STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235249	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation St Francis	915 N River Rd Saginaw, MI 48609

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation Pertains to Intake Number MI00149278. Based on observation, interview and record review, the facility failed to ensure the provision of bathing and hygiene care for two residents (#7 and #59) of four residents reviewed, resulting in a lack of bathing/showers, nail care, and personal hygiene. Findings include: Resident #7: On 1/21/25 at 11:31 AM, Resident #7 was observed in their room. The Resident was lying in bed on their back. The Resident was unshaven and their hair had a greasy with an unkept appearance. When queried regarding bathing and ADL care, Resident #7 indicated they do not get out of bed. When asked why they do not get out of bed, the Resident did not provide a response. Resident #7 was asked when they last had a shower and stated, Not had a shower in a long time. When asked why they had not had a shower, the Resident revealed they prefer bed baths because it is too difficult to sit up in the chair. When asked the last time they had a bed bath, Resident #7 stated they have diarrhea frequently and indicated the staff washes their peri area as needed. When queried how staff wash their hair when they take a bed bath, Resident #7 verbalized they don't. Resident #7 was then asked if they would be interested in taking a shower if a different chair and/or method, such as a shower bed, was used and indicated they would be willing to try. Record review revealed Resident #7 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included depression, Parkinson's disease, cerebral infarction (stroke), and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required moderate to total assistance for personal hygiene and bathing. On 1/23/25 at 7:57 AM, Resident #7 was observed in their room. The Resident was in bed on their back with their eyes closed. The Resident was unshaven. Their hair had a greasy and unkept appearance. Review of Resident #7's Point of Care (POC) bathing and showering documentation in the Electronic Medical Record (EMR) for the past 30 days revealed documentation of bathing two times. Review of Resident #7's EMR revealed a care plan entitled, I have self-care deficit R/T (related to): cerebral palsy, debility (Initiated: 8/24/24). The care plan included the interventions: (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- I am assist of 1 with Bathing (Initiated: 8/24/24) - I am assist of 1 with Grooming/hygiene (Initiated: 8/24/24) - I am assist of 2 with Toileting (Initiated: 8/24/24) (Initiated: 8/24/24) Another care plan entitled, I am non-compliant with care. I often refuse to get up for shower, and /or bed bath . (Initiated: 8/24/24) was present in Resident #7's EMR. The care plan included the interventions: - Get someone else to offer care when I refuse (Initiated: 8/24/24) - Offer social service . as needed (Initiated: 8/24/24) Review of documentation in Resident #7's EMR revealed one specific documentation of care refusal. The Nursing-Progress Note was dated 11/6/24 at 11:11 AM and specified, Resident refused to have fingernails cleaned and trimmed. Resident #59: On 1/21/25 at 10:58 AM, Resident # 59 was observed in their room. The Resident was in bed, positioned on their back. The call light was on the floor and not within the Resident's reach. An interview was completed at this time. When queried regarding the care they receive at the facility, Resident #59 stated, Could be better. When asked how it could be better, Resident #59 replied, Not get my brief changed as often as I need. When queried regarding bathing and showering, Resident #59 stated, Not good. Resident #59 was asked when their last shower was and stated, Probably a week and a half ago. Resident #59 was asked if they want to take a shower and stated, Yes. Resident #59 continued, The shower chair is uncomfortable. Resident #59 was asked if they informed staff that the shower chair was uncomfortable and verbalized they had. When asked if staff offered any alternatives to the shower chair, Resident #59 replied, No. When queried if they refuse bathing and/or showering, Resident #59 indicated they have refused a shower because of the shower chair but do not refuse bed baths. The Resident's fingernails were long and visibly dirty with an unknown dark colored substance under them. When queried regarding if they know when they need to use the bathroom, Resident #59 replied, Yeah. Resident #59 was asked if they put their call light on when they need to use the restroom and stated, The staff complain when I use the call Light. When asked how the staff complain, Resident #59 revealed staff take a long time to respond and are snippy when they come in their room. Resident #59 further revealed they are incontinent because the staff do not answer quickly enough to help them and then take a long time to change them. Record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses which included depression, anxiety, cerebral infarction (stroke) with resulting left sided hemiplegia and hemiparesis (one sided paralysis), pain, and rectal cancer. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and was totally dependent upon staff for toileting hygiene and transferring. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #7's Point of Care (POC) bathing and showering documentation in the Electronic Medical Record (EMR) for the past 30 days revealed documentation of bathing two times on 1/3/25 and 1/17/25. The documentation indicated the Resident refused bathing on 1/7/25 and 1/14/25. Review of Resident #59's EMR revealed a care plan entitled, Resident has an ADL self-care performance deficit related to generalized weakness (Initiated: 8/16/24). The care plan included the interventions: - I am assist of 1 with Grooming/hygiene (Initiated: 8/16/24) - I am assist of 2 with Bed Mobility (Initiated: 8/16/24) - I am dependent with Locomotion (Initiated: 8/16/24) - I am dependent with Toileting (Initiated: 8/16/24) - (I) am assist of 2 with Bathing (Initiated: 8/16/24) - I am assist of 2 with maxi lift, may leave sling underneath me while in wheelchair as I allow (Initiated: 8/16/24) There was no documentation of ADL care refusal noted in Resident #59's EMR progress note documentation. On 1/23/25 at 1:34 PM, an interview was completed with RN B. When queried if staff should document resident refused in the EMR if a Resident refuses care and/or treatment, RN B indicated they should. Review of facility policy/procedure entitled, Call Light Accessibility and Timely Response (Dated 8/16/23) revealed, The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance . Staff will ensure the call light is plugged in, functioning, within reach of residents, and secured, as needed. The call system will be accessible to residents while in their room at bedside as well as in the bathroom and shower room . 22347

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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** 38471 Based on observation and record review the facility failed to ensure nursing assessments were completed for two residents (#71 and #231) of three residents reviewed for assessment and monitoring, resulting in a delay in assessment and treatment for bowel management and skin/back rash of Residents #71 and #231. Findings Include: Resident #231: During initial tour on 1/21/2025, Resident #231 shared she developed a rash on her coccyx that extends to her back from the briefs used daily for incontinence care. She continued the rash is the shape of the brief and rom what staff from told her the rash is reddened with small bumps. She continued the rash was causing her great discomfort, but nursing staff mixed a cream to assist. On 1/2/2025 at 11:50 AM, Nurse P stated Resident #231's mid to lower back was reddened and it is in the same area where the brief would sit. The reddened area spanned the width of her back and wrapped slightly onto her sides. She was made aware of the area yesterday but does not know when it began. On 1/22/2025 at 8:00 AM, a review was completed of Resident #231's medical records and it revealed she was readmitted to the facility on [DATE] with diagnoses that included, Sepsis, Crohn's Disease and Acute Embolism. Further review yielded the following results: Hospital Discharge Summary 1/7/2025: .she also had cutaneous candidiasis (fungal skin infection), treated with topical clotrimazole. The patient's condition improved, and she is stable for discharge . Admission Evaluation 1/8/2025: There were no skin issues listed on the admission assessment. Care Plan: .Observed skin condition with ADL care daily: report abnormalities .provide preventive skin care routine and prn (as needed) . MAR (Medication Administration Report): Skin evaluation weekly: completed on 1/14/25 and 1/20/25 but no other documentation regarding the area on her back and buttocks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review was completed of the CNA (Certified Nursing Assistant) task list. It showed CNA's documented incontinence care completed daily but there was no subsequent documentation related to the reddened area on back/coccyx area. Progress Notes: 1/21/2025 at 14:55: Resident presented with a macular popular rash to back and buttocks .Yeasty rash associated with antibiotic use . On 1/23/2025 at approximately 2:55 PM, Resident #231 was interviewed in the presence of Unit Manager H regarding the rash to her back and coccyx area. Resident #231 shared she believes it began on Saturday as it was reddened, hot and uncomfortable. On Tuesday is when they started a treatment, and she now has some relief. Unit Manager H stated they were apprised of the rash on Tuesday and a treatment was put in place. The resident does have a history of the rash prior to her readmission but the discharge summary stated stable/resolved, and the admission assessment did not indicate a rash. Manager H is uncertain as to why facility staff would not have alerted the nurses to the rash when it began. Review was completed of the facility policy entitled, Skin and Wound Guidelines, revised 3/20/2024. The policy stated, .Body audits are completed u the licensed nurse routinely and documented in the residents' electronic medical record. By the nursing assistant will inform the licensed nurse of any new areas of skin breakdown for evaluation and documentation . 37668 Resident #71 An interview was completed with Resident #71 on 1/21/25 at 12:12 PM. When queried if they had any concerns regarding their care, Resident #71 replied, No communication. When asked what they meant, Resident #71 verbalized they did not feel staff communicated to one another. Resident #71 was asked for an example and stated, I haven't had a BM (bowel movement) since last Tuesday. When queried if they informed staff, Resident #71 verbalized they had. The Resident revealed they were going to ask for something to help them again. Resident #71 indicated their stomach was hurting and upset because they need to go. Directly following the interview with Resident #71, the Resident was observed asking Licensed Practical Nurse (LPN) Z for something to help them have a BM. LPN Z was heard asking the Resident when their last BM was and then telling them they would have to get back to them. Record review revealed Resident #71 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included ulcerative colitis, fecal (stool) impaction, depression, and gastrointestinal hemorrhage (bleeding in digestive tract). Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and was able to complete all ADL's independently with the exception of supervision with showering/bathing. Review of Resident #71's care plans in the Electronic Medical Record (EMR) revealed the Resident did not have a care plan in place related to bowel/bladder care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #71 did have a care plan in place titled, I have self-care deficit R/T (related to): debility (Initiated: 8/27/24), The care plan included the interventions: - I am assist of 1 with Toileting (Initiated: 8/27/24) - I am assist of 1 with gait belt and RW with Transfer (Initiated: 8/27/24) Review of Resident #71's Point of Care (POC) Bowel Elimination documentation for the past 30 days revealed Resident #71's last documented BM was seven days previously on 1/14/25 (Tuesday). An interview was completed with LPN AA on 1/23/25 at 8:35 AM. When queried how nursing staff monitor Resident's BM's to identify constipation, LPN AA stated, It has changed in the last couple of years. BM's are reviewed by management in their morning meeting. When asked how the nursing staff assigned to care for the Resident's are involved in the morning meeting, LPN AA verbalized they are not and revealed management enters orders in the EMR because orders will just show up if a Resident has not had a BM in three days. When queried regarding Resident #71's bowels, LPN AA verbalized the Resident is able to use the restroom without assistance and will inform staff when they have a BM and will tell us if they are feeling constipated. Review of Resident #71's EMR on 1/22/25 revealed the Resident received medication and had two BM's on 1/21/25 at 4:38 PM and 10:46 PM. Review of documentation revealed there was no documentation of nursing assessment of the Resident's abdomen and/or bowel sounds prior to medication administration for constipation and no bowel movement for seven days. An interview was conducted with the Director of Nursing (DON) on 1/23/25 at 12:37 PM. When queried if they were aware Resident #71 did not have a bowel movement from 1/14/25 until 1/21/25 and had to request something to assist them have a BM, the DON stated they were not aware. When queried regarding the facility policy/procedure related to monitoring resident bowel movements to prevent constipation and potential medical concerns associated with constipation, the DON revealed they would need to review the policy. When asked if a nursing assessment should be completed and documented for a Resident who has not had a bowel movement in seven days prior to administration of medications, the DON stated, Should do a bowel assessment. The DON indicated they would address with the nurse assigned to the Resident. A policy/procedure related to bowel protocol/management was requested from the facility Administrator on 1/23/25 at 7:26 AM. At 8:47 AM on 1/23/25, the Administrator responded, We do not have a policy for bowel protocol / management.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347 Based on observation, interview and record review, the facility failed to prevent a Stage III coccyx pressure ulcer from developing for 1 resident (Resident #76), and failed to implement meaningful and planned interventions for 1 resident (Resident #332), of 2 residents reviewed for pressure ulcers, resulting in a Stage III infected pressure ulcer, IV antibiotic usage, and hospitalization with the potential for delayed healing of pressure ulcers. Findings Include: Review of hospital records dated 1/22/25, stated The patient had Covid and pneumonia in December (2024) and was admitted from 12/7/24 to 12/26/24 and has been in rehabilitation (living at the facility) until today. The patient was getting settled his noon nursing facility (the resident was transferred from the facility to a Assisted Living facility/ALF on 1/22/25), they (ALF) noticed of the wound and thought it looked significant and recommended that he come to the emergency department. Do (the ER physician) have concerns that patient may be developing cellulitis (inflammation/infection of skin) around his sacral (coccyx area) wound. Do believe he needs to be admitted for IV antibiotics and to see wound care. Spoke with (hospital physician) hospitalist and discussed the medical management of the patient's case. They agreed to admit the patient for infected decubitus (coccyx area) ulcer stage III. Patient is still symptomatic with decubitus sacral ulcer with surrounding cellulitis and has not achieved medical stability for safe discharge from the hospital. I am concerned that, if discharged today (on 1/22/25, day of discharge from the facility), the current condition would worsen and an adverse event like cysts and deaf (death) may occur. Large stage 2-3 sacral ulcer with severe tenderness to palpation. 600 mg Zyvox IVPB (antibiotic given per IV) and 1 g Maxipime IVPB (antibiotic given per IV) were ordered for the patient's infected sacral ulcer. Diagnosis: Infected decubitus ulcer, stage III, dehydration. Review of hospital records dated 1/28/25, stated I (Infectious Disease physician) was consulted from Infectious Disease perspective regarding the patient having a infected sacrococcygeal decubitus ulcer. Patient has redness, tenderness, induration around the margins of the ulcer. Patient also has leukocytosis (high white blood cells in blood, indicating saver infection). Resident #76: Review of the Face Sheet, Nursing Admission assessment dated [DATE], nursing notes dated 12/26/24 through 1/22/25, physician orders dated 12/27/24 through 1/22/25, revealed Resident #76 was [AGE] years-old, alert and able to make his needs known, admitted to the facility on [DATE], and required staff assistance with all Activities of Daily Living/ADL's. The resident's diagnosis included, cervical disc disorder, acute respiratory failure, muscle weakness, dysphagia (swallowing deficit), cancer of the prostate, cognitive communication deficit, atrial fibrillation, and history of falls. Review of the facility admission skin total body eval dated 12/27/24, revealed numerous bruises and scratches, however no documentation of any pressure ulcers was found. No coccyx stage III pressure ulcer was documented by staff. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observation of the resident's coccyx pressure ulcer dressing change was done on 1/21/25 at 11:00 a.m., Nurse, LPN N did the dressing. When Nurse N went to take the dressing off his coccyx area, there was no dressing. Nursing Assistant/CNA O stated I took it off earlier, it had BM on it. The CNA did not inform the nurse when she removed the coccyx dressing. The resident had a large stage III pressure ulcer on his coccyx area; he complained of pain and discomfort during the application of a dressing. Review of the resident's shower sheets done on 1/22/25, revealed only 1 shower sheet available that was filled out for the resident from his admission to discharge. Nurse Manager, RN H and the Director of Nursing looked for additional shower sheets, however no other sheets were available. Review of the resident's only shower sheet dated 1/14/25, revealed no documentation of any pressure ulcers and stated, No skin concerns. Review of the physician order dated 1/6/25, stated House zinc paste every 12 hours for reddened coccyx. Review of the facility at risk for alteration in skin integrity care plan dated 12/30/24, revealed staff were to observe skin condition with ADL care daily; report abnormalities. Review of the facility actual skin impairment care plan dated 1/14/24, and nursing notes dated 1/14/24, revealed the resident had developed macerated skin on the coccyx area, and staff were to do weekly treatment documentation (including measuring). Review of the physician order dated 1/20/25, stated Cleanse area on coccyx with normal saline, apply calcium alginate to wound bed, cover with abd (dressing) secure with tape, z guard to surrounding areas of maceration. Review of the physician order dated 1/20/25, stated Order to discharge to ALF on 1/21/25, with skilled home care services including PT/OT, nurse and home health aide. During an interview done on 1/21/25 at approximately 11:40 a.m., Family Member #2 stated every time I come here, he is soiled and wet, he has gone down since he has been here. Family Member #2 revealed the resident did not have any pressure ulcers when he was admitted to the facility. A second observation of the resident was done on 1/21/25 at 11:00 a.m. when he was at the nursing desk waiting to be discharged ; he was complaining about pain in his feet, so Nurse, RN P took him in a private room and evaluated his feet. Nurse P found 2 more pressure ulcers (on both feet) that were not documented prior to 1/21/25 (the day the resident was discharged). Review of the nursing note dated 1/21/25 at 11:00 a.m., stated At approximately 11 am this nurse (Nurse, RN P) was called into room to assess a resident (Resident #76). Upon assessment a area was found on the back of his left heel. This area was approximately 4 x 4 x 0.0, there was no open areas and had approximately .02 area of redness surrounding area (this was a unstageable pressure ulcer per Nurse P verbalization to surveyor, it was a harden black cap (eschar) on top of a pressure ulcer), no odor, no drainage. This nurse also assessed an area on the right foot between the first and second toe and the second and third toe that had a small open area approximately 1 x 1 x .01 small open area in the middle (a small pressure ulcer). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the facility Communication with physician form dated 1/21/25 at 13:46 (1:46 p.m.), stated Area of unstageable eschar (harden black cap over pressure ulcer) was found on the left heel. A small open area between the first and second toe and between the second and third toe. During an interview done on 1/21/25 at 11:15 a.m., Nurse P stated I would of checked (the resident for pressure ulcers and wound abnormalities) more frequently then weekly. 37668 Resident #332: On 1/22/25 at 9:19 AM, an observation occurred of Resident # 332 in their room. The Resident was sitting in bed with a meal tray on the overbed table in front of them. The Resident's heels were positioned directly against the bed. When spoke to, Resident #332 made eye contact but did not engage when asked questions. On 1/22/25 at 10:32 AM, Resident #332 was observed sitting in a Broda chair (reclining, high back wheeled chair with solid, padded leg and footrests). Resident #332 was visibly upset and crying and their lower extremities and heels were positioned directly against the solid leg/footrest of the chair. A Hoyer (mechanical lift) sling was under the Resident in their Broda chair. Record review revealed Resident #332 was a [AGE] year-old individual who was admitted to the facility on [DATE] with diagnoses which included cerebral infarction (stroke) with right sided hemiplegia and hemiparesis (one sided paralysis), Multiple Sclerosis (MS), aphasia (impaired ability to understand language and express speech), and Deep Tissue Injury (DTI) pressure ulcers (wound caused by pressure with unknown depth) on their left ankle and both heels. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required maximum to total assistance with transferring, mobility, toileting, bathing, and dressing. The MDS further detailed the Resident had three unstageable DTI pressure ulcers. Review of Resident #332's Electronic Medical Record revealed a Care Plan entitled, At risk for alteration in skin integrity related to: currently has 3 DTI's admitted with, incontinence, and immobility (Initiated: 12/31/24). The care plan included the interventions: - Elevate heels as able (Initiated: 12/31/24) - Encourage and assist as needed to turn and reposition; use assistive devices as needed (Initiated: 12/31/24) - Use pillows/positioning devices as needed (Initiated: 12/31/24) A second care plan entitled, Resident has Deep Tissue Injuries to right heel, right ankle, left heel (Initiated: 12/31/24) was also present in Resident #332's EMR. This care plan included the interventions: - Administer treatment per physician orders (Initiated: 1/3/25) - Heel Protectors (FYI) (Initiated: 12/31/24) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/23/25 at 7:30 AM, Resident #332 was observed sitting near the nurses' station with a blanket over their head. The Resident did not respond when spoke to. Their lower extremities and heels were positioned directly against the leg/footrest of the Broda Chair. A Hoyer (mechanical lift) sling was under the Resident in their Broda chair. At 9:41 AM on 1/23/25, Resident #332 was observed sitting in the same place near the nurses' station and in the same position in their Broda chair. Certified Nursing Assistant (CNA) CC took Resident #332 to their room to complete incontinence care with CNA BB and an observation of care was completed. When queried how long Resident #332 had been sitting up in their Broda chair, both CNA BB and CNA CC stated, Been up since before we got here. When asked what time they started work, the staff revealed they start at 6:00 AM. When queried if they had repositioned the Resident in their Broda chair since they started work at 6:00 AM, both staff verbalized this was the first time they had provided care to the Resident today. Resident #332 was noted to have dressings in place to both their heels/ankles. During care an open wound was observed on the Resident 's left coccyx. The center of the wound was red, and the surrounding tissue was white in color. The removed brief had bright red blood where it had been positioned against the wound. When queried, CNA CC and CNA BB stated the area had healed and had reopened. A second open wound was observed towards the back of the Resident's left mid upper thigh. This wound bed was red in color with the first layers of skin gone, elongated, irregularly shaped, and larger than a quarter in size. When queried regarding the wound on the Resident's thigh, both CNA's verbalized the area was new. The location of the open wound on the Resident's left thigh correlated with the location of the Hoyer sling was positioned for transfer. When queried if the wound was located where the sling had been positioned, both CNA CC and CNA BB confirmed it was. CNA CC stated the Resident may need a bigger sling because it's digging in. At 10:00 AM, the Resident's assigned Nurse was unable to be located, and Unit Manager Registered Nurse (RN) B was asked to come to the room. RN B entered the room to observe the wounds. RN B verbalized the open area on the Resident's coccyx was caused by moisture and indicated they would obtain cream to apply to the area. When queried regarding the area on the Resident's left upper/mid-thigh, RN B confirmed the area was new. When asked if the wound was caused by the Hoyer sling, RN B did not provide a direct response but indicated it was possible. RN B exited the room at this time and returned with the Director of Nursing (DON). The DON revealed they were going to apply a dressing to the new wound on the Resident's left upper/mid-thigh. Review of documentation in Resident #332's EMR revealed the following: - 12/31/24 at 4:00 PM: Admission Evaluation . Clinical Evaluation Integumentary (Skin) . abnormality . Right buttock: 3.5 x 2.5 cm (centimeter) pink/white area . Left Heel: 5 x 4 cm eschar to inner heel, 4 x 4 (cm) dark area lateral outer heel . Right heel: 5 x 6 cm blister filled area to inner heel . Other: Dark skin on left outer ankle . - 1/1/25 at 9:03 AM: Physician Team - Progress Note . Sacral decub (Pressure Ulcer) at level 3 (full thickness tissue loss). Right heel blister . Sacral decub is stable. Right heel is stable. Both medial and lateral malleolus, eschar of the right heel . Skin and Wound: Intact . - 1/10/25 at 11:46 AM: Physician Team - Progress Note . Left heel skin damage . Skin and Wound: Intact . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Upon request for all Resident #332's pressure ulcer wound documentation, the facility provided documentation related to the Rear Left Malleolus (ankle), Lateral (side) DTI and Rear Right Malleolus DTI. No documentation was provided for the sacrum pressure ulcer identified in the Physician note on 1/1/25 and/or any other pressure injuries. On 1/23/24 at 11:44 AM, Resident #332 was observed sitting alone by the wall in the [NAME] Hall, near the nurses' station, in their Broda Chair. The Resident's lower extremities and heels were positioned directly against the leg/footrest of the Broda chair. An interview was completed with the DON on 1/23/25 at 12:24 PM. When queried regarding the new wound identified on Resident #332's left upper/mid-thigh, the DON stated, I put a border gauze on it. A review of the Resident's EMR at this time revealed the open area had been documented as MASD (Moisture Associated Skin Damage). When queried how the area was MASD when it was not an area covered by a brief and not in an area prone to moisture, the DON replied, I have to chose something to put it (wound) in (the EMR) and we will change it after the wound nurse evaluates it. When queried if the wound was caused by rubbing from the Hoyer sling, the DON stated, I am doing an investigation. The DON was asked if the open wound was in the area where the Hoyer sling would rub/apply pressure and did not provide a response. When queried how often Resident #332 should be turned and repositioned in their Broda chair, the DON did not provide a direct response. When queried regarding observations and staff interviews revealing the Resident had not been repositioned for approximately four hours, no explanation was provided. Review of Resident #332's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for January 2025 revealed the following: - Skin prep to blister on right heel every 12 hours for Blister (Start Date: 1/1/25 at 9:00 AM). The TAR was blank, indicating the treatment was not completed on 1/9/25 at 9:00 AM and 1/12/25 on 9:00 AM. - Skin prep to Dark spot Lateral heel and Dark spot on lateral heel every 12 hours for Wound care (Start Date: 1/1/25 at 9:00 AM) The TAR was blank, indicating the treatment was not completed on 1/9/25 at 9:00 AM and 1/12/25 on 9:00 AM. - Betadine to Eschar to left inner heel, wrap with ABD pad every day shift for Wound care (Start Date: 1/1/25 at 6:00 AM). The TAR was blank, indicating the treatment was not completed on 1/9/25, 1/12/25, 1/13/25, and 1/15/25. - Boarder dressing to right buttock, ever 2 days and as needed every day shift every 2 day(s) for Wound care (Start Date: 1/1/25). The TAR was blank, indicating the treatment was not completed on 1/3/25, 1/9/25, 1/13/25, 1/13/25, and 1/15/25. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Left heel DTI apply skin prep daily every day shift for DTI (Start Date: 1/3/25). The TAR was blank, indicating the treatment was not completed on 1/9/25 and 1/12/25. -Left outer ankle-DTI-apply skin prep daily every day shift for DTI (Start Date: 1/3/25). The TAR was blank, indicating the treatment was not completed on 1/9/25 and 1/12/25. - NO: Zinc hose paste to sacral area daily and prn (as needed) for MASD every day shift for MASD (Start Date: 1/3/25). The TAR was blank, indicating the treatment was not completed on 1/9/25 and 1/12/25. - Right Hell (sic) -apply skin prep daily DTI every day shift for DTI (Start Date: 1/3/25). The TAR was blank, indicating the treatment was not completed on 1/9/25 and 1/12/25. On 1/23/25 at 1:34 PM, an interview was completed with RN B. When queried if staff should document resident refused in the EMR if a Resident refuses care and/or treatment, RN B indicated they should. When queried regarding observations of Resident #332's heels/lower extremities being positioned directly against the leg/footrests of their Broda chair, RN B did not provide a response. When asked why the Resident did not have heel boots in place as per their care plan, RN B stated, I will discuss with (the DON). Review of the facility Skin and Wound procedure dated 3/20/24, revealed staff were to do weekly skin checks. Review of the facility Skin and Wound Guidelines Policy dated 3/20/24, stated Body audits are completed: BY licensed nurse routinely and documented in the resident's electronic medical record. By the nursing assistant during scheduled baths/showers (twice weekly showers), and if indicated during routine daily care. The nursing assistant will inform the licensed nurse of any new areas of skin breakdown for evaluation and documentation. Pressure Ulcer: Localized damage to the skin and underlying soft tissue, usually over a bony prominence or related to a medical or other device. Can be present as intact skin or an open ulcer and may be painful.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview, record review, the facility failed to implement and operationalize policies and procedures to ensure safe care and maintenance of PowerMidline (intravenous (IV) catheter inserted in the arm with the tip of the catheter positioned near the axillary for long term IV treatment) use and care per professional standards of practice and manufacturer's recommendations for one resident (Resident #61) of one resident reviewed, resulting in improper IV medication reconstitution, inappropriate PowerMidline flushing technique, lack of infection control standards, and the potential for infection, phlebitis (inflammation in vein), embolism (blockage in blood vessel), infiltration (medication administration into surrounding tissue), unnecessary pain and decline in overall health. Findings include: Resident #61: On 1/22/25 at 9:21 AM, Resident #61 was observed sitting in a recliner in their room. An interview was completed at this time. An IV pole and pump with a bag of Cefepime (antibiotic) 1 gram hanging on the pole and the IV tubing was fed through the pump. The tubing was not connected to the Resident and the IV antibiotic bag was empty. When queried regarding the IV pump and medication, Resident #61 pulled up the left sleeve of their shirt to display a PowerMidline. A sticker was present on the midline which specified the dressing was due to be changed 1/28. When queried regarding the midline, Resident #61 verbalized they recently returned to the facility from the hospital and needed ongoing antibiotics. With further inquiry, Resident #61 verbalized the midline was inserted at the hospital. Resident #61 was asked the reason they were receiving IV antibiotics and stated they had a UTI (Urinary Tract Infection). When queried regarding nursing staff care of the midline IV catheter, Resident #61 verbalized facility nursing staff have administered their IV medication but have not done anything with the PowerMidline dressing. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 3:07 PM, a medication pass observation for Resident #61's IV antibiotic was completed with Licensed Practical Nurse (LPN) Z. The Cefepime 1 gram was in a Duplex (dual-chamber IV bag, prefilled with diluent in the upper chamber and medication in the lower chamber) IV administration container. LPN Z did not reconstitute the medication (to reconstitute a Duplex IV medication, the sticker is removed from the drug chamber and the top chamber containing the diluent solution is folded down. The seal between the chambers is squeezed to release the diluent solution into the medication. The Duplex bag is then shaken and checked to ensure there is no particulate matter) prior to entering Resident #61's room. Upon entering Resident #61's room, Resident #61 was observed sitting in their recliner. LPN Z obtained the IV pole with tubing and moved it next to the Resident. The tubing was dated 1/21 but did not include a time. LPN Z did not bring new IV tubing into the room. When queried how long IV tubing is able to be used, LPN Z revealed the tubing is changed daily and is able to be used for 24 hours. When queried how they knew when the tubing was due to be changed as the sticker on the tubing did not have a time, LPN Z stated, The other nurse just hung it this morning. When queried why the tubing was dated 1/21/25 if it was hung this morning, LPN Z responded that the other nurse must have put the wrong date on the tubing. LPN Z then spiked (inserted the IV tubing into the Duplex IV medication administration bag) the IV Cefepime with the IV tubing. LPN Z was not observed reconstituting and shaking the IV medication in the Duplex bag to ensure it was dissolved prior to spiking. When asked if they had mixed the IV medication in the Duplex container, LPN Z stated, Yes, you just didn't see me. LPN Z stated they were able to break the seal on the IV medication bag quickly because they were strong. LPN Z did not shake the Duplex bag, nor did they check to ensure the medication and diluent had mixed. LPN Z proceeded to wipe the top of the Luer lock connection port on Resident #61's midline catheter with an alcohol pad three times across the top of the connection port in a straight motion. LPN Z immediately began to attach a 10 milliliter (mL) Normal Saline (NS) flush to the connection port without allowing the connector hub to dry. LPN Z was stopped and asked what the facility policy/procedure was related to disinfection of IV catheter hubs prior to access and indicated they wipe with an alcohol pad. When queried if the facility utilizes the Scrub the Hub procedure, LPN Z responded that they didn't know what that meant. When asked if they are supposed to clean or scrub the connection port in a twisting motion and around the side of the Luer lock connection port where the IV flush and tubing attach to the midline per facility policy/procedure, LPN Z stated they wiped the top of the port and verbalized that was the method they always used. When asked how long they are supposed to clean or disinfect the port for, LPN Z revealed they did not know. When asked if the Luer lock connection should be allowed to dry after wiping with an alcohol pad prior to connecting the flush and/or tubing, LPN Z responded, I don't know. Is it? LPN Z then proceeded to attach the 10 mL flush to Resident #61's midline and began flushing the line using a continuous flush technique. LPN Z was not observed checking for blood return. LPN Z was stopped and asked if they had checked for blood return and stated, Yes, you just didn't see me. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN Z was asked to check for blood return and was observed pulling back on the flush syringe. No blood return was present. When queried if they observed blood return when the checked previously, LPN Z stated, No there was no blood, but I checked. When queried if blood return should be observed, LPN Z replied, Did not need to be. LPN Z resumed flushing the midline using a continuous technique. When asked if they are supposed to use a pulsating technique when flushing a midline, per facility policy/procedure, LPN Z verbalized they did not know what a pulsating technique was. LPN Z was asked if Resident #61's midline was positional and responded that they did not understand the question. When queried if blood return was observed when flushing the midline if the Resident's arm was moved to a different position, LPN Z verbalized they were unaware that extremity positioning may affect blood return when flushing a midline. LPN Z then began to connect the IV tubing to the midline port. LPN Z was stopped and asked if IV medications should be infused and administered via a midline when blood return is not present and stated, Yes. LPN Z further elaborated they had been a nurse for [AGE] years and had never been told that they could not infuse medication in a midline without blood return. When asked what the facility policy/procedure was in relation to infusion of IV medication via a midline when blood return is not present, LPN Z responded they did not know. When queried if they had administered Resident #61's IV medication and/or flushed their midline previously, LPN Z responded they had not. LPN Z then revealed (Registered Nurse [RN] P) had assisted them with medication pass and administered the Resident's morning dose of IV antibiotic. When queried if they received any information from (RN P) and/or in nurse-to-nurse report related to not receiving blood return when flushing the Resident's midline, LPN Z responded they had not. LPN Z was then asked if the Resident's Physician was aware there was no blood return when flushing the midline and stated they didn't know. When queried why blood return is checked when flushing a midline, LPN Z was unable to provide any reasons and/or clinical rationale. LPN Z was then asked to review the facility policy/procedure prior to administering the medication. LPN Z exited the room at this time. LPN Z returned to the Resident's room on 1/22/25 at 3:58 PM. LPN Z stated they spoke to the Director of Nursing (DON) and called Resident #61's Physician. LPN Z verbalized the Resident's Physician ordered portable X-ray to confirm position of the midline prior to administering the IV antibiotic medication. With further inquiry regarding facility policy/procedure related to care and use of midline IV lines including cleaning/disinfection of the connection hub and assessment for blood return, LPN Z stated, I didn't know any of that. Record review revealed Resident #61 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included acute cystitis (bladder inflammation often caused by bacterial infection), Transient Ischemic Attack (commonly called a mini-stroke), diabetes mellitus, and orthostatic hypotension (decrease in blood pressure with positional change) Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and completed all Activity of Daily Living (ADL) activities independently with the exception of supervision to moderate assistance with ambulation and tub/shower transfers. Review of Resident #61's Electronic Medical Record (EMR) revealed the Resident was transferred to the hospital Emergency Department (ED) on 1/17/25 due to a change in condition and returned on 1/21/25. Review of Resident #61's Electronic Medical Record (EMR) revealed a care plan entitled, Potential for complications at midline insertion site. Inserted in left arm (Initiated: 1/21/25). The care plan included the interventions: (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dressing change by physician order and prn (as needed) if soiled or wet (Initiated: 1/21/25) - Flush IV line per physician orders (Initiated: 1/21/25) - Report to physician signs & symptoms of infection/infiltration such as redness, swelling, drainage, tenderness to touch, or fever (Initiated: 1/21/25) Review of Resident #61's Health Care Provider (HCP) orders revealed the following: - Cefepime . Use 1 gram intravenously three times a day for UTI with hematuria growing provedentia (bacteria) for 13 Days (Ordered and Start: 1/21/25; End Date: 2/3/25; Discontinued: 1/22/25) - Cefepime . Use 1 gram intravenously every 8 hours for UTI with hematuria growing provedentia (bacteria) for 13 Days (Ordered: 1/22/25; Start: 1/22/25; End Date: 2/4/25) - Change IV Midline Tubing Daily one time a day for safety monitoring (Ordered: 1/22/25; Start Date: 1/23/25) - IV Midline: Change Dressing (location): left arm as needed for safety monitoring (Ordered and Start: 1/22/25) - IV Midline: Change Dressing (location): left arm every day shift every Mon for safety monitoring (Ordered: 1/22/25; Start Date: 1/27/25) - Monitor IV insertion site for signs & symptoms of infection every shift (Ordered and Start: 1/22/25) There was no HCP order pertaining to flushing the midline IV catheter in Resident #61's EMR. An interview was conducted with RN P on 1/23/25 at 11:44 AM. When queried if they administered Resident #61's IV antibiotic on 1/22/25, RN P confirmed they had. When asked if blood return was noted when they flushed the midline, RN P stated, Yes, but I had to reposition. RN P then stated, I would not have administered (the medication) if I didn't (get blood return). An interview was completed with the Director of Nursing (DON) on 1/23/25 at 12:24 PM. The DON was informed of observations during Resident #61's medication pass with LPN Z. When queried regarding the observations, the DON did not provide further explanation. Review of facility provided policy/procedure entitled, Catheter Insertion and Care: Flushing Central Venous and Midline Catheters (Revised: July 2016) revealed, Policy . Flushing Technique . 2. Use a push-pause or pulsing motion for flushing technique. 3. Aspirate for blood return to confirm patency prior to administration of medications and solutions . (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of DUPLEX(R) Container Directions for Use ([NAME] Medical, 2023) revealed, Reconstitute: Unfold the DUPLEX Container and point the set port in a downward direction. Starting at the hanger tab end, fold the DUPLEX Container just below the diluent line, trapping all air above the fold. To activate, squeeze the folded diluent chamber until the seal between the diluent and powder opens, releasing diluent into the drug powder chamber. Shake the diluent-powder mixture until the drug powder is completely dissolved. Visually inspect the reconstituted solution for particulate matter . Administer . Starting at the hanger tab end, fold the DUPLEX Container just below the solution line, trapping all air above the fold. Squeeze the folded DUPLEX Container until the seal between the solution and set port opens, releasing solution to set port. Using aseptic technique, remove the foil tab cover from the set port and attach sterile administration set . Review of Bard Access Systems, Inc. How to Care For Your Midline . PowerMidline (Revised 2016) revealed, Flushing your Midline Catheter . It is recommended to: o Flush each lumen of the catheter after every use. Use a 10 mL or larger syringe. o Flush each lumen of the catheter with at least 10 mL of sterile saline, using a pulse or stop/start technique . The PowerMidline (Trademark) Catheter should be flushed after every use, or at least every 12 hours when not in use . The recommended steps in the procedure are . 4. Using friction, clean the injection cap with an alcohol wipe for 10-15 seconds. Allow the cap to air dry - do not touch the cap during this time .

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to provide behavioral health care and services for one resident (Resident #332) of one resident reviewed, resulting in a lack of timely and ongoing assessment of distress related to adjustment, timely evaluation for consent to receive behavioral health services, and expressions of emotional and psychosocial distress. Findings include: Resident #332: On 1/22/25 at 9:19 AM, an observation occurred of Resident # 332 in their room. The Resident was sitting in bed with a meal tray on the overbed table in front of them. When spoke to, Resident #332 made eye contact but did not engage when asked questions. On 1/22/25 at 10:32 AM, Resident #332 was observed sitting in a Broda chair (reclining, high back wheeled chair with solid, padded leg and footrests). Resident #332 was visibly upset and crying. When asked what was wrong, Resident #332 stated, Wanna go home. Resident #332 only repeated they wanted to go home when asked additional questions and continued to cry. Facility staff were in the area but did not approach, speak to, nor attempt to provide emotional support to the Resident. Record review revealed Resident #332 was a [AGE] year-old individual who was admitted to the facility on [DATE] with diagnoses which included cerebral infarction (stroke) with right sided hemiplegia and hemiparesis (one sided paralysis), Multiple Sclerosis (MS), and aphasia (impaired ability to understand language and express speech). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required maximum to total assistance with transferring, toileting, bathing, and dressing. The MDS further detailed the Resident displayed no behaviors. Review of Resident #332's Electronic Medical Record revealed a Care Plan entitled, At risk for changes in behavior and mood r/t (related to) _____ (blank) (Initiated: 12/31/24). The care plan included the interventions: - Administer medications per physician orders (Initiated: 12/31/24) - Non-Pharmacological Interventions: (Specify) [Blank] (Initiated: 12/31/24) - Encourage resident to attend activities of choice (Initiated: 12/31/24) - Evaluate for physical needs: hunger, thirst, positioning, toileting, pain, cold/warm, etc. (Initiated: 12/31/24) (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A second care plan entitled Resident chooses not to agree with plan of care, may be resistive, refuse, or noncompliant with care or treatment as evidenced by . edema (swelling) to feet. Resident educated on elevating feet throughout day but insists on sitting in wheelchair/Broda Chair related to: Personal Preference (Initiated: 01/14/25). The care plan included the interventions: - Offer reassurance when resident upset, agitated, or confused (Initiated: 01/14/25) - Refer to Social Services prn (as needed) (Initiated: 01/14/25) - Encourage verbalization of needs, fears, concerns, and allow resident time to express self (Initiated: 01/14/25) On 1/23/25 at 7:30 AM, Resident #332 was observed sitting near the nurses' station with a blanket over their head. The Resident did not respond when spoke to. At 9:41 AM on 1/23/25, Resident #332 was sitting in their Broda chair crying. Certified Nursing Assistant (CNA) CC approached the Resident and pushed them back to their room in their Broda chair. Upon entering the Resident's room, CNA BB entered to assist CNA BB to transfer the Resident to their bed and provide incontinence care. Resident #332 continued to cry and was asked what was wrong. Resident #332 stated, Want to go back to my old room. When asked if they had recently moved rooms, Resident #332 continued to cry and repeat that they wanted to go back to their old room. CNA BB and CNA CC were then asked if Resident #332 had moved rooms and verbalized they had. When queried if they knew why, the staff indicated the Resident moved from short to long term care. Resident #332 continued to cry and display signs and symptoms of emotional distress. Resident #332 repeated they wanted to go back to their old room and CNA CC told the Resident they would take them to sit in the other hall when they were done completing care. An interview was conducted with CNA BB on 1/23/25 at 11:16 AM. When queried regarding Resident #332's emotional state and observations of crying, CNA BB revealed the Resident frequently cries and is often upset. CNA BB stated, (Resident #332) was close with a CNA who quit and revealed that former employee was able to calm the Resident. When queried what they do to assist and provide emotional support to the Resident, CNA BB revealed they try to talk to the Resident but it doesn't seem to work and take the Resident to sit in the hallway in the [NAME] Hall. When asked about the Resident sitting in their Geri-chair in the center/nurses' station area of the facility, CNA BB responded that Resident #332 is not supposed to be left alone in their room. When asked why, CNA BB revealed the Resident did not like to be alone in their room. Review of Resident #332's EMR revealed another care plan titled, At risk for falls . (Initiated: 12/31/24) included the intervention Encourage Resident to be in activities or nurses' station when up in wheelchair (Initiated: 1/20/25). A review of Resident #332's census documentation in the EMR revealed the Resident was moved from the [NAME] Hall of the facility to their current room in the St. [NAME] Hall on 1/10/25. Review of documentation in Resident #332's EMR revealed the following: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 1/2/25 at 6:20 PM: Social Work . Late Entry . admissions assessment: The patient was alert and oriented to person and place (A&Ox 2). The initial BIMS assessment conducted by therapy resulted in a score of 6/15, indicating severe cognitive impairment . will continue to monitor for cognitive fluctuations throughout the patient's stay. The patient scored a 7/27 on the PHQ-9, indicating mild current symptoms of depression . no diagnosis of depression or anxiety . SW will continue to monitor the patient's progress and follow up closer to the discharge date for further planning . - 1/8/25 at 3:19 AM (Lock Date): Social Services Admission Assessment . Legal Papers of Authority (Power of Attorney, Guardian, etc.) . None . Initial admission goals . Return to the community . Prior level of function . Independent . - 1/9/25 at 5:51 PM: Social Work . Discharge Planning: The resident has a planned discharge to home on 1/10/25 with skilled home care services . New Durable Medical Equipment (DME) has been ordered, including a Maxi Lift (mechanical lift for transfers), Broda chair, and hospital bed . Transportation was arranged . Discharge Planning Update: The resident's son contacted the facility after 5 PM to inform us that the previously provided discharge address is incorrect. He stated that he still wishes for (Resident #332) to be discharged home despite the change in address and is currently communicating with his daughter and other family members to determine if his mother can be discharged to their home instead . - 1/10/25 at 6:40 PM: Social Work . The planned discharge for the resident was scheduled for January 10th at 2:00 PM, as previously arranged . Prior progress notes documented the social worker's ongoing efforts to obtain the updated discharge address from the family . Attempts were made to contact the family today to obtain the updated discharge address. The son and daughter stated they did not have the address. The son indicated he would be in communication with the insurance company even after explain to him a few time why resident's coverage was being denied. The insurance company reiterated the denial of coverage days and offered a peer-to-peer review. The peer-to-peer review was submitted, and the results were a denial. The family was then contacted in the presence of the billing specialist and the administrator. The available options were explained: 1. Accept the current discharge date and provide the necessary address. 2. Disenroll from the managed care plan and transition to long-term care (LTC) status temporarily. 3. Privately pay for continued care. The SW reiterated the resident's previously expressed desire to be discharged home. The daughter became visibly upset and agitated as the billing specialist explained the options . The resident was informed of the plan change and the LTC process was initiated . - 1/15/25 at 1:31 PM: Nursing - Progress Note . Resident has been crying throughout shift, stating wants to go home. Resident has been on private phone with family, crying. Nurse Practitioner (NP) here and aware - 1/15/25 at 6:01 PM: Physician Team- Progress Note . Late Entry . Patient is being evaluated today for follow up in management of chronic disease . PSYCH: Normal affect and mood for patient baseline . Patient has been tearful still this week; started on antidepressant . Patient was supposed to discharge home last week on 1/10/25 with skilled home care services . however children state they can no longer care for (Resident) around the clock . Review of Resident #332's HCP orders in the EMR revealed Escitalopram Oxalate (Lexapro- antidepression medication) Oral Tablet 5 milligrams (mg) . 1 tablet by mouth at bedtime for depression was ordered and started on 1/15/25. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #332's EMR revealed no documentation that Resident #332 had been seen and/or evaluated by a Mental Health Provider. There were no signed consents and/or documentation of declination for any ancillary services present in Resident #332's EMR and no documentation of incompetency to make medical decisions. An interview was completed with the Director of Nursing (DON) on 1/23/25 at 12:46 PM. When queried regarding observations of Resident #332's tearfulness, emotional distress, and statements regarding wanting to go home and back to their prior room, the DON acknowledged but did not provide a response. When queried if the Resident had been seen by a Mental Health Provider, the DON reviewed and confirmed there was no documentation from a Mental Health Provider in the Resident's EMR. When queried why the Resident had not been evaluated, the DON revealed the Resident's HCP would need to do a referral order. A review of Resident #332's HCP orders revealed no order for evaluation by a Mental Health Provider. When queried what interventions the facility had implemented to assist the Resident, the DON responded that the NP had started an antidepressant medication on 1/15/25. When asked why a medication was initiated but a Mental Health Provider was not considered at that time, no further explanation was provided. An interview was completed with Social Work (SW) Designee DD on 1/23/25 at 2:05 PM. When queried regarding their role at the facility, SW Designee DD revealed they were not a social worker and worked part time under the direction of the corporate SW. SW Designee DD was asked if they had seen Resident #332 and stated, Yes, the last time was related to their discharge. When queried what occurred with Resident #332's discharge, SW Designee DD stated, The facility decided, on the day of planned discharge, to not take (Resident #332) home. SW DD continued, (Resident #332) is long term now. When queried how Resident #332 responded when informed that their discharged home was canceled, SW Designee DD revealed the Resident was very upset. When asked if the Resident was deemed incompetent, SW Designee DD verbalized the Resident made their own decisions. When queried regarding documentation in the EMR indicating the Resident's family was making medical decisions, without the Resident present, when the Resident was competent, SW Designee DD replied the family would have to take the Resident home as they were unable to care for themselves. When queried regarding observations of the Resident crying and stating they want to go home and go back to their old room, SW Designee DD revealed they were aware of the Resident's behaviors. When asked if the Resident had been seen by a Mental Health Provider, SW Designee DD confirmed they had not. When asked if the Resident was going to be evaluated, SW Designee DD revealed the Resident was not on the list for the Mental Health Provider. SW Designee DD was asked about the facility process/procedure related to obtaining consent for ancillary services including Mental Health Provider treatment and revealed a consent/declination form for the service is reviewed with and signed by the Resident upon admission. When asked if the form is only completed when a Resident wants the service, SW Designee DD stated, The form is declination as well as consent and specified the form is completed and signed whether the Resident wants the service or not. When queried where Resident #332's consent/declination form for Mental Health Services was located, SW Designee DD revealed the ancillary services consent/declination form was not completed for Resident #332 because they were planning on going home. When asked why the consent for Mental Health Services was not obtained when the Resident's discharge plan changed, SW Designee DD verbalized it should have been. With further inquiry regarding the Resident being started on an antidepressant, crying and statements, SW Designee DD verbalized the Resident was having a difficult time adjusting to the facility and not being able to go home. SW Designee DD indicated they would speak to the Resident. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy/procedure entitled, Behavior Management Program (Dated: 12/1/2016) revealed, It is the policy of the Facility to assess each resident to determine the need for or continued need for a psychoactive medication. To develop and implement necessary interventions to improve behaviors identified by history or staff, to utilize non pharmaceutical approaches when able and to manage behaviors according to federal/state regulations . 4. Each resident will receive the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. 5. The resident's interdisciplinary care plan must contain interventions (including non-pharmacologic if appropriate) and resident-specific goals for managing behaviors. Plans are to be reviewed and revised at least quarterly and updated as indicated .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures for medication and medical supply labeling, storage, and disposal in one of one medication rooms and two of two medication carts reviewed, resulting in a medication cart being left unlocked and unattended, a lack of dating of medications with specified time frames for use after opening, expired medications, open and undated medications, and the potential for residents to receive medications with altered efficiency. Findings include: On 1/22/25 at 2:04 PM, Licensed Practical Nurse (LPN) Z was observed walking away from a medication cart in the hallway near room [ROOM NUMBER] towards the nursing station and medication room at the other end of the hallway. The medication cart was left unlocked. While the medication cart was left unlocked and unattended, a different staff member walked down the hall to the cart but did not lock the cart. At 2:09 PM on 1/22/25, LPN Z was observed walking down the hall, towards the medication cart. When LPN Z reached the cart, they were asked if the cart was unlocked. LPN Z did not respond verbally but locked the cart. LPN Z was asked if medication carts are supposed to be locked when unattended, LPN Z confirmed they were and stated, You distracted me. When asked if they had time to complete a tour of their medication cart, LPN Z indicated they did. A tour of the St. Joe's Men's Hall medication cart was completed with LPN Z at this time. The following items were present in the cart: - Open and undated foil pouch of Ipratropium/Albuterol 0.5 mg (milligram)/3 mg inhalation solution for Resident #41. One vial was loose and not contained in a foil pouch. When queried if the medication needed to be labeled with the date opened per facility policy/procedure and how long the medication was able to be used after being opened, LPN Z revealed the medication was not dated when opened and was able to be used until the expiration date. The manufacturer recommendations for Ipratropium/Albuterol 0.5 mg/3 mg inhalation solution specified the medication vials should be protected from light, kept in the protective foil pouch until use, and used within a week once opened. - Earwax Removal Kit for Resident #65. The kit was dated as opened 12/18/24 and expired in 10/2024. - Breo Ellipta 100 mcg (microgram)/25mcg inhaler for Resident #25. The inhaler was opened 10/24/24. When queried how long the medication was able to be used for after opened, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The inhaler package clearly specified, Discard 6 weeks after opened . - Breo Ellipta 100 mcg/25mcg inhaler for Resident #25. The inhaler was dated as opened on 12/4/24. - Breo Ellipta 100 mcg/25mcg inhaler for Resident #13. The inhaler was dated as opened on 11/23/24. - Proheal Liquid Wound Recovery, 30 fluid (fl) ounce (oz) container; Open and undated - Insulin Lispro 100 units per milliliter (mL), Opened 11/4/24 for discharged Resident #333 - Atropine sulfate solution 1% eye drops for Resident #36; Opened 1/18/25 The medication insert specified the medication should be discarded 28 days after opening - Atropine sulfate solution 1% eye drops for Resident #32; Opened 9/17/24 - Assure Prism Glucometer Control Solution; Opened 9/17/24 The box specified the solution should be discarded three months after opening the bottle. - Assure Prism Glucometer Testing Strips were observed in the top right-hand drawer of the cart in a medication cup. A testing strip container was not present in the drawer. When queried why the strips were not in the original container, LPN Z replied, There were none in the facility and I had to borrow (glucometer strips) from another cart. LPN Z was asked if they were saying there was no glucometer strips in the entire building, LPN Z verified that was what they were saying. Upon request to complete the narcotic medication count in the cart, LPN Z stated they need to hand an IV (intravenous) antibiotic and indicated they did not have time. An observation of the IV medication administration was completed with LPN Z. Following completion of the medication administration observation, LPN Z was asked to complete the narcotic medication reconciliation in the medication cart. LPN Z stated, I don't have time now and walked away. A tour of the St. Joe's Medication Room was completed on 1/23/25 at 7:28 AM with Unit Manager Registered Nurse (RN) B. The following items were present: - Multiple batteries were stored in the medication refrigerator. When asked if storing anything other than medications in the medication refrigerator, RN B revealed they were not sure and wound need to check the policy. - 100 count box of [NAME] Consult Fecal Occult Blood Tests Kits; Expired: 10/31/24 - Tussin 4 fluid (fl) Ounce (oz); Expired 12/24 - One box of Assure Prism Glucose Control Solution; Expired: 12/7/24 - Ceravite Senior Multivitamin, 60 tablets; Expired: 11/24 - Geri-Kot Senna 8.6 milligram (mg), 200 tablet bottle; Expired: 1/25 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One bottle of Calcium 600 mg with 10 mcg Vitamin D3; Expired: 1/25 - Gericare liquid pain relief- acetaminophen 160 mg/5mL; 16 fl oz container; Expired: 10/24 - Gericare liquid pain relief- acetaminophen 160 mg/5mL; 16 fl oz container; Expired: 1/25 - Staple Remover Kit; Expired: 5/24 A tour of the St. Joe's Women's Medication Cart was completed with LPN AA on 1/23/25 at 8:12 AM. The following items were present in the medication cart: - Azo urinary pain relief supplement, 30 tablets; Expired: 9/24 - Budesonide 0.5mg/2mL inhalation solution opened and undated for Resident #5. The medication information on the foil container specified, Use within 2 weeks after opening. - Cosopt Ocumeter Plus Eye solution, 10 mL container for Resident #4. Opened and undated. While completing the narcotic medication reconciliation for the cart with LPN AA a visibly soiled oral syringe was in a cup along with a container of Morphine Sulfate 20 mg/5mL liquid solution. When queried why the visibly soiled syringe was in the medication drawer, LPN AA stated, We do not have extra. When asked if they were saying the oral syringe placed in the resident's mouth was stored in the medication cart along with other resident's medication, LPN AA confirmed. When queried if the oral syringe is washed and allowed to air dry prior to being returned to the medication cart, LPN AA responded that the syringe did not appear to be washed. Review of facility policy/procedure entitled, Medication and Treatment Storage (Dated 8/7/23) revealed, It is the policy of this facility to ensure accurate labeling and dating of medications and treatments for safe administration and safe and secure storage (including proper temperature controls, appropriate humidity and light controls, limited access/ and mechanisms to minimize loss or diversion) of all medication and treatments . All medications and biological's will be stored in locked compartments . All drugs, which require light protection while in storage/ remain in the original package, in closed drawers or cabinets, or in a specially wrapped manner until the time of administration. Eye/ ear, and nasal drugs and biological's are stored separate from oral medications and topical (external) use medications . Labeling of medications and biological's dispensed by the pharmacy will be consistent with applicable federal and State requirements and currently accepted pharmaceutical principles and practices including expiration dates (when applicable) and with appropriate accessory and precautionary instructions . Medications designed for multiple administrations (e.g., inhalers, eye drops), the label will identify the specific resident for whom it was prescribed. Multi-use vials will be dated when the vial is first accessed. If a multi-dose vial has been opened or accessed (e.g., needle-punctured)/ the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial . Medication, treatments, biological's, and supplies will be maintained per manufacturer guidelines. Expired, discontinued, or deteriorated drugs or biological's will be returned or destroyed per pharmacy return/destruction guidelines .