46955 Based on observation, interview, and record review, the facility failed to timely identify the formation of pressure ulcers and consistently implement ordered wound care treatments for 2 (Resident #3 and #5) of 2 residents reviewed for pressure ulcers, resulting in the development of a facility acquired Unstageable Pressure Ulcer (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) for R3 and a Deep Tissue Injury (intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister) for R5, and the increased likelihood for delayed wound healing and/or worsening of wounds and overall deterioration in health status. Findings include: Resident #3 (R3) Review of the medical record revealed that Resident #3 (R3) was initially admitted to facility 4/19/21 with diagnoses including diabetes mellitus type 2, lymphedema, morbid obesity, and localized edema. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/24/24 revealed that R3 had a Brief Interview for Mental Status (BIMS-a cognitive screening tool) score of 6 (severe cognitive impairment). Section M of the same MDS reflected that R3 was at risk of developing pressure ulcers, had 2 venous ulcers, but was not on a turning/repositioning program. Review of R3's ADL (Activities of Daily Living) Care Plan reflected that R3 required assist of one for dressing and assist of 2 for toilet use, transfers, and bed mobility. In an observation and interview on 5/14/24 at 12:33 PM, R3 was observed sitting in wheelchair, in room, with gauze wraps visible to bilateral lower legs. R3 stated that she had sores on her legs and bottom, that she was uncomfortable and did not feel good but was unable to elaborate on either further. In an observation and interview on 5/14/24 at 3:02 PM, R3 was observed lying in bed, on back, with left leg bent at knee and right leg extended straight out. R3 again stated that she did not feel well and that her bottom was sore but was unable to elaborate further prior to closing eyes and providing no further response to questions. In an observation and interview on 5/15/24 at 8:11 AM, R3 was observed lying in bed, on back, with legs extended straight out. R3 opened eyes when name called and when questioned stated that her bottom was sore but better prior to closing eyes and providing no further response to additional questions. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/15/24 at 1:22 PM, Licensed Practical Nurse (LPN) I was observed to prepare wound supplies and complete R3's pressure ulcer treatments. During preparation of supplies at treatment cart, LPN I confirmed familiarity with R3, stated that she had fairly new pressure ulcers at buttock region and had provided pain medication to R3 just prior as the treatments were uncomfortable for her. Upon entering room in presence of LPN I and N, R3 was observed lying in bed, on back, with head of bed at an approximate 30 degree angle. Both LPN I and N repositioned R3 onto right side with LPN I observed to remove bordered foam dressings at right iliac crest and left buttock region. Left buttock noted to present with open ulcer measuring approximately 1.5centimeters (cm) x (by) 1.0cm with pale yellow slough (non-viable tissue adhered to the wound bed that must be removed from the wound for healing to take place) at central wound aspect and dark pink granulation (healthy pink to red tissue) toward wound edge. Right iliac crest region (bony surface toward upper buttock/hip region) observed to present with small open ulcer measuring approximately 0.5cm x 0.5cm with pale yellow slough at central wound aspect and light pink tissue toward wound edge. Surrounding tissue of both open wounds noted to be intact but fragile with mild dry/flaky skin. Review of R3's medical record completed with the following findings noted: Braden Scale For Predicting Pressure Sore Risk dated 4/24/24 reflected score of 11 indicating high risk for pressure ulcer development. Skin & Wound Evaluation dated 4/23/24 indicated a new in-house acquired unstageable (due to slough and/or eschar) right iliac crest pressure ulcer measuring 1.2cm x 2.2cm. Wound bed indicated as pink or red with remainder of wound assessment form including exudate, periwound, and wound pain noted to be blank. Skin & Wound Evaluation dated 4/26/24 indicated the same unstageable right iliac crest pressure ulcer now measuring 1.0cm x 1.1cm with 70% slough in wound base, light drainage, and moderate pain at dressing change. Skin & Wound Evaluation dated 5/3/24 indicated the same unstageable right iliac crest pressure ulcer now measuring 0.5cm x 0.5cm with 60% slough in wound base, light drainage, and moderate pain at dressing change. Skin & Wound Evaluation dated 5/10/24 indicated the same right iliac crest pressure ulcer to now be presenting as a Stage 3 pressure ulcer measuring 0.4cm x 0.3cm with 30% slough in wound base, light drainage, and moderate pain at dressing change. Skin & Wound Evaluation dated 5/3/24 indicated a new in house acquired deep tissue injury at left gluteus (buttock) measuring 2.3cm x 1.2cm with 100% epithelial tissue in wound base and moderate pain at dressing change. Skin & Wound Evaluation dated 5/10/24 indicated the same left gluteus pressure ulcer now presenting as a Stage 3 ulcer measuring 1.5cm x 0.9cm with 70% granulation tissue and 30% slough in wound base, light drainage, and moderate pain at dressing change. Physician order dated 10/18/22 stated, Ensure low-air loss pressure redistribution surface is on and operational. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Physician order dated 3/13/24 stated Body audit one time a day every Mon for skin observation, 0-No skin breakdown, 1-Previously identified wound/breakdown, 3-Newly identified wound/breakdown-describe in progress note. Review of corresponding order on Treatment Administration Record (TAR) dated 4/1/24 - 4/30/24 reflected completion on 4/15/24, 4/22/24, and 4/29/24 with no newly identified wounds noted although facility acquired unstageable pressure ulcer identified at R3's right iliac crest on 4/23/24 (1 day after completion of body audit) and facility acquired deep tissue injury identified at R3's left gluteus on 5/3/24. Physician order dated 4/23/24 stated, Cleanse sacrum with wound cleanser, Apply medihoney to wound bed, Skin prep to peri wound, Cover with foam dressing, Complete treatment daily. Review of corresponding TAR dated 4/1/24 - 4/30/24 reflected that from the 4/24/24 date of treatment initiation through 4/30/24 that the treatment was completed only 5 out of the 7 days as the treatment administration boxes on 4/27/24 and 4/30/24 were noted to be blank. Physician order dated 5/1/24 stated, Cleanse sacrum with wound cleanser, pat dry, apply triad, apply comfort foam dressing. Physician order dated 5/3/24 stated, Wound: right iliac crest: Cleanse sacrum with wound cleanser, pat dry, apply medihoney to wound bed and cover with a bordered foam dressing. Physician order dated 5/10/24 stated, Wound: right iliac crest: Cleanse with wound cleanser, pat dry, apply Medi honey to wound bed and cover with a bordered foam dressing. Physician order dated 5/3/24 stated, Wound: Left Gluteus: Wash wound with wound cleanser and pat dry. Apply skin prep and cover with a bordered foam dressing daily . Physician order dated 5/10/24 stated, Wound: Left Gluteus: Wash wound with wound cleanser and pat dry. Apply Medi-honey and cover with a bordered foam dressing daily . Physician order dated 5/3/24 stated, please give resident morphine BEFORE wound care. Skin Impairment Care Plan Focus with an 8/4/21 date of initiation and 5/13/24 date of revision stated, I have skin impairments .right iliac crest pressure injury, left gluteus PI [pressure injury] with associated interventions including, low air loss mattress has been in use with a 4/28/24 date of initiation. Resolved interventions within the same care plan included Turn and reposition q2h (every 2 hours) and pressure redistribution cushion to wheel chair both with an 8/4/21 date of initiation and 4/11/24 resolution date and Low air loss mattress with an 8/4/21 date of initiation and 4/18/24 resolution date. Potential impairment to skin integrity care plan focus with a 4/11/24 date of initiation and 5/14/24 revision date was noted with associated interventions including, Assist and encourage to turn and reposition, Assist with incontinent care use moisture barrier cream after incontinent episodes, and Education to resident on wound prevention (R3's BIMS score = 6 limiting ability to understand/retain provided education) all with a 4/11/24 date of initiation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Comprehensive review of R3's progress notes from 4/1/24 through 4/23/24 was not noted to include a nursing progress note or Wound Nurse Practitioner (NP) Encounter Note to indicate monitoring of or concern/risk for skin alterations to coccyx/buttock region. No nursing progress note was noted for the 4/23/24 date to reflect right iliac crest pressure ulcer identification or treatment although R3's Skin & Wound Evaluation dated 4/23/24 indicated a new in-house acquired unstageable ulcer on that date and review of physician orders included a treatment order to same region on that date. Additionally, no preventative coccyx/buttock treatment order was noted prior to unstageable wound formation. Physician Encounter Note with an indicated Date of Service of 4/22/24 and Signed Date of 4/28/24 stated, . Chief Complaint .Seen regarding regulatory visit as well as coccyx wound .Skin: Somewhat unavoidable sacral wound to coccyx area. Patient with difficulty turning poor nutrition and hospice status all of which make the wound more likely to progress . Wound NP Encounter Note dated 4/26/24 reflected right iliac crest unstageable pressure ulcer assessment as contained within Skin & Wound Evaluation dated 4/26/24. Wound NP Encounter Note dated 5/3/24 reflected newly identified left gluteus deep tissue injury and ongoing right iliac crest unstageable pressure ulcer assessments contained within Skin & Wound Evaluations dated 5/3/24. IDT Note dated 5/8/24 stated, .IDT note r/t [related to] skin. Resident has an unstageable pressure ulcer to her right iliac crest .Resident has a DTI to her left gluteus .Resident has an air mattress and offloading boots in place. Care plan was reviewed and is appropriate. Wound NP Encounter Note dated 5/10/24 reflected right iliac crest and left gluteus stage 3 pressure ulcer assessments as contained within Skin & Wound Evaluation dated 5/10/24. In an interview on 5/15/24 at 4:06 PM, Director of Nursing (DON) B stated that the facility's skin management program included completion of a weekly skin assessment prompted by a Body Audit order with documentation within the TAR to reflect absence of skin breakdown, previously identified breakdown, or newly identified breakdown. DON B stated that with any newly identified breakdown the expectation was for a corresponding progress note to be completed and a treatment order to be obtained and written. DON B stated that the IDT reviewed all progress notes from the prior 24-hour period at a meeting each weekday morning and when any skin alteration was noted an audit would be completed to verify that an appropriate treatment order was in place. DON B further stated that if any noted concern exited for a newly identified would or ulcer (pressure, vascular, diabetic, surgical), that either she or one of the facility's unit managers would assess further, take a picture if warranted, and assure an appropriate treatment was in place until the Wound NP and RN (Registered Nurse) rounded each Friday. Per DON B, upon completion of weekly assessments, the Wound NP and RN would then provide her with a face-to-face report regarding each resident's wound status as well as any medical equipment recommendations, follow up testing, or wound clinic referrals. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In a follow-up interview on 5/16/23 at 9:53 AM, DON B confirmed familiarity with R3, stated that she had both chronic vascular wounds and fairly recent facility acquired pressure ulcers to buttock region. Upon referencing R3's medical record, DON B confirmed that the right iliac crest pressure ulcer was identified, assessed, and documented on (per the Skin & Wound Evaluation dated 4/23/24) by the assigned nurse on 4/23/24. DON B further stated that although she did not assess R3's wound herself on that date she recalled discussing the wound presentation with the assigned nurse and following up with R3's physician for a treatment order (confirmed that the 4/23/24 sacral wound treatment order was for the newly identified right iliac crest ulcer). Upon review of the corresponding April TAR, DON B confirmed that as the 4/27/24 and 4/30/24 treatment administration boxes were not signed out as completed, there was no documentation to indicate that the ordered treatment was completed on either date. DON B further confirmed that upon identification, on 4/23/24, R3's right iliac crest wound presented as an unstageable pressure ulcer, stated that she could locate no notes or assessments that reflected any concern or compromise to region prior, or any prior physician order for protective skin care to buttock region. DON B stated that she would not have expected wound to be at an unstageable level with initial identification but acknowledged that R3's 4/15/24, 4/22/24, and 4/29/24 Body Audit reflected no newly identified wounds and could find no documentation that a CNA had identified or alerted nursing staff to any skin changes to region with routine cares or application of standard protective barrier cream. Per DON B, following the identification of R3's right iliac crest unstageable pressure ulcer, a new treatment was initiated but that as R3 was known to be at risk for breakdown due to incontinence, non-ambulatory status, and dependence for transfer and bed mobility, that pressure reduction measures were already in place including a low air loss mattress, boots to legs, standard wheelchair cushion, and assist with repositioning. DON B confirmed that despite identification of R3's unstageable pressure ulcer on 4/23/24 that no new pressure reduction measures were initiated as all warranted interventions were already in place. Upon further review of R3's medical record, DON B stated that the Wound NP and RN identified a new deep tissue pressure injury to R3's left buttock region with their routine weekly assessment on 5/3/24 and that further review included no documentation to reflect that the facility staff had identified the ulcer prior to that date/time. DON B confirmed that a treatment was initiated on that same date for the newly identified wound but that as all pressure reduction measures remained in place that no additional measures were implemented. Additionaly, DON B stated that she could follow-up with hospice services to see if they had a more specialized pressure reduction mattress or wheelchair cushion that could be trialed to decrease risk of additional pressure ulcer formation to R3's buttock region. Resident #5 (R5) Review of the medical record revealed that Resident #5 (R5) was readmitted to facility 1/3/24 with diagnoses including multiple sclerosis, unspecified dementia, polyneuropathy, peripheral vascular disease, and stiffness of right and left ankle not elsewhere classified. Review of the MDS with an ARD of 5/8/24 reflected a staff assessment for mental status indicating that R5 had both short and long-term memory impairment with severely impaired cognition for daily decision making. Section M of the same MDS reflected that R5 was at risk of developing pressure ulcers and had unhealed pressure ulcers including a facility acquired deep tissue injury. Review of R5's ADL Care Plan reflected that R5 was dependent with assist of two for transfers, bathing, dressing, toileting needs, and bed mobility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an observation on 5/14/24 at 9:49 AM, R5 was observed lying in bed, on back, with head of bed positioned at an approximate 45-degree angle. R5's legs were observed to be extended straight out with soft, green, cushioned boots in place bilaterally. R5's eyes were open but R5 offered no response to questions. A blue positioning wedge was noted on floor to right of bed. On 5/14/24 at 12:30 PM, R5 was observed lying in bed, positioned toward left side with head of bed at an approximate 45-degree angle. A blue positioning wedge was noted on the windowsill to the right of R5's bed. On 5/15/24 at 1:22 PM, Licensed Practical Nurse (LPN) I was observed to prepare wound supplies and complete R5's pressure ulcer treatment. During preparation of supplies at treatment cart, LPN I confirmed familiarity with R5, stated that R5 had a chronic pressure ulcer to her sacrum and a new pressure ulcer to her right heel. LPN I stated that ongoing pressure reduction precautions for R5 included a low air loss mattress and green boots, both of which had physician orders and had been in place prior to formation of the right heel wound with no new interventions, to her knowledge, after formation with exception of skin prep (a protective film designed to protect intact skin) application for protection. Upon entering room in presence of LPN I and N, R5 was observed lying in bed, toward right side, with blue positioning wedge at left back region. Upon LPN I's removal of R5's soft green boot at right lower extremity and lifting of R5's right leg, an approximate 2.0cm x 1.5cm area of intact deep purple skin with brown discoloration at edges noted to back of right heel. Review of R5's medical record completed with the following findings noted: Braden Scale For Predicting Pressure Sore Risk dated 4/3/24 reflected score of 12 indicating high risk for pressure ulcer development. Skin & Wound Evaluation dated 5/3/24 indicated a new in-house acquired deep tissue injury at right heel measuring 2.3cm x 1.1cm with 100% epithelial tissue in wound base. Skin & Wound Evaluation dated 5/10/24 indicated the same right heel deep tissue injury now measuring 2. 8cm x 1.3cm with 100% epithelial tissue in wound base. Physician order dated 3/13/24 stated, Ensure low-air loss pressure redistribution surface is on and operation. Physician order dated 3/26/24 stated, [NAME] offloading boots in place at all times, please remove q [every] shift and check skin integrity. Review of corresponding TAR dated 4/1/24 - 4/30/24 reflected availability for day shift documentation only with 4/1, 4/6, and 4/30 administration boxes noted to be blank/not signed out as completed. Review of corresponding TAR dated 5/1/24 - 5/31/24 reflected availability for day shift documentation only. No evening/night shift documentation noted in R5's medical record to reflect the routine application of R5's green offloading boots. Physician order dated 5/1/24 stated, Skin prep bilateral heels, leave open to air. Nursing/Clinical Note dated 5/1/24 stated, .During dressing change to coccyx writer observed a quarter sized area to right heel that was dark purple in color .Treatment orders adjust . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Wound NP Encounter Note dated 5/3/24 reflected right heel deep tissue injury assessment as contained within Skin & Wound Evaluation dated 5/3/24. IDT Note dated 5/8/24 stated, .IDT note r/t wounds .DTI (deep tissue injury) to right heel which is stable . continues to have an air mattress and resident has off loading boots in place .Interventions and treatments remain in place and appropriate. Wound NP Encounter Note dated 5/10/24 reflected right heel deep tissue injury assessment as contained within Skin & Wound Evaluation dated 5/10/24. Care Plan Focus with a 10/2/20 date of initiation and 5/7/24 revision date stated, I have .PI [pressure injury] to my right heel . with associated interventions including, Assist to turn and reposition with a 10/2/20 date of initiation and 4/19/24 revision date, and Boots to Bilateral feet and Low air loss mattress to bed with a 5/4/24 date of initiation. Resolved care plan interventions within same care plan included, LAL [low air loss] mattress with a 3/4/24 date of initiation and 4/19/24 resolved date, low air loss mattress to bed with a 10/2/20 date of initiation and 3/4/24 resolved date, Float my heels using offloading boots with a 10/2/20 date of initiation and 3/12/24 resolved date. In an interview on 5/15/24 at 2:30 PM, Certified Nurse Aide (CNA) S confirmed familiarity with R5 and that she was her assigned aide that date. Per CNA S R5 was dependent for all care including bed mobility, bathing, dressing, incontinency care, and transfers. CNA S stated that R5 had wounds on her bottom for a long time and had just developed one at her right heel. Per CNA S, the assigned nurse did all the treatments but that she continued to make sure she had her green boots on and was repositioned in bed approximately every 2 hours. In an interview on 5/15/24 at 4:39 PM, DON B confirmed familiarity with R5, stated that she had a chronic sacral ulcer that would open and close and that she also had a DTI at right heel identified on 5/1/24 by assigned nurse. DON B stated that skin prep was implemented at the time of ulcer identification but that as had low air loss mattress, green offloading boots, routine assist with repositioning already in place prior to ulcer identification that no new interventions were initiated post ulcer identification including the implementation of new or alternative heel offloading devices. DON B further stated that IDT meeting held post wound identification with collaborative decision that all interventions and treatments remained in place and appropriate despite the fact that R5's right heel pressure ulcer developed with those same interventions in place.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on observation, interview, and record review, the facility failed to prevent a fall with major injury for one (Resident #38) of three reviewed, resulting in Resident #38 falling out of bed during care and sustaining a femur fracture. Findings include: Review of the medical record revealed Resident #38 (R38) admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included fracture of lower end of right femur and hemiplegia and hemiparesis following a stroke. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/10/24 revealed R38 scored 11 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS). On 5/14/24 at 10:25 AM, R38 was observed in bed with a brace on their right leg. On 5/14/24 at 10:55 AM, R38 was observed in a Broda chair. R38 reported they fell out of bed and broke their leg while Certified Nursing Assistant (CNA) F was providing care. Review of Witnessed Fall incident report dated 3/31/24 revealed Assigned Cena [CNA] to resident was giving care changing resident's brief while holding resident over on her side during care resident started to slide out of bed during change staff lowered resident to floor mat and called for help. Review of the Interdisciplinary Team (IDT) Note dated 4/1/24 revealed IDT reviewed fall from the day before, Resident rolled out of bed during care. Denied pain or discomfort at time of incident however reported pain a few hours later to the right knee. [Physician] ordered Xray of the right knee that indicated fracture of the femur. [Physician] made aware and gave order to send to hospital for eval [evaluation] and treatment. Review of the care plan revealed R38 required extensive assistance by two staff members to turn and reposition in bed. The intervention was dated 4/27/22. In an interview on 5/15/24 at 2:06 PM, Nursing Home Administrator (NHA) A reported R38 sustained a fall with fracture on 3/31/24 while CNA F provided care. NHA A reported CNA F did not use the appropriate number of staff required to provide bed mobility. In a telephone interview on 5/15/24 at 3:12 PM, LPN R reported R38 required two staff members for care. LPN R reported CNA F initially reported care was provided with two staff members, but it was later determined that CNA F provided care alone and R38 fell out of bed and fractured her leg. Attempts were made to contact CNA F via telephone on 5/15/24 at 3:04 PM and 5/16/24 at 12:23 PM but were unsuccessful. Review of the hospital discharge summary dated 4/3/24 revealed R38 sustained a right distal femur fracture with a locked hinged braced recommended for non-operative management. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/16/24 at 10:01 AM, Social Worker (SW) E reported R38 loves to sit in the dining room by the window. SW E reported since R38 sustained the fracture, R38 has had increased yelling, calling out, and signs of depression. SW E reported she believed some of that was attributed to pain and being stuck in bed due to the fracture. SW E reported R38 was very anxious while on bed rest. In a telephone interview on 5/16/24 at 10:57 AM, Licensed Practical Nurse (LPN) P reported R38 had increased pain after the fracture and has required a change in their pain medication regimen. LPN P also reported R38's anxiety had increased since the fracture and required an increase in anxiety and depression medications. In a telephone interview on 5/16/24 at 11:04 AM, LPN Q reported after R38 sustained the fracture, R38 was afraid to get out of bed and had a lot of anxiety. LPN Q reported R38 no required a Hoyer lift to transfer from bed, which was a change. Review of the care plans revealed prior to the fracture, R38 transferred with a sit to stand mechanical lift and after the fracture, R38 required a Hoyer lift to transfer. Review of the facility's Past Non-Compliance Worksheet revealed Resident was rolled out of bed while CNA was providing incontinent care. Root cause analysis was CNA did not use appropriate number of staff required to provide bed mobility. The deficient practice was corrected on 4/3/24 after the facility completed the following: 1. CNA F was suspended pending investigation. 2. R38 had x-ray completed that identified right distal femur fracture and was transferred to the hospital for further follow up. 3. Director of Nursing (DON)/designee completed audit of falls for the last 30 days to identify if any were related to not using appropriate number of staff required for bed mobility. 4. Nursing staff were reeducated on using appropriate number of staff per plan of care for bed mobility. 5. Nurse managers/designee completed random monthly audits of nursing staff to ensure they are using the appropriate number of staff required for bed mobility. 6. DON/designee completed 5 random weekly audits for four weeks of staff members assisting residents with bed mobility to ensure appropriate number of staff required per plan of care for bed mobility. 7. Results of audits were put through QAPI for further follow up and recommendation. On 5/16/24 at 2:46 PM, NHA A reported CNA F's employment was terminated on 4/3/24.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27446 Based on observation, interview, and record review the facility failed to ensure two out of three residents (Resident #6 and 32) had water available at the bedside, resulting in the potential for dehydration. Findings included: Resident #6 (R6): Per the facility face sheet R6 was admitted to the facility on [DATE] and readmitted on [DATE]. Diagnosis included dysphasia (difficulty in swallowing). In an observation and interview on 5/14/2024 at 11:00 AM, R6 was observed to have no water in his room. A small 7 oz clear cup was observed on the over the bed table that had juice in it, no other fluids were noted. R6 was asked why he did not have any water in his room, in which R6 stated that the staff would not let him have any water. R6 said he had to have thicken fluids and did not like the taste of the thickened water. In an observation and interview on 5/15/2024 at 2:34 PM. R6 was observed to be in his room sitting on the side of his bed. A small Styrofoam cup with a lid and straw was observed to be on the same table. The cup was dated 5/15 1st (shift), and was observed to have water with ice in it that was not thickened which R6 could not drink. In an observation on 5/16/2024 at 12:50 PM, R6 was observed in bed. A a small Styrofoam cup with ice and water was observed on the over the bed table. The water was not thickened. A small glass cup of orange juice was noted on the table also. The orange juice was thickened. Review of a physician's order revealed that on 9/4/2023 R6 was ordered to have nectar thick liquids. The order was marked as active (not discontinued). Review of a Minimum Data Set (MDS) assessment section KO510 dated 9/4/2023, revealed R6 was on thickened liquids. Review of an MDS dated [DATE] revealed R6 was assessed to be on thickened liquids. Review of a care plan dated 9/15/2020 and revised on 9/15/2023, revealed R6 was at risk for dehydration related to being on thickened liquids. Review of R6's Kardex (document used by Certified Nurse Aid [CNA] to know how to provide care for a resident) revealed R6 was to receive nectar thick liquids. Review of a Nutritional Evaluation . dated 3/5/2024, revealed under section B. Diet Orders, R6 was on thickened liquids that were to be of nectar consistency. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/17/2024 at 8:14 AM, Certified Nurse Aid (CNA) X stated that all residents were given water at the start of each shift with the date and shift written on the cup. CNA X said R6 was to receive nectar thick liquids. CNA X said R6 did not like his water to be thickened, and would sometimes drink the thickened water and sometimes would not. CNA X said R6 would ask for non-thickened water but she would tell him he could not have that. In an interview on 5/17/2024 at 10:10 AM, Registered Dietician (RD) W said R6 was on nectar thick liquids, and stated that R6 would ask her for non-thickened ice water, but said she would tell him that he was not able to have that for safety. Resident #32 (R32): Per the facility face sheet R32 was admitted to the facility on [DATE], and readmitted on [DATE]. In an observation and interview on 5/14/2024 at 11:20 AM, R32 was in her room lying down, and was observed to have a 7 oz cup of water that was half empty, no other water was observed to be in room. R32 was asked if staff brought her fresh water daily or every shift. R32 said she would get her own water, from the bathroom sink, because staff never brought her water. In an observation and interview on 5/15/2024 at 2:46 PM, R32 was observed to be up walking in her room. The same type of water cup from 5/14/2024 was observed on the night stand, the cup was empty. R32 once again stated that staff did not bring her water, so she just filled up (the 7 oz cup) with water from the bathroom. In an interview on 5/17/2024 at 8:58 AM, Licensed Practical Nurse (LPN) J stated that the CNAs were to pass water each shift to residents. In an interview on 5/17/2024 at 12:20 PM, Administrator A stated that it was her expectation that each resident would received fresh water each shift.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27446 Based on observation, interview, and record review the facility failed to ensure four out of four observed resident room call lights were answered timely, resulting in the potential for unmet needs. Findings Included: In an observation on 5/14/2024 at 11:44 AM, the call light for room [ROOM NUMBER] was observed to be on. Two staff members were observed to pass by room [ROOM NUMBER] and not stop to answer the call light. At 11:47 AM the call light for room [ROOM NUMBER] was observed to be on, and one staff member was observed to walk by room [ROOM NUMBER] and not stop to answer the call light. At 11:48 AM a nurse was observed to walk past room [ROOM NUMBER], and go into room [ROOM NUMBER] without addressing the call light for room [ROOM NUMBER]. At 11:56 AM, the call light for room [ROOM NUMBER] was observed to be on, and at 11:58 AM, a staff member was observed to look up at the call light but turned and walked away without responding to the call light. At 12:07 PM room [ROOM NUMBER] call light was observed to be on. Five staff members were observed standing in the hall by the nursing station but did not respond to the call light. The nurses' station was observed to have a board on the wall that lit up and made an audible sound when a call light was turned on. The board also revealed which room the call light was on for. On 5/15/2024 at 2:50 PM, while standing in the hallway, the call light for room [ROOM NUMBER] was observed to be one. Two staff members were observed to walk past room [ROOM NUMBER] and did not stop to respond to the call light. In an interview on 5/17/2024 at 12:20 PM, Administrator A stated that it was her expectation that all staff answer call lights, and get the appropriate staff member if they are not able to fill the resident's need.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on observation, interview, and record review the facility failed to ensure a medication was administered within the prescribed parameters and not in excessive dose for one (Resident #38) of six reviewed. Findings include: Review of the medical record revealed Resident #38 (R38) admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included fracture of lower end of right femur and hemiplegia and hemiparesis following a stroke. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/10/24 revealed R38 scored 11 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS). On 5/14/24 at 10:55 AM, R38 was observed in a Broda chair near the window in the dining room. Review of the Physician's Order dated 4/3/24 revealed an order for acetaminophen (Tylenol) give 1000 milligrams (mg) every 6 hours for pain not to exceed 3000 mg in 24 hours. Review of the Medication Administration Records (MAR) dated April and May 2024, revealed 1000 mg of acetaminophen was scheduled to be administered at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. R38 received 4000 mg of acetaminophen from 4/4/24 through 5/14/24 which exceeded the ordered parameter of not exceeding 3000 mg in 24 hours. In an interview on 5/16/24 at 10:49 AM, Director of Nursing (DON) B reviewed R38's acetaminophen order and agreed the ordered doses exceeded the prescribed parameter of 3000 mg.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46954 Based on observation, interview and record review, the facility failed to ensure appropriate infection control practices during wound care for two (Resident #3 and #5) of two reviewed for wound care, resulting in the potential for cross contamination and the spread of infection. In a wound care observation on 5/15/24 at 1:34 PM, Licensed Practical Nurse (LPN) I removed her gloves, entered R3's bathroom, and washed her hands with soap and water for approximately four seconds. In an observation on 5/15/24 at 1:41 PM, Licensed Practical Nurse (LPN) N removed her gloves, entered R3's bathroom, and washed her hands with soap and water for approximately five seconds. In a wound care observation on 5/15/24 at 1:55 PM, LPN I removed her gloves, entered R5's bathroom, and used soap and water to wash her hands for approximately five seconds. In a wound care observation on 5/15/24 at 1:57 PM, LPN I entered R5's bathroom, and washed her hands with soap and water for approximately four seconds. In an wound care observation on 5/15/24 at 1:59 PM, LPN I doffed gloves, entered R5's bathroom, and washed her hands with soap and water for approximately six seconds. In a wound care observation on 5/15/24 at 2:04 PM, LPN I removed her gloves, entered R5's bathroom, and washed her hands with soap and water for approximately five seconds. According to the Centers for Disease Control and Management regarding handwashing, Rub your hands together until the soap forms a lather and then rub all over the top of your hands, in between your fingers and the area around and under the fingernails. Continue rubbing your hands for at least 20 seconds. Rinse your hands well under running water . In an interview 5/16/24 at 12:53 PM, MDS Coordinator O reported that the timing expectation for hand washing with soap and water would be to wash hands for at least 20 seconds. In an interview on 5/16/24 at 2:45 PM, Nursing Home Administrator A stated that per the facility policy, hands need to be washed with soap and water for at least 20 seconds.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22050 Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant effecting 53 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and decreased air quality. Findings include: On 05/14/24 at 10:50 A.M., The flooring surface within resident room [ROOM NUMBER] was observed extremely tacky and sticky. Numerous dead insect carcasses (flies) were also observed within the restroom bathtub. On 05/14/24 at 01:19 P.M., Human feces was observed within the 2nd Floor Shower 1 Room shower stall, directly beneath the polyvinyl chloride (PVC) shower chair. The human feces measured approximately 1-inch-wide by 3-inches-long. On 05/15/24 at 09:05 A.M., A common area environmental tour was conducted with Director of Environmental Services C. The following items were noted: 2nd Floor The Northeast exterior window screen was observed loose-to-mount, allowing potential pests (flying insects) to enter the building. Two acoustical ceiling tiles were observed stained from previous moisture exposure, directly above the southeast portable terminal air-conditioning (PTAC) unit. Shower 1 Room: The toilet seat was observed loose-to-mount. Human feces was also observed within the shower stall. The human feces measured approximately 1-inch-wide by 2-inches-long. Day Room: 1 of 2 exterior window screens were observed (etched, scored, torn). The damaged window screen measured approximately 3-feet-wide by 5-feet-long. 3rd Floor The southeast and southwest exterior windowpanes were observed moist and fogged within the sealed double pane frame. Facilities Director for Preferred Care D stated: I will have to replace both fogged windows. On 05/15/24 at 01:50 P.M., An environmental tour of sampled resident rooms was conducted with Director of Environmental Services C. The following items were noted: (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	202: The restroom commode base caulking was observed (etched, scored, particulate). The restroom hand sink basin was also observed draining very slow. The Bed 1 drywall surface was further observed (etched, scored, particulate). The damaged drywall surface measured approximately 2-feet-wide by 2-feet-long. Director of Environmental Services C indicated he would contact maintenance as soon as possible. 211: The restroom commode base caulking was observed (etched, scored, particulate). The restroom return-air-exhaust ventilation grill was also observed soiled with dust and dirt deposits. 220: The entire resident room was observed extremely malodorous (urine and body odor). 221: The restroom commode base caulking was observed (etched, scored, particulate). 229: The restroom commode base caulking was observed (etched, scored, particulate). 232: The restroom hand sink faucet goose neck was observed (etched, scored, corroded). 322: The foyer overhead light bulb was observed non-functional. 335: The restroom hand sink faucet goose neck was observed (etched, scored, corroded). On 05/15/24 at 03:20 P.M., An interview was conducted with Director of Environmental Services C regarding the facility maintenance work order system. Director of Environmental Services C stated: We have the TELS system. On 05/16/24 at 10:45 A.M., Record review of the Policy/Procedure entitled: Cleaning and Disinfection of Environmental Surfaces dated 08/2019 revealed under Policy Statement: Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA bloodborne pathogens standard. Record review of the Policy/Procedure entitled: Cleaning and Disinfection of Environmental Surfaces dated 08/2019 further revealed under Policy Interpretation and Implementation: (9) Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visible soiled. (10) Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. On 05/16/24 at 11:00 A.M., Record review of the Policy/Procedure entitled: Maintenance Service dated 12/2009 revealed under Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Record review of the Policy/Procedure entitled: Maintenance Service dated 12/2009 further revealed under Policy Interpretation and Implementation: (1) The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. On 05/16/24 at 11:15 A.M., Record review of the Direct Supply TELS Work Orders for the last 60 days revealed no specific entries related to the aforementioned maintenance concerns.