STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265425	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor Health Care Center	11900 Jessica Lane Raytown, MO 64138

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727 Based on interview and record review, the facility failed to ensure a Notice of Medicare Provider Non-Coverage (NOMNC) ((Centers for Medicare and Medicaid Services (CMS) form CMS-10123) and a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form (CMS)-10055) was provided to the resident or their representative for two sampled residents (Residents #14 and #49) out of three sampled residents who were discharged from Medicare part A (insurance that covers inpatient hospital care, skilled nursing facility, lab tests, surgery, home health care for individuals who are [AGE] years of age and above or disabled). The facility census was 74 residents. Review of the undated Form Instructions for the NOMNC CMS-10123 form showed the NOMNC must be delivered at least two calendar days before Medicare coverage services end. Review of the CMS memo (S&C-09-20), dated 1/9/09, showed: -The NOMNC, form CMS-10123 is issued when all covered Medicare services end for coverage reasons. -If the SNF believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the provider believes that an otherwise covered item or service may be denied as not reasonable or necessary, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary's potential liability for payment for the non-covered services. The SNF's responsibility to provide notice to the resident can be fulfilled using the SNF ABN (form CMS-10055). -The SNF ABN provides an estimated cost of items or services in case the beneficiary had to pay for them him/herself or through other insurance they may have. -If the SNF provides the beneficiary with either the SNF ABN or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits, the provider has met its obligation to inform the beneficiary of his/her potential liability for payment and related standard claim appeal rights. Issuing the NOMNC to a beneficiary only conveys notice to the beneficiary of his/her right to an expedited review of a service termination. Review of the facility policy titled Medicare Documentation dated 8/25/22 showed the policy did not include instructions to provide a SNF ABN or a NOMNC at least two days prior to Medicare coverage ending. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #49's SNF Beneficiary Protection Notification Review form completed by the facility during the survey showed: -The resident's last covered day for Medicare Part A services was 8/23/24. -The facility initiated the discharge from Medicare Part A services when benefit days were not exhausted. -A SNF ABN and a NOMNC was not provided to the resident or representative. 2. Review of Resident #14's SNF Beneficiary Protection Notification Review form completed by the facility during the survey showed: -The resident's last covered day for Medicare Part A services was 8/30/24. -The facility initiated the discharge from Medicare Part A services when benefit days were not exhausted. -A SNF ABN and a NOMNC was not provided to the resident or representative. 3. During an interview on 9/25/24 at 11:54 A.M., the Social Services Director said: -He/She has been the Social Services Director for a couple of weeks. -The residents were discharged from Medicare Part A services before he/she started working at the facility. -There are no copies of a SNF ABN or a NOMNC for Residents #49 and #14. -The current process is: --Therapy sends him/her a note when therapy is ending for a resident. --He/She gets the NOMNC/SNFAB signed. --He/She keeps a copy and gives a copy to med to upload. During an interview on 9/27/24 at 11:57 A.M., the Director of Nursing said: -The Social Services Director was responsible for providing notice of termination of Medicare Part A benefits to the resident or their representative. -The did not have a Social Services Director in August 2024. -No one else was designated to provide the notices when they did not have a Social Services Director. -The NOMNC and SNF ABNs should have been provided two days prior to services ending.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38452 Based on observation and interview, the facility failed to maintain a safe, clean, comfortable and homelike environment including, but not limited to, unbroken furniture and/or window treatments, clean and comfortable sleeping conditions, and a physical layout of the facility that maximized people with disabilities' independence, met The Americans with Disabilities Act (ADA) requirements, and did not pose a safety risk and/or tripping hazards. These deficient practices had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in at least four locations throughout the building. This facility had a census of 74 residents with a licensed capacity of 91 residents at the time of the survey. 1. Observation on 9/24/24 at 11:48 A.M. during the initial facility walk-through inspection showed the plumbing clean out (the access point for a sewer line and is considered a means to access the sewer line for cleaning and unclogging) in the middle of the 300 Hall by resident room [ROOM NUMBER] was missing its cover which allowed for an approximately (app.) 1/2 inch (in.) deep, 9 in. diameter drop in the floor that someone could catch their foot or walker on. Observation on 9/24/24 between 3:10 P.M. and 3:45 P.M. during a follow-up facility walk-through inspection with the Maintenance Supervisor (MS) showed the 100, 200, and 300 Halls' resident rooms had their numerals in both Arabic and Braille next to their doors. During an interview on 9/24/24 at 3:33 P.M. the MS said that he/she was going to change out the room numbers on the 400, 500, and 600 Halls because those resident rooms only had regular numbers and no Braille. Observation on 9/25/24 between 10:31 A.M. and 1:01 P.M. during another facility follow-up walk-through inspection with the MS showed the following: -The 400, 500, and 600 Halls' resident rooms had regular numbers next to their doors. -In resident room [ROOM NUMBER] there was a four-drawer chest with the front of the 2nd drawer from the top lying inside the drawer itself, and some slats in the window blinds missing. -In resident room [ROOM NUMBER] bed #2 had several long rips in the mattress top. -In resident room [ROOM NUMBER] the inside hinged edge of the bathroom door was cracked and broken towards the bottom to the point of showing that it was a hollow-core door. During an interview on 9/25/24 at 1:04 P.M. the Environmental Services Supervisor (EVS) said the following: -If any Housekeepers, nursing staff, or anyone noticed a damaged mattress they reported it to him/her and they would order a new one. -They had replaced a couple about a month or so ago. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-It was the same process for damaged furniture or window blinds, but the MS is included on those too. During an interview on 9/26/24 at 12:53 P.M. the MS said the following: -He/She would order new blinds when reported. -The EVS or Administrator would do the mattresses and furniture. During an interview on 9/26/24 at 2:46 P.M. the Administrator said the following: -The facility should be free from any tripping hazards. -The EVS, or the MS could order any furniture, mattresses, or blinds when needed, they just had to wait for their corporate office to approve it.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727 Based on interview and record review, the facility failed to notify the resident and/or the resident's representative(s) of a transfer to a hospital, including the reasons for the transfer in writing and failed to provide the Ombudsman (a resident advocate who provides support and assistance with problems and/or complaints regarding the facility) a copy of the notification for three sampled residents (Residents #33, #73, and #40) out of 19 sampled residents. The facility census was 74 residents. Review of the Facility's Resident Transfer/Discharge, Immediate Discharge, and Therapeutic Leave Policy dated 5/14/2024 showed: -Any resident transferred or discharged under a Facility-Initiated Transfer or discharge the Facility must: --Notify the resident and the resident representative the reason for the transfer or discharge in writing in a manner they understand. --Notify a representative of the Office of the State Long-Term Care Ombudsman. ---A copy of the discharge/transfer notice shall be sent to the Ombudsman at least 30 days in advance of the discharge or as soon as possible. ---In the case of an emergency or immediate discharge, copies shall be sent to the Ombudsman. This notice shall be sent when practicable and a monthly list is acceptable and should include if the resident's return is expected. -The written notice shall include the following information: --Reason for the transfer or discharge. --Effective date of the transfer or discharge. --Location to which the resident is being transferred or discharged , including specific address. --Resident's right to appeal the transfer or discharge. -The Notice of transfer or discharge shall be given at least thirty days prior to the transfer or discharge. -In the case of an emergency or immediate transfer or discharge, the notice shall be as soon as practicable before the transfer/discharge. -Emergency or immediate discharge is permitted if it specifically alleged in the notice that: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Immediate transfer or discharge is required by resident's urgent medical needs. --Or the resident has not resided in the Facility for 30 days. -The Facility shall provide sufficient preparation and orientation to ensure that the resident as a safe and orderly transfer or discharge, including informing the resident where he/she is going and taking steps to minimize anxiety. -Orientation may include explaining to a resident why they are going to the emergency room , other location, or leaving the facility. -Orientation should be documented in the medical record including the resident's understanding regarding the transfer or discharge. 1. Review of Resident #33's discharge assessment dated [DATE] showed the resident discharged to an acute hospital with his/her return anticipated. Review of the resident's medical records showed no discharge notice dated 5/26/24. Review of the resident's entry tracking forms showed the resident returned from the hospital on 6/2/24. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 7/28/24 showed the resident was moderately cognitively impaired. Review of the resident's discharge assessment dated [DATE] showed the resident discharged to an acute hospital with his/her return anticipated. Review of the resident's medical records showed no discharge notice dated 8/1/24. Review of the resident's entry tracking forms showed the resident returned from the hospital on 8/7/24. During an interview on 9/25/24 at 9:31 A.M., the Administrator said: -The Ombudsman notifications were in the previous Social Service Director's (SSD) emails. -He/She was trying to find out if he/she could retrieve the emails. During an interview on 9/26/24 at 11:19 A.M., the resident said he/she did not receive discharge notices for these hospitalization s. During an interview on 9/27/24 at 8:41 A.M., Licensed Practical Nurse (LPN) A said the charge nurse was responsible for sending the discharge notice when a resident was being sent to the hospital. Review of an email from the Ombudsman sent on 9/27/24 at 11:09 A.M. showed he/she did not receive a list of residents discharged from the facility for August 2024. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/27/24 at 11:57 A.M.: -The Director of Nursing (DON) said: --The charge nurse usually sent the discharge notice. --It should be documented in a progress note when the discharge notice was sent. --The Social Services Director could send the discharge notice on Monday if the charge nurse did not do it on Sunday. -The Regional Director of Operations (RDO) said: --The discharge notice should have been completed and scanned under the documents/miscellaneous tab in the electronic health record. -The Administrator said: --He/she was not aware the notifications of the August 2024 discharges were not made to the Ombudsman. --The Social Services Director was responsible for notifying the Ombudsman of resident discharges, but they did not have a Social Services Director in August 2024. --Nursing should have documented in a progress note when the discharge notice was provided to the resident and/or guardian. -The Regional Clinical Supervisor said the Administrator should have sent the August 2024 discharges to the ombudsman while they had no Social Services Director. 37576 2. Review of Resident #73's Admission Record showed he/she was admitted on [DATE] and readmitted on [DATE] and was discharged to a hospital on 8/14/24 with the following diagnoses: -Type 2 Diabetes Mellitus [condition that affects the way the body processes blood sugar (glucose)]. -Severe protein-calorie malnutrition (insufficient intake of protein). Review of the resident's Health Status Note dated 8/14/2024 at 10:04 A.M., showed: -The DON informed the nurse that the resident was requesting to be sent to the emergency room due to his/her physical decline. -The DON said the resident's sister was made aware of decision to transfer to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Emergency Medical Technicians (EMT) in facility at that time to transfer to hospital for evaluation/treatment if indicated. During an interview on 9/25/24 at 11:33 A.M., the Administrator said: -He/She could not find any nursing or progress notes of the resident being transferred to the hospital. -He/she could not find the discharge notice and/or the Ombudsman notification of the resident being transferred/discharged to the hospital. During an interview on 9/27/24 09:43 A.M., LPN A said: -When a resident was sent out to the hospital a progress note was written showing: --The reason the resident was sent to the hospital. --Who was notified: physician, family/representative. -He/She did not know if family/representative had to be notified in writing of a transfer or discharge. -He/She did not know who was responsible for sending a written notice. Review of the resident's electronic medical record on 9/27/24 showed no documentation that the resident, family, or representative received written notice of the resident's transfer to the hospital. During an interview on 9/27/24 11:57 A.M., the DON said: -When a resident was discharged from the facility a progress note should be written as to where the resident went and who was notified. -The resident's family/representative should be notified in writing of the resident's discharge to the hospital. 42955 3. Review of Resident #40's Face Sheet, undated, showed the resident was diagnosed with dementia (loss of memory, language, problem-solving and other thinking abilities), anxiety disorder (apprehension, tension, or uneasiness that stems from the anticipation of danger) and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). Review of the resident's quarterly MDS dated [DATE], showed the resident was moderately cognitively impaired. Review of the resident's Electronic Health Record (EHR) Progress Notes, dated 8/26/2024, showed: -There was no documentation of a discharge in the resident's record. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was no documentation of the ombudsman being notified of a discharge. -Emergency Medical Services (EMS) was called and the resident was sent to the emergency room (ER). -Writer spoke with resident's daughter. 4. During an interview on 9/25/24 at 6:11 A.M., Certified Nursing Assistant (CNA) A said: -The nurses sent residents to the hospital. -He/She did not know who sent the discharge notice. -The nurses contact the resident's family. During an interview on 9/26/24 at 10:34 A.M., LPN A said: -Residents have face sheet and medication list sent with them when they were sent out to the hospital. -The nurse who sent the resident out was responsible for notifying the family and the physician. -The nurse who sent the resident out was also responsible for completing the discharge notice. During an interview on 9/26/24 at 11:16 A.M., the Assistant Director of Nursing (ADON) said: -When residents were sent out to the hospital, they had their face sheet and medication list. -Whoever sent out the resident contacted the ER and notified them the resident was on their way. -Face sheet, medication list, a copy of electronic Medication Administration Record (E-MAR) were sent with the resident. -The charge nurse or the SSD sent the discharge notice with the resident. During an interview on 9/27/24 at 11:58 A.M., the DON said: -When a resident was discharged to the hospital the face sheet and medication list was sent with them. -The charge nurse discharging the resident was responsible for sending that information. -The documents should have been scanned in the documents of the EHR. -A note should be in the EHR progress notes that the family was contacted. -He/She was unsure if the resident's family was notified, he/she went to the hospital. -The SSD was responsible for sending the discharge notice and notifying the Ombudsman. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was no one in the position in August 2024. -No one else was designated to do those while the position was vacant. During an interview on 9/27/24 at 11:58 A.M., the RDO said: -The charge nurse initiated the discharge notice documents and notified the Ombudsman. -The Social Service Director also would send the discharge notice and notify the Ombudsman depending on the day. -They should be scanned in the EHR under documents. -If the documents were not available then it wasn't done. MO00241127

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955 Based on interview and record review, the facility failed to provide a bed hold notification to a resident or resident representative upon transfer or discharge for three residents (Resident #40, #33, and #14) out of 19 sampled residents. The facility census was 74 residents. Review of the facility's Bed Hold Policy, date 11/6/23, showed: -When a resident was admitted to the facility, they received a copy of the bed hold policy from the Admission Packet. -When a resident was discharged to the hospital or went on therapeutic leave, the facility provided a a copy of the Bed Hold Policy to the resident or resident representative. -When a resident was admitted following a hospitalization or therapeutic leave, the resident will be admitted to the facility if they continue to require services from the facility and was eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. 1. Review of Resident #40's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 6/24/24, showed: -The resident was moderately cognitively impaired. Review of the resident's Electronic Health Record (EHR) Progress Notes, dated 8/26/2024, showed: -Emergency Medical Services (EMS) was called and the resident was sent to the emergency room (ER). -There was no bed hold documentation. During an interview on 9/26/24 at 10:34 A.M., Licensed Practical Nurse (LPN) A said: -The resident went to hospital for slurred speech. -The nurse who sent the resident out was responsible for sending the bed hold policy. During an interview on 9/26/24 at 11:16 A.M., the Assistant Director of Nursing (ADON) said: -When residents were sent out to the hospital, their face sheet and medication list was sent with them. -If they were anticipated to return they were given a bed hold policy. During an interview on 9/27/24 at 11:58 A.M., the Director of Nursing (DON) said: -When a resident was discharged to the hospital the bed hold, was sent with them. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The charge nurse discharging the resident was responsible for sending the bed hold policy. -The documents should have been scanned in the documents of the EHR. -A note should be in the EHR progress notes that the family was provided a bed hold. -He/She was unsure if a bed hold policy was sent with the resident. During an interview on 9/27/24 at 11:58 A.M., the Regional Director of Operations (RDO) said: should bed hold notice be given? -The charge nurse initiated the discharge documents. -The Social Service Director (SSD) also would complete and send the bed hold policy out, depending on the day. -They should be scanned in the EHR under documents. -A bed hold policy should have been issued to the resident. -If the documents were not available then it wasn't done. 22727 2. Review of Resident #33's discharge assessment dated Sunday, 5/26/24 showed the resident discharged to an acute hospital with his/her return anticipated. Review of the resident's medical records showed no bed hold policy notice dated 5/26/24. Review of the resident's entry tracking forms showed the resident returned from the hospital on 6/2/24. Review of the resident's quarterly MDS dated [DATE] showed the resident was moderately cognitively impaired. Review of the resident's discharge assessment dated [DATE] showed the resident discharged to an acute hospital with his/her return anticipated. Review of the resident's medical records showed no bed hold policy notice dated 8/1/24. Review of the resident's entry tracking forms showed the resident returned from the hospital on 8/7/24. During an interview on 9/26/24 at 11:19 A.M., the resident said he/she did not receive bed hold policies for the hospitalization s. During an interview on 9/27/24 at 8:41 A.M., LPN A said the charge nurse was responsible for sending the bed hold policy when a resident was being sent to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/27/24 at 11:57 A.M.: -The DON said: --The charge nurse usually sent the bed hold notice. --It should be documented in a progress note when the bed hold policy notice was provided. --The SSD could send the bed hold policy notice on Monday if the charge nurse did not do it on Sunday. -The Regional Director of Operations said the bed hold policy notice should have been completed and scanned under the documents/miscellaneous tab in the electronic health record. 51303 3. Review of Resident #14's undated Facesheet showed he/she originally admitted [DATE] with most recent admission 8/8/2024 and was his/her own responsible person. Review of resident's Nursing Progress Note dated 7/23/24 at 2:09 A.M. showed: -He/She wanted to be transported to the hospital via ambulance. -He/She wanted to be sent out to the hospital for further evaluation. Review of the resident's medical record showed no bed hold policy notice dated 7/23/24. Review of resident's Social Service Progress Note dated 7/24/24 at 11:56 A.M. showed: -The resident was admitted to the hospital. -There was no documentation of a bed hold notice. During an Interview on 9/25/24 at 10:30 A.M. the RDO said: -The charge nurse would send the bed hold policy when the resident was sent to the hospital. -The facility had 24 hours to get the bed hold policy to the guardian. -If the charge nurse did not send the bed hold policy with the resident, the SSD would follow up. During an interview on 9/26/24 at 11:52 A.M. the MDS Coordinator said: -Nursing would give the bed hold policy on transfer to the hospital. -The SSD would follow up the next business day and send the bed hold policy if nursing had not sent it at time of transfer. (continued on next page)

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	265425	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/27/24 at 11:58 A.M. the DON said: -The Charge Nurse was responsible for sending the bed hold policy. -The SSD would follow up and send the bed hold policy if the Charge Nurse had not provided it.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS-a federally mandated assessment instrument completed by the facility staff for care planning) was accurate for one sampled resident (Resident #17) out of 19 sampled residents. The facility census was 74 residents. Review of the facility policy titled MDS 3.0 Care Assessment Summary and Individualized Care Plans, revised 11/6/23, showed: -Section L is used to document any dental problems. -Section L was to be completed by nursing staff. -The MDS defined the dental health of the resident and included an assessment of mouth and facial pain. -The focus of section L was the relationship between poor oral health, the quality of life, and the nutritional status of the resident. -MDS's must be kept current and up to date. 1. Review of Resident #17's clinical admission assessment, dated 4/3/24 showed: -The resident had his/her own teeth. -Observation of dental status was not assessed. -Mouth issues were not assessed. Review of the resident's admission MDS, dated [DATE] showed the resident: -Was cognitively intact. -Did not have any dental problems upon admission to the facility. -Did not have any missing teeth upon admission to the facility. -Did not have any abnormal teeth issues upon admission to the facility. Review of the resident's Care Plan, revised 4/23/24 showed no mention of teeth problems or concerns. During an interview on 9/23/24 at 11:56 A.M., the resident said: (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had many missing teeth. -He/She was missing teeth on his/her admitted into the facility. -He/She had a hard time chewing food on occasion. -He/She would like to get some dentures. -He/She had not seen a dentist since being admitted into the facility. During an interview on 9/26/24 at 12:00 P.M., the MDS Coordinator said: -A dental assessment should have been completed on the resident as part of the clinical admission assessment. -The nurses and the Director of Nursing (DON) were responsible for completing the clinical admission assessments. -He/She would expect to have been notified if a resident was missing their natural teeth. -He/She would expect the missing of a resident's natural teeth to be placed on the MDS and the care plan. -He/She would expect a resident who had missing teeth to be able to see a dentist after admission to a facility and be offered dentures. During an interview on 9/27/24 at 11:58 A.M., with the DON and the Regional Director of Operations (RDO), said: -The MDS coordinator is responsible for keeping accurate and up to date MDS's. -The MDS was updated on initial assessment, quarterly, and if there was a change in condition. -Teeth issues, including missing teeth should have been reflected on a resident's MDS. -Initial teeth assessments should have been performed by nursing staff. -He/She was unaware of the resident's dental concerns and missing teeth.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727 Based on observation, interview and record review, the facility failed to comprehensively assess a resident who experienced a significant change in status for one sampled resident (Resident #33) out of 19 sampled residents. The facility census was 74 residents. Review of the facility's policy titled Significant Change dated 11/6/23 showed: -The facility staff would identify within 14 days a significant change in two or more areas of decline or improvement in the resident's physical or mental condition. -If the resident showed a decline or improvement in two or more areas a significant change assessment would be completed within 14 days. -The significant change was a major decline or improvement in the resident's status that would not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan or both. 1. Review of Resident 33's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 4/28/24 showed the following staff assessment of the resident: -Moderately cognitively impaired. -Independent with all activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting) except he/she required moderate/partial assistance with bathing/showering. -Walked independently. -Did not use a wheelchair. -Displayed mood symptoms that indicated moderately severe depression. -Had occasional pain. -Had no falls. -Weighed 222 pounds. Review of the resident's health status note dated 5/17/24 showed the resident had a blood infection and was on intravenous antibiotics. Review of the resident's inter-disciplinary team meeting note dated 5/29/24 showed: -The team met regarding the resident's change of condition. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It was determined the resident would benefit from being moved from the independent side of the building to the medical side of the building. Review of the resident's admission summary dated 6/2/24 showed the resident had a fall with altered mental status. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident: -Moderately cognitively impaired. -Independent with eating, oral hygiene, personal hygiene, and chair/bed-to-chair transfer. -Required partial/moderate assistance with toileting hygiene, dressing, putting on and taking off footwear, toilet transfer, and shower transfer. -Required substantial/maximum assistance with bathing/showering. -Had no pain. -Had one non-injury fall. -Weighed 206 pounds (a 7.21% loss over three months) Review of the resident's care plan updated on 7/28/24 showed the resident: -Had impaired thought processes related to a diagnosis of schizophrenia (a chronic mental illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others). -Had bipolar disorder (a disorder characterized by extreme mood swings from depression to mania). -Had no plan of care for falls. Review of the resident's discharge summary dated 8/1/24 showed the resident was sent to the hospital for a nephrostomy (a tube inserted into the kidney and drains urine into a bag). Observation on 9/23/24 at 1:42 P.M. and on 9/24/24 at 8:58 A.M., showed the resident was in his/her wheelchair in the hallway. During an interview on 9/25/24 at 9:50 A.M., the MDS Coordinator said: -The resident had declined, had unsteady gait, and had fallen. -The resident had metabolic encephalopathy (a brain disorder that occurs when a chemical imbalance in the blood affects the brain) after a hospitalization . -The resident was no longer walking and required a wheelchair. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident needed more assistance than before. -He/She thought he/she did a significant change MDS. During an interview on 9/27/24 at 11:57 A.M., the Director of Nursing (DON) said: -They should identify changes in residents' condition with rounding and assessments. -They should have initiated a significant change MDS for the resident.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727 Based on observation, interview and record review, the facility failed to accurately assess the resident's dental status for two sampled residents (Resident #33 and #51), and failed to accurately assess and implement strategies for unintended weight gain and loss for one sampled resident (Resident #19) out of 19 sampled residents. The facility census was 74 residents. Review of the facility's policy titled Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) 3.0, Care Assessment Summary and Individualized Care Plans dated 11/6/23 showed: -The purpose of the policy was to ensure the MDS was completed accurately. -The dental health section of the MDS was to be completed by nursing staff. -The dental health section of the MDS was to be used to document any dental problems. -Section K (swallowing/nutrition status): --Was to be completed by the dietary manager. --Used to assess conditions that affected the resident's ability to maintain adequate nutrition and hydration. --Monitored for triggered weight gains and losses. --Triggered gains or losses were 5% in 30 days, 7.5% in 90 days or 10% in 180 days. --Documented any nutritional approaches. 1. Review of Resident #33's dental progress note dated 2/13/23 showed: -The resident was interested in dentures. -Four of his/her teeth were removed. Review of the resident's dental progress note dated 2/16/23 showed: -Four of his/her teeth were removed. -The fifth tooth was not removed because the resident did not get numb on that tooth. Review of the resident's annual MDS dated [DATE] showed the staff assessed the resident as having no dental issues. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's monthly nurse's dental notes dated 4/6/24 showed the staff assessed the resident as: -Had his/her own teeth. -Had cavities and/or broken teeth. Review of the resident's dentist's progress note dated 5/1/24 showed: -The resident had one tooth and one root tip on the bottom jaw. -Alveoloplasty (a common dental procedure often performed following a tooth extraction) was needed with maxillary (upper) teeth extractions. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident: -Was moderately cognitively impaired. -Had no hearing, speech, or vision impairment. -Was independent with eating and oral hygiene. Review of the resident's care plan revised 7/28/24 showed nothing was included regarding the resident's teeth. During an interview on 9/24/24 at 8:58 A.M. the resident said: -He/She asked about seeing a dentist at least a month ago. -He/She did not remember who he/she asked about seeing a dentist. -He/She desperately needed to see a dentist. -He/She needed all his/her teeth pulled. Observation on 9/24/24 at 8:58 A.M. showed: -The resident had multiple missing teeth. -The teeth the resident had were discolored black and/or yellow. -The resident had multiple teeth that were misaligned and/or were broken. During an interview on 9/25/24 at 9:50 A.M., the MDS Coordinator said: -The resident's teeth were in poor condition and needed to be removed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's teeth were damaged from Lithium (a medication used to treat mood disorders, reduced the amount of saliva in one's mouth which could lead to dental issues such as tooth decay and gum disease). -The annual MDS indicating the resident had no dental issues was inaccurate. During an interview on 9/27/24 at 11:57 A.M., the Director of Nursing (DON) said: -Nursing staff and Social Services were responsible for assessing the condition of residents' teeth. -They discussed residents' teeth in their daily nurses' meeting. -The MDS should accurately reflect the resident's condition at the time of the MDS. 51303 2. Review of Resident #51's admission MDS Section L Oral/Dental status dated 3/1/24 showed: -No documentation of any dental concerns. --NOTE: The MDS was not marked to indicate this resident had missing teeth. Review of the resident's Nutrition Assessment -Registered Dietician Evaluation dated 3/16/24 showed: -He/She was on a regular diet and regular consistency. --He/She had his/her own teeth. Review of the resident's Quarterly MDS's dated 6/1/24 and 8/30/24 Section L, Dental, showed no issues with teeth. Review of the resident's undated Care Plan did not show a dental care plan. Observation on 9/23/24 at 2:02 P.M. showed the resident had multiple missing teeth. During an interview on 9/26/24 at 11:52 A.M. the MDS coordinator said: -He/She would look through the resident's chart to obtain information. -He/She was not aware of the resident's missing teeth. -He/She reviewed/updated care plans every 3 months and with changes. During an interview on 9/27/24 at 11:58 A.M. the DON said: -He/She expected the MDS to be correct. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She expected the care plan to be individualized. -He/She expected a resident with multiple missing teeth to have his/her dental status identified on the MDS and care plan. -He/She was not aware Resident #51 had missing teeth. -He/She expected a resident with multiple missing teeth on admission to be seen by dental. 42955 3. Review of Resident #19's face sheet, undated, showed: -The resident was admitted to the facility on [DATE]. -Diagnoses included moderate protein-calorie malnutrition (in adequate intake of calories resulting in muscle weakness), diabetes (a disease causing elevated levels of blood sugar, potentially leading to kidney, heart and vision problems), and generalized muscle weakness. Review of the resident's quarterly MDS, dated [DATE], showed: -The resident was severely cognitively impaired. -The resident's weight was 133 pounds. Review of the resident's weight record located in the Electronic Health Record (EHR), showed: -On 7/9/2024 the resident's weight was recorded as 126.0 pounds. -On 8/6/2024 the resident's weight was recorded as 161.8 pounds. --This was a weight gain of 22.1 percent (%) in 30 days. --There were no notes addressing the weight change. -On 8/11/2024 the residents weight was recorded as 161.8 pounds. -On 9/7/2024 the resident's weight was recorded as 150.5 pounds. --This was a weight loss of 7.5 % in 30 days. Review of the resident's Physician Order Summary (POS), with order date of 9/19/20, showed the resident was ordered a regular diet. Review of the resident's care plan dated 9/20/24, showed: -The resident was on a regular diet. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The dietician reviewed the resident's chart quarterly to ensure a regular diet was still proper for the resident. During an interview on 9/25/24 at 6:11 A.M., Certified Nursing Assistant (CNA) A said: -He/She was unsure who did the weights on residents. -He/She was unaware if the resident had lost or gained weight. During an interview on 9/25/24 at 6:22 A.M. CNA B said: -He/She was unaware of the resident having weight loss or weight gain. -He/She was unaware if the resident was on supplements. During an interview on 9/25/24 at 7:58 A.M., CNA C said: -The resident was a picky eater and did not like a lot of pasta or gravy. -The resident was given sandwiches if he/she did not like the meal. -He/She was unaware if the resident had a weight loss. -He/She was unaware of a large weight gain. -He/She was unaware if the resident was on any dietary supplements. During an interview on 9/25/24 12:59 at P.M., the Registered Dietician (RD) said: -He/She was aware of the resident's weight issues. -He/She did not believe the resident had actual weight loss and questioned the accuracy of the recent weights. -He/She was unsure of how the weights were taken, either standing, wheelchair, or mechanical lift. -He/She asked staff for a reweigh the resident earlier this week and had not received the weight yet. -He/She believed the resident needed a new baseline weight. -He/She did not feel it necessary to start nutritional supplements until the reweigh was received. During an interview on 9/26/24 at 10:34 A.M., Licensed Practical Nurse (LPN) A said: -He/She was unaware if the resident had a weight loss or gain. -He/She had not seen the resident eat very much. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nursing staff provided encouragement during meals. -The resident was very picky about his/her food. -Resident's were weighed monthly by nursing staff. -Nursing staff monitored weights and entered them in the EHR. -The EHR indicated a weight loss or gain of five or more pounds. -When there was an indication of a weight loss or gain the nurse called the physician and let him/her know. -The physician would then call the dietician and order a supplement. During an interview on 9/27/24 at 11:58 A.M., the Director of Nursing (DON) said: -He/She was made aware of the resident's weight issues by the charge nurse. -The team also discussed weights at weekly meetings. -The RD reported any issues as well. -Monthly weight changes were triggered when there was a weight difference of five pounds plus or minus in a month. -He/She was aware of the recent weight loss and was going to reweigh the resident but had not done it yet. -The RD checked weights every month and reported weight issues and recommendations to him/her. -The RD was aware the resident had a recent weight loss and asked for the resident to be reweighed. -The RD was aware the resident had a weight gain in August, but was not sure it was accurate. -The RD recommended the resident be in the dining room for meals. -He/She believed the RD ordered a protein shake. -It should have been on the Physician Order Sheets (POS) and care plan. -He/She was aware the RD requested the resident be reweighed, -The resident was reweighed but he/she was unsure if was charted. -The physician should have been made aware of the weight gain and the (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	loss. During an interview on 9/27/24 at 11:58 A.M., the Regional Director of Operations (RDO) said: -The DON should have been aware the resident had weight fluctuations and requested the resident be reweighed to set a new baseline. -The resident should have been put on weekly weights. -Nursing staff weighed the residents and charted it in the EHR. -The charge nurse was responsible for letting the physician know of any weight loss or gains. -The scale should have been calibrated and the resident reweighed. -Weekly weights could be done without a physician order.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727 Based on observation, interview and record review, the facility failed to develop a comprehensive person-centered care plan for four sampled residents (Residents #33, #54, #20 and #51) out of 19 sampled residents. The facility census was 74 residents. Review of the facility's policy titled Comprehensive Care Plans dated as revised on 6/26/24 showed: -The facility staff would develop and implement a comprehensive, person-centered care plan for each resident to meet the resident's needs. -The care plan would include resident-specific interventions. 1. Review of Resident #33's baseline care plan dated 2/5/21 did not include anything about the resident's teeth. Review of the resident's dental progress note dated 2/13/23 showed: -The resident was interested in dentures. -Four teeth were removed. Review of the resident's dental progress note dated 2/16/23 showed: -Four of his/her teeth were removed. -The fifth tooth was not removed because the resident did not get numb on that tooth. Review of the resident's annual Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 12/16/23 showed the staff assessed the resident as having no dental issues. Review of the resident's monthly nurse's dental notes dated 4/6/24 showed the staff assessed resident as: -Had his/her own teeth. -Had cavities and/or broken teeth. Review of the resident's dentist's progress note dated 5/1/24 showed: -The resident had one tooth and one root tip on the bottom jaw. -Alveoloplasty (a common dental procedure often performed following a tooth extraction) was needed with maxillary (upper) teeth extractions. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor Health Care Center	11900 Jessica Lane Raytown, MO 64138

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident: -Was moderately cognitively impaired. -Had no hearing, speech, or vision impairment. -Was independent with eating and oral hygiene. Review of the resident's care plan revised 7/28/24 showed nothing was included regarding the resident's teeth. During an interview on 9/24/24 at 8:58 A.M. the resident said: -He/She asked about seeing a dentist at least a month ago. -He/She did not remember who he/she asked about seeing a dentist. -He/She desperately needed to see a dentist. -He/She needed all his/her teeth pulled. Observation on 9/24/24 at 8:58 A.M. showed: -The resident had multiple missing teeth. -The teeth the resident had were discolored black and/or yellow. -The resident had multiple teeth that were misaligned and/or were broken. During an interview on 9/25/24 at 9:50 A.M., the MDS Coordinator said: -The resident's teeth were in poor condition and needed to be removed. -The resident's teeth were damaged from Lithium (a medication used to treat mood disorders, that reduced the amount of saliva in one's mouth which can lead to dental issues such as tooth decay and gum disease). -The annual MDS indicating the resident had no dental issues was inaccurate. -He/She should have included dental needs in the resident's care plan. 2. Review of Resident #54's admission MDS dated [DATE] showed the following staff assessment of the resident: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Received high risk medications including insulin (a hormone that lowers the level of glucose (a type of sugar) in the blood) injections, antianxiety medication (medication to treat anxiety (a psychiatric disorder that involves extreme fear, worry and nervousness)), and antidepressant medication (medication used to treat clinical depression-(a mood disorder that consists of intense sadness and a loss of interest or loss of pleasure in activities and/or life)). -Some of his/her diagnoses included diabetes, anxiety disorder, and depression. -Psychotropic drug (any drug that affects brain activities associated with mental processes and behavior) use triggered as a focus area and would be addressed in the resident's care plan. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident: -Received high risk medications including insulin injections, antianxiety medication, and antidepressant medications. -Some of his/her diagnoses included diabetes, anxiety disorder, and depression. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident: -Received high risk medications including insulin injections, antianxiety medication, and antidepressant medication. -Some of his/her diagnoses included diabetes, anxiety disorder and depression. Review of the resident's Physician's Order Sheet (POS) dated September 2024 showed the resident: -Received insulin for diabetes. -Received an antidepressant medication for major depressive disorder. -Received an antianxiety medication for generalized anxiety disorder. Review of the resident's care plan last updated on 9/9/24 showed no care plan for diabetes, insulin, depression, antidepressant medication, anxiety, or antianxiety medications. During an interview on 9/25/24 at 9:50 A.M., the MDS Coordinator said he/she would normally care plan diabetes, insulin, depression, antidepressant medication, anxiety, and antianxiety medications and he/she just missed them when developing the care plan. 51303 3. Review of Resident #51's undated Face Sheet showed he/she was initially admitted on [DATE] and the most recent admission to the facility on [DATE] with the following diagnoses: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Heart Failure (HF-disorder that impairs the ability of the heart to fill with or pump a sufficient amount of blood throughout the body). - Chronic Pain Syndrome. -Venous Insufficiency (Chronic) (Peripheral) condition in which the veins have problems sending blood from the legs back to the heart. -Cellulitis (an infection of deep skin tissue) of unspecified part of limb. Review of the resident's Admission MDS dated [DATE] showed the staff assessed the resident as having no dental issues. Review of the resident's Quarterly MDS's dated 6/1/24 and 8/30/24 showed the staff assessed the resident as having no dental issues. Review of the resident's Care Plan dated 7/24/24 did not show a Dental care plan. Observation on 9/23/24 at 2:02 P.M. showed the resident had multiple missing teeth. During an interview on 9/23/24 at 2:02 P.M. the resident said: -He/She was unsure the last time he/she saw a dentist. -He/She provided his/her own oral care. -He/She wanted dentures. During an interview on 9/25/24 at 11:50 A.M. LPN D said he/she was not aware of the resident's missing teeth. During an interview on 9/26/24 at 11:52 A.M. the MDS Coordinator said he/she was not aware the resident had missing teeth. During an interview on 9/27/24 at 11:58 A.M. the Director of Nursing (DON) said: -He/She was not aware Resident #51 had missing teeth. -He/She expected a resident with multiple missing teeth to have his/her dental status identified on the care plan. 37576 4. Review of Resident #20's Admission Record showed he/she was admitted on [DATE] and readmitted on [DATE] with the following diagnoses: -Morbid (severe) obesity (a disorder involving excessive body fat that increases the risk of health problems). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Chronic Obstructive Pulmonary Disease (COPD - a disease process that decreases the ability of the lungs to perform ventilation). -Acute (sudden onset) and Chronic (persisting for a long time or constantly recurring) respiratory failure (results from inadequate gas exchange by the respiratory system) with hypoxia (low oxygen levels in the body tissues). -Atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on the artery walls causing obstruction of blood flow) without angina pectoris (severe pain in the chest spreading out to other areas cause by inadequate blood supply to the heart). Review of the resident's Admission MDS dated [DATE] showed the resident was frequently incontinent of bladder and bowels. Review of the resident's Health Status Note-skin only evaluation dated 8/22/24 late entry showed -Skin Issue: #001 Location: Coccyx (Back of body above buttocks). Review of the resident's POS dated September 2024 showed: -Weekly skin assessments every day shift every Thursday. -Monitor for signs and symptoms of infection or open areas. -Abrasion to left posterior thigh: --Cleanse with normal saline or wound cleanser. --Pat dry. --Apply Xeroform dressing to wound bed and cover with border gauze dressing. --Every day shift AND as needed for soiled/dislodged. Review of the resident's Hot Rack Notes dated 9/12/24 at 9:34 A.M., showed the nurse assessed the resident's skin and noted: -An abrasion to the left posterior thigh. -Pink colored wound bed, no drainage. -Redness to peri wound (the area around the wound)/surrounding skin. -Redness to the right posterior thigh. -Encouraged the resident to limit time up in wheelchair daily. -Physician was made aware with new treatment order given via telephone. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/23/24 at 11:57 A.M., the resident said he/she had sores on his/her buttocks. Review of the resident's Skin/Wound Note dated 9/24/2024 at 2:24 P.M., showed: -Date of service was 9/19/2024 9:00 A.M. -Wound on back healed today. --Weeks in Treatment: 14. -New open wound on left posterior thigh currently classified as a Category/Stage III (full-thickness skin loss extending into the tissue beneath the skin, forming a small crater). --Date acquired was 9/16/2024. --Cleanse wound with Cleanser - xeroform gauze. --Cover wound with Bordered Gauze. --Change daily and as needed (PRN) for soiling and/or saturation. --Pressure Relief/Offloading: Wheelchair Pressure Redistribution Cushion per Facility Policy/Protocol. Review of the resident's Care Plan showed no interventions for peri cares or wound cares. During an interview on 9/26/24 at 11:52 A.M., The MDS Coordinator said: -He/she got updated information from the facility morning meetings on resident changes and or needs. -A resident's care plan could be updated by the nurse, the MDS Coordinator or the Social Services Director. -He/she went through the care plans every three months and updated them when needed. During an interview on 9/27/24 at 9:41 A.M., Licensed Practical Nurse (LPN) A said: -The Certified Nursing Assistants (CNA)'s let the nurses know if there was anything different or new with a resident. -The nurse assessed the resident. -If the care plan needed to be updated the nurse, Director of Nursing (DON), Assistant DON (ADON), or the MDS Coordinator put the new information in. 5. During an interview on 9/27/24 at 11:57 A.M., the DON said: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The MDS Coordinator was responsible for the overall care plan development. -The care plan should reflect the resident's current condition and plan of care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955 Based on interview and record review, the facility failed to notify the resident or the resident representative of meetings for care plan development, review, and revision, for one sampled resident (Resident #67) and failed to update the care plan for falls, pain, and infections for three sampled residents (Resident #33, #14 and #51) out of 19 sampled residents. The facility census was 74 residents. Policies regarding care plan invitations and care plan invitations were requested and not received. 1. Review of Resident #67's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 7/29/24, showed: -The resident was moderately cognitively impaired. -The resident was diagnosed with anxiety disorder (feelings of fear, dread, and uneasiness that may occur as a reaction to stress), depression (a low mood or loss of pleasure or interest in activities for long periods of time), and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). During an interview on 9/23/24 at 12:34 P.M., the resident said: -He/She was unsure what a care plan was. -He/She could not remember if he/she had been invited to the care plan meeting. -He/She understood the process and confirmed he/she had not been to a care plan meeting in the past. During an interview on 9/25/24 at 6:11 A.M., Certified Nursing Assistant (CNA) A said: -He/She found information about the resident in the care plan. -Residents should be invited to care plan meetings. During an interview on 9/25/24 at 6:22 A.M., CNA B said: -Resident's needs were addressed on the care plan. -He/She believed the resident was invited to care plan meetings. -Unsure if there were care plan meetings as he/she worked nights. During an interview on 9/25/24 at 7:58 A.M., CNA C said: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Residents should get invited verbally to care plan meetings. -He/She was unaware if the resident had one recently. During an interview on 9/25/24 at 9:32 A.M., the Social Service Director (SSD) said: -He/She started this position two weeks ago. -Care plan due date notifications were generated in the Electronic Health Record (EHR). -The MDS Coordinator handled care plan meeting notifications while the facility transitioned between SSD's. -Meeting notifications were mailed out to families, and they were offered by zoom, phone, or in person. -The resident would have received a notice himself/herself, if he/she was his/her own person. -The resident had a care plan update on 4/29/24 and on 7/29/24. During an interview on 9/25/24 at 9:56 A.M., the MDS Coordinator said: -The resident's care plan meeting was not done with the resident present. -The resident's care plan was updated but he/she did not have a meeting. -He/She did not have time to do meetings with residents or resident representatives. -He/She was responsible for MDS's at two buildings and his/her time management needed improvement. During an interview on 9/26/24 at 11:16 A.M., the Assistant Director of Nursing (ADON) said: -He/She started this position about a month ago. -It was his/her understanding that residents were invited to their care plan meetings. During an interview on 9/27/24 at 11:58 A.M., with the Director of Nursing (DON) and the Regional Director of Operations (RDO) the RDO said: -The resident and resident representatives were notified of care plan meetings via the telephone and should be in writing. -Everything should be in writing, even the invites for residents. -The MDS coordinator was responsible for inviting residents to care plan meetings. -Any letters were uploaded into documents in the EHR or in a binder. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Unless there was documentation in the resident's clinical notes then there was no proof the care plan meeting was done. 22727 2. Review of Resident #33's quarterly MDS dated [DATE] showed the resident had not fallen since admission or prior assessment, whichever was more recent. Review of the resident's health status note dated 4/7/24 showed the resident was sent to the hospital emergency department related to his/her altered mental status after a fall. Review of the resident's discharge assessment dated [DATE] showed the resident had two or more non-injury falls since admission or prior assessment, whichever was more recent. Review of the resident's discharge assessment dated [DATE] showed the resident had one non-injury falls since admission or prior assessment, whichever was more recent. Review of the resident's quarterly MDS dated [DATE] showed the resident had one non-injury fall since admission or prior assessment, whichever was more recent. Review of the resident's care plan updated 7/28/24 showed falls and fall-prevention interventions were not included in the care plan. During an interview on 9/25/24 at 9:50 A.M., the MDS Coordinator said: -The resident had declined and had unsteady gait. -The resident had fallen. -He/She should have included falls in the resident's care plan. During an interview on 9/27/24 at 11:57 A.M.: -The DON said: --Falls should have been added to the resident's care plan. --The MDS Coordinator, DON, ADON, and charge nurses should update care plans. --The care plan should be accurate and reflect the resident's current status. -The RDO said: --The charge nurses were educated on how to update care plans. --The MDS Coordinator was responsible overall for ensuring care plans were updated. 51303 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #14's undated Facesheet showed he/she originally admitted on [DATE] with the most recent admission on 8/8/24 and had the following diagnoses: -Bilateral primary osteoarthritis (a degenerative disease of the bones and joints) of knee. -Pain in leg unspecified. -Urinary Tract Infection, site not specified. Review of the resident's Nursing Progress Note dated 7/23/24 at 2:09 A.M. showed: -He/She wanted to be transported to the hospital via ambulance. -He/She wanted to be sent out to the hospital for further evaluation. Review of the resident's Social Service Progress Note dated 7/24/24 at 11:56 A.M. showed the resident was admitted to the hospital. Review of resident's Nursing Progress Note dated 9/13/24 at 3:11 P.M. showed he/she was sent to the hospital. Review of the resident's nurses notes dated 9/14/24 at 11:09 A.M. and 9/14/24 at 8:14 P.M. showed the resident was out of the facility at the hospital. Review of the resident's Order Recap Summary dated April 2024 to August 2024 showed: -Diflucan (an antifungal medication) oral 150 milligram (mg) give one tablet at bedtime for yeast for one day dated 7/22/24. -Obtain an urinalysis one time only for pain 7/23/24. -Ceftazidime (an antibiotic) Intravenous Solution, reconstitute 2 gram (gm), use one vial at bedtime for Urinary Tract Infection (UTI - an infection of one or more structures in the urinary system) for three days dated 8/8/24 to 8/11/24. -Cephalexin (an antibiotic) capsule, 500 milligrams (mg) give one capsule three times a day for UTI 9/14/24 to 9/22/24. -Cephalexin capsule, 500 mg give one capsule three times a day for UTI 9/22/24 with no stop date. Review of the resident's Order Recap Summary dated September 2024 showed: -Cephalexin capsule 500 mg give one capsule three times daily for urinary tract infection (UTI). -The MAR was marked to show the medication was unavailable. Review of the resident's care plan showed there was no care plan that addressed yeast, recurrent UTI, or antibiotic or antifungal medication usage. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #51's undated Face Sheet showed he/she was initially admitted on [DATE] and the most recent admission to the facility on [DATE] with the following diagnoses: -Heart Failure (HF-disorder that impairs the ability of the heart to fill with or pump a sufficient amount of blood throughout the body). -Chronic Pain Syndrome. -Venous Insufficiency (Chronic) (Peripheral) condition in which the veins have problems sending blood from the legs back to the heart. -Cellulitis (an infection of deep skin tissue) of unspecified part of limb. -Alcohol Abuse, uncomplicated. Review of the resident's Admission MDS dated [DATE] showed: -He/She received as needed (PRN) pain medications. -He/She did not receive non-medication interventions. -He/She had pain present. -He/She had frequent pain. -Pain intensity score was an eight, a very strong pain that made it difficult to do anything including physical activity and conversation. Review of the resident's Quarterly MDS dated [DATE] showed: -He/She received PRN pain medications. -He/She did not receive non-medication interventions. -He/She had pain present. -He/She had frequent pain. -Pain occasionally affected sleep. -Pain occasionally interfered with day-to-day activities. -Pain intensity score was an eight, a very strong pain that makes it difficult to do anything including physical activity and conversation. Review of the resident's Care Plan dated 7/24/24 showed: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Tramadol (used to relieve moderate to moderately severe pain) 50 mg one tablet every 8 hours as needed for pain. Review of the resident's Nurse Practitioner progress note dated 9/14/24 at 4:59 P.M. showed an order for Tramadol Oral Tablet 50 mg Give one tablet by mouth every 8 hours as needed for pain. During an interview on 9/23/24 at 11:10 A.M. the resident said: -He/She did not feel well and was in pain. -He/She wanted to lay down and be left alone. During an interview on 9/23/24 1:59 P.M. the resident said: -He/She was in pain due to arthritis and cellulitis in his/her legs. -He/She rated his/her pain at a seven. -The pain was in the shoulders, knees, and wounds and it was chronic. -The facility didn't do anything. During an interview on 9/25/24 at 11:12 A.M. the resident said: -His/Her knees were bone on bone. -He/She needed knee injections. -He/She wanted physical therapy. -He/She felt he/she was not receiving the care that was needed. During an interview on 9/25/24 11:13 A.M. Licensed Practical Nurse (LPN) D said: -The resident had an order for a Lidocaine patch and a cream. -The resident did not have an order for controlled medication due to substance abuse history. -The DON would know about the resident's history. During an interview on 9/25/24 at 11:22 A.M. the DON said: -The resident had a history of substance abuse that included street drugs such as [NAME] meth (a highly addictive & dangerous drug with devastating effects on your health). -The resident also drank hard liquor. 5. During an interview on 9/26/24 at 11:52 A.M. the MDS Coordinator said: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She attended the clinical meetings when possible, to obtain information to revise care plans. -He/she was responsible to update/revise care plans. -The residents should have individualized care plans. -The residents should have care plans for pain, infections and/or antibiotics. -He/She reviewed/updated care plans every 3 months and with changes. During an interview on 9/27/24 at 11:58 A.M. the DON said: -He/She expected the care plan to be individualized. -He/She expected a resident with multiple missing teeth to have dental issues identified on the MDS and care plan. -He/She was not aware the resident had missing teeth. -He/She expected antibiotics to be on the care plan. -He/She expected the pain care plan to identify sites, types of pain and the plan to address. -He/She expected the care plan to be updated with new orders, antibiotics, referrals, refusals of treatment plan and communication to the provider/physician. -He/She, the ADON and the MDS Coordinator were responsible for updating care plans.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469 Based on observation, interview, and record review, the facility failed to properly administer medications by not having a physician's order stating the resident was able to self administer medications , failed to administer medications within the allotted time frame, and failed to ensure prescribed medications were available for one sampled resident (Resident #41) out of 19 sampled residents. The facility census was 74 residents. Review of the facility's policy, General Medication Administration Process dated 6/26/24 showed: -Keep medication cart stocked with adequate supplies. -Ensure medications were administration were followed; right time. -Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. -Observe resident consumption of medication. 1. Review of Resident #41's face sheet showed he/she was readmitted to the facility on [DATE] with the following diagnoses: -Chronic Obstructive Pulmonary Disease (COPD a group of lung diseases that block airflow and make it difficult to breathe). -Tracheostomy status (a surgically created opening through the neck into the trachea to allow air to fill the lungs) -Malignant Neoplasm of Bronchus and lung (cancer of the lungs) -Cannabis abuse (addiction to marijuana). -Cocaine abuse (an addition to Cocaine which was a stimulant that produces euphoria). -Hypertension (high blood pressure). -Chronic pain syndrome. -Malignant Neoplasm of Liver and bile duct (cancer of the Liver). -Chronic kidney disease (a long standing disease of the kidneys leading to renal failure). -Gastro-Esophageal Reflux disease (GERD - a digestive disease in which stomach acid or bile irritates the food pipe lining). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Other Psychoactive substance dependence (a strong desire or sense of compulsion to take the substance). -Other abnormalities of breathings. -Chest pain. -Depression. -The resident was his/her own responsible person. Review of the resident's Care Plan, dated 6/10/24 showed: -The resident had a potential to have been physically aggressive related to poor impulse control. -Staff were to anticipate the resident's needs, comfort level and pain. -Staff were to monitor, document, and report as needed any signs or symptoms of the resident posing a danger to self or others. -The Care Plan did not address self administering of medications. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by the facility for care planning) dated 9/2/24 showed: -He/She was cognitively intact. -He/She had a cardiorespiratory condition (heart and lungs). -He/She had cancer. -He/She had high blood pressure. -He/She had renal (kidney) failure. -He/She had depression. -He/She had COPD. -He/She was on scheduled and as needed pain medications. -He/She was on high risk medications; opioid and antidepressants. Review of the resident's Physician's Order Sheet dated September 2024 showed the following orders: -Atorvastatin Calcium (medication used to treat high cholesterol and may reduce the risk of heart attack and other heart problems) one 20 milligram (mg) tablet by mouth once a day for lowering cholesterol and prevent heart disease, dated 9/22/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Duloxetine hydrochloride (HCL) oral capsule delayed release particle 20 mg one capsule by mouth two times a day related to depressive disorder, dated 9/22/24. -Hydrocodone (medication used to treat severe chronic pain)- Acetaminophen 5/325 mg one tablet by mouth four times a day for pain. -Amlodipine Besylate (hypertension- high blood pressure) 5 mg, one tablet by mouth for hypertension, 9/22/24. -Sucralfate 1 Gram (GM) one tablet by mouth two times a day related to GERD, dated 9/22/24. -Tramadol (a controlled substance when combined with other substances, especially heroin or cocaine soul cause respiratory distress and death) HCL 50 MG one tablet by mouth at bedtime, dated 9/22/24. -Albuterol sulfate inhaler (medication that treats and prevents breathing difficulties such as wheezing from lung diseases) two puffs every four hours for shortness of air or wheezing, dated 9/22/24. -Albuterol Sulfate nebulizing (a machine that turns medication into a mist) solution 1.25 mg/3 milliliter (ml) one vial inhale orally via nebulizer every six hours as needed for wheezing, dated 9/22/24. -Budesonide Formoterol Fumarate inhalation aerosol 160/4.5 micrograms (mcg)/ACT two puffs inhale orally two times a day related to COPD (rinse mouth after use), dated 9/22/24. -Fluticasone Propionate inhalation aerosol 44 MCG/ACT one puff inhale orally two times a day related to COPD, dated 9/22/24. -May go out on leave with medications, dated 9/19/24. -Check mouth after giving medications to observe for cheeking medication every shift, dated 9/19/24. -There was no Physician's order which stated the resident was able to self administer the medications. Review of the resident's current medical record showed there was no evaluation for the resident to self administer medications. Observation on 9/23/24 at 12:09 P.M. showed: -The resident had a nebulizer and mask at bedside. -There were three inhalers at bedside; Albuterol (used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases), Fluticasone (used to relieve symptoms of rhinitis such as sneezing and a runny, stuffy, or itchy nose and itchy, watery eyes caused by hay fever), and Budesonide (a medication used to manage and treat inflammatory diseases, mainly affecting the airways). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was one full plastic tube of Albuterol nebulizer treatment at bedside. During an interview on 9/23/24 at 12:09 P.M. the resident said: -He/she administered his/her own inhalers and nebulizer treatments. -The physician gave him/her permission to administer his/her own medications. -The facility ran out of his/her medications. -One of the medications the facility did not have for him/her was a pain medication Hydrocodone and he/she called 911 to go to the hospital for pain control. -One of the Certified Medication Technicians (CMT) always gave him/her medications late. -He/She would have preferred to have the medications at breakfast not almost noon. Observation on 9/24/24 at 1:00 P.M. showed: -The resident had a nebulizer and mask at bedside. -There were three inhalers at bedside; Albuterol, Fluticasone, and Budesonide. -There was one full plastic tube of Albuterol nebulizer treatment at bedside. During an observation and interview on 9/25/24 at 7:26 A.M. with CMT C during medication pass showed: -He/She handed the resident a full tube of Albuterol nebulizer treatment. -He/She asked if the resident needed another inhaler. -The resident answered he/she was still good (had enough). -The resident said the other CMT was always late giving him/her morning medications. -The resident pulled two of the three inhalers out of his/her pocket to show the CMT. -The third inhaler was sitting on the resident's bedside table. -He/She said the resident was able to administer his/her own inhalers and nebulizer treatments. -He/She said the resident had a physician's order to administer his/her own inhalers and nebulizer treatments. -He/She looked on the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for the physician's order to allow the resident to self administer the medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She said there was no order and there should have been an order to allow the resident to self administer the inhalers and nebulizer treatments per self. -The resident had said often the other CMT gave him/her medications late. -Medications should have been given one hour before or after the scheduled time frame. -They have an open time frame for medications 6:00 A.M. to 10:00 A.M. for morning medications. -The resident liked to have his/her medications after breakfast. -The resident was out of some of his/her medications a couple of weeks ago for a couple of days. -One of the medications was the resident's Hydrocodone which he/she took for cancer. -He/She had told the Nurse and the Nurse had called the physician. -The Charge Nurse would have been responsible for ensuring the resident had an order to leave the medications at bedside. During an interview on 9/25/24 at 7:40 A.M. Licensed Practical Nurse (LPN) B said: -If a resident was able to self administer any medications including inhalers or a nebulizer treatment they would have needed an evaluation and a physician's order. -The resident had an order to leave medications such as the inhalers and nebulizer treatment at the bedside as that was what they had always done. -He/She was not able to find a physician's order nor an evaluation in the resident's chart for self administration of the inhaler or nebulizer treatments. -The resident had told him/her several times that he/she would like to have medications closer to breakfast rather than at 11:00 A.M. -One of the CMT's sometimes gave the resident medications late. -Staff had a period of one hour before or after the 6:00 A.M. to 10:00 A.M. timeframe to administer medications. -He/She looked at the administration times and there were a couple of times the resident had received medications at 11:20 A.M. which was late. -If a resident preferred medications to be given closer to breakfast staff should try to do so. -The resident had been out of a couple of medications a week or so ago. -He/She had called the Pharmacy, the physician and told the Charge Nurse. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Medications were usually ordered two or three days before a resident would have ran out. -The Pharmacy makes two deliveries a day so there was no reason to run out. -The Pharmacy needed the Physician to sign the prescription. -The facility also had an Emergency Kit (E kit) to get medications for a resident if needed. -He/She had tried to get the medication from the E Kit but was not able to do so. -He/She had not told anyone about not being able to obtain the medication from the E kit. -The resident got mad and called 911 for Emergency Medical Services (EMS) to take him/her to the hospital. -The resident came back and was threatening to call EMS a second time when they still did not have his/her pain medications. Observation on 9/26/24 at 1:24 P.M. showed there were three inhalers at the resident's bedside; Albuterol, Fluticasone, and Budesonide. Review of the resident's Nurses' Notes dated September 2024 showed: -On 9/17/24 Trazadone (an antidepressant used to treat depression) and Amlodipine (relaxes your blood vessels so that blood can move through them more easily and your heart does not have to work as hard) were on order. -On 9/18/24 Trazadone Amlodipine, and Sucralfate (used to treat and prevent the return of duodenal ulcers (ulcers located in first part of the small intestine) were on order. -On 9/19/24 Tramodol, Amlodipine, and Sucralfate were on order. -On 9/22/24 medications were discontinued (no documentation as to why). Review of the resident's MAR and TAR dated 9/15/24 showed: -Amlodipine was given at 11:07 A.M. (outside of the 6:00 A.M. to 10:00 A.M. plus one hour). -Atorvastatin (used to lower the amount of cholesterol in the blood) was given at 11:07 A.M. (outside of the 6:00 A.M. to 10:00 A.M. plus one hour). Review of the resident's MAR and TAR dated 9/24/24 showed: -Atorvastatin was given at 11:20 A.M. (outside the 7:00 A.M. to 10:00 A.M. plus one hour). -Duloxetine (used to treat depression and anxiety) was given at 11:20 A.M. (outside the 7:00 A.M. to 10:00 A.M. plus one hour). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Hydrocodone was given at 11:20 A.M. (outside the 7:00 A.M. to 10:00 A.M. plus one hour). -NOTE: The facility was not able to print a copy of the actual timestamp medications were given, this information was verified with Medical records. During an interview on 9/24/24 at 10:00 A.M. the Administrator said: -The facility received two deliveries a day from the Pharmacy. -The resident should not have run out of medications. -The resident went out to the hospital because he/she did not have pain medications. -The resident had went out for a family visit prior to going to the hospital. -While at the hospital the resident had tested positive for Cocaine use. -This was conveyed to the facility from the hospital prior to the resident returning to the facility via telephone call. -There was no discharge paperwork or documentation from the hospital. -The physician was notified and discontinued the resident's medications until he/she evaluated him/her as he/she had just started service with the facility. -There should have been documentation in the resident's chart but there was not. During an interview on 9/24/24 at 10:30 A.M the Pharmacist said: -The facility received two deliveries a day from the pharmacy there was no reason for a resident to run out of medications. -They had been waiting on a signature from the physician to fill the resident's order. -The facility had just changed physicians on 9/23/24 and maybe this had been the hold up. During an interview on 9/27/24 at 12:00 P.M. the Director of Nursing said: -He/She expected to find an evaluation for a resident to keep medications at bedside. -He/she expected to find an order for a resident to keep medications at bedside. -He/She would expect medication delivery to be made by pharmacy during the next delivery run or by the next day for a medication the resident was already taking. -If a medication was not available, he/she or the charge nurse should have been notified. -Mediations were considered late if they were over one hour past the scheduled time. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-They have changed Medical Directors and and it is taking a day or so to get new prescriptions for the residents. -After talking to the pharmacy they have 72 hours to get a script to the residents. -This has been an issue with the Physician signing the script. -The resident had an issue with drugs when he/she went to the hospital so the Dr was holding medications.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150 Based on interview, and record review, the facility failed to follow physician's orders for obtaining Prothrombin Time (PT: a test used to help detect and diagnose a bleeding disorder or excessive clotting disorder) and International Normalized Ratio (INR: calculated from a PT result and is used to monitor how well the blood-thinning medication is working to prevent blood clots) labs for one sampled resident (Resident #17) on Coumadin (an anticoagulant) out of 19 sampled residents. The facility census was 74 residents. Review of the facility policy titled High Risk Medications Anticoagulants Policy, revised 6/26/24, showed: -Routine labs, including baseline and subsequent labs, shall be ordered for each resident requiring anticoagulation medication. -Results shall be communicated to the physician in a timely manner. -Lab results that are outside the normal limits or target range for the individual resident, but not critical values, shall be communicated to the physician within 24 hours. -Lab results that are considered critical values per facility lab specificity shall be communicated to the physician immediately upon receipt of the critical lab value, but no greater than two hours. 1. Review of Resident #17's Face sheet, with an admitted [DATE] showed the resident: -Had acute embolism and thrombosis (blood clot) of unspecified deep veins of right lower extremity. -Had personal history of other venous thrombosis and embolism. -Had history of Transient Ischemic Attack (TIA: a temporary blockage of blood flow to the brain). -Had history of Cerebral Infarction (occurs because of disrupted blood flow to the brain due to problems with the blood vessels that supply it). Review of the resident's Care Plan dated 4/4/24 showed: -The resident had a history of Deep Vein Thrombosis (DVT: A blood clot in a deep vein, usually in the legs). -Monitor laboratory values to monitor/document effect of anticoagulant therapy, report values outside of therapeutic range. -The resident was on anticoagulation therapy. -Anticoagulation labs were ordered and to report abnormal finding to the physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Admission Minimum Data Set (MDS-A federally mandated assessment tool required to be completed by facility staff for care planning) dated 4/11/24 showed the resident: -Was cognitively intact. -Had a diagnosis of DVT. -Was on anticoagulation therapy. Review of the resident's Physician's Order Sheet (POS) dated 4/4/24 showed the following physician's order for PT/INR lab draw every Monday and Thursday. Review of the resident's lab results report, dated 9/25/24, showed: -23 missing lab results for PT/INR's from 4/4/24-9/25/24. -3 missing PT/INR lab results from the month of April. -3 missing PT/INR lab results from the month of May. -8 missing PT/INT lab results from the month of June. -2 missing PT/INR lab results from the month of July. -5 missing PT/INR lab results from the month of August. -2 missing PT/INR lab results from September. During an interview on 9/23/24 at 1:22 P.M. the resident said: -The facility was not drawing his/her labs twice per week on a consistent basis. -He/She was supposed to get PT/INR lab draws every Monday and Thursday. -He/She had told staff about the missing lab draws, but he/she could not recall which staff he told. During an interview on 9/25/24 at 12:00 P.M., Agency Licensed Practice Nurse (LPN) D said: -He/She was unaware how often the resident was ordered to get PT/INR labs drawn. -He/She has never noticed a missing PT/INR lab. -He/She was supposed to call the physician with PT/INR results and document in the nurses noted in the electronic medical record. During an interview on 9/25/24 at 1:22 P.M., the Director of Nursing (DON) said: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-PT/INR labs should be drawn on the resident twice per week. -Physician should be notified when results are abnormal. During an interview on 9/27/24 at 11:58 A.M., the DON and the Regional Director of Operations (RDO) said: -He/She would expect PT/INR labs to be drawn twice per week if they were ordered to be done twice per week. -He/She would expect lab results back from the lab within 24 hours after being drawn. -He/She would expect staff to communicate with the physician and document in a nursing note if results were not present or abnormal. -He/She assumed that the missing labs were not done, if they were not documented in the lab result section in the electronic medical record.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 51150 Based on observation, interview, and record review, the facility failed to provide toenail care or an appointment with a podiatrist for one sampled resident (Resident #17) out of 19 sampled residents. The facility census was 74 residents. A podiatry policy was requested and not provided. 1. Review of Resident #17's Face Sheet showed the resident was admitted to the facility with the following diagnoses: -Morbid obesity. -Dysfunction of lower extremity. Review of the resident's Admission Minimum Data Set (MDS-A federally mandated assessment tool required to be completed by facility staff for care planning) dated 4/11/24 showed the resident: -Was cognitively intact. -Required maximal/substantial assistance with personal hygiene. During an interview on 9/23/24 at 1:22 P.M. the resident said: -He/she had requested to see a podiatrist to care for his/her toenails. -He/she made this request to the previous social worker and the current administrator. -He/she had never seen a podiatrist since being in the facility. -He/she had pain in his/her feet from his/her toenails being so long. -He/she was told months ago by the administrator that he/she would be able to see a podiatrist but never had. Observation on 9/23/24 at 1:30 P.M., showed: -The resident had unkept and untrimmed toenails. -The resident's toenails were long and thick. During an interview on 9/25/24 at 10:36 A.M., Certified Nursing Assistant (CNA) F said: -If a resident requested to see a podiatrist, he/she would report it to the charge nurse. -He/she knew that the resident was wanting and needing to see a podiatrist. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she had reported the resident's need to see a podiatrist to the previous social worker and the administrator. During an interview on 9/25/24 at 11:45 A.M., CNA D said: -He/she was aware the resident needed to see a podiatrist. -He/she had reported the need for the resident to see a podiatrist to a charge nurse. -He/she could not recall which charge nurse he/she reported information to. -The Director Of Nursing (DON) also was aware that the resident was needing to see a podiatrist. During an interview on 9/25/24 at 12:00 P.M., Licensed Practical Nurse (LPN) D said: -He/she was aware that the resident needed to see a podiatrist. -He/she reported to the DON the resident needed to see a podiatrist. During an interview on 9/25/24 at 1:22 P.M., the DON, said: -He/she was aware that the resident needed to see the podiatrist. -He/she added the resident to the list to be seen by the podiatrist the next time he/she was at the facility. -He/she thought that the resident had already been seen by the podiatrist. During an interview on 9/26/24 at 11:00 A.M., the Social Services Director said: -He/she was responsible for setting up the resident appointments with the podiatrist. -A resident should be seen by a podiatrist with 48-72 hours of admission into the facility. -He/she was unaware that the resident needed to see a podiatrist. -He/she would have expected if a resident needed to see a podiatrist, it would have been communicated to the charge nurse, the DON, and himself/herself. -He/she would have expected that a nursing note had been made in the resident's electronic medical record of his need to see a podiatrist. During an interview on 9/27/24 at 11:58 A.M., the DON and the Regional Director of Operations (RDO), said: -He/she was aware of the resident needing to see a podiatrist. -When a resident needed to see a podiatrist, the social worker makes the appointment. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she would have expected the need for the resident to see a podiatrist be communicated to the social worker. -He/she was unaware why the resident had not seen a podiatrist yet. -The facility had no podiatry notes or nursing notes to provide regarding the resident's need to see a podiatrist.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150 Based on interview and record review, the facility failed to ensure the safety when on 6/19/24 Agency Certified Nursing Assistant (CNA) E transferred one sampled resident (Resident #17) identified as a fall risk, by himself/herself that caused a fall which resulted in a closed right sided tibial fracture (a tibial fracture occurs along the length of the bone, below the knee and above the ankle), and failed to complete a fall investigation for the fall, out of 19 sampled residents. The facility census was 74 residents. Review of the facility policy titled Safe Resident Handling Transfers Policy, revised 5/14/24, showed: -All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. -While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts are a safer alternative and should be used. -Staff members were expected to maintain compliance with safe handling/transfer practices. -The staff was to use gait belts with residents that could not independently ambulate or transfer for the purpose of safety. -Two staff members must be utilized when transferring residents with a mechanical lift. -Resident lifting and transferring would be performed according to the resident's individual plan of care. Review of the facility policy titled Incidents and Accidents Policy, revised 5/18/24, showed: -Incident/accident reports are part of the facility's performance improvement process. -Falls require an incident/accident report. -The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. -Documentation should include the date, time, nature of the incident, location, initial findings. Immediate interventions, notifications and orders obtained or follow up interventions. -If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnesses it and submit that documentation to the Director of Nursing and/or administrator. Review of the facility policy titled Fall Prevention Program, revised 6/26/24, showed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. -A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level. -The nurse will indicate the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. -The nurse will refer to the facility's high risk or low/moderate risk protocols when determining primary intervention. -When a resident experiences a fall, the facility will: Assess the resident, complete a post fall assessment, complete an incident report, notify physician and family, review the resident's care plan, and update as indicated, document all assessments and actions, and obtain witness statements in the cases of injury. 1. Review of Resident #17's Face Sheet with an initial admitted [DATE], showed the resident was admitted to the facility with the following diagnoses: -Morbid obesity (A disorder that involves having too much body fat, which increases the risk of health problems). -Dysfunction of lower extremities. -Muscle wasting and atrophy (Muscle atrophy is the wasting or thinning of muscle mass. It can be caused by disuse of your muscles or neurogenic conditions), multiple sites. -Difficulty in walking. -Primary osteoarthritis (Osteoarthritis occurs when the flexible, protective tissue at the ends of bones, called cartilage, wears down), right hip. Review of the resident's admission Minimum Data Set (MDS-A federally mandated assessment tool required to be completed by facility staff for care planning), dated 4/11/24, showed the resident: -Was cognitively intact. -Was in a wheelchair. -Could not walk. -Required substantial/maximal assistance to stand. -Required full assistance from chair/bed to chair transfers. -Did not have any ability to complete a chair/bed to chair transfer and the helper had to do all the effort to transfer from chair/bed to chair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Had no history of falls. Review of the resident's Care Plan, revised 4/23/24, showed the resident: -Was a fall risk (FRAPSS risk for falls related to deconditioning, gait/balance problems). -No documentation on how the resident transferred from surface to surface. -Was unaware of safety needs. -Would be evaluated by physical therapy and treated as ordered. Review of the resident's Occupational Therapy Evaluation and Plan of Treatment note obtained from the therapy department, dated 6/10/24, showed: -Resident required a sit to stand lift (An assistive device that allows residents to be transferred between a bed and a chair or other similar resting places, using electrical or hydraulic power) for functional transfers, shower chair, or power wheelchair. -Resident was dependent on a sit to stand lift for shower transfers. -Resident was dependent on a sit to stand lift for toilet transfers. -Resident was unsteady when standing. -Resident could not stand without support for ten seconds. -Resident had fears about falling. Review of the resident's nursing progress note, dated 6/19/24, showed: -The resident had a fall due to transferring from the shower chair to the toilet. -His/Her right knee gave out and he/she was guided to the floor. -The resident complained of pain (to his/her right knee). -The Physician was notified and an X-ray was ordered. Review of the facility's fall investigation, dated 6/19/24, showed: -The resident was lying on his/her back on the ground stating his/her right knee hurt. -He/She was getting out of the shower and transferring to the toilet when his/her knee gave out and he/she was guided to the floor by the (unidentified) CNA. -No injuries observed at the time of the incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-No injuries observed post incident. -A section on the report was check marked that a statement was given by staff on 6/21/24. --No documentation which staff were interviewed/provided a statement and no documentation the resident was interviewed. -Note: No witness/staff statement was completed at the time of the fall in the investigation. -Note: No root cause analysis was completed at the time of the fall. Review of the resident's nursing progress note, dated 6/20/24 at 1:51 P.M., showed: -The resident complained of continued and increased pain post fall on 6/19/24. The resident rated his/her pain an eight out of 10 (10 being the worst pain). -Mobile x-ray negative. -The resident request transfer to the hospital for assessment and treatment. -The Physician was notified. Review of the resident's Hospital history and physical notes, dated 6/20/24, showed: -Computerized Tomography scan, (CT scan, is a type of imaging that uses X-ray techniques to create detailed images of the body) showed a mildly displaced and impacted fracture involving the medial (toward the middle of the body) tibial plateau (the tibial plateau is the flat top part of your tibia bone. The tibia (shin bone) goes from your knee to your ankle), extending into the tibial spines. -Additional mildly displaced fracture along the far lateral aspect (toward the outside of the body) of the lateral tibial plateau. -Probable nondisplaced fracture involving the fibular head (The fibula is a long bone in the lower extremity that is positioned on the lateral side of the tibia). -Resident was admitted to the medical surgical unit for treatment. During an interview on 9/23/24 at 11:56 A.M., the resident said: -He/She had a fall on 6/19/24 that resulted in a broken leg. -He/She informed Agency CNA E that it took two people or a sit to stand lift to transfer him/her before Agency CNA E attempted to transfer the resident by himself/herself without the lift. -Agency CNA E responded, No, it will be okay and attempted to transfer resident by himself/herself. -Agency CNA E was an agency staff and he/she had not seen Agency CNA E since the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-After his/her shower, Agency CNA E rolled the resident up to the grab bar in the shower chair and asked the resident to grab the bar and stand up. -The shower chair was unlocked, and it rolled from underneath the resident and he/she fell on the floor. -He/she fell hard and knew something was broke. His/Her pain after the fall was a 20, on a 0-10 pain scale. -He continued to have severe pain and requested to be sent to the hospital for evaluation on 6/20/24. During an interview on 9/25/24 at 11:03 A.M., the Occupational Therapy Assistant (OTA) said: -He/She was the therapy manager for the facility. -At the time of the resident's fall, his/her transfer order recommendations were to use a sit to stand lift with two persons assist. -If an event happened that required new or additional therapy recommendations, those new or additional recommendations would have been made verbally during the next scheduled morning staff meeting with the department heads after an event took place. -He/She did not have documentation when the recommendation was communicated with the facility staff. -Transfer orders were communicated with staff in the morning staff meetings. -Therapy orders were not entered into the resident's electronic charting by the therapy department. -At the time of the residents fall, the resident should have always had at least 2 staff members assisting with transfers. During an interview on 9/25/24 at 11:45 A.M., CNA D said: -Prior to the fall, he/she transferred the resident with a hoyer lift and minimum 2 person assist at all times. -Prior to the fall, he/she believed the resident's transfer orders were a sit to stand lift, but the facility did not have one available to use for the resident due to residents' weight, so the staff used a hoyer to transfer him/her instead. -There should have never been only one person attempting to transfer the resident solely. During an interview on 9/25/24 at 12:00 P.M., Agency Licensed Practical Nurse (LPN) D said: -He/She worked with the resident prior to the fall but could not recall how the resident transferred at that time. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-He/She was unaware of the resident's transfer order prior to the residents fall in June. During an interview on 9/25/24 at 1:22 P.M., the Director of Nursing (DON) said: -The resident's transfer orders were in the electronic medical record. -Prior to the resident falling, the residents transfer order was either a standby with two persons assist or a sit to stand with two persons assist. During a phone interview on 9/26/24 at 11:54 A.M., Agency CNA E said: -He/She was giving the resident a shower on the day that he/she fell . -He/She wheeled the resident in the shower chair up to the transfer bar near the toilet and asked the resident to stand up to transfer the resident to his/her wheelchair. -The resident's knee gave out on him/her and he/she lowered the resident to the floor. -He/She was the only staff member in the shower house at the time of the transfer. -He/She was unaware of the resident's transfer orders, but always transferred him/her by himself/herself with a gait belt (A gait belt or transfer belt is a device put on a patient who has mobility issues, by a caregiver prior to that caregiver moving the patient). -He/She was not educated by facility staff on the resident's transfer orders. During an interview on 9/26/24 at 12:00 P.M., the MDS Coordinator said: -A residents transfer orders should have been on the resident's care plan. -He/She did not recall therapy department communicating a transfer technique for the resident prior to the resident's fall. -He/She could not locate the transfer technique on the resident's care plan prior to his/her fall. -Prior to the residents fall, the resident had a transfer order for a sit to stand and two CNA's should have been assisting with the resident transfers. During an interview on 9/27/24 at 11:58 A.M., the DON and the Regional Director of Operations (RDO), said: -The therapy department was in charge of determining how a resident should be transferred and it should be noted in the initial assessment in the electronic medical record. -He/She did not recall therapy department communicating a transfer technique for the resident prior to the resident's fall. -The resident's care plan should have transfer orders within them. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Staff members have access to care plans and transfer orders. -Staff members were educated on where to find a resident's transfer orders, including agency staff members. -The DON and the Administrator were in charge of completing fall investigations. -It would be expected that a fall investigation be completed with: witness statements, root cause analysis, new interventions to prevent future falls, and factors involving the fall. -Prior to fall, the staff were using a sit to stand to transfer the resident. -On the day of the fall, the resident should have had two people assisting with the transfer. -He/She (DON) was unaware that there was one staff member with the resident when he/she fell . During a phone interview on 9/27/24 at 1:42 P.M., Physician A said: -He/She was aware that the resident had a fall in the shower. -He/She was unsure of how the resident was supposed to be transferred at the time of the fall. -He/She did not recall the resident requiring a hoyer lift transfer prior to the fall. -He/She was unaware if the resident should have been a one person, or a two person transfer at the time of the fall, but with the resident's morbid obesity and extreme weight, he/she would not want to transfer the resident alone.

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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. 51150 Based on observation, interview, and record review, the facility failed to ensure communication between the facility and dialysis (a mechanical way to filter the blood and remove waste when the kidneys stop functioning) treatment center was maintained and ongoing to ensure the continuum of care and failed to maintain and implement post dialysis assessment orders to ensure safety for one sampled resident (Resident # 38) out of 19 sampled residents. The facility census was 74 residents. A dialysis policy was requested but not received. 1. Review of Resident #38's Care Plan dated 11/15/22 showed the resident: -Had dialysis three times a week due to End Stage Renal Disease (ESRD- a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life) -Was to be monitored for any signs and symptoms of infection (redness, swelling, warmth, or drainage) to the access site by facility staff. Review of the resident's Physicians Order Sheet (POS) dated 12/29/23, showed: -Facility staff was to ensure the resident was ready by 10:00 A.M., every Monday, Wednesday, and Friday related to dependence on renal dialysis. -Note: There were no orders for assessment of signs and symptoms of infection at the site of dialysis. -Note: There were no orders for assessment of thrill (A vibration felt above the incision line of the fistula. It's caused by blood flowing through the fistula) and bruit (A whooshing or swooshing sound heard near the fistula incision site. It's caused by the high-pressure flow of blood through the fistula). Review of the resident's Quarterly Minimum Data Set (MDS-A federally mandated assessment tool required to be completed by facility staff for care planning) dated 8/20/24 showed the resident: -Was cognitively intact. -Has renal insufficiency, renal failure, or ESRD. -Was receiving dialysis. Observation on 9/23/24 at 10:00 A.M., showed the resident was out of the facility for dialysis. Observation on 9/25/24 at 10:35 A.M., showed the resident was out of the facility for dialysis. During an interview on 9/25/24 at 12:00 P.M., agency Licensed Practical Nurse (LPN) D said: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she was an agency nurse. -He/she worked a couple days a week at the facility. -He/she was unaware of any special orders to complete when the resident returned from dialysis. -The only thing that he/she knew to do upon the resident returning from dialysis was to check and make sure that the resident was not bleeding through his/her dressing and to remove the dressing after 24 hours. -A dialysis communication sheet should be sent with and come back with the resident each time the resident receives dialysis. -The dialysis communication sheets were placed in a binder at the nurse's station, but he/she was unaware of where the location of the binder was. -If the resident failed to return to the facility with the communication sheet, the charge nurse should have called the dialysis company and documented this conversation in a nurses note in the electronic medical record. -The charge nurse was responsible for calling the dialysis company to clarify any new orders that the dialysis company started on the resident. -The dialysis company did not call the facility when the dialysis company initiated new orders. Observation on 9/26/24 at 10:52 A.M., showed: -The resident had an Arteriovenous (AV) Fistula Shunt (An AV fistula is a connection that's made between an artery and a vein for dialysis access) in his/her right arm. -The AV fistula shunt was open to air and not covered. During an interview on 9/26/24 at 11:00 P.M., the resident said: -He/she received dialysis three times per week. -He/she did not recall nurse assessments when he/she returned from dialysis three times per week. During an interview on 9/27/24 at 9:22 A.M., LPN A said: -The facility had a dialysis binder, but it got lost. -He/she was unaware of how long the binder had been missing. -He/she created a new one the day prior. Observation on 9/27/24 at 9:30 A.M., showed: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A new binder was created and at the nurse's station. -No communication forms were in the binder for the resident. -Note: The facility provided dialysis communication forms for: 8/16/24, 8/30/24, and 9/25/24. No other dialysis communication forms could be located for the resident. During an interview on 9/27/24 at 11:58 A.M., the DON and the Regional Director of Operations (RDO), said: -The staff was made aware of changes of condition and new orders from the dialysis center by the dialysis communication form. -The dialysis communication forms were kept in a binder at the nurse's station. -He/she was made aware that the dialysis binder was missing. -He/she was unaware of where the dialysis binder was. -It was expected that if a resident came back from dialysis without a dialysis communication form, the charge nurse was to call the dialysis facility and have the form faxed over to the charge nurse. -It was expected that a resident came back from dialysis with a communication form after every dialysis visit. -It was expected that a dialysis communication form be placed in the dialysis binder each time a resident returned from dialysis. -It was expected that the nursing staff would have completed an assessment of thrill and bruit and infection on residents each time a resident returned from dialysis. -Nursing assessment after a resident returned from dialysis should have been documented in the electronic medical record. -If a resident did not have an order to assess thrill and bruit and assess for infection, it would have been expected that the staff call the physician and get an order. -Treatment administration records and care plans should have included assessment's for thrill, bruit, and signs of infection.

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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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37576 Based on interview and record review, the facility failed to provide the required annual 12 hours of in-service training for Certified Nursing Assistants (CNA). The facility census was 74 residents. Review of the facility Nursing Assistant Training Program Policy dated 5/18/24 showed: -Each nursing assistant shall be provided at least 12 hours of in-service training annually, based on his/her employment date, not calendar year. -It is the responsibility of the employee to attend/complete mandatory in-service training's to maintain employment status with the facility. -A review of the employee's attendance/completion records shall be performed at least annually, such as at time of performance review. -Some of the minimum training includes: --Dementia management and care of the cognitively impaired. --Abuse, neglect, and exploitation prevention. --Resident rights and facility responsibilities. --Behavioral health. --Identification of changes in condition. 1. Review of the Facility assessment dated [DATE] showed: -The facility was licensed for 91 beds. -The average number of occupied beds during the previous quarter was 67.8. -The training time required for newly hired CNA's was 8.25 hours which included: --Compliance and ethics training. --Abuse: preventing, recognizing and reporting. --Resident rights. --Sexual harassment for employees. --Workplace violence. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265425	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Care of cognitively impaired. --Communicating with older adults with dementia. -Use of the computer training program to complete all or some of the CNA required 12 hours of training. Review of the Employee List showed the following five CNA's were employed for the last 12 months or longer: -CNA B hired on 4/5/2022. -CNA C hired on 5/2/2007. -CNA H hired on 7/6/2023. -CNA K hired on 8/8/2023. -CNA L hired on 7/13/2023. Review of the facility In-Services and Education book for last 12 months dated September 2023 to August 2024 showed: -No competency reviews were found for any of the five listed CNA's during the previous 12 months. -The in-services/education sign-in sheets provided did not include the following required training's during the previous 12 months: --Dementia/Alzheimer care. --Misappropriation. --Behavioral training. -CNA B received one hour of in-service which did not include the above required training's or Abuse and Neglect. -CNA C received ten hours of in-service which did not include the above required training's or Abuse and Neglect. -CNA H received eight hours of in-service which did not include the above required training's or Abuse and Neglect. -CNA K received four hours of in-service which did not include the required above training's Abuse and Neglect. -CNA L was not listed on any of the in-service sign in sheets during the previous 12 months. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Requested copies of the computer training for the five listed CNA's from the Director of Nursing (DON) and the Administrator on 9/27/24 and did not receive. During an interview on 9/27/24 at 8:50 A.M., CNA H said: -There were in-service meetings that went over different topics. -In-services were not every month. -Sometimes staff were handed a review sheet to read and sign that he/she read it. -He/She did the computer training's when he/she had time. -He/She was not sure of all the topics that he/she had done. -He/She did not believe he/she had been watched or observed doing resident cares. During an interview on 9/27/24 at 9:13 A.M., CNA J said: -Sometimes staff were handed a review sheet to read and sign that he/she read it. -He/She did the Relias computer training's when he/she had time. -There had been some in person in-services. -He/She has had the Abuse/Neglect, behavioral in-services but not sure of the last time he/she had them or if they were in person or on the computer. During an interview on 9/27/24 at 11:57 A.M., the DON said: -CNA's should receive at least 12 hours of in-services, education and training's a year. -Some of the in-services/education were done through the computer training program. -He/She and the Assistant DON (ADON) could monitor the program. -In-Services, education and training's should include: --Infection Control. --Dementia/Alzheimer care. --Misappropriation. --Behavioral training. --Resident Rights. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In person in-services were held monthly and presented by different facility department heads depending on the subject. -Staff evaluations and competencies should be audited at least quarterly by the DON or the ADON.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37576 Based on observation, interview, and record review, the facility failed to ensure staffing was posted correctly including the total number and actual hours worked for Registered Nurses (RN's), Licensed Practical Nurses (LPN's), Certified Nursing Assistants (CNA's), and Certified Medication Technicians (CMT's) directly responsible for resident care per shift which could have the potential to affect all residents, staff, and visitors of the facility. The facility census was 74 residents. Requested the facility policy for daily posted staffing and did not receive it. 1. Review of the Facility assessment dated [DATE] showed nursing services required daily was: -1 Director of Nursing (DON) full time days. -4 LPN's. -4 CMT's. -10 CNA's. Observation on 9/23/24 at 10:10 A.M., of the glass case bulletin board in the common area near the 600-hall showed: -Staffing sheets for 9/20/24, 9/21/24, 9/22/24 and 9/23/24. -The staffing sheets showed the names of the staff working for each position. -Did not show the number of hours worked for each staff. -Did not show census for the day. Observation on 9/23/24 at 2:46 P.M., of the main nursing station for the 400, 500, and 600 halls showed: -A white board (a wipeable board with a white surface used for posting information that can be erased and rewritten on) on the wall behind main nurse station showed the following: -24-hour daily nursing hours report. -Date of 7/24/24. -Day shift: --RN 16 hours. --LPN 24 hours. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--CMT 24 hours. --CNA 60 hours. -Night shift: --LPN 24 hours. --CMT 24 hours --CNA 60 hours. --One staff doing a 1:1 (a resident needs around the clock supervision). -Did not show the number of staff for each position. -Did not show the census for the day. Observation on 9/23/24 at 2:55 P.M., of the 100, 200, and 300 halls nursing station did not have any posted staffing. Observation on 9/24/24 at 11:02 A.M., of the main nursing station for the 400, 500, and 600 halls showed: -A white board on the wall behind main nurse station showed the following: -24-hour daily nursing hours report. -Date of 7-24-24. -Day shift: --RN 16 hours. --LPN 24 hours. --CMT 24 hours. --CNA 60 hours. -Night shift: --LPN 24 hours. --CMT 24 hours --CNA 60 hours. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--One staff doing a 1:1. -Did not show the number of staff for each position. -Did not show the census for the day. Observation on 9/24/24 at 11:05 A.M., of the glass case bulletin board in the common area near the 600-hall showed: -Staffing sheets for 9/23/24 and 9/24/24. -The staffing sheets showed the names of the staff working for each position. -Did not show the number of hours worked for each staff. -Did not show the census for the day. Observation on 9/24/24 at 11:15 A.M., of the 100, 200, and 300 halls nursing station did not have any posted staffing. During an interview on 9/25/24 at 5:58 A.M., the DON said the night shift had: -Two nurses one on each side of the facility. -Four CNA's on the main side 400, 500, and 600 halls. -One CNA on the back side 100, 200, and 300 halls those residents are more independent with own cares. Observation on 9/25/24 at 8:15 A.M., of the main nursing station for the 400, 500, and 600 halls showed: -A white board on the wall behind main nurse station showed the following: -24-hour daily nursing hours report. -Date of 9/24/24. -Day shift: --RN 16 hours. --LPN 24 hours. --CMT 24 hours. --CNA 60 hours. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Night shift: --LPN 24 hours. --CMT 24 hours --CNA 60 hours. --One staff doing a 1:1. -Did not show the number of staff for each position. -Did not show the census for the day. Observation on 9/25/24 at 8:20 A.M., of the glass case bulletin board in the common area near the 600-hall showed: -Staffing sheets for 9/24/24 and 9/25/24. -The staffing sheets showed the names of the staff working for each position. -Did not show the number of hours worked for each staff. -Did not show the census for the day. Observation on 9/25/24 at 8:25 A.M., of the 100, 200, and 300 halls nursing station did not have any posted staffing. Observation on 9/26/24 at 2:15 P.M., of the main nursing station for the 400, 500, and 600 halls showed: -A white board on the wall behind main nurse station showed the following: -24-hour daily nursing hours report. -Date of 9/26/24. -Day shift: --RN 16 hours. --LPN 24 hours. --CMT 24 hours. --CNA 60 hours. -Night shift: (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--LPN 24 hours. --CMT 24 hours --CNA 60 hours. --One staff doing a 1:1. -Did not show the number of staff for each position. -Did not show the census for the day. Observation on 9/26/24 at 2:20 P.M., of the glass case bulletin board in the common area near the 600-hall showed: -Staffing sheets for 9/25/24 and 9/26/24. -The staffing sheets showed the names of the staff working for each position. -Did not show the number of hours worked for each staff. -Did not show the census for the day. Observation on 9/26/24 at 2:25 P.M., of the 100, 200, and 300 halls nursing station did not have any posted staffing. Observation on 9/27/24 at 9:07 A.M., of the main nursing station for the 400, 500, and 600 halls showed: -A white board on the wall behind main nurse station showed the following: -24-hour daily nursing hours report. -Date of 9/27/24. -Day shift: --RN 16 hours. --LPN 24 hours. --CMT 24 hours. --CNA 60 hours. -Night shift: --LPN 24 hours. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--CMT 24 hours --CNA 60 hours. --One staff doing a 1:1. -Did not show the number of staff for each position. -Did not show the census for the day. Observation on 9/27/24 at 9:10 A.M., of the glass case bulletin board in the common area near the 600-hall showed: -Staffing sheets for 9/26/24 and 9/27/24. -The staffing sheets showed the names of the staff working for each position. -Did not show the number of hours worked for each staff. -Did not show the census for the day. Observation on 9/27/24 at 9:15 A.M., of the 100, 200, and 300 halls nursing station did not have any posted staffing. During an interview on 9/27/24 at 9:20 A.M., CNA J said: -Staffing sheets were in the glass case by the 600 hall on the main nurse's station. -Staffing sheets showed the names of the staff working each shift. -Did not think the staffing sheets were on the 100, 200, 300 nursing station. During an interview on 9/27/24 at 9:20 A.M., LPN A said: -Daily staffing sheets were on the bulletin board on the main nurse's station near the 600 hall. -The staffing sheets showed who was working that day. -Not sure if the staffing sheets should have the hours each staff worked or the facility census. -There was a white board behind the main nurses' station that showed the number of hours for each staff position. During an interview on 9/27/24 at 11:57 A.M., the DON said: -The daily staffing sheet was posted daily in the glass bulletin board at the main nurses' station. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The staffing sheet showed the name of the staff working for each nursing position for that day and shift including the RN. -The staffing sheet did not show the total number of hours worked for each position. -The staffing sheet did not show the daily facility census. -The number of hours worked for each nursing position was on the white board behind the main nursing station. -The facility daily census was not on the white board. -There was no staffing posted on the 100, 200, 300 hall nurses' station. -Daily staffing should include the hours for each position and the facility census. These were not on the same form. -The daily staffing should be posted on the 100, 200, 300 hall side of the facility.

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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** 42955 Based on interview and record review, the facility failed to ensure the Medication Regimen Review (MRR) completed by the pharmacist was reviewed and responded to by the facility physician(s) for two sampled residents (Resident #19 and #45) out of 19 sampled residents. The facility census was 74 residents. Review of the facility's Medication Regimen Review Policy, dated 6/26/24, showed: -Each resident was reviewed at least once a month by a licensed pharmacist. -The MRR was a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. -Review of the medical record was to prevent, identify, and resolve medication-related problems, medications errors and other recommendations. -The pharmacist communicated any irregularities to the facility physician, Director of Nursing (DON), or staff of any urgent needs. -The facility staff acted upon all recommendations according to procedure for addressing medication regimen review irregularities. 1. Review of Resident #19's undated face sheet showed the resident was diagnosed with type 2 diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy) and gout (a type if arthritis causing buildup of uric acid in the joints). Review of the resident's consultant pharmacist progress note dated 9/2/24 in the Electronic Health Record (EHR) showed: -The consultant pharmacist reviewed the resident's medication regimen. -The pharmacist recommended the physician evaluate the need for a scheduled uric acid level on the Physician's Order Sheet (POS) for therapy monitoring due to the resident's Allopurinol (a synthetic drug used to treat gout) 100 milligrams (mg). Review of the resident's EHR showed no physician's response to the pharmacist's recommendation. Review of the resident's POS dated September 2024 showed: -The resident had an order for Allopurinol 100 mg. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-NOTE: There was no order for measuring/monitoring uric acid levels. 2. Review of Resident #45's quarterly MDS dated [DATE], showed: -The resident was moderately cognitively impaired. -The resident's diagnoses included: --Type 2 diabetes. --Epilepsy (a burst of uncontrolled electrical activity between brain cells). Review of the resident's consultant pharmacist progress note dated 9/2/24 in the EHR showed the consultant pharmacist reviewed the resident's medication regimen and provided recommendations for the physician. Review of the resident's EHR, viewed on 9/26/24, showed no physician notes addressing the pharmacist recommendations. 3. During an interview on 9/24/24 at 1:56 P.M., the Director of Nursing said: -He/She received pharmacist recommendations through email. -He/She was unaware they were available in the EHR. -He/She reviewed emails from the pharmacist and talked to the physician about the recommendations. -He/She also talked to the physicians in person. -He/She had no documentation of discussing recommendations with the physician. -When the physicians come in he/she reviewed the pharmacist recommendations with the physicians and told them what the pharmacy recommendations were. -They then made the updates. During an interview on 9/24/24 at 2:06 P.M., the consultant pharmacist said: -He/She had been serving the facility as the consultant pharmacist for ten years. -He/She conducted MRR's every 30 days, usually in the first seven days of the month. -He/She put recommendations into the EHR. -The Physician then went into the EHR to address the recommendations. -He/She ran reports from the EHR that indicated if the physician had seen the new recommendations and their response. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Sometimes the recommendations were not addressed for six months and he/she had to redo the recommendations. During an interview on 9/25/24 at 12:21 P.M., the Administrator said he/she was unable to locate any physician responses for Residents #19 and #45 During an interview on 9/26/24 at 11:16 A.M. the Assistant Director of Nursing (ADON) said: -He/She was not familiar with MRR's yet, and did not have email access. -The pharmacist was able to access the EHR and enter recommendations for the physician. -The physician viewed the recommendations in the EHR. During an interview on 9/27/24 at 11:58 A.M., the DON said: -The pharmacist made recommendations in the EHR. -The physician was able to go in the EHR and document his/her responses. During an interview on 9/27/24 at 11:58 A.M., the Regional Director of Operations (RDO) said if there was no documentation then he/she could not prove it was being done.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 39469 Based on observation, interview, and record review, the facility failed to ensure medication carts were locked when staff was not in sight of the cart, failed to ensure medication carts were clean and did not contain other non medical objects, failed to ensure the medication refrigerator's temperature was within temperature range by not checking it daily, failed to ensure nursing staff was counting narcotics at the beginning and end of each shift for three sampled residents, (Resident #61, #42, and #325) out of 19 sampled residents. The facility census was 74 residents. Review of the facility's policy, Medication Storage Policy, dated 5/18/24 showed: -All drugs and biologicals would have been stored in locked compartments under proper temperature controls. -During a medication pass, medications must be under the direct observation of the person administering medications or locked. -Any discrepancies which could not been resolved must have been reported immediately as follows: -Notify the Director of Nursing (DON), charge nurse, or designee and the pharmacy. -Complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted. -Staff may not leave the area until discrepancies were resolved or reported as unresolved discrepancies. -All medications requiring refrigeration were to have been stored in refrigerators located in the medication rooms. -Temperatures were to have been maintained within 36 to 46 degrees Fahrenheit (F). -Charts were to have been kept on each refrigerator and temperature levels were to have been recorded daily by the charge nurse or other designee. -In the event that a refrigerator was malfunctioning, the person discovering the malfunction must promptly report such finding to the Maintenance Department for emergency repair. Review of the facility's policy, Controlled Substance Administration and Accountability Policy, dated 5/14/24 showed: -The facility would have safeguards in place in order to prevent loss, diversion or accidental exposure. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The charge nurse or other designee was to have conducted a daily audit of the required documentation of controlled substances. -Areas without an automated dispensing systems utilize a substantially constructed storage unit with two locks and a paper system for for 24 hour recording of controlled substance use. -The amount on hand was to have been checked against the amount used daily from the documentation records. -For areas without an automated dispensing system, two licensed nurses account for all controlled substances and access keys at the end of each shift. -Any discrepancy in the count of controlled substances or disposition of the narcotic keys was to have been resolved by the end of the shift during which it was discovered. -Staff may not leave the area until discrepancies were resolved. 1. Observation on 9/25/24 at 7:03 A.M. of the 100/200/300 hall Nurses' medication cart with Licensed Practical Nurse (LPN) B showed: -There was a container of bleach wipes and a bottle of isopropyl alcohol (rubbing alcohol used in cleaning) in the locked narcotic box with the residents' prescribed medications. -There was a pair of used toe nail clippers, a lighter, a box cutter, a computer mouse, and a stapler in a drawer with the residents' prescribed medications. During an interview on 9/25/24 at 7:03 A.M. LPN B said: -There should not have been any other items in with the residents' prescribed medications. -The person who had used the cart was responsible for ensuring it was clean and there were no items that didn't belong in the medication cart. 2. Observation on 9/25/24 at 7:26 A.M. of the Certified Medication Technician's (CMT) medication cart for 100/200/300/ halls with CMT C showed: -The drawers had a brown colored debris in with the residents' prescribed medications. -There was one loose red oblong pill in a drawer with the residents' prescribed medications. During an interview on 9/25/24 at 7:26 A.M. CMT C said: -There should not have been loose pills in the medication cart drawers. -The person who had used the cart was responsible for ensuring it was clean and there were no items that didn't belong in the medication cart. 3. Observation on 9/25/24 at 7:26 A.M. showed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The night shift nurse (LPN C) left without counting the narcotics in the locked medication drawer with the day shift CMT (CMT C) for the CMT medication cart for the 100/200/300 halls. During an interview on 9/25/24 at 7:26 A.M. CMT C said: -The night shift nurse should have counted the narcotics with him/her before leaving. -There were many blanks where there should have been two signatures verifying the count was correct. -The person coming on shift counts with the off going staff and both of them should have signed at the same time they had counted. -If there was a blank space the DON should have been notified. -He/She had not notified the DON but should have when there were not two signatures. -He/She would count without the second person to count with him/her. During an interview on 9/25/24 at 7:30 A.M. LPN B said: -He/she had told the night shift nurse (LPN C) not to leave before counting with the day shift CMT. -The narcotic count should have been signed by two nurses at the beginning and end of each shift. -The oncoming nurse should have counted with the off going nurse. -There should not have been any blanks. -The DON should have been notified. -He/she knew there were many blanks but had not said anything to the DON. During an interview on 9/25/24 at 7:30 A.M. LPN C declined to be interviewed. Observation on 9/26/24 at 8:20 A.M. showed the night shift nurse (LPN C) left without counting with the day shift CMT. During an interview on 9/26/24 at 8:20 A.M. LPN B said he/she had told the night shift nurse not to leave before counting with the day shift CMT. During an interview on 9/26/24 at 8:20 A.M. LPN C declined to be interviewed. 4. Observation on 9/25/24 at 7:47 A.M. of the medication pass with CMT C showed: -He/She went into a resident's room to administer medications. -He/She left the medication cart unlocked for three minutes while in the resident's room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The cart was facing outward. -One resident walked by the unlocked cart within two feet of it. Observation on 9/25/24 at 7:51 A.M. of the medication pass with CMT C showed: -He/She went into a resident's room to administer medications. -He/She left the medication cart unlocked for two minutes while in the resident's room. -The cart was facing outward. -One resident walked by the unlocked cart within two feet of it. Observation on 9/25/24 at 7:55 A.M. of the medication pass with CMT C showed: -He/She went into a resident's room to administer medications. -He/She left the medication cart unlocked for two minutes while in the resident's room. -The cart was facing outward. -One resident walked by the unlocked cart within two feet of it. During an interview on 9/25/24 at 7:55 A.M. CMT C said if staff were not in front of the medication cart it should have been locked he/she had forgotten to lock the cart. During an interview on 9/25/24 at 8:30 A.M. LPN B said staff should never leave the medication cart unlocked if they were not directly in front of it. 5. Observation on 9/25/24 at 8:00 A.M. of the September 2024 medication refrigerator log for 100/200/300 hall with LPN B showed: -Out of 24 shifts, 11 shifts showed the temperature was blank, indicating it was not checked. -On 9/14/24 showed there was no thermometer. -There was no documentation from 9/14/24 to 9/23/24. -On 9/24/24 the temperature was recorded at 25.0 degrees Fahrenheit (F) (below freezing) and the refrigerator's temperature was reset. --There was no documentation the temperature was rechecked. --There was no documentation the maintenance department was notified. -There were more than 10 insulin pens in the medication refrigerator, directions on the box said to keep insulin between 36 to 46 degrees F do not freeze. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-One vial of Tuberculin (TB -a bacteria, a skin test for TB injected into the skin) was in the refrigerator, directions said TB was to be stored at 35 to 46 degrees F. -There was no documentation the pharmacy had been notified about the medications that had been at a temperature that was out of range. During an interview on 9/25/24 at 8:10 A.M. LPN B said: -The night shift nurse was responsible for checking the temperature in the medication refrigerator. -There should not have been any days missed. -If the temperature was out of range the nurse should have told the charge nurse. -He/She did not know what to do if the medications had been frozen. -The DON was ultimately responsible for ensuring medications were stored at the correct temperature. 6. Review of Resident #61's Individual Patient Narcotic Record with LPN B showed: -The resident had a Physician's order for Hydrocodone/Tylenol (pain medication) 5/325 milligram (mg) one or two tablets by mouth to be given every six hours as needed. -On 9/22/24 the count was 60. -From 9/22/24 to 9/25/24 10 times two tablets were given for a total of 20 tablets. -The remaining amount documented was 42 tablets (verified by surveyor and LPN B). -60 tablets minus the 20 given should have equaled 40. 7. Review of Resident #42's Individual Patient Narcotic Record with LPN B showed: -The resident had a Physician's order for Lorazepam (used to treat anxiety) 0.5 mg tablet one tablet by mouth every four hours as needed. -On 9/17/24 the count was 15. -On 9/17/24 the medication was given twice. -The remaining amount was 11 (verified by surveyor and LPN B). -The count was corrected by staff to have been 11. -15 minus 2 should have equaled 13. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. Review of Resident #325's Individual Patient Narcotic Record with LPN B showed: -The resident had a Physician's order for Tramadol Hydrochloride (medication for moderate to severe pain) 50 mg tablet to be given every six hours as needed. -The resident had a second order for Tramadol Hydrochloride 50 mg tablet to be given every six hours. -On 9/20/24 at 12:00 A.M. the record showed the resident received one as needed pill from the nurse and one as needed pill from the CMT. -On 9/25/24 at 6:00 A.M. the nurse gave the resident one scheduled pill and one as needed pill. -LPN B did not know why this had happened. -The DON should have been notified, he/she had not reported anything to the DON. 9. Review of the CMT Narcotic Count sheet dated July 2024 showed: -7/1/24 to 7/8/24 (two shifts per day with two signatures per shift) out of 32 opportunities there were 23 times there were missing signatures. -There were 11 out of 16 shifts with no card count at the end of the shift. -Started with 11 cards, four were added, two were subtracted should have equaled 13, facility showed 11. -7/9/24 to 7/26/26 the narcotic count sheet was missing. -7/27/24 to 7/31/24 out of 20 opportunities there were 11 times there were missing signatures. -There were 7 out of 10 shifts with no card count at the end of the shift. Review of the CMT Narcotic Count sheet dated August 2024 showed: -8/1/24 to 8/30/24 (two shifts per day with two signatures per shift) out of 120 opportunities 55 times there were missing signatures. -There was no documentation for 8/31/24. -There were 23 out of 60 shifts with no card count at the end of the shift. -Started with 11 cards, 12 were added, eight were subtracted should have equaled 15, facility showed 9. Review of the CMT Narcotic Count sheet dated September 2024 showed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-9/1/24 to 9/25/24 (two shifts per day with two signatures per shift) out of 96 opportunities 60 times there were missing signatures. -There were 26 out of 48 shifts with no card count at the end of the shift. 10. Review of the Nurses' Narcotic Count sheet dated July 2024 showed: -7/1/24 to 7/31/24 (two shifts per day with two signatures per shift) out of 124 opportunities 15 times there were missing signatures. -There were 29 out of 62 shifts with no card count at the end of the shift. Review of the Nurses' Narcotic Count sheet dated August 2024 showed: -8/1/24 to 8/31/24 (two shifts per day with two signatures per shift) out of 124 opportunities 12 times there were missing signatures. -There were 14 out of 62 shifts with no card count at the end of the shift. -Started with 15 cards, four were added, 10 were subtracted should have equaled nine, facility showed 10. Review of the Nurses' Narcotic Count sheet dated September 2024 showed: -9/1/24 to 9/25/24 (two shifts per day with two signatures per shift) out of 98 opportunities 16 times there were missing signatures. -There were 13 out of 48 shifts with no card count at the end of the shift. -On 9/25/24 the night shift nurse had pre signed the Narcotic count sheet before the day shift nurse arrived at the facility. 11. During an interview on 9/27/24 at 12:00 P.M. the DON said: -Staff were to keep the medication carts locked if they were not directly in front of it. -Two nursing staff were expected to count the narcotics at the beginning and end of each shift. -The on coming nurse and the off going nurse would count at the same time ensuring the count was correct. -There should not have been any blank spaces, or he/she should have been notified. -The DON and Assistant DON have done audits weekly on the narcotic count sheets. -There should not have been an non medical objects in the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The staff member who had used the cart was responsible for ensuring the cart was clean without other objects in it. -Pharmacy also did cart audits. -The night shift charge nurse was responsible for ensuring that the medication refrigerator was within range, every night shift. -If the medication refrigerator was out of range it was expected staff notified the maintenance department so it could be adjusted and the medication did not freeze. -If the medications were out of range then the Pharmacy should have been notified and they would have directed them what to do. -The acceptable temperature range for the medication refrigerator was 36 to 42 degrees F. -The temperature should have been rechecked if it had been adjusted and documented on the temperature log sheet. -The DON, Charge Nurse, and CMT did weekly audits of the temperature on the medication refrigerator.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727 Based on observation, interview and record review, the facility failed to provide dental services to two sampled residents (Resident #33 and #51) out of 19 sampled residents. The facility census was 74 residents. Review of the facility's policy titled Dental Services dated as revised on 6/26/24 showed: -The dental needs of each resident were identified through the physical assessment and Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) assessment process and were addressed in each resident's plan of care. -The oral/dental status of the resident would be documented according to assessment findings. -Oral care and denture care would be provided for identified needs and as part of the resident's plan of care. -Referrals to a dental provider were to be made as appropriate. -The Social Services Director maintained contact information for dental service providers. -The facility would assist the resident with making dental appointments and arranging transportation. 1. Review of Resident #33's baseline care plan dated 2/5/21 did not include anything about the resident's teeth. Review of the resident's dental progress note dated 2/13/23 showed: -The resident was interested in dentures. -Four of the resident's teeth were removed. Review of the resident's dental progress note dated 2/16/23 showed: -Four of the resident's teeth were removed. -The fifth tooth was not removed because the resident did not get numb on that tooth. Review of the resident's annual MDS dated [DATE] showed the staff assessed the resident as having no dental issues. Review of the resident's monthly nurse's dental notes dated 4/6/24 showed the staff assessed resident as: -Had his/her own teeth. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Had cavities and/or broken teeth. -Did not have: --Broken or loosely fitted dentures. --Mouth or facial pain. --Discomfort/difficulty with chewing. --Abnormal mouth tissue. --Inflamed/bleeding gums or loose teeth. Review of the resident's dentist's progress note dated 5/1/24 showed: -The resident had one tooth and one root tip on the bottom jaw. -Alveoloplasty (a common dental procedure often performed following a tooth extraction) was needed with maxillary (upper) teeth extractions. Review of the resident's monthly nurse's dental notes dated 5/14/24 and 7/2/24 showed the staff assessed the resident as: -Had his/her own teeth. -Did not have: --Broken or loosely fitted dentures. --Cavities or broken teeth. --Mouth or facial pain. --Discomfort/difficulty with chewing. --Abnormal mouth tissue. --Inflamed/bleeding gums or loose teeth. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident: -Was moderately cognitively impaired. -Had no hearing, speech, or vision impairment. -Was independent with eating and oral hygiene. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan revised 7/28/24 showed nothing was included regarding the resident's teeth. Review of the resident's Physician's Order Sheet (POS) dated September 2024 showed a physician's order dated 11/14/22 that the resident may see a dentist. Review of the resident's monthly nurse's dental notes dated 9/6/24 showed the staff assessed the resident as: -Had his/her own teeth. -Did not have: --Broken or loosely fitted dentures. --Cavities or broken teeth. --Mouth or facial pain. --Discomfort/difficulty with chewing. --Abnormal mouth tissue. --Inflamed/bleeding gums or loose teeth. Review of the resident concerns questionnaire dated 9/15/24 showed the resident did not need dental services. Observation on 9/24/24 at 8:58 A.M. showed the resident: -Had multiple missing teeth. -The teeth the resident had were discolored black and/or yellow. -Had multiple teeth that were misaligned and/or were broken. During an interview on 9/24/24 at 8:58 A.M. the resident said: -He/She asked about seeing a dentist at least a month ago. -He/She did not remember who he/she asked about seeing a dentist. -He/She desperately needed to see a dentist. -He/She needed all his/her teeth pulled. During an interview on 9/25/24 at 9:50 A.M., the MDS Coordinator said: (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's teeth were in poor condition and needed to be removed. -The resident's teeth were damaged from Lithium (a medication used to treat mood disorders and reduces the amount of saliva in one's mouth which can lead to dental issues such as tooth decay and gum disease). -The comprehensive MDS indicating the resident had no dental issues was inaccurate. -He/She should have included dental needs in the resident's care plan. -They needed to schedule an appointment for the resident because he/she needed to have all his/her teeth removed. During an interview on 9/24/24 at 3:26 P.M., the Social Services Director said: -He/She was new to the facility. -He/She looked at the resident's most recent dental notes (5/1/24). -Nothing was done after the dentist's recommendation (from 5/1/24) for teeth extractions. -The Social Services Director would have been responsible for scheduling the teeth extractions and obtaining transportation. During an interview on 9/27/24 at 11:57 A.M., the Director of Nursing (DON) said: -Nursing staff and Social Services were responsible for assessing the condition of residents' teeth. -They discussed residents' teeth in their daily nurses' meeting. -Nursing would normally obtain an order for the dental procedure that was recommended. -When dental services were needed, they sent an email to the Social Services Director to schedule an outside dental appointment. -They should have followed up with the dental recommendations made. 51303 2. Review of Resident #51's undated Face Sheet showed he/she was initially admitted on [DATE] and the most recent admission to the facility on [DATE] with the following diagnoses: -Heart Failure (HF-disorder that impairs the ability of the heart to fill with or pump a sufficient amount of blood throughout the body) -Chronic Pain Syndrome (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Venous Insufficiency (Chronic) (Peripheral) condition in which the veins have problems sending blood from the legs back to the heart. -Cellulitis (an infection of deep skin tissue) of unspecified part of limb. Review of the resident's current Order Summary Report showed a physician's order dated 2/21/24 that the resident may see the dentist. Review of the resident's Admission MDS dated [DATE] Section L, Dental, showed no issues with teeth. Review of the resident's Nutrition Assessment -Registered Dietician Evaluation dated 3/16/24 showed: -He/She was on a regular diet and regular consistency. -Resident had his/her own teeth. Review of the resident's Quarterly MDS's dated 6/1/24 and 8/30/24 Section L, Dental, showed the resident had no issues with his/her teeth. During an interview on 9/23/24 2:02 P.M. the resident said: -He/She was unsure the last time he/she saw a dentist. -He/She had missing teeth. -He/She wanted dentures. Observation on 9/23/24 at 2:02 P.M. showed the resident had multiple teeth missing. During an interview on 9/24/24 at 2:44 P.M. the Social Service Director (SSD) said: -He/She was new to the facility. -He/She did the admission contract and would obtain consent forms. -He/She did not know if the resident had seen the dentist. During an interview on 9/25/24 at 11:12 A.M. Licensed Practical Nurse (LPN) B said: -He/She was contract staff. -He/She was not aware of the resident's missing teeth or request to see dentist. During an interview on 9/26/24 at 11:52 A.M. the MDS Coordinator said: -He/She was not aware of the resident's missing teeth. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38452 Based on observation and interview the facility failed to keep the walk-in refrigerator, and walk-in freezer floors clean; failed to retain operable thermometers in all refrigerators and/or freezers to confirm adequate temperature ranges; failed to safeguard against foreign material possibly getting into food and/or beverages; failed to keep trash dumpsters lidded; failed to consistently measure and document hot food temperatures at the oven and/or stove, or steam table to ensure they were suitably cooked, and cooked longer if needed, to lessen the chance of bacterial contamination; failed to maintain plastic and/or rubber cutting boards and utensils in good condition to avoid food safety hazards (cross-contamination); failed to separate damaged foodstuffs; failed to store foodstuffs within acceptable temperature parameters; and failed to ensure the proper labeling, refrigeration, and/or disposal of foodstuffs to preserve their freshness, in accordance with State of Missouri rules and regulations, established national guidelines, and professional standards for food service safety. These deficient practices had the potential to affect all residents, visitors, volunteers, and staff who ate food from the kitchen. The facility's census was 74 residents with a licensed capacity for 91 residents at the time of the survey. 1. Observation on 9/23/24 between 9:24 A.M. and 10:10 A.M. during the initial kitchen inspection with the Dietary Manager (DM) showed the following: -The ice machine in the kitchenette off the kitchen proper had a non-sealing gasket on its lid. -The manual can opener had paper debris on the blade. -A red handled spatula in the top utensil drawer that had chips on and around its blade and crumbs in the bottom of its drawer and the middle drawer. -Four of five 50 ounce (oz.) cans of cream of chicken soup on a baker's rack in the Dry Storage (DS) were dented on their sides and/or upper rims and a 6 pound (lb.) 14 oz. large can of black beans on the can dispenser rack was heavily dented on its side -One open 1 gallon (gal.) jug of 13 jugs of soy sauce on a bottom shelf of a rack in the southwest corner of the DS was approximately (app.) 3/5 full and its label read to Refrigerate after Opening for Quality. -The green, beige, white, and red cutting boards by the east window were excessively scored to the point of plastic flaking off. -There were 15 undated jars of 16 oz. grated parmesan cheese in the walk-in refrigerator with plastic trash and a lettuce leaf on the floor, and an undated 4 oz. vanilla ice cream cup and paper trash on the floor of the walk-in freezer. -There were no visible thermometers in the Serving Room refrigerator or either of the walk-ins. (continued on next page)

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Edgewood Manor Health Care Center	11900 Jessica Lane Raytown, MO 64138

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 9/23/24 at 11:48 A.M. during the initial facility Life Safety Code (LSC) outdoor perimeter inspection with the Maintenance Supervisor (MS) showed the north lid of the west dumpster was flipped backward completely. Observation on 9/24/24 at 12:01 P.M. during a follow-up outer perimeter LSC inspection showed the north lid of the west dumpster was flipped backward completely. Observation on 9/24/24 between 12:26 P.M. and 12:43 P.M. showed the following: -There was a red handled spatula in the top utensil drawer that had chips on and around its blade and crumbs in the bottom of its drawer and the middle drawer. -Two remaining 50 oz. cans of cream of chicken soup on the baker's rack in the DS were dented on their sides and/or upper rims and a 6 lb. 14 oz large can of black beans on the dispenser rack was heavily dented on its side. -One open 1 gal. jug of 13 jugs of soy sauce app. 3/5 full on a bottom shelf in the southwest corner of the DS read Refrigerate after Opening for Quality on its label. -The green, beige, white, and red cutting boards by a window were excessively scored. -There were 15 16 oz. undated jars of grated parmesan cheese in the walk-in refrigerator with a lettuce leaf on a bottom shelf and butter pod on the floor. -There was no thermometer in the Serving Room fridge or either of the walk-ins. -The food temperature log sheet for 9/2/24 in a binder by the walk-in refrigerator had temperatures recorded for breakfast and lunch, but none for dinner, and no further days filled out. Observation on 9/25/24 at 9:45 A.M. during another follow-up outer perimeter LSC inspection showed the south lid of the west dumpster was flipped backward completely. During an interview on 9/26/24 at 1:44 P.M. the new DM said the following: -The cooks were responsible for cleaning the walk-in floors. -He/She would expect if a foodstuff read store at a certain temperature on its label that it would be. -Damaged foodstuffs were separated out, they contact the food vendor for a credit, and then they are thrown out. -Damaged food preparation items were brought to their attention by the dietary staff and replaced. -He/She would expect food to be free of foreign substances. -Food temperatures should be taken and recorded when they were done cooking, when they were served, and if a resident complained about it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Refrigerators and freezers should have extra thermometers inside. -After each meal or meal clean-up the leftover garbage was thrown away, bagged up, and taken outside to the dumpsters.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37576 Based on interview and record review, the facility failed to ensure documentation and monitoring for ongoing hospice care (a type of health care that focuses on comfort care of a terminally ill resident) visits and communication with hospice staff, and failed to obtain pertinent documentation of the delivery of hospice care services for one sampled resident (Resident #42) out 19 sampled residents. The facility census was 74 residents. 1. Review of Resident #42's Admission Record showed he/she was admitted on [DATE] and admitted to hospice on 9/11/24 with the following diagnoses: -Dementia (a general term for a decline in mental ability resulting in memory loss) 4/16/24. -Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions) 4/16/24. -Senile degeneration of the brain (also known as Senile dementia- a mental deterioration [loss of intellectual ability] that is associated with or the characteristics of old age) 9/12/2024. Review of the resident's hospice communication book had the following documents: -The Long-Term Care/Hospice Coordination of Care Form which showed: --Code Status as Full code. --The resident's room number. --Hospice Diagnosis: Senile Degeneration of the Brain. --The name of the Hospice Company. --Hospice Nurse visits on these days: 1-2 times a week. --Long-Term Care Aide to provide Bath/Shower on these days: 2 times a week. --Hospice Aide to provide Bath/Shower on these days: 2-3 times a week. --Wound care shows N/A. --Dated 9/11/24 by a Registered Nurse (RN). -Sign In sheets showed: --9/11/24 by the RN admission nurse. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--9/13/24 (unable to read the signature or title of person). -No other documentation was in the book. -No documentation of any hospice staff seeing the resident after admission to current date of 9/24/24. -No Care Plan in book. -No Physician named. Review of the resident's Physicians Order Summary dated September 2024 showed Do Not Resuscitate (DNR - an order from a doctor that resuscitation should not be attempted if a person suffers cardiac or respiratory arrest) dated 9/19/24. Review of the resident's DNR showed it was signed by the resident representative on 9/19/24. Review of the resident's DNR showed it was signed by the resident's physician on 9/19/24. During an interview on 9/24/24 at 2:09 P.M., Certified Nursing Assistant (CNA) J said: -He/She knew when a resident went on to hospice from the daily report from off going shift. -A resident's code status was in the resident's chart. -Not sure what information was in a resident's hospice book. -Did not know when the hospice nurse or aide visited the resident. During an interview on 9/27/24 at 11:57 A.M., the Director of Nursing(DON) said: -All information of hospice cares or visits for a hospice resident should be in the resident's hospice book. -The hospice nurse's admission of a resident to hospice should be in the resident's hospice book. -The hospice nurse saw the resident weekly and informed the DON of any changes or updates to the resident before leaving the facility. -The hospice nurse visits and what they did should be in the resident's hospice book. -The hospice aide saw the resident at least weekly and did cares including bathing/showering. -The hospice aide visits should be in the resident's hospice book with what cares were done. -The hospice aide informed the DON of what he/she did and any changes to the resident before leaving the facility. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The hospice staff informed the facility DON of any changes to the resident's care verbally and put it in the hospice book. -The resident's care was coordinated between the hospice staff and facility staff by communicating verbally with the DON and writing it in the resident's hospice book. -The following information should be in the resident's hospice book: --The name of the resident's Physician. --A hospice care plan. --What the resident's cares should be. --The hospice staff that visited the resident with the date and what cares were performed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38452 Based on observation, interview, and record review, the facility failed to establish and maintain a comprehensive, facility-specific infection prevention and control program designed to help prevent the development and transmission of Legionella (A [NAME] of pathogenic Gram-negative bacteria that includes the species L. pneumophila, causing legionellosis, all illnesses caused by Legionella, including a pneumonia-type illness called Legionnaires' disease and a mild flu-like illness called Pontiac fever) and/or other water-borne pathogens (a bacterium, virus, or other microorganism that can cause disease), in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) standards and guidelines. This deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in the facility. The facility failed to properly screen and follow their policies for tuberculosis (TB-a communicable disease that affects especially the lungs, that is characterized by fever, cough, difficulty in breathing, abnormal lung tissue and function) for eight out of nine new employees sampled for TB screening. This practice had the potential to affect all residents, employees, and visitors to the facility. The facility failed to ensure staff practiced Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities example residents with wounds or indwelling medical devices) for one sampled resident (Resident #49) who had a colostomy (a surgical opening into the large intestine), for one sampled resident (Resident #28) who had a supra pubic catheter (a surgically created connection between the bladder and the skin to drain urine from the bladder in individuals with an obstruction of normal urinary flow), and one sampled resident (Resident #20) who had a pressure ulcer (an injury to the skin and underlying tissue resulting from prolonged pressure on the skin), failed to ensure staff was educated on EBP, failed to ensure staff were cleansing their hands during a medication pass, and failed to ensure a nebulizer mask (liquid medicine delivered as a mist that was inhaled through a mouthpiece or mask) was kept in a sanitary condition for one sampled resident (Resident #41) out of 19 sampled residents. The facility census was 74 residents with a licensed capacity for 91 residents at the time of the survey. 1. Observation on 9/23/24 between 9:24 A.M. and 10:10 A.M. during the initial facility Life Safety Code (LSC) kitchen inspection with the Dietary Manager (DM) showed there was a three-sink area, an ice machine, a low-heat chemical dish-washing machine, and a hand-washing sink. During an interview on 9/23/24 at 2:07 P.M. the Administrator said the following: -They had only been working at this facility for about six months and they had not had the chance to go through the whole disaster manual yet. -They could not say if there was a copy of their disaster manual at the nurses' desks. Review of the undated binder from their East Nurse Station entitled Edgewood Manor Disasters Book showed it was full of their residents' admission face sheets only. Observation on 9/24/24 between 3:10 P.M. and 3:45 P.M. during the facility LSC walk-through inspection with the Maintenance Supervisor (MS) showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The building was equipped with a full fire sprinkler system and had its incoming water supplied by the local water company. -There was a piped fire sprinkler riser room (A dedicated space for fire protection equipment) which served the whole facility's system. -There were housekeeping closets and water heaters throughout the six resident room hallways. -There were at least 54 resident rooms with private or shared bathrooms and sinks. -There was a laundry area with two commercial grade clothes washers. -There were two Shower Rooms, two gender specific public restrooms, and a Beauty Shop with a sink. Review of the facility's binder entitled Edgewood Manor Disaster Manual, last reviewed 2/27/23 and provided by the Administrator, under the heading, Legionnaire - Water Management Program, was a 35-page policy and procedure which showed the following: -The answers to the 2-page Worksheet to Identify Buildings at Increased Risk for Legionella Growth and Spread showed the building was a healthcare facility that housed people primarily older than 65-years overnight and therefore needed a water management program. -The Water Management Facility Documentation Form listed a previous Administrator and Maintenance Supervisor. -The page with the heading Water System Diagram had a written explanation of the water flow throughout the facility, but no schematic, diagram, or flowchart of the facility's water system that indicated areas of risk with the potential likelihood and risk level for each. -There was no facility-specific risk management plan assessment that considered all elements of the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) industry standard #188. -There was no completed CDC toolkit assessment. -There were sampling results on the water analyzed 8/16/24, but no documentation of any site logbook being maintained with any cleanings, sanitizings, descalings, and/or inspections mentioned. During an interview on 9/26/24 at 12:53 P.M. the MS said the following: -He/She took samples of the facility's water and sent them off to a lab for testing. -He/She was somewhat familiar with the federal requirements. -He/She educated themselves on them by reading their policy and asking the lab questions about it. During an interview on 9/26/24 at 2:46 P.M. the Administrator said the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Their MS was responsible for implementing the Legionella program. -He/She believed they were aware of some of the basic requirements. -They had not had a chance to look at all of their policy, however. 22727 2. Review of the facility's policy titled Tuberculosis Testing dated 6/29/23 showed new employees would receive a two-step Tuberculin Skin Test (TST-used to screen for TB). Review of the facility's list of employees hired since the facility's last annual survey showed: -Employee A was hired on 7/16/24. -Employee B was hired on 6/25/24. -Employee C was hired on 5/29/24. -Employee D was hired on 8/27/24. -Employee E was hired on 6/25/24. -Employee G was hired on 4/17/24. -Employee H was hired on 8/6/24. -Employee J was hired on 7/2/24. Review of the above employees' employee files showed employees A, B, C, D, E, G, H, and J did not have any TSTs completed. During an interview on 9/24/24 at 3:46 P.M., the Human Resources Director said: -He/She started working at the facility at the end of July 2024. -He/She asked the Director of Nursing (DON) to make sure the employee TSTs were completed. During an interview on 9/25/24 at 1:19 P.M., the Administrator said: -They were supposed to be doing TSTs on new employees when they were in orientation at another facility owned by the same company. -He/She thought it was being done there but it was not. -The TSTs should have been done prior to hire. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/27/24 at 11:57 A.M., with the DON present, the Regional Director of Operations (RDO) said: -The TSTs were supposed to be administered on the employee's first day of orientation at another facility, which was their human resources hub. -The TSTs were supposed to be read 48 hours after administration at this facility where the DON was supposed to print the form, read the TST and sign the form. -The TST had to be read before the employee worked on the floor. -The second-step of the TSTs were to be given at the facility they were working at within 21 days of the first TST being read. -The second-step TST was the responsibility of the DON. -They just got a Human Resources Director for this facility in July 2024, so the responsibility of TB screening will shift to the Human Resources Director. 37576 3. Review of the facility's policy, Infection Prevention and Control Program, dated 5/7/24 showed: -The designated Infection Preventionist was responsible for oversight of the program and served as a consultant to out staff on infectious diseases, implementing isolation precautions, staff and resident exposures, surveillance, and investigations of exposures of infectious diseases. -See Infection Preventionist Policy. -All staff were responsible for following all policies and procedures related to the program. -A system of surveillance was to have been utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. -The Infection Preventionist serves as the leader in surveillance activities, maintained documentation of incidents, findings, and any corrective actions made by the facility and reported surveillance finding to the facility's Quality Assessment and Assurance Committee. -All staff should have assumed that all residents were potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. -Hand hygiene was to have been performed in accordance with the facility's established hand hygiene procedures. -All staff was to have used personal protective equipment (PPE) according to established facility policy governing the use of PPE. See PPE policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Licensed staff was to have adhered to safe injection and medication administration practices, as described in relevant facility policies. -All staff would have received training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function. -All staff was to have demonstrated competence in relevant infection control practices. -Direct care staff was to have demonstrated competence in resident care procedures established by our facility. -The facility would have conducted an annual review of the infection prevention and control program, including policies and procedures based upon the facility assessment which included any facility and community risk. -Following the review, the infection and prevention control program would have been updated as necessary. The facility did not have a policy for Infection Preventionist. The facility did not have a policy for EBP. The facility did not have a hand washing policy. Review of Resident #28's Admission Record showed he/she was admitted with the following diagnoses: -Neuromuscular Dysfunction of the Bladder (a disorder of urinary bladder control due to damage to the spinal cord or to the nerves supplying the bladder). -Retention of urine (a condition in which urine cannot empty from the bladder). Review of the resident's Physicians Order Summary (POS) dated September 2024 showed: -Supra Pubic Catheter 20 FR (French scale -a unit of measurement used to size catheters) with a 30 cubic centimeter (cc-a measure of volume in the metric system) balloon (a flexible part of the catheter tip that is inflatable to hold the catheter in the bladder). -Cleanse urostomy (Urinary diversion - a surgically created opening in the abdominal wall through which urine passes) site with wound cleanser twice a day (BID) and as needed (prn); cover with abdominal pad dressing (ABD pad an extra thick primary or secondary dressing used for wounds) two times a day for Prophylaxis (action taken to prevent disease, especially by specified means or against a specified disease). Observation on 9/23/24 at 1:18 P.M., of the resident's room showed: -No posted signage on the door or near the door for EBP precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-No isolation cart outside the room for the required Personal Protective equipment (PPE-gowns, gloves, face masks, goggles or face shields) for staff to wear while doing resident cares. Observation on 9/24/24 at 1:15 P.M., of the resident's Suprapubic catheter care and Perineal care (care to the area between the anus and the exterior genitalia) showed: -Certified Nursing Assistants (CNA)'s J, CNA M and Licensed Practical Nurse (LPN) A did not put on the EBP PPE before entering the resident's room. -CNA J and CNA M did not change gloves after the perineal care before changing the resident's bed linen. -CNA J, CNA M and LPN A did not wear the EBP PPE when doing cares for the resident. -No posted signage on the door or near the door for EBP precautions. -No isolation cart outside the room for the required PPE. During an interview on 9/27/24 at 8:50 A.M., CNA H said: -He/She washed his/her hands and put on gloves when entering a resident's room to do any cares. -He/She removed gloves and washed or sanitized his/her hands before putting on clean gloves if he/she touched other items during cares. -He/She removed gloves and washed or sanitized his/her hands and put on clean gloves when going from a dirty body part to a clean body part. -He/She removed gloves and washed his/her hands when finished with resident cares. During an interview on 9/27/24 at 9:13 A.M., CNA J said: -Should wash hands and put on gloves when entering a resident's room to do any cares. -Should change gloves wash or sanitize hands when going from a dirty body part to a clean body part during perineal care. -Should change gloves wash or sanitize hands if he/she touched other items in room during perineal cares. -Should wash or sanitize hands between any glove changes. -He/She did not know what EBP was thought it was an ointment to place on a resident's buttock. -He/She had not received any education pertaining to EBP. -Did not know he/she was supposed to be wearing PPE when caring for any resident with a catheter, colostomy, or tube feeding. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-There were no signs showing to wear PPE on resident doors who had catheters, colostomies, or tube feedings. -There were no isolation carts with PPE outside of residents rooms who would require EBP. -Had not worn any type of PPE for residents who may need EBP except for gloves when doing cares. During an interview on 9/27/24 at 9:30 A.M., LPN A said: -He/She thought EBP was an ointment. -Had not received any education on EBP. --When informed what EBP was LPN A said he/she had received education in July 2024 on the online training program when he/she started at the facility. -Would know which residents would need EBP/PPE by looking at the resident's care plan. -EBP/PPE was required if the resident had any type of tubes going into the body. -The facility did not put signs for EBP/PPE on the resident's doors who required it. -The facility did not keep carts with EBP/ PPE in them outside of the resident rooms. -If a resident required the use of EBP/ PPE he/she went to central supply to get the needed items. -He/She did wear PPE while doing Resident #28's Supra pubic catheter care this morning. During an interview on 9/27/24 at 9:40 A.M., the resident said: -LPN A did change his/her Supra pubic catheter dressing this morning. -LPN A did not wear a gown or mask during the cares. 4. Review of Resident #20's Admission Record showed he/she was admitted on [DATE] and readmitted on [DATE] with the following diagnosis: -Morbid (severe) obesity (a disorder involving excessive body fat that increases the risk of health problems). Review of the resident's POS dated September 2024 showed: -Abrasion to left posterior thigh: Cleanse with normal saline or wound cleanser. Pat dry. Apply Xeroform (a medicated) dressing to wound bed and cover with border gauze dressing every day shift and as needed for soiled/dislodged. 9/12/2024. -Eucerin cream (a brand name of dry skin cream) apply to bilateral lower extremities and shin area every shift for dryness and monitor for signs and symptoms of infection or open area. 8/23/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Weekly skin assessments every day shift every Thursday. 3/28/2024. Observation on 9/23/24 at 11:55 A.M. of the resident's room showed: -No posted signage on the door or near the door for EBP precautions. -No isolation cart outside the room for the required PPE for staff to wear while doing resident wound care. During an interview on 9/23/24 at 11:57 A.M., the resident said: -Had pressure sores on his/her buttocks that wound care saw. -Had a scabbed area on his/her left shin. Observation on 9/26/24 at 10:05 A.M. of the resident's perineal care by CNA G and LPN B showed: -CNA G touched the resident's motorized chair then removed the resident's brief without changing gloves or sanitizing his/her hands and putting on new gloves. -CNA G cleaned the resident's buttock then perineal area without changing gloves or sanitizing his/her hands and putting on new gloves. -CNA G removed gloves and put on new gloves without sanitizing his/her hands. -LPN B removed gloves and sanitized his/her hands, he/she picked up some paper towels that were on the floor and placed in trash, he/she did not wash or sanitize his/her hands. -LPN B left the room to get a larger gown for the resident. -LPN B washed his/her hands on re-entering the room. During an interview on 9/26/24 at 10:30 A.M., CNA G said: -He/She should have changed his/her gloves during perineal cares between dirty and clean areas and if gloves become dirty. -Should have washed his/her hands between glove changes. -Should have washed his/her hands after removing gloves at end of resident cares. Observation on 9/26/24 at 10:34 A.M. of the resident's wound care by LPN B showed: -He/She sanitized his/her hands and put on gloves. -He/She cleansed the small wound on the left posterior (back) thigh and placed the Xeroform on the wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She did not wash or sanitize his/her hands, he/she changed gloves and placed a bordered gauze dressing over the area. -He/She did not wash or sanitize his/her hands, he/she changed gloves and cleaned the resident's left shin as ordered. -He/She did not wash or sanitize his/her hands, he/she changed gloves and placed barrier cream on the back of the resident's right thigh reddened area. -He/She removed the gloves, did not wash his/her hands then took the trash to the dirty utility room. During an interview on 9/26/24 at 10:45 A.M., LPN B said: -He/She would ask the resident about his/her pain level before starting wound cares. -NOTE: LPN B was needed and the interview was abruptly ended with no other questions or answers asked and answered. 39469 5. Review of Resident #49's face sheet showed he/she had the following diagnoses: -Colostomy. -Malignant neoplasm of the colon (a cancer of the colon). Review of the resident's Care Plan dated 7/24/24 showed: -He/She had a colostomy due to malignant neoplasm of the colon. -NOTE: the Care Plan did not address EBP. Review of the resident's Admission Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 8/4/24 showed: -He/She was cognitively intact. -He/She had a colostomy. -He/She had malignant neoplasm of the colon. -The MDS did not address EBP. Review of the resident's POS dated September 2024 showed the following order: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Change the colostomy bag and wafer (the pouching system around the stoma (the opening of the colostomy), use water to clean around the site, pat dry. Cut the wafer to fit the stoma. Change every three days on the night shift and as needed, dated 9/22/24. -There was no order for EBP. Observation on 9/23/24 at 10:47 A.M. showed: -There was no sign for EBP on the resident's door. -There was no isolation cart for PPE. During an interview on 9/25/24 CNA B said: -He/She did stoma cares for the resident. -During cares he/she would wear gloves and a mask. -He/She would not have worn a gown. -There were no masks in the resident's room. -Every resident's room had a box of gloves. During an interview on 9/25/24 at 7:58 A.M. CNA C said: -When he/she did stoma care on the resident he/she would have worn gloves, no mask, no gown. Observation on 9/25/24 at 10:11 A.M. of stoma care showed: -CNA C changed the resident's colostomy bag wearing only gloves. During an interview on 9/26/24 LPN A said: -During colostomy care staff should have worn gloves, a gown, and a face shield. -Supplies were available in central supply. During an interview on 9/26/24 at 11:16 A.M. the Assistant Director of Nursing (ADON) said: -He/She was unsure if the resident should have been on EBP. -He/She used a gown for his/her own protection. -The staff should have been trained on EBP. 6. Review of Resident 41's face sheet showed he/she had the following diagnoses: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe).) -Malignant Neoplasm of Bronchus and lung (a cancer that begins in the lungs and often spreads). -Tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea(windpipe) from outside the neck). Review of the resident's care plan dated 6/4/24 showed: -He/She had a tracheostomy and performed own cares. -It did not show he/she had nebulizer treatments. -It did not show he/she was able to administer own breathing treatments. Review of the resident's Discharge Summary MDS dated [DATE] showed: -He/She had Cardiorespiratory conditions (heart and lungs). -He/She had COPD. -He/She had cancer. -No breathing problems was checked. -He/She was receiving tracheotomy cares. Review of the resident's POS dated September 2024 showed the following orders: -Change nebulizer/oxygen tubing every Sunday on night shift, dated 9/19/24. -Oxygen at two liters per nasal cannula (a device that delivers extra oxygen through a tube into your nose) as needed, dated 9/19/24. -Albuterol Sulfate Inhalation Nebulization solution (medication used to prevent and treat wheezing,difficulty breathing,caused by lung diseases) 1.25 milligrams(mg)/3 milliliters (ml) one vial inhale orally via nebulizer every six hours as needed for wheezing, dated 9/22/24. Observation on 9/23/24 at 10:05 A.M. showed: -He/She had a tracheostomy. -His/Her nebulizer mask was on the dirty floor, not in a bag. -There was no date on the tubing. During an interview on 9/23/24 at 10:05 A.M. the resident said: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She had a tracheostomy for four years and took care of it himself/herself. -He/She did not think the staff had ever changed out the tubing. -The staff had not provided a bag for the nebulizer. -The staff was supposed to have provided a humidifier for the oxygen. -He/She had asked the nurse several times and still did not have a humidifier. -He/She had not seen the staff ever clean the nebulizer mask. Observation on 9/24/24 at 8:00 A.M. showed: -The nebulizer mask and tubing sitting on a dirty (greasy) plastic cart, not in a bag. During an interview on 9/25/24 at 7:56 A.M. Certified Mediation Technician (CMT) C said: -The resident was able to do his/her own nebulizer treatments. -The tubing for the nebulizer should have been changed out weekly by the night shift CNA's. -The nebulizer mask should have been changed out weekly by the night shift CNA's. -The oxygen tubing, nebulizer mask and tubing should have been in a bag with the date it was changed written on it. -The tubing and mask should not have been on the floor. -Anyone could change the nebulizer mask and tubing. -He/She had seen the tubing and nebulizer on the floor. -He/She did not change the tubing or the nebulizer mask, Observation on 9/25/24 at 8:50 A.M. showed: -LPN B looked into the resident's room and saw the nebulizer mask on the floor. -He/She did not change out the tubing or the nebulizer mask. During an interview on 9/25/24 at 8:50 A.M. LPN B said: -Oxygen tubing or tubing for the nebulizer should have been changed out weekly by the night shift CNA's. -The nebulizer mask and tubing should have been in a bag with the date it was changed out written on it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Anyone who went in the room should have seen the tubing and mask on the floor and changed it out. Observation on 9/25/24 at 9:00 A.M. showed: -The nebulizer mask and tubing sitting on a dirty (greasy) plastic cart, not in a bag. 7. Observation on 9/25/24 at 7:46 A.M. with CMT C showed: -He/She did not cleanse his/her hands before delivering a resident's medications to him/her. -When the CMT came out of the resident's room he/she reached into the trash and pulled out a piece of paper with his/her bare hands. -He/She did not cleanse his/her hands before continuing medication pass. -He/She went into a different resident's room to deliver medications. -He/She did not cleanse his/her hands when he/she came out of the room and continued medication pass. During an interview on 9/25/24 at 8:00 A.M. CMT C said: -Staff should cleanse their hands before starting medication pass, after the medication pass, and after administering medications to each resident. -He/She should not have reached into the trash without washing his/her hands after. -The DON had provided education on hand washing. During an interview on 9/25/24 at 8:50 A.M. LPN B said: -The Administrator and DON had provided education on hand washing. -Staff should wash their hands before and after medication pass. -Staff should wash their hands after delivering medications to each resident. -The CMT should have washed his/her hands after reaching into the trash. 8. During an interview on 9/27/24 at 9:32 A.M. the Infection Preventionist/LPN said: -Handwashing should have been done before and after doing cares with a resident. -Staff was expected to wash their hands after passing medications after every third resident. -The CMT should have washed his/her hands after reaching into the trash bag. -Residents who had a catheter, feeding tube, or tracheostomy should have had EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-There should have been a sign on the door to alert staff EBP was to be used with that resident. -There should have been an isolation bag with PPE hanging on that door. -He/She should have provided education to the staff regarding EBP, he/she had not done this. -He/She had no documentation of infection control training that had been provided to the staff, such as monitoring hand washing. -He/She had not provided any education to staff regarding hand washing. -Oxygen tubing and equipment such as a nebulizer mask should have been changed out on Sundays. -The oxygen equipment should have been changed out by a CNA on Sunday night with a date on the bag that it had been changed. -Even if the resident self-administered nebulizer treatments the staff was responsible for changing it out. -He/She was responsible for ensuring Infection policies were followed by the staff. During an interview on 9/27/24 at 12:00 P.M. the DON, RDO, and Administrator said: -During a medication pass staff should have cleansed their hands before and after the medication pass, and after administering medications to each resident. -The CMT should have washed his/her hands after reaching into the trash. -Anyone with a manmade opening to the body should have been on EBP. -This would have included; catheters, feeding tubes, colostomy, and wounds. -There should have been a sign on the resident's door alerting staff to use EBP with that resident. -There should have been an isolation cart so that staff would have had access to PPE. -EBP should have been documented in the resident's care plan. -They were expected to have worn a gown, gloves, and a mask while providing cares for the resident. -No education had been provided to the staff regarding EBP. -The DON was responsible for ensuring staff was using EBP and had been educated on it. -Oxygen tubing/nebulizer equipment should have been stored in a clean plastic bag even if the resident was self-administering. -Oxygen tubing/nebulizer equipment should not have been on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The CNA's were responsible for changing the tubing out weekly on the night shift. -The oxygen tubing should have been stored in a clean bag with the date it was changed out written on it.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 39469 Based on interview and record review, the facility failed to designate one or more individuals with the required primary professional training as an Infection Preventionist (IP) for the facility's Infection Prevention control program. The facility census was 74 residents. The certifications were requested for all employees who were certified in the IP program and were not received at the time of exit. 1. Review of the Centers for Disease Control (CDC) online IP course showed: -The Minimum Data Set (a federally mandated assessment tool completed by facility staff for care planning) Coordinator had completed 15 of the 26 modules for the CDC IP course. -He/She worked 15 hours a week as the IP. During an interview on 9/27/24 at 9:32 A.M. the MDS Coordinator said: -He/She had started the IP course a couple of years ago. -He/She had not finished the IP course. -He/She was not certified in the IP program. -He/She worked 15 hours a week as the IP. During an interview on 9/27/24 at 12:00 P.M. the Director of Nursing (DON) said: -He/She had completed the IP program training and had the certification. -The Administrator had also completed the IP program training and had the certification. -The MDS Coordinator had not completed the IP program training and was not certified.

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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** 39469 Based on interview and record review, the facility failed to ensure residents received or were provided education for the pneumococcal (vaccine that protects against the bacteria that causes pneumonia) vaccinations for two sampled residents (Resident #24 and #325) out of five residents sampled for vaccines. The facility census was 74 residents. Review of the facility's policy, Infection Prevention and Control Program, dated 5/7/24 showed: -Residents should have been offered the pneumococcal vaccines recommended by the Centers for Disease Control upon admission, unless contraindicated or had received the vaccinations elsewhere. -Education should have been provided to the residents and or their representatives regarding the benefits and potential side effects of the immunizations prior to offering the vaccines. -Residents would have had the opportunity to refuse immunizations. -Documentation would reflect the education provided and details regarding whether the resident received the immunizations. 1. Review of Resident #24's entry tracking form showed the resident admitted to the facility on [DATE] and was over [AGE] years old. Review of the resident's medical records showed no documentation regarding the resident's pneumococcal vaccine status. 2. Review of Resident #325's entry tracking form showed the resident admitted to the facility on [DATE]. Review of the resident's medical records showed no documentation regarding the resident's pneumococcal vaccine status. 3. During an interview on 9/27/24 at 9:32 A.M., the Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) Coordinator said: -The Director of Nursing (DON) was responsible for ensuring the immunizations were done. -Documentation regarding the resident's pneumococcal vaccine status should be charted in the immunization tab in the electronic health record (EHR). -The pneumococcal vaccine should be offered and administered during the resident's first week at the facility if the resident was over 65 or immunocompromised (when one's immune system is weakened, making it harder to fight off infections and diseases). -If the resident declined the pneumococcal vaccine, they should put a progress note in the EHR and the resident should sign the vaccine form saying they declined it. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Education on the risks and benefits of the pneumococcal vaccine was included in the admission packet. During an interview on 9/27/24 at 11:57 A.M., the DON said: -They had a consent form for the administration of the pneumococcal vaccines that should be filled out. -The charge nurses were supposed to offer the pneumococcal vaccines within 72 hours of the resident's admission and administer it if the resident consented. -Documentation regarding the pneumococcal vaccines should be in the resident's EHR. -If the resident declined the pneumococcal vaccines, education provided to the resident regarding the risks and benefits of the pneumococcal vaccines should be documented in the resident's progress notes. -They had handouts for education and declination of pneumococcal vaccines. -He/She spot checked the administration of vaccines. -Their process of offering and administering the pneumococcal vaccines needed some work.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469 Based on interview and record review, the facility failed to ensure two sampled residents (Residents #24 and #325) out of five residents sampled for vaccines were offered the Coronavirus Disease ((COVID-19) is an infectious disease caused by a virus that causes symptoms of a respiratory illness) vaccine. The facility census was 74 residents. Review of the facility's policy titled COVID-19 Vaccine: Educate and Offer dated 6/26/24 showed: -All residents would be offered the COVID-19 vaccine unless the immunization was medically contraindicated, or the resident had already been vaccinated. -If the resident already received the COVID-19 vaccine, the facility would ask for documentation of the vaccination. -The facility would provide a copy of the package insert for the COVID-19 vaccine being offered. -The facility would maintain copies of any material used to educate residents about the COVID-19 vaccine. -The resident had the option to accept or refuse the COVID-19 vaccine. -The resident would sign the consent form indicating whether they have consented or declined the COVID-19 vaccination. -A copy of the form would be kept in each resident's medical record. -The facility would document in the resident's chart that the resident was provided with education about the benefits and potential risks associated with the COVID-19 vaccine. -The Director of Nursing (DON) would serve as the facility point of contact for ensuring that all residents are educated about and offered the COVID-19 vaccine. 1. Review of Resident #24's entry tracking form showed the resident admitted to the facility on [DATE]. Review of the resident's medical records showed no documentation regarding the resident's COVID-19 vaccine status. 2. Review of Resident #325's entry tracking form showed the resident admitted to the facility on [DATE]. Review of the resident's medical records showed no documentation regarding the resident's COVID-19 vaccine status. (continued on next page)

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an interview on 9/27/24 at 9:32 A.M., the Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) Coordinator said: -The DON was responsible for ensuring the immunizations were done. -Documentation regarding the resident's COVID-19 vaccine status should be charted in the immunization tab in the electronic health record (EHR). -The COVID-19 vaccine should be offered and administered during the resident's first week at the facility. -If the resident declined the COVID-19 vaccine, they should put a progress note in the EHR and the resident should sign the vaccine form saying they declined it. -Education on the risks and benefits of the COVID-19 was included in the admission packet. During an interview on 9/27/24 at 11:57 A.M., the DON said: -They had a consent form for the administration of the COVID-19 vaccine that should be filled out. -The charge nurses were supposed to offer the COVID-19 vaccine within 72 hours of the resident's admission and administer it if the resident consented. -Documentation regarding the COVID-19 vaccine should be in the resident's EHR. -If the resident declined the COVID-19 vaccine, education provided to the resident regarding the risks and benefits of the COVID-19 vaccine should be documented in the resident's progress notes. -They had handouts for education and declination of COVID-19 vaccines. -He/She spot checked the administration of vaccines. -Their process of offering and administering the COVID-19 vaccine needed some work.