STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235281	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearstream Rehabilitation and Nursing Center	240 E North St Hastings, MI 49058

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to ensure residents were cared for with dignity and respect for 1 (Resident #54) of 2 residents reviewed for dignity, resulting in the potential for feelings of embarrassment, frustration, depression, and loss of self-worth and an overall deterioration of psychological well-being. Findings include: Resident #54 Review of an Minimum Data Set (MDS) assessment revealed Resident #54 was originally admitted to the facility on [DATE] with pertinent diagnoses which included diabetes. Review of an MDS assessment for Resident #54, with a reference date of 2/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #54 was cognitively intact. During an interview on 3/31/25 at 1:48 PM, Resident #54 reported that she was frustrated with how some of the staff interacted with and talked about residents. Resident #54 reported that a few days ago, she had overheard Certified Nursing Assistants (CNA) P and Q in the hallway making fun of a resident. Resident #54 reported that she had heard one of the CNA's ask the resident if he ever showered, and that the resident smelled like fish. Resident #54 reported that she was very upset by this so she reported it immediately to Unit Manager (UM) CC. Resident #54 was not able to confirm which resident staff were talking to, since she overheard it from her room, but she reported that she was still very upset because it just bothered me hearing staff talk about us like that. Resident #54 reported that the way that staff interacted with residents was on ongoing problem, and that she had reported it to management on several occasions. During an interview on 4/2/25 at 10:29 AM, Social Services Director (SSD) GG reported that Resident #54 had reported concerns to her before about the way that staff treated her. SSD GG reported that she felt like Resident #54 typically had concerns with agency staff, and she had never looked into the concerns reported to her by Resident #54 before because usually the agency staff never come back after the concerns are reported. SSD GG confirmed that Resident #54 had reported concerns to her related to overhearing staff talk about residents in the hallway. SSD GG reported that she thought that those concerns were being addressed by the nursing team. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/25 at 12:28 PM, UM CC reported that Resident #54 did recently report concerns related to how staff were talking about a resident. UM CC reported that Resident #54 was unable to report the correct name of the resident that she thought staff were talking about, so she did not investigate that concern further. UM CC confirmed that Resident #54 had overheard the staff talking from her room, so she did not see which resident room the staff were in at the time. UM CC reported that she had talked to CNA P and Q that night and told them to keep their voices down and make sure that people could not hear them. UM CC confirmed that she did follow up with any of the residents on the hall to see if they had concerns with how staff were treating them, or investigate the concern further. UM CC confirmed that she did not report this concern to the Nursing Home Administrator (NHA) or the Director of Nursing (DON), but that she did report the concern to the Assistant Director of Nursing (ADON). During an interview on 4/02/25 at 2:12 PM, CNA P reported that she had been accused of talking loudly and inappropriately in front of residents recently and had been talked to by UM CC about this. CNA P reported that UM CC had told her that she needed to be quiet, and that she needed to stop talking about residents. CNA P reported that she did not know why UM CC had talked to her, and that she did not elaborate on what had been reported to her. CNA P reported that she had ongoing concerns with how staff treated residents. CNA P reported that she did not say anything that she felt was inappropriate on the night that UM CC talked to her. CNA P reported that she had ongoing issues with Resident #54, and that Resident #54 had reported concerns about her to the nurse that night, but she did not know why. During an interview on 4/2/25 at 2:23 PM, CNA Q reported that she had recently been talked to by UM CC along with two other CNA's about being quiet and not talking about residents. CNA Q reported that she had overheard CNA P and CNA WW talking about a resident while in a resident room. CNA Q reported that she heard one of the CNA's discussing that the resident was incontinent (lack of control of bladder or bowels), being lazy, and that the resident smelled bad. CNA Q reported that she was not sure which staff member said this about the resident, but that one CNA said it and the other agreed. CNA Q was unable to confirm which resident room the staff were in so she did not know which resident the CNA's were discussing. During an interview on 4/2/25 at 2:29 PM, ADON C reported that she had been made aware of Resident #54 reporting a concern to UM CC. ADON C reported that she was unaware of the details of the concerns reported to UM CC. ADON C reported that she did not investigate the concern further because she thought that UM CC had handled it. ADON C confirmed that she had issues with CNA P and CNA WW in the past related to how they were caring for residents. During an interview on 4/2/25 at 3:25 PM, DON B reported that he had not been aware of the concern that Resident #54 had reported to UM CC. DON B confirmed that UM CC should have reported this concern to him, and that the facility should have looked into this concern further. On 4/1/2025 at 1:43 PM, this writer requested grievance forms from Resident #54 from the last 3 months. The facility did not provide any grievance forms for Resident #54 prior to survey exit. Review of an Educational Opportunity form dated 4/26/18 for CNA P revealed, Educational Prompt: (CNA P) raised voice at a resident stated If you want my job stay here until 10. I'm not dealing with it. Then slammed the door

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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 an updated and accurate advanced directive information was in place for 1 of 19 residents (Resident #338) 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 #338 Review of an Admission Record revealed Resident #338 was originally admitted to the facility on [DATE] with pertinent diagnoses which included hypertension (high blood pressure). Review of Resident #338's Designation of Patient Advocate Form dated 7/23/24 revealed Resident #338 had designated Family Member (FM) RR as her patient advocate to act in accordance with her end of life decisions .2. Specific Instructions Regarding Life-Sustaining Treatment: I understand I do not have to choose one of the instructions regarding life sustaining treatment listed below. If I choose one, I will sign below mu choice. Choice 1: I do not want my life to be prolonged by providing or continuing life sustaining treatment if any of the following medical conditions exist: I am in an irreversible coma or persistent vegetative state. I am terminally ill and life-sustaining procedures would serve only to artificially delay my death. Under any circumstances where my medical condition is such that the burdens of treatment outweigh the expected benefits. In weighing the burdens and benefit of treatment, I want my Patient Advocate to consider the relief of suffering and the quality of my life as well as the extent of possibly prolonging my life. I understand that this decision could or would allow me to die. If this statement reflects your desires, sign here. This was signed by Resident #338. Review of Resident #338's Determination of Inability to Participate in Complex Decision Making form dated 8/28/24 indicated that Resident #338 had been evaluated and was deemed unable to make medical treatment decisions, and that FM RR Durable Power of Attorney (DPOA) was activated, and FM RR would be responsible for making medical treatment decisions. It was noted that Resident #338 was listed as a Full Code at the facility. Indicating that all life sustaining treatment would be performed on Resident #338 if needed. Review of Interdisciplinary Team (IDT) Progress Note dated 11/5/24 revealed, .Quarterly Care Conference held for Resident. Resident is in facility for long term care. Resident is a Full Code but DPOA would like to change code status to DNR (Do Not Resuscitate) . Review of Resident #338's Progress Note dated 1/24/2025 revealed, Contacted FM RR and does not want any part of medical decision making for resident any longer. Social services notified to address this concern. (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 Interdisciplinary Team (IDT) Progress Note dated 2/4/25 revealed, Resident's DPOA is active and (FM RR) does not want to continue taking responsibility and the process for guardianship will be started . During an interview on 4/2/25 at 8:18 AM, FM RR reported that he had informed the facility that he wanted Resident #338's code status to be DNR. FM RR reported that the facility was supposed to send him the paperwork to change Resident #338's code status, but he never received it. FM RR reported that he had been making the medical treatment decisions for Resident #338, but he lived in another state and it made it hard for him, so he had requested the facility obtain a guardian for Resident #338. During an interview on 4/2/25 at 10:08, Social Services Director (SSD) GG reported that she had been made aware in November 2024 that FM RR wanted Resident #338's code status changed to DNR. SSD GG reported that the facility was supposed to send him the paperwork to sign, but that they did not do this. SSD GG was unable to report why the facility had not sent the paperwork. SSD GG reported that she was also aware that FM RR no longer wanted to make medical treatment decisions for Resident #338. SSD GG reported that the facility had not started the process of obtaining a legal guardian for Resident #338 because she had been sent to the hospital on 2/18/25 and recently returned to the facility. SSD GG reviewed Resident #338's Designation of Patient Advocate Form dated 7/23/24 with this writer and confirmed that Resident #338 did not want life sustaining treatment, which would be indicated under the full code status.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on interview, and record review, the facility failed to notify the responsible party of a change in resident condition in 1 of 2 residents (R7) reviewed for notification of changes, resulting in the guardian/emergency contact not being made aware of an injury of unknown origin (R7) causing the inability to participate in timely medical decision-making. Findings include: According to the Minimum Data Set (MDS) dated [DATE], R7 was moderately cognitively impaired as evidenced by her BIMS (Brief Interview Mental Status) score of 10/15. Her diagnoses included dementia and Alzheimer's disease with no mention of intermittent urinary catheterization. Review of R7's Progress Note dated 3/15/2025 at 00:30 (AM) revealed, . When doing straight cath at this time noted that her labia (inner and outer folds of vulva at either side of vagina) was bruised bilaterally (both sides) and swollen. Had 1/4-inch laceration above urethra (duct that drains urine from body) . During an interview on 4/2/25 at 12:27 PM, Registered Nurse (RN) EE stated, (R7) on 3/15/25 she had to be cathed, when I separated the labia, it was swollen and black and blue and a small scratch like thing above the labia. I asked the nurse from the shift before me about it and said yes the area was swollen and bruised and had not told anyone about it, including family. I told the ADON (Assistant Director of Nursing), who asked me if I had called the family. I did not contact the family. During an interview on 4/2/25 at 12:15 PM, Director of Nursing (DON) B stated,(R7's) Emergency Contact/Resident Representative was not notified on 3/15/25 when the bruising and tear were found.

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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** 38666 Based on observation, interview, and record review the facility failed to ensure 2 rooms (Resident #61's room and the Spa room between C and D hall) were maintained in a sanitary and orderly manner and failed to ensure a home-like dining environment for 1 (the locked memory care unit's dining room; Living Moments Lane) of 2 dining rooms resulting in being unsatisfied, having a dining experience with an institutionalized practice rather than home-like, and the potential for feelings of sadness and/or discontent with one's living environment. Findings include: During an observation on 04/01/25 at 08:36 AM, in the locked memory care unit, residents dining in the unit's dining room at all tables were served their breakfast meals on top of trays that were placed on top of the dining table and left there for the duration of the meal. During an observation on 04/01/25 at 01:14 PM, in the locked memory care unit, residents dining in the unit's dining room at all tables were served their lunch meals on top of trays that were placed on top of the dining table and left there for the duration of the meal. During an observation on 04/02/25 at 08:15 AM, residents were observed in the facility's main dining room (where resident's from the three of the four units could dine at; the other unit is the locked memory care unit) eating breakfast, and meals were not left on the tray. Instead of placing the meal trays on the dining table that held the cup, bowl, plate, and silverware the dining ware items were taken off the tray and placed in front of the resident directly onto the dining table in front of residents. During an observation on 04/02/25 at 08:32 AM, in the locked memory care unit, residents dining in the unit's dining room at all tables were served their breakfast meals on top of trays that were placed on top of the dining table and left there for the duration of the meal. During an interview on 04/02/25 at 09:08 AM, Dietary Director UU reported she doesn't know why the locked memory care unit served the meals on the trays in the dining room but the main dining room doesn't serve that way. Dietary Director UU reported the dietary staff put the food on the trays to be placed in the meal carts to be taken to the units/dining rooms and then nursing staff handle the trays from there. During an interview on 04/02/25 at 09:45 AM, Director of Nursing (DON) B reported meals should not be served on trays on the table in the dining rooms within the facility. DON B confirmed the meals shouldn't be served differently, on the trays on the table in the dining room, of the locked memory care unit. (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 04/02/25 at 10:07 AM, Certified Nurse Aide (CNA) VV reported in the locked memory care unit staff served residents' meals on the trays on the dining room's tables, but in the other part of the building (the dining room where the other three units' residents can dine) food is taken off the trays and put on the table in front of the residents. CNA VV reported this way of serving differently based on the unit was how it has been done and stated, Just doing what I'm told. CNA VV reported she doesn't know why it is done this way in the locked unit but not out in the non-locked dining area of the building. Review of the facility's Meal Service, Nursing Responsibility policy, adopted 7/11/2018, stated, Be courteous and encourage an enhanced, pleasant dining atmosphere. Resident's in the facility's locked memory care unit's are placed there due to impaired cognitive status and therefore during interviews were unable to report if being fed on trays on the dining table bothered them or not, or how they had dined at home prior to admission to the unit. Applying the reasonable person concept, meals served on trays which are placed on the table in front of the diner can increase the institutional feel of the dining environment and make it less home-like. A reasonable person likely would choose to not be served meals on trays in a dining room. 38384 R61 According to the Minimum Data Set (MDS) dated [DATE], R61 was cognitively intact as evidenced by her BIMS (Brief Interview Mental Status) score of 14/15. During an observation and interview on 3/31/25 at 12:15 PM, R61 was awake in bed with her head-of-bed (HOB) at the window. The windowsill track was littered with dead bugs, dust, and debris. The tile sill was cracked and chipped with a large chunk of it missing. The veneer around the bed head board was pulled away from the wood leaving an area large enough to put a hand through. R61 stated, I keep my house neat, tidy, and clean. I would never have my house like this. I have a handyman that helps me at home to keep things fixed. I'm glad I'm going home tomorrow. During an observation and interview on 4/1/25 at 8:00 AM, the window curtain at R61's HOB had a stain the size of a saucer cup at eye level of the resident. R61 stated, I'll be glad when I go home today. I would have stains like this cleaned up. 38905 During a tour of the spa room between the C hall and D hall, with Maintenance Director (MD) DD, at 2:46 PM on 3/31/25, observation found a padded shower chair with stuck on and smeared brown debris. When asked if he could see the accumulation, MD DD, stated yes. Observation of the supply and stock cabinet in the spa room, found black spotted debris on the inside walls of the top left door of the cabinet. Further interview with MD DD found that the facility is planning to do some renovations in the spa room and remove the cabinet at some point.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 This citation pertains to intake MI00150533 Based on interview, and record review, the facility failed to prevent the misappropriation of resident narcotic medications in 1 of 1 residents (Resident #64) reviewed for misappropriation of property, resulting in loss of resident's pain medication, and the potential for uncontrolled pain and discomfort. Findings include: Resident #64 Review of an Admission Record revealed Resident #64 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness. Review of the facility's Drug Diversion Investigation revealed, On Thursday January 23rd at approximately 4:30 PM (Director of Nursing B) received a phone call from (Facility pharmacy) regarding a narcotic discrepancy regarding (Resident #64) Percocet (narcotic) script (prescription) . The pharmacy stated that they had a discrepancy for 20 unaccounted for Percocet . (DON B) was also unable to locate the shift narcotic count sheet for same said script. There was no line item on the count sheet where the medication was removed from count. An audit of all medication carts and their narcotic drawers took place. A Chart review for (Resident #64) was completed looking for the narcotic count sheet. All four medication carts in the building were audited along with the medication room. The medication in question remained unable to be located. On Friday January 24th, 2025, a police report was filed . An audit of all controlled substances on (Facility unit) was conducted to compare narcotic sheet sign outs with MAR charting. Based on this audit, interviews were conducted with two nurses, (Registered Nurse (RN) XX) and (Licensed Practical Nurse (LPN) AA) .(RN XX) was interviewed on Friday January 24th, 2025, at 3 pm. (RN XX) stated that she was unaware of any missing narcotic medications or narcotic count sheets. She was unable to recall what narcotic sheet she signed out the January 17th, 2025, 1900 dose of Percocet that she administered to (Resident #64). (RN XX) was not (sic) on duty when the missing medication was signed in at the facility and she is unable to account for its where about at this time. After the interview (RN XX) took a drug test. It was positive for opioids and oxycodone. At this time (RN XX) was suspended pending further investigation. (LPN AA) was interviewed on Friday January 24th at 3:30 pm. She had not worked on or around the date of the missing medication coming into the facility . At the end of the interview (LPN AA) took a urine drug screen and it was negative. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the investigation it was discovered that on January 20th, 2025, (Facility Medical Doctor (FMD)YY) had sent a script for (Resident #64) Norco (narcotic medication) to the Pharmacy. The Norco script arrived later that evening and was signed for by (RN XX). It was further determined that she failed to add this medication to the shift-to-shift narcotic count sheet. She should have had a narcotic card count of 35 scripts at this time, but she only accounted for 34. On Monday January 27th, 2025, (RN XX) was asked to provide a valid script for her controlled substance, and to come in for a few more questions. (RN XX) provided an undated script for Norco. (DON B) asked if her initials (initials redacted) were the ones on the Norco Narcotic Count sheet for (Resident #64) dated 1/20/25 and she said, yes. When asked why the medication and script was not logged onto her shift-to-shift count sheet, she was unable to provide an explanation and continued to deny having taken any medications from the facility . Conclusion: While the medication is still unable to be located. It is suspected that on January 20th to January 21st during (RN XX) shift she pulled the Percocet card out of the Narc (narcotic) drawer and replaced it with the Norco card script that had just arrived from Pharmacy. This kept the narcotic card count correct, but failed to reflect the addition of the Norco Script and removal of the Percocet Script. Due to the nurse not being able to produce a script for oxycodone, not having an explanation for the missing narcotic card and narcotic sheet and not following procedure with the adding of the Norco script to the narcotic count log, the facility has concluded that the diversion was substantiated. (RN XX) submitted a letter of resignation to (DON B) on Monday January 27th, 2025, effective immediately prior to (the facility) separating employment with (RNXX) . Review of Resident #64's Medication Administration Record revealed that RN XX was the last nurse to document the administration of Percocet for Resident #64 on 1/17/25. During an interview on 4/2/25 at 1:46 PM, LPN AA reported that she had been questioned by DON B regarding missing narcotic medications for Resident #64. LPN AA reported that had talked to Medical Doctor (MD) YY about changing Resident #64's pain medication from Percocet to Norco because in the past the facility had used Norco to treat Resident #64's pain prior to dressing changes, and it always seemed to work well for him. LPN AA reported that Resident #64 had been in and out of hospital a few times around that time with different issues and her first thought was that maybe there was a new medication that was causing some of the side effects Resident #64 reported, so she talked to MD YY and asked to discontinue the Percocet for Resident #64 and try Norco again, which he agreed to do. LPN AA reported that when the Norco prescription was delivered, the nurse that received it should have added the Norco to the count log and then removed the Percocet to destroy. LPN AA reported that the new Norco prescription for Resident #64 was delivered on 1/11/25 and she was not at the facility that day so she did not know what had happened. LPN AA confirmed that she took a drug test at the facility and her drug screen was negative. During an interview on 4/2/25 at 7:49 AM, RN XX reported that she was questioned by DON B in January 2025 because the pharmacy had reported missing medications. RN XX reported that DON B went over the narcotic count sheet with her and asked her if she knew why the medications were missing. RN XX reported that she was unable to answer why there were missing narcotic medications and she did not know what had happened. RN XX was unable to report why the narcotic count card was noted at 34 instead of 35. RN XX confirmed that the facility did ask her take a drug test. RN XX reported that she thought her drug test was only positive for opioids, which was a medication she was prescribed. RN XX reported that she did provide the facility with a prescription for the opioid medication that she took. RN XX reported that she did not know anything else about the investigation because she chose to resign on 1/27/25. RN XX reported that she did not resign because she was being investigated for possible drug diversion. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It was noted that the facility had provided photos of RN XX and LPN AA urine drug screen results in the drug diversion investigation folder. The photos noted that RN XX' urine drug screen showed positive results for opioids and oxycodone and LPN AA urine drug screen was negative. During an interview on 4/2/25 at 2:45 PM, DON B reported that he had completed the investigation into the missing narcotic medications. DON B reported that when he was notified by the pharmacy that there was a discrepancy in the narcotics, he immediately audited the facility carts to try to find the missing medication. DON B reported that when he was unable to locate the missing narcotic, he began an drug diversion investigation. DON B reported that he had noted when he reviewed the narcotic count logs and discovered that RN XX had signed for the the new prescription of Norco for Resident #64, but did not add the new prescription to the count, so the count remained at 34, when it should have been 35. DON BB reviewed the investigation file with this writer and showed this writer the count sheets and where RN XX failed to document the new norco prescription and the removal of the percocet prescription on the narcotic count sheet. DON B reported that Resident #64's order had been changed from Percocet to Norco, so the Percocet should have been removed from the cart, and destroyed by two nurses together. DON B reported that since RN XX could not report why she did not remove the Percocet card from the cart, and since she was the nurse that had signed for the delievery of the Norco, tested positive for opioids and oxycodone and was unable to provide a valid script to support the use of those medications, it was determined that RN XX had diverted the percocet from Resident #64. During an interview on 4/2/25 at 1:13 PM, Consulting Pharmacist (CP) OO reported that she had been notified about the missing narcotics in January 2025. CP OO confirmed that the facility was not able to locate the missing narcotic medication. CP OO reported that nurses were supposed document all new narcotics delivered and removed from the count log, and RN XX had failed to document the delivery of the norco prescription and the removal of the percocet narcotic. CP OO reported that is was pretty easy to track RN XX on the missing narcotics, because she had signed for the delivery of the norco prescription, and she was the last to document the administration of Percocet to Resident #64. CP OO confirmed that she audited the narcotic count logs every month and frequently noted discrepancies in nurses documenting administration of narcotics on the count log but not in the resident's medication administration record. Review of an Disciplinary Action Report for RN XX dated 7/26/24 revealed, Rule Violated: Following Department Policies and Procedures. Describe what happened: Medication were signed out of the narcotic book as given, but were not signed out in the MAR as given. These PRN (as needed) medications must be signed out to ensure the safety for the residents .

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on interview and record review, the facility failed to operationalize its abuse policy and procedure for 1 resident (R7) of 2 residents reviewed for potential sexual abuse, resulting in staff not reporting observations of abuse to the Nursing Home Administrator immediately, potential for further resident to resident observations of abuse to go unreported and uninvestigated. Findings include: According to the Minimum Data Set (MDS) dated [DATE], R7 was moderately cognitively impaired as evidenced by her BIMS (Brief Interview Mental Status) score of 10/15. Her diagnoses included dementia and Alzheimer's disease with no mention of intermittent urinary catheterization. Review of R7's Progress Note dated 3/15/2025 at 00:30 (AM) revealed, . When doing straight cathed (using a device to drain urine from bladder) at this time noted that her labia (inner and outer folds of vulva at either side of vagina) was bruised bilaterally (both sides) and swollen. Had 1/4-inch laceration above urethra (duct that drains urine from body) . During an interview on 4/1/25 at 4:22 PM, Nursing Home Administrator (NHA) A stated, I am the Abuse Coordinator. Today (4/1/25) was the first day I heard about the injury to (R7). (ADON) (Assistant Director of Nursing) C) brought it to my attention. The first staff heard about injury of unknown origin to (R7) was a progress note written 3/15/25. An injury of unknown origin should be reported to me immediately if suspicious in nature. During an interview on 4/1/25 at 4:25 PM, Director of Nursing (DON) B stated, I was called on 3/15/25 at 5:30 AM by the ADON telling me (R7) she read a progress note about (R7) having a bruised swollen labia with a tear. The NHA was not notified by the ADON or myself. During an interview on 4/1/25 at 5:20 PM, Licensed Practical Nurse (LPN) Y stated, I got an order from (Physician KK) to straight cath (R7). While straight cathing (R7), I noticed a red mark by her clitoris (female genital organ) and slight swelling. I told the oncoming nurse (RN EE). I did not report what I saw to the Abuse Coordinator I just talked to the ADON the next morning. During an interview on 4/2/25 at 12:27 PM, Registered Nurse (RN) EE stated, (R7) on 3/15/25 she had to be cathed, when I separated the labia, it was swollen and black and blue and a small scratch like thing above the labia. I asked the nurse from the shift before me about it and said yes, the area was swollen and bruised and had not told anyone about it, including the Nursing Home Administrator/Abuse Coordinator. I told the ADON (Assistant Director of Nursing), who asked me if I had notified anyone, and I did not. Review of facility Abuse Training completion signature page, dated December 2024, RN EE and LPN Y acknowledged they received the training including types of abuse/neglect and to report all allegations and/or suspicions of abuse must be reported to the Administrator or designee immediately. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy Abuse and Neglect dated 7/11/2018, revealed, .It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse . or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations . The administrator is the abuse coordinator in this facility, and is responsible for developing and implementing abuse prevention training curriculum . Identify events, such as suspicious bruising of residents . An injury should be classified as an injury of unknown source when both of the following conditions are met: -The source of injury was not observed by any person, or the source of injury could not be explained by the resident; and -The injury is suspicious because of the extent of the injury or the location of the injury (example: the injury is located in an area not generally vulnerable to trauma) . All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee .REPORTING: all allegations and/or suspicions of abuse/neglect must be immediately reported to the facility Administrator or designee in the absence of the administrator.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview, and record review, the facility failed to update and revise the person centered care plan in a timely manner with appropriate interventions for the prevention of falls for 1 resident (#43) from a total sample of 19 residents, with the potential for physical, mental, and psychosocial unmet care needs and harm. Findings include: .One of the biggest safety challenges is preventing falls .3 of every 4 nursing center residents fall each year . Nursing staff must have the knowledge and skills to prevent injury from falls .Previous falls, diminished strength, gait and balance impairments, medications, Alzheimer's disease or dementia, vision impairment and environmental risk factors .Staffing and organization of care. Inadequate staffing may leave residents who are likely to fall without proper supervision . https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/facilities/ltc/mod3sess3.html Resident #43: Review of an Admission Record revealed Resident #43 was a male with pertinent diagnoses which included lack of coordination, muscle weakness, dementia, and Alzheimer's disease. Review of Care Plan for Resident #43 revised on 12/30/24, revealed, .Resident at risk for falls r/t (related to) stroke, lack of coordination, muscle weakness . with the intervention .Dycem placed under wheelchair cushion for positioning .encourage resident to be in high traffic area when not in bed .Encourage the use of call light. Place call light on edge of bed for placement when up in chair .Administer medications as directed. Refer to current physician orders and/or medication administration record (MAR). Report any abnormal s/sx (signs & symptoms) and adjust plan of care as directed .Keep bed in lowest position when not performing mobility and/or care tasks .Anticipate and meet resident's needs .Ensure Pressure Pad call light is within reach, provide cueing and reminders for use as appropriate with level of cognition .ACTIVITY REVIEW for diversional activities .DROP SEAT (TILT BACK) WHEELCHAIR SEAT to assist in lowering center of gravity . FOOTRESTS ON WHEELCHAIR: RIGHT SIDE .ROOM NEARER TO NURSING STATION . Review of General Progress Note dated 3/11/25 at 12:46 PM, revealed, .This writer was notified by NHA (nursing home administrator) that there was a fall on A Hall. This writer walked into residents' room and observed resident laying on the floor on his Right side next to his bed. Resident was wearing nonskid socks; floor was dry and free of clutter. Was attempting to self-transfer from bed to wheelchair. Asked resident if he was hurting anywhere, denied pain. ROM (range of motion) in all extremities WNL (within normal limits). (Resident #43) was assisted to a sitting position, and head to toe assessment was performed. This writer and CNA assisted resident to standing position, and into his wheelchair. V/S obtained; neuros initiated. PCP, Guardian, and Hospice to be notified . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Incident Report dated 3/11/25 at 12:40 PM, revealed, .This writer was notified by NHA (Nursing Home Administrator) that there was a fall on (Resident #43's) Hall. This writer walked into resident's room and observed resident laying on the floor on his Right side next to his bed. Resident was wearing nonskid socks; floor was dry and free of clutter. Was attempting to self-transfer from bed to wheelchair . Review of Post Fall assessment dated [DATE], revealed, .IMMEDIATE care plan intervention put in place at time of incident: place w/c (wheelchair) at ft (foot) of bed when not in use and be sure floor mat is in place . Review of Fall Risk assessment dated [DATE] at 6:28 PM, revealed, .A. History of Falling: Has the resident ever fallen before? Yes .Impaired Mobility .2. Overestimates or forgets limits .Score: 75 . Note Score of 45 or greater indicated resident was a high risk for falls. Review of General Progress Note dated 3/23/2025 at 11:29 AM, revealed, .Floor nurse reported the following: Happened in resident room CNA passing door observed resident sitting on floor in front of room door. assessed resident. no visible injury noted. denies pain other than usual pain. vs 94/59, 98.8, 113, 20, po2 89% on RA. Active and Passive ROM (range of motion) per usually. Right side upper and lower extremities non-moveable. Left side Active and Passive without pain. assisted resident to standing position, into w\c PCP, POA, and Hospice were notified of the fall. During an observation on 04/01/25 at 08:54 AM, Resident #43 was observed lying in bed, he did not have the fall mat next to the side of his bed. During an observation on 04/02/25 at 09:39 AM, Resident #43 was observed lying in his bed, lights off, and his fall mat was placed in the far right corner of his room folded up near his closet area. Resident #43 was lying sideways in the bed left foot off the side the bed and had his pillow against the window. During an observation on 04/02/25 at 09:59 AM, Resident #43 was observed in bed his fall mat was over in the right far corner still by his closet. In an interview on 04/02/25 at 02:06 PM, Certified Nursing Assistant (CNA) UU reported the CNAs would look at the kardex. This writer and CNA UU reviewed the kardex for Resident #43's safety section there was no intervention for a fall mat. Reviewed the whole kardex and there was no intervention for a fall mat to be used while the resident was in bed. In an interview on 04/02/25 at 10:08 AM, Licensed Practical Nurse (LPN) W reported the fall mat should have been on the side of the bed as he does self-transfer and has had falls previously. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/02/25 02:12 PM, Director of Nursing (DON) B reported he was called to the room by the Nursing Home Administrator as the nurse was on a break. DON B reported it would be ideal for the care plan to be updated by nurse as they were given access to update the care plans. DON B reported the interdisciplinary team (IDT) also met on Fridays each week to review all the falls for the week and the team would review orders, care plans, interventions and determine if therapy needed to get involved, and tried to determine the root cause of the fall. DON B reported he does frequent rounding on the units and checked in with staff and residents to ensure the care plan interventions were being implemented. DON B reviewed the medical record for Resident #43 and determined the intervention for a fall mat to be in place was not in Resident #43's care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on observation, interview, and record review, the facility failed to maintain professional standards of nursing practice and notify the provider of missed medication doses, 2 of 19 residents (Resident #6 and Resident #338) reviewed for professional standards, resulting in missed medications and treatments, and the potential for the worsening of a condition and a delay in treatment. Findings include: 47659 Resident #6 Review of an Admission Record revealed Resident #6 was originally admitted to the facility on [DATE] with pertinent diagnoses which included atrial fibrillation (irregular rapid heart rate that commonly causes poor blood flow). Review of Resident #6's Medication Administration Orders (MAR) revealed, Symbicort Inhalation Aerosol 160-4.5 MCG/ACT (Budesonide-Formoterol Fumarate Dihydrate) (combination inhaler used to treat asthma and chronic obstructive pulmonary disease) 2 puff inhale orally every morning and at bedtime . During a medication administration observation on 4/1/25 at 8:19 AM, Licensed Practical Nurse (LPN) Y was preparing Resident #6's morning medications and reported that she could not find Resident #6's inhaler. LPN Y reported that the inhaler must not have been re-ordered so she would not be able to give Resident #6 her ordered morning dose of the inhaler medication. LPN Y reported that nurses were responsible for re-ordering medications when they were low, and that many of the staff were not good at re-ordering medications. LPN Y reported that is was common for residents to miss medications when they were not re-ordered timely and that she would need to order the medication. During a follow up interview on 4/1/25 at 12:11 PM, LPN Y reported that she did not notify the facility's medical doctor that Resident #6 had missed her morning dose of Symbicort. LPN Y reported that she didn't think it was necessary to contact the facility's medical doctor because it was just an inhaler. Resident #338 Review of an Admission Record revealed Resident #338 was originally admitted to the facility on [DATE] with pertinent diagnoses which included hypertension (high blood pressure). Review of Resident #338's MAR revealed, Coreg Oral Tablet 3.125 MG (Carvedilol) (blood pressure medication). Give 1 tablet by mouth two times a day for HTN (hypertension) hold dose if SBP (systolic blood pressure) less than 90 or HR (heart rate) less than 50. Review of Resident #338's MAR revealed, Enteral Feed Order two times a day for prevent clogging. Flush q12 hours with 60 ml water via PEG (tube inserted into the stomach and used to provide medication and nutrition when a person is unable to eat or drink normally). Start date 4/1/25 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an medication administration observation and interview on 04/01/25 08:00 AM, LPN Y reported that the facility did not have any of Resident #338's medications available because Resident #338 was readmitted to the facility the day before, and she did not know if the nurse that readmitted Resident #338 yesterday had ordered the medications. LPN Y also reported that Resident #338 was readmitted with a peg tube used for tube feeding, but Resident #338 did not have feeding tube orders in place. LPN Y reported that she did not know if Resident #338 was supposed to receive enteral feedings, or flushes for her peg tube, and that she was going to have to ask the Unit Manager about Resident #338's feeding tube. LPN Y reported that she was able to obtain most of Resident #338's medications from the facility's Pyxis (automated medication dispensing system), but that the facility did not have Resident #338's Coreg medication, so Resident #338 would miss her morning dose of Coreg. LPN Y reported that nurses were responsible for ordering medications for residents when they were admitted to the facility as well as re-ordering medications before a resident ran out. LPN Y did not know the process for when nurses were expected to re-order resident medications, and reported she would typically reorder medications when there were 2-3 days of the medication left. During an interview on 4/02/25 at 12:06 PM, Registered Nurse (RN) FF reported that nursing staff at the facility were not good at reordering medications, and residents often missed medications because the facility did not have them. RN FF confirmed that she did not know the policy for re-ordering medications, but that she would reorder them when there were 3-4 days left. RN FF reported that when a resident missed a medication she would use her judgement on if she should notify the provider or not. During an interview on 4/2/25 at 12:12 PM, Unit Manager (UM) BB reported that nurses were responsible for calling the pharmacy when a resident is admitted to the facility to ensure that the medications would be delivered before their next dose is due. UM BB confirmed that nurses were also responsible for reordering medications for residents, and were suppose to order them when the resident had 5 doses remaining. UM BB confirmed that nurses were expected to notify the provider anytime a resident missed a medication. UM BB reported that two nurses were supposed to be review admission orders with a second nurse to ensure accuracy of orders. During an interview on 4/2/25 at 12:36 PM, UM CC confirmed that she was the Unit Manager for the unit that Resident #338 resided on. UM CC reported that she had not been notified by LPN Y that Resident #338 did not have orders in place for her feeding tube. UM CC reviewed Resident #338's electronic medical record (EMR) with this writer and confirmed that the facility had not put orders in place for Resident #338's feeding tube until 4/1/25, which was 24 hours after she was admitted . UM CC confirmed that Resident #338 had missed her feeding tube being flushed on 3/31/25 and the morning flush on 4/1/25. UM CC reported that nursing staff should have followed the hospital discharge orders for Resident #338, and she should have not missed any care for her feeding tube. UM CC confirmed that two nurses were suppose to verify new admission orders for accuracy and to ensure all orders were in place. During an interview on 4/2/25 at 1:46 PM, LPN AA reported that she was the nurse that readmitted Resident #338 to the facility. LPN AA confirmed that she had not put in orders for Resident #338's peg tube, and that she had just looked at the medication orders for Resident #338. LPN AA reported that Resident #338 was admitted back to the facility late in her shift, and she probably missed a few things with Resident #338's admission. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/2/25 at 11:38 AM, Pharmacist PP reported that the pharmacy delivered medications to the facility twice and day, and that they were also available 24 hours a day to drop ship urgent medications the same day. Pharmacist PP confirmed that the pharmacy was able to provide medications via drop ship if the nursing staff called and requested it. Pharmacist PP reported that if a resident was admitted after the cut off times for the daily deliveries, the nurse could call and request a drop shipment to ensure that the resident did not miss any medication doses. During an interview on 4/2/25 at 2:45 PM, Director of Nursing (DON) B reported that the night shift nurses were expected to review the facility's medication carts nightly and reorder any medications that were low. DON B reported nurses were expected to reorder medications when there were 7 doses remaining. DON B reported that nurses were expected to notify the provider anytime a resident missed a medication dose. DON B confirmed that residents should never miss a medication dose because the facility failed to reorder it timely. DON B reported that nurses were expected to ensure medications were ordered for a new admission by requesting a pharmacy drop shipment if needed. DON B reported that nurses were supposed to verify admission orders with a second nurse to ensure accuracy. DON B confirmed that he had several concerns with Resident #338 readmission orders. DON B confirmed that the nurse did not have a second nurse verify the orders, and that tube feed orders were not in place for Resident #338. DON B confirmed that the facility provider should have been notified about Resident #6 missing a dose of her symbicort inhaler. Review of the facility's Medication Order policy last reviewed 8/1/24 revealed, POLICY: It is the policy of this facility that medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Verbal orders are received only by licensed nurses or pharmacists and confirmed in writing by the prescriber. Procedure: .3. If the prescribed medication is not available: Attempt to pull the medication from the Back-up box. If the medication is not available in the back-up box, notify the provider and follow up with directives given.

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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. 38666 Based on observation, interview, and record review the facility failed to ensure facial hair grooming was offered and/or provided and/or clean hair was maintained for 4 (Residents #12, 14, 17, 53) of 6 residents reviewed that were dependent on staff for activities of daily living resulting in unwanted facial hair, debris in hair, appearing unkempt, and the potential for feeling embarrassed or having decreased self-worth. Findings include: Resident #12 Review of Resident #12's most recent brief interview for mental status score, dated 2/19/2025, was scored 5 which indicated Resident #12 had severe cognitive impairment. During an observation and interview on 03/31/25 at 10:57 AM, Resident #12 was seated in her wheelchair in the dining/activity room of the locked memory care unit of the facility, appeared confused, and was unable to answer questions asked by the surveyor. Resident #12 had long white facial hairs over the surface of her chin. The hairs' lengths varied, but many were approximately half an inch in length. During an observation on 03/31/25 at 03:49 PM, Resident #12 was seated in her wheelchair facing the television in the activity/dining room of the memory care unit and her white chin hairs observed remained the same as they had appeared on 03/31/25 at 10:57 AM. During an observation on 04/01/25 at 08:27 AM, Resident #12 was seated in her wheelchair at a table in the activity/dining room of the memory care unit and was observed to have facial hair that presented the way it had during observations made the day prior, 03/31/2025. During an observation on 04/01/25 at 01:34 PM, Resident #12's facial hair remained on her face unshaven and was in the activity/dining room. During an interview on 04/02/25 at 09:30 AM, Director of Nursing B was asked to provide any documentation that would explain why Resident #12's facial hair was not shaven, and no documentation was received before the end of the survey. Review of Resident #12's activity of daily living (ADL) care plan, revised 4/2/25, stated, Resident (#12) has an ADL self-care performance deficit .The resident is Dependent requiring assistance by 1 staff with personal hygiene .This also includes shaving of facial hair . Resident #14 Review of Resident #14's most recent brief interview for mental status score, dated 2/1/25, was scored 3 which indicated Resident #14 had severe cognitive impairment. (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 and interview on 03/31/25 at 10:50 AM, Resident #14 was seated upright in her wheelchair in the dining/activity room of the locked memory care unit of the facility, appeared confused, and was unable to answer questions asked by the surveyor. Resident #12 had long white facial hairs over the surface of her chin and across her entire top lip. The hairs of the upper lip were the length and quantity that presented like a mustache. Facial hair lengths varied, but many were approximately half an inch in length on the chin. During an observation on 03/31/25 at 03:48 PM, Resident #14 was seated in the dining room of the memory care unit and her facial hair presented the same way it had on 3/31/25 at 10:50 AM. During an observation on 04/01/25 at 08:46 AM, Resident #14 was eating breakfast in the dining room of the memory care unit. Resident #14's facial hair presented the same it had as the day prior, 03/31/25. Standing at the entrance to the dining room with Resident #14 approximately 10 feet away at a table her facial hair was clearly visible. During an observation on 04/01/25 at 01:31 PM, Resident #14 was eating lunch in the dining room of the memory care unit. Resident #14's facial hair presented the same it had as earlier that day; 04/01/25 at 08:46 AM. During an observation on 04/02/25 at 08:39 AM, Resident #14 was eating breakfast in the dining room of the memory care unit. Resident #14's facial hair presented the same as it had on 03/31/25 and 04/01/25. During an interview on 04/02/25 at 09:30 AM, Director of Nursing B was asked to provide any documentation that would explain why Resident #14's facial hair was not shaven, and no documentation was received before the end of the survey. Review of Resident #14's activities of daily living (ADL) care plan, revised 9/17/2019, stated, (Resident #14) requires assistance with ADL's. An intervention, dated 4/2/25, stated, PERSONAL HYGIENE: The resident requires hand over hand/Dependent assistance by 1 staff with personal hygiene and oral care. This also includes shaving of facial hair as needed with shower days. During an interview on 04/02/25 at 12:35 PM, family member NN of Resident #14 reported Resident #14 would not have wanted facial hair, would have wanted it shaved, and she had observed Resident #14 ask staff to shave her during a visit in the past, but couldn't recall the date of that occurrence. Resident #17 Review of Resident #17's most recent brief interview for mental status score, dated 2/28/25, was scored 0 which indicated Resident #17 had severe cognitive impairment. (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 and interview on 03/31/25 at 11:05 AM, Resident #17 was seated in her wheelchair in the memory care unit's activity/dining room. She was confused and unable to answer questions asked by the surveyor. Resident #17 had a visible black mustache across the upper lip and long hairs on her chin with varying length. Some chin hairs were approximately one half inch in length. Resident #17 also had brown debris, unknown material, in various areas on the top of her head's hair with most accumulated towards the front of the head. The brown material was on top of the hair and not down at the scalp area. At approximately 8 feet away the brown material across the top of her hair was visible. During an observation on 04/01/25 at 09:11 AM, Resident #17 was asleep in her bed. The facial hair and brown flakes on top of her head's hair was still present as it was observed on 03/31/25 at 11:05 AM. During an observation on 04/02/25 at 08:38 AM, Resident #17 was seated in her wheelchair in the memory care unit's dining room eating breakfast. Her facial hair and debris in her head's hair presented as they had on 03/31/25 and 04/01/25. During an interview on 04/02/25 at 09:30 AM, Director of Nursing B was asked to provide any documentation that would explain why Resident #14's facial hair was not shaven, and no documentation was received before the end of the survey. Review of Resident #17's activities of daily living (ADL) care plan, created 11/27/2024, stated, Resident (#17) has an ADL self-care performance deficit r/t Pervasive Developmental Disorder (also known as autism spectrum disorder; group of developmental delays). Resident #53 Review of Resident #53's most recent brief interview for mental status score, dated 3/26/25, was scored 0 which indicated Resident #53 had severe cognitive impairment. During an observation and interview on 04/01/25 at 08:26 AM, Resident # 53 was seated in her wheelchair in the activity room waiting for breakfast in the locked memory care unit. Resident #53 had many long chin hairs of varying length, with the longest one being approximately an inch in length. The resident was confused and unable to answer questions asked by the surveyor. During an observation on 04/02/25 at 08:39 AM, Resident #53 was eating breakfast in the dining room, seated upright in her wheelchair, and her chin hairs presented as they had on 04/01/25 at 08:26 AM. Review of Resident #53's activities of daily living (ADL) care plan, revised 3/10/2021, stated, Resident (#53) has an ADL self-care performance deficit r/t (related to) dementia. During an interview on 04/02/25 at 08:48 AM, Registered Nurse (RN) FF reported she wasn't aware if Residents #12, 14, 17, and 53 desired having facial hair or not. RN FF reported the staff focus first on getting the bath done and sometimes the facial hair doesn't get addressed. RN FF reported she wasn't aware of any documentation that would have shown refusals/choosing not to have facial hair grooming completed or that would have indicated a preference to have facial hair for Residents #12, 14, 17, and 53. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Shaving policy, adopted 7/11/2018, stated, It is the policy of this facility to improve the resident's appearance. In accordance with the resident's preference. Residents #12, 14, 17, and 53 had severe cognitive impairment and couldn't answer questions regarding if they wanted facial hair or how it made them feel. Applying the reasonable person concept, a female resident, not always but often, wouldn't desire to have facial hair and it potentially could be bothersome and/or cause feelings of embarrassment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 41424 Based on observation, interview, and record review, the facility failed to provide the necessary care and services to prevent, treat, and promote healing of pressure ulcers in 1 of 1 residents (Resident #288) reviewed pressure ulcers, resulting in the potential for delayed healing of pressure ulcers, infection and the development of new ulcers. Findings include: Review of an Admission Record revealed Resident #288 was a female with pertinent diagnoses which included pressure ulcer of right buttock stage 3, pressure ulcer of left ankle unstageable, pressure ulcer of left heel stage 3, chronic venous hypertension with ulcer of bilateral lower extremity (sustained high blood pressure in leg veins leading to open sores or wounds that are slow to heal), and pressure ulcer of other site stage 3. Review of Care Plan for Resident #288 with an initiation date of 3/25/25, revealed the focus, .The resident has cellulitis of the (SPECIFY) r/t (related to) Fragile skin .RLE lymphatic generalized vascular ulcer admission 03.25.25 .LLE lymphatic generalized vascular ulcer admission 03.25.25 .Left lateral foot Unstageable admission 03.25.25 .Right posterior thigh Stage III pressure admission 03.25.25 .Right middle thigh stage III pressure 03.25.25 .Right distal thigh stage III Pressure03.25.25 .Left heel stage III pressure admission 03.25.25 .Right gluteal cleft stage III pressure 03.25.25 admission . with the intervention .Educate the resident that prevention of cellulitis starts with good hygiene. Any breaks in the skin should be reported to staff/MD immediately Give antibiotics for infection and mild analgesics to relieve discomfort as prescribed by Physician. Monitor/document side effects and effectiveness .Identify and document risk factors; peripheral arterial disease, chronic use of steroids, weakened immune system, chickenpox, shingles, or chronic edema . Review of Nursing Admission Screening/History dated 3/20/25 at 4:16 PM, revealed, .L. Skin: 31. Right buttock Pressure .8.0 L x 1.0 W x 0.5 D .35. Right thigh (rear) Pressure .1.5x1.5x0.2 .35. Right thigh (rear) Pressure .2.0x2.5x0.2 .35. Right thigh (rear) Pressure .1.5x 1.5x0.2 .43. Right lower leg (rear) Pressure (no measurements) .50. Left Heel Pressure .0.3x0.3x0.1 .46. Left ankle (inner) Pressure .2.0x2.0 Unstageable . Review of Nursing Admission Screening/History dated 3/20/25 at 4:16 PM, revealed, .M. ADL's/Functional Devices: 1a. Bed Mobility: 2. Assistance of staff . Review of Skin Observation Tool dated 3/31/24 at 9:21 PM, revealed, .4. Patient has NEW alteration in skin integrity? .Yes .Other Specify Pressure Bilateral Lower extre .50. Left heel pressure .32. Left Buttock Pressure .Other Pressure Under Abd Fold .Other Specify Pressure Other Left foot . No measurements were noted in the assessment. Review of Order dated 3/21/25, revealed, .Bilateral boots on while in bed and up in chair as she allows . every day and night shift for Wounds assess skin prior to application and after removal . Review of Kardex dated 4/1/25 at 9:48 AM, revealed, no intervention for bilateral boots. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 03/31/25 at 11:09 AM, Resident #288 was observed in her room, lying in her bed in a supine position. During an observation and interview on 03/31/25 at 02:38 PM, Resident #288 reported the facility had not gotten her up out of bed today, she reported the facility had not gotten her up since her admission, and the staff did not take her to the bathroom even though she was continent; the staff had her use the bed pan. This writer observed Resident #288's feet, and she did not have on bilateral boots for offloading, her legs and feet were placed directly on the bed. Observed both lower legs from just below the knee down to the ankle, both lower legs, heels and feet were wrapped in kerlix gauze dated 3/30/25. In an interview and observation on 04/01/25 09:36 AM, Resident #288 was observed lying in bed, supine position, head of the bed was approximately 60 degrees, and she did not have the bilateral boots on for offloading and her legs were directly on the bed. Resident #288 reported the staff had not placed the bilateral boots on her last night as well. During an observation on 04/01/25 at 1:45 PM, Resident #288 was not observed up in her room, not observed in the hallway or participated in an activity. During an observation on 04/02/25 09:34 AM, Resident #288 was observed lying in bed, she was in supine position, she had her head of bed up approximately 80 degrees and she was eating her breakfast, she had on a gown, and a stocking winter hat. Observed she had her legs on the bed, no bilateral boots, pillows, or other offloading device was noted under her legs/heels. This writer observed light blue boots on the chair by her wheelchair. Resident #288 reported the facility staff did not place the blue boots on her feet last night. Review of General Progress Note dated 3/22/2025 at 12:53 PM, revealed, .Resident with purulent drainage from wounds on left lower leg and left thigh red and warm to touch, also had low grade temp this morning . Review of General Progress Note dated 3/22/2025 at 2:50 PM, revealed, .Talked with (First Name) at (Medical Provider Service) and notified her of purulent drainage and temp. Received order for Keflex 500mg TID (three times a day) x7days . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/02/25 at 11:24 AM, Unit Manager BB performed a dressing change on Resident #288's right lower leg. Resident #288 was observed to not have pillows under her legs and the bilateral boots for offloading were on the chair in her room. Resident #288 raised her leg and UM BB cut the tape and removed the kerlix and ABD pad, the leg was placed back down on the protective pad, and when she lifted the leg up, the pad underneath was spotted with multiple spots of bright red blood. UM BB had to removed multiple little pieces of bandage/gauze that were stuck underneath the back of her leg, on her calf, which were covered it dried blood and exudate. During an observation of Resident #288's right lateral lower leg there were multiple open sores running the length of her lower leg, skin was pink/reddish appearing with open weeping areas. On the lateral side of her right foot, she had a dark brown spot which appeared to possibly be a scab with multiple areas of dry flaky skin. Resident #288 had a scab located above the outer ankle area; her toenails have the appearance of a severe fungal toenail infection with brown, crumbly nails. UM BB cleaned the calf with normal saline and the lateral outer side of her right lower leg with saline, opened TAO (triple antibiotic ointment) and applied to the wounds. UM BB reported she had 4 spots right now, but this writer observed multiple open spots on the lateral lower leg and on the back of the leg on the calf. This writer observed drainage has wept through the kerlix on the left inner lower leg and UM BB reported there was a pad underneath her leg on the bed due to the left leg weeping. When finished UM BB did not reapply the bilateral boots for offloading and neither did Certified Nursing Assistant (CNA) M who had assisted with supporting Resident #288's leg and foot during the application of the treatment and dressing. Review of Medication Administration Record/Treatment Administration Record (MAR/TAR) for March 25, revealed, .Bilateral boots on while in bed and up in chair as she allows .every day and night shift for Wounds assess skin prior to application and after removal . Review of dates 3/21/25-PM noted with initials; 3/22/25 -3/31/25: 6AM and 6PM noted with initials indicated Resident #288 had the bilateral boots on. Review of MAR/TAR for April 25 revealed, .Bilateral boots on while in bed and up in chair as she allows . every day and night shift for Wounds assess skin prior to application and after removal . Review of 6AM for 4/1/25, 4/2/25 with initials and 6 PM for 4/1/25, 4/2/25 with initials indicated Resident #288 had the bilateral boots on. During an observation on 04/02/25 at 02:54 PM, Resident #288 was lying supine in her bed, head of the bed was approximately 75 degrees, her legs were straight out in front of her, bilateral boots for offloading were observed on the chair in the same position they were earlier. Resident #288 reported the staff had not placed the bilateral boots for offloading on her today. In an interview on 04/02/25 at 02:55 PM, Certified Nursing Assistant (CNA) M reviewed Resident #288's kardex (care interventions) in the medical record for the intervention of bilateral boots. CNA M was unable to find the intervention for bilateral boots for offloading in the kardex. In an interview on 04/02/25 at 02:58 PM, Licensed Practical Nurse (LPN) CC reported for Resident #288 they would float her heels as she allows, and she had an order offloading boots. LPN CC reported if the resident refused to offload, she would provide encouragement and would educate the resident on what could happen if the resident refused the offloading. LPN CC reported she would stress the importance of doing so. LPN CC reported if the resident still refused, she would create a progress note in the record which reported the refusal. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/02/25 at 03:06 PM, Assistant Director of Nursing (ADON) C reported her expectation would be documented in the MAR/TAR as a refusal as it was an order for the intervention. ADON C reported there would also be a progress note entered into the medical record for the refusal. In an interview on 04/02/25 at 3:43 PM, ADON C reported the nurses would complete a weekly skin observation and if there were any changes those would be noted on the assessment. ADON C reported UM BB also did her observation and measurements of the wounds and would put a note in the medical record. Review of Skin & Wound Management revised 7/22/24, revealed, .Licensed Nurse skin observation is completed based on policy, which includes upon admission, readmission, weekly, and as needed. Results of skin observation will be documented by following methods: Upon admission and/or readmission: .Complete skin section within the Nursing Admission Screening/History to document all areas of breakdown, excoriation, discoloration, and/or other unusual findings in skin condition with initial set of measurements . Will include location, initial set of measurements and description of skin condition .Care plan will be developed for skin potential and actual via AVHS.IDT- Baseline/Interim Care Plan UDA within the first 48 hours .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview and record review, the facility failed to ensure safety precautions and use of assistive devices for 1 (Resident #33) of 4 residents which have the potential to negatively affect the residents highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #33: Review of an Admission Record revealed Resident #33 was a male with pertinent diagnoses which included acquired absence of right leg above the knee, multiple sclerosis (immune system eats away at the protective covering of the nerve fibers and interrupts communication between the brain and the rest of the body), blindness left eye, and muscle wasting and atrophy (loss of muscle mass and strength). Review of Care Plan for Resident #33 revealed the focus, .(Resident #33) is at risk for falls r/t (related to) blind in left eye/low vision, medication use . with intervention .Transfer: Resident is able to use slide board . Review of General Progress Notes dated 6/7/2024 at 7:51 PM, revealed, .Writer observe resident laying on back on floor in bedroom. Assessed .CNA express that she slid patient to floor while transferring client from bed to wheelchair no injuries all extremities in ROM denies pain denies hitting head vitals 159/77, 88, 96, 98. 2, 18 . Review of General Progress Note dated 6/10/2024 at 4:15 PM, revealed, .The floor nurse reported the following regarding the incident, Writer observe resident laying on back on floor in bedroom. Assessed CNA express that she slid patient to floor while transferring client from bed to wheelchair no injuries all extremities in ROM (range of motion) denies pain denies hitting head vitals 159/77, 88, 96, 98.2, 18 . Review of Incident Report dated 6/7/24 at 7:00 PM, revealed, .Nurse alerted to resident room by assigned CNA. Writer observed resident laying on back in bedroom .Patient Description: Patient express he fell during assisted transfer .Client assessed by nurse, used hoyer lift until re-evaluated by therapy .Statement: CNA expressed she attempted to pivot transfer patient when fall occurred. As He stood up the transfer to chair, he did not help stand up he was set back on side of bed and his butt and bed pad slid right off the bed onto the floor. I set him down and made sure he was safe and notified the nurse .Gait belt was being used. Resident was sitting up on the edge of the bed. Bed was a little higher than the level of the chair seat to facilitate safe transfer. Resident was Dead weight and no assist during the transfer once resident was off of the bed . Review of Fall Risk assessment dated [DATE] at 7:04 PM, .Morse Fall Risk Scale: Score of 60 . which indicated the resident was high risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Incident Report dated 2/18/25 at 9:45 PM, revealed, .This nurse was notified by A Hall CNA that help was needed to get this resident off the floor. When this nurse walked in resident was sitting on his butt next to his bed facing the dresser with his wheelchair behind him. Resident denied hitting his head and denied any pain or discomfort. Resident was helped off the floor and into resident's bed by this nurse and A Hall CNA .Patient Description: Resident stated I told her that she had to use the slide board, and she did not use the slide board. She lifted me up by herself and then had to sit me down on the floor .Immediate Action Taken: A Hall CNA was educated on the importance of using the slide board for resident transfers. This showed where to obtain the Kardex (care interventions) for transfer status of residents and stated if there are any questions or concerns to ask this nurse for help with transfers or where to find information regarding resident . Review of General Progress Note dated 2/18/2025 at 9:45 PM, revealed, .This nurse was notified by A Hall CNA that help was needed to get this resident off the floor. When this nurse walked in resident was sitting on his butt next to his bed facing the dresser with his wheelchair behind him. Resident denied hitting his head and denied any pain or discomfort. Full head to toe assessment was completed. No noted injuries. Vital signs obtained. Resident was helped off the floor and onto resident's bed by this nurse and A Hall CNA . Review of Fall Risk assessment dated [DATE] at 9:45 PM, revealed, .Morse Fall Risk Scale: Score of 60, High Risk of Falling .Has the resident ever fallen before .Yes .Know the limits of their abilities to ambulate safely? .Knows own limits . This writer attempted to contact CNA JJ and did hear back from her prior to exit. Review of CNA Clinical Orientation Checklist dated 1/29/25, revealed, CNA JJ completed training for Fall Prevention and Use of Slide Rails/Padding/Floor mats and was signed off she had received the training. In an interview on 04/02/25 at 7:35 AM, Licensed Practical Nurse (LPN) Z reported when she went to assist the CNA JJ, the resident was by his nightstand with his leg out in front of him, she assessed him, and he was fine. LPN Z reported CNA JJ reported he was on the floor, and she had to lower him the floor as she was transferring him. LPN Z reported CNA JJ told her she had used the board, but she provided education to the CNA on where to find transfer status. LPN Z reported Resident #33 had reported to her, CNA JJ did not use a slide board and there was no gait belt used. In an interview on 04/01/25 at 02:40 PM, Resident #33 reported he was transferred from his wheelchair to his bed, and the Certified Nursing Assistant (CNA) didn't use the slide board and did not have a gait belt on him. Resident #33 reported he fell from the height of his wheelchair seat to the floor. Resident #33 reported the CNA must've thought she was strong enough. Resident #33 reported his slide board was normally placed against the foot board of his bed, leaning up against it. In an interview on 04/02/25 at 02:25 PM, Director of Nursing (DON) B reported he was at times to transfer independently but Resident #33 should have staff assistance for safety concerns with him for transfers. DON B reported he should have one person staff assist with the slide board and a gait belt should be used.

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F 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or arrange emergency care by a doctor 24 hours a day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on interview and record review, the facility failed to ensure emergency physician services were utilized by facility staff for one resident (R7) of 19 reviewed for emergency physician care needs, resulting in not receiving prompt physician emergency services and the increased potential for complications to a serious health condition. Findings include: According to the Minimum Data Set (MDS) dated [DATE], R7 was moderately cognitively impaired as evidenced by her BIMS (Brief Interview Mental Status) score of 10/15. Her diagnoses included morbid obesity, anxiety disorder, metabolic encephalopathy, chronic obstructive pulmonary disease (COPD), and chronic respiratory failure. Review of R7's Progress Note dated 3/19/25 at 14:45 (2:45 PM) indicated R7 had returned from the hospital at this time. Review of R7's Progress Note dated 3/20/2025 at 4:13 (AM) revealed, Patient still has yet to void since returning from the hospital the evening of 3/19. This writer called patients provider (Physician KK) afterhours line at approximately 1:10 AM and left a message. Still no response from (Physician KK) at 2:30 AM. This writer called (facility's medical provider name) on-call and left a message at approximately 2:35 AM for the on-call provider to call back. After no returned call this writer called (facility's medical provider name) on-call again at approximately 3:30 AM and a message was left. At 3:40 AM this writer called (Medical Director YY) personal number after getting no response from (facility's medical provider name) or (Physician KK). At 3:45 AM (facility's medical provider name) nurse practitioner (NP) called back, and this writer explained to the provider that the patient had not voided since returning from the hospital last evening 3/19. I also informed the NP that the patient is not a (facility medical provider name) patient and that patient's doctor (Physician KK) hadn't responded to my message. I informed the NP that I was calling to get an order to straight cath the patient and the NP informed this writer that she could not give the order to do so because the patient is not a patient of the facility's medical provider. It was noted the resident had not been relieved of urine for approximately 13 since returning from the hospital. It was not documented if R7 had been relieved of urine while at the hospital. During an interview on 4/2/25 at 10:32 AM, Director of Nursing (DON) B stated, There is no plan for (Physician KK's) residents if he does not call back or comes in to see his patients that reside in the facility. During an interview on 4/2/25 at 10:52 AM, Receptionist MM stated, (Physician KK) is independent and does his own calls. An answering machine gives a number to call if after-hours. If the call is a true emergency (Physician KK) would call the person back. Review of R7's Progress Note dated 3/20/2025 at 9:42 (AM) revealed, .just back from (name of hospital) stay (3/16 - 3/19/25) .Unable to void yesterday and this AM straight cath for 600cc .No void on 3/20 at 0100 (AM) with bladder scan 400cc, and straight cath on 3/20 at 0700 (AM) with 600cc out 8. Urine Retention (continued on next page)

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F 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to https://www.ncbi.nlm.nih.gov/, The urinary bladder can store up to 500 ml of urine in women . People already feel the need to urinate (pee) when their bladder has between 150 and 250 ml of urine in it. Age: Bladder capacity tends to decrease with age. Attempts were made on 4/1/25 at 3:59 PM and 4/2/25 at 10:18 AM to contact LPN ZZ with no return call by end of survey 4/2/25 at 5:30 PM.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than five percent in 2 of 11 residents (Resident #338 and #6) reviewed for medication administration, resulting in a medication error rate 12% and the potential for adverse effects. Findings include: Resident #338 Review of an Admission Record revealed Resident #338 was originally admitted to the facility on [DATE] with pertinent diagnoses which included hypertension (high blood pressure). Review of Resident #338's MAR revealed, Coreg Oral Tablet 3.125 MG (Carvedilol) (blood pressure medication). Give 1 tablet by mouth two times a day for HTN (hypertension) hold dose if SBP (systolic blood pressure) less than 90 or HR (heart rate) less than 50. Review of Resident #338's MAR revealed, Depakote (antipsychotic medication) ER Oral Tablet Extended Release 24 Hour (Divalproex Sodium) Give 1 tablet by mouth two times a day related to bipolar disorder Review of Resident #338's MAR revealed, Depakote ER Oral Tablet Extended Release 24 Hour 500 MG (Divalproex Sodium) Give 1 tablet by mouth every morning and at bedtime related to bipolar disorder . During a medication administration observation on 4/1/25 at 8:19 AM, Licensed Practical Nurse (LPN) Y reported prepared Resident #338 's medications. LPN Y reported that Resident #338 was readmitted to the facility the night before, and her medications had not been ordered from the pharmacy yet, so she would need to pull them from the facility's pyxis (machine that stores and dispenses medications). LPN Y pulled two Depakote pills from the Pyxis. It was noted that the Depakote pills were 125 mg (milligrams) each. LPN Y returned to her medication cart and placed one 125 mg pill in a cup to administer to Resident #338. LPN Y reported that she would need to return the second 125 mg pill to the pyxis because she did not need it. LPN Y was observed returning the Depakote pill with the assistance of Director of Nursing (DON) B. LPN Y returned to the medication cart and reported that the facility did not have Resident #338's morning dose of Coreg 3.125 mg available, so she would have to omit this medication dose. LPN Y then finished opening the remainder of Resident #338's medications and entered Resident #338's room and administered the medications to her. It was noted that Resident #338 took the 125 mg Depakote pill. LPN Y then returned to the medication cart and documented the medications as given, except for the Coreg, which was documented as not given. During medication reconciliation, this writer noted that LPN Y had documented the Depakote medication as administered under the order Depakote (antipsychotic medication) ER Oral Tablet Extended Release 24 Hour (Divalproex Sodium) Give 1 tablet by mouth two times a day related to bipolar disorder which did not indicate what dose of Depakote should have been administered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 4/1/25 at 1:10 PM, Director of Nursing (DON) B confirmed that he had assisted LPN Y in returning the 125 mg Depakote pill to the pyxis. DON B went to the medication storage room with this writer and showed this writer the Depakote pill that had been returned. DON B confirmed that the dose of the Depakote pill was 125 mg. DON B reported that he had just entered a new order for Resident #338's Depakote because he had been notified by the facility pharmacy that Resident #338's Depakote order did not include a dose. DON B reported that Resident #338's Depakote order was supposed to be 500 mg twice a day. DON B reviewed Resident #338's MAR with this writer and confirmed that LPN Y had documented that she had administered the Depakote on the order which did not indicate a dose. DON B confirmed that one 125 mg pill was not the accurate dose, and LPN Y missed this. DON B confirmed that nurses were expected to follow the rights of medication administration, which includes verifying the order, prior to administering medication, and this was missed. During an interview on 4/2/25 at 1:27 PM, LPN Y reported that she did not realize that Resident #338's order did not indicate a dose, and she did not know why she administered 125 mg of Depakote. LPN Y confirmed that she had made a medication error and did not follow Resident #338's order. Resident #6 Review of an Admission Record revealed Resident #6 was originally admitted to the facility on [DATE] with pertinent diagnoses which included atrial fibrillation (irregular rapid heart rate that commonly causes poor blood flow). Review of Resident #6's Medication Administration Orders (MAR) revealed, Symbicort Inhalation Aerosol 160-4.5 MCG/ACT (Budesonide-Formoterol Fumarate Dihydrate) (combination inhaler used to treat asthma and chronic obstructive pulmonary disease) 2 puff inhale orally every morning and at bedtime . During a medication administration observation on 4/1/25 at 8:19 AM, Licensed Practical Nurse (LPN) Y was preparing Resident #6's morning medications and reported that she could not find Resident #6's inhaler. LPN Y reported that the inhaler must not have been re-ordered so she would need to omit Resident #6's ordered morning dose of the symbicort as the facility did not have it available. Review of the facility's Administration of Drugs policy last reviewed 8/1/24 revealed, POLICY: It is the policy of this facility that medications shall be administered as prescribed by the attending physician. Procedures: .14. Prior to administering the resident's medication, the nurse should compare the drug and dosage schedule on the resident's MAR with the drug label. NOTE: If there is any reason to question the dosage or the schedule, the nurse should check the physician's orders .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47659 Based on observation, interview, and record review, the facility failed to properly label, date, and store medications in 1 out of 1 medication carts resulting in the potential for decreased efficacy of medications and the exacerbation of medical conditions. Findings include: During an observation of the B hall medication cart with Registered Nurse (RN) FF on 4/1/25 at 12:48 PM, one opened insulin lispro (Humalog) pen was noted in the top shelf of the cart. The pen was labeled with the resident's name, but the date the medication was opened was missing. RN FF confirmed that nurses were suppose to label the insulin pens when they open them, and this was missed. In the stock meds (medications used for multiple residents) area of the cart there was one opened bottle of Mucus ER (Medication to help thin mucus) which did not have an open date, and one opened bottle of Cetirizine 10 mg (Allergy medication) that also did not include an opened date. RN FF reported that nurses were suppose to label the medications when they were opened, and this was missed. During an interview on 4/2/25 at 2:45 PM, Director of Nursing (DON) B reported that the night shift nursing staff were expected to review the medication carts and ensure that all medications were labeled with open dates, and that nurses should label medications when they are opened.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 38666 Based on observation, interview, and record review the facility failed to consistently provide residents with their food and beverage preferences for 12 residents (Residents #17, 53, 65, 2, 64, 85, 12, 14, 76, 22, 24, and 338) out of a facility census of 88 resulting in incorrect items provided, decreased satisfaction, and the potential for frustration, weight loss, and/or dehydration. Findings include: During an observation on 04/01/25 at 08:55 AM, Resident #17's breakfast tray was delivered to the dining room of the locked memory care unit and the meal ticket stated, Beverages Apple Juice, Chocolate Boost (nutritional supplement drink), . She was provided a red beverage (not apple juice) and was given a Vanilla Ensure Plus nutritional supplement drink (this is not a comparative product as it contains 110 calories more than an original Boost drink). Additionally, the alternate product provided was vanilla, when her meal ticket preference indicated the Chocolate flavor should be provided. During an interview on 04/01/25 at 08:59 AM, Registered Nurse FF reported if Resident #17 sleeps through breakfast when she wakes up they offer her an ensure. Review of Resident #17's nutrition care plan, revised 2/14/25, stated, Resident (#17) has nutritional problem or potential nutritional problem .Supplements as ordered . During an observation on 04/01/25 at 09:02 AM, Resident #53 was served a vanilla Ensure Plus, but her meal ticket stated, Boost. The products are not the similar in nutrive value as Ensure Plus contains 110 more calories than a Boost. During an observation on 04/01/25 at 09:04 AM, Resident #65 had consumed 100% of his solid foods, but his red beverage (not apple juice) cup appeared to have little to none consumed. His meal ticket on the table stated, Beverages Apple Juice . During an observation on 04/01/25 at 09:16 AM, Resident #2's meal was served with a red beverage (not apple juice) and an Ensure Plus nutrition supplement. Resident #2's meal ticket stated, Beverages Apple Juice, Boost, ., however she was given a red juice and an Ensure Plus. Observed in her room was an unopened Chocolate Boost dated 3/31/25 which indicated Boost was available, but she was served an Ensure Plus at this meal. The meal ticket also stated, Note Likes the sweet breakfasts. Please send TWO when having Pancakes, French Toast, and Waffles. Resident #2 was served only one portion of French toast; not a double portion. During an interview on 04/01/25 at 09:18 AM, Certified Nurse Aide (CNA) VV entered Resident #2's room and confirmed Resident #2 likes the sweet breakfasts and will often eat a double portion. CNA VV confirmed Resident #2 was only served one portion and not a double portion of the French toast and reported it depends if they (the kitchen) have enough or who is serving regarding if Resident #2 received double portions. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 04/01/25 at 01:04 PM, Resident #64's lunch meal in the facility's main dining room had broccoli served on the plate. The meal ticket for Resident #64 stated, Dislikes Broccoli .Note Will only eat these Vegetables. Cream corn, carrots, green beans, salad, and COLD beets. During an observation on 04/01/25 at 01:08 PM, Resident #85's lunch meal served in the facility's main dining room had a vanilla Ensure Plus, but the meal ticket stated, Supplements BOOST. Vanilla Ensure Plus is a different product than boost and contained 110 more calories than Boost. During an observation on 04/01/25 at 01:14 PM, Resident #17 was eating lunch in the dining room of the locked memory care unit of the facility near the back door. Resident #17 was served a vanilla Ensure Plus and a red beverage (not apple juice). Resident #17's meal ticket stated, Beverages . Apple Juice, Chocolate Boost . At the same table, Resident #12 was served a vanilla Ensure Plus, but her meal ticket stated, Boost. At the table closest to the dining room entrance Resident #14 was served mashed potatoes and gravy but in her dislikes section of the meal ticket it stated, Dislikes .Gravies . During an observation and interview on 04/01/25 at 01:24 PM, Resident #2 was served lunch in the locked memory care unit's dining room which included a vanilla Ensure Plus supplement drink, but her meal ticket stated, Beverages .Boost. Certified Nurse Aides VV and N reported the beverages and supplements come on the trays from the dietary department. CNA N confirmed they had Boost drinks in their unit's refrigerator. During an observation on 04/01/25 at 01:28 PM, Resident #76 was eating lunch in a chair in front of the television of the locked memory care unit's activity/dining room. Resident #76's lunch meal was served with a vanilla Ensure Plus, but his meal ticket stated, Beverages boost . During an observation and interview on 04/02/25 at 08:15 AM, Resident #22 was eating breakfast in the facility's main dining room. Resident #22 was served a red beverage (not apple juice) and reported he doesn't like the red beverage and prefers apple juice. Resident #22 reported he only gets apple juice served sometimes. Resident #22's meal ticket stated, Beverages .4 oz (ounce) Apple Juice. During an observation on 04/02/25 at 08:19 AM, Resident #24 was eating breakfast in the facility's main dining room. Resident #24 reported she is a diabetic and prefers sugar free condiments and estimated she receives sugar free condiments/jellies twice a week. Resident #24 was served regular/non-sugar free strawberry jam and grape jelly. Resident #24's meal ticket stated, CCHO - NAS (consistent carbohydrate (a diabetic diet intervention) no added salt diet) .Note Sugar Free Condiments .Would like Hot Cereal: Sunday, Tuesday, Thursday, Saturday .Would Like Fruit Loops: Monday, Wednesday, and Friday. This meal observed was on a Wednesday, and Resident #24 was served oatmeal and not fruit loops. During an observation and interview on 04/02/25 at 08:24 AM, Resident #338 was eating independently in the main dining room of the facility. Resident #338 was served a red beverage (not apple juice or orange juice). During an interview at the meal Resident #338 reported she couldn't drink it asked the surveyor what the red beverage was. Resident #338's meal ticket stated, Beverages 4 oz Apple of (or) Orange Juice). Resident #338 proceeded to ask facility staff for an apple or orange juice. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 04/02/25 at 08:30 AM, Resident #2's breakfast was served in her room of the locked memory care unit. Resident #2 was served a red beverage (not apple juice) and a strawberry Mightyshake nutritional drink. Resident #2's meal ticket stated, Beverages Apple Juice, Boost. The Mightyshake (4 fluid ounces) is a different drink than Boost (8 fluid ounces) and has a different fluid content. During an observation on 04/02/25 at 08:32 AM, Resident #17 on the locked memory care unit was served a strawberry Mightyshake nutritional drink and a red beverage (not apple juice). Resident #17's meal ticket stated, Beverages Apple Juice, Chocolate Boost . During an observation on 04/02/25 at 08:34 AM, Resident #53 was eating in the locked memory care unit's dining room. Her meal ticket stated, Beverages Boost . but was provided a strawberry mighty shake nutritional drink. During an interview on 04/02/25 at 09:09 AM, Dietary Director UU confirmed the beverage line on residents' meal tickets were based on preferences and stated. Dietary Director UU reported whatever the resident or the family had reported as a preference is what is displayed on the meal tickets. Dietary Director UU confirmed the only red colored drinks were punch, cranberry, or Boost breeze (a nutritional drink supplement) and not apple juice or an apple juice blend. Dietary Director UU reported the facility's Registered Dietitian reported they could swap Boost for Ensure, and vice versa, and confirmed this was for the regular versions and not the Plus versions. Dietary Director UU reported the Ensure Plus version of ensure is newer to the facility. Dietary Director UU reported she she doesn't order the nutrition drink supplements and they (the kitchen/dietary department) give what they have when serving the meals/beverages. Review of the facility's Food Refusals, Substitutes for policy, adopted 7/11/2018, stated, Purpose: To provide an adequate diet within the food preferences of the residents .Every effort will be made to ascertain individual food preferences upon admission and at quarterly resident interviews so that equivalent food substitutes can be prepared in advance of meal service . Substitutes provided should be from the same food group and nutritionally equivalent . Per the nutritional drinks/supplements' manufacturer websites, Ensure Plus, 8 fluid ounces, is 350 calories and 13 grams of protein. Original Ensure, 8 fluid ounces, is 250 calories and 9 grams of protein. Boost original, 8 fluid ounces, is 240 calories and 10 grams of protein. Boost is available in a Plus version which is 360 calories and 14 grams of protein Mightyshake (strawberry), 4 onces (not 8 and therefore contained a different quantity of fluid), is 220 calories and 6 grams of protein. When Ensure Plus was provided instead of Boost original it was not of similar nutritive value; a 110 calorie differential. Applying the reasonable person concept, in regards to preferences, someone likely would prefer the taste of one nutritional supplement over the other. The residents observed on the locked memory care unit were unable to vocalize how being given the incorrect items made them feel or the impact it had on their consumption for nutritional drinks, other beverages, and foods.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on observation, interview, and record review the facility failed to effectively implement infection control measures that included: 1.) effective implementation of Enhanced Barrier Precautions (EBP) for 2 residents (R7 and R338) 19 residents reviewed for infection control, resulting in the potential for cross contamination of infection to a vulnerable population. Findings include: R7 According to R7's medical records, an Order Summary dated 3/23/25, indicated R7 Maintain foley catheter with 18 Fr 10 cc balloon (size) for urinary retention (diagnosis). Further review of R7's Order Summary on 3/31/25, did not indicate the resident was placed on EBP. Review of R7's Care Plan did not indicate a resident-specific treatment plan for Enhanced Barrier Precautions. Review of R7's Progress Note dated 3/22/2025 at 22:45 (10:45 PM) revealed, .Foley catheter 16FR (french) 10cc balloon inserted. Observed on 3/31/25 at 11:52 AM, R7 lying in bed with a urinary catheter bag attached to her bed. During an interview on 3/31/25 at 11:58 AM Housekeeping (HSKG) E stated, I am a newer employee. The only way I know if a resident is on any type of Transmission-Based Precautions is the signage that is posted on the door before I enter it. During an observation and interview on 4/1/25 at 8:15 AM, there was no EBP signage/notification or PPE (Personal Protection Equipment) on or by R7's door or room to indicate the resident should be on EBP. R7 was in bed awake with an urinary catheter bag attached to her bed frame and visible from doorway. R7 was wearing oxygen via nasal cannula (NC). Unit Manager (UM) CC entered R7's room and with bare hands untangled the resident's foley tubing and oxygen tubing. UM CC stated, (R7) went out to the hospital for a few days and came back with the urinary catheter because she was unable to void. I'm not sure if she has a leg strap for the catheter tubing. Without donning the appropriate PPE, UM CC moved aside R7's bedding and touched the resident's inner right thigh with bare hands moving aside what she described as a leg strap holding the urinary catheter tubing close to the insertion site. UM CC reported the leg strap was peeling away. During an interview on 4/1/25 at 5:03 PM, Director of Nursing (DON) B stated, A resident that has a urinary catheter should be placed on Enhanced Barrier Precautions for infection control purposes. (R7) was not placed on EBP until today 4/1/25. I expect all nursing staff to know to wear PPE when touching catheter tubing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the U.S. Department of Health and Human Services Centers for Disease control and Prevention (CDC), Providers (medical staff) and staff (facility) must wear gloves and a gown for High-Contact resident care activities including device-care or use of urinary catheters. 47659 Resident #338 Review of an Admission Record revealed Resident #338 was originally admitted to the facility on [DATE] with pertinent diagnoses which included hypertension (high blood pressure). Review of Resident #338's Care Plan revealed, (Resident #338) has an enteral feeding tube (tube that delivers liquid nutrition directly to the stomach or small intestine) .Physician order to feeding tube patent. Date Initiated: 04/02/2025 . During an observation on 4/1/25 at 11:51 AM, Resident #338 was sitting in a wheelchair in her room. Certified Nursing Assistant (CNA) AAA was making Resident #338's bed. It was noted that CNA AAA did not have on a gown or gloves. CNA AAA then applied gloves and assisted Resident #338 to brush her teeth. It was noted that CNA AAA did not have a gown on. It was noted that there was a sign outside of Resident #338's door which indicated that she was enhanced barrier precautions, and gowns and gloves were required for direct care activities with Resident #338. During an interview on 4/1/25 at 11:53 AM, LPN Y confirmed that Resident #338 was on enhanced barrier precautions because she had a feeding tube.