STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Ridge Manor	3111 Highway A Mansfield, MO 65704

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51209 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of need for one resident (Resident # 39) when staff did not place the resident's call light where it could be accessed by the resident. The facility census was 39. Review of the facility policy titled, Use of Call Light, dated March 2015, showed the following: -Answer all call lights in a prompt, calm, courteous manner; -When providing care to the residents, be sure to position the call light conveniently for the resident's use; -Tell the resident where the call light is and show him/her how to use the light; -Be sure all call lights are placed on the bed at all times, never on the floor or bedside stand. 1. Review of Resident #39's face sheet (brief resident profile sheet) showed the following: -admitted [DATE]; -Diagnoses included stroke. Review of the resident's care plan, dated 06/04/24, showed the following: -Resident had a diagnosis of flaccid hemiplegia (a condition that occurs after a stroke and is characterized by a complete lack of voluntary movement in one side of the body) affecting left nondominant side that limit abilities, required maximum assistance with most activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting); -Make sure the resident's call light is within reach at all times. Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 06/10/24, showed the following: -Resident was severely cognitively impaired; (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident was dependent on all other ADL's including dressing, toilet use, and personal hygiene; -Impairment on one side of the body; -Diagnosis of stroke. Observation on 09/10/24, at 10:16 A.M., showed the resident lay in bed with the call light clipped to the head of the bed on the resident's left side of the body (not accessible to the resident). Observation on 09/10/24, at 10:36 A.M., showed the resident's call light was clipped to the head of the bed on the resident's left side of the body (not accessible to the resident). Observation on 09/11/24, at 1:55 P.M., showed the resident's call light was clipped to the head of the resident's bed on the resident's left side of the body (not accessible to the resident). reach. During an interview on 09/11/24, at 3:45 P.M., Certified Nurse Aide (CNA) C said the following: -Call lights should be next to a resident; -He/She would pin them on the resident's chest; -Everyone should have a call light. During an interview on 09/11/24, at 4:02 P.M., CNA D said the following: -He/She would connect the call light to a resident or a resident's bed where a resident can reach it; -Everyone should have a call light; -He/She would give the resident his/her call light or connect it to his/her bed where he/she could reach it, not at the head of the bed. During an interview on 09/12/24, at 9:36 A.M., Registered Nurse (RN) H said the following: -Call lights should be attached to a shirt or a sheet where a resident can reach them; -The resident's call light should be on his/her shirt where he/she can reach it with his/her right hand because that is the resident's non-affected side; -The resident's call light should not be placed at the head of the bed. During an interview on 09/12/24, at 11:22 P.M., the Director of Nursing (DON) said the following: -Call lights should be pinned to a resident's chest or on the bed on a resident's non affected side; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-All residents should have a call light in reach, or have it addressed in the care plan if they are not safe to have them. During an interview on 09/12/24, at 4:13 P.M., the Administrator said the following: -Call lights should be in reach; -All residents should have a call light; -Call lights should not be clipped to the head of the bed.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31464 Based on record review and interview, the facility failed to complete the required Preadmission Screening and Resident Review (PASARR - a two level tool used to screen each resident in a nursing facility for mental disorder or intellectual disability prior to admission) prior to or upon admission to the facility for one resident (Resident #42). The facility census was 39. Review of the facility's Admission Packet showed a checklist showing Obtain DA 124C (preadmission screening related to psychological diagnoses). Review showed the facility did not provide a written policy pertaining to PASARRs. 1. Review of Resident #42's face sheet (gives brief profile information) showed the following: -admitted [DATE]; -Diagnoses included personal history of suicidal behavior with attempted self-injury, burn of unspecified degree of head, face, and neck, anxiety disorder, paranoid schizophrenia with acute exacerbation (mental disorder with symptoms of distrust, suspicion, and fear of others without reason, delusions - belief in something unreal, hallucinations -hearing or seeing things not present, and confused thoughts), insomnia, high blood pressure, and type 2 diabetes. Review of the resident's care plan, last revised on 08/17/24, showed the following information: -Takes medications to treat paranoid schizophrenia and anxiety disorders. Staff to monitor for side effects. Resident to see tele-psych (virtual psychologist appointments); -History of confusion due to diagnoses of paranoid schizophrenia and anxiety. Resident able to make needs known. Resident has minimal socialization outside of his/her room. Staff to re-orient to the day/time/season etc. as necessary, encourage involvement in activities, monitor for signs/symptoms, and monitor for abnormal behaviors. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 08/17/24, showed the following information: -Cognition intact; -Diagnoses included anxiety disorder and schizophrenia; -Medications included anti-psychotic (given routinely only) and antianxiety. Review of the resident's Level I Nursing Facility Pre-Admission Screening for Mental Illness, Intellectual Disability or Related Condition, dated and submitted by the hospital on 05/06/24, showed the following: (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Major mental illness diagnoses included schizophrenia, psychotic disorder, schizoaffective disorder, and bipolar disorder (fluctuating depressed/manic episodes); -Impairment regarding Adaptation to Change: serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interactions, agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations, self-injurious, self-mutilation, suicidal (thoughts, gestures, threats, or attempts), physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability, or requires intervention be mental health or judicial system; -Within the last 2 years, the individual experienced one psychiatric treatment episode that was more intensive than routine follow-up care (such as had inpatient psychiatric care; was referred to a mental health crisis/screening center; had attended partial care/hospitalization or had received Program of Assertive Community (PACT) or Integrated Case Management Services); -Within the last 2 years, due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community or intervention by housing or law enforcement officials; -Initial admission (to the hospital) on 04/14/24 for self-inflicted burns to face; -Corrections were requested by the state agency on 05/09/24; -Corrections made by the submitter on 05/10/24; -Correction requested on 05/13/24; -Application locked due to correction not made to the online application. During an interview on 09/12/24, at 9:31 A.M., the Director of Nursing (DON) said the MDS Coordinator is fairly new and only does MDS duties several days per week. The DON has a background in MDS completion and continues to help out while the MDS Coordinator is learning. The facility missed the email requesting further correction to the resident's Level I submission. During an interview on 09/12/24, at 3:30 P.M., the Corporate QA RN (Quality Assurance Registered Nurse) said the corporation did not have a policy pertaining to PASARRs. Staff was told to follow the regulations for completing them. During an interview on 09/12/24, at 4:13 P.M., the Administrator and the QA RN said the Level I PASARR should be completed prior to the nursing facility admission (usually by the hospital). The MDS Coordinator and DON would be responsible for submitting corrections or completing new assessments as soon as possible.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 51209 Based on record review and interview, the facility failed to ensure that each resident's written care plan was accurate and up-to-date, when staff failed to care plan hospice services for two residents (Resident #39 and Resident #2). The facility census was 39. 1. Review of Resident #39's face sheet (brief resident profile sheet) showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - refers to chronic bronchitis and emphysema, a pair of two commonly co-existing diseases of the lungs in which the airways become narrowed. This leads to a limitation of the flow of air to and from the lungs causing shortness of breath), stroke, depression, anxiety, and post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event); -Resident on hospice services. Review of the resident's current Physician Order Sheet (POS) showed an order, dated 06/04/24, for hospice evaluation and treatment. Observation on 09/12/24, at 9:36 A.M., showed a hospice book that indicated the resident received care from hospice). Review of the resident's care plan, dated 06/04/24, showed staff did not care plan related to the resident's referral for, or use of hospice services. Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 06/10/24, showed staff did not document the resident received hospice services. During an interview on 09/12/24, at 8:54 A.M., Certified Nurse Aide (CNA) F said the resident received hospice services. He/She knew this because the hospice provider came in to give the resident baths. He/She would be able to know what the facility would provide and what hospice would provide by what was documented on the care plan. During an interview on 09/12/24, at 9:00 A.M., CNA G said the resident received hospice services and he/she knew this because the resident was in a special bed. He/she would provide the basic care that he/she provides to everyone and he/she was not sure what hospice would provide to the resident. During an interview on 09/12/24, at 9:36 A.M., Registered Nurse (RN) H said the resident was on hospice services and that hospice should be on the care plan. 48187 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #2's face sheet showed the following information: -admitted [DATE]; -Diagnoses included schizophrenia (a serious mental health condition that affects how people think, feel and behave), urinary tract infection, dysphagia (difficulty speaking), and falls. Review of the resident's Patient-Specific Letter of Agreement Inpatient and Respite Care Services, dated 04/12/24, showed hospice services were provided. Review of the resident's quarterly MDS, dated [DATE], showed the resident received hospice services. Review of the resident's current nurses' progress notes showed the following: -On 08/14/24, the Weekly Summary showed the resident continued on hospice services. -On 08/28/24, the Weekly Summary showed the resident continued on hospice services; -On 09/04/24, the Weekly Summary showed the resident continued on hospice services; Review of the resident's care plan, revised 06/19/24, showed staff did not care plan related to the resident's use of hospice services. During an interview on 09/11/24, at 11:53 A.M., RN L said that the resident was currently on hospice services and is being documented on a weekly progress note that the resident is on hospice. RN L said hospice should be care planned. During an interview on 09/11/24, at 11:56 A.M., RN H said that the resident was currently on hospice. RN H said that the nurses assess and document a weekly note that includes that the resident is on hospice. Hospice should be on the care plan. During an interview on 09/12/24, at 1:15 P.M., the MDS Coordinator said the resident was on hospice and he/she would expect it to be on his/her care plan. During an interview on 09/11/24, at 1:28 P.M., the Director of Nursing (DON) said the care plan should be updated with hospice services. The resident was on hospice. During an interview on 09/12/24, at 4:15 P.M., the Administrator said the resident was currently on hospice and had been for a while now. 3. During an interview on 09/12/24, at 1:15 P.M., the MDS Coordinator said care plans should be up-dated quarterly or as needed with any significant change. The MDS Coordinator and DON are the only staff that up-date the care plans. Hospice should be on the care plan. The MDS Coordinator said that he/she doesn't get to spend a lot of time on care plans as he/she is mostly working the floor as a charge nurse. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. During an interview on 09/12/24, at 11:22 A.M., the DON said hospice should be addressed on the facility care plan. 5 During an interview on 09/12/24, at 4:13 P.M., the Administrator said hospice should be on the facility care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31464 Based on observation, record review, and interviews, the facility failed to assist all dependent residents with activities of daily living to maintain good grooming when the facility staff failed to perform peri-care for one resident (Resident #41) following an episode of incontinence and toileting. The facility census was 39. 1. Review of Resident #42's face sheet (gives basic profile information about the resident) showed the following: -admitted [DATE]; -Diagnoses included metabolic encephalopathy (brain dysfunction that occurs due to a chemical imbalance in the blood) and congestive heart failure (CHF - irregular heart function). Review of the resident's care plan, last updated 08/15/24, showed the following: -Staff to assist with toileting; -Staff to provide changing and peri-care with each incontinent episode to keep skin clean and free from odor and breakdown; -Staff to apply barrier creams with each incontinent episode to maintain good skin integrity. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 08/21/24, showed the following: -Severely impaired cognition; -Frequently incontinent of bladder; -Occasionally incontinent of bowel; -Required substantial/maximal assistance for toileting hygiene. Observation on 09/10/24, at 2:05 P.M., showed the following: -Certified Nurse Aide (CNA) C and CNA D donned gloves and assisted the resident to walk to the toilet. The back of the resident's pants were wet. -The resident held onto the grab bar while the CNAs lowered his/her pants and wet brief; -The resident sat on the toilet. -CNA C removed his/her gloves and left the bathroom to retrieve a fresh brief and dry pants. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA C handed new gloves to CNA D and without performing hand hygiene, they both changed their gloves. -Without performing any peri-care, the CNAs placed the new brief and clean pants on the resident. -The CNAs ambulated with the resident back to his/her recliner. During an interview on 09/12/24, at 1:04 P.M., CNA J said staff should do peri-care whenever a resident is changed or after they use the bathroom. Staff should do peri-care regardless of whether or not there is any output. When toileting a resident staff should put gloves on, undue the brief, use two wipes to clean the resident's peri-area, take off the gloves to refasten brief or place new one. If the gloves become dirty, they should be changed. They don't do hand hygiene in between glove changes. During an interview on 09/12/24, at 12:51 P.M., CNA F said he/she would do peri-care when toileting a resident and every two hours regardless. Staff should put gloves on and use wipes to do peri-care. If the gloves get dirty, staff should wash their hands and put a new pair on. The clean, dry brief should be place using a clean pair of gloves. During an interview on 09/12/24, at 1:55 P.M., the Director of Nursing (DON) said staff should assist residents with peri-care and/or toileting. Staff should clean the front first, wiping from front to back, change gloves and sanitize their hands, and then clean the back side. Staff should sanitize their hands before touching other things, utilizing hand sanitizer, and wash their hands when they are finished caring for the resident. During an interview on 09/12/24, at 4:13 P.M., the Administrator and the corporate QA RN (Quality Assurance Registered Nurse) said staff should always perform peri-care with incontinence and/or toileting. Staff should change their gloves and sanitize their hands during care and sanitize hands before touching other things or re-dressing the resident.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on observation, interview, and record review, the facility failed to provide an ongoing program of meaningful activities based on residents' interests and abilities when the staff failed to provide a complete activity schedule with a variety of daily activities, failed to complete activities as scheduled, and failed to document steps taken to provide meaningful activities for nine residents (Resident #13, #17, #14, #39, #9, #16, #7,#40, and #16) out of a sample of 20 residents. The facility had a census of 39. Review of the facility policy titled, Activity/Recreational Therapy Manual last reviewed on 03/2012, showed the following: -The purpose was for the facility to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident; -To enhance the quality of the residents daily life; -Upon admittance, annually, and upon significant change, an initial assessment was to be completed including background information, preference interviews, activity pursuit patterns, and additional pertinent information; -Quarterly assessments will be completed to evaluate the resident's current activity program and determine if changes need to be made; -The quarterly assessments include participation in activities, socialization patterns, resident preferences, and other factors; -The Activity Director charts progress notes in the residents' charts upon admission, quarterly, and with significant changes; -The progress notes should include resident interests, based on their feedback, response to activity, and activity involvement; -Resident participation is documented in the clinical record, on a daily basis by the Activity Director or designee and should include the resident's attendance, participation, refusal, and level of participation; -Activity Director should develop a monthly calendar based on resident's needs and interests; -Calendar should list the time of the activity; -Monthly calendar should be provided to each resident; -Plans and promotes meaningful activities based on the resident's interests and desires to provide a more homelike atmosphere in the facility; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Schedule activities that will involve as many residents as possible; -Care plan will address resident's interests and needs. 1. Review of the residents' activities sign in sheets, dated January 2024, showed the following: -Bingo held on 01/04/24, 01/09/24, and 01/30/24; -No other documented activities. Review of the residents' activities sign in sheets, dated February 2024, showed the following: -Bingo held on 02/08/24, 02/12/24, 02/20/24, 02/23/24, and 02/27/24; -No other documented activities. Review of the residents' activities sign in sheets, dated March 2024, showed the following: -Bingo held on 03/05/24, 03/08/24, 03/12/24, 03/19/24, and 03/26/24; -No other documented activities. Review of the residents' activities sign in sheets, dated April 2024, showed the following: -Bingo held on 04/04/24, 04/09/24, 04/16/24, 04/19/24, 04/24/24, and 04/26/24; -No other documented activities. Review of the residents' activities sign in sheets, dated May 2024, showed the following: -Bingo held on 05/09/24, 05/14/24, 05/21/24, 05/24/24, and 05/31/24; -No other documented activities. Review of the residents' activities sign in sheets, dated June 2024, showed the following: -Bowling held on 06/03/24; -Bingo held on 06/05/24; -Corn Hole held on 06/06/24, eight resident participated; -Karaoke held on 06/07/24, twelve residents participated; -Movies held on 06/10/24, ten residents participated; -Bingo held on 06/11/24; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ring toss held on 06/12/24, ten residents participated; -Movies held on 06/17/24, ten residents participated; -Leisure time, read a book held on 06/19/24, five residents participated; -Bingo held on 06/21/24; -Movies held on 06/24/24, ten residents participated; -Bingo held on 06/25/24; -No other documented activities. Review of the residents' activities sign in sheets, dated July 2024, showed the following: -Bowling held on 07/01/24, eight residents participated; -Bingo held on 07/02/24; -Firework's display held on 07/04/24, 27 residents participated; -Karaoke held on 07/05/24, nine residents participated; -Bingo held on 07/09/24, 07/12/24, 07/19/24, 07/23/24, 07/26/24, and 07/30/24; -No other documented activities. Review of the residents' activities sign in sheets, dated August 2024, showed the following: -Bingo held on 08/27/24, seven residents participated; -Bingo held on 08/30/24, ten residents participated; -No other documented activities. Review of the residents' activities sign in sheets, dated 09/01/24 to 09/11/24, showed the following: -Bingo held on 09/03/24, nine residents participated; -Bingo held on 09/11/24, twelve residents participated. 2. Review of the facility activity calendar, posted in the television room at the facility, showed on 09/09/24, at 1:30 P.M., corn hole scheduled. Observation on 09/09/24, at 1:30 P.M., showed no corn hole activity was being done at the facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the facility calendar posted in the television room at the facility, showed the following: -On 09/01/24, televised church, no time listed; -On 09/02/24, at 10:00 A.M. hydration; 10:30 A.M. phone calls; 12:00 P.M. lunch; 1:00 P.M. mail; and 1:30 P. M. movie; -On 09/03/24, Bingo, no time displayed; -On 09/04/24, at 10:00 A.M. hydration; 12:00 P.M. lunch; and podiatrist; -On 09/05/24, at 10:00 A.M., hydration; 12:00 P.M. lunch; 1:00 P.M., mail; and 1:30 P.M., leisure time; -On 09/06/24, Bingo, no time listed; -On 09/07/24, Activity of choice, no time listed; -On 09/08/24, televised church, no time listed; -On 09/09/24, at 1:30 P.M., corn hole; -On 09/10/24, no activity, in-service; -On 09/11/24, at 10:00 A.M. hydration; 12:00 P.M. lunch; and 1:30 P.M. basketball; -On 09/12/24, volley balloon, no time listed; -On 09/13/24, bingo, no time listed; -On 09/24/24, happy birthday; -On 09/15/24, televised church, no time listed; -On 09/16/24, hydration at 10:30 A.M.; phone at 12:00 P.M.; lunch at 1:00 P.M.; mail at 1:30 P.M.; and movie; -On 09/17/24, bingo, no time listed; -On 09/18/24, leisure time; -On 09/19/24, resident council, no time listed; -On 09/20/24, bingo, no time listed; -On 09/21/24, activity of choice; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 09/22/24, televised church, no time listed; -On 09/23/24, hydration, phone calls, lunch, bowling for prizes, no times listed; -On 09/24/24, bingo, no time listed; -On 09/25/24, treats at activity and foosball, no times listed; -On 09/26/24, read a book, no time listed; -On 09/27/24, bingo, no time listed; -On 09/28/24, activity of choice, no time listed; -On 09/29/24, televised church, no time listed; -On 09/30/24, games for prizes, no times listed. 4. Observation on 09/10/24, at 9:49 A.M., of the activity room showed the following: -The room contained a basketball goal and foosball; -A shelf with various games; -A door with a sign on it that said remain locked at all times. Observation on 09/12/24, at 11:45 A.M., showed a lower cabinet in the 100 hall TV room contained three editions of Reader's Digest and three romance novels. The cabinet was at floor level and covered with a door. 5. Observation and interview on 09/11/24, starting at 10:34 A.M., showed the following: -Nurse Aide (NA) I passed out various drinks on 200 hall; -NA I said the hydration listed on the calendar was what he/she was doing. It consisted of going around to each resident who can have drinks and providing them Kool-aide, coffee, water or tea. This was done at 10:00 A.M. and 8:00 P.M. 6. Review of Resident #13's face sheet showed the following: -admitted [DATE]; -Diagnoses included above the knee amputation, diabetes, insomnia, schizoaffective disorder (combination mental disorder including delusions, hallucinations, depressed/manic periods), anxiety, limitation of activities due to disability, pain, and major depressive disorder. Review of the resident's Activity Assessment - Comprehensive, dated 07/03/24, showed the following: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Most common use of time: sleeping in his/her chair in his/her room; -Average time involved in activities (when awake and not receiving treatments or care): Some - from 1/3 to 2/3 of time; -Preferred activity settings: none of the above listed; -Hobbies: watching television; -Preferred program style: Refuses to participate; -Program time preference: does not like to participate in activities; -Participation barriers: none; -Participation strengths: social skills; -General activity preferences: reading/writing, watching TV; -Past interests included: animals/pets, board games, cooking, current events, dining out, drawing/painting, movies/theater, quilting/crochet, outdoor activities, resident council, and woodworking; -Focus of programming: no interest at all. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 07/11/24, showed the following: -Cognition intact; -Sometimes socially isolated. Review of the resident's care plan, last updated 07/11/24, showed the following: -Psychosocial well-being: Right leg amputated above the knee. Resident has constant worry that he/she may lose the other leg. Resident has episodes of depression related to these events; -Mood state: Loss of interest in things due to worrying and anxiety about health. Resident is anxious and depressed at times. Staff to encourage resident to get out of bed and come out of the room to socialize with others. Staff to spend 1:1 time with resident and allow resident to vent feelings. During interviews on 09/09/24, at 11:15 A.M., and on 09/10/24, at 1:43 P.M., the resident said he/she had been a resident for a long time and was tired of Bingo and Scrabble. He/she would be interested in doing something new, otherwise he/she would just stay in his/her room. The facility does not have enough activities, they play bingo a lot and they sometimes cancel the activities. During an interview on 09/12/24, at 10:32 A.M., the Activities Director said the resident could have money for activities, but he/she spends money on food instead. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of Resident #17's face sheet showed the following: -admitted [DATE]; -Diagnoses included schizoaffective disorder (combination mental disorder including delusions, hallucinations, depressed/manic periods), heart disease, diabetes, and presence of right artificial hip joint. Review of the resident's Activity Assessment- Comprehensive, dated 10/03/23, showed the following: -The resident was most active in the afternoon; -The resident was involved in some activities from 1/3 to 2/3 of the time; -Preferred setting was the day/activity room; -Preferred small groups; -Participated twice weekly; -No participation barriers; -Participation strengths included being self-motivated and social skills; -General activity preferences include watching television and talking/conversing; -Past interests include animals/pets, board games, cooking, current events, dining out, movies, outdoor activities, woodworking; -Focus of programming included outdoor activities and talk-oriented activities. Review of the resident's MDS, dated [DATE], showed the following: -Severely cognitively impaired; -The resident's activity preferences listed as somewhat important to have books, newspapers, and magazines to read, listen to music, be around animals, keep up with the news, do thing with groups of people, and go outside to get fresh air when the weather was good. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately cognitively impaired; -Preferences were not completed; -Required partial to moderate assistance with activities of daily living (ADL's) including dressing, toilet use, and personal hygiene. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's social services and activity progress notes, dated 03/01/24 through 09/12/24, showed staff did not document regarding activities for the resident. Observation on 09/10/24, at 8:55 A.M., showed the resident lay in bed awake, the room dark, with the television off. Observation and interview on 09/11/24, at 1:40 P.M., showed 11 residents in the dining room playing bingo. Observation and interview on 09/11/24, at 1:46 P.M., showed the resident lay in bed, room dark, and television not on. The resident said staff did not tell him/her bingo was being played. He/she would like a deck of playing cards, but has never been offered them. He/she has never been given a calendar of what the activities for the month are. During an interview on 09/12/24, at 10:32 A.M., the Activities Director said the following: -He/she was not aware that the resident wanted playing cards, there are cards in the back room; -No one will play with the resident, because he/she picks His/her nose and makes it bleed. Review of the resident's care plan, last revised 09/12/24, showed the following: -Resident is to participate in at least one activity a week as he/she feels able and with staff assistance; -Post a calendar in the resident's room for staff to read to the resident; -Assist the resident to activities that may be of interest to the resident; -Encourage the resident to go to activities. 8. Review of Resident #14's face sheet showed the following information: -admitted [DATE]; -Diagnoses included developmental disorders of scholastic skills, schizoaffective disorder, bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and hallucinations. Review of the resident's current physician order sheet showed an order, dated 11/29/23, for resident may participate in activities as tolerated. Review of the resident's quarterly MDS, dated [DATE], showed the following information: -Mildly cognitively impaired; -Preferences were not completed; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sometimes socially isolated. Review of the resident's record showed staff did not complete an activity assessment for the resident. Review of the resident's care plan, revised 06/26/24, showed psychosocial well-being care planned. Facility staff to monitor frequently and report any changes in mood or behaviors to charge nurse. During an interview on 09/10/24, at 1:48 P.M., the resident said bingo was about the only activity they have. He/she would like more activities and has told the nurses. He/she gets bored and wishes there was more to do besides watch television and sleep. Observation and interview on 09/11/24, at 9:18 A.M., showed the resident laying on his/her bed watching television. The resident said that he/she was bored and would like to paint, but is currently out of painting supplies. There were no painting supplies in the activity room that he/she would be interested in. 9. Review of Resident #39's face sheet showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD- refers to chronic bronchitis and emphysema, a pair of two commonly co-existing diseases of the lungs in which the airways become narrowed. This leads to a limitation of the flow of air to and from the lungs causing shortness of breath), stroke, depression, anxiety, and post-traumatic stress disorder (PTSD-A disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). Review of the resident's admission MDS, dated [DATE], showed the following: -Severely cognitively impaired; -Dependent on staff for ADL's -Activity preferences showed it as somewhat important to listen to music he/she liked, to be around animals, keep up with the news, do thing with groups of people, do his/her favorite activities, go outside to get fresh air when the weather was good, and participate in religious services or practices. Review of the resident's Activity Assessment- Comprehensive, dated 06/11/24, showed the following: -The average time resident involved in activities was unknown; -The resident had no preferred activity settings; -The resident's preferred program style was 1:1; -Program time preference was afternoon; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Participation barriers included ability to understand, mental status, and physical endurance; -The resident had no participation strengths; -General activity preferences included crafts/art, music, and watching television; -Past interests included animals/pets, board games, cooking, current events, dining out, drawing/painting, movies, quilting/crochet, outdoor activities, music, resident council, woodworking, and word games; -Focus of programing included group games and outdoor activities. Review of the resident's care plan, last revised 06/18/24, showed staff did not address the resident's activity preferences or an activity plan for the resident. Review of the resident's activity progress notes, dated 06/04/24 through 09/11/24, showed staff did not document regarding activity attendance, refusals, or participation. Review of the resident's social services progress notes, dated 06/04/24 through 09/11/24, staff did not document regarding activities preferences or activity attendance for the resident. During an interview on 09/12/24, at 10:32 A.M., the Activities Director said the following: -He/she provides activities specific to residents. He/she pulled out a bag of interactive hand toys for the resident and said the resident does come to bingo. During an interview on 09/12/24, at 9:36 A.M., Registered Nurse (RN) H said the resident liked to play with blocks and Legos. Since the resident was in the hospital the last time, the resident does not have much of an interest in them. During an interview on 09/12/24, at 11:22 A.M., the Director of Nursing (DON) said the resident liked to do things that involve his/her hands. The resident liked to play with Legos before going to the hospital. The resident does well with sitting at the desk talking to the nurse or certified medication technician (CMT) one-on-one. During an interview on 09/12/24, at 1:15 P.M., the MDS Coordinator said the resident liked to be included. The resident liked to go to bingo and karaoke. His/her care plan should include things the resident likes to do. 10. Review of Resident #9's face sheet showed the following information: -admitted [DATE]; -Diagnoses included schizoaffective disorder, Type II diabetes (blood sugar is too high), generalized anxiety disorder borderline intellectual functioning (below average cognitive ability), and chronic pain. Review of the resident's Activity Assessment, dated 08/20/24, showed the following: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Average time involved in activities, some from 1/3 to 2/3's of the time; -Prefers activities in the day/activity room; -Prefers large groups and in the afternoons; -Likes music, reading/writing, watching television, and talking; -Current interests included animals, board games, dining out, drawing, movies, music. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Very important to do things with groups of people; -Very important to do favorite activities. Review of the resident's current care plan, last revised 09/06/24, showed the following: -Resident needs staff to invite him/her to activities and assist to find the location; -Staff to provide resident 1:1 to decrease episodes of restlessness; -Resident liked games; -Resident has difficulty staying focused on task and liked to be around others. Review of the resident's medical record, dated 01/01/24 to 09/12/24, showed staff did not document related to the activities the resident participated in. Observation and interview on 09/10/24, at 1:43 P.M., showed the following: -Six residents were sitting in the television room; -The resident said they did not have corn hole yesterday; -He/she would like a paper activity calendar. During an interview on 09/11/24, at 3:31 P.M., the resident said the following: -He/she goes to bingo on Tuesdays and Friday; -He/she believed someone came and told him/her they were having bingo today; -The Activities Director and the laundry person do activities; -He/she would like to do other activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. Review of Resident #16's face sheet showed the following information: -Readmitted [DATE]; -Diagnoses included paranoid schizophrenia (hallucinations, delusions and unusual ways of expressing themselves). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Preferences were not completed. Review of the resident's current care plan, last revised 09/06/24, showed staff did not address the resident's activity interests. Review of the resident's medical record, dated 01/01/24 through 09/12/24, showed staff did not document completion of an activity assessment or quarterly reviews of activity interests. Review of the resident's medical record, dated 01/01/24 through 09/12/24, showed staff did not document related to activities the resident participated in. 12. Review of Resident #7's face sheet showed the following information: -Readmitted [DATE]; -Diagnoses included schizoaffective disorder, generalized anxiety disorder (excessive worry), and insomnia (difficulty falling and staying asleep). Review of the resident's Activity Assessment, dated 01/25/24, showed the following: -Average time involved in activities, some from 1/3 to 2/3's of the time; -Prefers activities in the day/activity room; -Prefers large groups and in the afternoons; -Likes crafts/arts and watching television; -Current interests include animals, board games, current events, dining out, drawing, movies, music, word games, and outdoor activities. Review of the resident's current care plan, last revised 07/22/24, showed staff did not care plan the resident's preferred activities. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Activity preferences was not completed. Review of the resident's medical record, dated 01/01/24 and 09/12/24, showed staff did not document progress notes documented related to activities the resident participated in. Observation and interview on 09/10/24, beginning at 1:43 P.M., showed the following: -Six residents were sitting in the television room; -The resident said they did not have corn hole on 09/09/24; -He/she doesn't know if they're having activities today; -He/she looks at the calendar on the wall; -Sometimes they cancel activities if there's not staff to do them; -Sometimes the Activity Director will do bingo, karaoke, and a movie if he/she has time. 13. Review of Resident #40's face sheet showed the following: -admitted [DATE]; -Diagnoses included high blood pressure, depression, insomnia, pain, and heart failure. Review of the resident's Activity Assessment- Comprehensive, dated 04/25/24, showed the following: -The resident is involved in activities most of the time, more than 2/3 of the time; -Preferred setting is the day/activity room; -Preferred program style is large groups; -Time preference is afternoon; -No participation barriers; -No participation strengths; -Activity preference is watching television; -Past interests included animals/pets, board games, cooking, dining out, movies, outdoor activities, music, resident council, and woodworking; -Program focus is outdoor activities. Review of the resident's admission MDS, date 05/1/24, showed the following: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively intact; -His/her activity preferences showed it as very important to have books, newspapers, and magazines to read, to do things with groups of people, and to get outside to get fresh air when the weather was good and somewhat important to listen to music he/she likes, to be around animals, to keep up with the news, to do favorite activities, and participate in religious services or practices. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Staff did not document activity preferences. Review of the resident's care plan, last revised 08/02/24, showed staff did not address the resident's activity preferences or interests or any plan for activities. During interviews on 09/10/24, at 9:49 A.M., and 09/12/24, at 10:32 A.M., the Activities Director said the resident knows the facility has books and where they're at. There are both fiction and non-fiction books. 14. Review of Resident #16's face sheet showed the following information: -Readmitted [DATE]; -Diagnoses included paranoid schizophrenia. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Activity preferences not completed. Review of the resident's current care plan, last revised 09/06/24, showed staff did not care plan related to activity interests. Review of the resident's medical record, dated 01/01/24 through 09/12/24, showed staff did not complete an activity assessment or quarterly reviews of activity interests. Record review of the resident's medical record, dated 01/01/24 through 09/12/24, showed staff did not document related to activities the resident participated in. During an interview on 09/12/24, at 10:32 A.M., the Activities Director said the resident had been asked if he/she wants to be involved and he/she doesn't. He/she also hurt a scout's feelings and he/she does not feel that is right. 15. During an interview on 09/11/24, at 3:45 P.M., CNA C said he/she does not know if they do anything different for a resident that does not want to or cannot come out their room. Activities and restorative staff go around and tell the residents about the activity for the day. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	16. During an interview on 09/11/24, at 4:02 P.M., CNA D said activities were listed on the calendar in the television room. Sometimes the CNAs will tell the residents about activities, sometimes activities will, and other times they will page overhead. 17. During an interview on 09/12/24, at 12:51 P.M., CNA F said the following: -Activities are posted on the board in the television room; -The Activities Director walks around and invites residents to activities; -He/she doesn't know anything about a paper calendar; -He/she is not sure if the staff ask residents which activities they prefer. 18. During an interview on 09/12/24, at 1:09 P.M., Licensed Practical Nurse (LPN) K said the following: -The facility used to hand out fliers for the week, but now they announce the activities daily and they have the board; -There was also a daily activity sheet that listed lunch and he/she hasn't seen that in some time either; -The Activity Director is responsible for activities and he/she also has a couple of helpers; -Residents complain all of the time about activities being canceled or not having enough; -It seems like movie night gets moved a lot, or they cancel Bingo because there isn't a staff to do it; -He/she has probably seen Bingo done about 20 times in the last nine months. 19. During an interview on 09/12/24, at 9:36 A.M., Registered Nurse (RN) H said the following: -The activities are posted on the calendar in the television room or announced on the intercom; -CNAs will remind the residents about the activity. Activities will come and remind them as well; -No written calendars are handed out; -There is no way to know what a resident's preferences are; -A resident's preferences are not documented anywhere; -A resident's participation in activities are not documented anywhere that he/she is aware of; -Staff is not instructed to do anything different for residents who do not participate in activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	20. During interviews on 09/10/24, at 9:49 A.M., and on 09/12/24, at 10:32 A.M., the Activities Director said the following: -When hired, he/she was not given direction on how activities should be done; -Residents used to like to exercise, but they decided they didn't want that; -He/she tried to get them involved in other activities; -Some residents come to activities, mostly Bingo; -He/she does have another aide that's appointed to help, but they use him/her as an aide on the floor a lot; -He/she sits down with residents one-on-one to see what activities they want to do; -Residents like karaoke, corn hole, but several don't want to get out of bed; -He/she asked residents what time they want to have activities; -When he/she set up church, it was in the morning and the residents decided they didn't want mornings so it was moved to the afternoon and it was their nap time and no one came; -He/she completed an activity assessment when a resident was admitted and annually thereafter; -He/she provided puzzles and word books for various residents; -Some times aren't on the activity board. The afternoon activities are held at 1:30 P.M. He/she tells residents this and goes over it on admit; -If not enough residents show up, some activities can't be done; -He/she determines what activities to do, based upon how many residents show up for the activities; -The door is kept locked in the game room because residents have stolen. One time he/she put candy bars back there and a resident stole all of them; -If residents ask staff, they will unlock the door. Someone has a key at all times; -The activities listed on the calendar, such as hydration and lunch, are on the calendar because residents wanted to know when they were held; -He/she doesn't make calendars anymore. The residents throw them away and it's a waste of paper; -He/she said they're supposed to have Bingo, which he/she showed on the calendar, but they're having in-service today so they will make it up another day; -He/she had activities usually after the resident council meeting; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If residents refused or don't participation, he/she usually makes a note; -Since January he/she hasn't been making notes in resident's records about activities; -He/she keeps a log of who attends the activities; -He/she used to print out the calendars and put them on the resident's closet doors and they tore them off and threw them away. 21. During an interview on 09/12/24, at 1:15 P.M., the MDS Coordinator said the following: -The residents' activities care plan should have things the resident likes to do and what they have an interest in; -The care plan should say what they do and don't like; -The care plan should say if they don't participate in activities; -All care plans should say for everyone to encourage the residents to be involved 22. During an interview on 09/12/24, at 11:22 A.M., the DON said the following: -The activities calendar is posted in the television room; -Certain activities are announced overhead; -All residents are supposed to get a calendar in their rooms; -The CNAs or activities staff will go room-to-room and remind the residents before an activity; -If the residents do not want to participate in the activity for the day, they ask them if they can get them anything else; -Some residents just do not like to do anything; -She does not think it is documented anywhere if they do or do not participate in activities. -Activities should be on the care plan. 23. During an interview on 09/12/24, at 4:18 P.M., the Administrator said the following: -Activities should be part of the resident's care plan; -The Activity Director [TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31464 Based on observation, record review, and interviews, the facility failed to ensure staff followed acceptable standards of care when staff did not change gloves or sanitize their hands during care for the indwelling suprapubic catheter (tubing inserted directly into the bladder through the abdomen to drain to an exterior collection bag) of one resident (Resident #20). The facility census was 39. 1. Review of Resident #20's face sheet (gives basic profile information) showed the following: -admitted to the facility on [DATE]; -Diagnoses included bipolar disease (mental disorder causing alternating depressive and manic episodes), generalized anxiety disorder, insomnia, muscle weakness, history of urinary tract infection (UTI), benign prostatic hyperplasia (BPH; enlarged prostate gland) with lower urinary tract symptoms, testicular hypofunction, indwelling urethral catheter, impaired cognitive function and awareness, and schizophrenia (mental disorder including hallucinations and delusions). Review of the resident's quarterly Minimum Data Set (MDS; a federally mandated comprehensive assessment tool completed by facility staff), dated 07/04/24, showed the following information: -Cognition mildly impaired; -Indwelling catheter in place; -Continent of bowel. Review of the resident's physician order sheet, current as of 09/12/24, showed the following: -an order, dated 01/06/23, for an indwelling catheter, size 14 French with 10 milliliter (ml) bulb/balloon; -an order, dated 01/06/24, to change the catheter monthly; -an order, dated 01/06/24, for catheter care every shift. Review of the resident's care plan, last updated 07/06/24, showed the following: -Problem start date: 01/13/23 -Chronic suprapubic catheter, inserted due to diagnosis of BPH and urinary retention; goal to remain free of complications from BPH and chronic UTIs; empty catheter every shift and/or as needed; monitor and record output; perform catheter care every shift and as needed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/11/24, at 2:25 P.M., showed RN L donned a gown, gloves, and mask while in the hallway outside the resident's room, then turned the knob to open the door and enter the room. RN L explained the procedure to the resident, who rested on his/her bed. Without changing the contaminated gloves or performing hand hygiene, RN L lowered the resident's sweatpants to expose the abdominal (SP: suprapubic) insertion site of the catheter and removed the old gauze drain sponge surrounding the insertion site. The RN went to the sink and applied soap and water to a washcloth, then used it to clean around the SP insertion site. RN L secured the catheter tubing with one gloved hand and cleaned the tubing in a motion away from the body, did not change gloves or perform hand hygiene, and dried the tubing using a dry part of cloth. Still without changing gloves or performing hand hygiene, the RN placed a new drain sponge around site, replaced the waistband of pants, and then removed his/her gloves, gown and mask and washed his/her hands. During an interview on 09/11/24, at 3:00 P.M., RN L said staff should don gloves after washing/sanitizing their hands. Staff should change gloves after cleaning the catheter insertion site, but he/she did not remember to do so during the above observed catheter care. During an interview on 9/12/24, at 4:13 P.M., the Administrator and the corporate QA RN (Quality Assurance Registered Nurse) both said staff should wash/sanitize their hand prior to donning gloves. Staff should change gloves and sanitize their hands after cleaning a catheter, before touching clean items.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51209 Based on record review, observation, and interview, the facility failed to provide care per standards of practice when staff failed to address one resident's (Resident #39) complaints of pain in a timely manner. The facility census was 39. Review of the facility's policy Pain Management Guidelines, dated January 2017, showed the following: -The goal of pain management will be to control pain so it will not interfere with the ability to have restful sleep patterns, perform activities of daily living (ADL's- dressing, grooming, bathing, eating, and toileting), participate in usual activities, or cause problems with mood or behaviors; -A licensed nurse or certified nurse aide (CNA) may assess and communicate degrees of pain to the person administering the pain medications to the residents; -Hospice residents will be provided pain medications according to the hospice program and physician orders; -The resident's description of his/her pain will be documented in the nurses progress notes/aide charting and/or on the MAR of the resident's medical record. 1. Review of Resident #39's face sheet (brief resident profile sheet) showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - refers to chronic bronchitis and emphysema, a pair of two commonly co-existing diseases of the lungs in which the airways become narrowed. This leads to a limitation of the flow of air to and from the lungs causing shortness of breath), stroke, depression, anxiety, and post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event); -Resident on hospice services. Review of the resident's care plan, dated 06/04/24, showed the following: -Alert with episodes of fluctuating orientation related to behaviors with diagnoses of PTSD, anxiety, depression, and stroke; -Complains of pain and try to get pain medication, even when they are not due yet; -Goal of adequate pain control; -Staff to monitor for control of pain; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff to offer the resident as needed (PRN) pain medications with complaints of break-through pain; -Staff to offer non-pharmacological interventions, such as position changes or massage; -Staff to do quarterly and PRN pain assessments. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/10/24, showed the following: -The resident did not receive scheduled pain medications; -The resident had frequent pain; -The resident's pain frequently affected sleep patterns; -The resident's pain frequently affected his/her ability to complete day to day activities. Review of the resident's pain assessment and evaluation, dated 06/13/24, showed the following: -Resident had frequent pain in the last five days; -Pain made it frequently difficult for the resident to sleep over the last five days; -Pain frequently limited the resident's day-to-day activities; -The resident expressed pain through anxiety, agitation/restlessness, anger, sleep disturbance, and verbal reports; -The resident rated his/her pain as severe over the last five days; -The resident described his/her pain as shooting, stabbing, and throbbing; -The resident reported pain all times of the day; -Resident made vocal complaints of pain; -Resident was not on a scheduled pain regimen. Review of the resident's current Physician Order Sheet (POS) showed the following: -An order dated 07/12/24, for hydrocodone/acetaminophen (a narcotic that treats pain) 10/325 milligrams (mg), one tablet by mouth, every six hours, as needed; -An order, dated 07/12/24, for morphine concentrate (narcotic that can treat moderate to severe pain)100 mg/5 milliliters (ml), 0.25 ml by mouth, every two hours, as needed. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's September 2024 Medication Administration Record (MAR) showed the following: -On 09/10/24, at 7:15 A.M. staff administered morphine concentrate for leg pain rated 7 out of 10. Staff documented resident resting after administration ; -On 09/10/24, at 11:15 A.M., staff administered morphine concentrate for leg pain rated 8 out of 10. Staff documented resident resting after administration. Observation on 09/10/24, of the resident, showed the following: -At 2:36 P.M., the resident yelled out. The resident lay in the bed complaining of pain to his/her left arm, both leg, and knees. The resident had a blanket and sheet placed across his/her midsection, but not covering his/her legs; -At 2:38 P.M., the resident began yelling for pain medication. The resident said, Nurse! I need something for pain; -At 2:42 P.M., the resident began moaning loudly in pain and rubbing his/her legs together. The resident said, I can't hardly stand it; -At 2:44 P.M., a staff member walked past the door and the resident began yelling for help; -At 2:46 P.M., the resident continued to moan loudly while still rubbing his/her legs together; -At 2:48 P.M., the resident began yelling, Nurse!; -At 2:53 P.M., the resident said, I'm still hurting bad, worse; -At 2:55 P.M., the resident yelled out, I'm freezing, I'm freezing, bring another blanket; -At 2:58 P.M., the resident began repeatedly saying please. He/she then said, sometimes you have to wait a minute, it feels like it's been 30; -At 3:00 P.M., the resident told a staff member in the hall, Nurse, that pain medicine didn't work, I'm still hurting like crazy; -At 3:06 P.M., the resident lay in bed rubbing his/her left arm and muttering to self; -At 3:14 P.M., the resident said he/she continued to hurt in his/her legs, knees, and arms; -At 3:17 P.M., the resident lay in bed talking to self. No staff entered in the room to check on him/her. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 3:24 P.M., the resident said loudly he/she had pain in all his/her joints, hurts about every day. The resident complained of being cold. Certified Nurse Aide (CNA) C entered the room. CNA C said he/she heard the resident say he/she was cold. The CNA covered the resident with a blanket. The resident told the aide he/she had pain in his/her joints. CNA C said he/she thought the resident was on scheduled pain medication and did not know for sure if he/she could have anything right now. The CNA said he/she would check with the nurse and left the room. During an interview on 09/10/24, at 3:24 P.M., the resident said sometimes he/she could get up and do stuff. The pain did not usually affect or prevent him/her from doing daily activities. Sometimes, the pain affected his/her sleep. The resident said the pain was better. During an interview on 09/10/24, at 3:40 P.M., Registered Nurse (RN) H said he/she did not know the resident had complained of pain. The CNA did not tell him/her about the resident's complaints of pain. The resident was not on scheduled pain medication. The nurse said he/she could go give the resident something for pain. Review of the resident's September 2024 MAR showed the following: -On 09/10/24, at 4:00 P.M., staff administered morphine concentrate, for leg pain rated 7 out of 10. Staff documented the dose was not effective; -On 09/10/24, at 5:45 P.M., staff administered hydrocodone/acetaminophen for leg pain rated at 8 out of 10. Staff documented the dose was effective. During an interview on 09/11/24, at 2:41 P.M., Certified Medication Technician (CMT) E said the following: -No one reported the resident's pain to him/her on 09/10/24, or he/she would have given the resident a pain pill; -He/She gave the resident hydrocodone/acetaminophen on 09/10/24, at 5:45 P.M., when the resident sat at the desk yelling out that his/her legs hurt; -He/she said would assess a resident for pain when giving a pain pill, but he/she assumed the nurses were responsible for assessing pain. During an interview on 09/11/24, at 3:45 P.M., CNA C said the following: -He/She would report pain to the CMT and nurse immediately; -Staff can tell when the resident is in pain by nonverbal cues and other time he/she can verbally tell; -Regardless of the way the pain is communicated, he/she would report it; During an interview on 09/11/24, at 4:02 P.M., CNA D said that he/she would report a resident's complaint of pain immediately to the nurse or CMT. The resident can voice complaints of pain verbally. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/24, at 8:54 A.M., CNA F said the following: -He/She would report pain to the nurse or CMT immediately; -He/She knows when the resident is having pain because he/she yells out; -Pain pills do help the resident and normally work within 30 minutes; -The resident's pain affects him/her from getting up/going to meals; -The resident's pain affects his/her sleep. During an interview on 09/12/24, at 9:00 A.M., CNA G said the following: -He/She would reposition a resident complaining of pain to see if that relieves the pain. He/She would also report the pain to the nurse and the CMT immediately; -He/She knows the resident has pain because the resident yells out; -The resident's pain sometimes affects him/her going to meals; -Pain pills seem to help the resident sometimes, but if he/she has already been yelling for a long time they don't seem to work as well. During an interview on 09/12/24, at 9:36 A.M., Registered Nurse (RN) H said the following: -The nurses only assess pain when they give a PRN medication; -There is no routine pain assessments; -If a resident can verbally describe pain, he/she would use a pain scale of 1 to 10; -If a resident cannot verbally describe pain, he/she would look for nonverbal cues such as crying, grimacing, yelling, or rubbing a body part; -The resident can verbalize his/her pain; -The resident also has non verbal cues such as yelling and crying; -The pain medication helps sometimes; -Sometimes the morphine does not help, sometimes the Norco does better; -All of the resident's pain medications are PRN; -The resident's pain sometimes effects his/her ability to attend meals; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's pain sometimes effects his/her sleep as the resident will yell out more when he/she is in pain. During an interview on 09/12/24, at 10:47 A.M., the resident's primary physician said the following: -Since the resident is on hospice, he would expect staff to give him/her pain medication; -The resident is on a starting dose of morphine, which he would consider low, and could be increased if not effective; -He would expect staff to notify him if the resident's pain medication was not effective. During an interview on 09/12/24, at 1:15 P.M., the MDS Coordinator said she would expect pain management to be on the care plan and that she would expect staff to follow the care plan. During an interview on 09/12/24, at 11:22 A.M., the Director of Nursing (DON) said the following: -The nurses assess for pain; -The residents should be assessed for pain when a resident says they are in pain, during the weekly skin assessment, and before and after a PRN medication is given; -If a resident has chronic pain, they should be assessed every shift; -The nurses document the pain assessment on the MAR or in the nurse's notes; -If a resident is verbal, they should be assessed using a 1 to 10 scale; -If a resident is non verbal, they should be assessed by looking for grimacing, crying, rubbing legs together, or holding body parts; -Staff can tell when the resident has leg pain because the resident will move his/her legs and cry out; -To assess the resident's pain, staff should ask him/her where if it hurts and where, and look for nonverbal cues; -When the resident is crying out or if he/she asked for pain medication, he/she would give it immediately; -The pain pills do a good job controlling his/her pain most of the time; -The resident's pain does not keep him/her from getting up for meals as far as she is aware; -The resident's pain does effect his/her sleep. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31464 Based on record review and interview, the facility failed to ensure that all residents who were trauma survivors received care per standards of practice when staff did not address the the diagnosis of Post-Traumatic Stress Disorder (PTSD - disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event) in the medication record or in the care plan, to include triggers and interventions, and failed to ensure care staff were aware of the PTSD history, to include triggers and interventions, for one resident (Resident #41). The facility census was 39. Review of the facility assessment, updated 10/25/23, showed the following information: -The facility may accept residents with, or who may develop, common diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management including PTSD; -The facility will manage the medical conditions causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, and care of individuals with trauma/PTSD; -The facility will provide person-centered/directed care. Staff to find out what upsets him/her and incorporate this into he care planning process. Staff to make sure staff caring for the resident has this information. Review showed the facility did not provide a policy related to PTSD. 1. Review of Resident #41's face sheet (gives basic profile information about the resident) showed an admitted [DATE]. Review of the resident's PASARR Level II Evaluation (Preadmission Screening and Resident Review (PASARR) - a two level tool used to screen each resident in a nursing facility for mental disorder or intellectual disability prior to admission), completed by hospital staff on 05/09/24, showed the following information: -No contact with his/her three children; -He/she and spouse started using drugs/alcohol together at an early age. Spouse currently supposed to be in alcohol/drug rehab program, but recently signed out of the program. At this time the spouse is not allowed to visit, per family's request; -Resident/spouse had a house that burned to the ground last year and now living in a [NAME] house on sibling's property; (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Sibling reports he/she and siblings grew up in a very abusive home environment. Parent remarried to an abusive partner with heavy drug/alcohol involvement in the home. All siblings experienced significant mental/physical abuse and witnessed significant domestic violence in the home. All siblings, including this resident, reported they were sexually abused; -Sibling reported resident attempted suicide once by hanging and once by cutting him/herself. Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 05/21/24, showed the resident's diagnoses included traumatic brain dysfunction, seizure disorder, and anxiety disorder. Review of resident's nurses' notes showed the following: -On 07/29/24, at 2:07 A.M., the resident returned from outing with family and had been punching, pushing, trying to bite, and kicking at staff and attempting to elope. Attempts to calm resident down and redirect have not been effective. Staff gave as needed medication, but resident still wound up. Staff following him/her around to prevent elopement, but aggressive behaviors continue. Staff contacted nurse practitioner and received order for Haloperidol (an antipsychotic medication) 1 milligram (mg) IM (injected in the muscle) given now. The medication has not stopped behaviors; -On 07/29/24, at 4:28 A.M., resident continued with aggressive behaviors and refused redirection. Staff received order from nurse practitioner to send resident out for evaluation. Emergency medical services (EMS) left with resident at 3:00 A.M. Review of the resident's face sheet showed on 08/02/24 the diagnosis of post-traumatic stress disorder was added. Review of resident's nurses' notes showed on 08/03/24, at 4:45 A.M., resident arrived back at the facility at 11:00 P.M. Resident reported he/she was glad to be back and have a pleasant affect. Resident placed on 15-minute checks. Review of the resident's care plan, last reviewed 08/15/24, showed the staff did not address the new diagnosis of PTSD, the resident's triggers for PTSD, or interventions related to PTSD. Review of the resident's quarterly MDS, dated [DATE], showed the resident's diagnoses included PTSD. Review of the facility provided matrix (a form requested on survey entrance with brief details of resident care needs), completed on 09/09/24, showed the staff identified the resident had PTSD/trauma. During an interview on 09/11/24, at 1:55 P.M., the resident's sibling said they have tried to educate the facility staff on the resident's emotional triggers. The resident and his/her siblings were molested as children and agitation will escalate if staff make him/her lie down for any personal care. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/24, at 11:28 A.M., Certified Nurse Aide (CNA) P, who was the designated shower aide for the day, said the resident gets agitated sometimes. The CNA thinks the family being present often over stimulates him/her; then he/she wants them there all the time. He/she was not aware of any psychological history for the resident or a diagnosis of PTSD. During an interview on 09/12/24, at 12:55 P.M., CNA G said he/she gets a report from the previous shift on the residents. Other staff should know and pass on information regarding a resident's triggers and care needs. He/she did not know of any specific triggers for the resident or his/her psychological background. During an interview on 09/12/24, at 1:04 P.M., Licensed Practical Nurse (LPN) K said he/she was contracted staff and had worked in the facility often, but hadn't been there for the past month. A CNA said the resident's spouse had come in drunk and upset the resident. The LPN was unaware of other triggers or psychological background for the resident. During an interview on 09/12/24, at 1:40 P.M., the MDS Coordinator said he/she did not know who added the diagnosis of PTSD. A diagnosis of PTSD should be listed under behaviors in the care plan. The MDS Coordinator was unaware of the resident's history, the reason for the PTSD diagnosis, or any triggers for the resident. He/she said they didn't think they'd need to list any specific triggers, just that there is a history of traumatic event, to inform the staff. During an interview on 09/12/24, at 1:55 P.M. the Director of Nursing (DON) said staff should have carried the diagnosis over to the care plan to identify and notify staff of history and triggers. He/she was not previously aware of the resident's history of being abused/molested as a child or the house fire. During an interview on 09/12/24, at 4:13 P.M., the Administrator and the corporate Quality Assurance Registered Nurse said a diagnosis of PTSD should be noted in the resident's care plan with specifics and triggers. The Administrator was unaware of the reason for the resident's PTSD diagnosis or any triggers.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 31464 Based on interview and record review, the facility failed to complete performance reviews of every certified nurse aide (CNA) at least once every 12 months when staff failed to document competency evaluation and performance review for two staff (CNA N and CNA M). The facility census was 39. Review showed the facility did not provide a written policy pertaining to nurse aide competency reviews. 1. Review of personnel records showed the following CNAs had been employed for more than one year: -CNA N - Hire date of 12/20/22; Re-hire date of 04/26/23; -CNA M - Hire date of 01/27/23; Re-hire date of 06/28/23; -Staff did not have documentation of a yearly performance review for CNA N and CNA M. During an interview on 09/11/24, at 9:08 A.M., the Director of Nursing (DON) said the facility did scheduled monthly in-services for all staff, with some specific to nursing and the CNAs. They did not have documentation on annual performance reviews. During an interview on 09/12/24, at 3:30 P.M., the corporate Quality Assurance Registered Nurse (QARN) said the corporation did not have a specific written policy pertaining to the completion of CNA annual competencies. The facility should complete the competencies for all CNAs and include skills such as catheter care, transfers, peri-care (perineal; genital) with incontinence or toileting, hand washing, and glove use. During an interview on 09/12/24, at 4:13 P.M., the Administrator said the facility should be completing annual competencies for the CNAs with documentation on the performance reviews. The competencies should include skills such as catheter care, peri-care, toileting, assisted transfers and mechanical lifts.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48187 Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention and control program when staff failed to complete appropriate hand hygiene and use PPE appropriately while providing wound care for one resident (Resident #32). Facility staff also failed to complete appropriate hand hygiene while providing indwelling suprapubic catheter (tubing inserted directly into the bladder through the abdomen to drain to an exterior collection bag) care for one resident (Resident #20). The facility census was 39. Review of the facility policy, titled Handwashing, dated 03/2015, showed the following information: -Purpose to reduce transmission of organisms from resident-to-resident, staff-to-resident, and resident-to-staff; -Wash hands with soap and water. Review of the facility policy, titled Enhanced Barrier Precautions (EBP) to Infection Control Guidance, updated 03/2024, showed the following information: -Policy purpose was to prevent broader transmission of multidrug-resistance organisms and to help protect patients with chronic wounds and indwelling devices; -EBP should be implemented until wounds have resolved or indwelling medical devices have been removed; -Staff are to use EBP when providing high-contact resident care activities such as performing wound cares; -Equipment include gloves and gown; -Conduct proper hand hygiene before starting care; -Gloves and donning and doffing of gown are required when conducting high-contact resident care activities such as wound care; -Gloves and gown should be removed and discarded after each resident care encounter; -Personal Protective Equipment (PPE) should be placed in proximity outside the resident's door and a trash can in the resident's room for disposal prior to leaving the room. Review of the facility policy, titled Wound Care and Treatment, dated 07/2015, showed the following information: -Handwashing and glove usage will be done according to guidelines; -Put on gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Remove soiled dressing and place in trash bag; -Remove gloves and place in trash bag; -Wash hands and put on clean gloves; -Clean the wound according to the physician orders; -Remove gloves and place in trash bag. Put on clean pair of gloves (handwashing or alcohol gel usage if skin is contaminated when gloves removed); -Apply clean dressing; -Position resident comfortably with call light with-in reach; -Clean the environment with Sani/bleach wipes; -Discard trash; -Remove gloves and wash hands; -Document. 1. Review of Resident #32's face sheet (brief resident profile sheet) showed the following information: -admitted [DATE]; Diagnoses included stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) of sacral region (the triangular bone at the base of the spine that connects the lower back to the pelvis), heart failure, hypertension (high blood pressure), and depression. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/16/24, showed the following information: -Required extensive assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene; -Always incontinent of bowel and bladder. Review of the resident's care plan, revised 06/30/24, showed the following information: -Staff to use EBP when providing cares while in the resident's room; -Assist with repositioning and toileting; -Monitor skin for any signs of breakdown such as redness, blisters, and open areas. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's current Physician Order Sheet showed the following information: -An order, dated 07/17/24, to cleanse wound with hypochlorous acid (no need to rinse from wound or skin, use to irrigate and scrub the wound bed, protect peri-wound with skin prep, lightly pack tunnel (a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound) with a long thin piece of Hydrofera Blue (antibacterial wound dressing) and cover with ABD pad (gauze) for moderate to heavy drainage. Treatment to be done every other day and as needed if soiled. -An order, dated 08/16/24, clean coccyx wound with Vashe (wound cleanser), place Puracol (collagen wound dressing) in wound, cover with gauze, then apply foam dressing to cover gauze, with skin prep around dressing, Place Suresite (transparent film dressing) over wound and surrounding area. Treatment to be done every other day. Observation on 09/11/24, at 10:38 A.M., showed the following information: -Registered Nurse (RN) L parked a treatment cart outside the resident's room with drawers facing the resident's room and gathered supplies; -RN L completed hand hygiene and donned gown, surgical mask, and gloves before entering resident's room; -RN L removed the old dressing and placed in biohazard bag; -RN L cleansed wound with wound cleanser and sterile Q-tip, then placed Q-tip in biohazard bag; -RN L changed gloves without performing hand hygiene; -RN L applied skin prep to skin around wound then placed Hydrofera Blue in wound; -RN L pulled his/her face mask down exposing his/her nose with gloved hand; -RN L changed gloves without performing hand hygiene; -RN L covered wound with ABD pad and secured with tape; -RN L changed gloves without performing hand hygiene; -The resident repositioned to left side; -RN L removed old dressing and placed in biohazard bag; -RN L cleansed wound with wound cleanser; -RN L while kneeled at the bedside near the wound, pulled his/her mask from face, fanned face with his/her hand and stated he/she was trying to get some air; -RN L applied skin prep to skin around wound; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-RN L changed gloves without performing hand hygiene; -RN L applied Puracol dressing to wound; -RN L removed gloves (did not perform hand hygiene), left room with gown on, went to treatment cart to obtain ABD pad; -RN L returned to room, ABD pad placed without gloves and secured with tape; -RN L pulled mask from face, fanned face with his/her hand, and said he/she could not breath with the mask covering his/her face; -RN L removed gown and mask and washed hands. During an interview on 09/11/24, at 11:53 A.M., RN L said staff should use hand hygiene after changing gloves, but said I don't. I cleanse my hands good at the beginning and wash them again when I am all done with wound care. I change my gloves between dirty and clean and that should be good. During an interview on 09/11/24, at 11:56 A.M., RN H said staff should wash their hands or use hand hygiene before and after wound care and any time they change their gloves. During an interview on 09/11/24, at 1:28 P.M., the Director of Nursing (DON) said that staff is expected to wear gown, gloves and mask when providing cares on all EBP residents. The DON expected staff to wash hands or use hand hygiene before and after donning and doffing gloves and every time gloves are changed. The DON expected the mask to cover the nose and mouth of staff when performing cares and staff should not remove the face mask or pull the mask from the face while performing cares with a gloved hand. The DON expected staff to complete the wound care, then remove all PPE, including mask, and wash hands before leaving the resident's room. During an interview on 09/12/24, at 4:15 P.M., the Administrator said that he/she would not expect staff to pull face mask down and fan face while performing wound cares. He expected staff to wash hands or use hand hygiene after removing gloves. 2. Review of Resident #20's face sheet showed the following: -admitted [DATE]; -Diagnoses included history of urinary tract infection (UTI), benign prostatic hyperplasia (BPH - enlarged prostate gland) with lower urinary tract symptoms, and indwelling urethral catheter. Review of the resident's quarterly MDS, dated [DATE], showed the following information: -Cognition mildly impaired; -Indwelling catheter in place; -Continent of bowel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's physician order sheet, current as of 09/12/24, showed the following: -An order, dated 01/06/23, for an indwelling catheter; -An order, dated 01/06/24, to change the catheter monthly; -An order, dated 01/06/24, for catheter care every shift. Review of the resident's care plan, last updated 07/06/24, showed the following: -Chronic suprapubic catheter inserted due to diagnosis of BPH and urinary retention; -Goal to remain free of complications from BPH and chronic UTIs; -Staff to empty catheter every shift and/or as needed, monitor and record output, and perform catheter care every shift and as needed. Observation on 09/11/24, at 2:25 P.M., showed the following: -RN L donned a gown, gloves, and mask while in the hallway outside the resident's room, then turned the knob to open the door and enter the room; -RN L explained the procedure to the resident, who rested on his/her bed. Without changing the contaminated gloves or performing hand hygiene, RN L lowered the resident's sweat pants to expose the abdominal insertion site of the catheter and removed the old gauze drain sponge surrounding the insertion site; -The RN went to the sink and applied soap and water to a washcloth, then used it to clean around the SP insertion site. (The RN did not complete hand hygiene.); -RN L secured the catheter tubing with one gloved hand and cleaned the tubing in a motion away from the body without changing gloves or performing hand hygiene. RN L then dried the tubing using a dry part of the cloth; -Without changing gloves or performing hand hygiene, the RN placed a new drain sponge around site and replaced the waistband of pants. During an interview on 09/11/24, at 3:00 P.M., RN L said staff should don gloves after washing/sanitizing their hands. Staff should change gloves after cleaning the catheter insertion site, but he/she did not remember to do so during the above observed catheter care. During an interview on 9/12/24, at 4:13 P.M., the Administrator and the corporate QA RN (Quality Assurance Registered Nurse) both said staff should wash/sanitize their hand prior to donning gloves. Staff should change gloves and sanitize their hands after cleaning a catheter, before touching clean items.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 45176 Based on observation, record review, and interview, the facility staff failed to ensure the facility was maintained in a sanitary and comfortable fashion when staff failed to keep the outside of the ice machine clean and failed to keep all light fixtures, vents, and ceiling areas clean. The facility census was 39. 1. Review of the facility's policy titled Ice Maker, dated May 2015, showed staff would clean the outside of the machine week. Staff would wash the outside of the ice machine monthly with a soft brush or cloth and dry. Review of the facility's Ice Machine Cleaning Schedule showed the machine was to be cleaned monthly. Staff last documented cleaning the ice machine on 08/31/24. Observations on 09/09/24, beginning at 9:13 A.M., of the ice machine in the kitchen showed the following: -The outside had white and brown buildup along the crevasses of the machine at the top; -The right side of the machine had three long streaks of white; -The left side of the machine had much of it covered with white streaks and a crusty white substance; -Above the door opening there was a dirty substance. Observations on 09/11/24, beginning at 8:50 A.M., of the ice machine in the kitchen showed the following: -Outside of the ice machine had white and brown buildup along the crevasses of the machine at the top; -The left side of the machine had much of it covered with white streaks and a crusty white substance. During an interview on 09/11/24, at 1:39 P.M., Dietary Aide (DA) A said the following: -Evening shift staff are responsible for cleaning the outside of the ice machine at the end of their shift; -Kitchen has a cleaning schedule for daily, weekly, and monthly items; -The ice machine is listed on the cleaning schedule. During an interview on 09/11/24, at 1:49 P.M., DA B said the following: (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-When he/she remembers, he/she wipes down the outside of the ice machine with a sanitizing rag nightly; -He/she will also clean above the door, but not as often. During an interview on 09/11/24, at 1:44 P.M., the Dietary Manager (DM) said the following: -Staff have a cleaning schedule for the kitchen, but cleaning the outside of the ice machine is not on the cleaning schedule; -Staff should be cleaning the outside of the ice machine once a day; -He/she is responsible for ensuring staff clean the ice machine. During an interview on 09/11/24, at 2:02 P.M., the Maintenance Director said dietary staff were responsible for cleaning the outside of the ice machine. During an interview on 09/11/24, at 1:56 P.M., the Administrator said the following: -He wasn't sure whose responsible it to clean the outside of the ice machine; -He would expect staff to keep the outside clean. The ice machine should not have white streaks or crust or grime on it; -The DM was responsible for making sure the ice machine was cleaned regularly. 2. Observations on 09/09/24, beginning at 9:13 A.M., and on 09/11/24, at 1: 39 P.M., of the kitchen showed the a florescent light, and ceiling around the light, located in front of the stove and above the table, had brown spots present. During an interview on 09/11/24, at 1:49 P.M., DA B said maintenance cleans the ceiling and lights on the ceiling. During an interview on 09/11/24, at 2:02 P.M., the Maintenance Director said the following . -He/she cleans the fluorescent lights in the kitchen when he/she changes out the bulbs. It is not on his/her cleaning schedule; -He/she doesn't clean the ceiling in the kitchen. During an interview on 09/11/24, at 1:44 P.M., the DM said the following: -Maintenance cleans the lights and the ceiling; -When kitchen staff find an issue, they write the issue on the clip board located at the nurses' station; (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she doesn't know how often maintenance cleans the lights or ceiling; -He/she didn't notice the brown spots on the light or ceiling. During an interview on 09/11/24, at 1:56 P.M., the Administrator said the following: -He knew maintenance changed the bulbs out, but he wasn't sure if maintenance cleaned the lights and the ceiling; -He would expect the lights and ceiling to be clean; -Maintenance has a book at the nurses' station where any issues should be noted. 3. Observations on 09/09/24, beginning at 9:13 A.M., and on 09/11/24, at 11:42 A.M. and 1: 39 P.M., of the kitchen showed the ceiling vent, just before entering the kitchen, had fuzzy lint hanging from it. During an interview on 09/11/24, at 1:39 P.M., DA A said the following: -Maintenance was responsible for cleaning the ceiling vents; -He/she didn't think about looking at the ceiling and didn't notice the fuzzy lint on the vent. During an interview on 09/11/24, at 1:49 P.M., DA B said he/she doesn't do anything with the ceiling vents and doesn't know who is supposed to clean them. During an interview on 09/11/24, at 2:02 P.M., the Maintenance Director said he/she doesn't clean the vents and doesn't know who is supposed to clean them. During an interview on 09/11/24, at 1:44 P.M., the DM said the following: -He/she wasn't sure who was supposed to clean the vents on the ceiling; -He/she didn't realize the vent had fuzzy lint. During an interview on 09/11/24, at 1:56 P.M., the Administrator said maintenance should be taking care of the vents, ensuring they don't have fuzzy lint.