STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakehouse Healthcare & Rehabilitation Center	3737 Bryant Avenue South Minneapolis, MN 55409

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 6 of 6 residents (R18, R15, R53, R142, R208, R386) who were seated at the dining room table with other residents who were served meals without being served meals themselves resulting in them waiting for their meals while tablemates dined and for 1 of 1 resident (R386) who was brought to the dining room ungroomed in a hospital gown. In addition, the facility failed to ensure dignity was maintained for 1 of 1 (R164) observed for lack of clothing in bed. Findings include: Dining R203's significant change Minimum Data Set (MDS), dated [DATE], indicated R203 was cognitively intact. During an interview on 7/29/24 at 1:51 p.m., R203 stated food trays would often sit out in a serving cart waiting to be served to residents for over 30 minutes, often causing food to be served cold and past scheduled mealtimes. During observation on 7/31/24 at 7:30 a.m., R53 and R208 were sitting out in the main dining area. R208 was sitting in her wheelchair with her head resting against the table. During observation on 7/31/24 at 8:30 a.m., breakfast trays were brought up and on the unit and four residents were sitting out in the main dining area, including R53 and R208. The four residents were seated without drinks or food. During observation on 7/31/24 at 8:36 a.m., R386 was brought out to the dining room in a hospital gown, a blanket over her lap and greasy, matted unbrushed hair. During observation and interview on 7/31/24 at 1:51 p.m., R386 was back in bed, family member (FM)-H was present and stated he had brought R386 clothes yesterday to wear, just one outfit because she had lost so much weight, and he was not sure what size clothes she wore. FM-H stated, as long as her bottom isn't hanging out, that is the best we could hope for. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/1/24 at approximately 10:00 a.m., nurse manager and registered nurse (RN)-H voiced understanding of the importance of creating a dignified and home like dining experience for the residents. RN-H further confirmed she would not expect a resident to appear the way R386 looked, stating I was surprised how her hair looked and R386 should have had her hair brushed before going to the dining room. During observation on 7/31/24 at 8:50 a.m., an unnamed therapy staff member entered the dining room to see a resident for therapy and stated, Oh! You haven't eaten yet stating he would come back later to see the resident for therapy. During observation on 7/31/24 at 8:53 a.m., R80 was wheeled to the dining room and the first breakfast trays were being passed out. R80 was seated at a table with R53 and R208 and was immediately served her breakfast tray. R53, R80 and R208 still were not served any drinks and R53 and R208 had been waiting approximately 1.5 hours for breakfast and were still not served. During observation on 7/31/24 at 8:58 a.m., at a second table R381 entered the dining room and was given her breakfast tray. R386 was still at the table without any food. During observation on 7/31/24 at 9:03 a.m., R53 and R208 were given their breakfast trays. R53, R80 and R208 were still not offered or served any drinks with their food. During observation on 7/31/24 at 9:15 a.m., R381 asked R386 if she was hungry and wanted something to eat, R386 responded by nodding her head yes. R53, R80, and R208 were brought drinks after asking surveyor for something to drink. A facility aide brought over cranberry juice without asking what R53 or R208 would like to drink, even when they had asked for water. At 9:18 a.m., R386 was served her breakfast tray, 20 minutes after her tablemate R381. During an interview on 7/31/24 nursing assistant (NA)-M stated morning breakfast service was a bit rough that morning because he was the only NA on the floor who knew the residents. During an interview on 8/1/24 at 12:40 p.m., the director of nursing (DON) stated the facility, could work on something to ensure the residents had a home like, dignified dining experience. 49339 R18's significant change Minimum Data Set (MDS) assessment dated [DATE], identified R18 had severe cognitive impairment and required moderate assistance of staff for eating. R142's significant change MDS assessment dated [DATE], identified R142 had severe cognitive impairment and required maximal assistance with eating. On 7/31/24 at 8:33 a.m., the breakfast meal service was observed on 5th floor main dining room. There were tables of resident's already eating who had been served their entree. Observed was a square table that could seat four residents by the nursing station along the side of dining room with resident rooms where R18, R142 and tablemates were seated. R18 and R142's tablemates were served breakfast and were eating independently. At 8:47 a.m., R18 and R142's tablemate had finished eating and was talking on her cell phone at the table. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 8:48 a.m., R142 was served breakfast. At 8:50 a.m., an unidentified staff came back to the table with drinks for R142, sat down next to her to assist her to eat and told R18 to sit back as R18 was resting her head on the table (17 minutes after observation began). At 8:56 a.m., an unidentified staff served R18 breakfast and grabbed a chair to sit down next to assist her with eating (23 minutes after observation began). 7th Floor Observation R15's significant change MDS assessment 6/1/24, identified R15 with intact cognition and required set up assistance with eating. On 8/01/24 at 12:21 p.m., the afternoon meal was observed in the main dining room on 7th floor. R15 was seated at a table of four and two of his tablemates had been served lunch. At 12:34 p.m., R15's third tablet mate received her food. At 12:35 p.m., R15 received his tray (14 minutes after observation began). During interview on 7/31/2024 at 10:29 a.m., nursing assistant (NA)-H stated that residents that are independent with eating are served meals first and residents who need help are served afterwards. NA-H verified that residents that need assistance with meals sit at tables with residents that don't need assistance with meals. NA-H stated they are responsible for getting room trays ready and delivered to resident rooms also. During interview on 7/31/24 at 2:26 p.m., licensed practical nurse (LPN)-C verified that meals are served by staff. They stated, the people who need assistance are the last one who get their meals. LPN-C verified that residents who need assistance with meals sit with residents who are independent with eating. LPN-C verified that serving meals can take time as they serve a lot of residents. During interview on 7/31/24 at 2:28 p.m., registered nurse (RN)-I verified there is an order to how trays are delivered to residents. RN-I stated, to my understanding, independent residents get their meals first, moderate assistance get their meals next and then the residents who need the most assistance get served last. RN-I verified the more assistance the resident needs with eating, the longer they must wait to be served. RN-I verified residents with different need levels sit together at tables. RN-I stated they think this is so there is more staff to help assist residents to eat. 49034 Clothing R164's significant change Minimum Data Set (MDS) dated [DATE], indicated R164 had severely impaired cognition. R164's quarterly MDS dated [DATE], indicated R164 did not speak, rarely/never understood verbal content, and was diagnosed with dementia. In addition, R164 was dependent on staff for bed mobility, lower body dressing, and toileting hygiene. R164's care plan dated 7/19/24, indicated R164 required the assistance of two for dressing. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/29/24 at 2:49 p.m., resident representative (RR)-C stated she visited R164 almost daily. RR-C stated after staff would assist R164 to bed, she noticed his pants would often be left off, left around his ankles, or left around his knees. RR-C stated she knew this was something R164 would not like and would not have done if he was still dressing himself. RR-C stated she could tell that it bugged him, and it bugged her that they kept doing it. RR-C stated she had told staff previously, but the facility used so many agency staff it never seemed to be communicated to the incoming shifts that he didn't like this. RR-C stated that although she had told staff she didn't feel like she should have to tell people not to do that. During observation and interview on 7/30/24 at 2:04 p.m., R164 was observed in bed wearing a T-shirt and a brief with no pants on. Nursing Assistant (NA)-J stated he had assisted R164 to bed after lunch. NA-J stated he had taken and left R164's pants off so R164 did not wet the bed and his pants because then he would have to change both of those. NA-J stated he worked for an agency and had never worked with R164 previously and that was how he was taught to put people to bed. During an interview on 8/1/24 at 2:26 p.m., the director of nursing (DON) stated if R164 or his representative wished for R164's pants to be left on in bed, they should be left on.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview, and document review, the facility failed to ensure a self-administration of medications (SAM) assessment was completed to allow a resident to safely self-administer medications for 1 of 1 (R184) residents reviewed for self-administration of medications. Findings include: R184's admission Minimum Data Set (MDS) dated [DATE], indicated R184 had moderate cognitive impairment, didn't have signs of delirium, and didn't refuse cares or medications. The MDS indicated R184 was dependent with showers, lower body dressing, toileting, bed mobility, and transfers. R184 needed substantial assistance with upper body dressing, oral hygiene and eating. R184's Clinical diagnosis record printed 1/31/24, indicated diagnoses of dysphagia (difficulty swallowing) following unspecified cerebrovascular disease (condition that affect blood flow and the blood vessels in the brain), gastrostomy status (surgical procedure that creates an opening in the abdomen and into the stomach, allowing for the insertion of a feeding tube), hemiplegia (paralysis of one side of the body) and paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease) following cerebral infarction (stroke) affecting right dominant side, chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breath), chronic respiratory failure with hypoxia (low oxygen level in the blood) , protein-calorie malnutrition, chronic atrial fibrillation (heart arrhythmia that causes the upper chambers of the heart to beat irregularly and quiver for5 more than 12 months), atrial flutter (condition in which the heart's upper chambers beat too quickly), and dysthymic disorder (a mild but long-term form of depression). R184's Clinical Physician orders printed 7/31/24 lacked orders for the self-administration of medications. R184's electronic medical record reviewed 7/31/24, lacked an assessment for self-administration of medications. During observation on 7/31/24 at 8:00 a.m., registered nurse (RN)-G filled the nebulizer chamber with albuterol sulfate (medication for shortness of breath) nebulizer 2.5 milligrams (mg)/3 milliliters (ml) vial. RN-G asked R184 if she should start the nebulizer machine. R184 answered, he will do it himself when he returned from smoking. RN-G stated that was okay and left the room. During interview on 7/31/24 at 8:05 a.m., RN-G was questioned if R184 was able to start the nebulizer machine on his own. RN-G said, He wants to smoke first, he can hold it by himself. He will ask somebody to turn it on. During observation on 7/31/24 at 11:30 a.m., residual nebulizer solution was observed remaining in the nebulizer cup. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/31/24 at 11:37 a.m., RN-G said she started the nebulizer machine for him and left the room. RN-G added, He doesn't like it when we stay in the room, and he is doing his neb treatment. RN-G said the order to self-administer medications should be okay by the doctor. RN-G was not sure if R184 had an order to self-administer medications. During interview on 7/31/24 at 1:09 p.m., R84 stated the nurses pour the medication in the nebulizer cup. I don't need help to turn on and off the nebulizer machine. The nurse never stays in the room while I do my neb treatment. During interview on 7/31/24 at 1:42 p.m., nurse manager (RN-E) stated a doctor's order, and a self-administration assessment were needed to self-administer a nebulizer treatment. RN-E verified R184 didn't have a self administration order or an assessment. RN-E stated the assessment needed to be completed to establish if resident was able to safely administer his own medication. A facility's self-administration of medications policy and procedure was requested but not received.

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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. 44656 Based on observation and interview the facility failed to ensure vinyl floors were clean and in good condition for 2 of 5 resident dining rooms (2nd floor memory care unit and 3rd floor) and 1 of 1 (R134) resident rooms reviewed for environment. Findings include: R134's quarterly Minimum Data Set, dated dated dated , 7/20/24 documented R134 with severe impairment of cognitive skills, physical and verbal symptoms directed towards others, had an indwelling catheter. In addition, R134 with diagnoses of Alzheimer's disease, dementia, seizures, depression, anemia, renal insufficiency (decreased kidney function), neurogenic bladder (disruption of the nervous system and the bladder) and obstructive uropathy (difficulty voiding). Also, R134 required extensive assistance of one staff member with bed mobility, eating, toilet use and required setup or clean-up assistance with oral hygiene. R134's Profile in the electronic medical record (EMR) listed family member (FM-A) as Responsible Party, primary Emergency Contact, Power of Attorney, Care Conference Person, Essential Caregiver, Financial Responsibility and Health Care Agent. During interview with FM-A on 7/29/24 at 3:25 p.m., FM-A stated, The room is sometimes really smelly. I don't think it is cleaned as much as it should be. The floor looks unswept or mopped. During observation on 7/29/24 at 3:50 p.m., the floor in R134's room was observed to be tacky to walk on causing shoes to stick to the floor. During observation and interview on 7/30/24 at 7:33 a.m., and 7:43 a.m., the second-floor memory care unit main dining room floor was observed to be tacky to walk on causing shoes to stick to the floor at the Northwest corner in front of the window. Trained medication aide (TMA)-A stated the floors were, super-sticky and said the housekeeping staff was responsible for cleaning the floor after every meal. During observation and interview on 7/30/24 at 7:57 a.m., TMA-B verified the second-floor memory care unit main dining room floor was tacky to walk on causing shoes to stick to the floor at the Northwest corner in front of the window. TMA-B stated the housekeeping department, is supposed to be cleaning it up. TMA-B then stated he would notify the housekeeping department to clean the floor. During observation and interview with the director of social services (SW)-A on 7/30/24 at 2:17 p.m., a section of the third-floor main dining room floor was tacky to walk on causing shoes to stick to the floor. An unidentified staff member walked to the resident refrigerator and walked around the sticky section of the floor. SW-A stated, yes, it appears sticky and stated she would notify housekeeping to clean the floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with head of maintenance (DOE) on 7/30/24 at 3:49 p.m., DOE stated, the floor care is done by a third-party company that we contracted for. Daily housekeepers are going by doing floor care in each resident room. The floors are cleaned after every meal in dining rooms. During observation and interview on 7/31/24 at 7:19 a.m., the second-floor memory care unit main dining room floor at the Northwest corner in front of the window was observed to be tacky to walk on causing shoes to stick to the floor. TMA-B verified the floor was sticky, yes, it is for sure. TMA-B walked over to housekeeper (H-C) and asked him to use the floor machine to clean the floor. H-C stated the food spills, make it [floor] dirty. My mop will not pick this sticky stuff up. And I don't know when the floor was last cleaned by the machine, but it should be. This is too sticky. During observation and interview with registered nurse (RN)-C on 7/31/24 at 7:44 a.m. in R134's room, RN-C stated, the floor is sticky here. It should be cleaned. We are to tell housekeeping. The dark matter on floor appears to be food which means the floor was not cleaned recently. During interview with RN-D on 7/31/24 at 7:52 a.m., in R134's room, RN-D stated, the floor is dirty here at the head of the bed. It looks like old food on the floor here and should be mopped up. During interview with facility associate administrator (AA) on 7/31/24 at 10:09 a.m., AA stated, they [housekeepers] did not strip the floor before waxing it. I had to scrape it today and showed the contract team that it was waxed. They should not have waxed the old floor anyways. The old wax was never removed. All the [memory care and third floor dining room floors] need to be waxed correctly. AA stated the same was true for R134's floor. Facility policy on environmental cleaning and maintenance of floors was requested but not received.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on interview and document review, the facility failed to ensure a written notice of transfer was sent to the office of the Ombudsman for long term care for 2 of 4 residents (R60, R27) reviewed for hospitalization . Findings include: R60 R60's quarterly Minimum Data Set (MDS) dated [DATE] identified R60 with diagnoses of a stroke with paralysis affecting the right dominant side, renal insufficiency, urinary tract infection, diabetes, and an unhealed pressure ulcer to right heel. R60's electronic medical record (EMR) section titled Profile identified primary emergency contact, power of attorney (POA), care conference person, and financial responsibility person as emergency contact (EC)-A. R60's Progress Notes (PN) tab, the notes are listed in vertical columns titled, Effective Date, Type, Note, Care Plan Item or Task, Dept, Shift Report, 24 Hour Report. R60's PN from licensed practical nurse (LPN)-D, dated 4/23/24 at 10:24 p.m. documented, Note Text: Resident send to HCMC ER at 2130. PN on 4/23/24 at 10:28 p.m. documented EC-A was notified of R60's emergency room transfer. The PN failed to document a bed hold was discussed. R60's hospital discharge summary identified a hospitalization from [DATE] to 4/29/24 and that R60, is unable to verbalize understanding of condition and treatment plan due to patient having dementia. During review of R60's EMR, no written notices of transfer was issued. R27 R27's quarterly MDS dated [DATE], identified R27 was cognitively intact and had diagnoses of coronary artery disease (narrowing or blockage of heart's arteries), heart failure (heart muscle does not pump blood as well as it should), hypertension (high blood pressure; pressure in blood vessels is too high), peripheral vascular disease (narrowed blood vessels reduce blood flow to legs or arms), kidney disease (loss of kidney function), diabetes mellitus (condition which causes high blood sugar), schizophrenia (mental health condition which affects how people think, feel and behave), and asthma (chronic condition which inflames and narrows the airways in the lungs and makes it hard to breathe). R27's EMR section titled Profile identified R27 as own responsible party and financial responsibility and EC-B as emergency contact one, care conference person, and health care agent. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27's PN from LPN-I dated 1/22/24 at 6:15 p.m., indicated R27 went to HCMC emergency room via ambulance and was admitted for atrial fibrillation (fast, abnormal heart rhythm). R27's hospital discharge summary identified a hospitalization from [DATE] to 1/25/24. R27's EMR lacked evidence a written notification of transfer was sent to the ombudsman for long term care. During interview with nurse manager of R60's resident unit, registered nurse (RN)-F on 8/1/24 at 10:43 a.m., RN-F stated the expectation of nursing staff was to provide a paper copy of the Transfer Notice to the resident or POA and then document in the resident's EMR under the Progress Notes with Type of note labeled as, Bed Hold and not Note Text. RN-F reviewed PN for both R60 and R27 and stated, I cannot find a bed hold or information that was offered. It should have been done and documented but wasn't. During interview with the director of social services (SW)-A on 8/1/24 at 11:16 a.m., SW-A stated they faxed a report to the ombudsman which listed discharges, hospitalization s, deaths, and other information from the EMR portal. SW-A reviewed the reports for 1/24 and 4/24 and verified they did not include hospitalization s for R60 or R27. During interview with the director of social services (SW)-A on 8/1/24 at 11:26 a.m., SW-A stated the expectation of nursing staff was to fill out and provide the bed hold and transfer forms to residents prior to the transfer. Also, SW-A stated if the transfer were emergent then the resident or guardian would be notified by phone to request a bed hold. Regardless of whether the transfer or discharge were emergent, SW-A stated the expectation of staff to document the conversation or attempts in a progress note. SW-A reviewed R60's and R27's progress notes and stated, it is not mentioned in [the] progress notes and it should be. During additional interview with SW-A on 8/1/24 at 12:12 p.m., SW-A and vice president of clinical operations (CO) noted a technical glitch between the EMR portal and the Admission/Discharge - To/From report. A ticket was submitted, and they would compare the portal and report until the report accurately pulled all needed information. During interview on 8/1/24 at 2:25 p.m., administrator acknowledged the technology issue with the report faxed to the ombudsman and stated communication with the ombudsman was important and they did not lack communication with them. Per email communication with the Office of Ombudsman for Long-Term Care on 8/2/24 at 8:17 a.m., the Ombudsman was not notified of R60's and R27's transfers or discharges. The facility did not have a policy for notification of transfer to the ombudsman. 48299

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on interview and document review, the facility failed to ensure a level I Pre-Admission Screening and Resident Review (PASARR) was completed prior to admission for 1 of 1 residents (R63). Findings include: R63's significant change Minimum Data Set (MDS) dated [DATE], indicated R63 had intact cognition. R63's medical diagnoses list dated 4/19/24, indicated R63 was diagnosed with generalized anxiety disorder, major depressive disorder, and schizoaffective disorder (a mental health condition that is marked hallucinations, delusions, and mood disorder symptoms, such as depression, mania) R63's PASARR dated 10/12/23, indicated the PAS [PASARR] is not final until the lead agency sends the documentation to the nursing facility. R63's entire medical record was reviewed and lacked evidence a final determination had been received by the county or managed care program as directed by the PAS. During an interview on 7/31/24 at 8:43 a.m., the director of social services (SW)-A stated after reviewing R63's preadmission screening dated 10/12/23, she believed this was the final documented and indicated R63 did not require any additional screening. SW-A stated she would look into the issue and confirm that this was the final PASARR for R63. During an interview on 8/1/24 at 8:27 a.m., the senior linkage line representative (SLL) stated she had reviewed the PAS that they had on file for R63 that said the PAS [PASARR] is not final until the lead agency sends the documentation to the nursing facility dated 10/12/23 and this was not the final PASARR. SLL stated the facility needed to reach out the lead agency, in this case Hennepin County. SLL stated the lead agency would process the PAS and give the facility the final determination, what the document described was not the final PASARR. During email communication on 8/5/24 at 12:47 p.m., administrator indicated the facility had a copy of R63's PASARR in the medical record and did not trigger for a level two PASARR assessment. On review the PASARR document provided was the same one dated 10/12/23 as described as above and did not contain the required final PASARR determination from the lead agency. A policy regarding PASARR completion or maintenance was requested and not received.

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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** 49034 Based on observation, interview, and record review the facility failed to ensure timeliness of person-centered care conferences for 3 of 5 residents (R9, R103, R134) reviewed for care conferences. R9 R9's quarterly Minimum Data Set (MDS) dated [DATE], indicated R9 was admitted on [DATE], and had no cognitive deficits. A review of R9's medical record indicated R9's last care conference was on 2/1/24 and did not demonstrate that a care conference occurred after 2/1/24 or a reason this would not have been practicable for R9. During an interview on 7/29/24 at 2:21 p.m., R9 stated she didn't remember having a care conference with facility staff since the beginning of the year and wished she had been more updated and involved in her care. During an interview on 7/30/24 at 3:04 p.m., social worker (SW)-B stated the social work department had gone through a lot of turnover and there was a backlog of care conferences. SW-B stated after reviewing R9's medical record it looked like R9 should have had a care conference to correlate with her MDS in May but that had not occurred. R103 R103's quartely MDS dated [DATE] identified R103 as cognitively intact, with diagnoses of neuroleptic induced Parkinsonism, heart failure, and diabetes. During review of R103's Care Conference Summary section of the electronic medical record (EMR), R103's EMR lacked evidence of any care conferences between 1/25/24 and 8/1/24 despite MDS data was submitted on 3/27/24 and 6/27/24. During interview with R103 on 8/1/24 at 3:48 p.m., R103 stated, no I haven't had a care conference this year. I don't know the plan for me. [sic] would like to know so I can plan or figure out what to do. R134 R134's quarterly Minimum Data Set, dated dated dated , 7/20/24 indicated R134 with severe impairment of cognitive skills, physical and verbal symptoms directed towards others, had an indwelling catheter. In addition, R134 with diagnoses of Alzheimer's disease, dementia, seizures, depression, anemia, renal insufficiency (decreased kidney function), neurogenic bladder (disruption of the nervous system and the bladder) and obstructive uropathy (difficulty voiding). Also, R134 required extensive assistance of one staff member with bed mobility, eating, toilet use and required setup or clean-up assistance with oral hygiene. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of R134's Care Conference Summary section of the electronic medical record (EMR), R134's EMR lacked evidence of any care conferences between 1/25/24 and 6/26/24 despite MDS submission of data on 4/19/24. During interview with the director of social services (SW)-A on 7/30/24 at 8:04 a.m., SW-A stated she was responsible for ensuring care conferences were scheduled and completed corresponding to MDS timeframes including change of condition. SW-A reviewed R103 and R134's EMR and stated, there probably has been a lapse in care conferences. Looks like there was one that wasn't done from January to June 2024. SW-A stated the importance of timely care conferences, to review care with family and staff. During an interview on 8/1/24 at 2:24 p.m., the director of nursing (DON) stated they had a massive turnover with the social work department and was aware of issues with care conference completion. The DON stated the care conferences should have been completed quarterly, annually, and as needed. The DON stated this was important to ensure communication was occurring between the facility and the resident, and to ensure the care plan included the resident's goals and wishes. Facility policy regarding timing of care conferences was requested but not received.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to ensure routine personal care and hygiene (i.e., bathing, nail care, hair combing) was offered and/or completed for 5 of 6 residents (R39, R184, R134, R179, R383) reviewed for activities of daily living (ADLs) and who required staff assistance to complete such care. Findings include: R39 R39's significant change Minimum Data Set (MDS), dated [DATE], identified R39 had moderate cognitive impairment, demonstrated no delusional thinking, and was not diabetic. On 7/29/24 at 2:01 p.m., R39 was observed seated in his electric wheelchair while in his room. R39 had visibly long fingernails present on both hands, and the edge of the nail being multiple millimeters (mm) long on several nails with a dark-colored substance present underneath multiple nail edges. R39 was interviewed and stated the bathing he was provided at the care center was usually inadequate adding, [They] spray you a little bit and call it done. R39 stated the poor bathing assistance was turning my fingernails brown. R39 stated he needed help to clip and clean them but nobody from the care center ever offered help reiterating he wanted them clipped adding aloud, I sure would. R39's care plan, dated 6/15/24, identified R39 had an ADL self-care deficit with dictation reading, Refuses to shower prefers to wash self-up in bathroom. Care needs fluctuate throughout the day. The plan listed several interventions for R39 including, PERSONAL HYGIENE/ORAL CARE: The resident is independent. However, the care plan lacked information on what, if any, help or assistance R39 needed with nail care, including finger or toenails. The following day, on 7/30/24 at 1:50 p.m., R39 was observed laying in bed while in his room. R39's fingernails remained long and soiled as had been observed the day prior. R39's POC (Point of Care) Response History, printed 8/1/24, identified a 21-day review period of bathing support provided to R39. This identified staff recorded assistance on 7/16/24, 7/21/24, and 7/25/24. However, the data lacked further specific information on what cares were offered or completed. R39's medical record was reviewed, including progress notes and assessments (i.e., skin checks), and lacked evidence R39 had been offered or assisted with nail care within the past several weeks despite having visibly long, soiled nails present. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 7/30/24 at 1:58 p.m., nursing assistant (NA)-H stated they had worked with R39 multiple times prior and described him as often refusing care adding, [he] will not let you do anything for him. NA-H stated R39 was scheduled for a shower that day (7/30) and, earlier, NA-H offered it but R39 refused. However, NA-H stated they did not offer R39 any nail care or clipping. NA-H stated the NA can do such care if the resident is not diabetic but nail care, including if offered or refused, was not usually charted or documented. NA-H stated R39 often scratches himself adding, he does that a lot. Later, at 2:17 p.m., R39 came off the elevator in his electric wheelchair and NA-H observed R39's fingernails with the surveyor present. NA-H verified their length and condition expressing aloud, It's dirty. R39 was again asked about clipping his fingernails and was agreeable. On 7/30/24 at 2:20 p.m., registered nurse manager (RN)-E was interviewed. RN-E stated nail care was typically done as needed but usually offered on the scheduled bath days. RN-E stated the NA was able to complete it if the resident was not diabetic and, if refused, the nurse should document a progress note in the medical record adding, They document the refusal. At 2:22 p.m., the director of nursing (DON) joined the interview. DON stated R39 often refused care adding, I'm surprised he said yes to [NA-H]. DON verified the NA charting doesn't have the ability to record any nail care offered and refused, but expressed nail care should be offered with bathing adding, The expectation is nail care is a part of it. RN-E stated the only documentation they could locate was a progress note (dated 7/2/24) which outlined R39 refused his shower, and RN-E verified R39 would need staff help to clip the nails. RN-E and DON both acknowledged the lack of any documentation to demonstrate nail care had been offered or provided within the past several weeks. DON stated it was important to ensure nail care was offered and, if able, completed to promote good hygiene and as it was a dignity thing. R184 R184's admission MDS, dated [DATE], identified R184 had moderate cognitive impairment, demonstrated no delusional thinking, required substanital/maximal assistance with personal hygiene, and was not diabetic. On 7/29/24 at 5:57 p.m., R184 was observed while in his room. R184's right hand had a visible contracture with the finger turned into the palm making a nearly closed fist; however, the left hand had multiple long fingernails present with the nail edge being several millimeters (mm) in length and some having a dark-colored debris present underneath. R184 stated he was helped with a bath every week and looked down at his nails when asked about them. R184 was asked if staff helped him or offered to clip them ever and he responded aloud, They haven't so far. R184 stated he wanted his nails clipped and kept shorter. R184's care plan, dated 7/12/24, identified R184 had an ADL self-care deficit along with several interventions which included, PERSONAL HYGIENE: The resident requires assistance from staff with personal hygiene and oral care. The care plan lacked information or direction on nail care for R184. R184's POC Response History, printed 8/1/24, identified a 21-day review period of bathing support provided to R184. This identified staff recorded assistance on 7/14/24 and 7/21/24. However, the data lacked further specific information on what cares were offered or completed. R184's medical record was reviewed, including progress notes and assessments (i.e., skin checks), and lacked evidence R184 had been offered or assisted with nail care within the past several weeks despite having visibly long, soiled nails present. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/31/24 at 10:15 a.m., NA-H was interviewed. NA-H explained they had worked with R184 prior and he was typically accepting of cares adding, He's [R184] cool with me. NA-H stated nail care was typically done with bathing and not documented in the medical record, however, if it was offered and refused then the nurse would record it in the notes. Further, NA-H stated R184 was scheduled for a Sunday evening (PM) bath. At 10:24 a.m., NA-H and the surveyor looked at R184's nails while he was seated outside smoking. NA-H verified the length and condition adding, They need to be trimmed down. NA-H stated the debris under the nails appeared like he's itching or something. NA-H stated they would clip them that day. When interviewed on 7/31/24 at 11:28 a.m., RN-G stated R184 was usually accepting of cares and the NA could clip his nails if he wanted them done. RN-G stated any nail care offered and refused, should be recorded in the progress notes and then staff should let the manager know. 44656 R134 R134's quarterly Minimum Data Set, dated dated dated , 7/20/24 documented R134 with severe impairment of cognitive skills, physical and verbal symptoms directed towards others, had an indwelling catheter. In addition, documented R134 with diagnoses of Alzheimer's disease, dementia, seizures, depression, anemia, renal insufficiency (decreased kidney function), neurogenic bladder (disruption of the nervous system and the bladder) and obstructive uropathy (difficulty voiding). Also, R134 required extensive assistance of one staff member with bed mobility, eating, toilet use and required setup or clean-up assistance with oral hygiene. R134's Profile in the electronic medical record (EMR) listed family member (FM-A) as Responsible Party, primary emergency contact, Power of Attorney, care conference person, essential caregiver, financial responsibility and health care agent. R134's Kardex (nursing assistant care sheet) printed 7/31/24, identified R134 requiring assistance of one staff member for personal hygiene. During interview with FM-A on 7/29/24 at 3:25 p.m., FM-A stated, [R134] would not like it if he were unshaved and hair looking greasy and uncombed. During observation on 7/29/24 at 3:50 p.m., R134 laying in bed sleeping with face unshaved and hair glossy and uncombed. Review of R134 electronic medical record (EMR) under Tasks tab, the nursing assistant daily documentation of Task: ADL-Personal Hygiene for the month of July 2024, R134 did not refuse support for How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands. During observation on 7/31/24 at 7:38 a.m., R134 was observed laying on bed with a dried brown stain on pillowcase adjacent to his mouth. R134's hair was glossy, oily and uncombed and his face had whiskers .25 inches long. R134's lips were dry and chapped with a dried white substance in corner of left side of mouth. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview with registered nurse (RN)-C in R134's room on 7/31/24 at 7:44 a.m., RN-C verified the stained pillowcase, it is soiled. [R134] it needs to get washed up. Appears like [R134] has not been shaved in over a week. Aides are to offer sponge baths and shave men if they allow them to. If they refuse the shave or bed bath, I expect the aides to let me know and we can re-approach. During observation and interview with registered nurse (RN)-D in R134's room on 7/31/24 at 7:52 a.m., RN-D stated, Yes, [R134] appears to not have been shaved or cleaned up. Hair is oily looking. During interview with nursing assistant (NA)-B on 7/31/24 at 8:00 a.m., NA-B stated she was familiar with R135. NA-B stated nursing assistants receive a verbal report each day and are expected to review the electronic medical record (EMR) in the care plan Kardex (nursing assistant care sheet) to determine what tasks such as personal cares, diet intake, and outputs, and dressing assistance are supposed to be done for each resident. NA-B stated the nursing assistants who work on the memory care unit do not receive any paper list or care sheets on the residents. NA-B stated nursing assistants are expected to shave men, as needed or as allowed. NA-B looked in R135's EMR and verified she was unable to determine when R135 was shaved or cleaned up. During interview with RN-C on 7/31/24 at 1:24 p.m., RN-C stated, yes [R134] looked like he did not have shave in a long time. 47495 R179 R179's quarterly MDS, dated [DATE], indicated R179 was admitted to the facility on [DATE], was cognitively intact and required partial to moderate assistance with personal hygiene. R179's Care Plan, dated 6/5/24, indicated R179 had an ADL [activities of daily living] self-care performance deficit r/t [related to] a recent hospitalization with right humerus [upper arm bone] fx [fracture], DM2 [diabetes mellites type II], and hx [history] of CVA [cerebral vascular accident] and required staff assistance with personal hygiene. During observation and interview on 7/29/24 at 6:17 p.m., R179 was laying in her bed, her fingernails and toenails were noticeably long, approximately 1/4 inch and her toenails appeared to be starting to curve over. R179 stated she had asked staff to cut her nails or see the podiatrist but had not heard a thing about it. R179 stated staff had told her they could not cut her nails because she had diabetes. During an interview on 7/31/24 at 9:39 a.m., nursing assistant (NA)-M stated he would not cut a resident's fingernails or toenails if they had a diagnosis of diabetes, but the nursing assistants should notify the nurse if a resident needed toenails or fingernails cut or requested to see the podiatrist. During an interview on 7/31/24 at 11:38 a.m., licensed practical nurse (LPN)-F stated any nurse can cut or trim a resident's fingernails if they have a diagnosis of diabetes, toes nails would depend on an assessment and if he felt comfortable enough to cut them, often the resident would see podiatry for their toenails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/1/24 at approximately 10:30 a.m., nurse manager and registered nurse (RN)-H stated it was expected that any nurse would be able to cut a resident's fingernails or toenails, even with a diagnosis of diabetes. RN-H stated she had cut R179's toenails yesterday evening, 7/31/24. During an interview on 8/1/24 at 12:40 p.m., the director of nursing (DON) stated it was expected that a resident with long toenails or fingernails should have their nails cut or trimmed on bath day. R383 R383's admission MDS, dated [DATE], indicated R383 was admitted to the facility on [DATE], was cognitively intact and required partial to moderate assistance with activities of daily living (ADLs) to include toileting, bating and dressing. R383's Care Plan, dated 7/15/24, indicated R383 had an ADL self-care performance deficit r/t [related to] recent hospitalization for traumatic ischemia [reduced blood flow] of muscle, COPD [chronic obstructive pulmonary disease, lung disease causing restricted airflow and breathing problems], emphysema [a condition in which the air sacs of the lungs are damaged and enlarged, causing breathlessness], and schizoaffective disorder [a mental health condition including schizophrenia and mood disorder symptoms] and required assistance from one staff member with showering or bathing. R383's Task-ADL Bathing, printed 7/31/24, indicated R383 bath day was Wednesday and had not received a bath or shower since she admitted to the facility, indicating on 7/24/24 and 7/31/24 resident refused. During observation and interview on 7/29/24 at 2:29 p.m., R383 was sitting on her bed dressed in a hospital gown, her hair was noticeable greasy and matted. R383 stated she had not had, or been offered, a shower since she got the facility. During an interview on 7/31/23 at 11:38 a.m., licensed practical nurse (LPN)-F stated if he was made aware of a resident refusing a bath or shower, he would approach the resident and explain the benefits of accepting a shower but was not 100% sure what the facility policy or expectation was for refusal. LPN-F further stated he had never heard of R383 refusing cares and she was usually very easy to work with. During a follow up observation and interview on 8/1/24 at 12:01 p.m., R383's hair continued to look greasy and matted and her finger and toenails were approximately 1/4 inch long with dark matter under the fingernails. R383 stated she had not refused a shower yesterday and a staff member had come to her room a few hours ago to ask her about a shower and offered to help her tomorrow with a shower. During an interview on 8/1/24 at approximately 10:30 a.m., nurse manager and registered nurse (RN)-H stated it was expected for a resident to be offered a shower at least three times and to pass it on to the next shift if they continue to refuse, stating it would also be expected that the nurse be made aware. RN-H was unaware of R383 refusing any cares or showers. RN-H further stated it would be expected that toe and fingernails be trimmed and clean, even if a resident refused a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/1/24 the director of nursing (DON) stated it was expected that all residents are getting a shower or bath, stating I will make sure it gets done.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to develop proactive interventions to promote appropriate bowel function and decrease the risk for discomfort or further complications for 1 of 1 resident (R9) reviewed for bowel management. In addition, the facility failed to transcribe prescription orders for 1 of 1 (R78) reviewed for non-pressure related skin breakdown. Findings include: R9's quarterly Minimum Data Set (MDS) dated [DATE], indicated R9 had no cognitive deficits and required moderate assistance with transferring, bathing, and toileting hygiene. The MDS indicated R9 always had bowel incontinence and a toileting program was not currently being used. R9's medical diagnoses dated 3/22/24, indicated R9 was diagnosed with diabetes, bilateral lower extremity ulcers, respiratory failure, heart failure, kidney disease, and chronic pain syndrome. R9's care plan dated 3/22/24 indicated the resident had bowel incontinence with decreased physical functioning. R9's care plan included the following interventions last updated on 3/22/24: check resident every two hours and assist with toileting as needed until a routine was established, observe for a pattern of incontinence, and initiate toileting schedule if indicated. The care plan included the following interventions last updated on 5/18/22: provide bedpan/bedside commode and perineal care after each incontinent episode. R9's care plan dated 6/14/24, indicated R9 had pain to both lower extremities due to injuries, with the following intervention dated 5/18/22, monitor for side effects of pain medication such as constipation and report occurrences to the physician. The care plan did not indicate what R9's usual pattern or desired frequency of bowel movements. R9's Bowel/Bladder assessment dated [DATE], indicated R9 had bowel incontinence and used a narcotic, antidepressant, and calcium channel blocker medication. The assessment indicated R9's activities of daily living goal was to improve her current level of function by the review date with the intervention of an assist of one staff member with close supervision to use the commode over the toilet. The assessment indicated that R9 had a routine bowel elimination pattern. The assessment indicated the care plan was updated to include checking on the resident every two hours to assist the resident with toileting as needed until a routine was established, they would observe for patterns of incontinence and initiate a toileting schedule as indicated, provide a bedpan/bedside commode, and provide peri-care after each incontinent episode. R9's order summary report dated 4/15/24, included an order for one tablet of 5-325 milligrams (mg) of oxycodone-acetaminophen (a narcotic pain medication) scheduled for four times a day. The summary included an order dated 3/22/24, for one tablet of 8.6 mg of sennosides (medication for constipation) two times a day. The order summary did not include any additional scheduled bowel medications that had been attempted since the addition of sennosides on 3/22/24. R9's bowel movement task history dated 7/1/24 through 7/29/24, indicated R9 had no bowel movement on the following days, 7/2/24-7/5/24, 7/9/24- 7/12/24, 7/14/24-7/16/24, 7/20/24-7/22/24,7/24/24, 7/26/24-7/29/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9's provider note dated 7/12/24, indicated R9 denied nausea or an upset stomach at the time of assessment and her abdomen was soft. The note indicated R9 was taking multiple medications which put her at risk for side effects. R9's progress note dated 7/19/24 at 10:51 p.m., indicated R9 had normal bowel sounds, was incontinent of bowel, and had no bowel symptoms. R9's progress notes dated 6/30/24 to 7/29/24 were reviewed and did not include additional bowel assessments (excluding 7/19/24) or new interventions to prevent R9 from developing feelings of constipation. R9's progress notes did not indicate the facility had updated the provider on R9's continued reports of constipation. The facility Standing Orders dated 2024, included the following steps to be followed when constipation was reported: consider rectal check for possible impaction, encourage 2000 milliliters (mL) of fluid daily unless contraindicated, consult nutrition services for dietary recommendations, two tablets of 8.6 mg of sennosides given during the evening as needed for three days, one 10 mg suppository of Bisacodyl (medication for constipation) daily as needed for three days, reattempt sennosides or Bisacodyl if no results after 24 hours and notify the provider, and lastly monitor and record results from treatment. During an interview on 7/29/24 at 2:31 p.m., R9 stated she received one tablet of sennosides to help her prevent constipation, but she has been receiving it for a while and felt it was no longer helpful. R9 stated it had been about one to two weeks since she had a full bowel movement, and it was starting to feel uncomfortable and she had communicated this to nursing staff in the past. R9 stated they had not tried anything new to help her with her constipation in a while. During an interview on 7/30/24 at 3:12 p.m., R9 stated she has been chronically constipated and it has been frustrating for her as she felt like no one had been doing anything to help her. R9 stated she would like to have a bowel movement more often than every three days, but the nursing staff didn't seem to intervene until she was already constipated. During an interview and observation on 7/30/24 at 3:18 p.m., registered nurse (RN)-A stated she was the nurse in charge of R9's care for the day shift. RN-A stated she had not assessed if R9 had active symptoms of constipation but R9 had not reported any symptoms to her and she was confident R9 would as R9 had reported feeling constipated various times in the past. RN-A stated nursing staff should have been assessing bowel movement status every day but thought this occurred on the night shift. RN-A was observed attempting to locate a bowel movement history on the electronic medical record but was unable to locate this information. RN-A stated she was unsure what R9's usual bowel pattern was or what her goal was for often she wanted to have a bowel movement. RN-A stated after it had been three days of a resident not having a bowel movement, they would initiate the standing bowel management orders, but she was unsure if this was needed at this time. RN-A stated nursing staff did not notify the provider of constipation unless the standing orders were unsuccessful. RN-A stated R9 was receiving scheduled sennosides for constipation prevention but was unsure what else was being utilized to help prevent constipation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/31/24 at 1:54 p.m., RN-K, the unit nurse manager, stated she and the day shift nurse oversaw monitoring and trending bowel movements. RN-K stated she was aware R9 had a history of struggling with constipation as it had been reported to nursing staff previously. RN-K acknowledged R9's risk for constipation related to her narcotic use and lack of activity. RN-K stated the last time she saw an update to her narcotic regimen was on 4/15/24 and it looked like R9 had not had any updates to her scheduled bowel medication regimen since before this date. RN-K stated she was unsure if the provider had been updated on R9's pattern of symptoms of constipation. RN-K stated nursing staff waited for R9 to report symptoms of constipation or after three days of R9 not having a bowel movement and then the floor nurse would initiate the standing orders. RN-K stated she was unaware if a toileting schedule had been initiated but after reviewing the medical record, did not note any additional interventions to assist R9 with her feelings of constipation since 3/22/24. During an interview on 8/1/24 at 2:38 p.m., the director of nursing (DON) stated it was important that nursing staff review the bowel movement records and identify any patterns so the resident can be reassessed as needed and the provider can be updated if the current bowel regimen is not preventing the resident from having symptoms of constipation. A policy regarding bowel management was requested and not received. 49654 R78 R78's readmission Minimum Data Set (MDS) indicated R78 had substantial cognitive deficits and required substantial/maximal assistance to bathe, and dress lower body and partial moderate assist with dressing upper body. R78's medical diagnoses included altered mental status, dementia, rash and other nonspecific skin eruption and generalized pustular psoriasis (scaly skin with infected blisters). R78 progress notes dated 7/29/24, indicated R78 returned to the facility on [DATE] following a hospital admission on 7/20/24. R78's care plan indicated the resident required skin inspections during cares to observe for redness, open areas and nursing staff to complete weekly body audits. Hospital discharge summary dated 7/29/24, indicated R78 was admitted with urosepsis (generalized infection involving the urinary tract), was given intravenous antibiotics and subsequently developed a rash due to generalized pustular psoriasis flare. Upon discharge R78 was prescribed Triamcinolone acetonide 0.1% cream (medication to treat psoriasis) and white petroleum jelly ointment to treat rash. Further, R78 was prescribed cyclosporine (psoriasis medication) 100 milligrams (mg), rosuvastatin (cholesterol lowering medication) 5 mg, and calcium (mineral supplement) 500 mg. A review of R78's medical record on 7/30/24 did not reflect the new orders for Triamcinolone acetonide 0.1 % cream and white petrolium jelly,to treat skin rash, however the additional new prescriptions were prescribed and had been given to R78. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/31/24 at 08:43 a.m., registered nurse (RN)-F stated when a resident returned from the hospital the health unit coordinator (HUC) processes any new orders and the orders are second checked by a nurse to verify accuracy. If the HUC is unavailable the floor nurse would enter any new orders and a second nurse would verify. RN-F stated she could see the orders for the creams in R78's discharge summary but could not locate the creams in his active orders. RN-F stated when R78 came back from the hospital she was the verifying nurse and she had ultimately missed the order. During interview on 8/1/24, at 09:21, director of nursing (DON) stated upon admission or re-admission, new orders are processed by the HUC, and a nurse will verify the orders for accuracy. DON stated her expectation was nursing staff working the shift on which the resident arrives, or at the latest on the next shift, would transcribe, verify, and order any new medications from the pharmacy. DON confirmed R78's new physician ordered creams were not transcribed within her expected time frame and in fact were not completed until two days later 7/31/24. She went on to state it was important for R78 to receive his prescribed treatment to assist in healing his skin and not cause pain or discomfort.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure orders for an audiology referral were acted upon in a timely manner to promote better hearing and quality of life for 1 of 2 residents (R39) reviewed who expressed difficulty with hearing. Findings include: R39's significant change Minimum Data Set (MDS), dated [DATE], identified R39 had moderate cognitive impairment but demonstrated no delusional thinking. Further, the MDS identified R39 had adequate hearing (i.e., no difficulty in normal conversation) and did not use hearing aids. On 7/29/24 at 1:56 p.m., R39 was interviewed. R39 stated his hearing seemed to be getting worse as of late and added, The wax has gotta get cleaned out of my ears. R39 stated nobody from the care center had asked him about his hearing and wished they would so he could get new hearing aides. R39 stated he thought an audiology appointment was set-up with the VA (Veterans Administration) but was not adding, I sure wish they'd get it set up. R39's Nursing Assessment - Admission/Readmission + Careplan - V13, dated 4/15/24, identified a section labeled, Oral, Vision and Hearing Status, which outlined R39 was able to hear at level of conversation and did not use hearing aids. The section concluded with an area labeled, Additional Hearing Ability/Ears Comments, which was answered with, N/A. The completed evaluation lacked evidence the ears were physically inspected, including with an otoscope, to determine wax build-up or evidence if a hearing appointment was offered. R39's Progress Note, dated 4/16/24, identified R39 was seen by the medical provider for their initial visit. A physical exam was recorded which listed R39 as, HOH [hard of hearing], along with a diagnosis reading, H91.93 Bilateral hearing loss, unspecified ., with orders, Consult to audiology. The note concluded with a section labeled, Plan, which directed, Consult in-house audiology. Dx [diagnosis]: HOH, eval for hearing aides. R39's Care Conference Summary - V2, dated 6/24/24, identified a care conference was held for R39 on 6/21/24, with R39 being invited but not attending. A section labeled, Appointments, listed fields to record applicable appointment dates (either upcoming or last had) and this included a field labeled, Audiology. However, this was left blank and not completed; nor was there evidence the audiology referral order from earlier (dated 4/16/24) was reviewed. When interviewed on 7/30/24 at 1:58 p.m., nursing assistant (NA)-H stated they had worked with R39 multiple times and described him as resistant to cares adding, He will not let you do anything for him. NA-H stated they had once in awhile heard R39 complain about his hearing or make a comment like, I can't hear you. NA-H stated they last heard this comment sometime ago, adding, Maybe about a month ago. NA-H stated they had not reported the comment to the nurses so they were not sure if they knew or not. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39's medical record was reviewed and lacked evidence R39's difficulty hearing had been comprehensively assessed to determine what, if any, immediate interventions could be completed to improve his hearing (i.e., wax removal); nor evidence the ordered audiology consult had been acted upon and scheduled despite staff hearing comments about ongoing, difficulty hearing. On 7/30/24 at 2:33 p.m., registered nurse manager (RN)-E and the director of nursing (DON) were interviewed. DON verified in-house audiology services were available, however, had not been scheduled for R39 as they were unaware R39 had complaints of poor hearing. RN-E and DON both verified staff should be reporting those complaints so they can be acted upon and, if needed, a treatment (i.e., Debrox) could be started. RN-E verified R39's medical record lacked evidence the hearing difficulties had been evaluated or acted upon for immediate treatment adding, I don't see anything. DON acknowledged the consultation order from April 2024, and stated they would look into it further. DON and RN-E both acknowledged hearing issues should be acted upon and, if needed, evaluated adding it was important because we don't want it to get worse. On 7/31/24 at 7:55 a.m., DON was interviewed and verified the consult order had been transcribed into the medical record but not completed. DON stated they were going to reach out to the VA and get it scheduled. DON expressed the unit had a health unit coordinator (HUC) who resigned abruptly which could have contributed to the appointment being missed. A facility policy on audiology services and hearing examinations was requested, however, none was received.

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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** 49654 Based on observation, interview, and document review, the facility failed to ensure 1 of 1 residents (R195) with repeated falls had implemented interventions to promote safety and reduce the risk of falls. Findings include: R195's admission minimum data set (MDS), dated [DATE], indicated R195 had diagnoses including cerebral infarct (stoke), hemiplegia (paralysis on one side of the body), and hemiparesis (unable to fully use one side of the body), history of falling with injuries and muscle weakness. Further, R195 required extensive assistance with bed mobility, transfers, and toileting. R195's care plan indicated he was at risk for falls with history of falls related to unsteady gait, cognitive deficits, and syncope. Interventions included R195's call light should be within reach, and to provide a safe environment. R195's physical device assessment, dated 7/25/24, indicated R195 required a perimeter mattress (a mattress that creates a raised edge to decrease falls from bed). Additionally, the medical record indicated a physician order dated 7/25/24, for R195 to use a perimeter mattress. R195's care plan did not indicate the use of a perimeter mattress. During observations between on 7/30/24, at 09:41 a.m., R195 way lying in bed watching TV with their left leg hanging slightly off edge of bed. R195 was observed with a standard air mattress on their bed. During subsequent observations on 7/31/24 and 8/1/24 R195 continued to be observed with a standard air mattress on their bed. During interview on 7/31/24, at 01:58 p.m., registered nurse (RN)-G stated residents who have falls can have multiple interventions included a low bed, call don't fall signs, floor mats or a perimeter mattress. RN-G stated falls are reviewed daily by the interdisciplinary team (IDT) and interventions are determined by the team. Furthermore, RN-G stated R195 had a physical device assessment on 7/25/24 and was determined R195 would benefit from a perimeter mattress. An order was received on 7/25/24 and a requisition should have been placed at that time. RN-G was unable to locate a request for the perimeter mattress and confirmed that R195 did not currently have a perimeter mattress in place. During interview on 8/1/24. At 09:21a.m., director of nursing (DON) stated the IDT reviews resident falls daily and collaboratively plan for interventions to best meet each residents' individual needs. DON stated if an order is received from a provider for a medical device to reduce falls, she would expect the device to be immediately put into place, or within 24 hours if device needed to come from an outside durable medical equipment company. DON stated she understood R195 had an order to use a perimeter mattress but confirmed it had not been implemented. DON stated it is important to implement interventions and physician orders to decrease the risk of falls and potential injuries to residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy Fall Mitigation Program dated April 1,2022 indicated each resident will be assessed for fall risk and will receive the care and services in accordance with their individualized level of risk to minimize the likelihood of falls.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview and document review, the facility failed to comprehensively reassess to determine what, if any, additional interventions with pain management were needed for 1 of 3 residents (R39); and failed to assessed and develop non-pharmacological interventions to promote comfort for 2 of 3 residents (R69, R131) reviewed for pain management. Findings include: R39 R39's significant change Minimum Data Set (MDS), dated [DATE], identified R39 had moderate cognitive impairment but demonstrated no delusional thinking. The MDS outlined R39 consumed scheduled pain medication and had pain on an almost constant basis during the review period. R39's most recent Pain Interview 23 - V1, dated 6/5/24, identified R39 received schedule pain medication but no as-needed (PRN) or non-pharmacological interventions for pain. The evaluation outlined R39 reported pain almost constantly which occasionally affected his sleep. The pain was listed as being rated, 9, along with Moderate. The evaluation concluded, Resident has scheduled pain medications, has not used any prn meds this assessment period. The evaluation lacked further dictation, including from R39, to say if this plan was effective or sufficient for R39's pain management goals or needs. R39's care plan, dated 6/15/24, identified R39 had chronic pain due to a physical disability, previous stroke and depression. A goal was listed which read, The resident will not have an interruption in normal activities due to pain through the review date, along with several interventions including administering medications as ordered, anticipating his pain needs, and monitoring his pain episodes to remove/limit causes when possible. On 7/29/24 at 2:04 p.m., R39 was observed while in his room and had no obvious physical signs of pain present (i.e., grimace, moaning). However, R39 was interviewed and expressed he had pain ever since I broke my hip prior. R39 described the pain as a burning and reiterated it was just a nuisance. R39 stated his pain, at this time, was about a five [5] and was worse when moving around adding he took Tylenol or something but it was not always helpful to lower the pain. R39 stated he wished more could be done but added, If you complain or something they [staff] think you're a sissy. R39 stated the staff rarely, if ever, offer him heat or ice packs for his hip, either. R39's recent Regulatory Visit note, dated 6/18/24, identified R39 was seen by the nurse practitioner to follow up on multiple chronic conditions. The note outlined R39's medications which included Biofreeze (topical pain gel; kept at bedside), Belbuca 450 micrograms (mcg) twice daily, and duloxetine 40 milligrams (mg; antidepressant, sometimes used for chronic pain). The evaluation listed a section labeled, PLAN, which directed to discontinue R39's duloxetine dose and, Start duloxetine 60 mg po [by mouth] once daily. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39's Medication Administration Record (MAR), dated 7/2024, identified R39's physician-ordered and provided medications as initialed by staff. The MAR outlined the new order for duloxetine with dictation, Duloxetine HCL . 60 mg by mouth in the morning for musculoskeletal pain , along with a start date, 06/19/2024. The MAR included the order for Belbuca Buccal Film 450 mcg twice a day along with a space to record, Pain Level, which had a daily number recorded for R39's reported pain level. These recorded pain levels ranged from 0 to 10, with over 15 episodes of pain rated at 5 or higher being listed despite the medication increase on 6/19/24. When interviewed on 7/31/24 at 11:11 a.m., registered nurse (RN)-G stated they had worked with R39 multiple times and he often complained about pain adding, He will tell you it's 10/10. RN-G stated they provide R39 his scheduled pain medication and, when that is given, they ask him about pain to which R39 states is everywhere but mostly in his leg. RN-G stated the floor nurses complete the Pain Interview (evaluation) but any re-evaluation, such as after pain medications are adjusted, would be done by the nurse in charge adding the manager. RN-G stated any re-evaluation should be in the medical record under an assessment (i.e., Pain Interview) or progress note. R39's medical record, including progress notes and physician notes, was reviewed and lacked evidence R39 had been comprehensively reassessed after the medication adjustment to ensure it was effective or what, if any, additional interventions were wanted or needed to promote comfort despite R39 have multiple pain levels recorded at moderate (i.e., 5) or above. On 7/31/24 at 2:34 p.m., registered nurse manager (RN)-E was interviewed and verified they reviewed R39's medical record. RN-E verified the last completed Pain Interview was 6/5/24 and there had been no others since then despite R39's medication being increased afterward. RN-E stated, typically, the nurses will enter an order to follow-up after medication adjustments but expressed it was good practice to follow up with a pain assessment. RN-E stated R39 was often difficulty to evaluate for pain as he'd often just say, I'm OK, I'm OK. RN-E expressed it was important to ensure pain was re-evaluated after intervention adjustment (i.e., medication change) to help make sure that it's effective and if it isn't then what our next intervention is going to be. RN-E acknowledged the lack of documentation in R39's medical record to show re-evaluation and expressed, We'd [nursing leadership] like to see more [documentation]. 49339 R69 R69's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R69 had severely impaired cognition. Assessment indicated in section J-Health Conditions section J0100 pain medication section A: been on a schedule pain medication regimen marked yes, section B: received PRN pain medication marked yes, section C: received non-medication interventions for pain marked no. Further the form indicated R131 frequently has pain which occasionally effects sleep and day-to day activities and rated pain at a 6 out of 10 on a pain scale. R69's face sheet, printed on 8/1/24, identified the following diagnoses: chronic pain syndrome, epigastric (stomach) pain, low back pain, chronic pain, and dysphagia (difficulty swallowing). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 7/29/2024 at 2:02 p.m., R69 reported having pain. A single page hanging on the wall at the end of the bed was observed which indicated, Tube Feeding flush every 4 hours, scheduled pain meds every 4 hours please do this in a timely manner - thank you. R69 stated they don't do anything except medication here and it's not helping. R69 further indicated he would like to try other things. R69 stated they have never offered him a cold or warm pack and believes it would help. R69's care plan, printed 8/1/24, indicated, resident is on pain medication therapy r/t [related to] nerve pain with an intervention of use non-pharmacological interventions. The care plan lacked evidence of what non-pharmacological interventions have been tried, what has been effective and not effective and what non-pharmacological interventions should be used. R69's Order Summary Report, printed 8/1/24, indicated the following orders for pain/pain management: -Acetaminophen (medication used to relieve pain) give 1,000 milligrams (mg) via J-tube (tube placed into small intestine) three times a day for pain -Capsaicin Cream (topical cream used to relieve pain) 0.075 % Apply to Lower extremity topically three times a day for nerve pain -Gabapentin (anitconvulsant medication, sometimes used to relieve pain) Oral Solution Give 8 milliliters (ml) via G-Tube (tube place into the stomach) three times a day for pain 250 mg/5 ml -Lidoderm (topical patch used to relieve pain)Patch 5 % (Lidocaine) Apply to Right shoulder topically as needed for pain Apply for 12 hours and remove -Methocarbamol (medication used to relieve muscoloskeletal pain) give 750 mg via J-Tube four times a day for musculoskeletal pain -oxycodone (narcotic pain medication used to treat moderate to severe pain) HCl Oral Tablet give 5 mg by mouth every 4 hours as needed for G-tube pain -oxycodone HCl Oral Tablet 5 MG give 5 mg by mouth every 4 hours for Pain for 7 Days The order summary report lacked evidence of any non-pharmacological interventions. R69's July's MAR/TAR (medication administration record and treatment administration record) lacked evidence of an order for any non-pharmacological intervention orders. It further lacked evidence of any non-pharmacological intervention being offered and/or declined. A pain scale was used on the administration of Tylenol and Oxycodone which showed pain scale ratings of 0-9. MAR/TAR lacked evidence of non-pharmacological interventions being offered prior to administration of pain medication. R169's pain interview, dated 7/31/24, indicated R69 received scheduled and PRN pain medication. A radio-button answered not assessed/no information was answered for non-medication intervention for pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R69's progress note, dated 7/30/24, indicated Res complained of new onset of pain to g-tube site on 7/30/24 with mediation administration and flushing. Primary NP updated and will assess res on 7/31/24. Res G-tube and surrounding skin intact and without issue at this time. According to res pain relief is effective but only for a short time. Nursing staff to continue to offer PRN and schedule pain relief and update primary NP as needed. R69's progress note, dated 7/31/24, indicated new order for oxycodone received abdominal x-ray ordered. A further review of R69's progress notes, dated 7/1/24 to 8/1/24, were reviewed. Progress notes lacked evidence of any non-pharmacological interventions being offered to R69 for pain. R131 R131's quarterly MDS assessment dated [DATE], identified R131 had intact cognition. Diagnoses included: hypertension (high blood pressure), traumatic brain injury (brain dysfunction caused by an outside force), abnormal weight loss, dysphagia (difficulty swallowing), and alcohol use. Assessment further indicated in section J-Health Conditions section J0100 pain medication section A: been on a schedule pain medication regimen marked yes, section B: received PRN pain medication marked no, section C: received non-medication interventions for pain marked no. During observation and interview on 7/29/2024 at 1:33 p.m. R131 indicated he has chronic pain. R131 stated he has pain in his hip because he broke it while ago and pain in my left shoulder. R131 stated they take Tylenol for the pain. R131 stated they have not been offered any other interventions for pain. R131 stated, they don't offer me anything like a heating pad or ice, and further indicated he would like to try something besides medication. R131's care plan, printed 8/1/24, indicated, resident is on pain medication therapy r/t [related to] left hip fx [fracture] pain with an intervention of use non-pharmacological interventions. The care plan lacked evidence of what non-pharmacological interventions have been tried, what has been effective and not effective and what non-pharmacological interventions should be used. R131's Order Summary Report, printed 8/1/24, indicated all active orders for R131. The order summary report lacked evidence of any non-pharmacological interventions. R131's July's MAR/TAR lacked evidence of an order for any non-pharmacological interventions. The record does indicate an order for the following: Tylenol extra strength 500 milligram (mg) - administer 1,000 mg by mouth three times a day for pain. The MAR/TAR lacks pain level rating with each administration of pain medication. R131's most recent Pain Interview Assessment, dated 6/17/24, indicated resident is on scheduled pain medication. Further the document indicated by a radio-button answered no that R131 received non-medication intervention for pain. The assessment indicated he had occasional pain in the last 5 days which occasionally limited his day-to-day activities and rated his pain at a 3 out of 10 on a pain scale. R131's progress notes, dated 1/1/24 to 8/1/24, were reviewed. Progress notes lacked evidence of any non-pharmacological interventions being offered to R131 for pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/30/24 at 2:15 p.m., nursing assistant (NA)-I indicated they work full-time and are familiar with work processes. NA-I indicated that R69 and R131 both have chronic pain. NA-I indicated when pain is reported to them, they are trained to report the pain to the nurse for follow up. NA-I indicated that nurses provide any medication or non-pharmacological interventions to residents. NA-I verified nursing assistants do not provide any non-pharmacological interventions to residents without direction from a nurse as this needs to be documented. During interview on 7/31/2024 at 12:17 p.m., registered nurse (RN)-E verified they are familiar with R69 and R131. RN-E verified both residents have chronic pain. RN-E stated they are unaware of the last time R131 had physical therapy. RN-E verified pain needs to be evaluated by a nurse when reported. RN-E stated it is important to know the location of pain, how severe, if it is on-going or occasional, if they are scheduled or PRN (as-needed) medication and to update the provider. RN-E stated nursing assistants should report any pain that a resident reports to them to the nurse for follow up. RN-E stated any interventions provided, whether medication or non-pharmacological (any type of healthcare intervention which is not primarily based on medication) interventions, would be charted in the medication administration record. RN-E stated, technically we are supposed to put in a progress note but it gets missed. RN-E verified non-pharmacological interventions should be documented in progress notes and on the MAR/TAR. During interview on 8/01/24 at 11:39 a.m., licensed practical nurse (LPN)-C verified they are familiar with R69 and R131. LPN-C verified R69 has known chronic pain and rates it at an 8 out of 10 on a pain scale. LPN-C verified R131 has known chronic pain that is controlled with scheduled pain medication and currently not using any PRN pain medication. LPN-C verified any non-pharmacological interventions would be listed in the order section of the medical record and would be charted on. LPN-C stated, on second floor we use oils and stuff to help with some behaviors and those are charted on, but we don't use them up here. LPN-C verified neither R131 or R69 are being offered or utilizing any non-pharmacological interventions to help manage their known chronic pain. On 8/1/24 at 2:47 p.m., director of nursing (DON) stated, residents with pain should be offered non-pharmacological interventions such as repositioning, warm or cold packs and then the nurse is going to document whether or not it was effective or non-effective. DON verified non-pharmacological intervention would be found on the MAR/TAR (medication/treatment administration record). A policy on use of non-pharmacological interventions for pain was requested but not provided.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview and document review, the facility failed to ensure direct-care nursing staff were appropriately trained and competent in the use of a external ventilator machine used for 1 of 1 resident (R17) who used the machine on overnight hours and had significant respiratory disease/impairment. Findings include: R17's quarterly Minimum Data Set (MDS), dated [DATE], identified R17 had intact cognition along with several medical conditions including heart failure, Parkinson's Disease, seizure disorder, respiratory failure, and chronic lung disease (i.e., asthma, COPD). On 7/29/24 at 2:31 p.m., R17 was observed seated in an electric wheelchair while in her room with oxygen in place via a nasal cannula. R17 had a hospital-style bed placed next to the wall and adjacent to the bed was a [NAME] Respironics Trilogy 100 machine (a portable, external ventilator) positioned on a vertical stand with a nasal mask (i.e., nasal port with strap to secure around head) attached and draped over the device. The vertical stand and attached medical device consisted of the machine itself, a suspended bag of sterile water along with tubing connected to a visible water chamber with condensation present on the top (i.e., bubbling), and tubing then connected from the chamber to the mask draped over. R17 stated she used the device every night while asleep adding someone from an outside company comes in every six to eight weeks to change the tubing and all that on the ventilator. R17 stated staff did not touch or manage the device adding not without getting yelled at by me. R17 stated she was unsure what, if any, actions staff took with the machine at night (i.e., adjusting, monitoring) adding when she was attached to it and asleep she was dead and [whatever they did] probably wouldn't phase me. Further, R17's doorway, which opened to the hallway, had a white-colored sign posted on it which read, Please do not disturb beween [sic] 10P and 7A [below] O2 check OK. R17's care plan, dated 7/25/24, identified R17 had an altered respiratory status with shortness of breath (SOB), sleep apnea and COPD (chronic obstructive pulmonary disease). The care plan listed, Will refuse to wear trilogy at times or remove during the noc [night]. A goal was listed which outlined, . will have no complications r/t [related to] SOB through the review date, along with several interventions to help meet this goal. The interventions included giving medications as ordered, oxygen at 2 liters per minute (LPM), and, Current Trilogy Settings: 1: please adjust flow rate/rise time for patient comfort 2: reduce target tidal volume to 380 cc (based on predicted lean body weight 43kg for 59 in height), and, Trilogy machine as ordered. Routine cleaning per SHO [house orders]. The care plan lacked information on R17 self-use of the machine or what, if any, potential alarms on the machine meant or, if applicable, the needed staff actions. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 7/31/24 at 11:22 a.m., registered nurse (RN)-G stated they had worked with R17 multiple times and verified they were currently assigned her care for that shift. RN-G stated R17 used the Trilogy machine during the overnight hours and, during the day and evening, only used oxygen in her cannula. RN-G stated the night shift mostly had to address or deal with the machine, however, the nurses on other shifts did, at times, have to clean it and wash the chamber. RN-G stated they did not, at least to their recall, remember anyone from the care center doing training with them on the device or what to do if it was in use and alarmed adding, Not really. R17's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 7/2024, identified R17's current treatments and spaces for staff to record their administration. The MAR included an order which read, TRIOLOGY MACHINE AT HS [bedtime] and NAPS, Titrate oxygen as needed for Sats 89-94% at bedtime ., with a listed start date, 04/20/2024. The MAR and TAR lacked any additional guidance on how to apply/remove the device, or alarm mitigation, if needed. Later on 7/31/24, at 1:45 p.m., R17 was interviewed and stated she had significant respiratory disease. R17 stated she applied and activated the Triology machine herself adding, I wouldn't trust them [staff] to touch it. R17 stated she had woken up with the machine alarming at night before and, when asked how she addressed it, just responded, I deal with it myself. R17 stated she would ask staff for help with it, if needed. When interviewed on 8/1/24 at 6:47 a.m., licensed practical nurse (LPN)-E verified they were the nurse assigned to R17 during the previous overnight shift adding they had worked on overnights with R17 multiple times. LPN-E stated R17 needed not much help or care during the nights but once in awhile would ask for help with that machine [Triology]. LPN-E stated the machine was like a CPAP and usually R17 would only ask for the water to be replaced in it and never with the mask application or such. LPN-E stated R17 managed the machine by herself and they had never been told, either by staff or R17, it had ever alarmed prior. LPN-E stated if the machine alarmed, they would inspect it and troubleshoot it to figure out what happened and how to fix it adding R17 was the only one with this kind of machine. LPN-E stated there was no user manual for the device present on the unit to their knowledge and expressed if something happened, R17 would wake up and tell them if she needed help. LPN-E stated the care center had not provided any education to them on the device to their recall, however, expressed they felt if something happened with it they could adequately address it adding, I could figure it out. On 8/1/24 at 9:44 a.m., registered nurse manager (RN)-E was interviewed. RN-E stated R17 had used the Trilogy device for over a year now and the night nurse sometimes helped apply the mask to ensure she's putting it on right. RN-E stated the machine' settings were pre-programmed so it was simply a turn-on or turn-off system. RN-E stated they could not recall what, if any, education the device itself had been done with staff adding, I don't think so, no [any done]. RN-E stated they felt the machine itself would display an error, if it happened, and then tells you [itself] what's going on with it. RN-E stated if staff were unable to resolve an error or if the device developed air leaks, the staff could always call the vendor, Northwest Respiratory to help manage it. RN-E stated the facility used to have a nurse educator who would help, if needed, train staff on use of medical devices but added, I'm not sure if we have one in place now. RN-E acknowledged the importance of ensuring staff are trained in the use of the Triology machine as staff need to know how the machine operates and who to call if issues developed with it. Further, RN-E stated there was no user manual for the device, at least to their knowledge, at the nurses' station but one was maybe kept in R17's room. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the recertification survey, from 7/29/24 to 8/1/24, evidence of what, if any, staff training with R17's Triology 100 was requested; however, none was received. In addition, a request was made of the device' reporting with what, if any, alarm(s) had triggered for the past 30 day period; however, this was not received or provided. On 8/1/24 at 10:53 a.m., the director of nursing (DON) and assistant director of nursing (ADON) were interviewed. DON stated the previous nurse educator had resigned several months prior and verified no education with staff on the device had been completed to their knowledge. DON expressed R17 had the device for a long period of time and had not, thus far, had any issues with using it on her own; however, acknowledged it was important to ensure staff knew how the device worked and what to do if an error or alarm activated. Further, ADON stated they believed a user' manual for the device was in R17's somewhere and were going to go look for it. A Trilogy 100 Ventilator Information and User Guide for Qualified Health Professionals manual, dated March 2020, identified a detailed walk-through of the device including filter changing, screen icon details, and setting applications. The manual outlined two types of ventilation circuits were available using the device, including active and passive, and how to set-up each one with the machine along with a red-colored exclamation point warning reading, Please check that circuit type if properly configured. The manual outlined how to connect oxygen to the device along with humidified air. The manual outlined how to review, set and monitor alarm parameters and indicated three types of alarms could trigger on the device including high-priority which, . require immediate response by the operator, the alarm mute button with flash red and the screen message will appear red. A graph showing multiple potential alarm reasons was included, along with corresponding staff-actions to resolve them. A facility' policy on staff competency with medical device training was requested, however, none was received.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were fully addressed or acted upon for 1 of 5 residents (R164) reviewed for unnecessary medications. Findings include: R164's significant change Minimum Data Set (MDS) dated [DATE], indicated R164 had severely impaired cognition. R164's quarterly MDS dated [DATE], indicated R164 did not speak and rarely/never understood verbal content. In addition, R164 was dependent on staff for bed mobility, lower body dressing, and toileting hygiene. R164's medical diagnoses report dated 1/27/23, indicated R164 had dementia without behavioral disturbance, epilepsy, and depression. R164's Order Summary Report dated 3/30/23, included an order dated 3/30/23 for 12.5 milligrams (mg) of quetiapine (an antipsychotic medication) every evening for agitation. The report included an order dated 6/21/24, with no end date for one mg of as-needed lorazepam (a psychotropic medication used to treat seizures) that could be given every 15 minutes for two doses. R164's Consultant Pharmacist Recommendation to Physician dated 3/26/24,, indicated R164 received as-needed lorazepam. The report indicated that as-needed psychotropic medications should have a 14-day stop date, unless a longer time frame is deemed appropriate by the physician. The report indicated if the duration of use needed to be extended past 14 days, to provide a rationale for continuing use and a specific duration of therapy. The provider responded on 4/15/24 to continue the as-needed lorazepam order as written as the benefits outweigh the risks. The response did not address the pharmacist's recommendation to include a specific duration of therapy. R164's Consultant Pharmacist Recommendation to Physician dated 3/26/24, indicated R164 was receiving quetiapine for a diagnosis of agitation which is not considered an appropriate indication for antipsychotic use. The report indicated if the antipsychotic use was to continue, to clarify the appropriate diagnosis. The provider responded on 4/15/24 by indicating the medication was useful for insomnia and the family did not want the medication discontinued so the order would be continued for agitation and insomnia per family's wishes. R164's Consultant Pharmacist Recommendation to Physician dated 4/26/24, indicated R164 received as-needed lorazepam. The report indicated that as-needed psychotropic medications should have a 14-day stop date, unless a longer time frame is deemed appropriate by the physician. The report indicated if the duration of use needed to be extended past 14 days, to provide a rationale for continuing use and a specific duration of therapy. The report did not include a signature with a correlating date but included the note, completed on 4/15. The response did not address the pharmacist's recommendation to include a specific duration of therapy. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R164's Consultant Pharmacist Recommendation to Physician dated 4/26/24, indicated R164 was receiving quetiapine for a diagnosis of agitation which is not considered an appropriate indication for antipsychotic use. The report indicated if the antipsychotic use was to continue to clarify the appropriate diagnosis. The report did not include a signature with a correlating date but had the note, completed on 4/15. R164's Consultant Pharmacist Recommendation to Physician dated 5/26/24, indicated R164 received as-needed lorazepam. The report indicated that as-needed psychotropic medications should have a 14-day stop date, unless a longer time frame is deemed appropriate by the physician. The report indicated if the duration of use needed to be extended past 14 days, to provide a rationale for continuing use and a specific duration of therapy. The report did not include a signature with a correlating date but had the note, completed 7/29/24. The response did not address the pharmacist's recommendation to include a specific duration of therapy. R164's Consultant Pharmacist Recommendation to Physician dated 5/26/24, indicated R164 was receiving quetiapine for a diagnosis of agitation which is not considered an appropriate indication for antipsychotic use. The report indicated if the antipsychotic use was to continue, to clarify the appropriate diagnosis. The report did not include a signature with a correlating date but had the note, completed 7/29/24. R164's nursing progress note dated 6/21/24 at 2:23 p.m., indicated the pharmacist had recommended a 14 day stop date on lorazepam and per the provider, they were to continue the order as written as the benefits outweigh the risks. The progress note did not indicate a specific duration of therapy for the as-needed lorazepam. R164's Consultant Pharmacist Recommendation to Physician dated 6/25/24, indicated R164 received as-needed lorazepam. The report indicated that as-needed psychotropic medications should have a 14-day stop date, unless a longer time frame is deemed appropriate by the physician. The report indicated if the duration of use needed to be extended past 14 days, to provide a rationale for continuing use and a specific duration of therapy. The provider responded on 7/29/24 to continue the as-needed lorazepam order due to its indication of use. The response did not address the pharmacist's recommendation to include a specific duration of therapy. R164's Consultant Pharmacist Recommendation to Physician dated 6/25/24, indicated R164 was receiving quetiapine for a diagnosis of agitation which is not considered an appropriate indication for antipsychotic use. The report indicated if the antipsychotic use was to continue, to clarify the appropriate diagnosis. The provider responded on 7/29/24 and indicated the diagnosis was resistant anxiety. R164's Medication Administration Record (MAR) dated 7/1/24 through 7/30/24, indicated one milligram (mg) of as-needed lorazepam was given on 7/21/24. The record included an order dated 1/31/23 that indicated R164 sleeps for 12hrs+ per family and should be gotten up last in the morning. R164's nursing progress note dated 7/31/24 at 9:00 a.m., indicated the provider gave an order to continue the lorazepam as ordered due to the indication. R164's nursing progress note dated 7/31/24 at 11:37 a.m., indicated the pharmacy recommendations were completed and to see the recommendations that were uploaded that day. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview at 12:14 p.m., nurse practitioner (NP)-A stated she was the provider reviewing R164's pharmacist reviews. NP-A stated she had noticed that the pharmacy recommendations were reissued monthly but didn't think that the pharmacist had seen the previous provider response made on 4/15/24, so she had referenced back to that response. NP-A confirmed a stop date had not been added to the as-needed lorazepam as she did not know it was necessary. NP-A stated it was unclear why R164 was using quetiapine so on 7/29/24 she had updated the order to include an indication of resistant anxiety but was unable to specify what symptoms of resistant anxiety R164 currently had. NP-A stated she did not reach out to the pharmacist to receive clarification on why the recommendations were being reissued for the as-needed lorazepam use and the quetiapine use. During an interview on 8/1/24 at 12:35 p.m., the consulting pharmacist (PH) stated she had difficulty getting the facility/providers to fully respond to her recommendations for R164, so she had been reissuing them monthly since March. The PH stated she sent recommendations to the facility on ce a month and would then follow up the next month to ensure the recommendations were completed. The PH stated she had reviewed the response from the March recommendation and an appropriate diagnosis for antipsychotic use was not given, so she had reissued the recommendation. The PH stated agitation was not an appropriate indication for antipsychotic use and would have expected a medical diagnosis such as schizophrenia, delusional disorder, or bipolar disorder. The PH stated the facility had not established a duration of use for R164's as-needed lorazepam so she had reissued that recommendation monthly also. The PH stated she had not had a conversation or further reached out to the provider, medical director, or other facility staff to explain the repeated recommendations to the facility staff. During an interview on 8/1/24 at 2:28 p.m., the director of nursing (DON) stated nursing staff had reviewed the pharmacy recommendations, but there had been a misunderstanding regarding the requirement for a stop date for as-needed psychotropic medication, so it had not been addressed. The DON stated agitation was not an appropriate indication for antipsychotic medication and the order should have been updated to include an appropriate indication before the start of the survey, but it had not been. The DON stated she was unaware of the nursing staff or the provider reaching out to the pharmacist for clarification on recommendations. A policy regarding pharmacist medication regimen reviews was requested and not received.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on observation, interview and document review the facility failed to have an indication for use and resident specific target behaviors while taking antipsychotic medications for 1 of 5 residents (R383) reviewed for unnecessary medications. In addition, the facility failed to ensure as-needed antipsychotic medications were limited to 14 days of use or given a specific duration of therapy to ensure necessity and reduce the risk of complication for 1 of 5 residents (R164) reviewed for unnecessary medication use. In addition, the facility failed to ensure an appropriate indication was given for continued antipsychotic medication for 1 of 5 residents (R164) reviewed for unnecessary medication use. Findings include: R383's admission Minimum Data Set (MDS), dated [DATE], indicated R383 was cognitively intact and had received an antipsychotic medication during the seven-day look back period. R383's Orders, dated 7/18/24, indicated an order for Olanzapine (an antipsychotic medication used to treat mental disorders, including schizophrenia and bipolar disorder) 10 milligrams (mg) by mouth twice a day, however it lacked an indication for use. R383's Orders, dated 7/11/24, indicated Psychotropic Behavior Monitoring with 26 generic behaviors for staff to monitor for. R383's Care Plan, dated 7/15/24 indicated R383 used antipsychotic medication r/t [related to] Dx [diagnosis] of schizoaffective disorder [a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania], panic disorder with anxiety, and obsessive compulsive disorder [a long-lasting disorder in which a person experiences uncontrollable and recurring thoughts (obsessions), engages in repetitive behaviors (compulsions), or both] however lacked any specific target behaviors. R383's July Medication Administration Record (MAR), indicated R383 had received Olanzapine 10 mg twice a day but lacked an indication for use to inform staff administering medication why R383 was receiving the medication. During an interview on 7/31/24 at 7:44 a.m., licensed practical nurse (LPN)-F confirmed the MAR did not contain an indication for use for R383's Olanzapine stating, I would have to look it up [what the medication was used for] because it is not in the order. During an interview on 8/1/24 at approximately 10:00 a.m., nurse manager and registered nurse (RN)-H stated it was the expectation that all medications have an indication for use to monitor if a medication is effective or not. RN-H confirmed the psychotropic behavior monitoring was not tailored to be resident specific but was a generic check box to select for any resident taking a psychotropic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/1/24 at 12:40 p.m., the director of nursing (DON) indicated it would be expected for medications to have an indication for use and antipsychotic medications to have resident specific target behaviors. The DON stated it would be important to ensure they are treating the correct symptoms and to monitor for effectiveness of the medication. A facility policy on administering antipsychotic medication was requested and not received. 49034 R164's significant change Minimum Data Set (MDS) dated [DATE], indicated R164 had severely impaired cognition. R164's quarterly MDS dated [DATE], indicated R164 did not speak and rarely/never understood verbal content. In addition, R164 was dependent on staff for bed mobility, lower body dressing, and toileting hygiene. R164's medical diagnoses report dated 1/27/23, indicated R164 had dementia without behavioral disturbance, epilepsy, and depression. R164's care plan dated 9/29/23, indicated R164 had a mental health disorder with physical behaviors of grabbing, yelling out, and being resistant to care related to an intellectual disability and dementia. R164's Order Summary Report dated 3/30/23, included an order dated 3/30/23, for 12.5 milligrams (mg) of quetiapine (an antipsychotic medication) every evening for agitation. The report included an order dated 6/21/24 with no end date for one mg of as-needed lorazepam (a psychotropic medication used to treat seizures) that could be given every 15 minutes for two doses. R164's Consultant Pharmacist Recommendation to Physician dated 3/26/24, indicated R164 received as-needed lorazepam. The report indicated that as-needed psychotropic medications should have a 14-day stop date, unless a longer time frame is deemed appropriate by the physician. The report indicated if the duration of use needed to be extended past 14 days, to provide a rationale for continuing use and a specific duration of therapy. The provider responded on 4/15/24 to continue the as-needed lorazepam order as written as the benefits outweigh the risks. The response did not address the pharmacist's recommendation to include a specific duration of therapy. R164's Consultant Pharmacist Recommendation to Physician dated 3/26/24, indicated R164 was receiving quetiapine for a diagnosis of agitation which is not considered an appropriate indication for antipsychotic use. The report indicated if the antipsychotic use was to continue, to clarify the appropriate diagnosis. The provider responded on 4/15/24 by indicating the medication was useful for insomnia and the family did not want the medication discontinued so the order would be continued for agitation and insomnia per family's wishes. R164's nursing progress note dated 6/21/24 at 2:23 p.m., indicated the pharmacist had recommended a 14 day stop date on lorazepam and per the provider, they were to continue the order as written as the benefits outweigh the risks. The progress note did not indicate a specific duration of therapy for the as-needed lorazepam. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R164's Medication Administration Record (MAR) dated 7/1/24 through 7/30/24, indicated one milligram (mg) of as-needed lorazepam was given on 7/21/24. The record included an order dated 1/31/23 that indicated R164 sleeps for 12hrs+ per family and should be gotten up last in the morning. R164's nursing progress note dated 7/31/24 at 9:00 a.m., indicated the provider gave an order to continue the lorazepam as ordered due to the indication. The MAR included target behaviors of R164 being resistant to care, yelling out, and grabbing, with interventions of speaking calmly, re-approaching, family assistance, or redirecting, which were documented on every shift. During an interview and observation on 7/29/24 at 2:42 p.m., resident representative (RR)-C stated she visited R164 frequently and has not noticed agitation but felt staff don't have enough practice on completing activities of daily living for R164's and can cause R164 to push during cares. R164 was observed sleeping in bed. During an interview on 8/1/24 at 10:29 a.m., nursing assistant (NA)-A stated he works with R164 frequently and had not noticed R164 being agitated or having any other behaviors when staff were not interacting with him. NA-A stated R164 was frequently sleeping during the day and only seemed to push staff when they were rolling him in bed and completing cares. R164 was observed sleeping in his wheelchair. R164's Consultant Pharmacist Recommendation to Physician dated 6/25/24, indicated R164 received as-needed lorazepam. The report indicated that as-needed psychotropic medications should have a 14-day stop date, unless a longer time frame is deemed appropriate by the physician. The report indicated if the duration of use needed to be extended past 14 days, to provide a rationale for continuing use and a specific duration of therapy. The provider responded on 7/29/24 to continue the as-needed lorazepam order due to its indication of use. The response did not address the pharmacist's recommendation to include a specific duration of therapy. R164's Consultant Pharmacist Recommendation to Physician dated 6/25/24, indicated R164 was receiving quetiapine for a diagnosis of agitation which is not considered an appropriate indication for antipsychotic use. The report indicated if the antipsychotic use was to continue, to clarify the appropriate diagnosis. The provider responded on 7/29/24 and indicated the diagnosis was resistant anxiety. During an interview on 8/1/24 at 12:35 p.m., the consulting pharmacist (PH) stated she had difficulty getting the facility/providers to fully respond to her recommendations for R164, so she had been reissuing them monthly since March. The PH stated she had reviewed the response from the March recommendation and an appropriate diagnosis for antipsychotic use was not given, so she had reissued the recommendation. The PH stated agitation was not an appropriate indication for antipsychotic use and would have expected a medical diagnosis such as schizophrenia, delusional disorder, or bipolar disorder. The PH stated the facility had not established a duration of use for R164's as-needed lorazepam so she had reissued that recommendation monthly also. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview at 12:14 p.m., nurse practitioner (NP)-A confirmed a stop date had not been added to the as-needed lorazepam as she did not know it was necessary. NP-A stated it was unclear why R164 was using quetiapine, so on 7/29/24 she had updated the order to include an indication of resistant anxiety but was unable to specify what symptoms of resistant anxiety R164 had. NP-A stated the previous provider had talked with RR-C who was upset because R164 was not falling asleep at the same time every night and had requested the medication be continued so they had. NP-A stated, Maybe it [quetiapine] was more appropriate in the past and was unable to give an indication for current use. During an interview on 8/1/24 at 2:28 p.m., the DON stated nursing staff had reviewed the pharmacy recommendations, but there had been a misunderstanding regarding the requirement for a stop date for as-needed psychotropic medication, so it had not been addressed. The DON stated agitation was not an appropriate indication for antipsychotic medication use and the order should have been updated to include an appropriate indication before the start of the survey, but it had not been.

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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** 48065 Based on observation, interview, and document review, the facility failed to ensure a medication administration error rate of less than 5 percent (%). Twenty medication administration errors occurred out of 31 opportunities resulting in a 64.52% medication error rate for 2 of 4 residents (R184 and R376). Findings include: R184's admission assessment Minimum Data Set (MDS) dated [DATE], indicated R184 had moderate cognitive impairment, didn't have signs of delirium, and didn't refuse cares or medications. MDS indicated R184 was dependent with showers, lower body dressing, toileting, bed mobility, and transfers. R184 needed substantial assistance with upper body dressing, oral hygiene and eating. R184's Clinical diagnosis record printed 1/31/24, indicated diagnoses of dysphagia (difficulty swallowing) following unspecified cerebrovascular disease (condition that affect blood flow and the blood vessels in the brain), gastrostomy status (surgical procedure that creates an opening in the abdomen and into the stomach, allowing for the insertion of a feeding tube), hemiplegia (paralysis of one side of the body) and paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease) following cerebral infarction affecting right dominant side, chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breath), chronic respiratory failure with hypoxia (low oxygen level in the blood) , protein-calorie malnutrition, chronic atrial fibrillation (heart arrhythmia that causes the upper chambers of the heart to beat irregularly and quiver for more than 12 months), atrial flutter (condition in which the heart's upper chambers beat too quickly), and dysthymic disorder (a mild but long-term form of depression). R184's Clinical Orders report printed 7/31/24, indicated may crush meds unless contraindicated. The report indicated the following medications were to be administered via the gastric tube: 10 milligrams (mg) of baclofen three times a day (medicaton to treat neuropathic pain), 7.5 mg of metoprolol twice a day (medicaton to treat high blood pressure), 20 mg of escitalopram oxalate daily (medicaton to treat depression), 5 ml (100mg) of gabapentin three times daily (medicaton to neuropathic pain), one tablet of sennoside twice a day (medicaton to treat constipation), and 0.38 ounces of banatrol with bimudo probiotic twice as day. R184's Clinical Orders report lacked indication if medications could be crushed together or if they could be administered together. During an observation and interview on 7/31/24 at 8:00 a.m., registered nurse (RN)-G was observed removing the baclofen, metoprolol, escitalopram, and sennoside from its packaging and placing them in the same medication cup. The medications were then transferred to a clear medication bag and crushed together using a manual levered machine. RN-G measured the gabapentin solution and poured the solution in a plastic cup. RN-G added the crushed medications to the plastic glass, added the banatrol, filled the glass with water, and mixed all the medications together. RN-G stated, all the medications are going to the stomach, that's how we do it. RN-G administered 60 milliliters (ml) of water via the gastric tube, administered the combined medication solution through the gastric tube, and then again, flushed the tube with 60 ml of water. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/31/24 at 11:37 a.m., RN-G verified they did not have a provider order to administer all the crushed medications medications together. RN-G added but they are all scheduled at the same time. During interview on 7/31/24 at 1:42 p.m., nurse manager RN-E stated medications administered via tube feedings needed to be crushed individually, administered one at the time, and to use water boluses between medications. NN-E stated administering medications together was not the correct way to do it and the medications needed to be administered one at the time. R376 R376's significant change Minimum Data Set (MDS) dated [DATE], indicated R376 was cognitively impaired, had no delirium or hallucinations and did not refused cares. R376 was independent with transfers, bed mobility, walked short distances, and needed supervision with personal hygiene and dressing. R376's Clinical Diagnosis record printed 7/31/24, indicated diagnosis of oropharyngeal phase dysphagia (swallowing problems in the mouth and/or the throat), gastrostomy status (surgical procedure that creates an opening in the abdomen and into the stomach, allowing for the insertion of a feeding tube), ankylosis spondylitis of spine (inflammatory arthritis), traumatic brain injury, chronic obstructive pulmonary disease (inflammatory arthritis), severe protein-calorie malnutrition, and acute respiratory failure with hypoxia ((a medical emergency that occurs when the body's tissues don't have enough oxygen). R376's Clinical Orders report printed 7/31/24, indicated may crush meds unless contraindicated. The report indicated the following medications were to be administered via the gastric tube: 50 mg - 3 tablets of sertraline (antidepressant) daily, 25 micrograms of cholecalciferol (vitamin D) capsule daily, 1 mg of folic acid (vitamin B-12), 15 ml -100 mg/ml of levetiracetam (medication for epilepsy) twice daily, one mineral multivitamin tablet daily, 17 grams of polyethylene glycol (medication for constipation) 3350 daily, 10 mg of Zyrtec (allergy medication), 100mg (10ml) of lacosamide (anticonvulsant) twice daily, 1000 mg (20ml) of valproate sodium (medication to treat seizures) solution twice daily. R376's Clinical Orders report lacked indication if medications could be crushed together or if they could be administered together. During an observation and interview on 7/31/24 at 8:35 a.m., licensed practical nurse (LPN)-F was observed removing the sertraline, cholecalciferol, folic acid, multivitamin, and Zyrtec in the same medication cap. The medications were then transferred to a clear medication bag and crushed together using a manual levered machine. LPN-F measured levetiracetam, lacosamide, and valproate sodium and poured them in the same plastic cup. LPN-F then added the crushed medications and the polyethylene glycol to the liquid medications, filled the glass with water and mixed them together with a plastic spoon. LPN-F flushed the gastric tube with water, administered medications and flushed the gastric tube with water. LPN-F stated he wasn't sure if they had an order to crush and administer all the medications together. During interview on 7/31/24 at 1:28 p.m., LPN-F stated he wasn't sure if it was safe to mix all medications together. LPN-F stated that this was his first experience administering medications via a tube feeding. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 8/1/24 at 8:27 a.m., nurse manager RN-H stated unless you have an provider order that is okay to mix the medications together, you should administer one medication at the time and flush with water in between. RN-H stated the concern of giving the medications together was a potential for interactions or a decrease in the efficacy of the medications. During interview on 8/1/24 at 12:29 p.m., pharmacist (PH) stated it was not recommended to combine and mix medication and then administer them via a gastric tube. PH stated there was not enough scientific data to know how the medications interact or how they were absorbed when they are crushed and administered together. PH stated it was up to the providers to authorize the crushing of medications together and administering them via gastric tubes. During interview on 8/1/24 at 2:55 p.m., director of nursing (DON) stated we have the responsibility to clarify the orders on admission. We need to have the right medication, the right dose, the right diagnosis, and the right frequency. The nurse must ask those questions. Some medications are prescribed for different reasons. But is their patient taking the medication for seizures or what? Regarding the administration of medications via gastric tubes, DON stated a provider order is required to administer medications together because it could cause interactions. Interactions could even be life threatening or have a negative outcome. The order needs to come from the provider. DON stated It is 101 nursing, if you have 10 meds, you need 10 med cups, one for each medication. It is basic nursing. Facility's policy titled Medication administration via Enteral Tube dated 4/1/22, indicated each medication will be administered separately. Policy also indicated medications may be administered together with a provider's order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44656 Based on observation and interview, the facility failed to ensure mediations were kept locked or under direct observation of authorized staff in areas where residents, staff and guests could access medications on 3 of 5 resident floors. Findings include: During observation and interview on 7/29/24 at 6:14 p.m., an unattended and unlocked medication cart was observed located along a knee-high wall facing the seventh floor dining room during mealtime. Registered nurse (RN)-A returned to the medication cart and verified it was unlocked and, it should be locked to stop anyone from getting in. During observation and interview on 7/31/24 at 1:10 p.m., an unattended and unlocked medication cart was observed located along a knee wall facing the fifth floor dining room with 12 seated residents in wheelchairs and walkers and two residents in wheelchairs rolling past the cart. During interview with licensed practical nurse (LPN)-B stated he was responsible for the unlocked medication cart and stated, I should always lock the cart when I leave it. Because the residents can get access to it. During observation and interview on 8/1/24 7:54 a.m., an unattended and unlocked medication cart was observed located along a knee wall facing the fifth floor dining room with 12 seated residents in wheelchairs and walkers in the area. LPN-C stated he was responsible for the unlocked medication cart and stated, the med cart should be locked because it is regulation. [sic] keep others from getting into the cart and getting the meds. During continuous observation on 8/1/24 from 11:30 a.m. to 11:47 a.m., an unattended and unlocked medication cart was observed on second floor in front of the nursing station until the DON walked by and locked the medication cart. During interview with second floor nurse manager (RN)-H stated, leaving the cart unlocked [sic]concern because anybody can open it and take medications. During interview with the third floor nurse manager RN-B on 8/1/24 at 7:58 a.m., stated, medication carts [sic] always lock before leaving the cart [sic] when leaving because we have residents here that can rummage through them and get access to them, and we do not want to have the risk of them getting into the carts and accessing the meds. During interview with director of nursing (DON) on 8/1/24 at 9:02 a.m., DON stated, we teach nurses to keep the med carts locked once you are stepping away. No matter what. If you can't reach the cart, you must lock the cart. Facility policy titled Medication Administration dated May 2024 identified, Medications are administered by licensed nurses, or other staff who are legally authorized to do so.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview and document review, the facility failed to ensure routine dental services were provided or offered to promote oral hygiene and reduce the risk of complication (i.e., chewing issues, cavities) for 4 of 4 residents (R39, R50, R134, R179) reviewed for dental services. Findings include: R39 R39's significant change Minimum Data Set (MDS), dated [DATE], identified R39 admitted to the care center in April 2024 and had moderate cognitive impairment but demonstrated no delusional thinking. Further, the MDS section labeled, Section L - Oral/Dental Status, outlined spaces to record if R39 had broken or loose-fitting dentures, abnormal mouth tissue, or obvious tooth cavities but the section was answered, Z. None of the above were present. R39's Census listing, printed 7/31/24, identified R39 current payer source recorded as, Veterans Administration. On 7/29/24 at 1:54 p.m., R39 was observed seated in his wheelchair while in his room. R39 was interviewed, and expressed he had little to no natural teeth adding, I gotta go see the dentist. R39 explained he wore dentures previously, however, his family member lost them awhile back and, as a result, he had gone without them for a long time. R39 stated he typically went through the VA (Veterans Administration) for medical appointments, however, nobody from the care center had asked about or helped him arrange a dental examination or visit since he admitted . R39 stated he wanted to get to a dentist to check on getting new dentures and expressed frustration with both the care center and the VA adding, They're even slacking now-a-days. R39's Nursing Assessment - Admission/Readmission + Careplan - V13, dated 4/10/24, identified R39 was alert and oriented to person, place, time and situation. The evaluation contained a section labeled, Oral, Vision and Hearing Status, which provided several questions to be answered by staff. This section identified R39 used dentures with both an upper and lower partial being checked; R39 needed no assistance with oral cares; and he had a mouth condition recorded as, Within Normal Limits. The evaluation continued and listed spacing to record, Last Dental Visit, however, this was answered with, N/A. The completed evaluation lacked evidence if the denture fitment (i.e., secure, loose) had been evaluated, nor if R39 had been asked or offered a dental examination. A subsequent Nursing Assessment - Admission/Readmission + Careplan - V13, dated 4/15/24, was also located. This completed evaluation outlined the same section labeled, Oral, Vision and Hearing Status, however, now recorded R39 as having natural teeth with the multiple options to check for denture use being left blank. The section provided labeled, Last Dental Visit, was answered with, Unknown, and another section labeled, Additional Oral Status Comments, was answered, WNL [within normal limits]. However, again, the completed evaluation lacked evidence if R39 had been asked or offered a dental examination, nor was there clarification on which evaluation (i.e., 4/10/24 or 4/15/24) was accurate regarding R39's actual oral condition (i.e., natural teeth or denture use). (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39's care plan, dated 4/10/24, identified R39 had an ADL (activities of daily living) self-care deficit and listed multiple interventions including, PERSONAL HYGIENE/ORAL CARE: The resident is independent. However, the care plan lacked any specific problem statements, goals or interventions for R39's oral condition or dental needs despite R39 having conflicted evaluations completed with, at least one, indicating denture use. R39's Care Conference Summary - V2, dated 6/24/24, identified R39 was invited to the care conference held on 6/21/24, but he did not attend. The summary contained multiple spaces to record various information discussed and/or obtained during the conference which included a section labeled, Appointments, with directions included, Dental and Vision are to be completed annually unless otherwise noted ., and spaces to record dates of either upcoming or last known evaluations with another section labeled, Appointment Comments, however, all of these spaces were left blank and not completed. The summary lacked evidence R39 had been asked, either before or after the conference since he didn't attend, about the need for a dental appointment. When interviewed on 7/31/24 at 11:11 a.m., registered nurse (RN)-G explained if a resident developed dental issues, they would call the medical provider and get a referral order to the dentist. RN-G stated they had heard some people [onsite dental] used to come but was not sure if such still happened. RN-G stated the nurses, upon admission, complete a general assessment which included the oral cavity and verified this was documented using the evaluation in the record (i.e., Nursing Assessment - Admission/Readmission). RN-G reviewed R39's completed evaluations and verified 'N/A' was recorded on 4/10/24, but expressed they were not sure what such language meant or why it had been recorded. R39's entire medical record was reviewed and lacked evidence R39 had been asked, offered or refused a dental examination since admission to the care center several months prior. When interviewed on 7/31/24 at 2:34 p.m., registered nurse unit manager (RN)-E verified they had reviewed R39's medical record, and they explained the nurses' complete an initial evaluation upon admission and record it using the provided forms (i.e., Nursing Assessment - Admission/Readmission). RN-E verified R39 had multiple evaluations completed with conflicting data being recorded and expressed, since R39 in-fact had no natural teeth, someone should have followed up with him to see if a dental appointment was needed adding they were now working on getting one arranged. RN-E verified the nurses who complete the initial evaluations should be asking about a dental appointment and recording such then, if wanted or needed, refer the information to the health unit coordinators (HUC) to get scheduled. RN-E verified the lack of documentation in the medical record to demonstrate R39 had ever been asked about a dental appointment and expressed it was important to offer such appointments as bad teeth or dentition could cause issues like bad nutrition, dehydration and it was important for their health overall. Further, RN-E verified the Care Conference Summary had spacing to record appointments but this was left blank adding R39 had possibly been offered and refused then, But we still didn't chart it. On 7/31/24 at 2:53 p.m., the licensed social worker (SW)-C verified they completed the Care Conference Summary for R39 (dated 6/24/24). SW-C acknowledged the spaces to record appointment information was left blank stating it was blank cause I don't have anything [information on them], and added the form typically has data entered to show when the last appointment for each discipline. SW-C stated they were unaware R39 didn't have his dentures present at the care center and expressed any need for a dental appointment, including initially being asked about one, would start with the nursing department adding, That all goes through nursing. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47495 R50 R50's admission Minimum Data Set (MDS), dated [DATE], indicated R50 was admitted to the facility on [DATE], was cognitively intact and required partial to moderate assistance with oral care. The MDS further indicated R50 had broken or loose fitting full or partial dentures and had no natural teeth. R50's Nursing Admission Assessment, Oral, Vision, and Hearing Status, dated 6/19/24, indicated R50 had no teeth and her last dental visit was unknown. R50's electronic medical record (EMR) lacked evidence that a dental visit had been offered to R50 since her admission on 6/19/24. R50's progress notes, dated 7/31/24 indicated, social services was informed [by surveyor] that resident was interested in receiving a visit from the dentist. R50 confirmed her interest in having a dental appointment. During observation and interview on 7/29/24 at 6:47 p.m., R50 was lying in bed, with her dinner tray near her, and was edentulous (without teeth). R50 stated she had dentures, but they were broken. R50 further confirmed staff have not offered any dental services to her to address her broken dentures since she was admitted to the facility. R134 R134's quarterly Minimum Data Set, dated dated dated , 7/20/24 indicated R134 with severe impairment of cognitive skills, physical and verbal symptoms directed towards others, had an indwelling catheter. In addition, R134 with diagnoses of Alzheimer's disease, dementia, seizures, depression, anemia, renal insufficiency, neurogenic bladder, obstructive uropathy and receiving antipsychotics, antidepressants. Also, R134 required extensive assistance of one staff member with bed mobility, eating, toilet use. And required setup or clean-up assistance with oral hygiene. During interview with family member (FM)-A on 7/29/24 at 3:24 a.m., FM-A stated, [R134] has dental issues. It's been over a year since he was seen. Review of Care Conference Summary dated 6/26/24, Section D. Appointments identified, Dental and Vision are to be completed annually unless otherwise noted and 1. Dental: [blank]. In the section titled, Appointment Comments: Reviewed desired/requested ancillary services as above. The summary lacked indication of any dental appointments. Review of R134's EMR lacked documentation of dental evaluations or visits after 10/6/22. R134's care plan dated 4/28/22 direct staff to, Coordinate arrangements for dental care, transportation as needed/as ordered. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the director of social services (SW)-A on 8/1/24 at 8:04 a.m., SW-A stated expectation of facility to set up the [dental] referrals and that family (FM-A), decided that dental visits are not a priority. SW-A stated, [dental services] should be offered and should be documented. SW-A reviewed R134's EMR and stated the EMR lacked documentation of discussion with FM-A regarding dental services. During interview with director of nursing (DON) on 8/1/24 at 9:05 a.m., DON stated expectation of dental services, must be done every six months and prn. DON stated the facility had a gap in health unit coordinator (HUC) and that is what happened with missing dental appointments. DON stated, if the [care conference] discussion involves delay or not doing it then it should be offered. And should be documented. R179 R179's quarterly MDS, dated [DATE], indicated R179 was admitted to the facility on [DATE] and was cognitively intact. R179's Nursing Admission Assessment, Oral, Vision and Hearing Status, dated 7/25/24, indicated R179 had no oral concerns, and her last dental visit was approximately 1 year ago. R179's electronic medical record (EMR) lacked evidence that a dental visit had been offered to R179 since her admission on 6/5/24. R179's progress note, dated 7/31/24, indicated social services was informed [by surveyor] that R179 requested a dental appointment. R179 confirmed to social services wanting to see the dentist to address some tooth pain she was having. During an interview on 7/29/24 at 6:32 p.m., R179 stated she has been having tooth pain, especially when she eats, stating she had told staff but has not been offered a dental visit. During an interview on 7/31/24 at 11:38 a.m., licensed practical nurse (LPN)-F stated the initial oral assessments are done by either the assessment nurse or the floor nurse when a resident is admitted to the floor. LPN-F stated a dental visit was offered if there was an issue or problem identified with the initial oral assessment. During an interview on 7/31/24 at 7:53 a.m., nurse manager and registered nurse (RN)-H stated if a resident was admitted with broken or sore teeth then the nurses would assess when their last dental visit was, stating the social worker would set up the dental appointments. RN-H stated if a resident was admitted without dentures or broken dentures they should be offered dental services on admission. During an interview on 7/31/24 at 7:59 a.m., social worker (SW)-C stated if a resident had an issue with their oral assessment, such as mouth pain, it would get relayed to him and he would make a referral for a dental visit. SW-C stated he was unaware of any issues with R50 or R179. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 8/1/24 at approximately 10:00 a.m., nurse manager and registered nurse (RN)-H stated it was expected that all residents were offered dental appointments at admission but was unable to produce any documentation that dental appointments were offered, stating dental appointments would start being offered at the resident 48-hour care conference. During an interview on 8/1/24 at 12:40 p.m., the director of nursing stated it was expected that a dental visit was offered to all residents at admission, long-term, and short-term residents. The DON further stated it was expected the staff document when a dental visit was offered. A facility' provided Dental Services policy, dated 2/2024, identified routine and emergency dental services were available to meet a resident's oral health needs in accordance with the assessment and plan of care. The policy outlined social services will assist with making appointments and, if needed, transportation arrangements and outlined, If dentures are damaged or lost, residents will be referred for dental services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview and document review, the facility failed to ensure food was delivered and served in a timely manner to preserve desired temperatures of food for 3 of 3 residents (R158, R39 and R146) reviewed for dining. This had the potential to affect all residents of facility that received meal trays. Findings include: During survey initial kitchen tour on 7/29/24 at 11:57 a.m., the kitchen supervisor (KS) provided surveyor with printed copy of the document Mealtimes with three columns. First column identified meals and units. The other two columns identified, Dietary Starts: and Cart Arrives on Site: There was notation at bottom of form stating, Note: Meal delivery times may vary by 10 minutes from posted schedule and was documented as below. Meal Times: Cart Arrives on Site BREAKFAST: 2R: 7:15 AM 3G: 7:30 AM 2G: 7:45 AM 7G: 8:00 AM 5G: 8:15 AM 6G: 8:30 AM LUNCH: 2R: 11:15 AM 3G: 11:30 AM 2G: 11:45 AM 7G: 12:00 PM 5G: 12:15 PM 6G: 12:30 PM DINNER: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2R: 4:45 PM 3G: 5:00 PM 2G: 5:15 PM 7G: 5:30 PM 5G: 5:45 PM 6G: 6:00 PM During interview on 7/29/24 at 11:57 a.m., KS stated the expectation of facility staff was to start serving meal trays once they arrive to the units. R158 R158's Significant Change Minimum Data Set (MDS) dated [DATE] identified R158 with intact cognition and resided on the 7G unit of facility. During interview with R158 on 7/29/24 at 4:38 p.m., R158 stated, food is bad. Cold when it should be warm. During observation on 7/30/24 at 7:43 a.m., food cart was not present on 2R. Two residents were seated in dining room and no staff were present. Posted sign on kitchenette stated cart was to arrive at 7:15 AM. During observation on 7/30/24 at 8:04 a.m., food cart was present in 3G dining room with three residents sitting at the dining room tables. No meals were being passed and no staff were present. Posted sign on kitchenette stated cart was to arrive at 7:30 AM. During observation on 7/30/24 at 8:11 a.m., food cart was present in the 7G dining room with twenty-four residents seated at dining room tables. No food was served to any of the residents. Two rolling carts inside the kitchenette had milk and juice in plastic bins with ice. Posted sign on kitchenette stated cart was to arrive at 8:00 AM. During interview with nursing assistant (NA)-E on 7/30/24 at 8:38 a.m., on the 7G unit, NA-E stated he had worked for facility for over a year and, no food is yet up here, even in the kitchen. NA-E stated, I always thought it [meal cart] was brought up at nine-o-clock. NA-E stated, We do try to serve the dining room first and then another aide will serve the room trays. During observation on 7/31/24 at 8:57 a.m., food started to be served to 7G residents in the dining room, fifty-seven minutes after posted meal cart was to arrive per kitchenette posting. R39 R39's significant change Minimum Data Set (MDS), dated [DATE], identified R39 had moderate cognitive impairment but demonstrated no delusional thinking during the review period. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 7/29/24 at 1:42 p.m., R39 expressed multiple complaints about the care center' meal service including the food on the room-delivered meal trays was often cool. R39 stated the kitchen brought them up and then the trays sit out in the dining room for half an hour after they serve out there [to people seated in the dining room; see F807]. R39 stated it was an ongoing issues and he had complained about it prior but staff told him, You keep complaining and you'll be gone [discharged]. R39 reiterated he wanted hot, palatable meals served but the service was poor adding, It's still happening. R146 R146's significant change MDS, dated [DATE], identified R146 had intact cognition and demonstrated no delusional thinking during the review period. On 7/29/24 at 1:03 p.m., R146 was observed laying in bed while in his room. R146 had a bedside table pulled close to the bed which had a meal tray sitting on top with a domed lid covering. R146 was asked about the care center food and responded by shaking his head in a 'no' motion (side to side) and saying aloud, like this, while his hand making a side to side motion (i.e., 'so-so'). R39 stated he typically ate meals in his room and voiced the food was often bland tasting and not warm when it was finally served adding, It [food] just isn't presented well. During interview on 8/1/24 at 8:50 a.m., family member (FM)-B explained R146 admitted to the care center about six months prior due to unsafe living conditions at the home and a series of falls. FM-B stated they visited often and R146 had been eating less lately adding aloud, The food there sucks. FM-B explained the family was worried about R146's nutritional intake and, as a result, had been trying to bring in items to bolster his intake due, in part, to the poor meals served. During observation and interview with dietary aide (DA)-A and DA-B on 7/31/24 at 9:06 a.m. on the 7G dining room, DA-A temped R158's scrambled eggs that had immediately been set in front of him. Temperature registered 113 degrees Fahrenheit. DA-A stated the temp was too low and R158 stated the eggs were too cold. DA-B stated, [7G residents] supposed to get their food at 8:15 a.m., to 8:30 a.m., but we are late today. During interview with KS on 7/31/24 at 12:35 p.m., KS stated, I would say the food that was delivered today was late. If the food did not get to 2R until after 9:00 a.m., then it is 45 minutes late and the food delivered this morning to 7th floor was late also. During observation on 7/31/24 at 1:02 p.m. on 6G, food was still being delivered to residents in the main dining room. Posted sign on kitchenette stated cart was to arrive at 12:30 p.m During interview with facility dietician (DC) on 7/31/24 at 1:43 p.m., DC stated, Food should not be delivered late. If it is delivered late, then I would be concerned about potential for infection. Liquids being delivered to resident rooms must always be covered. I would be concerned about contamination and being served too warm. Scrambled eggs and oatmeal should be at least 140 degrees when delivered to rooms and when served. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with the regional director of dietary services (RD) on 7/31/24 at 2:21 p.m., RD stated the facility started a new food service company on May 1, 2024. RD stated, forty-five minutes is too long to wait for the carts to be delivered to the units. Those carts are not insulated, and staff should not be giving trays to the residents 45 minutes to an hour after the food arrives on the floor. During interview with R158 on 8/1/24 at 11:15 a.m., R158 stated the scrambled eggs that were temped by DA-A on 7/31/24 for breakfast was, not warm enough for me. During observation and interview with RD on 8/1/24 at 12:39 p.m., on the 7G unit, RD was asked to temp a lunch tray that was delivered to a resident room. The brat was temped at 124.2 degrees Fahrenheit. RD stated, this is not where we need it [food temps] to be and declined to offer surveyor a test tray. RD stated, I noticed the staff pulled the meal trays out of the meals carts and put them on top of the counter and let them wait. The meal trays would at least be warmer when served directly from the meal cart and not allowed to be sitting on the counter getting cold. Resident council meeting minutes for February 16, 2024, identified, food is being brought to the floor in a timely manner however the aides on the floor aren't serving it right when it comes. Resident Council Action form dated 6/13/24 provided to the DON identified, Residents expressed food isn't passed out right when the carts come up. There was no implementation date or staff signature on the form. Facility policy on food temperatures and timing of serving food was requested but not received. 33925

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview and document review, the facility failed to ensure drinks of preference were offered or served to promote adequate fluid intake and improve meal satisfaction for 1 of 2 residents (R39) reviewed who expressed their preferences of meal items were not honored. Findings include: R39's significant change Minimum Data Set (MDS), dated [DATE], identified R39 had moderate cognitive impairment but demonstrated no delusional thinking during the review period. On 7/29/24 at 1:42 p.m., R39 was observed in his electric wheelchair while in his room. R39 had a meal tray present on his bedside dresser which had a coffee cup filled with coffee and a white Styrofoam cup filled with a dark-red colored juice. R39 expressed multiple complaints about the care center meal service and food quality, and stated he wished they'd serve him milk with meals instead of that red crap as he pointed to the cup on his meal tray. R39 stated he had repeatedly asked for milk with meals but added, I ask them for milk but don't get it. R39 reiterated his displeasure multiple times with this and stated when he complains about it, it would get better for a day to two then go back to various juices instead of milk. R39's nutritional care plan, dated 7/25/24, identified R39 had a low body mass index (BMI) and consumed a regular diet with thin liquids. The care plan listed multiple interventions for R39's nutrition including, Food/beverage preferences: like: strawberry, however, lacked any recorded beverage preferences or dislikes. On 7/31/24 at 8:24 a.m., the morning meal service on R39's unit was observed. A gray-colored mobile cart was pushed onto the unit which had numerous meal trays present inside. The trays contained plated, covered food along with white-colored menu slips on each which contained the respective resident' name, diet information and spacing to record likes, dislikes, and beverage preferences. At 8:27 a.m., nursing assistant (NA)-H helped remove various trays from the mobile cart and placed them on another metallic rack while NA-G pushed a cart around the dining room which had multiple juices, water and milk on it with residents seated at the tables being asked for their drink preferences. NA-H stated the trays being placed on the metallic racks were room trays. At 8:33 a.m., registered nurse manager (RN)-E removed R39's meal tray from the mobile cart and placed it on the metallic rack. R39's white-colored menu slip was on the tray which listed his name along with a listing of various food or drinks along the bottom which included, * Apple ., and, * Milk, Low . However, a majority of the menu slip was covered with a napkin and not immediately visible. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39's meal tray then remained on the metallic rack until 8:43 a.m., (nearly 20 minutes after it arrived to the unit) when NA-H returned to the rack and pushed it over the the mobile juice cart. NA-H then started to pour and place various juices on the respective trays, including R39's, which remained on the metallic rack. When asked how they know which beverages or drinks to put on the room trays, NA-H stated they knew they knew their preferences adding aloud, I'm used to them, so I know exactly. NA-H then looked at R39's meal tray, however, did not move the napkin to read the entire menu slip. NA-H removed a Styrofoam cup from a sleeve and filled it with ice and water, then poured another cup full of milk. NA-H placed the milk on the nurses' station ledge and then removed another cup and poured it full of a dark red-colored drink. NA-H placed the ice water and red-colored drink on R39's meal tray and started to push the metallic rack towards the rooms. The surveyor asked NA-H about the poured milk which remained on the nurses' station ledge and NA-H stated, I skip it. NA-H left the milk on the ledge and then pushed the metallic rack to the resident' rooms which included R39's room. At 8:56 a.m., NA-H placed R39's tray in his room on the bedside dresser. R39 was not present in the room and NA-H stated, I just drop it here. NA-H was asked about the white-colored menu slip, dated 7/31/24, on the tray which had three items, including milk, listed on it with a star (i.e., *) next to them. NA-H reviewed the menu slip and verified the section labeled, Beverage Pref:, was left blank but expressed the starred items were the major things that they like. NA-H verified they didn't serve R39 any milk, despite it being starred on the slip, and expressed they served him the cranberry juice instead as, He [R39] doesn't like milk. NA-H reiterated, I'm used to them [residents] so I know. NA-H verified they had not asked or questioned R39 on what drinks he wanted with the breakfast meal that day. NA-H stated R39 would once in awhile complain about the drinks on his meal tray but they (NA-H) attributed such to just him changing his mind at times. Further, NA-H stated the kitchen staff made and sent-up the white-colored menu slips for each meal. When interviewed on 7/31/24 at 1:06 p.m., RN-E stated they believed the starred items on the menu slips were what they prefer but added, I could be wrong though. RN-E stated the staff were told to review the menu slips and ensure the diet served matches the diet listed but also staff were told to get to know your residents and what they like and don't like. RN-E stated the kitchen or dietary department had never, to their recall, explained to inform the staff what the starred items actually meant. On 7/31/24 at 1:27 p.m., the kitchen supervisor (KS) was interviewed. KS explained the white-colored menu slips were made in the kitchen for each meal and sent up with the trays to the units adding the starred drink items were a preference, a beverage preference. KS stated the kitchen sends up the drinks and beverages to the units and the CNAs take it from there to pass them out. KS stated the starred items didn't necessarily mean they should be passed at each meal but verified the NA should be asking the resident which drinks or beverages they wanted for each meal. KS stated this was important to do for customer service and to ensure the resident is getting what they're wanting. A facility policy on resident drink preferences with meals was requested, however, none was received.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49034 Based on observation and interview the facility failed to ensure all food items were properly covered when served to residents to reduce and/or prevent the risk of food borne illness. This practice had the potential to affect all residents who received their meals from the kitchen. Findings include: During observation and interview on 7/29/24 at 6:00 p.m., nursing assistant (NA)-N poured beverages into cups and mugs and placed on multiple meal trays which were on an uncovered cart. Uncovered cheesecake desserts were also on the individual meal trays. NA-N wheeled the uncovered cart from the dining room down the hall and passed the meal trays to at least six individuals in their rooms pushing the cart further down the hall between rooms. NA-N stated the beverages came up to the sixth floor in covered pitchers and could be poured into cups in the dining room and taken uncovered to residents' rooms. During observation and interview on 7/31/24 at 9:12 a.m., NA-P wheeled an uncovered cart passing meal trays on the sixth floor which had uncovered bowels of cereal, brown sugar, milk, and other beverages. NA-P stated they did not have lids on the sixth floor to cover the brown sugar and other items. During observation and interview with dietary aide, (DA)-A on 7/31/24 at 9:12 a.m. on 6G, DA-A temped a room tray that was being delivered. Four room trays were present on the meal tower cart and all the trays with uncovered orange juice, coffee, apple juice, and hot chocolate. DA-A stated she was unaware of whether liquids needed to be covered when delivered to resident rooms. During interview with director of nursing (DON) on 7/31/24 at 10:04 a.m., DON stated, liquid drinks should be covered when bringing them to resident rooms. During interview with kitchen supervisor (KS) on 7/31/24 at 12:35 p.m., KS stated, Food is [to be] covered when traveling a distance like down a hallway, to a different unit or floor, based upon standards of practice for infection control and food safety. KS stated, My understanding is that the food that is transported must have covers on them. During interview with NA-C on 7/31/24 at 1:05 p.m., NA-C stated, it is not good to leave the drinks uncovered when delivering meal trays to residents in their rooms. We are supposed to cover them any time we deliver them to the resident rooms. During interview with facility dietician (DC) on 7/31/24 at 1:43 p.m., DC stated, Liquids being delivered to resident rooms must always be covered. I would be concerned about contamination and being served too warm. During interview with regional director of dietary services (RD) on 7/31/24 at 2:21 p.m., RD stated, Fluids must be covered [sic] concern for cross contamination and infection control if they are not covered when delivered to resident rooms. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 8/1/24 at 12:39 p.m. in the 7G unit dining room, RD stopped NA-F as he was pushing the meal cart tower down the hall to resident rooms. There were 3 resident room meal trays on the cart. The carrot cake rolls and liquids were uncovered. RD instructed NA-F that the carrot cake roll desserts needed to be covered along with all liquids before transporting. RD verified carrot cakes and liquids were not covered. During interview with NA-F on 8/1/24 at 1:13 p.m., NA-F stated, we should be making sure the food is covered when transporting it including the milk and juice. I did not know or maybe I forgot the carrot cake needs to be covered also, which [it] wasn't when I was delivering those three trays. Facility policy on covering food during transport and delivery was requested but not received.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview and document review, the facility failed to ensure laundered linens were handled and sorted in a clean, sanitary environment to reduce the risk of contamination for 1 of 1 main washrooms reviewed; failed to ensure staff consistently implemented transmission-based (TBP) and enhanced barrier precautions (EBP) to reduce the risk of infectious spread for 4 of 4 residents (R134, R83, R54 and R2); and failed to ensure general COVID-19 mitigation methods (i.e., masking) were correctly and consistently implemented on units with active infection. These findings have potential for a cumulative effect and, as a result, have potential to affect all 228 residents, staff and visitors within the care center. Findings include: Laundry Room: On 7/30/24 at 8:21 a.m., a tour of the campus main washroom was completed with laundry aide (LA)-A present. The washroom consisted of a large single space with commercial washing machines on one side, and three [NAME] commercial dryers on the opposite. In the center of the room, positioned outside the dryers (direction they open to), were a series of tables pushed together with multiple, white-colored linens stacked on them to form a large pile. The wall surrounding the table had various mobile racks with various clothing items placed on them. However, attached to the wall were multiple AirKing bladed fans and the grates covering the blades of the fans had significant, copious gray and black-colored dust build-up present and were facing the cleaned linen stacked on the tables. In addition, a large [NAME] Mobile Air Conditioner was on the floor and also facing the tables of stack linen. The machine was activated and moving air towards the clean linen, however, the grate covering the blades of the unit also had significant, dark gray-colored dust and debris build-up present. LA-A verified the condition of the grates and stated maintenance was supposed to be cleaning them to their knowledge, however, it had been several weeks since they were last done to their recall. LA-A stated staff could, if needed, make a maintenance slip out to have them cleaned but they had not done so themselves as they weren't exactly sure how to do it. At this time, the housekeeping supervisor (HS) entered the interview and expressed they had recently started working at the campus and were going to find out how the conditioner and fans were being cleaned. HS verified the devices were pointed at clean linen and soiled adding, They need to be cleaned. HS stated the fans and conditioner should be kept clean to reduce possible contamination of the clean linens. The district manager of environmental services (DMES) entered the interview and also verified the fan and conditioner grate' condition adding, We should take care of them. LA-A verified the fans were not on a routine cleaning schedule to their knowledge. DMES stated the maintenance personnel may be cleaning them or have more information. On 7/30/24 at 3:47 p.m., the director of engineering (DOE) was interviewed. DOE verified they oversaw the maintenance department and expressed cleaning of the soiled devices observed in the washroom really would fall under my department. DOE stated the fan and conditioner grates were cleaned on a upon request basis but they were going to likely implement a monthly schedule moving forward. DOE verified nobody had asked or presented the soiled grates to their department prior to survey and stated they should be cleaned adding them having built-up dust and debris posed a fire safety hazard. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the recertification survey, from 7/29/24 to 8/1/24, no flowsheet(s) or documented tracking was provided to demonstrate the fans and air conditioner unit were on a cleaning schedule prior to the survey. On 8/1/24 at 1:03 p.m., the assistant director of nursing (ADON) and regional nurse consultant (RNC) were interviewed. ADON explained themselves, along with RNC, were helping to manage and oversee the facility' infection control program. ADON and RNC expressed the washroom was audited from an environmental standpoint at times, however, were unsure if it had been audited as part of the infection control program. ADON verified staff are educated on clean linen handling and RNC expressed the fans and conditioner grate was going to be added to a schedule for routine cleaning moving-forward adding, I think definitely the practice needs to change. ADON stated soiled grates blowing onto clean linen was a cross-contamination risk, and they verified the linens were used house-wide. A facility' policy on clean linen handling was requested, however, none was received. 44656 R134 R134's quarterly Minimum Data Set, dated dated dated , 7/20/24 indicated R134 with severe impairment of cognitive skills, physical and verbal symptoms directed towards others and had an indwelling catheter. In addition, R134 with diagnoses of Alzheimer's disease, dementia, seizures, depression, anemia, renal insufficiency (form of kidney failure), neurogenic bladder(bladder control problem due to a brain, spinal cord, or nerve issue), obstructive uropathy (disorder of the urinary tract due to obstructed urine flow), and received antipsychotics, antidepressants. Also, R134 required extensive assistance of one staff member with bed mobility, eating, toilet use. R134's physician orders dated 7/29/24 direct staff for, Isolation: Resident is on Enhanced respiratory precaution due to tested positive for COVID on 7/23/24 and is in a contagious stage. Resident will be on isolation for 10 days in a private room. R134's nursing progress note dated 7/23/24 stated, Note Text: Resident test positive for covid 19 @ this time, Resident appeared to be lethragic [sic] today with poor appetite, T. 98.2, in bed @ this time and will encourage isolation. During observation on 7/29/24 at 3:50 p.m., an Airborne Infection Isolation room sign was posted on outside of resident door. Sign stated, wear gown, N95, eye protection (Goggles or face shield), One pair of gloves. PPE cart was placed outside the door with N95 masks, gowns, gloves and hand sanitizer in the unit. PPE unit did not contain face shields or goggles. During continuous observation on 7/29/24 at 5:44 p.m. to 5:52 p.m., nursing assistant (NA)-A exited R134's room wearing PPE gown, N95 mask, and gloves. NA-A was wearing prescription eyeglasses and opened the PPE cart and then walked back into R134's room without eye protection. At 5:57 p.m., NA-A exited R134's room with a meal tray. During interview with NA-A on 7/29/24 at 5:58 p.m., NA-A verified R134 with Covid-19. NA-A verified he did not wear a face shield or goggles when assisting R134 with eating. NA-A stated, I was told it was ok to just wear my eyeglasses. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview with nursing manager and licensed practical nurse (LPN)-A on 7/29/24 at 6:03 p.m., LPN-A verified R134 was on respiratory precautions due to Covid. LPN-A stated, [facility] they allow us to use our [eye]glasses as eye protection and did not need to wear a face shield or goggles when working directly with R134. During observation on the second floor (with Covid outbreak) on 7/29/24 at 4:40 p.m., an unidentified staff member was wearing surgical mask below their nose while pushing a resident in a Broda chair to the dining room. During interview with RN-B on 7/30/24 at 9:00 a.m., RN-B stated the expectation of all staff was to wear required PPE gown, gloves, N95's and face shields or goggles when providing any kind of care to a Covid positive resident. Any time a staff enters a Covid room they are to don the PPE and remove it when they leave. Staff should not exit room with the PPE on to check the cart. [sic] important for staff to don and doff the PPE to prevent infection and to protect everyone including other staff, families and residents from infection. During interview with the DON on 7/31/24 at 10:04 a.m., DON stated Covid precautions include, gown, gloves, face shield and N95 mask. And staff should always wear all the required PPE including the face shield every time they enter the Covid positive room. Also, surgical masks worn above nose and mouth should be worn by all staff during outbreaks especially on the Covid units. Uncovered Soiled Linen/Garbage Carts in hallways. During observation on 8/1/24 at 7:51 a.m., on the fifth floor, a three-bin unit with each bin having a large plastic bag inside a mesh bag was observed in the hallway outside of a fifth floor resident room. One of the bins had a white plastic cover while the other two had no covers at all. The uncovered middle bin had a visible mound of laundry with a soiled red plaid shirt. that had a R30's name on a label inside the neck of the shirt. The uncovered right bin had soiled incontinence briefs and other trash in it. During observation and interview with nursing assistant (NA)-D on 8/1/24 at 7:53 a.m., NA-D exited room [ROOM NUMBER] with a small garbage bag and an arm full of soiled facility linen. NA-D placed the soiled facility linen including towels and bedsheet on top of the uncovered middle bin that had R30's personal shirt in it. NA-D then placed the small garbage bag into the uncovered soiled garbage bin. NA-D stated, [the two uncovered bins] are supposed to be covered but this one doesn't have covers. [laundry] is supposed to be covered for infection control. During observation and interview on 8/1/24 at 7:58 a.m., on the third floor a three-bin unit with each having a large plastic bag inside a mesh bag was in the hallway outside of room [ROOM NUMBER]. The middle bin was uncovered and had soiled Hoyer slings in it which were visible. Nursing manager and registered nurse (RN)-B grabbed the unit and wheeled it down the hall. RN-B stated, soiled linen and garbage should not be visible from the hall. RN-B stated, this is a concern for infection control. Each of these units [resident floors] have these 3 bin units for aides to put the trash and linen in them after providing care. One bin is for trash, one for personal laundry, and one for facility laundry. They should be covered when out in the hall. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview with the director of nursing (DON) on 8/1/24 at 9:12 a.m., DON stated uncovered soiled linen and garbage, should not be left visible in the hallway. DON stated rationale for covering soiled linen and garbage was, infection control thing. 48299 Enhanced Barrier Precautions: R83's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and diagnoses of neurogenic bladder (when a person lacks bladder control due to brain, spincal cord or nerve problems), kidney disease, epilepsy, and diabetes mellitus. R83 required substantial and/or maximal assistance for transfers and rolling left and right and partial and/or moderate assistance for toileting hygiene. R83's MDS identified R83 had an indwelling catheter and was frequently incontinent of bowel. R83's activities of daily living care plan revised 6/30/24, indicated R83 required a mechanical lift with two staff assistance for transfers. R83's care plan also indicated R83 had an indwelling catheter related to neurogenic bladder. During observation on 7/29/24 at 5:29 p.m., R83's door had a sign which read Enhanced Barrier Precautions and instructed staff to wear gloves and a gown for high-contact resident care activities which included transferring. A cart of personal protective equipment (PPE) was next to R83's door. NA-N and NA-O wore gloves, mask, and no gown to assist R83. NA-N and NA-O hooked the sling underneath R83 to the mechanical lift machine, placed the urinary catheter, which was within its privacy bag, on R83's lap, and transferred R83 from the bed to wheelchair. NA-N removed gloves and performed hand hygiene prior to leaving the room. NA-O still had gloves on and no gown and placed urinary catheter bag under R83's wheelchair and made R83's bed. NA-O removed gloves, wheeled R83 out to the dining room, and washed hands at the nurses' station. During interview on 7/29/24 at 5:45 p.m., NA-O stated they looked at the sign on residents' doors to know what kind of PPE to wear. NA-O verified R83 had a urinary catheter and stated staff needed gown and gloves when completing care such as emptying the urinary catheter but wore gloves when transferring. During interview on 7/29/24 at 6:12 p.m., NA-N stated residents who had a urinary catheter were on enhanced barrier precautions and needed gown and gloves when providing cares related to urinary catheters. NA-N verified R83 was on enhanced barrier precautions and stated staff needed gloves to transfer R83. During interview on 8/1/24 at 9:17 a.m., LPN-H stated residents with urinary catheters were placed on enhanced barrier precautions and confirmed R83 had a urinary catheter and was on enhanced barrier precautions. LPN-H stated gown and gloves were required to transfer R83 and was important to follow proper PPE procedures for safety reasons, such as not spreading MRSA (methicillin-resistant Staphylococcus aureus; bacteria which is resistant to many antibiotics). During interview on 8/1/24 at 9:40 a.m., LPN-G verified R83 had a urinary catheter and was on enhanced barrier precautions which required gown and gloves for transfers. LPN-G stated it was important to wear gown and gloves when transferring residents with urinary catheters to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 8/1/24 at 1:03 p.m., the assistant director of nursing (ADON) stated residents with urinary catheters required enhanced barrier precautions, and staff were expected to wear gown and gloves when providing hands on cares which included transfers. During interview on 8/1/24 at 1:36 p.m., the director of nursing (DON) expected staff to follow the precaution signs on residents' doors, and precautions were important to follow to prevent the spread of infection. Facility policy Enhanced Barrier Precautions dated 3/24, defined EBP as the use of gown and gloves during high-contact resident care activities for residents known to be colonized or infected with a MDRO (multidrug-resistant organism) as well as those at increased risk for MDRO acquisition, such as residents with urinary catheters. The policy indicated high-contact resident care activities included transferring. PPE: R54 quarterly Minimum Data Set (MDS) dated [DATE], indicated R54 was cognitively intact. R54 was independent with oral and toileting hygiene, putting on and off footwear and mobility, required set-up and/or clean-up assistance with eating, showering, upper body dressing, and personal hygiene, and supervision and/or touching assistance with lower body dressing. R54's MDS identified diagnoses of schizophrenia (mental health condition which affects how people think, feel and behave), malnutrition, hypertension (high blood pressure; pressure in blood vessels is too high), peripheral vascular disease (narrowed blood vessels reduce blood flow to legs or arms), coronary artery disease (narrowing or blockage of heart's arteries). R54's care plan undated, identified enhanced respiratory isolation due to COVID-19. R54's physician's order dated 7/29/24, identified enhanced respiratory precautions due to positive COVID test on 7/24/24. During observation on 7/29/24 at 6:09 p.m., R54's door had a sign which read Enhanced Respiratory Precautions and instructed staff to wear gown, N95 respirator, eye protection, and gloves to enter room. NA-N removed their surgical mask, performed hand hygiene, and donned N95, gown, gloves, and no eye protection and entered R54's room with a meal tray. At 6:10 p.m., NA-N exited R54's room and doffed gown, N95, gloves, performed hand hygiene, and placed on clean surgical mask. During interview on 7/29/24 at 6:12 p.m., NA-N verified R54 was on precautions for COVID-19 and required gown, gloves, and N95 to enter room. NA-N did not think there was eye protection in the PPE cart located next to R54's door. One face shield was observed in PPE cart. During interview on 7/31/24 at 1:47 p.m., NA-P verified R54 was on precautions for COVID-19 and required eye protection, gown, gloves, and N95 mask to enter room. NA-P stated R54 was independent to eat and had an occasional cough which made the eye protection important to wear. During interview on 8/1/24 at 9:40 a.m., LPN-G verified R54 was on precautions for COVID-19, and gown, gloves, N95 mask and eye protection were required to enter room. LPN-G stated it was important to follow PPE procedures, even to give R54 a room tray, to prevent transmission of COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 8/1/24 at 1:36 p.m., the director of nursing (DON) expected staff to follow the precaution signs on residents' doors, and precautions were important to follow to prevent the spread of infection. The facility policy Personal Protective Equipment dated 1/24, indicated the need for transmission-based precautions was a factor which determined the appropriate selection of PPE for a particular task. The policy identified personal glasses were not a substitute for goggles. The policy directed the charge nurse to check isolation supply carts twice per shift. 49339 R2's significant change MDS assessment, dated 6/26/24, indicated R2 had intact cognition. R2 was maximum to dependent on staff assistance for all activities of daily living (ADLs) except eating which she needed set up assistance. R2's diagnoses included: dementia (memory loss that disrupts daily life), hemiplegia (paralysis/inability to move of one side of the body), epilepsy (disorder in which nerve cell activity in the brain is disrupted causing seizures) and pain. During observation on 7/31/24 at 11:55 a.m., R2 was observed to have a single page document in a plastic page protector hung on the door that indicated: Respiratory Precaution Room. The sign had a person on it with PPE (proper protective equipment), it also included a stop sign on the sign with a picture of a hand along with the words: gown, N95, eye protection, one pair of gloves. At the bottom of the page, it indicated airborne infection isolation room: keep door closed if possible. To the left of the door was a three-drawer plastic bin to the left of the door which contained disposable gowns, N95 masks and face shields. On top of the plastic bin was hand sanitizer, disposable gloves, and disposable masks. During observation on 7/31/24 at 11:55 a.m., housekeeper (HSK)-D was observed with a surgical mask on pushing their cleaning cart to the entrance of R2's. HSK-D was observed using hand sanitizer, grabbing a disposable gown from the bin, putting the gown on followed by a pair of disposable gloves. HSK-K then entered R2's room. Upon exit of the room, HSK-D was observed to take off the gown and gloves and use hand-sanitizer but did not remove the surgical mask. During continual observation, HSK-D was observed to move their cart down the hallway to an adjacent room with a sign on the door, Enhanced Barrier Precautions. During the same continual observation, HSK-D was observed to use hand sanitizer, put on gloves and then a gown to enter the room, while continuing to wear the same surgical mask worn in R2's room. During interview at 7/31/24 at 12:09 p.m., HSK-D verified that they just completed cleaning R2's room. HSK-D verified they did not wear a N95 or a face shield. HSK-D stated, I can't breathe with those masks on. HSK-D stated, I changed my blue mask though, I carry them in my pocket. HSK-D verified PPE is to be worn to stop the spread of diseases. HSK-D verified that R2 was on precautions for COVID. During interview on 8/01/24 at 11:05 a.m., registered nurse (RN)-F verified R2 had COVID. RN-F stated that any staff needs to have full attire on when they enter COVID rooms, or any rooms PPE is needed in. RN-F verified that all staff get training on proper PPE use.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure recommended pneumococcal immunizations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided in a timely manner to reduce the risk of severe disease for 2 of 5 residents (R158, R17) reviewed for immunizations. Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/2023, identified several tables with corresponding recommendations when to receive various versions (i.e., PPSV23, PCV13, PCV20) of the pneumococcal vaccine. The graph labeled, Adults 19-[AGE] years old with chronic health conditions ., identified persons who received only a PPSV23 had an option to either get a PCV15 or PCV20 a year after the last PPSV23 dose. The conditions listed including alcoholism and cigarette smoking. Further, The graph labeled, Adults [at or older than] [AGE] years old, outlined persons with a complete series of pneumococcal vaccination (i.e., PCV13 at any age, PPSV23 at or above [AGE] years old) should have shared clinical decision-making between the resident and healthcare provider to determine if PCV20 was appropriate. R158's significant change Minimum Data Set (MDS), dated [DATE], identified R158 had intact cognition, demonstrated no delusional thinking, and had several medical conditions including chronic lung disease (i.e., asthma, COPD). R158's PointClickCare electronic medical record (EMR) immunization listing, printed 8/1/24, identified R158 was [AGE] years old along with his respective immunization history. This identified R158 received two doses of the PPSV23, with the last one being in 2010. The record lacked any other pneumococcal vaccinations being offered or received. On 7/30/24 at 9:54 a.m., R158 was interviewed and verified he was a current smoker. R158 stated he admitted to the care center back in early 2024, and had not been asked about getting any of the other recommended pneumococcal vaccinations since he admitted adding, They never talked to me about it. R158 stated he was open to more information on the vaccinations adding, I don't want to spread it to others. R158's medical record, including physician notes, was reviewed and lacked evidence any of the subsequent recommended pneumococcal vaccinations (i.e., PCV13 or PCV15/20) were discussed, offered or refused despite R158 admitting to the care center months prior. R17's quarterly MDS, dated [DATE], identified R17 had intact cognition, demonstrated no delusional thinking, and had several medical conditions including heart failure and respiratory failure. R17's PointClickCare EMR immunization listing, printed 8/1/24, identified R17 was [AGE] years old along with her respective immunization history. This identified R17 had received both the PPSV23 and PCV13, with the last administration being recorded as 3/2019 (over five years prior). The record lacked any other pneumococcal vaccinations being offered or received. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 1:45 p.m., R17 was interviewed and recalled getting some immunizations years prior for pneumonia. R17 stated they had not been asked about getting the newer, recommended PCV15/20 vaccination though adding, I have not. R17 stated had it been offered, they would have accepted it due to having poor breathing adding, I would take it yesterday. R17's medical record, including physician notes, was reviewed and lacked evidence any of the subsequent recommended pneumococcal vaccinations (i.e., PCV15/20) were discussed, offered or refused despite R17 having known cardiac and respiratory impairment. On 8/1/24 at 1:03 p.m., the assistant director of nursing (ADON) and regional nurse consultant (RNC) were interviewed. ADON explained themselves, along with RNC, were helping to manage and oversee the facility' infection control program since the previous infection preventionist (IP) had abruptly resigned a few months prior. ADON verified they had reviewed R158 and R17's respective medical records, and explained the PointClickCare information was the most current, including with data pulled from the MIIC (Minnesota Immunization Information Connection). ADON verified neither R158 or R17 had their respective, eligible doses offered or provided prior to the survey to their knowledge and expressed they had been, so far, unable to locate any documentation to demonstrate otherwise but would provide it, if located. ADON explained the previous IP apparently had been offering the vaccinations but not giving them. RNC stated, in hindsight, a quality assurance (QA) project should have likely been started for immunizations but had not been. RNC and ADON both verified they were going to review a 'whole house' audit now and get the immunizations offered, as needed, moving forward adding, It's in the process. ADON stated it was important to ensure vaccinations were offered and, if accepted, provided to promote resident' health adding, They have diagnoses that put them at risk. The facility' policy on pneumococcal vaccinations was requested, however, was not received.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to implement an effective pest control program to eliminate bed bugs from the building for 1 of 1 resident (R9) with the potential to affect all 11 residents residing on the odd side of the seventh floor. Findings include: R9's quarterly Minimum Data Set (MDS) dated [DATE], indicated R9 had no cognitive deficits and required moderate assistance with transferring, bathing, and toileting hygiene. The pest control company report dated 7/31/24 at 2:15 p.m., indicated R9's original room had been assessed by the pest control company, and a dead bed bug was noted. During an interview on 7/29/24 at 2:09 p.m., R9 stated she was moved from her original room to her current room last week because of a bed bug infestation. R9 stated she was supposed to move back to her old room soon but was scared as she didn't believe that the bed bugs were gone. During an interview and observation on 7/30/24 at 2:55 p.m., R9 was found still residing in the new room she had been given the previous week. R9 stated that the staff had moved her back to her old room yesterday. R9 stated staff had assisted her to bed, given her one of her bags, and then left the room. R9 stated she soon noticed these blackish-brown bugs everywhere on her bed and when she would touch them, blood would go everywhere. R9 stated the bed bugs kept climbing onto her body, leaving her covered in blood. R9 stated she was screaming for help and had her call light on, but she could not get out of bed by herself. During an interview on 7/30/24 at 3:02 p.m., registered nurse (RN)-K, the nurse manager for the unit, stated that R9's room had been found to have bed bugs last week after R9 had visitors. RN-K stated she was unsure how the bed bugs were managed as this was completed by the director of engineering (DOE). RN-K stated that R9 was moved out of the bed bug-infected room to a new one on 7/23/24 and moved back on 7/29/24. RN-K stated she was unsure who assessed the room before bringing R9 back. During an interview and observation on 7/30/24 at 3:33 p.m., R9's original room was observed with a bed on the left-hand side of the room pressed up against the wall. The bed sheets were observed with sporadic red/rust-colored stains and a small black-brown bug crawling across the bottom sheet. The bed frame was observed with a black/red grime-looking substance. The room was observed to have multiple open boxes with items overflowing and multiple personal bags on the floor of the room. The blinds were observed covered by a fabric topper. Clothing was observed overflowing out of the dresser. A multicolored personal blanket was observed on the floor. RN-K confirmed that the bug crawling on the bottom sheet was a bed bug. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakehouse Healthcare & Rehabilitation Center	3737 Bryant Avenue South Minneapolis, MN 55409

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/31/24 at 9:09 a.m., the DOE stated R9 had a repeat issue of bed bugs that had been treated last week with a heating system by MS-A. The DOE stated R9 had a lot of items in her room that were making it hard to get rid of all the bed bugs, but they had so far not done anything to address this issue. The DOE was asked to provide documentation showing any audits of other resident rooms on the unit and any documentation of treatment used to treat the bed bug infestation in R9's original room. During an interview on 7/31/24 at 1:03 p.m., maintenance staff (MS)-A stated he had dealt with the bed bug infestation in R9's room. MS-A stated he had used an electric heating device that was manufactured to kill bed bugs and reached 130 degrees for three days. MS-A stated the facility does not normally call a pest control service until after the heat treatment has not worked. MS-A stated it was up to housekeeping to deep clean R9's room, launder any loose linens, and check to ensure there were no more bed bugs before allowing the resident to re-enter the room. MS-A stated he had noticed a lot of stuff in R9's room and the room looked like it needed to be cleaned to make the bed bug treatment more effective. MS-A stated he had noted the bags and boxes in R9's room but did not think anyone had dealt with these items. MS-A stated he had checked one additional room for the spread of bed bugs, but this room did not share a wall and was separated by a hallway, a sitting area, and an elevator from R9's original room. MS-A was asked to confirm that he had not inspected the room that shared a wall with R9's room and he stated yes, he had only inspected the room that did not share a wall and was separated by a hallway, sitting area, and an elevator from R9's original room. During an interview on 7/31/24 at 1:34 p.m., the district manager for environmental services (DMES) stated he would have expected edge to edge cleaning, including the bed frame, all linens, all personal laundry, and curtains. The DMES agreed if grime and build-up were found on the bed frame he questioned if edge-to-edge had taken place. The DMES stated he did not expect housekeeping staff to bag up or clean personal items such as bags or boxes that were left in the resident's room. The DMES stated his staff was not responsible for assessing if bed bugs were still present before R9 moved back to her room. During an interview on 7/31/24 at 1:29 p.m., the associate administrator (AA) stated he began assisting with R9's bed bug issues this week but did not have knowledge of how it was handled the previous week. The AA stated he had been involved in moving R9 back to her original room on 7/29/24. The AA stated it should have been maintenance who assessed for bed bugs before R9 moved back to her room. The AA stated he had identified bed bugs on her bed after she had called facility staff into her room on 7/29/24. The AA stated that RN-K and he had decided R9 needed to be again removed from that room and they now had a pest control company on their way to assess the room before R9 returned. During an interview on 7/31/24 at 1:40 p.m., the DOE stated they had not previously had a pest control company out to inspect and give recommendations for the current bed bug infestation but one was here now. The DOE stated he had started three months ago, and MS-A was helping to train him. The DOE stated that MS-A was the one who would know about how the bed bug infestation was managed. The DOE stated he did not have documentation showing any audits of other resident rooms on the unit or any documentation of the treatment used to manage the bed bug infestation in R9's original room. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 7/31/24 at 1:44 p.m. in R9's original room, the outside pest control agent (PC)-A stated he had employee training on bed bug management that might be useful for the employees at the facility. PC-A stated it was important that all items that they could be, be placed in sealed bags and motioned at the bags and boxes on the floor. PC-A then stated it was important loose linens were also laundered and not left in the infested room and motioned to the loose linens on the floor and piling out of the resident closet. PC-A stated it was also important that the facility inspected the rooms near R9's room such as the room sharing a wall and the room below R9's room to ensure the bed bugs had not spread. The facility Bed Bug Protocol dated 3/14/24, indicated after staff were made aware of potential bed bugs, staff would attempt to capture the bug with scotch tape and then call maintenance to confirm the bug was a bed bug. Maintenance staff would then notify the supervisor of the presence of bed bugs. Staff would then bathe the resident and move them to a different room leaving all personal belongings behind. Maintenance staff would complete the heat treatment and then notify housekeeping so they could deep clean the room. Once the deep clean was completed, housekeeping would notify the administrator and the director of nursing that it was safe to move the resident back into their room.