STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Grand Rapids	2000 Leonard N E Grand Rapids, MI 49505

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 48637 Based on interview and record review, the facility failed to ensure resident dignity and rights to privacy were honored as reported by eight of nine residents during a confidential Resident Council meeting resulting in residents feeling frustrated and disrespected. Findings include: During a confidential Resident Council meeting on 7/25/2024 at 10:00 AM, eight of nine residents reported that they feel like their rights aren't respected and there is an ongoing issue related to privacy. One resident stated that she put a sign on her door so staff must knock when they enter her room and it was torn off the door and not replaced. Another resident said that his privacy isn't respected since staff walk into his room without knocking. Five of nine residents stated that on third shift, staff are often on their phones or tablets, have earbuds on and sometimes they will have conversations on the phone while in resident rooms. Review of the Resident Council minutes dated 5/22/2024 under the clinical department revealed (2 residents names omitted) said that people come in their rooms and don't even introduce themselves or say hello. During an interview on 7/25/2024 at 12:57 PM, Activities Director (AD) E stated that she wasn't aware of recent concerns regarding privacy and knocking. She said that there was a problem with knocking before and she thought it was rectified. During an interview on 7/25/2024 at 12:22 PM, Nursing Home Administrator (NHA) A stated that she thought privacy concerns showed an improvement through the audits that were completed.

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: 235038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 48637 Based on interview and record review, the facility failed to address and resolve concerns/ grievances reported in Resident Council Meetings as reported by seven of nine residents during a confidential Resident Council meeting resulting in unresolved concerns and unmet needs of residents. Findings include: During a confidential resident council meeting held on 7/25/2024 at 10:00 AM, seven of nine residents reported that concerns weren't getting resolved. They said sometimes management responds to grievances but there isn't a resolution. One resident said concerns such as showers, cold food and long call wait times have been brought up in Resident Council meetings and to various staff members and there still isn't a resolution. Another resident stated that the person in charge of grievances isn't doing a good job on follow up since they don't respond to concerns brought up. Review of the Resident Council minutes dated 1/23/2024 under the clinical department revealed (Resident name omitted) says he asks for something and is told to wait a sec (second). He says he has to keep asking as the time goes by. (Resident name omitted) said it takes sometimes 3 weeks before she gets a shower. (2 residents names omitted) say they know when their showers are supposed to be and they ask for them if they are offered to them. Under the dietary department, Many times food temp (temperature) is still an issue, being too cold. Review of the Resident Council minutes dated 2/20/2024 under the clinical department revealed (Resident name omitted) says her shower seems to be an issue almost weekly yet. Her schedule is Sundays and Wednesdays and nobody comes to offer her a shower. And when she brings it up the aide ignores her and makes an impression, he/she is too busy for it. (Resident name omitted) indicates she wants her shower very much twice weekly. Under the dietary department, Most all residents at this meeting said 75% of the time all the food is cold. Review of the Resident Council minutes dated 3/19/2024 under the clinical department revealed (Resident name omitted) says he has given up on the light and just yells for help until he is answered. Review of the Resident Council minutes dated 4/24/2024 under the clinical department revealed (Resident name omitted) commented that she had to wait 40-45 minutes before anyone comes to help her use the bathroom. Review of the Resident Council minutes dated 5/22/2024 under the clinical department revealed Ongoing complaint for (resident name omitted) who is not receiving her showers and being told they are understaffed or don't have time. She may be lucky to receive one a week and doesn't want to fight with anyone about it. Review of the Resident Council minutes dated 6/26/2024 under the clinical department revealed (Resident name omitted) said she sat on the toilet with the string pulled for 2 hours recently with no help. She says at times, there is no help. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/25/2024 at 11:14 AM, Activities Director (AD) E stated that during Resident Council meetings they discuss each department and she takes any concerns brought up to the managers who then follow up on them. When asked why old business was crossed off from the Resident Council minutes from January to June 2024, AD E stated that she reads the minutes from the previous month and discusses items that are not resolved and then goes back to the staff member responsible for resolution and goes to Nursing Home Administrator (NHA) A. AD E said she doesn't fill out grievances from resident council meetings unless it is for missing laundry items. During another interview on 7/25/2024 at 12:57 PM, AD E stated that she was aware that concerns regarding long call light wait times, showers and cold food that were brought up several times in Resident Council meetings and she gave those concerns to the appropriate department heads. Review of the Resident Council policy with an implementation date of 8/7/2020 and a review/ revision date of 10/20/2023 revealed, Policy Explanation and Compliance Guidelines: 9. Utilization of Response forms: a. A Resident Council Minutes and Quality Assistance Form will be utilized to track issues and their resolution. B. The facility department related to any issues will be responsible to address the item(s) of concern. 10. Council meetings Content: d. Follow-up on prior issues. 11. Administration Review of Council Minutes: a. The Administrator reviews the minutes to ensure i. All group concerns and grievances are investigated. ii. Any responses from departments within the facility are provided back to the council. B. Responses are presented at the next meeting, or sooner, if indicated. C. Individual concerns may be processed through the grievance procedure, 12. Relationship Between Resident Council and Quality Assurance: c. A Resident Council Minutes and Quality Assistance Form/Log will be utilized to track issues and their resolution. d. The facility department related to any issues will be responsible to address the item(s) of concern.

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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** 47659 Based on interview and record review, the facility failed to ensure accurate advanced directive information was in place for 1 of 3 (Resident #21) residents reviewed for advanced directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time), resulting in the potential for a resident's preferences for medical care to not be followed by the facility, or other healthcare providers. Findings include: Resident #21 Review of an Admission Record revealed Resident #21 was originally admitted to the facility on [DATE] with pertinent diagnoses which included adult failure to thrive. Review of Resident #21's Code Status (a medical team that indicates what to do if resident experiences cardiac or respiratory arrest) in the electronic health record (EHR) revealed that resident was listed as full resuscitation. Review of Resident #21's Advance Directive dated [DATE] which was signed by Resident #21's guardian, indicated that Resident #21's end of life preference were for no person to attempt to resuscitate in the event that Resident #21's heart or breathing stopped. During an interview on [DATE] at 12:35 PM, Certified Nursing Assistant (CNA) JJ reported that staff would look at at a resident's Code Status in the EHR to determine how to care for the resident in the event of an emergency that may require cardiopulmonary resuscitation (CPR). CNA JJ reported that resident's code status could also be found on the printed daily report sheets. Review of the daily report sheet for Resident #21 revealed that Resident #21's code status was not indicated on the sheet. During an interview on [DATE] at 1:48 PM, Registered Nurse L reported that staff would look at at a resident's Code Status in the EHR to determine how to care for the resident in the event of an emergency that may require cardiopulmonary resuscitation (CPR). During an interview on [DATE] at 5:40 PM, Guardian BB reported that she had signed a do not resuscitate (DNR) order on ,d+[DATE] because Resident #21's end of life wishes were to not receive CPR. During an interview on [DATE] at 2:50 PM, SW FF reported that the facility reviewed resident's code status at every care conference to ensure resident's end of life wishes were documented accurately in the EHR. SW FF was unable to report the date of Resident #21's most recent care conference. Social Worker (SW) FF reported that Resident #21's code status in the EHR did not reflect Resident #21's end of life wishes as indicated on his advance directive form, and that the facility had missed this error. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Do Not Resuscitate Order policy last revised [DATE] revealed, Policy: Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate order in effect .5. The Interdisciplinary Care Planning Team will review advance directives with the resident during quarterly care planning sessions or with a significant change of condition to determine if the resident wishes to make changes in such directives .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on observation, interview, and record review, the facility failed to provide access to bath linens and maintain sanitary conditions for 2 (Resident #13 and Resident #18) of 14 residents sampled for home-like environment, and 7 of 9 residents during a confidential interview, resulting in feelings of frustration, potential delay in care due to limited supplies, and unsanitary conditions. Findings include: Resident #13 Review of an Admission Record revealed Resident #13, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: multiple sclerosis (chronic disease that affect the central nervous system causing weakness, loss of coordination, numbness, pain), need for assistance with personal care, and generalized anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #13, with a reference date of 6/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #13 was cognitively intact. Section GG of the MDS revealed Resident #13 required dependent (helper does all the effort) to shower self. Section H of the MDS revealed Resident #13 was always incontinent of urine and bowel. Review of a Care Plan for Resident # 13, with a reference date of 3/16/24, revealed a focus/goal/interventions: Focus: Resident has episodes of bladder & bowel incontinence related to MS. Goal: Resident will be at reduced risk for complications from incontinence through next review. Interventions: check at regular intervals and change as needed, observe peri/rectal-area for redness, irritation, skin excoriation/breakdown; report, provide disposable incontinence products, provide peri-care after each incontinent episode. In an interview on 7/23/24 at 9:25am, Registered Nurse (RN) H reported the facility frequently ran out of linens, and as a result staff had resorted to buying their own wipes to care for residents. In an interview on 7/23/24 at 11:19am, Resident #13 reported the facility ran out of supplies like washcloths and the type of incontinence briefs that worked best for her. In an interview on 7/23/24 at 12:20pm, Certified Nursing Assistant (CNA) JJ reported the facility had a shortage of bariatric briefs and frequently ran out of washcloths for the residents. CNA JJ reported it was common for the day shift nursing staff to arrive and find no washcloths were available for resident care. CNA JJ reported it was the responsibility of the day shift to assist residents with getting washed up and dressed in the morning, but they did not have adequate supplies to do so. CNA JJ reported staff had resorted to cutting up towels to make washcloths at times. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/23/24 at 12:34pm, Certified Nursing Assistant (CNA) C reported the facility frequently ran out of washcloths and as a result, residents were not able to get washed up in the mornings. CNA C reported staff had resorted to buying their own wipes to care for the residents. CNA C reported there was also a shortage of the type of briefs that Resident # 13 preferred. CNA C reported 10 washcloths were delivered by laundry services this morning for care for the entire unit and that was not nearly enough. CNA C reported most of the residents on the unit were incontinent of bowel and bladder and required the use of several washcloths each time they were incontinent. CNA C reported at least 12 residents lived on the unit. CNA C reported the next linen delivery would not be until afternoon. During an observation on 7/23/24 at 12:42pm, 0 washcloths were available in the clean utility room for unit 3 of the healthcare center. During an observation on 7/23/24 at 1:15pm, laundry services restocked the clean utility closet on unit 3. During an observation on 7/23/24 at 1:17pm, a total of 10 washcloths were available in the clean utility closet of unit 3. In an interview on 7/25/24 at 10:59am, Certified Nursing Assistant (CNA) NN reported the facility frequently ran out of washcloths and bariatric sized briefs. CNA NN reported at times, staff taped 2 smaller briefs together to use for residents that needed the bariatric sized briefs and used pillowcases as washcloths, because the facility did not have the necessary supplies. In an interview on 7/25/24 at 1:19pm, Registered Nurse (RN) H reported the facility frequently ran out of bariatric sized incontinence briefs and the facility refused to purchase more. During an observation on 7/23/24 at 10:19am, 2 decorative artificial trees in the resident common area, near the bird aviary, were covered in a thick buildup of dust and debris that gave most of the leaves on both trees a fuzzy appearance. The collection of dust was approximately an 1/8 of an inch thick in several areas. Residents sat nearby watching television. During an observation on 7/23/24 at 10:33am, housekeeping staff performed cleaning tasks in the resident common area. During an observation on 7/25/24 at 2:07pm the artificial trees in the resident common area remained thickly coated with dust and debris. 47659 Resident #18 Review of an Minimum Data Set (MDS) assessment revealed Resident #18 was originally admitted to the facility on [DATE] with pertinent diagnoses which included heart failure. Review of a Minimum Data Set for Resident #18, with a reference date of 4/21/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #18 was cognitively intact. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/24/24 at 3:59 PM, Resident #18 reported that the facility was frequently running out of supplies. Resident #18 reported that it was common for the staff to not have enough wash cloths for resident care. Resident #18 reported that she had reported her concerns to management and anyone else that would listen but that the concern of low supplies had not been addressed. During an interview on 7/24/24 at 12:43 PM, Certified Nursing Assistant (CNA) M reported that the facility would frequently run out of linens, especially on the weekends. During an interview on 7/25/24 at 10:14 AM, Medical Doctor (MD) EE reported that the facility frequently ran out of supplies, especially bath linens. MD EE reported that the facility never had enough wash cloths for residents, and that staff had resorted to cutting towels to make wash cloths. 48637 During a confidential resident council meeting held on 7/25/2024 at 10:00 AM, seven of nine residents reported that there weren't enough towels, washcloths or linen to meet their needs. One resident stated that sometimes they have to use towels instead of washcloths since there wasn't enough supply of washcloths. Another resident said they don't have enough linen to change his bed when it's dirty. Resident Council members said they have brought this up to staff before but they still don't have enough supplies. Review of the Resident Council minutes dated 5/22/2024 under the housekeeping department revealed A few residents asked for hand towels to clean up with, they have to use big bath towels. 38905 During a tour of the laundry area, at 1:46 PM on 7/23/24, it was observed that an accumulation of trash, paper debris, and a couple washcloths were found underneath the false bottoms used to move clean linen from the washer to the dryers to the folding table. An interview with Laundry Aide (LA) O found that laundry staff are having a hard time keeping up with maintaining washcloths on the units. When asked if there was a par count on the floor to help maintain a certain number of linens, LA O stated she was unsure. During a tour of the bulk linen room, at 1:57 PM on 7/23/24, it was observed that no clean bulk washcloths were observed in stock. A follow up interview with LA O, at 12:29 PM on 7/24/24, found that the lack of washcloths has been going on for two or so weeks. A revisit to the Health Center one clean linen room, at 12:29 PM on 7/24/23, found seven wash cloths on the storage rack. A revisit to the Health Center two clean linen room, at 12:33 PM on 7/24/24, found zero wash cloths in the closet. At this time LA O was adding linens to the closets and added a dozen wash cloths. An interview with the NHA, at 12:40 PM on 7/24/24, found that the facility has decided to stop using disposable wipes and have decided to increase the use of wash cloths in order to compensate. The NHA stated that the facility has ordered 100 dozen washcloths they are waiting on to come in. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A revisit to Health Center 3 clean linen room, at 12:43 PM on 7/24/24, found one dozen wash cloths stacked up. A revisit to the bulk clean linen storage, at 12:50 PM on 7/24/24, found packed linens, but no packaged washcloths. An interview with EVS Account Manager N, at 12:55 PM on 7/24/24, found that there should be a par count for linens on the hallway in order to keep a minimum, and that last week they had created a par count list for the linen closets. At this time, an interview with Regional EVS Manager V, found that if the facility uses wipes there should be 3 wash cloths per resident and if the facility is not using wipes there should be 8 wash cloths per person (in the hallway linen closets).

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to ensure a Level II Preadmission Screening and Resident Review (PASARR) evaluation was completed for 1 (Resident #20) of 2 residents reviewed for PASARR Screening, resulting in the potential for unmet mental health and psychiatric care needs. Findings include: Resident #20 Review of an Admission Record revealed Resident #20 was originally admitted to the facility on [DATE] with pertinent diagnoses which included schizoaffective disorder, depressive type, major depressive disorder, and anxiety disorder, and suicidal ideations. Review of Resident #20s Preadmission Screening (PAS) Annual Resident Review (ARR) Level I Screening dated 3/26/24 indicated the following: Questions 1-4 in section II were marked Yes: 1. Resident #20 had a current diagnosis of mental illness. 2. Resident #20 had received treatment for mental illness. 3. Resident #20 had routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days. 4. There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgment. Presenting evidence may include, but is not limited to, suicidal ideations,hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others. The instructions at the bottom of the page indicated that if any answers to items 1-6 in Section II were marked YES to send one copy to the local Community Mental Health Services program (CMHSP), with a copy of form DCH-3878 if an exemption is requested . Review of Resident #20's Electronic Health Record (EHR) did not reveal a Level II PASARR screening. During an interview on 7/24/24 at 2:01 PM, Regional Social Worker (RSW) GG reported that she was responsible for completing the resident PASARR screenings. RSW GG reported that she had completed the level II screening for Resident #20 and noted Resident #20 as dementia exempt. RSW G reported that the level II screening was awaiting review and signature from the facility's medical doctor to be completed. RSW G reported that she was not responsible for ensuring that the facility completed the process for the PASARR screenings, therefore, she was unaware that Resident #20's level II screening was still awaiting review from the facility medical doctor. During an interview on 7/25/24 at 10:30 AM, Medical Doctor (MD) EE reported that she had not reviewed Resident #20's PASARR level II screening because she had not been informed by the facility that she was responsible for reviewing PASARR screenings, and that she did not have a login to review the forms.

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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** 41982 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for 2 (Resident #12 and Resident #27) of 14 sampled residents reviewed for care plans, resulting in an incomplete reflection of the residents' status and the potential for unmet care needs. Findings include: Resident #12 Review of an Admission Record revealed Resident #12 was a female, with pertinent diagnoses which included: stiffness of right wrist, stiffness of left wrist, stiffness of right hand, and stiffness of left hand. Review of a Minimum Data Set (MDS) assessment for Resident #12, with a reference date of 6/11/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #12 was cognitively intact. In an interview on 7/23/24 at 10:19 AM, Resident #12 reported she had splints for her hands that she was to wear at night, but that staff did not remind her to do so, and she would forget. Resident #12 reported she needed assistance to put the splints on. In an interview on 7/24/24 beginning at 3:14 PM, Therapy Staff (TS) Q and TS P reported Resident #12 had bilateral hand splints due to contractures. TS Q reported staff needed to assist Resident #12 to apply the splints. TS Q and TS P reported Resident #12 did have a known history of non-compliance with therapy recommendations. In a follow-up interview on 7/25/24 at 1:06 PM, TS Q and TS P reported Resident #12 should be wearing the hand splints and that the purpose of the hand splints were to maintain Resident #12's current range of motion and prevent further contracture. Review of an Occupational Therapy (OT) Discharge Summary for treatment period 2/19/24 - 4/17/24 revealed, Pt/CG will demonstrate .B (bilateral) wrist hand orthoses (splints) to reduce contractures risk and retain functional use of each UE (upper extremity) .Discharge (4/17/24) discontinued per pt request Comments: discontinued per pt request .Assessment and Summary of Skilled Services Skilled Interventions . BUE, fit of B (bilateral) WHO (wrist hand orthosis), good fit and can be reinstated but pt has refused to wear at this time . In an interview on 7/25/24 beginning at 10:56 AM, Medical Doctor (MD) EE was not sure about the splints for Resident #12's hands. MD EE was queried as to Resident #12's reported non-compliance and reported refusal to wear the hand splints. MD EE reported staff would need to know about the hand splints and history of non-compliance in order to document Resident #12's refusals to wear the splints to assess and address alternate interventions if needed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Grand Rapids	2000 Leonard N E Grand Rapids, MI 49505

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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	In an interview on 7/25/24 at 2:30 PM, Senior Director of Nursing (SDON) J reported, therapy recommendations would be care planned. Review on 7/25/24 at 1:37 PM of Resident #12's current care plan with revision history from 8/1/23 to 7/25/24 revealed no care planned focus, goals, or interventions related to Resident #12's non-compliance with therapy recommendations or hand splints. 48637 Resident #27(R27) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R27 admitted to the facility on [DATE] with diagnoses of End Stage Renal Disease, Type 2 diabetes, and depression. Brief Interview for Mental Status (BIMS) reflected a score of 10 out of 15 which indicated R27 was cognitively impaired (8-12 moderately impaired). During an interview on 7/24/2024 at 8:36 AM, R27 stated that he goes to dialysis 3 days a week and he thinks it is going okay. Review of R27's physician orders revealed the following orders related to his dialysis: hemodialysis 3 days a week on Mondays, Wednesdays, and Fridays, also orders state AV (atrioventricular) shunt site-monitor every shift for signs and symptoms of infection/bleeding, AV shunt site upper arm. Monitor for thrill and bruit every shift, call provider if absent. Review of R27's care plan revealed that there wasn't a nursing care plan for his dialysis status. During an interview on 7/24/2024 at 2:01 PM, Registered Dietitian (RD) W and RD X stated they put the nutrition care plan upon admission related to dialysis but the nursing dialysis care plan is put in by nursing. During an interview on 7/24/2024 at 2:55 PM, Senior Director of Nursing (SDON) J stated that the nursing dialysis care plan should be completed by the Minimum Data Set (MDS) coordinator upon admission. During an interview on 7/24/2024 at 3:02 PM, MDS Coordinator F stated that the dialysis care plan can be put in by any nurse upon admission but it is usually the DON or herself that completes it. MDS Coordinator F stated that she just put a nursing dialysis care plan in that day under impaired genitourinary status. During an interview on 7/25/2024 at 10:38 AM, SDON J stated that the nursing dialysis care plan was put in the day before. Review of R27's care plan revealed a care plan for impaired genitourinary status related to end stage renal disease had an initiation date of 7/24/2024. (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 the Care Planning Special Needs-Dialysis Policy with an implementation date of 1/1/2021 and a review/revision date of 10/30/2020 revealed, Policy Explanation and Compliance Guidelines: 2. The care plan will reflect the coordination between the facility and the dialysis provider and will identify nursing home and dialysis responsibilities. 3. Interventions will include, but not limited to: a. Documentation and monitoring of complications b. Pre- and post- weights c. Assessing, observing, and documenting care of access sites, as applicable d. Nutrition and hydration, including the provision of meals and snacks on treatment days e. Lab tests f. Vital signs g. Provision of medications on dialysis treatment days, such as which medications are: i. Administered during dialysis ii. Held prior to dialysis iii. Given prior to dialysis iv. Administered by dialysis staff h. Transportation arrangements i. Addressing any identified psychosocial needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46999 Based on observation, interview, and record review, the facility failed to provide routine showers for 4 (Resident #11, Resident #13, Resident #22, and Resident #35) of 6 residents reviewed for showers, and 7 of 9 residents who attended a confidential meeting, resulting in feelings of frustration, disappointment, and embarrassment about their personal appearance and overall, body cleanliness. Findings include: Review of Fundamentals of Nursing-E-Book (kindle Locations 50742-50744), [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME] Elsevier, Health Services. Kindle Edition revealed: Personal hygiene affects patients' comfort, safety, and well-being. Hygiene care includes cleaning and grooming activities that maintain personal body cleanliness and appearance. Personal hygiene activities such as taking a bath or shower . also promote comfort and relaxation, foster a positive self-image, promote healthy skin, and help prevent infection and disease. Resident #11 Review of an Admission Record revealed Resident #11, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: multiple sclerosis (chronic disease that affect the central nervous system causing weakness, loss of coordination, numbness, pain), paraplegia (paralysis of the lower body), anxiety disorder, and dependence on wheelchair. Review of a Minimum Data Set (MDS) assessment for Resident #11, with a reference date of 6/30/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #11 was cognitively intact. Section D of the MDS revealed Resident #11 experienced feeling down, depressed, or hopeless during 12-14 days of the 14-day assessment period. Section GG revealed Resident #11 was dependent (helper provided all the effort) for transferring from her bed to the wheelchair. Section H revealed Resident #11 was always incontinent of bowel. Review of a Care Plan for Resident #11, with a reference date of 9/15/23, revealed a focus/goal/interventions of: Focus: Resident has an ADL self-care performance deficit related to fatigue, fluctuating ADLs, generalized weakness, multiple sclerosis .paraplegia .Goal: Resident's Activities of Daily Living (ADL) needs will be met through next review. Interventions: .TRANSFERS: 2 person assist AND use the mechanical lift . BATHING: 1 person assist . Honor resident's choices and preferences whenever possible. In an interview on 7/23/24 at 10:03am, Resident #11 reported at times staff were not able to assist her with getting a shower twice as week as scheduled. Resident #11 reported her scheduled shower days were Wednesday and Saturday, but she was not always offered the opportunity to shower twice a week. Resident #11 expressed frustration about the lack of support to receive routine showers and reported she did not feel her hygiene needs were being met. Review of shower records for Resident #11, dated 4/24/24-7/24/24 revealed Resident #11 was not offered a shower during7 of 25 scheduled opportunities for that period. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13 Review of an Admission Record revealed Resident #13, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: multiple sclerosis (chronic disease that affect the central nervous system causing weakness, loss of coordination, numbness, pain), generalized anxiety disorder, and spinal stenosis (narrowing of space between vertebra which may cause pressure on spinal cord). Review of a Minimum Data Set (MDS) assessment for Resident #13, with a reference date of 6/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #13 was cognitively intact. Section GG of the MDS revealed Resident #13 required dependent (helper does all the effort) to shower self. Section H of the MDS revealed Resident #13 was always incontinent of urine and bowel. Review of a Care Plan for Resident # 13, with a reference date of 3/16/24, revealed a focus/goal/interventions of: Focus: Resident has an ADL self-care performance deficit related to multiple sclerosis . anxiety, depression . spinal stenosis .Goal: Resident's Activities of Daily Living (ADL) needs will be met through next review. Interventions: TRANSFERS: with 2 person assist AND use of mechanical lift. In an interview on 7/25/24, at 1:08pm, Resident #13 reported at times she was not offered the opportunity to shower twice a week. Resident #13 reported she felt frustrated and disappointed when staff did not offer her to opportunity to shower, and as the result of not having routine showers, she felt self-conscious about her appearance and overall personal hygiene. When further queried, Resident #13 reported showering was also important to her because it helped her maintain a better outlook and higher energy level. Review of shower records for Resident #13, dated 5/2/24-7/24/24, revealed Resident #13 was not offered a shower during 10 of 24 scheduled opportunities for that period. Resident #22 Review of an Admission Record revealed Resident #22, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: major depressive disorder, other specified anxiety disorders, cerebral infarction (stroke) with residual deficits, and chronic pain. Review of a Minimum Data Set (MDS) assessment for Resident #22, with a reference date of 5/23/24 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated Resident #22 was moderately cognitively impaired. Section GG revealed Resident #22 was dependent (helper does all the effort) to transfer from her bed to the wheelchair. Section H revealed Resident #22 was always incontinent of bowel. Review of a Care Plan for Resident #22, with a reference date of 9/13/23, revealed a focus/goal/interventions of: Focus: Resident has an ADL self-care performance deficit related to anxiety, depression, cognitive impairment, depression .generalized weakness, history of falls .Goal: Resident's Activities of Daily Living (ADL) needs will be met through next review. Interventions: BATHING: 1 person assist, TRANSFERS: with 2 person assist AND use of mechanical lift, honor resident's choices and preferences whenever possible. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/23/24 at 10:06am, Resident #22 slept in her bed. Her hair appeared greasy and disheveled and strong smell of urine was noted. During an observation on 7/25/24 at 12:59pm, Resident #22 sat in her wheelchair in the hallway. The resident's hair appeared greasy with large portions clumped together. Resident #22's fingernails appeared jagged, and several had brown debris under the nail tips. In an interview on 7/25/24 at 1:00pm, Resident #22 reported she did feel she received showers as frequently as she needed them. Resident #22 reported being clean was always important to her and she missed being able to shower herself without help. When further queried, Resident #22 reported she worried about her appearance and was concerned she odorous. Review of shower records dated 5/1/24-7/24/24 revealed Resident #22 was not offered a shower during 11of 24 scheduled opportunities during that period. In an interview on 7/24/24 at 12:10pm Certified Nursing Assistant (CNA) K reported it resident's sometimes were not offered showers when only one CNA was working on the hall. CNA K reported she was aware of at least 4 showers that were missed recently. Review of a facility policy titled Activities of Daily Living (ADLs) with a reference date of 12/28/23 revealed: Compliance Guidelines: .A resident who is unable to carry out activities of daily living receives the necessary services to maintain .personal hygiene . 47659 Resident #35 Review of an Admission Record revealed Resident #35 was originally admitted to the facility on [DATE] with pertinent diagnoses which included adult failure to thrive. Review of a Minimum Data Set (MDS) assessment for Resident #35, with a reference date of 6/14/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #35 was cognitively intact. During an interview on 7/23/24 at 1:18 PM, Resident #35 reported that she was supposed to get two showers a week, but she was often missing her showers. Resident #35 reported that she had recently gone 11 days without a shower. Resident #35 reported that she discussed her concerns of missing showers with facility management, but she was still missing showers. Review of Resident #35's Care Conference Note dated 7/5/24 revealed, .Summarize discussion on care plan conference: . (Resident #35) noted that when she first arrived there was about a week where she went without a shower. (Resident #35) was able to ask her schedule and found out that it was Thursday and Sunday. (Resident #35) reported that she did not get a shower yesterday . On 7/24/24 at 3:30 PM, a request for Resident #35's Shower Sheets was sent to the Nursing Home Administrator (NHA) A. The facility was not able to provide shower sheets for Resident #35. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/25/24 at 10:06 AM , Certified Nursing Assistant (CNA) K reported that CNA's were supposed to complete a shower sheet after each shower/bed bath, and if the resident refused a shower, that they would write refused on the shower sheet. CNA K reported that Resident #35 never refused showers. CNA K reported that residents were often missing showers because the facility did not have enough staff to assist residents with showers. CNA K reported that she knew that Resident #35 was frequently missing her showers, and she felt terrible about it. During an interview on 7/25/24 at 12:40 PM, Director of Nursing (DON) B reported that she was aware that residents were frequently missing their showers. DON B reported that the facility had recently discussed the issue at a staff meeting, but they had not yet implemented a new process to ensure residents were receiving their showers. 48637 During a confidential resident council meeting held on 7/25/2024 at 10:00 AM, seven of nine residents reported that they haven't been receiving showers. One resident said they change shower days often and they don't know when they are supposed to receive one. Another resident stated that she came in on 7/1/2024 and only had 2 showers since then. Residents said they seem to be forgotten and that makes them frustrated. Review of the Resident Council minutes dated 1/23/2024 under the clinical department revealed (Resident name omitted) said it takes sometimes 3 weeks before she gets a shower. (2 residents names omitted) say they know when their showers are supposed to be and they ask for them if they are offered to them. Review of the Resident Council minutes dated 2/20/2024 under the clinical department revealed (Resident name omitted) says her shower seems to be an issue almost weekly yet. Her schedule is Sundays and Wednesdays and nobody comes to offer her a shower. And when she brings it up the aide ignores her and makes an impression, he/she is too busy for it. (Resident name omitted) indicates she wants her shower very much twice weekly. Review of the Resident Council minutes dated 5/22/2024 under the clinical department revealed Ongoing complaint for (resident name omitted) who is not receiving her showers and being told they are understaffed or don't have time. She may be lucky to receive one a week and doesn't want to fight with anyone about it. During an interview on 7/25/2024 at 12:57 PM, Activities Director (AD) E stated that she was aware that concerns regarding showers was brought up several times in Resident Council meetings and she gave these concerns to the appropriate department head. During an interview on 7/25/2024 at 12:22 PM, Nursing Home Administrator (NHA) A stated that she thought shower concerns showed an improvement through the audits they completed.

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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** 47659 Based on interview and record review, the facility failed to ensure residents received care in accordance with professional standards in 1 (Resident #35) of 1 residents reviewed for quality of care, resulting in Resident #35 having dysuria (pain with urination) for approximately 2 weeks, due to the facility mishandling the lab specimen resulting in a significant delay in the treatment of vulvovaginits (infection or inflammation of the vagina or vulva) and the potential for a decline in overall physical, mental and psychosocial well being. Findings include: Resident #35 Review of an Admission Record revealed Resident #35 was originally admitted to the facility on [DATE] with pertinent diagnoses which included adult failure to thrive. Review of a Minimum Data Set (MDS) assessment for Resident #35, with a reference date of 6/14/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #35 was cognitively intact. Review of Resident #35's Orders revealed, . UA (urinalysis) w/reflex to C&S (culture and sensitivity) if appropriate. Start date: 7/12/24 . Review of Resident #35's Progress Notes dated 7/12/24 revealed, . Plan 15. Dysuria (pain with urination)/increased frequency. We will obtain and UA w/C&S if indicated, awaiting results . Review of Resident #35's Progress Notes dated 7/15/24 revealed, . (Resident #35) seen for regulatory visit on 7/12/24- at that time (Resident #35) had complaints of burning with urination and urinary frequency. Order was placed for UA with reflex culture. Spoke with (facility nurse) today- specimen was not collected over the weekend . During an interview on 7/23/24 at 1:18 PM, Resident #35 reported that she had been experiencing pain with urination for over two weeks. Resident #35 reported that the facility had taken a urine sample to check for a urinary tract infection on 7/12/24, but the facility did not get results from that urine sample. Resident #35 reported that she had been continuously reporting the discomfort she was experiencing to staff, but she felt that they were ignoring her concerns. Resident #35 reported that she had learned on 7/19/24 that the facility never received the results from the first urine sample when she was asked to provide another sample. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/24/24 at 4:08 PM, Registered Nurse (RN) HH reported that reported that Resident #35's urine sample that was obtained on 7/12/24 was sent to the wrong lab. RN HH reported that the facility had recently switched lab providers and the nurses were unclear on the new process was for obtaining labs. RN HH reported that nurses were responsible for monitoring for pending lab results, but this was missed for Resident #35. RN HH reported that a second urine sample was obtained from Resident #35 on 7/19/24. RN HH reported that nursing staff were responsible for assessing residents and reporting resident concerns to the provider. RN HH could not confirm if nursing staff were reporting Resident #35's continued reports of pain with urination to the provider from 7/12/24 through 7/19/24. During an interview on 7/25/24 at 10:14 AM, Medical Doctor (MD) EE reported that a urine sample was originally ordered for Resident #35 for suspected urinary tract infection on 7/12/24. MD EE reported that the facility did not obtain the second urine sample for Resident #35 until 7/19/24. MD EE reported that the facility had just started using a new lab provider, and the facility had a delay with the providers placing lab orders and nursing following the lab orders. MD EE reported that she was made aware that Resident #35 had been reporting pain with urinary symptoms on and off for the last two weeks, and that there was more urgency to her requests in the last week. MD EE confirmed that Resident #35 had not been assessed by a provider between 7/15/24 and 7/23/24. MD EE reported that she had been told by the facility's nurse practitioner that Resident #35 was in tears on 7/23/24 because of the pain she was experiencing, so she made the decision to start Resident #35 on a medication before the facility received the urinalysis results. MD EE reported that once the facility received the results from Resident #35's urinalysis, they were able to determine that Resident #35 did not have a urinary tract infection, and they began treatment for vulvovaginitis. MD EE confirmed that Resident #35's treatment was delayed because the first urine sample had gone missing. During an interview on 7/25/24 at 12:40 PM, Director of Nursing (DON) B reported that she was responsible for monitoring lab orders and ensuring the facility received results as the facility had just switched lab providers and some of the nurses had not yet received training on the new process. DON B reported that the facility switched to the new lab on 7/1/24. DON B was not able to confirm if she had monitored Resident #35's lab order on 7/12/24. DON B reported that it was her expectation that nurses were documenting resident assessments and reports of pain and then communicating those reports to the provider. DON B confirmed that Resident #35 did not have any documented assessments of symptoms in her electronic health record (EHR).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 41982 Based on observations, interviews, and record review, the facility failed to reassess resident's preference for use of therapy-recommended positioning device for 1 (Resident #12) of 2 residents reviewed for positioning, resulting in the potential for decreased range of motion and related complications, skin breakdown, worsening of contractures (hardening of the muscles, tendons, and other tissues) and pain. Findings include: Resident #12 Review of an Admission Record revealed Resident #12 was a female, with pertinent diagnoses which included: stiffness of right wrist, stiffness of left wrist, stiffness of right hand, stiffness of left hand, and acquired absence (amputation) of right toe. Review of a Minimum Data Set (MDS) assessment for Resident #12, with a reference date of 6/11/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #12 was cognitively intact. During an observation and interview on 7/23/24 at 10:19 AM, Resident #12 was in her room and was seated in her wheelchair. This surveyor noted Resident #12 was wearing an AFO (ankle foot orthosis) brace on her right leg. Resident #12 reported this was because of her toe. This surveyor noted that Resident #12's fingers appeared to be stiff and bent. Resident #12 reported she had splints for her hands that she was to wear at night, alternating hands (meaning wear the splint on one hand one night and the other splint on the other hand the next night and so on), but that staff did not remind her to do so, and she would forget. Resident #12 reported she needed assistance to put the splints on. Resident #12 reported she believed her hands were getting worse. Review of a physician's order for Resident #12 revealed, OT Recertification: continue skilled OT 3x/week (3 times a week) for 30 days to address skilled ROM (range of motion) BUE (bilateral (both sides) upper extremities), therapeutic exercise, therapeutic activity, seating/positioning/accessory issues at wheelchair, manual therapy, pt/cg (patient/caregiver) training BUE wrist hand orthoses (splint) updated regimen) Active 3/19/24. Review of an Occupational Therapy (OT) Discharge Summary for treatment period 2/19/24 - 4/17/24 revealed, Pt/CG will demonstrate .for updated OT Regimen for B (bilateral) wrist hand orthoses (splints) to reduce contractures risk and retain functional use of each UE (upper extremity) .PLOF (prior level of function prior to onset) splints present and in good condition from last OT recert period Baseline (2/19/2024) Reduced use with CG turnover and need for updated training by OT team. update fit and ensure no redness of skin Previous (4/12/2024) will put in place this week of 4/15/24 to finalize. Discharge (4/17/24) discontinued per pt request Comments: discontinued per pt request .Assessment and Summary of Skilled Services Skilled Interventions .BUE, fit of B (bilateral) WHO (wrist hand orthosis), good fit and can be reinstated but pt has refused to wear at this time . (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/24/24 beginning at 3:14 PM, Therapy Staff (TS) Q and TS P reported Resident #12 had bilateral hand splints due to contractures, specifically in her fingers. TS Q reported Resident #12's hand splint schedule was set up as every other night as she did not want to wear both splints on both hands every night because it was too hard for her to do anything with her hands in that case. TS Q reported she had posted a sign in Resident #12's room to alert staff that Resident #12 needed to wear the splints per that schedule. TS Q reported staff needed to assist Resident #12 to apply the splints. TS Q was queried regarding the Occupational Therapy (OT) Discharge Summary for treatment period 2/19/24 - 4/17/24 to which TS Q reported another therapist who no longer worked at the facility had done that discharge summary. TS Q and TS P reported Resident #12 did have a known history of non-compliance with therapy recommendations. In a follow-up interview on 7/25/24 at 1:06 PM, TS Q and TS P reported Resident #12 should be wearing the hand splints. TS Q and TS P reported the purpose of the hand splints were to maintain Resident #12's current range of motion and prevent further contracture. In an observation/interview on 7/25/24 beginning at 10:56 AM, Medical Doctor (MD) EE reported Resident #12 had an amputated toe and the facility had obtained diabetic shoes and an orthotic insert to address that. MD EE reported was not sure about the splints for Resident #12's hands. This surveyor explained that therapy staff had reported they had put a sign in the resident's room to notify staff of the need to apply Resident #12's hand splints on alternate hands each night. This surveyor, along with MD EE observed Resident #12's room and no such sign was found. MD EE was queried as to Resident #12's reported non-compliance and reported refusal to wear the hand splints. MD EE reported there should still be a physician's order in place for the splints and for staff to encourage and assist the resident with wearing them. MD EE reported staff would also be able to document Resident #12's refusal to wear the brace to assess and address alternate interventions if needed. MD EE reviewed Resident #12's physician orders to determine if there was an order in place for Resident #12's hand splints. No such order was found. In an interview on 7/25/24 at 2:30 PM, Senior Director of Nursing (SDON) J reported, depending on the recommendation from therapy, a physician order for the recommendation was needed and the recommendation would also need to be added to the care plan. Review on 7/25/24 at 1:37 PM of Resident #12's current care plan with revision history from 8/1/23 to 7/25/24 revealed no care planned focus, goals, or interventions related to Resident #12's non-compliance with therapy recommendations or hand splints.

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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** 46999 Based on observation, interview, and record review, the facility failed to ensure appropriate supra-pubic catheter care for 1of 2 residents (Resident #22) reviewed for catheter care, resulting in the potential for urinary tract infection and complications related to occlusion of catheter tubing. Findings include: Review of an Admission Record revealed Resident #22, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: tubulo-interstitial nephritis (inflammation of an area of the kidney), obstructive uropathy (condition that inhibits normal urine flow), unspecified hydronephrosis (excessive fluid in a kidney) and artificial openings of the urinary tract. Review of a Minimum Data Set (MDS) assessment for Resident #22, with a reference date of 5/23/24 revealed Section H of the MDS revealed Resident #22 had an indwelling urinary catheter. Review of a Care Plan for Resident #22, with a reference date of 12/18/23, revealed a focus/goal/interventions of: Focus: Resident has a need for indwelling catheter related to obstructive uropathy. Goal: Resident will have reduced catheter-related complications through the next review. Interventions: Observe for signs and symptoms of UTI and report to the Physician: blood in urine, cloudiness, foul smell . Change catheter and drainage system as clinically indicated per order(s). Observe for signs/symptoms of obstruction (leakage, increased sediment, etc.), infection, or if closed system was compromised. Review of a physician order for Resident #22 with a reference date of 6/1/24 revealed: Change Catheter PRN as clinically indicated s/s (signs and symptoms) of infection, obstruction (leakage, increased sediment), or if closed system was compromised. Review of a Treatment Administration Record revealed Resident #22's urinary catheter was last changed on 5/22/24. During an observation on 7/23/24 at 10:06am, Resident #22's urinary catheter tubing was filled with dark, orange-tinged urine and cloudy sediment was present. A strong smell of urine was present and could be detected before entering Resident #22's room but intensified near the resident. During an observation on 7/24/24 at 1:57pm, Resident #22's urinary catheter tubing contained dark yellow urine with cloudy white sediment. A strong smell of urine was present. In an interview, Registered Nurse (RN) H reported urinary catheter's should be changed when sediment is present. RN H observed the condition of the Resident #22's urinary catheter tubing and stated, It needs to be changed. When further queried, RN H reported the facility recently changed the catheter care protocol and catheters were no longer changed at the first of each month as they had been previously. When asked to determine when Resident #22's urinary catheter was last changed, RN H reported she did not know how to determine that information. When asked if the facility had developed a process for tracking the frequency urinary catheter replacement, RN H reported she did not know. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/24/24 at 2:22pm, Medical Director (MD) EE reported a urinary catheter should be changed when sediment or other symptoms of infection were present. MD EE reported Resident #22 having the same urinary catheter in place was too long and it could increase the risk of infection or other complications. MD EE reported she relied on the nursing staff to monitor the condition of Resident #22's urinary catheter and report any concerns to her. Review of a Catheter Care Procedure-Urinary policy with a reference date of 12/28/23 revealed: It is the policy of this facility to provide catheter care to all residents that have an indwelling catheter in an effort to reduce bladder and kidney infections .Catheter care may be provided by the nursing assistant and/or licensed nurse. Residents with indwelling urinary catheters will be provided catheter care in accordance with current clinical standards.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to ensure adequate care for residents who received enteral nutrition (tube feeding) in 1 (Resident #21) of 2 residents reviewed for tube feeding, resulting in the potential for aspiration pneumonia and spoiled tube feeding. Findings include: Resident #21 Review of an Admission Record revealed Resident #21 was originally admitted to the facility on [DATE] with pertinent diagnoses which included adult failure to thrive. Review of Resident #21's Orders revealed, Enteral Feed Order every shift related to dysphagia (difficulty swallowing) following cerebral infarction (stroke). Jevity (enteral feeding formula) 1.5 at 50 ml/hr continuous. Start date: 5/8/24. Review of Resident #21's Orders revealed, Head of bed elevated 30-45 degrees. Start date: 5/9/24. During an observation on 7/23/24 at 11:08 AM, Resident # 21 was lying in bed. It was noted that Resident #21's bed was not elevated to 30-45 degrees. Resident #21's tube feed was running at 50 ml/hr. The Jevity bottle was missing an open date, start date and time, and initials of the nursing staff member that started the tube feed on the bottle. During an observation on 7/25/24 at 8:15 AM, Resident #21 was lying in bed. It was noted that Resident #21's bed was not elevated to 30-45 degrees. Resident #21's tube feed was running at 50 ml/hr. The Jevity bottle was missing an open date, start date and time, and initials of the nursing staff member that started the tube feed on the bottle. During an observation and interview on 7/25/24 at 8:19 AM, Registered Nurse (RN) L entered Resident #21's room with surveyor and reported that Resident #21's head of bed was not elevated to 30-45 degrees and reported that Resident #21's Jevity bottle was missing an open date, start date and time, and initials of the nursing staff member that started the tube feed on the bottle. During an interview on 7/25/24 at 12:40 PM, Director of Nursing (DON) B reported that nurses were expected to ensure that residents were positioned with their head of bed elevated to 30-45 degrees during a tube feeding administration. Director of Nursing (DON) B reported that nurses were expected to ensure that tube feeding formula was labeled with the date and time that the formula was started. Review of the facility's Feeding Tube policy last revised. 6/30/22 revealed, .Feeding tubes will be maintained in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible .7. Feeding tubes will be utilized according to physician orders .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review the facility failed to obtain physician orders for use of oxygen for 1 of 1 resident (Resident #20) reviewed for respiratory care resulting in the potential for improper use, inaccurate settings, irregular cleaning, and respiratory infection. Findings include: Review of an Admission Record revealed Resident #20 was originally admitted to the facility on [DATE] with pertinent diagnoses which included weakness. Review of Resident #20's Orders did not reveal orders for oxygen administration. Review of Resident #20's Care Plan did not reveal a care plan focus area related to oxygen use. During an observation on 7/23/24 at 12:55 PM, Resident #20 was in lying in her bed. Resident #20 was receiving oxygen via nasal cannula. The oxygen concentrator was noted to be running at 3 liters/minute. During an observation on 7/24/24 at 12:05 PM, Resident #20 was in lying in her bed. Resident #20 was receiving oxygen via nasal cannula. The oxygen concentrator was noted to be running at 3.5 liters/minute During an interview on 7/24/24 at 4:08 PM, Registered Nurse (RN) HH reported that Resident #20 wore oxygen at all times. RN HH reported that she was not able to find an order for oxygen in Resident #20's electronic health record (EHR) and therefore was not able to report how much oxygen Resident #20 was ordered to receive. During an interview on 7/25/24 at 12:40 PM, Director of Nursing (DON) B reported that the facility did not have standing orders for oxygen, and that all oxygen use required a physician's order. DON B reported that the facility had missed obtaining a physician order for oxygen for Resident #20. During an interview on 7/25/24 at 10:14 AM, Medical Doctor (MD) EE reported that she was unaware that facility staff had placed Resident #20 on oxygen, and that she had not approved any orders for oxygen for Resident #20.

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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** 46999 Based on observation, interview, and record review the facility failed to provide adequate staff to meet resident needs for 6 (Resident #11, Resident #13, Resident #18, Resident #22, Resident #35 and Resident #12) of 14 residents sampled for sufficient staffing, and 7 of 9 resident who attended a confidential meeting. This deficient practice resulted in long call light wait times, lack of routine showers for dependent residents, limited resident supervision, staff burnout, and the potential for a decline in resident quality of life and/or quality of care. Findings include: Resident #11 Review of an Admission Record revealed Resident #11, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: multiple sclerosis (chronic disease that affect the central nervous system causing weakness, loss of coordination, numbness, pain), paraplegia (paralysis of the lower body), and anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #11, with a reference date of 6/30/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #11 was cognitively intact. Section D of the MDS revealed Resident #11 experienced feeling down, depressed, or hopeless during 12-14 days of the 14-day assessment period. Section E of the MDS revealed Resident #11 did not refuse care during the 14-day assessment period. Review of a Care Plan for Resident #11, with a reference date of 9/15/23, revealed a focus/goal/interventions of: Focus: Resident has an impaired mood/psychiatric status related to anxiety, change in residence leading to loss of autonomy and poor self-esteem, .MS (multiple sclerosis). Goal: Resident will have reduced complications related to altered mood/psychiatric status through the next review. Interventions: Encourage participation from resident to make own decisions, observe mood to determine if problems (i.e., anxiety, distress, etc.) appear to be related to external causes (.treatment .), Offer encouragement/assistance/support to maintain as much independence and control as possible, offer resident choices . to promote a feeling of self-worth and control over the environment. Review of an Activities Evaluation for Resident #11 with a reference date of 12/19/23 section 3 (Activity Patterns) revealed preferred wake up time in morning: early. In an interview on 7/23/24 at 10:02am, Resident #11 reported she felt frustrated about the delay she frequently experienced while waiting to get up in the morning. Resident #11 reported she preferred to get out of bed and get dressed around 10am each day but she often had to wait over an hour to get help. Resident #11 reported was also frustrated because some days the staff could not assist her with showers because there was not enough staff to care for other residents if one left the floor to assist her with a shower. Resident #11 reported it was common to have 1 nurse and 1 CNA working on her unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/23/24 at 11:32am, Resident #11 remained supported in bed when her husband arrived for a visit and began assisting her with getting dressed. In an interview on 7/23/24 at 12:21pm, Certified Nursing Assistant (CNA) JJ reported the facility consistently had open shift on the CNA schedule that went unfilled. CNA JJ reported when this happened resident showers took a hit because there was not enough staff to aid with showering. CNA JJ added today we have managers doing all sorts of stuff (resident care tasks), but that's not normal. During an observation on 7/24/24 at 11:19am, Resident #11 was in sleep clothing in bed. In an interview on 7/24/24 at 11:47am, Resident #11 reported had not been up yet and was frustrated because she requested help but because she needed 2 staff members for transfer assistance, she had to wait. Resident #11 reported she had been waiting approximately 20 minutes. Resident #11 stated It just makes me so mad that they're always shorthanded. Review of shower records for Resident #11, dated 4/24/24-7/24/24 revealed Resident #11 was not offered a shower during7 of 25 scheduled opportunities for that period. Resident #13 Review of an Admission Record revealed Resident #13, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: multiple sclerosis (chronic disease that affect the central nervous system causing weakness, loss of coordination, numbness, pain), generalized anxiety disorder, and spinal stenosis (narrowing of space between vertebra which may cause pressure on spinal cord). Review of a Minimum Data Set (MDS) assessment for Resident #13, with a reference date of 6/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #13 was cognitively intact. Section GG of the MDS revealed Resident #13 required dependent (helper does all the effort) to shower self. Section E of the MDS revealed Resident #11 did not refuse care during the 14-day assessment period. Review of a Care Plan for Resident # 13, with a reference date of 3/16/24, revealed a focus/goal/interventions of: Focus: Resident has an ADL self-care performance deficit related to multiple sclerosis . anxiety, depression . spinal stenosis .Goal: Resident's Activities of Daily Living (ADL) needs will be met through next review. Interventions: TRANSFERS: with 2 person assist AND use of mechanical lift. During on observation on 7/23/24 at 11:17am, Resident #13 was dressed in pajamas and sat supported in bed. In an interview on 7/23/24 at 11:19am, Resident #13 reported she liked to get up and get dressed between 9-10am but often had to wait more than an hour because there were not enough staff to provide the 2 person assistance she needed to transfer out of bed. Resident stated I'm kinda stuck here (referring to being in bed) if they can't help me get cleaned up. Resident #13 reported the facility regularly did not have enough staff to assist her with getting in or out of bed when she wanted to. Resident #13 also reported she preferred to eat her meals in the assisted living dining area, but often could not get up in time to do so. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/23/24 at 12:34pm, Certified Nursing Assistant (CNA) C reported Resident #13's unit needed to have 2 CNA's on day shift because 9 residents on the unit required assistance of 2 staff members for transferring in and out of bed. CNA C reported Resident #13 asked to get up at 10:30am on this date but CNA C had not been able to assist her. In an interview on 7/24/24 at 9:25am, Registered Nurse (RN) H reported Resident #13 regularly had to wait to get out of bed because she needed the assistance of 2 staff members. RN H reported when the facility had 3 CNA's for the entire skilled nursing facility and 2-3 nurses, it was not possible to assist resident's who need assistance of 2 staff in a timely manner. When further queried, RN H reported due to the level of staffing, she could not adequately supervise a resident who frequently wandered into other resident's rooms, and she worried about the resident's safety as well as the other resident's who frequently got upset by her wandering. RN H stated We do the best we can with what we have. In an interview on 7/25/24, at 1:08pm, Resident #13 reported at times she was not offered the opportunity to shower twice a week. Resident #13 reported she felt frustrated and disappointed when staff did not offer her to opportunity to shower, and as the result of not having routine showers, she felt self-conscious about her appearance and overall personal hygiene. When further queried, Resident #13 reported showering was also important to her because it helped her maintain a better outlook and higher energy level. Review of shower records for Resident #13, dated 5/2/24-7/24/24, revealed Resident #13 was not offered a shower during 10 of 24 scheduled opportunities for that period. Resident #22 Review of an Admission Record revealed Resident #22, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: major depressive disorder, other specified anxiety disorders, cerebral infarction (stroke) with residual deficits, and chronic pain. Review of a Minimum Data Set (MDS) assessment for Resident #22, with a reference date of 5/23/24 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated Resident #22 was moderately cognitively impaired. Section GG revealed Resident #22 was dependent (helper does all the effort) to transfer from her bed to the wheelchair. Section E revealed Resident #22 did not refuse care during the 14-day assessment period. Review of a Care Plan for Resident #22, with a reference date of 9/13/23, revealed a focus/goal/interventions of: Focus: Resident has an ADL self-care performance deficit related to anxiety, depression, cognitive impairment, depression .generalized weakness, history of falls .Goal: Resident's Activities of Daily Living (ADL) needs will be met through next review. Interventions: BATHING: 1 person assist, EATING: Supervision, TRANSFERS: with 2 person assist AND use of mechanical lift, honor resident's choices and preferences whenever possible. During an observation on 7/23/24 at 12:12pm, Resident #22 sat in the hallway with a bedside table in front of her and fed herself lunch. Resident noted to make throat clearing and gagging sound occasionally. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/24/24 at 12:28pm, Resident #22 sat in the hallway with a partially consumed lunch tray in front of her. Resident #22 made a gagging sound and was assisted back to her room by Registered Nurse (RN) H. In an interview on 7/24/24 at 2:03pm, Registered Nurse (RN) H reported Resident #22 had to eat in the hallway rather than in her room because she needed supervision while eating and there was not enough staff to supervise Resident #22 if she ate in her room. RN H reported she observed that Resident #22 was more comfortable and did not make a gagging sound when assisted with eating in her room, but the facility did not have enough staff to support her doing so. During an observation on 7/25/24 at 12:55pm, Resident #22 sat in the hallway with a partially consumed lunch tray on a bedside table in front of her. Resident #22's hair appeared extremely oily with thick strands stuck together across her entire scalp. Resident #22's fingernails were jagged with brown debris under several nails. In an interview on 7/25/24 at 1:01pm, Resident #22 reported she did not like being in the hallway/eating there and wanted to return to her room. Resident #22 voiced frustration and reported she was tired of waiting. When queried about her satisfaction with her hygiene, Resident #22 reported she felt she needed showers more regularly. Review of shower records dated 5/1/24-7/24/24 revealed Resident #22 was not offered a shower during 11of 24 scheduled opportunities during that period. In an interview on 7/23/24 at 12:21pm, Certified Nursing Assistant (CNA) JJ reported the facility consistently had open shifts on the CNA schedule that went unfilled. CNA JJ reported the facility had 1 CNA for each hall twice in the past week. CNA JJ reported when this happened resident showers took a hit because there was not enough staff to aid with showering. CNA JJ added today we have managers doing all sorts of stuff (resident care tasks), but that's not normal. In an interview on 7/24/24 at 9:25am, Registered Nurse (RN) H reported the facility had one nursing assistant for each hall during the day shift on this date. In an interview on 7/24/24 at 9:32am, Certified Nursing Assistant (CNA) M confirmed she was the only nursing assistant for the hall during the day shift on this date. In an interview on 7/24/24 at 12:10pm, Certified Nursing Assistant (CNA) K reported she had worked as the only CNA on a hall several times. CNA K reported when the facility only had 1 CNA on a hall, it was not possible to provide showers or adequate supervision to the residents. CNA K reported she seldom saw members of the management team assisting with resident care needs and categorized seeing it happen today as strange. CNA K confirmed she was the only nursing assistant working on her hall on this date. In an interview on 7/25/24 at 10:59am, Certified Nursing Assistant (CNA) NN reported on the facility regularly had less than the allotted number of CNA's on a shift and as a result, she had concerns about the amount of supervision the resident's received. CNA NN reported she voiced her concerns to management several times. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/24/24 at 11:53am, Nursing Scheduler (NS) MM reported the facility based the number of nursing staff on the facility's resident census. NS MM reported based on the census, the facility was allowed to schedule 6 nursing assistants (2 per hall) during the day shift and 3 nurses. NS MM reported the appropriate staffing for 3rd shift was 3 nursing assistants and 2 nurses. When further queried if the facility ever added extra staff based on resident acuity, NS MM reported that had not happened. NS MM reported it was her responsibility along with that of management and the floor nurses to try to fill staffing slots that opened as the result of staff calling in. NS MM reported sometimes the open positions went unfilled because other facility staff did not pick up the hours and the facility did not currently use contractual staff. NS MM reported the facility realized it was experiencing a high number of call ins and had recently implemented an attendance policy. In an interview on 7/25/24 at 2:59pm, Nursing Home Administrator (NHA) A confirmed the facility was not always operate with the number of staff deemed necessary. NHA A reported when this happened, the workload was redistributed amongst the staff that were present. NHA A reported number of staff allowed per day was based on the resident census and some resident acuity considerations, but she felt the facility did not have high acuity. NHA A reported several nursing staff members recently called her and voiced concerns related to the staffing level during a 30-minute telephone conversation. NHA A reported the nursing staff were working at the time of the call and she felt they might have been better able to meet resident needs on that day if they hadn't used that time to call her. NHA A reported she felt the facility did not need more staff, but the current staff needed to work better as a team. For additional information see citation F677. 47659 Resident #18 Review of an Minimum Data Set (MDS) assessment revealed Resident #18 was originally admitted to the facility on [DATE] with pertinent diagnoses which included heart failure. Review of a Minimum Data Set for Resident #18, with a reference date of 4/21/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #18 was cognitively intact. Review of a Minimum Data Set for Resident #18, with a reference date of 4/21/24 revealed that Resident #18 was dependent on staff for toileting, showering, and dressing. During an interview on 7/23/24 at 12:31 PM, Resident #18 reported that she had to frequently waited for long periods of time for staff assistance. Resident #18 reported that there were multiple occasions where she had to lay in soiled briefs while she waited for staff assistance. Resident #18 reported that the facility staff seemed short staffed and unable to complete care or answer call lights promptly nearly every day. Resident #35 Review of an Admission Record revealed Resident #35 was originally admitted to the facility on [DATE] with pertinent diagnoses which included adult failure to thrive. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Minimum Data Set (MDS) assessment for Resident #35, with a reference date of 6/14/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #35 was cognitively intact. During an interview on 7/23/24 at 1:18 PM, Resident #35 reported that she had gone 11 days without a shower. Resident #35 reported that the facility staff were unable to assist her with showers because they did not have the staff to assist with showers. During an interview on 7/25/24 at 10:06 AM, Certified Nursing Assistant (CNA) K reported that residents were frequently missing their showers because the facility did not have the staff to provide showers. CNA K reported that the facility often had one CNA on each unit, and when there was only one CNA on each unit, they were unable to assist residents with showers. During an interview on 7/24/24 at 8:17 AM, Registered Nurse (RN) H reported that the staffing ratios at the facility were often challenging. RN H reported that the facility would frequently work with only two nurses for three units. RN H reported that when nursing had to split the third unit, it would make completing any tasks difficult, especially administering medications on time. During an interview on 7/24/24 at 12:43 PM, CNA M reported that the facility often scheduled one CNA per unit, which made caring for residents that required two person assistance difficult. CNA M reported that CNA's often struggled to complete their tasks, and residents were frequently left to wait for the CNA's to find someone to assist them with completing care. During an interview on 7/25/24 at 10:14 AM, Medical Doctor (MD) EE reported that the facility was often short staffed. MD EE reported that she had witnessed several staff members in tears due to being overwhelmed with their work load. 48637 During a confidential resident council meeting held on 7/25/2024 at 10:00 AM, seven of nine residents reported that they waited for a long time for help. These residents stated that sometimes they have to wait 1 hour to 1 and 1/2 hours for help. Two residents stated that if they complain to an aide, they will take a longer time to help. Another resident stated that sometimes staff goes in the room and turns off the call light without meeting their needs. One resident stated that sometimes they have to change the shower day when they are shorthanded. They all agreed that it is harder to get help on third shift. Review of the Resident Council minutes dated 1/23/2024 under the clinical department revealed (Resident name omitted) says he asks for something and is told to wait a sec (second). He says he has to keep asking as the time goes by. Review of the Resident Council minutes dated 3/19/2024 under the clinical department revealed (Resident name omitted) says he has given up on the light and just yells for help until he is answered. Review of the Resident Council minutes dated 4/24/2024 under the clinical department revealed (Resident name omitted) commented that she had to wait 40-45 minutes before anyone comes to help her use the bathroom. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident Council minutes dated 6/26/2024 under the clinical department revealed (Resident name omitted) said she sat on the toilet with the string pulled for 2 hours recently with no help. She says at times, there is no help. During another interview on 7/25/2024 at 12:57 PM, AD E stated that she was aware that concerns regarding long call light wait times was brought up several times in Resident Council meetings and she gave these concerns to the appropriate department head. 41982 Resident #12 Review of an Admission Record revealed Resident #12 was a female, with pertinent diagnoses which included: unsteadiness on feet and need for assistance with personal care. Review of a Minimum Data Set (MDS) assessment for Resident #12, with a reference date of 6/11/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #12 was cognitively intact. Review of Resident #12's current Care Plan revealed a focus of Resident has an ADL (activities of daily living) self-care performance deficit . last revised 2/7/24 with pertinent care planned interventions which included: TOILETING: 1 person assist PERSONAL HYGIENE: 1 person assist and TRANSFERS: 1 person assist all of which had a date initiated of 8/7/23. In an interview on 7/23/24 at 10:19 AM, Resident #12 reported she sometimes had to wait 1/2 hour to get on the toilet because of staff call offs and less staff available to assist. Resident #12 went on to report that she has a bowel condition and when she has waited that long for assistance and held her bowel movement in too long, it was uncomfortable and she felt constipated.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 47659 Based on interview and record review, the facility failed to ensure physician ordered laboratory diagnostic services were obtained and completed in a timely manner in 1 (Resident #35) of 1 residents reviewed for laboratory services, resulting in delayed treatment/intervention related to lab results, increased pain/discomfort, and impaired coordination of care. Findings include: Review of Resident #35's Orders revealed, . UA (urinalysis) w/reflex to C&S (culture and sensitivity) if appropriate. Start date: 7/12/24 . Review of Resident #35's electronic health record (EHR) did not reveal any notes related to the delayed results of Resident #35's urinalysis that was ordered on 7/12/24. During an interview on 7/23/24 at 1:18 PM, Resident #35 reported that she had been experiencing pain with urination for over two weeks. Resident #35 reported that the facility had taken a urine sample to check for a urinary tract infection on 7/12/24, but the facility did not get results from that urine sample. Resident #35 reported that she had learned on 7/19/24 that the facility never received the results from the first urine sample when she was asked to provide another sample. During an interview on 7/24/24 at 4:08 PM, Registered Nurse (RN) HH reported that reported that she believed that Resident #35's urine sample that was obtained on 7/12/24 was sent to the wrong lab. RN HH reported that the facility had recently switched lab providers and the nurses were unclear on the new process was for obtaining labs. RN HH could not report how the facility tracked and monitored lab orders to ensure that they were completed and reviewed. During an interview on 7/25/24 at 10:14 AM, Medical Doctor (MD) EE reported that Resident #35's urine sample was first ordered on 7/12/24. MD EE reported that the facility had recently switched lab providers and there was a delay in orders being processed. MD EE reported that there was a lot of confusion among the nursing staff with the new lab ordering process. MD EE was not able to report how the facility was tracking and monitoring pending lab orders to ensure that they were completed. MD EE confirmed that Resident #35 experienced a delay in treatment and care due to the facility not ensuring the urine sample was sent to correct lab and following up on the urinalysis results. During an interview on 7/25/24 at 12:40 PM, Director of Nursing (DON) B reported that the facility had switched lab providers on 7/1/24. DON B reported that the facility was still working out the kinks and miscommunication on the new lab ordering process. DON B confirmed that education and training had not yet been provided to all nursing staff that were responsible for lab orders. DON B reported that she was currently responsible for monitoring all lab orders to ensure that they were completed. DON B could not confirm if she had followed Resident #35's lab order from 7/12/24, and she was unable to explain why Resident #35's lab order on 7/12/24 was not completed. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility's Laboratory and Diagnostic Guidelines policy last revised 10/26/23 revealed, Policy:This guideline is set up to track the timely completion, reporting and monitoring of laboratory and diagnostic tests, results, and notifications which are used to monitor resident status and/or therapeutic medication levels .10. The physician should be notified if the lab/diagnostic test is unable to be completed, reason why, and request for new orders .12. All notifications, attempts at notifications, and response should be noted in the resident ' s medical record .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905 Based on observation, interview, and record review the facility failed to provide food at a palatable temperature to 9 of 9 residents interviewed during resident council and 2 of 2 resident (Resident #15 and Resident #27) reviewed for food palatability, resulting in the potential for decreased food consumption and potential nutritional decline. Findings include: During a tour of lunch service, at 11:38 AM on 7/23/24, an interview with [NAME] QQ found that hot food on the steam table should be around 165F to stay hot for residents. At 11:48 AM on 7/23/24, a test stray of the regular meal was plated for the surveyor and placed on the health center one cart. At 11:52 on 7/23/24, the cart and test tray made it to the floor of Health Center one. At 12:07 PM on 7/23/24, all trays were passed from the health center one cart and the surveyor brought the test tray back to the conference room. At this time the following temperatures were found, Pasta/Meat was 122F and the peas were 121F. A revisit to the kitchen, at 8:03 AM on 7/24/24, found that the last breakfast cart of trays was sent out five minutes ago to health center one. A visit to Health Center one, with dietitian PP, found that a resident who had denied their breakfast tray and had their tray sitting on the meal cart. When asked when the cart came down to Health Center one, D PP stated that she timed stamped it at 7:58 AM. Once all the trays were taken from the Health Center one cart, the surveyor took the test tray back to the conference room and arrived at 8:10 AM and found the following temperatures of hot food: Scrambled egg was 124F, Sausage Links 103F and oatmeal was 125F. A revisit to the kitchen, at 8:23 AM on 7/24/24, found staff still plating assisted living residents for breakfast. At this time a temperature of the sausage links in the steam table were taken and found to be between 130F-140F. 48637 During a confidential resident council meeting held on 7/25/2024 at 10:00 AM, nine of nine residents reported that their food was cold whether they received it in their room or the main dining room. The residents agreed that drinks such as coffee and hot water were cold too. The residents stated that cold foods has been an issue for a while and it's not getting resolved. Review of the Resident Council minutes dated 1/23/2024 under the dietary department revealed, Many times food temp (temperature) is still an issue, being too cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident Council minutes dated 2/20/2024 under the dietary department revealed Most all residents at this meeting said 75% of the time all the food is cold. Resident #15 (R15) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R15 admitted to the facility on [DATE] with diagnoses of type 1 diabetes, anxiety, and depression. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R15 was cognitively intact (13 to 15 cognitively intact). During an interview on 7/23/2024 at 11:21 AM, R15 stated that his food is almost always cold when he gets it in his room. R15 said he goes to the dining room at times and it is cold there too. Resident #27(R27) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R27 admitted to the facility on [DATE] with diagnoses of End Stage Renal Disease, Type 2 diabetes, and depression. Brief Interview for Mental Status (BIMS) reflected a score of 10 out of 15 which indicated R27 was cognitively impaired (8-12 moderately impaired). During an interview on 7/24/202 at 8:42 AM, R27 stated that he eats in his room and the food is always cold. R27 also stated that the coffee is cold. During an interview on 7/25/2024 at 12:57 PM, AD E stated that she was aware that concerns regarding cold food was brought up several times in Resident Council meetings and she gave these concerns to the appropriate department head. During an interview on 7/25/2024 at 1:10 PM, Regional Dietitian (RD) W stated that sometimes residents aren't in their rooms when the tray is delivered and it sits there and when they get back to their room it's cold. RD W said that another tray should be requested at this time or nursing staff should notify the kitchen to deliver it later.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 48637 Based on interview and record review, the facility failed to consistently provide a nourishing nighttime snack to eight of nine residents who attended a confidential Resident Council meeting resulted in the potential for residents to have more than 14 hours between a substantial evening meal and breakfast the following day, decreased oral intake, and the potential for weight loss. Findings include: During a confidential resident council meeting held on 7/25/2024 at 10:00 AM, eight of nine residents reported that they don't get snacks at bedtime and if they ask for it, they are often given only one choice. One resident stated that there weren't any healthy choices, the snacks are salty and not diabetic friendly and there weren't choices in what they get at night. Another resident said that she thinks staff is eating resident snacks. Review of the document Mealtimes revealed that breakfast is served 7:30-8:30 AM and dinner is from 5:30-6:30 PM. The time from the end of dinner to breakfast the next morning is approximately 13- 14 hours. Review of the Resident Council minutes dated 6/26/2024 under the dietary department revealed (Resident name omitted) said she watches CNAs (Certified Nursing Assistants) take pocketful of snacks for the residents and eat them all. She has confronted a few CNAs, but nothing changes. During an interview on 7/25/2024 at 12:15 PM, Registered Dietitian (RD) W stated that the dietary staff stock the nourishment room and fridge with a variety of snacks: cheez-its, creme pies, chips, pudding, cottage cheese, beverages, milk, ice cream, sandwiches-tuna, egg salad and turkey every day. RD W said that nursing staff hands out the snacks during the day and at night. During an interview on 7/25/2024 at 12:21 PM, Nursing Home Administrator (NHA) 'A stated that dietary stocks the nourishment room every day and CNAs are supposed to pass them out. Review of the Offering/Serving Bedtime Snacks Policy with an implementation date of 10/20/2020 and a review/revision date of 1/01/2022 revealed, Policy Explanation and Compliance Guidelines: 1. The nursing staff offers bedtime snacks to all residents in accordance with the resident's needs, preferences and requests on a daily basis. 2. All diabetic or special diet bedtime snacks are labeled and dated. Each label contains the resident's name and room number. 4. Nursing staff delivers and serve snacks to residents. 5. Intake of bedtime snacks is documented in the medical record.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings include: During the initial tour of the facility, starting at 9:40 AM 7/23/24, a tour of the walk in cooler found a container of breakfast sausage tightly covered with saran wrap that was warm to the touch. At this time a temperature of the sausage links was taken and found to be 109F. An interview with [NAME] QQ, at 9:55 AM on 7/23/24, found that the sausage links were pulled from the breakfast line about an hour ago and placed in the walk-in cooler. An interview with Assistant Kitchen Manager OO, at 10:08 AM on 7/23/24, found that staff log cooling on a sheet on the cabinet. A review of the Cooling Temperature Log dated 2024, found that on 5/2 and 6/11 cooling for sausage was logged. Both items were stated to start cooling at 9:00 AM and by 11:00 AM both items were logged above 70F. During a revisit to the kitchen, at 10:58 AM on 7/23/24, an observation of the sausage links found them still tightly wrapped and covered in saran wrap. A temperature of the sausage links was found to be 78F at this time. An interview with Dietitian PP, found that the item will be discarded and the cook will be educated on proper cooling. According to the 2017 FDA Food Code section 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less . According to the 2017 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3)Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD. During the initial tour of the facility, at 9:42 AM on 7/23/24, observation of the walk in freezer found a box of raw hamburgers stored open and exposed to the elements. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (4) Except as specified under Subparagraph 3-501.15(B)(2) and in (B) of this section, storing the FOOD in packages, covered containers, or wrappings; During the initial tour of the kitchen, at 10:01 AM on 7/23/24, it was observed that one 14 inch sauce pan and two 12 inch sauce pans were found heavily encrusted with black carbon accumulation on the inside of the pans cooking surface. It was also noted that the surface of the pans were textured with an accumulation of encrusted carbon. An observation of the dish machine area, at 10:05 AM on 7/23/24, found the drain directly before trays into the dish machine was found to be loose and leaking water on the floor near the floor drain. According to the 2017 FDA Food Code section 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. An observation of the dish machines data plate, at 10:06 AM on 7/23/24, found that it requires a minimum wash temperature of 160F. An observation of the wash temperature gauge at this time found it was reading 156F while Assistant Kitchen Manager OO was doing dishes. A record review of the facilities Dish Machine Temperature Log, dated July 2024, found that the majority of the 67 logged wash temps were logged below the 160F required minimum stated on the dish machines data plate. According to the 2017 FDA Food Code section 4-501.110 Mechanical Warewashing Equipment, Wash Solution Temperature. (A) The temperature of the wash solution in spray type warewashers that use hot water to SANITIZE may not be less than: (1) For a stationary rack, single temperature machine, 74oC (165oF); (2) For a stationary rack, dual temperature machine, 66oC (150oF); (3) For a single tank, conveyor, dual temperature machine, 71oC (160oF); or (4) For a multitank, conveyor, multitemperature machine, 66oC (150oF). (B) The temperature of the wash solution in spray-type warewashers that use chemicals to SANITIZE may not be less than 49oC (120oF). According to the 2017 FDA Food Code section 4-501.15 Warewashing Machines, Manufacturers' Operating Instructions. (A) A WAREWASHING machine and its auxiliary components shall be operated in accordance with the machine's data plate and other manufacturer's instructions. (B) A WAREWASHING machine's conveyor speed or automatic cycle times shall be maintained accurately timed in accordance with manufacturer's specifications. During the initial tour of the kitchen, at 10:10 AM on 7/23/24, observation of the two door [NAME] cooler found open containers of thickened apple, orange, and cranberry juices. A review of the containers state the items are only good for 7 days after opening. During a tour of Health Center 1 pantry, at 11:19 AM on 7/23/24, it was observed that one open container of Vanilla Med Pass 2.0 was found with no date to indicate discard. Review of the product label found it is good for three days after opening. Further review of the unit found a nutritional chocolate shake with no date and manufactures directions that state the item is good 14 from thaw. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a tour of the Health Center 2 Pantry, at 11:25 AM on 7/23/24, it was observed that an open container of thickened cranberry and a nutritional chocolate shake were found without dates to indicate discard. According to the 2017 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) .