STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at St Louis Park LLC	3201 Virginia Avenue South Saint Louis Park, MN 55426

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 promote a dignified environment for 3 or 4 residents (108, R2, R49) reviewed for resident rights. Findings include: R108's quarterly Minimum Data Set (MDS) assessment, dated 5/14/24, indicated R108 had severe cognitive impairment and required partial to moderate assistance with activities of daily living (except eating) and ambulation in the unit hallways. During observation on 6/12/24 at 7:00 a.m., R108 and seven other residents were seated out in the dining room. Four of the residents had coffee in front of them and four had empty juice and coffee cups sitting in front of them. No interaction was observed between staff and residents as staff was still getting residents up for the day. During an interview and observation on 6/12/24 at 7:31 a.m., clinical coordinator and licensed practical nurse (LPN)-D stated breakfast was not served until around 8:30 most days, which was a long time for these residents to wait. During observation on 6/12/24 at 8:03 a.m., residents were still sitting in the dining area, a total of sixteen residents now, four residents with empty juice and coffee cups in front of them. One resident observed sitting at a table alone, with her forehead resting on the table. During observation on 6/12/24 at 8:10 a.m., there were eighteen residents out in the dining room, juice and coffee at the tables but no food at this time. Outside of the dining room was an empty sitting area with a television, one recliner, one love seat, one side chair and multiple dining room chairs and space for wheelchairs. During an interview on 6/12/24 at 8:12 a.m., certified nursing assistant (CNA)-J stated the process he followed was to get the residents who needed the most care up first and bring them out to sit in the dining room followed by residents who could ambulate on their own. CNA-J stated this order of getting residents up was for convenience to ensure they had enough time to get up all residents up before breakfast. (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 and observation on 6/12/24 at 8:22 a.m., R108 stated she was still waiting on breakfast (was observed in the dining room since 7:00 a.m.), stating I am hungry, hopefully soon. The residents in the dining room were becoming restless and loud as they were still waiting for breakfast, with residents who were ambulatory getting up and leaving the dining room area. During observation on 6/12/24 at 8:27 a.m., R108 was yelling out, I am hungry! from her seat at the table in the dining room. During observation on 6/12/24 at 8:35 a.m., a metal cart with breakfast trays was brought into the dining room and the first residents were served their breakfast. Residents at the same table were not served at the same, with 4 tables having one resident eating and the others at the table without food. Residents who required assistance with eating were served before residents who could feed themselves. All residents were served their food by 8:42 a.m. During an interview on 6/12/24 at 2:05 p.m., clinical coordinator and LPN-D stated each CNA had their own process for how and when they would get the residents up each morning. LPN-D stated breakfast used to come up earlier, around 7:30 a.m. - 7:45 a.m., which worked out better for the residents, stating the staff try to entertain the residents as best they can while waiting for breakfast. LPN-D stated it gets hard to keep the residents calm in the dining room, stating you can feel the energy change in the room as time goes on and it felt like we [staff] are just waiting for something to happen. LPN-D stated bringing the residents out to the TV room while waiting for breakfast was not something they had tried before but could try to reduce the institutionalized feel of the breakfast meal. During an interview on 6/13/24 at 1:51 p.m., the director of nursing (DON) stated they had just hired a new dietary manager and were working on food times and mealtimes, stating mealtimes used to be earlier. The DON stated the expectation would be to keep the residents engaged while waiting for breakfast either in their room or out in the main TV area. Clothing Labels R108's quarterly Minimum Data Set (MDS) assessment, dated 5/14/24, indicated R108 had severe cognitive impairment and partial to moderate assistance with activities of daily living (except eating) and ambulation in the unit hallways. During observation on 6/10/24 at 4:04 p.m., R108 was sitting in the main dining area, wearing blue slippers with her first and last name visible on the top of her slippers. During observation on 6/11/24 at 2:41 p.m., R108 was sitting in the main dining area, wearing blue slippers with her first and last name visible on the top of her slippers. During observation on 6/12/24 at 7:26 a.m., R108 was sitting in the main dining area, wearing blue slippers with her first and last name visible on the top of her slippers. R2 was also sitting at a table with her first and last name visible on the outside of her slippers. During an interview on 6/12/24 at 2:05 p.m., clinical coordinator and LPN-D stated she was aware clothing labels being visible on the outside of clothing was a dignity concern for residents, confirming the label should not be visible on R2's or R108's slippers. (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 6/13/24 at 8:27 a.m., laundry aide (LA)-A stated the process for labeling clothing, including slippers and socks, was to label clothing on the inside of clothing for the safety of the residents. During an interview on 6/13/24 at 1:51 p.m., the director of nursing (DON) confirmed the expectation for labeling clothing was to place all labels on the inside of clothing. 49034 R49's quarterly MDS dated [DATE], indicated R49 had moderate cognitive impairment and was diagnosed with kidney disease, depression, and a stroke with aphasia (a disorder affecting speech). The MDS indicated R49 was able to independently wheel 50 feet, required set-up help for eating, and was dependent on staff for transfers. R49's care plan dated 4/8/24, indicated R49 enjoyed watching television, visiting the courtyard, and socializing with peers. The care plan indicated staff would assist R49 with activities as needed and encourage and invite R49 to said activities. During an interview on 6/10/24 at 2:29 p.m., family member (FM)-B stated R49 had a stroke and had resulting difficulties with speech but R49 still knew what he wanted and was able to communicate through nodding to yes or no questions. FM-B stated when he came to visit, he would often find R49 sitting in the dining room with no activities going on or a television playing. FM-B stated it bothered him R49 was left there with nothing to do as he knew R49 would not like this. FM-B stated R49 was always an independent person and didn't necessarily like other group activities but had always liked to watch television. During an observation on 6/13/24 at 8:24 a.m., R49 was observed sitting at a dining table on the far-right side of the dining room facing the wall. During an observation on 6/13/24 at 8:42 a.m., R49 was observed sitting at a dining table eating breakfast. During an observation on 6/13/24 at 9:06 a.m., R49 was observed sitting at a dining table by himself eating breakfast. During an observation and interview on 6/13/24 at 9:19 a.m., R49 was observed sitting at a dining table by himself and when asked if he was done eating, R49 nodded his head yes. During an observation on 6/13/24 at 9:31 a.m., R49 was observed sitting at a dining table by himself. During an observation on 6/13/24 at 9:49 a.m., R49 was observed sitting at a dining table by himself facing the wall on the right side of the dining room. Three other residents were observed sitting around a table facing and watching television on the left side of the dining room (behind R49). When R49 was asked if he would like to watch television, he nodded his head yes. When asked if anyone had offered to bring him over to the television, he shook his head no. (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 observation and interview on 6/13/24 at 9:51 a.m., housekeeper (H)-A was observed sweeping up food debris from the dining room floor. H-A stated she had seen R49 and other residents sitting in the dining room with no entertainment for a long period after meals and this had led to residents becoming visibly upset to the point of crying in the past. During an observation on 6/13/24 at 10:07 a.m., R49 was observed sitting at a dining table by himself facing the wall on the right side of the dining room. R49 was observed attempting to push himself away from the table but the right wheel appeared locked so the wheelchair turned to the right but appeared unable to move farther. R49 was then observed to put his head in his hand and look down towards his lap. During an observation on 06/13/24 10:23 AM, RN-E, the nurse manager for the unit, was observed to approach and quickly converse with R49 and was then observed to leave the dining room. During an observation on 6/13/24 at 10:43 a.m., activity staff (A)-B was observed to approach R49 and ask if he wanted to sit by the tv, he nodded yes, and she pushed him in his wheelchair and sat him with the other residents watching television. During an interview on 6/13/24 at 10:48 a.m., RN-E stated she did not think anyone had offered to assist R49 to the other side of the dining room to watch television with the other residents until the occurrence at 10:43 a.m. RN-E stated she would have expected floor staff to offer R49 assistance to the other side of the dining room to watch tv or take him back to his room. During an interview on 6/13/24 at 1:47 p.m., the DON stated she would have expected floor staff to assess what R49's preferences were after a meal, such as returning to his room or participating in other activities. The DON stated she would not want R49 stuck sitting alone at his table with nothing to do as it could lead to feelings of sadness. Facility policy on dignity was requested and not received.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 44656 Based on observation and interview, the facility failed to ensure resident records which contained private, medical, and personal information were kept private and not accessible to unauthorized personnel for 1 of 1 residents (R35) reviewed for privacy. Findings include: During observation on 6/10/24 at 5:35 p.m., an unattended medication cart located at entrance of second floor dining room with laptop open to R35 medication list was observed. Dining room had 12 residents in the room eating dinner and numerous staff walking past the medication cart. During observation and interview with registered nurse (RN)-C on 6/10/24 at 5:36 p.m., RN-C walked up to the unattended medication cart and closed the laptop screen. RN-C stated, nurses should be sure the med carts are locked and laptop should be closed due to privacy. RN-C stated the nurse responsible for the unattended medication cart was not in the area and would try to locate them. During interview with licensed practical nurse (LPN)-B on 6/10/24 at 5:37 p.m., LPN-B stated he was responsible for the unattended medication cart and, it is a violation [to leave the resident medical record visible when walking away from the medication cart]. The laptop should be turned off due to HIPAA [Health Insurance Portability and Accountability Act]. During interview with director of nursing (DON) on 6/11/24 at 9:11 a.m., DON stated, medication carts should always be locked when staff step away from the cart. The laptop should be turned off [when leaving the med cart]. Facility policy provided to survey team by administrator titled Department of Health Combined Federal and State [NAME] of Rights for Residents in Medicare/Medicaid Certified Skilled Nursing Facilities or Nursing Facilities, revised 6/18/19 states, The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

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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, interview and document review, the facility failed to promote a dignified home like environment for 6 or 6 residents (R61, R13, R126, R22, R63, R68). Findings include: R61's Annual Minimum Data Set (MDS) assessment, dated 5/7/24, indicate admission to facility on 11/9/23 and had severe cognitive impairment. In addition, R61 with no impairment of upper and lower extremities, utilized a walker and wheelchair for mobility, and required substantial assistance with toileting and personal hygiene, and dressing. Also, R61 with diagnoses of benign prostatic hyperplasia (enlarge prostate gland making it difficult to empty bladder), polyneuropathy (numbness in extremities), urinary retention, transient ischemic attacks (cerebral stroke affecting brain function), adjustment disorder, and had an indwelling catheter (to drain urine from bladder into a bag). R61's physician orders (PO) dated 11/3/23 included, Foley Catheter: Please apply leg bag during the day & overnight bag during the evening/night. R61's care plan (CP) dated 6/7/23 indicate, Resident has history of refusing foley catheter leg bag during the day. Has been observed removing the catheter bag cover after it was applied by staff. The CP did not provide interventions to re-approach or offer alternatives to covering the bag when out of his room. During observation on 6/11/24 at 12:45 p.m., R61 sitting on seat of wheeled walker in the main lounge at a dining room table alone. R61's large uncovered catheter bag was hanging on the brake handle of his wheeled walker above the height of his bladder and visible to several staff and residents in the room. The uncovered catheter bag had yellow urine in the tubing and bag. During interview with registered nurse (RN)-A on 6/11/24 at 12:51 p.m., RN-A stated, not acceptable to have it [catheter bag] above the bladder. It must be below bladder and covered in a bag for dignity and privacy. RN-A stated, [it is] not ok for catheter to be exposed. During interview with nursing assistant (NA)-A on 6/11/24 at 12:55 p.m., NA-A stated, the urine bag should be covered in a bag for dignity and its got to be below the waist. Urine should flow in one direction, down. No one wants to see the urine in the bag. During interview with RN-C on 6/11/24, at 2:48 p.m., RN-C stated, catheter bags should always be covered for dignity. For [R61] it is care planned that we have tried everything to get him to agree to cover it up. He refuses. He gets nasty and we try again. I agree it is not ideal for the other residents to have to see his urine. Don't know what else we can do. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 6/12/24 at 7:29 a.m., R61 sitting on seat of wheeled walker in the second floor dining room. Five other residents (R13, R22, R126, R63, and R68) were seated at tables awaiting breakfast. R61 seated across from R13 at the dining room table. R61's urine drainage bag was uncovered and visible to everyone in the dining room including the nursing station adjacent to the dining room. During interview with R13 on 6/12/24 at the same time as observation, R13 stated, I can't see it from where I am sitting now but I don't really like that thing uncovered. Who wants to see another person's pee[urine]? I would rather not, especially when I am eating or out in the hall or at activities. During interview with R22, R126, R63, and R68 at 7:32 a.m., R22 stated, Its gross to see that pee in that bag. He don't care but I do. I don't want to see it while I am eating. R126 stated, Yeah, he [R61] don't care about the rest of us having to see that icky bag and [I] wish [R61] would go eat in his room so I don't have to see it. I just sit where I am not facing it. R63 stated, [R61] always walks around with that bag uncovered. And [I] wish he didn't because I do not like to eat with that bag visible to me. This is my home too, so I don't think I have to put up with it just because he doesn't want to cover it. R68 stated, why do we have to see that thing? [R61] don't look at it like we have to. I am about to eat here and I look away. Why is it ok for him to have that thing uncovered so all of us have to look at it? Its not fair. During interview with NA-F on 6/12/24 at 7:45 a.m., NA-F stated, [catheter bags] should be covered at all times because of dignity. And It bothers the other residents but he don't care. During interview with director of nursing (DON) on 6/13/24 at 8:11 a.m., DON stated expectation of all catheter drainage bags to be always covered with privacy bag due to, dignity. DON stated R61's care plan failed to provide guidance and suggestions for alternatives to his refusal of having a dignity bag to cover his catheter. DON stated there was discussion with the interdisciplinary team regarding his refusals but there was nothing in the medical record to address it. DON stated, R61's CP interventions failed to address re-approaching him or offering alternatives to covering the bag when out of his room. Facility policy on dignity was requested and not received.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 49339 Based on observation, interview, and document review, the facility failed to ensure residents on a secure memory unit were free from harm for 2 of 2 residents (R82 and R17) reviewed for resident-to-resident abuse. This resulted in actual harm when R17 was struck in the face by R82 causing a subconjunctival hemorrhage of the left eye (broken blood vessels in the eye) requiring emergency medical attention. Findings include: According to the state agency (SA) Incident Report, dated 6/9/24, identified a facility's reported allegation of physical abuse involving R17 and R82. The report outlined R17 reported he was struck by R82 in the eye with the incident occurring in R17's room. R17 had a laceration on his left eye and transported to the hospital for evaluation. R82 R82's quarterly Minimum Data Set (MDS) assessment, dated 5/15/24, identified R82 had dementia, post-traumatic stress disorder (a psychiatric disorder that may occur after experiencing or witnessing a traumatic event), restlessness, agitation, and severe impaired cognition. Furthermore, R82 demonstrated able to walk in room and unit independently, no hallucinations or delusions. No physical or verbal behaviors . R82 noted to wander daily and reject cares one to three days in the last 7 day look-back period for MDS. R82's care plan, identified R82 moved into facility on 8/5/21 and resides on locked memory care unit. R82's care plan included, -R82 at risk for alterations in behavior related to trauma, including PTSD(post-traumatic stress disorder) from time spent in Vietnam war with a goal resident will develop coping skills to address stated trauma . Interventions included: redirect resident to a different activity to help self sooth and when resident is getting agitated and engages in screaming, redirecting him from other residents is of value for safety. - R82 had a history of aggressive behavior including verbal and/or physical altercations with other residents, The goal was to prevent reoccurrence and keep other resident safe . -R82's has alteration in socialization related to difficulty engaging due to diagnosis of dementia and related cognitive deficits. Resident appears to enjoy visiting with staff and other resident around him. Resident would benefit from socializing with others during group activities. Resident also enjoys music groups and independently listening to music in his room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-R82 has alteration in behavior related to diagnosis of dementia. Resident often wanders and enters other residents' rooms , The goal related resident will respond to intervention by staff to calm and redirect . R82 does have periods of increased confusion and agitation will typically increase in the afternoon. At times, resident is difficulty to redirect .history of wandering . has history of physical altercations with other residents. Goal of resident will respond to interventions by staff to calm and redirect with a revision date of 4/19/24. Interventions included: Staff reported more wandering and anxiety in the night. Implement an exercise program where staff walk with him in the hallway for 5-10 minutes in the evenings to help release excess energy and anxiety with initiation date of 5/6/24. -R82 Care plan included an alteration in psychosocial wellbeing related to diagnosis of Dementia. Resident is pleasant at baseline, preferring to be around others for most of the day, liking to converse with others, though often conversation is hard to follow. Resident has periods of increased agitation or restless, will start walking around the unit quickly and asking others to help him get to his car. R82's treatment administration record (TAR) for 5/1/24 and 6/13/24 had the following order for staff to monitor and document altercations if the following behaviors were identified: picking at skin, restlessness, agitation, hitting, increase in complains, biting, kicking, spitting, cussing, racial slurs, elopement, staling, delusions, hallucinations, psychosis, aggression, refusing care. The records indicate staff checked the box R82 had behaviors every shift for the month of May and June except one shift. R82 had a history of behaviors prior to most recent incident involving R17 as indicated in R82 progress notes: -2/1/24 at 2:19 p.m.: exiting seeking .another resident keeps talking to resident .causing resident to become increasingly agitated. -3/7/24 at 1:21 p.m.: emotional and exit seeking -3/13/24 at 11:52 a.m.: agitated, pacing and shouting at others -3/13/24 at 9:42 p.m.: agitated -4/7/24 at 5:19 p.m.: was exit seeking and agitated. -5/3/24 at 6:31 a.m.: aggressive with staff with cares, resident not able to calm down, he started chasing other res [resident] cursing and yelling . difficult to calm down. -5/3/24 at 7:50 a.m.: physical altercation with another resident. R82 was transferred to the hospital for further evaluation as was bleeding from right eye. -5/4/24 at 7:23 a.m.: exhibited escalating behaviors including grabbing a fire extinguisher from wall, attempting to hit staff with it, and was unable to be redirected. All other resident doors needed to be shut for safety. R82 attempted to fight another resident. -5/4/24 at 9:59 p.m.: aggressive during cares and attempted to elbow a nursing assistant. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-5/9/24 at 11:52 a.m.: exit seeking. -5/18/24 at 4:03 p.m.: exit seeking. -6/1/24 at 9:44 p.m.: pacing the hallways, going back and forth between all the doors looking for how to get out. -6/4/24 at 7:17 a.m.: refused cares despite multiple attempts. -6/7/24 at 3:29 p.m.: attempted to strike a nursing assistant with the shower hose during care. -6/9/24 at 7:37 p.m., reported by R17 that R82 entered R17's room and struck him in the eye, R82 unable to explain. Although R82's TAR indicated behaviors charted daily by staff, the progress notes lacked daily documentation of what altercations R82 were exhibiting and what interventions were implemented. R82's nursing assistant care sheet, included R82 was independent with ambulation and transfers. History of res [resident] to res [resident] and whom altercations occurred with. R17 R17's care plan identified: -R17 is a vulnerable adult while residing in a skilled nursing facility and is at risk for decreased cognitive and physical ability related to diagnosis included dementia . The goal related resident will remain free from abuse and/or neglect . -R17 is at risk for alteration in psychosocial well-being related diagnosis of dementia while residing on a secure memory care unit. At baseline. Resident is pleasant to others, though often keeps to himself. Resident does like to watch TV in the common area with others. He likes to watch the other resident . Accused another resident of hitting him in the chin, no injury noted, and this was unwitnessed. Resident gets upset when other residents wander into his room . Stop sign on the doorway of his room to help prevent other resident form entering his room with a date initiated of 1/22/24 with a revision added after altercation on 6/12/24, [R17] often takes the stop sign off his door and he will put it in his drawers or closet. During an observation and interview on 6/10/24 at 2:03 p.m., R17's left eye was black and blue and the white of his eye was bright red. R17 indicated he was punched by another resident which caused his black and blue eye. R17 denied pain at this time. There was no stop sign observed to be on R17's door when entering. During follow up observation on 6/11/24 at 1:22 p.m., there was no stop sign observed to be hanging on R17's door. During breakfast on 6/12/24 at 8:17 a.m., R17 stated, he was hit in the eye by another resident. On 6/12/24 at 8:31 a.m., during an observation, it was noted there was no stop sign on R17's door. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at St Louis Park LLC	3201 Virginia Avenue South Saint Louis Park, MN 55426

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	R17's quarterly MDS assessment, dated 5/7/24, identified R17 had dementia, schizophrenia, slurred speech, and severe cognitive impairment. MDS indicated R17 used wheelchair for mobility and dependent on staff for transferring to and from wheelchair. R17 noted to have verbal behavioral symptoms directed towards others (threatening others, screaming at others, cursing at others) and other behavioral symptoms not directed towards others both of which occurred one to three days. R17's nursing assistant care sheet, identified R17 was HOH [hard of hearing] has a pocket talker to aide with HOH, R17 was Assist of 1 with transfers. He often self-transfers. Stop sign on his door to prevent others from entering. R17's progress notes included the following: 2/1/24 at 2:22 p.m. R82 had been wandering around the dining room and hallways exiting seeking and R17 continues to talk to R82 stating thinks like I'll knock you out, and I'll through you out the window. R17 has some speech that is hard to understand and R82 is becoming agitated with R17. Writer asked R17 not to talk to R82 and give him space. R17 continues to move seats in the dining room and go near R82 and make statements causing more and more agitation to R82. Staff will redirect as necessary. 6/9/24 at 7:33 p.m., writer went to resident room at around 8:20 a.m., to check with him and remind him to come out for breakfast. Noted resident left eye reddened. Per resident, someone came to his room and punched him to his eye. Resident was asked to come out with writer and identify the person who had punched him. He came out and went straight to dining area where he pointed at a resident R82. Resident has impaired speech, he was heard mumbling and pointed at R82 he punched me, he did it. sent to hospital for further evaluation. 6/9/24 at 10:23 p.m., patient returned from emergency department, no new orders, or treatments. R17's emergency department note, dated 6/9/24, indicated R17 was seen following an assault. R17 reported some pain in left eye and a little more difficult to see out of the left eye but is still able to see. CT scans indicated no evidence of acute hemorrhage, or skull fracture and no orbital, facial bone, or mandibular fracture. R17 discharge diagnosis subconjunctival hemorrhage of left eye. R17's record lacked interventions to prevent additional verbal or physical altercations. During an interview on 6/12/24 at 10:32 a.m., licensed practical nurse (LPN)-E verified working with R82 and R17 for over a year. LPN-E indicated received report R82 hit R17 . LPN-E reported no other incidents (verbal or physical altercations) between R17 and R82. LPN-E stated R17 should have a stop sign on his door but he takes it off all the time. LPN-E indicated the stop sign was to stop other residents from entering his room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 6/12/24 at 10:39 a.m., nursing assistant (NA)-M verified working with R82 and R17 for over a year. NA-M indicated they worked the morning of 6/9/24. NA-M stated they were in the dining room when R82 walked up to them and hit NA-M in the arm stating, do you need another? NA-M stated they encouraged R82 to sit in the dining room, and it was shortly after R17 reported R82 hit him in the face. NA-M stated they do not know of any other incidents (verbal or physical altercations) between the two residents but adds we have been trying to follow him around since this happened. NA-M verified R17 should have a stop sign on his door and does not have it on there. NA-M was able to find the stop sign which was found in R17's drawer. On 6/12/24 at 10:54 a.m., NA-B verified they are familiar with R17 and R82 and have worked with them for over a year. NA-B stated they knew about the physical altercation between R17 and R82. NA-B stated R82 has been more aggressive recently and difficult to get things done. NA-B stated, we just re-approach a lot and offer a lot of reassurance. NA-B stated there have been no other incidents (verbal or physical altercations) between R17 and R82. On 06/12/24 at 2:22 p.m., LPN-D verified they update the care plans. LPN-D reviewed the chart and verified the verbal altercation with R17 and R82 on 2/1/24. LPN-D verified the care plan had not been updated. LPN-D stated R17 was having an increase in behaviors due to having a gradual dose reduction on a medication, a urinary tract infection and then kidney stones. LPN-D verified this was not on his care plan. LPN-D indicated R17 and R82 are seated at separate tables in the dining room, R17 has a stop sign on his door, put in extra behavioral monitoring, the unit is small so we can watch people closely, and make sure staff are aware of the situation so we can continue to watch and see problems. LPN-D further indicated it's not like it's a daily occurrence referring to R17 and R82. LPN-D verified R17 or R82's care plans had not been updated following the 2/1/24 verbal altercation. On 6/13/24 at 12:04 p.m., administrative administrator (AA) and administrator verified they were familiar with R17 and R82 and recent incidents. AA indicated on 2/1/24 there was an argument between R17 and R82. The interventions to follow were staff asked R17 not to talk to R82, R82 was seen by Associated Clinic of Psychology (ACP) on 2/5/24 and a (Patient Health Questionnaire-9) PH-Q9 completed on 2/6/24 with no disturbances. AA and administrator agreed there were no similar incidents. AA stated she was on-call on 6/9/24 and received a call from the supervisor regarding the physical altercation. AA verified she filed the state agency report. AA explained what had been done immediately following the physical altercation. AA verified R17's care plan had been updated on 6/12/24 following the incident. When asked what had been added since the verbal altercation to R17's care plan to prevent another altercation, AA stated I don't know, I need to look thoroughly. AA verified R82's care plan had been updated on 6/12/24 regarding a new medication for behaviors. AA stated she needed to look at R82's care plan more to verify if it had been updated to reflect 2/1/24 incident. On 6/12/24 at 12:30 p.m., administrator stated, I did not have a chance to look into IDT [interdisciplinary team] notes yet. Administrator indicated I think there was education to staff on the floor following each of the incidence. An in-service training record for all staff, dated 2/15/24, indicated the abuse policy, review that facility must report abuse to the state within 2 hours, and when to notify nursing home administrator and notification of director of nursing guideline. Two items are highlighted on each: serious injuries such as a fracture and resident to resident altercations. The abuse prohibition / vulnerable adult policy was attached. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	No further documentation was provided on any education provided to staff regarding these incidents. Furthermore, no documentation was provided on how to ensure other resident safety with a resident with known and multiple aggressive behaviors. Documents provided by facility after survey exit, on 6/17/24, included R17 and R82's care plan with highlighted areas, ACP notes for R17 and R82, timeline of events following 2/1/24 and 6/9/24 incidents and R82 medication changes were reviewed. The additional documentation lacked evidence on how the facility ensured through specific interventions, staff education, or care planned interventions to ensure the safety of R17 from physical abuse from R82 who had known history and increasing aggressive behaviors. A facility policy titled Abuse Prohibition/Vulnerable Adult Policy, review date 3/24, was provided. The document indicated the purpose is to protect resident against abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals, or self-abuse. Furthermore, under the prevention section, The Interdisciplinary Care Plan Team reviews residents requiring behavioral interventions at least quarterly and/or during Target Behavior meeting to develop individual behavior plans.

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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. 44656 Based on interview and record review the facility failed to ensure timeliness of person-centered care conferences were conducted to ensure resident goals and preferences were discussed for 1 of 1 residents (R93) reviewed for care conferences. Findings include: R93's quarterly Minimum Data Set (MDS) assessment, dated 3/28/24 identified admission to facility on 4/6/22, was severely cognitively impaired, with diagnoses of hemiplegia (paralysis) affecting right dominant side, stroke, depression, gastrostomy (feeding through a tube into the abdomen), and Parkinson's (progressive brain disorder affecting muscle control, balance and movement). R93's electronic medical record (EMR) indicates MDS assessments were completed on 4/12/22, 7/9/22, 10/5/22, 1/3/23, 3/30/23, 6/9/23, 9/27/23, 12/28/23, and 3/28/24. R93's EMR indicated care conferences were conducted on 1/4/23, 3/29/23, 4/5/23, 10/5/23 and 2/19/24. R93's medical record failed to show care conference were conducted on 4/12/22, 7/22/22, 10/5/22, 6/9/23, 12/28/23. During interview with director of nursing (DON) on 6/13/24 at 8:27 a.m., DON stated care conferences are expected, to be done quarterly and with significant change status. During interview with social services director (SS)-D on 6 13/24 at 9:57 a.m., SS-D stated she had been in role since 2022. SS-D stated, care conferences should be done quarterly and 21 days after admission. SS-D stated care conference timing are expected to be done with each MDS assessment. SS-D looked in R93's EMR and stated his care conferences were, not done for a year. SS-D stated there were missing care conferences for R93. Facility policy on care conference timing was requested and not received.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview and record review, the facility failed to ensure routine personal hygiene assistance was provided to 2 of 2 residents (R28 and R56) reviewed for ADLs. In addition, facility failed to implement a communication system to ensure resident needs were met for 1 of 1 resident (R93) whose primary language was not English. Findings include: R28's quarterly Minimum Data Set (MDS) assessment dated [DATE] identified admission to facility on 1/5/12 and intact cognition. During observation on 6/10/24 at 2:13 p.m., R28 laying in bed, dressed and had black matter under her fingernails. During observation and interview with R28 on 6/11/24 at 2:27 p.m., R28 laying in bed, dressed and had black matter under her fingernails. R28 stated, No, no one asks me if they can cleanout my nails. They can be gross if not soaked and taken care of. The aide [nursing assistant] should be asking me at least. During interview with registered nurse (RN)-D on 6/11/24 at 2:27 p.m., RN-D stated she had worked full time at the facility for five years and normally worked on the unit with R28. RN-D stated, nurses are responsible for making sure the nails are cleaned and washed up for the day. RN-D looked at R28's nails and stated, they should be cleaned and trimmed. During interview with RN-C on 6/11/24 at 2:48 p.m., stated she was the nurse manager of the unit R28 resides on. RN-C stated, nursing assistants should take care of nail care right away. During interview with RN-C on 6/12/24 at 8:10 a.m., RN-C said she looked at R28's nails yesterday,they are taken care of now and verified R28 had black stuff under them which needed to be cleaned. During interview with director of nursing (DON) on 6/13/24 at 8:28 a.m., DON stated nail care is to be done, weekly and as needed. 49339 R56's quarterly MDS assessment, dated 4/4/24, indicated R56 had intact cognition. MDS indicated R56 required partial assistance for shaving. MDS indicated no behaviors or rejection of care. R56's care plan, identified R56 needed assist with facial shaving- weekly on bath day as needed. R56's nursing assistant care sheet identified R56 was assist of 1 for all ADLs-make sure she is completing hygiene daily. Shave facial hair as needed on shower day. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/24 at 1:21 p.m., R56 was observed standing in her room and had a facial beard, approximately half inch long. R56 stated, I would feel better if it was gone I would like to try something, maybe an electric razor. R56 indicated they gave me a razor once, but it left it rough, and further expressed that she did not like the facial hair, and would like it gone. On 6/11/24 at 1:15 p.m., R56 was observed in her room. R56 stated she had just taken a shower and stated, they helped me shave. R56 further expressed, I feel much better. R56 stated they don't always do that but did today .used a razor that just rolled over and it worked pretty good I feel a lot better. R56 stated it's been a while . I don't remember the last time they asked me about shaving. On 6/13/24 at 9:37 a.m., licensed practical nurse (LPN)-E stated R56 was assist of 1 with ADLs, needs set up, and needs staff assistance to shave facial hair once a week on shower days as needed. LPN-E verified this on the nursing assistance sheet. On 6/13/24 at 9:42 a.m., nursing assistant (NA)-J verified they are familiar with R56. NA-J stated R56 needs set up for most ADL's, further clarifying staff set up her clothing and she can put them on herself. NA-J stated R56 needs set up and stand by assist for showers and R56's facial hair is done by staff on shower days. NA-J stated it is important to keep R56 facial hair shaved for dignity purposes. On 6/13/24 at 11:15 a.m., director of nursing stated getting rid of facial hair for women is a dignity issue, want to make sure that residents are presentable and feel good. A facility policy titled Activities of Daily Living (ADLs)/Maintain Abilities Policy, dated 5/9/24, was provided. The document indicated it will create and sustain an environment that humanizes and individualizes each resident's quality of life. R93 R93's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicates admission to facility on 4/6/22, was severely cognitively impaired, and diagnoses of hemiplegia (paralysis) affecting right dominant side, stroke, depression, gastrostomy (feeding through a tube into the abdomen), and Parkinson's (progressive brain disorder affecting muscle control, balance and movement). In addition, R93's preferred language was documented as OTHER. R93's Care Area Assessment (CAAs) dated 6/29/23, identified Communication as a concern. R93's care plan (CP) dated 4/8/22 reads Alteration in communication r/t primary language Vietnamese. Resident does not understand English, with the interventions to; -Staff will use interpreter phone line schedule an interpreter to communicate with resident, -Speak clearly and distinctly to resident or use resident preferred communication method, -Alternate communication method, use of interpreter phone line. R93's care sheet updated 6/6/24, direct staff to Use interpreter line, resident speaks Vietnamese. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with nursing assistant (NA)-B on 6/10/24 at 1:36 p.m., NA-B stated he was full time employee and worked over fifteen years at facility and is familiar with R93. NA-B stated, I don't use anything to communicate with [R93]. There is nothing on the walls here to help us figure out what [R93] wants. I will usually just look at his face and speak slowly. I don't really know if [R93] understands me. [R93] just goes along with it. Nothing in the care sheet [that I know of] about communicating with [R93] using a language board or language line. During observation on 6/10/24 at 5:40 p.m., R93 sleeping in bed. Interpreter line phone number with password printed on paper is attached to R93's closet door. During interview with licensed practical nurse (LPN)-A on 6/11/24 at 8:38 a.m., LPN-A stated she was very familiar with [R93]. LPN-A stated, we don't do anything to help him communicate. There are no signs on the walls or near him to help us talk to him. We just ask yes or no questions. That is all. And, His primary language is not English. During interview with NA-F on 6/12/24 at 7:45 a.m., NA-F stated she was familiar with [resident care on R93's wing] NA-F stated, I go off facial expressions. I go by care plan and grimacing. He is not verbal and, [I have] never seen any staff use the interpreter line for R93. During interview with director of therapeutic services (DT) on 6/12/24 at 10:51 a.m., DT stated, I would recommend the interpreter [for staff to communicate with R93]. It is the best shot in the dark to communicate with him. R93 is non verbal. Also, R93 was given a communication board with pictures along with Vietnamese and English words. [It] should be there [and visible] for staff to bridge the gap. During interview with family member (FM)-A on 6/12/24 at 11:15 a.m., FM-A stated, there is a phone number staff can use to get an interpreter for R93. I expect them to use the language line if there is a question R93 can answer. During interview with RN-D on 6/12/24 at 11:20 a.m., RN-D looked at R93 electronic medical record (EMR) including care plan and stated, language board should be in the care plan. I don't see anything in R93 chart to tell staff [about using] a language board. During interview with RN-C on 6/12/24 at 11:32 a.m., RN-C looked at R93's EMR and stated, [R93] has a communication sheet that he can point to for us and, No it is not in the care plan for staff to use the communication sheets [language board] to communicate with [R93]. During interview with RN-H on 6/13/24 at 9:15 a.m., RN-H stated, If someone is not English speaking, we are supposed to use interpreter line to communicate such things as, 'where is your pain? And questions not requiring a yes or not answer. Also, RN-H stated, we all need to look in the care plan to see if we are to use an interpreter. Facility policy titled Interpreter Policy updated 02/2024 state, language access services must be provided to patients with limited English proficiency (LEP).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview and record review, the facility failed to ensure a resident's preferred activities for individual entertainment were available for 1 or 1 residents (R93) reviewed for activities. Additionally, facility failed to comprehensively assess for, and provide, individualized activities for 1 of 1 transitional care unit (TCU) resident (R106). Findings include: R93's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicates admission to facility on 4/6/22, was severely cognitively impaired, and diagnoses of hemiplegia (paralysis) affecting right dominant side, stroke, depression, gastrostomy (feeding through a tube into the abdomen), and Parkinson's (progressive brain disorder affecting muscle control, balance and movement). In addition, R93's preferred language was documented as OTHER. R93's Therapy Recreation Evaluation and Social History evaluation on 4/6/22 state R93 nationality of Vietnamese, and enjoyed fishing, listening to music and watching movies. R93's care plan (CP) dated 4/7/22 with a focus of, 1) Alteration in socialization, potential for activity deficit r/t Parkinson's and Hemiplegia with mobility deficit, Communication deficit. CP Intervention dated 4/18/22 state, Provide 1:1 activities offered as resident is willing to accept them. A CP intervention dated, 10/3/22 direct staff to, Offer one to one visits to include: reminiscing, discussion of family, life history, current events, historical facts, and other interests. R93's quarterly Care Conference Form, dated 2/19/24, state, Resident participates in independent activities like looking out the window, family visits, 1:1 staff visits. R93's May and June 2024 Therapeutic Recreation record indicate R93 not provided or offered activities for May 10, 11, 12, 18, 19, 24, 25, 26, 30th and June 1, 2, 9, and 11th. During interview with family member (FM)-A and primary emergency contact on 6/10/24 at 3:36 p.m., FM-A stated, I would like them [facility] to move him [R93] next to a window. And When [R93] first got there [admitted to facility] he was next to window but roommate wanted it too, so they [facility] moved him [away from window]. [R93] is very cooped up. Activities has not worked with him. [R93] used to have TV and now he doesn't. FM-A stated watching TV and window watching was an enjoyable activity for R93 before admission to facility. During interview with licensed practical nurse (LPN)-A on 6/11/24 at 8:38 a.m., LPN-A stated she was very familiar with [R93]. LPN-A was unaware of R93's preference to watch TV and sit by a window. During interview with nursing assistant (NA)-F on 6/12/24 at 7:45 a.m., NA-F stated, activities will come in the room but [I] don't know what he does. NA-F was unaware of R93's preference to watch TV and sit by a window. During interview with director of nursing (DON) on 6/13/24 at 8:32 a.m., DON stated, activities department will set up and arrange [R93] activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with therapeutic director (TR) on 6/13/24 at 10:44 a.m., TR stated expectation of therapeutic recreation staff to communicate with TR about what activities were provided and which residents attended the activities being offered. Then, TR would document in the Therapy Recreation form for each resident in their EMR. TR stated he was familiar with R93 and looked in the R93's EMR. TR stated R93 did not have visits on the weekends and that R93 did not have a TV or radio in his room. 47495 R106's significant change Minimum Data Set (MDS) assessment, dated 5/22/24, indicated R106 had severe cognitive impairment, was dependent on staff for activities of daily living, and was admitted to the facility on [DATE]. R106's Associated Clinic of Psychology (ACP) note, dated 4/15/24, indicated treatment recommendations including, R106 was reporting feeling bored and lonely. He may benefit from multiple strategies such as leaving the TV on his favorite channel, having music playing, one-to-one type activities, visits from family and other similar strategies may mitigate distress and improve quality of life. He may also like colorful blankets or stimulus that could be made available in his room. R106 ACP note, dated 5/13/24, indicated R106 stated he would like to participate more in things like music, TV shows, pet therapy and being read to. He is a good candidate for one-to-one type activities to be engaged in something like reading him. He continues to say he is depressed and anxious and will need strategies such as listening to music on headsets to help shift his thinking and mood. R106's electronic medical record (EMR) lacked an initial Therapeutic Recreational Evaluation and Social History form. R106's Admission Interdisciplinary Team (IDT) Note, dated 4/16/24, indicated R106 stated interest in structured and non-structured programming and was able to decide participation level in structured and non-structured programs. R106's Quarterly IDT Note, dated 5/30/24, indicated R106 stated interest in structured and non-structured programming and preferred independent leisure of choice. R106's Tasks documentation for activity participation for the month of June, printed 7/13/24, indicated different choices of activities for participation to document on such as TV room in group, wheelchair rides, 1:1 visits, group movies, group activities, family or friend visit, community outings, pet visits, socializing with others, sensory stimulation, group music, massage, etc., with an option for Active, Passive, Observation, or Independent participation. R106 had activity 27 (looking out the window/music/time spent in room) documented at 13:59 on the 4th, 5th, 6th, 7th, 8th, 10th, and 12th with participation listed as P for passive for his activity participation. During observation on 6/10/24 at 3:22 p.m., R106 was heard yelling out from his room, calling for staff, asking if he was going to get medications. R106 was laying in his bed in a hospital gown, with the door to his room half closed. No music was heard in the room and the TV was not on. During observation on 6/11/24 at 2:34 p.m. and 6/12/24 at 11:40 a.m., R106 was up in his wheelchair in his room, alone and without staff interaction, watching TV. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/24 at 11:02 a.m., the Therapeutic Recreational Director (TR) stated all residents, both transitional care and long-term residents, would be assessed at admission for social history and activities of interest using the Therapeutic Recreational Evaluation and Social History form. This form was used to create an individualized care plan and so staff was aware of what activities to invite residents to and what their interests were. The TR confirmed R106 did not have an initial assessment completed. During an interview on 6/13/24 at 12:20 p.m., nursing assistant (NA)-N stated R106 would voice feeling bored, stating he wanted to go home and get out of here. NA-N stated R106 liked fast cars and motorcycles and had been asking for a radio lately but did not have one. During an interview on 6/13/24 at 12:23 p.m., an unnamed recreational therapy aide confirmed they did have a radio for residents to use. During an interview on 6/13/24 at 1:51 p.m., the director of nursing (DON) stated the expectation was for all residents, including TCU residents, to be comprehensively assessed by the therapeutic recreation department upon admission. Facility policy on activities was requested and not received.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview and record review, the failed to provide services to maintain and/or prevent loss of range of motion and contracture care for 1 of 1 residents (R93) reviewed for limited range of motion. Further, the facility failed to maintain a resident's walking program to prevent any loss of independence, strength or range of motion for 1 of 1 resident (R108) reviewed. Findings include: R93's quarterly Minimum Data Set (MDS) assessment dated [DATE] included severely cognitively impaired, and diagnoses of hemiplegia (paralysis) affecting right dominant side, stroke, depression, and Parkinson's (progressive brain disorder affecting muscle control, balance and movement). R93's physician orders (PO) dated 2/1/23 indicates, Tx [treatment] to R[right] hand to protect from skin breakdown: Wash hand with warm soapy water, ensure skin is dried completely, weave gauze between fingers, place ABD (abdominal pads or ABD dressings for large or draining wounds) to palm of hand and wrap with kerlix. Change QOD [every other day]. Update manager and MD/NP [medical doctor/nurse practitioner] if open areas appear. Every evening shift every other day. R93's care plan (CP) goal dated 4/8/22 included, history of open area to palm of hand, Self care deficit related to impaired mobility, and contractures of [NAME] (upper right extremity) and associated interventions of Follow OT [occupational therapy] instructions and R93 required extensive assist of 1 with personal hygiene and dressing. During observation on 6/10/24 at 1:36 p.m., R93 sitting in wheelchair in room with right hand contracted and pulled into the torso with left hand supporting the right hand. Right hand had rolled up washcloth in it. During observation on 6/10/24 at 5:40 p.m., R93 in bed with rolled up washcloth in his hand. R93's clothes closet, which was across from R93's bed had printed PROM exercises taped to the closet door. PROM exercise instructions, dated 4/15/22 showed diagrams and explanations included, Ankle Rotation, Knee and Hip Flexion and Extension, Toe Flexion and Extension, Ankle Flexion and Extension, Hip Abduction and Adduction (out and in). Exercises should be done 2-3 times per day with 10-20 reps. The form had highlighted area stated, Do all movements slowly and smoothly. Don't force the body to move beyond its comfortable range. R93's nursing assistant care sheet updated 6/6/24, failed to include passive range of motion exercises to be provided to resident and what cares were needed for the right contracted hand. During interview with nursing assistant (NA)-B on 6/10/24 at 1:36 p.m., NA-B stated he was full time employee and worked over fifteen years at facility and familiar with R93. NA-B stated, I don't know anything about helping with R93's exercises. It should be on the care sheet and care plan for me to do. I don't' know anything about a splint for R93's hand . NA-B stated he was unaware of why there was a rolled up washcloth in R93's right hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 6/11/24 at 8:24 a.m., R93 in bed wearing hospital gown. Right hand with rolled up washcloth in it. During interview with licensed practical nurse (LPN)-A on 6/11/24 at 8:38 a.m., LPN-A stated she was familiar with R93 and was unaware why the washcloth was in his hand. LPN-A verified they were not in the care plan or orders and should be. During interview with NA-F on 6/12/24 at 7:45 a.m., NA-F verified being familiar with R93's wing and PROM was to be completed daily. NA-F was not aware of the washcloth or who placed it. During observation on 6/12/24 at 8:16 a.m., R93 laying in bed wearing hospital gown. Right hand with rolled up washcloth in it. During interview with occupational therapist (OT) on 6/12/24 at 9:45 a.m., OT stated PROM exercises are recommended for all residents with hand and limb contractures to prevent decline in mobility. OT stated therapy orders and recommendations are provided to the nurse manager on the unit once each residents is assessed on admission and as needed per physician order. The exercises are then posted with instructions to post on the closet door of each resident for staff to refer to when performing the daily exercises. Then, the nurse manager will update nursing assistant care sheets and the resident care plan to implement the PROM and other recommendations. OT looked in R93's EMR and stated, [I] don't know anything about a washcloth rolled up in [R93's] hand. Also, OT stated R93s EMR failed to identify what PROM exercises were recommended. During interview with the director of therapy (DT) on 6/12/24 at 10:17 a.m., DT stated all residents are seen for therapy evaluations upon admission. If [they have] contractures like R93, we find out if they had a splint [prior to admission] and assess them for it. DT stated R93 is non verbal so they [therapy] rely on family and nurses to determine if R93 tolerates it. DT looked in R93's EMR and stated, I would recommend a palm guard or rolled up washcloth [to R93's right hand]. I would expect that to be in his [R93's] care plan [and care sheets] to let staff know what to do with his hand. DT stated R93's care plan, orders, and care sheets did not have interventions to perform PROM or apply a washcloth or splint to R93's right hand. DT stated, I don't see it and it should be [in R93's EMR]. During interview with registered nurse (RN)-D on 6/12/24 at 11:22 a.m., RN-D stated, yes, he [R93} has a hand splint. All of this [including PROM exercises] should be in the care plan [sic] for staff to know what to do. RN-D looked in R93's EMR and stated, it should be in [R93's] care plan. I don't see anything in his chart to tell staff about his hand splint [and PROM]. During interview with family member (FM)-A on 6/12/24 at 11:15 a.m., FM-A stated he was R93's primary emergency contact, [R93] had a splint to right hand. He had one but I don't know if he still has one. I haven't seen it for along time. In fact, I don't know if he still has it. FM-A stated facility had not communicated with him in the past year about the contracture to R93's right hand. Also, FM-A stated he was unaware of R93 receiving any form of PROM exercises, and he should. During interview with director of nursing (DON) on 6/13/24 at 2:49 a.m., DON stated R93's EMR failed to address PROM and splint use or palm guard. DON stated, these should be in there for staff to know what to do and when. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R93 paper form received by DT to surveyor and downloaded on 6/13/24 at 11:26 a.m., titled Splint and ROM Implementation Timeline indicate occupational therapy recommended on 4/19/22, PROM established and paper copy with instructions provided to nursing-splinting not indicated due to pts noncompliance with splint assessment and trials. Form also indicated on 4/15/22 physical therapy established a PROM for R93 and, paper copy with instructions provided to nursing. 47495 R108's quarterly Minimum Data Sat (MDS) assessment, dated 5/14/24, indicated R108 had severe cognitive impairment, had no impairment to her upper or lower extremities and required partial to moderate assistance with activities of daily living (ADLs) including ambulation. R108's physician order, dated 4/25/24, directed staff to walk R108 three times a day to meals using a four wheeled walker. R108's care plan, dated 6/5/24, indicated R108 should be walked to meals three times a day using a four wheeled walker per therapy. R108's care sheet, printed 6/12/24, indicated the nursing assistants were to walk R108 three times a day to meals using a four wheeled walker. R108's Tasks documentation for the nursing assistance for the month of June indicated R108 walking in the unit hallway was documented as not applicable. During observation on 6/12/24 at 7:10 a.m., R108 was sitting out in the main dining area in her wheelchair, waiting for breakfast. During an interview on 6/12/24 at 7:15 a.m., nursing assistance (NA)-J stated the nursing assistants use the care sheets to know what cares to provide the residents. NA-J confirmed R108 can walk but was wheeled out in her wheelchair to the breakfast table after morning cares. During observation on 6/12/24 at 9:16 a.m., R108 was wheeled away from the dining room table and wheeled into her room. During an interview on 6/12/24 at 2:04 p.m., clinical coordinator and licensed practical nurse (LPN)-D stated the expectation was for the nursing assistants to follow the care sheets and walk R108 to meals. LPN-D confirmed the aides were not walking R108 to meals stating, they need to be better at that to help R108 maintain her mobility. During an interview on 6/13/24 at 1:51 p.m., the director of nursing (DON) confirmed it would be expected that the nursing assistants are following the care sheets and walking R108 to meals every day. A facility polity titled Activities of Daily Living (ADLs)/Maintain Abilities Policy updated 5/9/24, state the facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living.

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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 ensure pain with mobility (i.e., repositioning) was appropriately monitored and comprehensively re-assessed then, if needed, interventions developed to promote comfort with mobility for 1 of 2 residents (R92) reviewed for pain management. Findings include: R92's Medicare - 5 Day Minimum Data Set (MDS) assessment, dated 5/10/24, identified R92 had intact cognition and demonstrated no delusional thinking. The MDS outlined R92 consumed scheduled and as-needed (i.e., PRN) pain medication, however, did not receive any non-pharmacological interventions during the review period. The MDS recorded R92's pain interview responses (i.e., J0300 to J0600) as, Not assessed. R92's most recent MHM (Monarch Healthcare Management) Pain Evaluation - V3, dated 3/21/24, identified R92 consumed scheduled pain medication; however, did not receive any PRN medication or non-pharmacological interventions for pain. The evaluation outlined a pain interview was completed with R92 who denied pain or hurting during the five-day period adding a rating recorded as, 00. The evaluation listed a section labeled, Been on a scheduled pain medication regimen[?], which was marked and listed a corresponding section to complete, Describe treatment, any side effects and effectiveness. However, the section was completed only with, Butrans, lidocaine patch, Biofreeze, and lacked any recorded information on if these were effective or not, including with R92's input. A subsequent section labeled, Comments, outlined dictation which read, Resident stated that he does not have pain when he is laying down . his pain only occurs when he is hoyered and traveling. The completed evaluation lacked any further assessment of the pain with mobility (i.e., characteristics) or what, if any, additional actions were being taken for it despite it being identified with the current medication regimen listed. R92's care plan, identified R92 had an alteration in comfort and listed a goal which read, Resident will have adequate relief from pain . freedom from signs/symptoms [sic] of non-verbal indicators of pain. The care plan listed multiple interventions for this including providing non-medicinal forms of pain relief, giving pain medication as ordered, and encouraging him to verbalize pain. On 6/10/24 at 1:38 p.m., R92 was observed lying in bed while in his room and demonstrated no obvious physical signs or symptoms of pain (i.e., grimace, moaning). R92 was interviewed, and explained his knees were completely wrecked which caused him moderate pain adding, I hurt a lot all the time. R92 stated he was taking some medications for the pain, including Tylenol and a patch which starts with a B but they were not effective, and the pain remained. R92 stated they staff were aware he had pain but just respond to him saying there was nothing they could do. R92 reiterated he would like to know what, if any, other options existed for his pain (i.e., non-[NAME], stronger medications) and expressed the medications and patches were not really doing anything. R92's Medication Administration Record (MAR), dated 6/2024, identified R92's consumed and recorded medications for the month period. These outlined orders included: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Butrans . 5 MCG/HR . 1 patch transdermally . every Wed ., with a listed start date, 05/22/2024. A corresponding, Pain Level, was listed for each weekly application and all of them, so far, were recorded, 0. Diclofenac Sodium External Gel 1% . Apply to both knees topically two times a day ., with a listed start date, 05/01/2024. A corresponding, Pain Level, was recorded with each administration and, again, all of which were recorded, 0. R92's Nursing Home Visit (note), dated 5/1/24, identified R92 was seen by the nurse practitioner (NP) with a chief complaint listed, Chronic Pain. The note identified R92 had chronic pain syndrome, polyneuropathy, and osteoarthritis. A section labeled, Plan, outlined R92's pain management was discussed with him and the Butrans patch prescription was renewed, and Diclofenac gel (a topical pain relief gel) was started. The note listed R92's Butrans 5 micrograms (mcg)/hr applied weekly with notation, Could increase dose if needed in the future, along with evidence of past medications tried which caused side effects or were ineffective. The note included, Closely monitoring for pain at rest and with activity; Please notify physician if new onset of pain symptoms begin. On 6/12/24 at 9:41 a.m., nursing assistant (NA)-D was interviewed. NA-D verified they had worked with R92 multiple times prior and described him as needing 100% total help with cares and mobility. NA-D stated R92 needed help to reposition in bed and would sometimes get up from bed using a mechanical lift. NA-D stated R92 seemed pretty comfortable, however, did still complain of pain with repositioning and if getting up from bed adding it had been like that for a little while now. NA-D explained R92 had recently worked with therapy but couldn't tolerate it well as with mobility then, He [R92] will start to talk about pain, pain. NA-D stated they believed the nurses were aware of R92's pain with mobility (i.e., transfers) and repositioning. R92's subsequent Nursing Home Visit (note), dated 5/20/24, identified R92 was seen by the physician and, again, listed a chief complaint of, Chronic Pain. R92 was recorded as being seen while lying in bed and reporting to have bilateral knee pain . which is intermittent, and there were no concerns reported by nursing or therapy staff. A section labeled, Plan, identified R92's Butrans prescription was renewed and again included dictation, Could increase dose if needed in the future. R92's remaining medications were continued at the same doses; however, the note lacked evidence R92's specific pain with mobility and repositioning had been evaluated or discussed with him. In addition, R92's medical record was reviewed and lacked evidence R92 had been comprehensively reassessed for his pain management and what, if any, interventions had been evaluated or offered to reduce his pain with mobility-related activities despite R92 having continued, ongoing complaints of pain witnessed by the floor staff and recent medication changes (i.e., 5/1/24). Further, there was no recorded evidence a comprehensive evaluation had been conducted by the care center (i.e., MHM Pain Evaluation) to ensure R92's pain was being accurately tracked and monitored despite known, ongoing pain with mobility (i.e., only 0 recorded despite pain being identified). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 6/12/24 at 11:58 a.m., registered nurse (RN)-F explained they had worked with R92 multiple times and he needed total assistance for cares adding, We do everything for him. RN-F stated R92 was able to report any complaints he had, including pain, but expressed such complaints were very rare to their knowledge. RN-F stated R92 did still get up to his wheelchair, at times, but could only handle very few minutes before wanting to go back to bed adding they were unsure if it was pain-related or not. RN-F stated they ask R92 for his pain when they apply his patches, and expressed they were unaware R92 was expressing pain with repositioning. RN-F stated a comprehensive assessment of R92's pain, including after medication changes, was not typically done by the floor staff adding, Maybe the manger, I don't know. On 6/13/24 at 1:28 p.m., the director of nursing (DON) was interviewed. DON explained they had just prior gone and repeated the MHM Pain Evaluation - V3 for R92 and he did endorse having pain with repositioning, peri-cares, and transfers. DON explained the evaluation was typically done on a quarterly basis but if pain was consistently happening then it should have been repeated. DON reviewed R92's MAR and stated the pain level recordings were used to help monitor for pain and if the NA staff were hearing or seeing pain, including with mobility, then it should be reported to the nurse and they will do an assessment and capture it. DON stated R92 was under current service from the pain management physician and the nurse manager for R92's unit was on LOA, but they verified they couldn't locate documented evidence R92's pain with mobility-related activities had been comprehensively assessed in their medical record. DON stated it was important to ensure pain, including with specific activities, was assessed and accurately monitored to ensure appropriate medication management adding, It's important. A provided Pain Management Protocol policy, dated 3/2023, identified the care center would have an effective pain management plan in place for residents. It defined this as, . the process of alleviating the resident's pain to a level that is acceptable to the resident . based on her and her [sic] clinical condition and established treatment goals. The policy directed the interdisciplinary team (IDT) would identify residents with acute or chronic pain to establish a plan; and nursing would evaluate for pain upon admission, quarterly and if newly onset pain or worsening pain was identified. The policy added, The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated, for example wound care, ambulation, or repositioning. Further, the policy outlined monitoring of pain would be reassessed at regular intervals to ensure it was controlled and the regimen effective adding, Review should include frequency and intensity of pain, ability to perform activities of daily living (ADLs), sleep pattern, mood, behavior, and participation in activities. Any significant changes in levels of comfort would be discussed with the provider.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure post-dialysis access site monitoring was consistently completed and documented to provide continuity of care and reduce the risk of complication (i.e., bleeding, infection) for 1 of 1 resident (R49) reviewed for dialysis care and services. Findings include: R49's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R49 had moderate cognitive impairment and demonstrated no rejection of care behavior. The MDS indicated R49 was diagnosed with kidney disease with dialysis treatment and a stroke with aphasia (a disorder affecting speech). The MDS indicated R49 was able to independently wheel 50 feet, required set-up help for eating, and was dependent on staff for transfers. R49's Order Summary Report dated 6/22/23, indicated an order to monitor for bruit (whooshing sound) and a thrill (a powerful pulse felt at the top of the fistula) every shift. An order dated 6/13/24, indicated nursing staff should monitor and view the dialysis site to the left chest for bleeding and signs and symptoms of infection every shift. An order dated 6/12/24, indicated nursing staff should monitor dialysis site for bleeding every shift. R49's hospital After Visit Summary dated 12/20/23, indicated R49 had his central venous catheter (CVC) exchanged and new orders could be found in the discharge instructions. The discharge instructions indicated the CVC insertion site should be checked at least daily for signs and symptoms of infection such as redness, swelling, drainage, or tenderness. The discharge instructions indicated the CVC should be assessed every day to ensure the clamps were tightly secured over both ends of the tubing. R49's care plan dated 4/19/24, indicated R49 was at risk for injury from dialysis related to possible clotting, hemorrhaging, accidental disconnection, or infection. The care plan indicated that R49 received dialysis at an offsite clinic on Monday, Wednesday, and Friday. The care plan indicated that R49 had a fistula on his right upper extremity but did not indicate that R49 had a CVC on the left chest. The care plan listed several interventions for R49 including: check extremity access daily for warmth, redness, and signs of infection, chest fistula for thrill and bruit, if bleeding occurs apply pressure with clean gauze for 10 to 15 minutes, if not controlled call 911, notify the physician of edema, chest pain, elevated blood pressure, or shortness of breath, monitor dialysis site for bleeding, and nursing was to complete the pre-dialysis and post-dialysis assessment. R49's dialysis Treatment Details Report dated 6/5/24, indicated R49 received dialysis at an offsite clinic through a tunneled CVC in his left chest. R49's administration record dated 5/1/24 through 6/11/24, did not indicate daily assessments were completed on the CVC used for dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/24 at 9:57 a.m., registered nurse (RN)-B stated R49's right fistula had closed in the past and a dialysis catheter had been placed on R49's left chest. RN-B stated she referenced the orders to know when to assess the dialysis catheter. RN-B stated this was usually documented in the treatment administration record (TAR) when these assessments were completed. RN-B stated R49 had the dialysis catheter for a while so she was unsure why there was not an order to monitor the catheter as all she saw was an order to continue monitoring the fistula. RN-B stated she had worked with R49 frequently so she knew about the CVC but she did not see an order for monitoring it. RN-B stated she was unsure how someone new to R49 would know to monitor the site or where it was since there was not an order in. During an interview on 6/12/24 at 1:58 p.m., RN-E, the nurse manager for the unit, stated she would expect an order to be present in the medical record so nursing staff would know where the dialysis catheter was, what to monitor it for, and how often to monitor the site. RN-E stated it was important nursing staff were monitoring for signs and symptoms of infection as well as for bleeding every shift and when the resident came back from dialysis to prevent possible complications. During an interview and observation on 6/13/24 at 12:11 p.m., licensed practical nurse (LPN)-C stated he was the nurse in charge of R49's care. LPN-C stated he had not assessed R49's dialysis site yet today. LPN-C was observed to assess R49's left extremity. LPN-C stated he was not exactly sure where the dialysis site was. LPN-C was then observed to adjust R49's shirt so the dialysis site was viewed on the left chest. During an interview on 6/13/24 at 1:43 p.m., the director of nursing (DON) stated it was important the dialysis catheter was assessed daily for signs and symptoms of infection as well as bleeding and this should be shown in the administration record. The facility's Hemodialysis policy dated 11/22/19, indicated documentation requirements included daily checks of the access dialysis access site and evaluation for signs and symptoms of infection.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview and record review, the facility failed to comprehensively assess history of past trauma and implement care plan interventions to identify triggers for 1 of 1 residents reviewed (R18) whose diagnoses included post-traumatic stress disorder (PTSD). Findings include: R18's annual Minimum Data Set (MDS) assessment dated [DATE] identified admission to facility on 4/12/23, intact cognition, and diagnoses of seizure disorder, anxiety, depression, schizophrenia, bipolar disorder, and PTSD. R18's care plan (CP) goal dated 4/27/22 indicated, Resident has PTSD, R 18's mother was abusive and she was a victim of sexual assault in 1970, which may have resulted in pregnancy & a coma. R18 interventions included, Staff will utilize trauma informed care when working with resident, Staff will consider past trauma when engaging in work with resident, Consider past trauma when engaging with resident. R18's care plan lacked identified triggers to avoid re-traumatization. R18's nursing assistant care sheet, updated 6/6/24 failed to identify PTSD diagnoses and triggers. During interview with R18 on 6/10/24 at 5:41 p.m., R18 stated she had not been asked about their PTSD. R18 stated her triggers included, harsh tones, yelling, and raised voices. During interview with director of nursing (DON) and facility administrator on 6/10/24 at 6:25 p.m., the administrator stated trauma assessments were the responsibility of the social worker and are reflected in the electronic medical record. During an interview with nursing assistant (NA)-G on 6/11/24 at 1:07 p.m., stated he was familiar with R18. NA-G stated nursing assistant care sheets provide staff guidance on every residents needs such as transfer assistance, hearing aide/glasses/denture needs, grooming, toileting, days to weigh the resident, therapy schedules and skin care, including special needs/behavior monitoring. NA-G stated the care sheet is where he would expect triggers to be listed. NA-G verified PTSD is not listed on the care sheets. NA-G mentioned they would have to be told about what triggers R18 past trauma in order to avoid them for R18. During interview with registered nurse (RN)-D on 6/11/24 at 2:27 p.m., RN-D stated she was unable to locate what triggers R18 of her past trauma in R18 care plan and was important to know what they were. During interview with RN-C on 6/11/24 at 2:53 p.m., RN-C stated, PTSD history [sic] very sensitive to certain triggers [sic]. I expect triggers to be addressed so not to re-traumatize the resident. RN-C reviewed R18's EMR and stated, [R18's] care plan does not show what her triggers are so we do not know what to avoid or address. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with NA-F on 6/12/24 at 7:45 a.m., NA-F stated she was full time employee and worked primarily on unit with R18. NA-F stated, it is important to know what triggers are to avoid. NA-F stated expectation of resident trauma triggers, should be in the care plan [sic] care sheets. NA-F looked at R18's care sheet and care plan and stated, [it] doesn't say anything about her triggers and as for R18's care sheet, I don't see anything about her having any kind of trauma. NA-F stated the nursing assistant care sheet is where she would expect to see anything about triggers to avoid. During interview with DON on 6/13/24 at 8:20 a.m., DON stated, When someone has PTSD we should be looking at what the source of the trauma is. Care plan[s] should have triggers. [R18] care plan does not have triggers and it should. DON stated R18's care plan interventions, is generic and not patient specific. The staff are not going to know what behaviors or actions to avoid [sic] prevent re-traumatization. During interview with social worker director (SS)-D on 6/13/24 at 10:05 a.m., SS-D stated expectation of the social work department to fill out a trauma questionnaire on Admission and prn. SS-D stated, if they [residents] say they ar a trauma victim or [sic] PTSD, we put in trauma care plan and ACP (psychiatry) referral. SS-D looked in R18's EMR and stated, [R18] care plan interventions do not identify her triggers. Facility policy titled Trauma Informed Care dated 2/24/23, state Residents that have a history of trauma will have goals and interventions added to their care plan to address potential triggers and approaches to minimize or eliminate the effect of the trigger on the resident.

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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** 47495 Based on interview and document review, the facility failed to address and respond to the consulting pharmacist's (CP) medication regiment review (MRR) for 2 of 5 residents (R75 and R83) receiving psychotropics (a psychoactive medication taken to exert an effect on the chemical makeup of the brain and nervous system) reviewed for unnecessary medications. Findings include: R75's quarterly Minimum Data Set (MDS) assessment, dated 5/9/24, indicated R75 was admitted to the facility on [DATE], had severe cognitive impairment, was independent with ambulation and was receiving the following medications during the look back period; antipsychotics, antianxiety, antidepressants, and opioids. R75's MRR, dated 4/26/24, indicated it was unclear if R75's falls were related to medication and recommended considering reducing R75's Hydroxyzine order to 25 mg at 2:00 p.m. The report included: R75 had multiple falls within the past month and was receiving the following medications that may increase fall risk; Citalopram 20 milligrams (mg) daily (a medication used to treat depression, including major depressive disorder), Hydroxyzine 50 mg three times a day (a medication used to treat anxiety, nausea, vomiting, allergies, skin rash, hives, and itching), Lisinopril 5 mg daily (a medication used to treat high blood pressure and heart failure), Seroquel 50 mg twice a day (a psychotropic medication used to treat schizophrenia and bipolar disorder), and Lorazepam 1 mg daily (a benzodiazepine used to treat anxiety). R75's electronic medical record (EMR), including the MRR, lacked evidence of physician or prescriber response or follow-up. R75's care plan, dated 4/1/24 - 6/13/24, indicated R75 had five falls on the following dates; 5/26/24 (lowered to the floor due to perceived dizziness), 5/15/24, 5/13/24, 4/24/24, and 4/11/24. R83's quarterly MDS assessment, dated 3/12/24, indicated R83 was admitted to the facility on [DATE], had severe cognitive impairment, was independent with ambulation, and received the following medications during the look back period; antipsychotics and antidepressants. R83's Medical Diagnoses, printed 6/13/24, indicated R83 had several medical diagnoses including unspecified dementia with behavioral disturbances, atrial fibrillation, hypertension, chronic kidney disease, atherosclerotic heart disease, major depressive disorder, generalized anxiety, presence of cardiac pacemaker, obesity, fatigue and personal history of transient ischemic attack and cerebral infarction without deficits. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R83's MRR, dated 4/26/24, indicated, the Seroquel lacked an appropriate diagnosis, indicating dementia with behavioral disturbances but lacked psychotic features of dementia (i.e., hallucinations, paranoia, delusions) and a review of whether antipsychotic use was necessary. The report included: R83 was receiving the following medications; Seroquel 25 mg three times a day, Mirtazapine 7.5 mg every evening (an antidepressant used to treat depression), and Depakote extended release 125 mg daily and 500mg every evening (an anticonvulsant used to treat seizures and bipolar disorder). R83's order for Seroquel, dated 5/14/24, indicated R83 was receiving Seroquel for schizophrenia. R83's EMR lacked documented evidence of provider/prescriber follow up or response on the necessity of antipsychotic use. R83's MRR, dated 5/24/24, indicated to clarify the indication of Seroquel use as it was changed to Schizophrenia and R83 lacked an actual documented diagnosis of Schizophrenia. R83's EMR lacked evidence of a follow up response. During an interview on 6/13/24 at 12:35 p.m., clinical coordinator and licensed practical nurse (LPN)-D stated each director of nursing (DON) had their own process for addressing the MRR's. LPN-D stated the current process was for the DON to send the CP's MRR's to the clinical coordinators via email. If the recommendation was nursing related (i.e., orthostatic blood pressures, target behaviors) the clinical coordinator would address it. If the recommendation was for the provider (i.e., changing medication orders or diagnoses) the MRR was put into the provider mailbox for addressing. CONSULTANT PHARMACIST WAS CALLED TWICE WITH NO RESPONSE During an interview on 6/13/24 at 1:51 p.m., the director of nursing (DON) stated they were aware the process for MRR's was not working, stating with turnover of the health unit coordinator the MRR forms were ending up in the wrong box leading to MRR follow up being missed. A facility policy titled Medication Regiment Review, dated August 2019, indicated MRR recommendations would be documented and acted upon by the facility staff and/or prescriber, indicating the prescriber would accept and act upon the suggestion or reject the suggestion and provide an explanation for disagreeing.

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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 interview and document review, the facility failed to ensure a resident taking an antipsychotic medication had an appropriate diagnosis for use and was monitored for target behaviors for 1 of 5 residents (R83) reviewed for unnecessary medications. Findings include: R83's quarterly Minimum Data Set (MDS), dated [DATE], indicated R83 was admitted to the facility on [DATE], had severe cognitive impairment, was independent with ambulation, and received the following medications during the look back period; antipsychotics and antidepressants. R83's Medical Diagnoses, indicated R83 diagnoses including dementia with behavioral disturbances, major depressive disorder, generalized anxiety. R83's electronic medical record (EMR) lacked evidence of resident specific target behaviors or monitoring for behaviors, R83's MRR, dated 4/26/24, indicated R83 was receiving the following medications; Seroquel 25 mg three times a day, Mirtazapine 7.5 mg every evening (an antidepressant used to treat depression), and Depakote extended release 125 mg daily and 500mg every evening (an anticonvulsant used to treat seizures and bipolar disorder). The MRR indicated the Seroquel lacked an appropriate diagnosis, indicating dementia with behavioral disturbances but lacked psychotic features of dementia (i.e., hallucinations, paranoia, delusions). The MRR requested a review of whether antipsychotic use was necessary. R83's order for Seroquel, dated 5/14/24, indicated R83 was receiving Seroquel for schizophrenia. R83's EMR lacked documented evidence of provider/prescriber follow up or response on the necessity of antipsychotic use. R83's MRR, dated 5/24/24, indicated to clarify the indication of Seroquel use as it was changed to Schizophrenia and R83 lacked an actual documented diagnosis of Schizophrenia. R83's EMR lacked evidence of a follow up response. During an interview on 6/13/24 at 12:35 p.m., clinical coordinator and licensed practical nurse (LPN)-D stated each director of nursing (DON) had their own process for addressing the MRR's. LPN-D stated the current process was for the DON to send the CP's MRR's to the clinical coordinators via email. If the recommendation was nursing related (i.e., orthostatic blood pressures, target behaviors) the clinical coordinator would address it. If the recommendation was for the provider (i.e., changing medication orders or diagnoses) the MRR was put into the provider mailbox for addressing. LPN-D confirmed R83's EMR was missing target behaviors monitoring which is important in monitoring if an antipsychotic medication is effective. CONSULTANT PHARMACIST WAS CALLED TWICE WITH NO RESPONSE (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 6/13/24 at 1:51 p.m., the director of nursing (DON) stated they were aware the process for MRR's was not working, stating with turnover of the health unit coordinator the MRR forms were ending up in the wrong box leading to MRR follow up being missed. A facility policy titled Psychotropic Medication Use, undated, indicated, residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective and the Interdisciplinary team and the primary provider will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others.

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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, facility failed to ensure mediations were kept locked or under direct observation of authorized staff in areas where residents, staff and visitors could access medications. The deficient practice had the potential to affect 32 current residents on the unit. Findings include: During observation on 6/10/24 at 5:35 p.m., at entrance of the 2S dining room there was an unlocked medication cart. Dining room had 12 residents in the room eating dinner and numerous staff walking past the medication cart transporting residents. During observation and interview with registered nurse (RN)-C on 6/10/24 at 5:36 p.m., RN-C walked up to the unattended medication cart and locked the cart. RN-C stated, nurses should be sure the med carts are locked and laptop should be closed due to privacy. RN-C stated the nurse responsible for the unattended medication cart was not in the area and would try to locate them. During interview with licensed practical nurse (LPN)-B on 6/10/24 at 5:37 p.m., LPN-B stated he was responsible for the unattended medication cart and, it is a violation. I should lock it [medication cart] when I leave the cart. And, so no one can get in the medication cart here. During interview with director of nursing (DON) on 6/11/24 at 9:11 a.m., DON stated, medication carts should always be locked when staff step away from the cart. Because there are some meds in the carts that should not be available to residents. Facility policy on medication storage was requested and not received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview, and document review, the facility failed to utilize infection control practices while administering medications through gastrostomy tube for 1 of 1 residents (R93) observed for medication administration, utilize infection control practices while delivering meal trays to resident rooms for 7 of 7 residents (R35, R53, R58, R59, R64, R67, R112) observed for dining, while assisting multiple residents to eat at once for 7 of 33 residents (R2, R3, R14,R23, R33, R55, R80) observed for dining. In addition, the facility failed to implement and maintain enhanced barrier precautions (EBP) for 2 of 2 resident (R16, R93) reviewed for transmission based precautions. Furthermore, the facility failed to mitigate transmission of potential infections in relation to laundering of linens and personal items. Findings include: Med Admin R93 R93's quarterly Minimum Data Set (MDS) dated [DATE] state admission to facility on 4/6/22, was severely cognitively impaired, and diagnoses of hemiplegia (paralysis) affecting right dominant side, stroke, depression, gastrostomy (feeding through a tube into the abdomen), and Parkinson's (progressive brain disorder affecting muscle control, balance and movement). R93's physician orders (PO) dated 4/8/22 direct staff to, Crush each medication in 15ml of warm purified or sterile water and administer each separately using gravity. R93's PO dated 4/22/24 stated, Before administering medication, stop feeding for 30 minutes and flush the tube with at least 15 milliliters (mL) sterile water. During observation on 6/12/24 at 8:16 a.m., licensed practical nurse (LPN)-A entered R93's room with four medication cups of crushed medications and placed them on his bedside table. LPN-A then obtained the sixty cubic centimeter (cc) piston syringe from his bedside table and added water from a plastic cylinder into each medication cup. LPN-A then paused R93's enteral feeding that was running and removed his abdominal binder to access his GT. LPN-A then auscultated and assessed R93's GT for placement by connecting piston syringe with water in it to R93's GT port and injecting and withdrawing water. LPN-A then disconnected piston syringe from GT port and bent the tubing connected to the resident with her left hand while reaching over to the bedside table and aspirating (withdrawing) medication mixture from one medication cup with her right hand. LPN-A then connected the medication filled piston syringe to the GT port and unbent the GT that was attached to R93. LPN-A then administered medication and bent the GT with left hand and reached over to the bedside table to withdraw another medication. During this process LPN-A allowed the tip of the piston syringe to touch R93's hospital gown several times and used the piston syringe to add more water to the next medication cup. LPN-A then withdrew it into the piston syringe and repeated process until all four medications were administered. During administration LPN-A allowed the tip of the piston syringe to touch R93's hospital gown again before adding more water to the piston syringe and flushing the GT port to end the process. LPN-A re-connected enteral feeding tube and re-applied R93's abdominal binder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with LPN-A on 6/11/24 at 8:42 a.m., LPN-A stated she had not turned off R93's enteral feeding for thirty minutes prior to administering his medications per PO and, I should have. Also, the piston syringe should never touch the resident gown when administering GT meds. Contamination is a concern. During interview with director of nursing (DON) on 6/11/24 at 9:08 a.m., DON stated, GT feeding tip of piston syringe should not touch gown of resident due to risk of contamination. Staff should [have] replaced it and [sic] get a new one if the end touches anything like the gown of a resident. Facility policy titled Administering Medications through an Enteral Tube updated 3/23/23, stop the feeding at least 30 minutes prior to medication administration and restart at least 30 minutes after medication administration. And, Place the end of the tubing on a clean gauze pad positioned on the abdomen or chest of the resident. EBP R16 R16's quarterly MDS dated [DATE], stated admission to facility on 12/14/23, had intact cognition, and diagnoses of coronary artery disease (CAD), heart failure, peripheral vascular disease, diabetes, depression, and morbid obesity. In addition, 16 at risk for pressure ulcers and had diabetic foot ulcers. R16's physician orders dated 6/11/24 stated, Wound care: Left Gluteus: Cleanse with wound cleanser. Apply Calmoseptine (ointment). Cover with foam dressing. Every day shift and Wound care: Right Gluteus. Cleanse with soap and water. Apply Calmoseptine after peri-care. Every shift. R16's care plan (CP) revised on 5/30/24 stated, Problem: Resident is currently on Enhanced Barrier Precautions R/T MASD (moisture associated skin damage) on right and left gluteus, and Problem: Resident is currently on Enhanced Barrier Precautions R/T diabetic ulcer on Left Great toe. During observation and interview on 6/11/24 at 7:12 a.m., R16's door to hallway had an over-the-door hanger unit with PPE equipment contained in it for PPE gowns and gloves. R16's door and rest of room did not have signage indicating EBP. There was a PPE plastic garbage can with lid on it inside room next to foot of bed. The door was open to the hallway. R16 in electric wheelchair. Two staff members were in the room with a patient lift unit (Hoyer) sling attached to R16 and transfer initiated from wheelchair to bed. Nursing assistant (NA)-D wearing surgical face mask and gloves and no PPE gown. NA-E wearing gloves but no PPE gown. NA-D stated she, wear [sic] mask sometimes when we go into room. We wear a mask. He [R16] is not on precautions. During observation and interview with registered nurse (RN)-B on 6/11/24 at 7:19 a.m., RN-B entered R16 room with gloves and surgical mask but no PPE gown. RN-B assisted with Hoyer transfer of resident to bed. RN-B stated, [R16] no longer has a wound. Should not be on EBP now. During observation and interview with NA-C on 6/11/24 at 7:33 a.m., NA-C entered R16's room with a surgical mask on and gloves but no PPE gown. NA-C also assisting NA-E, NA-D, and RN-B with direct hands on care for Hoyer transfer from wheelchair to bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with director of nursing (DON) who is also the infection control preventionist (IC) on 6/11/24 at 8:59 a.m., IC looked in R16's EMR and stated, Yes, he has a MASD and should be on EBP. Oh wait, it was resolved last week on wound rounds. The nurse manager probably did not remove all of it [signage and PPE equipment]. She should have after the wound rounds. IC stated R16's EMR lacked progress notes or wound care notes indicating R16 was to come off of EBP prior to 6/11/24. IC stated staff wound not be aware of any changes or updates unless there was documentation to support it in the EMR and would expect all staff to follow EBP for R16 until the EMR was updated. R93 R93's care plan (CP) dated 4/3/24 state a focus of, Problem: Resident is currently on Enhanced Barrier Precautions R/T enteral feeding with Interventions/Tasks of, -Staff to follow Enhanced Barrier Precautions, -Staff to don/doff PPE (personal protective equipment) per enhanced barrier precautions when providing high contact cares. R93's physician orders dated 4/23/24 state, Resident is currently on Enhanced Barrier Precautions for Enteral Feed every shift. During observation and interview on 6/10/24 at 1:36 p.m., the shared room for R57 and R93's door to hallway had an over-the-door hanger unit with PPE equipment contained in it for PPE gowns and gloves. Signage posted on the door frame stated EBP expectation for staff who care for R93 to wear PPE gown and gloves when providing direct hands on care such as transferring. No PPE garbage can was observed inside or outside R93's room. NA-B exited room without a PPE gown, asking for licensed practical nurse (LPN)-A for assistance with transferring R93 into bed. LPN-A entered room with PPE gown, gloves, and surgical mask. LPN-A stated, R93 on EBP due to, He had a wound on the side of his knee. NA-B put on a PPE gown from the door unit and then entered R93 room. Both NA-B and LPN-A transferred R93 to bed using the Hoyer. After the transfer was completed, LPN-A exited room with her PPE gown, gloves and mask on and walked down the hall towards the nursing station. LPN-A did not wash her hands prior to exiting the room. NA-B removed gown and gloves and placed the used PPE into a plastic garbage can liner and closed it prior to exiting R93's room. NA-B was unaware of PPE garbage can ever being present in R93's room. During interview with LPN-A on 6/11/24 at 8:42 a.m., LPN-A stated, the PPE garbage should always [sic] in the [R93] room due to EBP. It was put in there yesterday after you [surveyor] was in here. LPN-A stated, I should not have walked out of his room with the gown and gloves on when we were transferring him. I should have removed them in the room and put them in a bag or something and then sanitized my hands before exiting the room [sic] and re-applied the gown and gloves before going back into his room to help [NA-B] with the Hoyer transfer. During interview with IC on 6/11/24 at 8:59 a.m., IC stated, staff should not be exiting EBP rooms with face mask, gown and gloves on. IC stated expectation of staff to follow EBP signage instructions to don and doff PPE when working with residents that have EBP signage posted on their doors. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy titled Enhanced Barrier Precautions revised 4/1/24, state, [EBP] refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [multi-drug resistant organism] as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Further, Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions and initiation of EBP for residents with wounds and indwelling medical devices (such as feeding tubes). Also, Position a trash can inside the resident room for discarding PPE (personal protective equipment) after removal, prior to exit of the room. High -contact resident care activities include, Dressing, Bathing, Transferring, Providing hygiene, Changing linens, Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, and Wound care: any skin opening requiring a dressing. 16 47495 STAFF FEEDING MULTIPLE RESIDENTS WITHOUT HAND HYGIENE During observation on 6/12/24 at 8:37 a.m., certified nursing assistant (CNA)-O was passing out breakfast trays to residents in the third-floor dining room. CNA-O then sat down to assist R2 with eating without performing hand hygiene. During observation on 6/12/24 at 8:45 a.m., CNA-O stopped assisting R2 with eating her breakfast and started assisting R23 with her breakfast without performing hang hygiene in between residents. During observation on 6/12/24 at 8:52 a.m., CNA-J was sitting between R14 and R55, assisting them both with eating their breakfast, switching between each residents' utensils with the same hand. CNA-J did not perform hand hygiene in between. R55 was noted to have a wet, non-productive cough. During an interview on 6/12/24 at 2:05 p.m., clinical coordinator and licensed practical nurse (LPN)-D stated the expectation was for the CNAs to perform hand hygiene before assisting residents with eating. During an interview on 6/13/24 at 1:51 p.m., the infection preventionist and director of nursing (DON) stated hand hygiene was expected before and after assisting residents with eating and in between residents if the same hand is being used to assist. 49034 DINING: R35's annual Minimum Data Set (MDS) dated [DATE], indicated R35 had intact cognition and was diagnosed with heart failure, kidney failure, diabetes, and respiratory failure. R53's quarterly MDS dated [DATE], indicated R53 had moderately impaired cognition and was diagnosed with diabetes, a stroke, and malnutrition. The MDS indicated that R53 required a feeding tube and a mechanically altered diet. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R53's order summary report dated 4/23/24, indicated R53 was on enhanced barrier precautions for enteral feed. R58's quarterly MDS dated [DATE], indicated R58 had intact cognition and was diagnosed with heart failure, diabetes, and asthma. R59's quarterly MDS dated [DATE], indicated R59 had intact cognition and was diagnosed with anemia, depression, and anxiety. The MDS indicated the presence of a surgical wound. R59's order summary report dated 6/10/24, indicated R59 had a wound and was on enhanced barrier precautions. R64's quarterly MDS dated [DATE], indicated R64 had intact cognition and was diagnosed with anemia and malnutrition. R67's quarterly MDS dated [DATE], indicated R67 had intact cognition and was diagnosed with a leg fracture. R112's quarterly MDS dated [DATE], indicated R112 had intact cognition and was diagnosed with kidney disease, diabetes, and hypertension. During an observation on 6/10/24 at 5:54 p.m., nursing assistants (NA)-H and NA-I were observed pushing a tall cart containing meal trays down the hallway toward resident rooms. NA-H was observed to enter R53's room with a meal tray in hand. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table, and exiting the room. A sign indicating R53 was on enhanced barrier precautions and everyone must: clean their hands, including before entering and when leaving the room was observed on the door. No hand hygiene upon entering or exiting the room was observed. NA-H was then observed to grab R58's room tray from the cart and enter R58's room. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table, and exiting the room. No hand hygiene upon entering or exiting the room was observed. NA-H was then observed to grab R35's room tray from the cart and enter R35's room. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table, and exiting the room. No hand hygiene upon entering or exiting the room was observed. During an observation on 6/10/24 at 6:00 p.m., NA-I was observed to enter R64's room with a meal tray, move personal items on the table, and exit the room. No hand hygiene was observed. NA-I was then observed to grab R67's tray, enter the resident's room, set the tray on the table, and exit. No hand hygiene was observed. NA-I was observed to grab R59's food tray, enter the resident's room, move items on the resident's table, and remove used-looking cup. A sign indicating R59 was on enhanced barrier precautions and everyone must: clean their hands, including before entering and when leaving the room was observed on the door. NA-I exited the room, and no hand hygiene was observed. NA-I was observed to grab the meal tray for R112 and enter the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/10/24 at 6:03 p.m. with NA-H and NA-I, NA-H stated they were taught to complete hand hygiene before starting to pass meal trays and when they are completed with all of the trays but not between individual rooms and NA-I agreed. NA-H and NA-I acknowledged they had not completed hand hygiene before entering and exiting the rooms above including the residents on enhanced barrier precautions. During an interview on 6/13/24 at 1:45 p.m., the director of nursing (DON) stated she expected the NAs to complete hand hygiene before and after a resident room while passing room trays to prevent the possible spread of infection. The CDC article, Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/27/24, indicates hand hygiene is an important part of stopping the spread of deadly germs to residents including those resistant to antibiotics. The article indicates hand hygiene should be completed after touching a resident or their surroundings, after contact with a contaminated surface, and immediately before touching a resident. The facility's Handwashing policy dated 2/24, indicated hand washing should be performed by all employees between tasks and procedures to prevent cross-contamination. 49339 ASSISTING MULTIPLE RESIDENTS WITH EATING WITHOUT PERFORMING HAND HYGIENE On 6/12/24 at 8:19 a.m., on 3rd floor dining room in men's care memory unit, it was observed staff assisting resident with breakfast. Nursing assistant (NA)-B alternating between feeding R80, R3 and R33. NA-B was observed using primarily one hand to assist the residents to eat. On 6/12/24 at 10:57 a.m., NA-B verified they were assisting 3 residents at the same time during breakfast today and verified the residents listed above. NA-B stated they wiped down the residents' hands prior to the meal. NA-B stated they did hand hygiene prior to starting to assist the residents with breakfast. NA-B verified they did not perform hand hygiene in between helping residents and used the same hand to feed all 3 residents. NA-B verified residents listed above are dependent on staff for assistance with meals. On 6/13/24 at 11:12 a.m., director of nursing (DON) stated it's a standard thing to perform hand hygiene while assisting residents with meals and between residents. DON stated it is important to ensure cross contamination doesn't occur and they need to clean their hands. F880 - WASH MACHINE During observation of laundry room tour on 6/12/24 at 9:08 a.m., a one-page document was observed hanging on a bulletin board by the entryway door, titled Any Shift Laundry Routine. The document provided guidelines on what should be done throughout shift indicating the start and end of shift. The start of shift indicated Load Dryers. At the end of shift, it indicated Load Washers . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/24 at 9:10 a.m., laundry aide (LA)-A and regional district manager (RDM) present during laundry room tour. LA-A verified they worked full-time in laundry services and were familiar with the job. LA-A and RDM verified the document titled Any shift laundry routine was up-to date with expectations. LA-A verified that prior to the end of their shift, they start with wash machines with a load of laundry. LA-A verified the laundry sits in the wash machine through the evening shift and night shift until the next day when staff from the laundry department come in to start their shift. LA-A verified when they start their shift in the morning, they take the laundry from the wash machine, that was started at the end of their shift the day prior and put it in the dry machine. On 6/12/24 at 9:13 a.m., RDM verified that she oversees the department and was covering as the manager was out. When asked about leaving laundry in the wash machine overnight, RDM stated, We are not supposed to do that anymore, we were told that last year. RDM stated she didn't realize it hadn't been updated and would get it corrected. RDM stated leaving wash in the wash machine overnight is of concern because it could grow bacteria and things on it. On 6/12/24 at 9:38 a.m., administrator stated laundry shouldn't be wet in the wash machine overnight due to potential bacteria growth. 6/12/24 at 1:43 p.m., RDM stated staff working were provided education regarding not leaving laundry in wash machines overnight, an updated laundry routine was hung. RDM stated the remaining laundry staff, and the manager will be in-services upon their return. A facility policy on wet linens/wash machine relating to infection control was requested and not received.

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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** 49339 Based on interview and document review, the facility failed to implement the current standards of vaccinations regarding pneumonia for 1 of 5 residents (R17) over [AGE] years old whose vaccinations histories were reviewed. Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old. R17's facility Immunization Record, print date 6/13/24, indicated he was [AGE] years old. The record indicated he received PPSV23 on 1/31/2013 followed by the PCV-13 on 10/4/2016. The immunization record lacked evidence of other pneumococcal immunizations offered, refused, or completed. R17's Care Conference Form, dated 5/8/24, summarizes a quarterly care conference. The form has a section to address immunizations: Section H: Immunizations (i.e., pneumococcal, influenza, Covid series) was not completed. The section lacked evidence of completion. On 6/13/2024 at 10:14 a.m., director of nursing verified that she is the infection preventionist for the facility. She verified that she oversees the immunizations. DON indicated the nurse managers review and determine what immunizations residents need and they will work with their power of attorney (POA) or guardian if they are not able to make their own decisions. DON verified R17's pneumococcal immunizations as listed above and would be eligible for the PCV20. DON stated she followed up with the nurse manager on the floor who has called R17's guardian, received approval for administration of PCV20. DON verified R17's guardian was updated regarding eligibility of immunization on 6/13/24, stated the nurse manager lost her list of who needs it but did call now. DON indicated it is important to offer residents immunizations they are eligible for. A facility policy titled Pneumococcal Policy, dated 2/24, was provided. Policy indicated to offer all residents the pneumococcal vaccines to aid in the prevention of pneumococcal/pneumonia infections by following the Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control (CDC) and/or the state Department of Health.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 33925 Based on observation, interview and document review, the facility failed to ensure closet doors in disrepair were reported and acted upon in a timely manner to promote a safe, homelike environment for 1 of 1 resident (R92) reviewed whose closet door was broken with exposed nails present. Findings include: A Vulnerable Adult Maltreatment Report, dated 7/2023, identified a general concern about the care center which included, . [it] needs major repairs and there are multiple things that are broken. R92's quarterly Minimum Data Set (MDS)assessment, dated 3/21/24, identified R92 had intact cognition and demonstrated no delusional thinking. On 6/10/24 at 1:46 p.m., R92 was observed lying in bed while in his room. The room had an off-white colored closet with double doors which opened towards the foot of R92's bed. However, the closet door was in disrepair with the door and attached frame being pulled away from the wall several inches exposing multiple construction nails with the bevel-end open to the outside (i.e., room). The door was loose to touch and the closet' interior was visible through the exposed gap between the frame and wall. The closet had visible clothing and CPAP (low pressure air machine used to help breathing) supplies inside. R92 was interviewed and stated the closet was broken and had been for a couple weeks. R92 stated he had asked staff to complete a 'work-order' for it to get it fixed, however, no action had been taken on it yet. R92 stated, I don't think anybody put in a work order [despite being asked]. R92 stated he wanted it fixed and was fearful the door would eventually fall off and onto his bed with him in it. Two days later, on 6/12/24 at 9:02 a.m., the closet door was again observed and remain in disrepair with exposed nails. When interviewed on 6/12/24 at 9:41 a.m., nursing assistant (NA)-D stated R92 needed 100% total help with cares and was mostly bed-bound. NA-D observed R92's closet door and stated aloud, It's coming apart! NA-D stated they were unaware the closet was in disrepair and attempted to move the closet door when it then fell completely off the wall. NA-D stated, It came out. R92 was present in his bed and again reiterated it had been in such condition for sure, over a week now. NA-D stated they were unsure if maintenance was aware of it or not and expressed they would get it entered in TELS [software] right away to be addressed. On 6/12/24 at 12:33 p.m., the director of maintenance (DOM) was interviewed. DOM explained if staff notice items in disrepair then a TELS work-order should be place so the maintenance staff can be updated about it. DOM stated they had just been made aware of R92's closet door being in disrepair (during the survey) as nobody put it on there [TELS]. DOM verified none of the staff had completed a TELS and, as a result, nobody from maintenance was aware it was in disrepair adding the closet door was pulled from the frame itself and needed multiple staff members to help repair it just prior. DOM stated R92 was mostly bed-bound so it was likely someone else, likely staff, who broke the door adding, It had to be somebody with quite some force. DOM reiterated it should have been reported to them for repair adding, I don't know how somebody [would] not notice that. DOM added, It could fall on somebody, and, It's a safety thing. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Work Order #16293, dated 6/12/24, identified R92's room along with a heading, Cloet [sic] door broken. A timeline was present which identified the tracking through the TELS system; this outlined it had been created on 6/12/24. There was no further evidence provided to demonstrate the broken closet door had been notified or addressed prior to 6/12/24. A facility' policy on maintenance requests or repairs was not received.