STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265589	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Peters Rehab and Healthcare Center	230 Spencer Road Saint Peters, MO 63376

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, and policy review, the facility failed to ensure three of 28 sampled residents (Resident (R) 30, R28, and R63) received services in a manner that promoted their dignity and enhanced their quality of life. R30 was observed as unshaven with long stubble facial hair and wearing clothing covered with food spills, residue, and crumbs. R28 and R63 required assistance with eating and facility staff were observed standing over them while assisting them. The facility census was 82. Findings include: Review of the Privacy and Dignity policy, dated 10/24/22 revealed, The facility promotes resident care in a manner and an environment that maintains or enhances dignity and respect, in full recognition of each resident's individuality . Staff assists residents in maintaining self-esteem and self-worth. Residents are groomed as they wish to be groomed. Residents are dressed appropriate to the time of day and season as well as individual preferences . The facility respects the resident's private space and property. Staff treats residents with respect including . speaking respectfully, listening carefully . 1. Review of R30's undated Admission Record located in the resident's electronic medical record (EMR) under the Profile tab revealed R30 was admitted to the facility on [DATE] with diagnoses including benign intracranial hypertension (increased intracranial pressure e.g. headache, vision loss, elevated intracranial pressure with normal cerebrospinal fluid), Alzheimer's disease, diabetes mellitus type two with neuropathy, and adult failure to thrive. Review of R30's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/01/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated the resident was moderately cognitively impaired. R30 required substantial/maximal assistance with showers and personal hygiene. R30 required partial/moderate assistance with upper and lower body dressing. No behaviors were identified on the MDS. Review of R30's Care Plan dated 07/06/23 located in the resident's EMR under the Care Plan tab revealed R30 had a focus area of, The resident has an ADL self-care deficit r/t [related to] Alzheimer's, limited mobility. The goal was to maintain R30's current level of function. Interventions included in pertinent part: (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Bathing/showering: Provide sponge bath when a full bath or shower cannot be tolerated . -Dressing: The resident is totally dependent on (1) staff for dressing . -Eating: The resident is able to: eat independently after setting up . -Personal hygiene/oral care: The resident is totally dependent on (1) staff for personal hygiene and oral care . The Care Plan did not specifically address shaving. The Care Plan did not identify a concern with refusals of care. Review of R30's Shower Sheets for March 2023 - 04/09/24 provided by the facility revealed R30 had been bathed/showered seven times: on 03/06/24, 03/07/24, 03/20/24, 03/23/34, 03/30/24, on 04/05/24, and on 04/06/24. No refusals were documented on the shower sheets. Observation on 04/08/24 at 10:01 AM, revealed R30 was in his wheelchair in the hallway outside his room. R30 had long stubble facial hair 1/2 long. The surveyor attempted to interview R30; however, R30 was groggy and did not converse with the surveyor or respond to the conversation. Additional observations on 04/08/24 at 12:09 PM; on 04/08/24 at 1:48 PM; on 04/09/24 at 10:02 PM; on 04/09/24 at 12:59 AM; on 04/09/24 at 2:49 PM revealed R30 remained unshaven. Observation on 04/09/24 at 2:49 PM, R30 was slumped down with his hips towards the edge of the chair, sitting in his wheelchair in the dining room. He was wearing a t-shirt that was covered with food spills, residue, and crumbs from the neckline all the way down to the edge of the t-shirt where it met his pants. There were multiple types of food, yellow, brown, and green adhered to the shirt with crumbs on top. R30's black sweatpants were also covered with food residue and crumbs down to his crotch. R30 continued to be unshaven and was asleep in the wheelchair. During an observation on 04/09/24 at 6:19 PM, R30 was in the dining room in his wheelchair with the same soiled clothing seen earlier and additional food crumbs and pieces of chips on his shirt. During an interview on 04/09/24 at 6:23 PM., Certified Nursing Assistant (CNA) 2 stated he came on shift at 3:00 PM and he was assigned to R30. CNA2 stated he had changed R30's incontinent brief since coming on his shift at 3:00 PM; however, had not provided any other care. When asked about R30's soiled clothing, CNA2 stated he noticed it was soiled and had brushed off the excess residue but had not changed R30's clothing, because R30 did not have clean clothes in his closet to wear. CNA2 and the surveyor went and looked at R30's closet and there were four clean shirts and a clean pair of sweatpants. CNA2 verified that R30's clothing was soiled and his stubble was long. CNA2 stated R30 should be shaved when he received a shower. CNA2 stated R30 was to be showered by other staff on 04/08/24 (his shower day); but he had not been. CNA2 stated R30 required assistance from staff for completion of activities of daily living (ADLs) such as showering, hygiene, and dressing. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/11/24 at 2:13 PM, the Director of Nursing (DON) and Regional Nurse Consultant (RNC) 1 stated they expected the staff to change a resident's clothing if it was soiled to maintain dignity. They stated if the resident refused care, it should be care planned. The DON was newly hired to the facility and did not have specific information regarding R30. During an interview on 04/12/24 at 9:53 AM, Licensed Practical Nurse (LPN) 4 stated R30 required maximum assistance with ADLs. She stated R30 was confused but did not exhibit behaviors. LPN4 stated R30 was cooperative with the provision of care. LPN4 stated R30 should be shaved with showers, provided twice a week. During an interview on 04/12/24 at 4:43 PM, the Administrator stated he was new to the facility (less than a month) and did not know the specifics regarding R30. He stated if R30 refused showers or shaving, it should be documented on the care plan. 2. Review of R28's undated Face Sheet provided by the facility revealed R28 was admitted to the facility on [DATE] with a diagnoses which included type 2 diabetes mellitus without complications, other rheumatoid arthritis with rheumatoid factor of other specified site, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of R28's quarterly Minimum Data Set (MDS), with an ARD of 12/26/23 and located in the resident's EMR under the Resident Assessment Instrument (RAI) tab revealed the facility was unable to complete a Brief Interview for Mental Status (BIMS) on the resident due to the resident being never or rarely understood and the resident had short and long term memory problems. Observation and interview on 04/09/24 at 9:12 AM during the breakfast meal, revealed CNA6 was standing over R28 assisting the resident with her breakfast. During an interview at the time of the observation, CNA6 stated The appropriate way to assist the residents with feeding is by sitting beside them. 3. Review of R63's undated Face Sheet provided by the facility revealed R63, was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease with late onset, depression, unspecified and muscle weakness, (generalized). Review of R63's quarterly MDS with an ARD of 02/21/24 and located in the resident's EMR under the Resident Assessment Instrument (RAI) tab revealed the facility assessed the resident to have a BIMS score of four out of 15 which indicated the resident was severely cognitively impaired. Observation and interview on 04/10/24 at 1:12 PM during the lunch meal revealed Nurse Aide (NA) 3 was standing over R63 assisting the resident with their meal. When asked about the proper way to assist a resident with their meal, NA3 replied, .don't stand over them. 4. During an interview on 04/11/24 at 10:55 AM, the Registered Dietitian (RD) stated staff should be seated while assisting residents with their meal. The RD also stated it was to be a homelike atmosphere, and no one should be standing over residents. During an interview on 04/11/24 at 2:46 PM, the DON and the Assistant Director of Nursing (ADON) stated staff should not stand over residents when assisting them with their meals. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	22411

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on interview, record review, and policy review, the facility failed ensure residents retained their right to exercise their rights for one of 28 sampled residents (Resident (R) 73). The facility did not provide R73 the opportunity to make their own decision regarding whom they wanted to contact and if they wanted to use a cell phone sent to them to communicate. The facility opened the resident's mail containing a cell phone, read a note inside the package intended for the resident, and contacted (Family Member (F) 73. FM 73 told the facility to not give the phone to the resident, even though the resident had not been adjudged incompetent by the court and legally retained his rights as a United States citizen. The facility census was 82. Findings include: Review of the facility's Resident Rights policy dated 05/01/23 revealed, Purpose - To promote and protect the rights of all residents at the facility .All residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the Facility . Review of R73's Admission Agreement dated 12/21/23 located in the resident's electronic medical record (EMR) under the Misc [miscellaneous] tab provided by the facility revealed, Resident has the sole right to make choices and decisions about his/her medical treatment and care. Other individuals only have the right to make such decisions if they are a court-appointed legal guardian, and/or an agent appointed under a valid Durable Power of Attorney (POA) for Health Care. In situations where there is a Durable Power of Attorney for Health Care, the agent does not have the authority to make decisions for the Resident unless and until the Resident is determined incapacitated . Review of R73's undated Admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed R73 was admitted to the facility on ,d+[DATE]. The Admission Record also indicated F73 was the resident's medical Power of Attorney (POA). R73 passed away in the facility on 03/07/24. Review of R73's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 12/26/23 located in the resident's EMR under the MDS tab revealed the facility assessed R73 to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact. Review of R73's Resident Preferences Evaluation dated 12/22/23 located in the resident's EMR under the Progress Notes tab revealed it was very important for the resident to be able to use the phone in private. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/24 at 11:56 AM, Interested Party (IP) 73 stated R73's POA authorized who R73 could and could not speak to. IP73 stated R73 had a girlfriend of approximately [AGE] years who historically spoke on the phone to R73 daily. IP73 stated when F73 took over as POA, she refused to let R73 speak to his girlfriend. IP73 stated R73's rights were violated and R73 became depressed. IP73 stated R73's girlfriend lived out of state and talking on the phone was how they communicated with each other. IP73 stated during the last two weeks of R73's life, he could not talk to his girlfriend based on the direction of his POA. IP73 stated she had mailed a cell phone to R73 after the one he had when he was admitted to the facility went missing. IP73 stated the facility took the phone away that they (IP73 and R73's girlfriend) mailed to R73 and gave it to his POA without R73's permission. During an interview on 04/09/24 at 1:21 PM, the Social Service Director (SSD) stated R73 had his own cell phone when he entered the facility, but something happened to it, possibly his POA (F73) removed it. The SSD stated F73 told her she would rather R73 and his girlfriend not talk. The SSD stated R73 received a phone through the mail from his girlfriend after his went missing. The SSD stated, We opened the phone [package the phone came in]. The SSD stated there was a letter in the box directing R73 to not let F73 have the phone. The SSD stated she contacted F73 and asked if R73 could have the phone. F73 instructed the SSD to get the phone and stated she would send it back to R73's girlfriend. The SSD stated F73 came and retrieved the phone from the facility. The SSD stated she did not ask R73 if he wanted to keep the phone. The SSD stated R73 never told her that he did not want to talk to his girlfriend. The SSD verified R73 was cognitively able to make his own decisions as reflected by the BIMS score of 14 and that he should have been able to make his own decisions until he was deemed incompetent. Review of R73's Social Services Note dated 01/04/24 located in the resident's EMR under the Progress Notes tab read, Spoke with POA [F73's name] she stated she does not want [R73's] girlfriend to call or have visitation with Resident. [F73] came to facility to get his phone on 01/03/24 [F73] stated she will not be giving the phone back to Resident. During an interview on 04/11/24 at 12:37 PM, Licensed Practical Nurse (LPN) 4 stated R73 was forgetful at times but could make his own decisions. LPN4 stated she remembered R73 had a phone and that his family came and took it. During an interview on 04/12/24 at 4:27 PM, the Administrator stated R73 passed away prior to the start of his employment. The Administrator stated his expectation was for residents' choices to be determined before family input was sought.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 25225 Based on interview, record review, and facility policy review, the facility failed to invite two of 28 sampled residents (Resident (R) 11 and R4) to participate in their care plan meetings. Both residents had been assessed as cognitively intact and expressed they would like to attend their own care plan meetings. The facility census was 82. Findings include: Review of the facility's policy titled, Care Planning dated 10/24/22 revealed, The Comprehensive Care Plan must be prepared by the IDT [interdisciplinary team]. The IDT team includes the following individuals . The resident and/or his/her family or legal representative; i. If the resident and his/her resident representative participation is determined not practicable for the development of the resident's care plan, an explanation should be included in the resident's medical record . The Facility will invite the resident, if capable, and their family to care planning meetings and use its best efforts to schedule care planning meetings at times convenient for the resident and family . 1. Review of R11's undated Admission Record located in the resident's electronic medical record (EMR) under the Profile tab revealed R11 was admitted to the facility on [DATE]. R11 had a family member who was his Power of Attorney (POA) in the event he became incapacitated Review of R11's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/16/24 located in the resident's electronic medical record (EMR) under the MDS tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. During an interview on 04/08/24 at 1:11 PM, R11 stated he had some health and mood issues currently such as pain and depression. R11 stated he had not been invited to or attended his care plan meetings. R11 stated he was interested in participating in his care and would like to attend care plan meetings. During an interview on 04/09/24 at 2:31 PM, the Social Service Director (SSD) stated, until about a month ago, she had been responsible for inviting families and residents to quarterly care plan meetings (coinciding with MDS due dates). The SSD stated when scheduling, the first thing she did was check with the family about scheduling. She stated R11's care plan was canceled the last couple of times by his Power of Attorney (POA). The SSD stated the care plan meeting was not conducted without R11's POA and she scheduled the meetings around the POA's availability. The SSD stated residents were also invited to their care plan meetings; however, she did not document this. She stated R11 had not come to the care plan meetings recently. During an interview on 04/12/24 at 11:02 AM, the SSD stated there was no sign in sheet for residents/families who attended care plan meetings. She stated attendance would be documented in the Plan of Care Note or on Care Plan Worksheets. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS tab in the EMR revealed MDS assessments were completed on 05/22/23, 11/22/23, and 02/16/24. Review of R11's Care Plan Worksheet dated 11/29/23 provided by the SSD revealed the invitation was sent to R11's POA on 11/29/23. Under the resident's attendance, No was documented. The line for documenting the reason the resident did not attend was blank/not filled out. The POA's attendance was documented, No answer. No additional information was noted on the form. Review of R11's Plan of Care Notes from 12/07/22 through the current date located in the resident's EMR under the Progress Notes tab revealed notes on 12/07/22, 02/13/23, 05/31/23, and 01/24/24 indicating R11's POA was invited to the meeting or attended the care plan meetings. There was no documented evidence of R11 being invited to or attending any of the meetings. During an interview on 04/11/24 at 3:08 PM, the Assistant Director of Nursing (ADON) stated she regularly attended care plan meetings and she did not remember R11 coming. During an interview on 04/11/24 at 1:40 PM, the Director of Nursing (DON) and Regional Nurse Consultant (RNC) 2 stated residents should be asked if they wanted to be part of the care plan meeting and they should be informed about the meeting a couple days ahead of time. The DON stated there should have been a progress note documenting the resident was invited. The DON also stated there should have been documentation of who attended the care plan meetings. During an interview on 04/12/24 at 4:46 PM the Administrator stated residents should be invited to their care plan meetings unless there was a guardian, etc. The Administrator stated residents should lead their care plan meeting if they could; it should be resident centered. 2. Review of R4's Admission Record, provided by the facility, revealed R4 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis, type 2 diabetes mellitus, and severe obesity. Review of R4's quarterly MDS, with an ARD of 12/28/23 and located under the MDS tab of the EMR, revealed R4 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R4's Progress Notes, located under the Progress Notes tab of the EMR, revealed R4 attended one care plan meeting in November 2023. There was no other documented evidence R4 was invited, encouraged, or assisted in attending her care plan meetings. During an interview on 04/08/24 at 3:41 PM, R4 stated her family member had attended her care plan meetings, but the facility did not involve her in her care plan meetings. R4 stated she would like to go and have input into her care. During an interview on 04/12/24 at 10:56 AM, the SSD was asked how R4 was involved in her care planning process. The SSD stated R4 was invited to and attended her care plan meetings. The SSD was asked to provide documentation of the invitations extended to R4 and evidence of the resident's participation in the care plan meetings. The SSD stated, I don't do a sign in sheet. I was never told to do a sign in sheet. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/12/24 at 12:24 PM, RNC 2 stated there was documentation R4 attended a care plan meeting during November 2023, but that was all. RNC2 stated, There is no other documentation.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, and record review, the facility failed to provide bariatric incontinent briefs in ample supply to meet residents' needs for three of three sampled residents (Resident (R) 4, R14, and R20) reviewed for accommodation of needs. The facility census was 82. Findings include: 1. Review of R4's Admission Record, provided by the facility, revealed R4 was admitted to the facility on [DATE] with diagnoses that included severe obesity. Review of R4's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 12/28/23 and located under the MDS tab of the electronic medical record (EMR), revealed R4 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. During an interview on 04/08/24 at 4:00 PM, R4 stated the facility did not have the size incontinent brief that she required, and the facility always ran out of bariatric briefs. During an observation and interview on 04/10/24 at 12:25 PM, R4 reported the facility was out of bariatric briefs again. R4 stated she wore a size 3xl (extra-large) to 4xl, and the aide had borrowed a 4xl brief from another resident to put on her. A package of 2xl briefs was noted in R4's room. 2. Review of R14's Admission Record, provided by the facility, revealed R14 was admitted to the facility on [DATE] with diagnoses that included muscle weakness, difficulty in walking, and need for assistance with person care. Review of R14's quarterly MDS, with an ARD 03/30/24 and located under the MDS tab of the EMR, revealed R14 scored 15 out of 15 on the BIMS, which indicated R14 was cognitively intact. During an observation and interview on 04/08/24 at 2:52 PM, R14 stated the facility was always running out of bariatric briefs. R14 stated the facility would run out, and they would have to use briefs that were too small, and that was very uncomfortable. R14 stated she wore a 3xl to 4xl, and the smaller briefs were too tight. A package of 2xl incontinent briefs was observed in R14's room. During an interview on 04/10/24 at 12:26 PM, R14 stated the facility was out of bariatric briefs. R14 stated the night shift aide went and got a package of 4xl briefs for her and told her at that time that there were two more packages. R14 stated the day shift aide went to get a package for another resident and there were not any, so the aide had to borrow briefs from her for another resident. R14 stated the facility ran out of the correct size briefs at least once a month. During an interview on 04/12/24 at 1:30 PM, R14 reported she had suffered diarrhea on this morning and had required at least three brief changes. 3. Review of R20's Admission Record, provided by the facility, revealed R20 was admitted to the facility on [DATE] with diagnoses that included polyarthritis, chronic pain, and fibromyalgia. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R20's annual MDS, with an ARD of 02/09/24 and located under the MDS tab of the EMR, revealed R20 had a BIMS score of 15 out of 15, which indicated R20 was cognitively intact. During an interview on 04/08/24 at 12:15 PM, R20 stated the facility continually ran out of bariatric briefs. R20 stated the aides would try to get the correct size for the residents, but it was not possible if there were not any in the correct sizes. R20 stated she wore a 3xl to 4xl incontinent brief and often had to wear a 2xl. R20 stated the 2xl was too tight for comfort. 4. During an interview on 04/11/24 at 10:36 AM, Nurse Aide (NA) 1 stated the incontinent briefs were kept in the supply closet on the 500 hall. NA1 stated she knew which size briefs her residents wore by how they fit when she put them on. NA1 stated the facility had ample small through 2xl briefs, but they ran out of the 3xl and 4xl a lot. NA1 stated R20, R16, R4, and R14 all wore 3xl to 4xl briefs now since the facility had changed brands. NA1 confirmed she had borrowed a 4xl brief from R14 yesterday so that R4 would have one. NA1 stated staff went to the Assistant Director of Nursing (ADON) and let her know they were running out of briefs, but the ADON would always say the truck is coming. NA1 stated she began employment at the facility during November 2023, and there had always been a lack of bariatric incontinent briefs. During an observation and interview on 04/11/24 at 10:47 AM of the supply room on the 500 hall,, NA1 confirmed there were no packages of 3xl or 4xl briefs in the supply room. During an interview with the Central Supply Clerk (CS) and Administrator on 04/11/24 at 4:19 PM, the CS stated she ordered supplies, including incontinent briefs, once a week and as needed. The CS was asked how she determined how many incontinent briefs to order. She stated the size was based on height and weight, staff reported back to her, and she added and deducted as necessary. The CS stated that staff had reported that residents were running out of bariatric briefs. She stated she had contacted the supplier and asked them to ship more. The Administrator stated the facility could borrow supplies from sister facilities, as necessary. The CS was asked how many bariatric briefs were used in a week. She stated that around three cases were ordered in the beginning but now she was ordering five. The CS stated there were 18 briefs to a package, and there were four packages in each case. The CS stated she previously had a list of sizes to order based on each resident, but the facility had a new supplier with different products and different sizing, and she had not updated her list yet. The CS stated she determined how many briefs were needed based on sizing and staff input. The CS stated used the list of sizes to make the sizing selections for the new briefs. The Administrator was asked to provide the supply invoices since 03/01/24, and the CS was asked to provide her incontinent brief size listing. Review of the incontinent brief size listing dated 02/12/24 and provided by the CS revealed R4 was recorded to wear a 3xl brief, R14 was recorded to wear a 3xl brief, and R20 was recorded to wear a 2xl brief. The listing identified 11 other residents as wearing 2xl briefs. Review of the incontinent brief supply invoices since 03/01/24 and provided by the Administrator revealed the following amounts of bariatric briefs were delivered to the facility: 03/08/24 - 2 cases delivered, 03/14/24 - 2 cases delivered, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/20/24 - 2 cases delivered, 03/27/24 - 2 cases delivered, 04/04/24 - 3 cases delivered, and 04/11/24 - 4 cases delivered. Two cases of bariatric briefs, containing four packages of briefs per case, equaled 8 packages of briefs delivered to the facility. 8 packages of briefs, with 18 briefs per package, equaled 144 individual briefs. 144 individual briefs split between four residents wearing them equaled 36 briefs per resident for a seven-day period. This equaled approximately five briefs per day per resident. During an observation and interview on 04/12/24 at 1:10 PM, Regional Nurse Consultant (RNC) 1 and the surveyor observed the 500 hall supply closet. RNC1 confirmed there were seven packages of 4xl briefs. There were no 3xl briefs. During an interview on 04/12/24 at 1:36 PM, the CS was asked how many residents wore bariatric briefs. The CS stated, The last time I counted, it was about four. When asked why she only ordered two cases of bariatric briefs from 03/08/24 through 03/27/24, the CS stated she was still getting used to the company, and at that time, there were only three residents who wore bariatric briefs. The CS stated she was still trying to help staff size the residents for the proper incontinent brief. The CS was asked when she became aware of the complaints regarding the lack of bariatric briefs. She stated, Just last week, and the shipment was delayed. The CS stated the supply was delivered on Tuesday, and she was missing one case of briefs from her order. The CS was asked when she began ordering five cases of briefs per week. She stated, This week. The CS made no reply when asked how many briefs a resident used per day, on average.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, and facility policy review, the facility failed to ensure one of three residents (Resident (R) 43) reviewed for room change out of a total sample of 28 residents were provided with written notice of room change, including the reason for the change, prior to the facility-initiated room change occurring. The facility census was 82. Findings include: Review of the facility's policy titled, Room or Roommate Change, dated 10/24/22 revealed, Purpose - To ensure that a resident is able to exercise their right to change rooms or roommates .Prior to changing a room or roommate assignment, the resident, the resident's representative (if available), the resident new roommate, and the resident current roommate will be given timely advance notice of such change. A. When the resident is being moved at the request of the Facility, the notice of a change in room assignment will be in writing and will include the reason (s) for such change . Social Services Staff will assist in orienting the resident to his or her new room and/or roommate . Information regarding room transfers will be documented in the resident's medical record . Review of R43's undated Admission Record located in the resident's electronic medical record (EMR) under the Profile tab revealed R43 was admitted to the facility on [DATE] with diagnoses including aseptic necrosis of the right femur (loss of blood flow to bone tissue causing the thighbone to die), schizophrenia, and alcohol abuse. Review of R43's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/15/24 located in the resident's EMR under the MDS tab revealed the facility assessed R43 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. During an interview on 04/08/24 at 11:36 AM, R43 stated she moved, on 04/01/24, from a different room to the room where she now resided. R43 stated she was told in the morning she would be moving to a different room and she was moved a few hours later to her new room. During an interview on 04/09/24 at 6:17 PM, R43 stated she did not receive written notice prior to the move. Review of R43's EMR showed no documentation of R43 being issued a room change notice, including the reason for the room change. The EMR did not contain documentation to R43's room change or any behaviors that precipitated the move. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/24 at 1:52 PM, the Social Service Director (SSD) stated when initiating a room change for a resident in the facility, she let the resident know they would be changing rooms; however, she did not do it in writing. The SSD stated if a room change was going to be initiated, she would write a list during the morning meeting and one of the staff would call the family first, and then staff would talk to the resident. The SSD stated R43 was moved due to a nurse witnessing R43 releasing medical information to her roommate's friend and due to R43 having alcohol in her room. The SSD stated R43 was moved closer to the Director of Nurse's (DON's) office. The SSD stated the resident was notified verbally in the morning and moved in the afternoon. The SSD verified no written notice was given. The SSD stated if R43 had requested, she could have seen the new room prior to the room change. The SSD verified she did not documented in R43's EMR the reason for the move or that R43 had moved. During an interview on 04/11/24 at 12:46 PM, Licensed Practical Nurse (LPN) 4 stated the process for an internal room change started with staff calling the resident's family about the room change. During an interview on 04/11/24 at 1:53 PM, the Director of Nursing (DON) and Regional Nurse Consultant (RNC) 1 stated residents should be notified 24 to 48 hours before a facility initiated room change. During an interview on 04/11/24 at 2:26 PM, RNC2 verified R43 changed rooms on 04/01/24.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 15406 Based on observation, interview, record review, and facility policy review, the facility failed to ensure grievances raised by the resident council were addressed and attempts were made to resolve the grievances for six of six residents who attended the resident council group interview (Resident (R) 5, R70, R18, R224, R41, and R20). Ongoing concerns included: call lights, staff not introducing themselves, staff not responding to residents' needs, staff talking on their phones, and food palatability issues. The facility census was 82. Findings include: Review of the facility's policy titled, Grievances and Complaints dated 10/24/22 revealed, The facility . ensures that there is a prompt review, investigation and response to and resolution of grievances and complaints . The policy did not include specific information related to grievances expressed during the resident council meeting. A resident council group interview was held on 04/10/24 at 2:30 PM with R70, R5, R18, R224, R41, and R20 in attendance. Their comments included: -All six residents stated the issues raised in the resident council group did not get resolved and the same issues were presented over and over. -R18 stated the new Administrator came to the March 2024 meeting; however, did not do anything about the residents' concerns. R18 stated there was always an excuse why things were not fixed; she further stated, I just want to see progress. -R5 stated, We will wait but how long? We expressed our concerns. Review of R5's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/01/24 located in the resident's electronic medical record (EMR) under the MDS tab revealed the facility assessed R5 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. Review of R20's annual MDS with an ARD of 02/09/24 located in the resident's EMR under the MDS tab revealed the facility assessed R20 to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R18's quarterly MDS with an ARD of 03/01/24 located in the resident's EMR under the MDS tab revealed the facility assessed R18 to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R224's significant change MDS with an ARD of 01/09/24 located in the resident's EMR under the MDS tab revealed the facility assessed R224 to have a BIMS score of 10 out of 15 which indicated the resident was moderately cognitively impaired. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R41's annual MDS with an ARD of 12/22/24 located in the resident's EMR under the MDS tab revealed the facility assessed R41 to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R70's quarterly MDS with an ARD of 01/05/24 located in the resident's EMR under the MDS tab revealed the facility assessed R70 to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of the facility's Resident Council Minutes from October 2023 to March 2024 (with the exception of February 2024 for which no minutes were provided) showed concerns were raised with call lights, staff not introducing themselves, staff not responding to residents' needs, staff talking on their phones, dietary palatability issues, and missing clothing as follows: a. Review of Resident Council Minutes dated 10/25/23 revealed: Dietary . less beans . Nursing . not introducing themselves . Housekeeping . missing socks. b. Review of Resident Council Minutes dated 11/28/23 revealed: Nursing . Weekends are bad. CMTs [certified medical technicians] . not introducing who they are . Dietary: too much rice, too many beans. grilled sand [sandwich] not grilled . Housekeeping . Laundry not coming back, wrong clothes coming back with wrong name on sticker . c. Review of Resident Council Minutes dated 12/22/23 revealed: Old business: . Nursing . weekends still not great but getting better. still not introducing themselves . New business . Dietary: Too much rice and beans. Put beets in different bowls, juice runs into food . Don't like tater tots. Fries are cold. Toast is soggy . Housekeeping . Missing underwear. d. Review of Resident Council Minutes dated 01/30/24 revealed: Old business: Aides not introducing themselves . New business: Need more flavor on chicken, toast is not toasted . would like crispy tater tots . Talking on phone outside of resident room or in resident's room . Housekeeping: A lot of missing clothes . e. Review of Resident Council Minutes dated 03/25/24 revealed: Old business: Aides still not introducing themselves . New business . Nursing: Call lights - taking some time, turned off without addressing, Staff saying they can't help other, I'm not your aide . tartar sauce for fish . During an interview on 04/09/24 at 2:05 PM, the Social Service Director (SSD) stated she was the Grievance Coordinator for the facility. The SSD stated she rarely initiated grievances for issues that were raised by the resident council group. The SSD stated each department was responsible for following up on pertinent issues raised in the meetings. During an interview on 04/09/24 at 2:10 PM, the Activity Director (AD) stated she helped facilitate and recorded the minutes from the Resident Council meetings. The AD stated she did not initiate grievances for issues that were raised in the meetings and stated there was no formal process to do so. The AD stated she made copies of the minutes and gave copies to the SSD, the Dietary Manager (DM), and to the Director of Nursing (DON). The AD stated it was up to the individual departments to follow up on the concerns from the minutes. The AD acknowledged repeated concerns regarding a failure to wear name tags/identify oneself to the residents, missing laundry, and food. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/11/24 at 2:03 PM, the DON indicated she was recently hired with the change in ownership of the facility. The DON stated she was aware of concerns in resident council meetings of staff wearing earbuds (talking on their phones) during work and not answering call bells. During an interview on 04/11/24 at 3:00 PM, the Assistant Director of Nursing (ADON) stated she was aware of the concerns from the resident council including staff not introducing themselves to the residents, staffing concerns, a lack of compassion towards the residents by staff, and staff being on their phones. During an interview on 04/12/24 at 4:10 PM, the Administrator stated he had been employed at the facility for a month since the change in ownership. He stated he was aware of the concerns noted in the Resident Council Meeting minutes and the residents' concerns were being addressed. He stated all staff had name tags now. He stated they were recruiting nursing staff with the goal of decreasing the percentage of agency staff. The Administrator stated the dietary department had been outsourced and now the facility had its own dietary staff.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on interview, record review, and facility policy review, the facility failed to ensure residents and/or their representative received written information about and assistance with formulating advance directives for three of three residents reviewed for advance directives (Resident (R) 4, R16, and R14) out of 28 sampled residents. The facility census was 82. Findings include: 1. Review of R4's Admission Record, provided by the facility, revealed R4 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis, type 2 diabetes mellitus, and severe obesity. Review of R4's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/28/23 and located in the electronic medical record (EMR) under the MDS tab, revealed R4 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R4 was cognitively intact. Review of R4's Social Services Quarterly Note, dated 03/12/24 and provided by the Administrator, recorded, . Advanced Directives 1. Has the resident/responsible party requested/made any changes related to advanced directives (i.e. living will, code status, decision making, etc)? . The questions were marked as No change in status. There was no documentation to show resident rights related to advance directives were reviewed with R16 and/or her representative. There was no documented evidence to show the facility's policies on advance directives were reviewed with R4. The note was signed by the Social Service Director (SSD), and there was no documented evidence to show R4 was involved in the process. Review of R4's Misc tab and Assessments tab of the EMR revealed no information related to advance directives. There was no documentation to show R4 had been provided education on advance directives or offered assistance in formulating an advance directive if she so chose. 2. Review of R16's Admission Record, provided by the facility, revealed R16 was admitted to the facility on [DATE] with diagnoses that included contractures, difficulty walking, and hemiplegia and hemiparesis of the left side. Review of R16's quarterly MDS, with an ARD of 01/10/24 and located under the MDS tab of the EMR, revealed R16 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R16's Misc tab and Assessments tab of the EMR revealed no information related to advance directives. There was no documentation to show R4 had been provided education on advance directives or offered assistance in formulating an advance directive if she so chose. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R16's Social Services Quarterly Note, dated 03/12/24 and provided by the Administrator, recorded, . Advanced Directives 1. Has the resident/responsible party requested/made any changes related to advanced directives (i.e. living will, code status, decision making, etc)? . The questions were marked as No change in status. There was no documentation to show resident rights related to advance directives were reviewed with R16 and/or her representative. There was no documented evidence to show the facility's policies on advance directives were reviewed with R16. The note was signed by the SSD, and there was no documented evidence to show R16 was involved in the process. 3. Review of R14's Admission Record, provided by the facility, revealed R14 was admitted to the facility on [DATE] with diagnoses that included muscle weakness, difficulty in walking, and need for assistance with person care. Review of R14's quarterly MDS, with an ARD of 01/10/24 and located under the MDS tab of the EMR, revealed R14 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R14's Social Services Quarterly Note, dated 03/05/24 and provided by the Administrator, recorded, . Advanced Directives 1. Has the resident/responsible party requested/made any changes related to advanced directives (i.e. living will, code status, decision making, etc)? . The questions were marked as No change in status. There was no documentation to show resident rights related to advance directives were reviewed with R16 and/or her representative. There was no documented evidence to show the facility's policies on advance directives were reviewed with R14. The note was signed by the SSD, and there was no documented evidence to show R14 was involved in the process. During an interview on 0 4/12/24 at 10:56 AM, the SSD stated advance directives were reviewed with residents when they were admitted to the facility. The SSD stated she did not review that information with residents or their representatives except during the care plan meetings. The SSD stated she reviewed what the residents' code status was and if there were any concerns. The SSD was asked what education she provided on advance directives during the care plan meetings. She stated, I don't do that part. During an interview on 04/12/24 at 11:05 AM, Regional Nurse Consultant (RNC) 1 stated there was no documented evidence the residents were provided information related to the formulation of advance directives. Review of the facility's policy titled, Advance Directives, revised 10/24/22, revealed, . If a resident does not have an Advance Directive, the facility will provide the resident and/or resident's next of kin with information about advance directives upon request . Upon admission, the Admissions Staff or designee will provide written information to the resident concerning his or her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives . During the Social Services Assessment process, the Director of Social Services or designee will also ask the resident whether he or she has a written advance directive . The Interdisciplinary Team will annually review the Advance Directive with the resident or responsible party to ensure that the directive still reflects the wishes of the resident .

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 16752 Based on interview, record review, and review of the facility's policy, the facility failed to complete an investigation for one of one resident reviewed for grievances (Resident (R) 33) out of 28 sampled residents. The facility failed to inform R33 of the outcome of an investigation into his/her missing brooch. The facility census was 82. Findings include: Review of the facility's policy titled, Grievances and Complaints revised 10/24/22 reads in part .The Facility ensures that there is no retaliation for filing a grievance or complaint and ensures that there is a prompt review, investigation and response to and resolution of grievances and complaints. The disposition of all resident grievances and/or complaints is recorded in the Facility's Resident Grievance/Complaint Log .The facility will inform the resident or his/her representative of the findings of the investigation and any corrective actions recommended in a timely manner . Review of R33's undated Admission Record, located in the resident's electronic medical records (EMR) under the Profile tab revealed the resident was admitted to the facility 06/27/19. Review of R33's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/26/24 and located in the resident's EMR under the MDS tab revealed the resident was assessed to have Brief Interview for Mental Status (BIMS) score of 15 out 15 which indicated the resident the resident was cognitively intact. During the initial tour on 04/08/24 at 10:30 AM, an R33 stated she had reported missing a gold watch type brooch to the facility staff in January 2024; however, she had not heard anything back from the facility about the outcome of her report. Review of the facility's grievance logs for January 2024 revealed no documented evidence of a grievance related to R33's missing brooch. Review of R33's property inventory list titled, Clothes List dated 07/01/19 and located in the resident's EMR under the Miscellaneous tab revealed the resident's brooch was not listed. Review of R33's Social Services Notes dated 01/25/24, located in the resident's EMR under the Progress Notes tab revealed the resident's family was contacted regarding the resident's missing brooch. The progress notes documented R33's family stated the resident never had a brooch. During an interview on 04/11/24 at 10:25 AM, the Assistant Director of Nursing (ADON) stated she vaguely remembered the incident regarding the resident's missing brooch. The ADON stated the investigation was assigned to the Social Services Director (SSD). The ADON stated she thought the SSD had contacted the resident's family in January 2024 when resident reported the missing brooch. The ADON stated she was not sure if the SSD followed up with the resident on the results of the investigation. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/12/24 at 10:55 AM, the SSD stated she contacted the R33's family regarding the resident's concern about a missing brooch. The SSD stated the resident's family stated the resident did not have a brooch and it was not necessary to file an investigation report. The SSD stated that she informed the resident of the findings; however, the SSD stated she could not produce any documented evidence she informed the resident of the results of the investigation. The SSD admitted that a grievance/complaint was never completed since the resident's family said it was not necessary. The SSD stated she was not familiar with the facility's current grievance and complaint policy. During an interview on 04/12/24 at 2:46 PM, R33 stated she had made several requests about the missing brooch but no one from the facility ever met with her. R33 also stated it was possible the brooch was never at the facility. R33 further stated she wished someone had told her sooner about the investigation that the brooch was never there.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, record review, and facility policy review, the facility failed to ensure two of 28 sampled residents (Resident (R)16 and R20) were free from abuse and neglect. On 4/7/24, Certified Nurse Aide (CNA) 7 refused to assist R16 out of bed, resulting in the resident laying in bed until the next shift arrived. On 4/8/24, R16 used her call light on the night shift to request help for repositioning. R16 continued to use her call light for assistance because no one came. R16 reported two agency staff members came into her room and said she was calling too much. When she informed the staff members that she would continue to call until someone helped her, one of the staff yanked the call light out of her hand, threw it on the floor, and told her that she would be sorry if she continued to call. On 4/7/24, the CNA assigned to R20 refused to help him/her get out of bed, told the resident to hurry up, and pushed her. When asked to not push her because she would fall down, the CNA told him/her to just hurry up then. R20 stated she felt like the incident was mental abuse. On 4/8/24, the night shift aide refused to help R20 into bed and provide incontinent care to him/her. R20 remained up in his/her wheelchair until 3:00 AM, and at that time, she told the aide that she would change her own brief. R20 stated she could not reach her briefs and remained in the same brief until the day shift when Nurse Aide (NA)1 changed his/her brief. R16 and R20 reported they had been neglected to facility staff; however, no action was taken. CNA 7 continued to work on R16's hall on 4/9/24, placing the resident at risk for continued abuse and neglect. The facility census was 82. The administrator was notified on 04/09/24 at 7:47 PM of the Immediate Jeopardy, which began on 04/07/24. Findings include: Review of the facility's policy titled, Abuse Prevention and Prohibition Program, revised 10/24/22, revealed, . Each resident has the right to be free from mistreatment, neglect, abuse . Staff, residents and families will be able to report concerns, incidents and grievances without fear of retribution or retaliation . Supervisors shall immediately intervene, correct, and report identified situations where abuse, neglect . is at risk for occurring . Facility maintains adequate staffing on all shifts to ensure that the needs of each resident are met . Physical Neglect . Inadequate provision of care .Caregiver indifference to resident's personal care and needs . Facility Staff are Mandatory Reporters . 1. Review of R16's Admission Record, provided by the facility, revealed R16 was admitted to the facility on [DATE] with diagnoses that included contractures, difficulty walking, and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or the inability to move on one side of the body) of the left side. Review of R16's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/10/24, revealed R16 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R16 was cognitively intact. The MDS showed R16 required substantial to maximum assistance with transfers. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/08/24 at 10:50 A.M., R16 reported that on 04/07/24, during the morning hours on the day shift, she asked Certified Nurse Aide (CNA) 7 to help her get out of bed. R16 stated CNA7 replied, I don't want to, but I guess I have to. R16 reported that she asked CNA7 if that was not her job and that CNA7 replied, If you want to get up, you do it. R16 reported CNA7 refused to get her out of bed. R16 stated the CNA was hateful and it made her angry. R16 stated the CNA would not provide her name. R16 stated she remained in bed until the evening shift when LPN1 and an unidentified CNA helped her get out of bed. R16 stated she reported the allegation of neglect to Licensed Practical Nurse (LPN) 1 at that time. During an interview on 04/09/24 at 12:08 P.M., LPN1 confirmed that on 04/07/24, R16 had reported the allegation of neglect to her. LPN1 stated she and a CNA took care of R16, making sure she was clean, dry, and comfortable. LPN1 confirmed the facility's policy was to report allegations of neglect to nursing management and that the Assistant Director of Nursing (ADON) had been on call supervisor on 04/07/24. During an interview on 04/09/24 at 12:46 P.M., the ADON was asked who the CNA was that was assigned to R16 and her hall on 04/07/24. The ADON reviewed staffing schedules and the EMR of residents and stated three of the aides who worked on 04/07/24 were here on this day. During an observation and interview on 04/09/24 at 12:57 P.M., the ADON and surveyor observed CNA7 working in the facility, providing direct care to residents. CNA7 confirmed to the ADON and surveyor she was assigned to R16 and the other residents on the 100 hall on the day shift on 04/07/24. During an interview on 04/09/24 at 1:01 P.M., while confirming with R16 that CNA7 was the agency staff member who refused to get her out of bed on 04/07/24, R16 reported she had used her call light on the 04/08/24 night shift to request help for repositioning. R16 stated she continued to use her call light for assistance because no one came. R16 reported that two agency staff members came into her room and told him/her she was calling too much. R16 stated she did not know the staff members' names. R16 stated she informed the staff members that she would continue to call until someone helped her. R16 stated one of the staff yanked the call light out of her hand, threw it on the floor, and told her that she would be sorry if she continued to call. R16 stated she had not reported the incident to anyone, but that R20 had trouble on the shift as well. 2. Review of R20's Admission Record, provided by the facility, revealed R20 was admitted to the facility on [DATE] with diagnoses that included polyarthritis, muscle wasting, repeated falls, and need for assistance with personal care. Review of R20's annual MDS, with an ARD of 02/09/24, revealed R20 had a BIMS score of 15 out of 15, which indicated R20 was cognitively intact. The MDS recorded R20 required partial to moderate assistance with transfers. During an interview on 04/08/24, R20 stated on 04/07/24 on the day shift, around 12:00 P.M., the CNA assigned to her hall refused to help him/her get out of bed. R20 stated the CNA eventually helped her and kept telling her to hurry up and started to push her. R20 stated the CNA told her this was not her usual assignment and I was just stuck down here so if you could just hurry up. R20 stated she asked the CNA not to push her because she would fall down. R20 stated the CNA told him/her to just hurry up then. R20 stated she had written the aide's name down but could not find it. R20 stated she felt like the incident was mental abuse. R20 stated she had not reported the incident to anyone. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/09/24 at 1:06 P.M., R20 reported that the night shift aide on the previous shift had refused to help her into bed and provide incontinent care to him/her. R20 stated he/she remained up in his/her wheelchair until 3:00 AM, and at that time, she told the aide that she would change her own brief. R20 stated she could not reach her briefs and remained in the same brief until the day shift when Nurse Aide (NA)1 changed his/her brief. R20 stated she reported the incident to NA1. During an interview on 04/09/24 at 1:10 P.M., NA1 confirmed R20 had reported the allegation of neglect to her. NA1 stated the facility's policy was to report allegations of neglect; however, she did not take any further action. NA1 stated she felt R20's incontinent brief had not been changed since she had finished her shift on 04/08/24 because she had inadvertently torn the plastic on the top of the brief when providing care on 04/08/24, and the brief R20 was wearing on the morning of 04/09/24 was torn in the exact same place. The facility provided an acceptable plan for removal of the immediate jeopardy on 04/11/24 at 12:34 PM. The survey team validated the immediate jeopardy was removed on 04/11/24. The deficient practice remained at a D scope and severity following the removal of the immediate jeopardy.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on interview, record review, and facility policy review, the facility failed to ensure allegations of neglect were reported to supervisors and/or the facility's Abuse Coordinator for two of 28 sampled residents (Resident (R)16 and R20). R16 reported allegations of neglect involving Certified Nurse Aide (CNA) 7 to Licensed Practical Nurse (LPN) 1. LPN1 did not report the allegations to the on-call nursing supervisor, Director of Nursing (DON), or Administrator, who was the facility's Abuse Coordinator. R20 reported allegations of neglect to (Nurse Aide) NA1. NA1 did not report the allegations to her supervisor or the facility's Abuse Coordinator. The facility census was 82. The administrator was notified on 04/09/24 at 7:47 PM of the Immediate Jeopardy, which began on 04/07/24. Findings include: Review of the facility's policy titled, Abuse Prevention and Prohibition Program, revised 10/24/22, revealed, . Each resident has the right to be free from mistreatment, neglect, abuse . Supervisors shall immediately intervene, correct, and report identified situations where abuse, neglect . is at risk for occurring . Facility Staff are Mandatory Reporters . 1. Review of R16's Admission Record, provided by the facility, revealed R16 was admitted to the facility on [DATE] with diagnoses that included contractures, difficulty walking, and hemiplegia and hemiparesis of the left side. Review of R16's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/10/24, revealed R16 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R16 was cognitively intact. The MDS recorded R16 required substantial to maximum assistance with transfers. During an interview on 04/08/24 at 10:50 A.M., R16 reported that on 04/07/24, during the morning hours on the day shift, she asked Certified Nurse Aide (CNA) 7 to help her get out of bed. R16 stated CNA7 replied, I don't want to, but I guess I have to. R16 reported that she asked CNA7 if that was not her job and that CNA7 replied, If you want to get up, you do it. R16 reported CNA7 refused to get her out of bed. R16 stated the CNA was hateful and it made her angry. R16 stated the CNA would not provide her name. R16 stated she remained in bed until the evening shift when LPN1 and an unidentified CNA helped her get out of bed. R16 stated she reported the allegation of neglect to Licensed Practical Nurse (LPN) 1 at that time. During an interview on 04/09/24 at 12:08 PM, LPN1 confirmed that on 04/07/24, R16 had reported the allegation of neglect to her. LPN1 confirmed the facility's policy was to report allegations of neglect to nursing management and that the Assistant Director of Nursing (ADON) had been the on call supervisor on 04/07/24. LPN1 confirmed she did not report the allegation of neglect to her supervisor, the on-call supervisor, or the Administrator. LPN1 stated she had overlooked notifying the on-call supervisor. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/09/24 at 12:30 PM, the ADON confirmed the facility's policy was to report allegations of neglect immediately. The ADON confirmed she had been the on-call supervisor on 04/07/24 and confirmed she did not receive a call regarding an allegation of neglect. 2. Review of R20's Admission Record, provided by the facility, revealed R20 was admitted to the facility on [DATE] with diagnoses that included polyarthritis, muscle wasting, repeated falls, and need for assistance with personal care. Review of R20's annual MDS, with an ARD of 02/09/24 and located in the EMR under the MDS tab, revealed R20 had a BIMS score of 15 out of 15, which indicated R20 was cognitively intact. The MDS recorded R20 required partial to moderate assistance with transfers. During an interview on 04/09/24 at 1:06 P.M., R20 reported that the night shift aide on the previous shift had refused to help her into bed and provide incontinent care to him/her. R20 stated he/she remained up in his/her wheelchair until 3:00 AM, and at that time, she told the aide that she would change her own brief. R20 stated she could not reach her briefs and remained in the same brief until the day shift when Nurse Aide (NA)1 changed his/her brief. R20 stated she reported the incident to NA1. During an interview on 04/09/24 at 1:10 PM, NA1 confirmed that R20 had reported the allegation of neglect to her. NA1 stated the facility's policy was to report allegations of neglect and confirmed she did not tell her supervisor, the Director of Nursing, or the Administrator. During an interview on 04/09/24 at 2:26 PM, the Administrator confirmed he was the facility's Abuse Coordinator and that all allegations of abuse and neglect should be reported to him. The Administrator confirmed the facility's policy was for allegations of neglect to be reported immediately. The Administrator confirmed he had not been informed of any allegations of neglect related to R16 and R20. The facility provided an acceptable plan for removal of the immediate jeopardy on 04/11/24 at 12:34 PM. The survey team validated the immediate jeopardy was removed on 4/11/24. The deficient practice remained at a D scope and severity following the removal of the immediate jeopardy.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on interview, record review and policy review, the facility failed to ensure residents were provided with a bed hold notice within 24 hours of emergent transfer to the hospital for one of three residents (Resident (R) 30) reviewed for hospitalization s out of a total sample of 28. This failure placed R30 and/or his Responsible Party at risk of not knowing to request a bed hold to be able to return to the facility. The facility census was 82. Findings include: Review of the facility's policy titled, Bed Hold, dated 10/24/22 revealed the purpose was, To ensure that the resident and/or their representative is aware of the Facility's bed-hold policy .the Facility advises residents or his/her personal representative in writing that the Facility has a bed hold policy and will hold the resident's bed for the state specified period, if the resident is transferred to a general acute care hospital . Review of the facility's policy titled, Transfer and Discharge, dated 10/24/22 revealed, Before the Facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility will provide written information to the resident or his/her resident representative which specifies i. The duration of the bed-hold during which the resident is permitted to return and resume residence in the nursing facility . Review of R30's undated Admission Record located in the resident's electronic medical record (EMR) under the Profile tab revealed R30 was admitted to the facility on [DATE] with diagnoses which included benign intracranial hypertension (increased intracranial pressure e.g. headache, vision loss, elevated intracranial pressure with normal cerebrospinal fluid), Alzheimer's disease, diabetes mellitus type two with neuropathy, and adult failure to thrive. R30's Family Member (F) 30 was identified as R30's responsible party. Review of R30's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/01/24 located in the resident's EMR under the MDS tab revealed the facility assessed R30 to have a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated the resident was moderately cognitively impaired. Review of R30's nursing Progress Notes, dated 12/07/23 located in the resident's EMR under the Progress Notes tab revealed R30 was transferred to the hospital, due to altered mental status change, all parties notified of transfer, and will follow up . Review of R30's Admission Summary Note dated 12/12/23 located in the resident's EMR under the Progress Notes tab revealed, Resident arrived at 2115 [11:15 PM] [on 12/11/23]. Report received from EMS [Emergency Medical Services]. Patient had a stroke which is why he went to the hospital. Review of R35's EMR revealed no documented evidence a bed hold notice was given to the resident and/or responsible party at the time (or within 24 hours) of his emergency transportation to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/08/24 at 10:01 AM, R30 was observed in his wheelchair in the hallway outside of his room. The surveyor attempted to interview R30; however, R30 did not converse with or respond to the conversation. A request was made to the administration on 04/12/24 for the bed hold notice for the 12/07/23 hospitalization of R30. No bed hold notice was provided prior to the survey team exiting the facility. During an interview on 04/12/24 at 11:11 AM, Regional Nurse Consultant (RNC) 1 stated no bed hold notice was provided to R30 or the responsible party with his hospitalization on [DATE].

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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** 16752 Based on observation, interview, and record review, the facility failed to provide activities of daily living (ADL) care for one of seven residents reviewed for ADLs (Resident (R) 176) out of 28 total sampled residents. R176, who was totally dependent on staff for ADLs, and was admitted on [DATE], did not receive a shower until 4/10/24. The facility census was 82. Finding include: Review of the R176's undated Admission Record located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease stage III and dementia. Review of R176's five day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/29/24 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident required substantial to maximum assistance with toileting and personal hygiene (showers and bathing). Review of R176's Care Plan initiated on 03/26/24 and located in the resident's EMR under the Care Plan tab identified the resident had a self-care deficit and was totally dependent on staff for personal hygiene cares. During an interview on 04/08/24 at 11:15 AM, Family Member (F) 176 stated R176 was admitted to the facility almost three weeks ago. F176 stated there had been times when the resident called for assistance to the bathroom, the resident did not make it to the bathroom and soiled himself. F176 also stated the resident was told he could only have a shower twice a week. F176 stated the resident had not received a shower since admission to the facility. Review of R176's Activities of Daily Living (ADL) sheet for the month of April and located in the resident's EMR under the Task tab revealed no documented evidence the resident had received any showers since his admission. Review of R176's Shower/Bath Sheets from the resident's admitted through 04/10/24, revealed the resident had only received one shower (on 04/10/24) since his admission. An interview on 04/10/24 at 1:10 PM with Certified Nursing Assistant (CNA) 6 revealed she gave the resident a shower this morning; however, she did not know if the resident had any previous showers. CNA6 also stated to her knowledge the resident did not refuse cares. On 04/12/24 at 03:02 PM the Director of Nursing (DON) was asked to review and interpret the resident's shower sheets. The Director of nursing stated that only one shower sheet (dated 04/10/24) could be found for R176. The Director of Nursing could not determine if the resident had any other showers since admission.

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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** 15406 Based on observation, interview, record review and facility policy review, the facility failed to ensure sufficient activities were provided to one of 28 sample residents (Resident (R) 20) and all five of five supplemental residents (R70, R5, R18, R51, R224, and R41). Failures included not offering activities on the weekends or offering outings. Activity participation was not documented; quarterly activity progress was not completed; and a care plan was not developed for R51 as directed by the facility's policy. The facility census was 82. Findings include: Review of the facility's policy titled, Activities Program dated 10/24/22 revealed, The Facility provides an Activity Program designed to meet the needs, interests, and preferences of residents . A variety of activities should be offered on a daily basis, which includes weekends and evenings . After completion of the initial Activity Assessment and the MDS, an individualized Care Plan will be developed and implemented for each resident .The resident's activity plan will be reviewed and updated at least quarterly . No less than quarterly, the Director of Activities or his or her designee will make a progress note . that includes the level of participation, perceived benefit, response to interventions outline in the Care plan, progress made toward goal and recommendations for activities .The Activity Department will maintain accurate records of each resident's participation in group, independent and room visit involvement. Participation will be documented daily . 1. Review of R51's undated Admission Record located in the resident's electronic medical record (EMR) under the Profile tab revealed R51 was admitted to the facility on [DATE]. Review of R51's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 12/29/23 located in the resident's EMR under the MDS tab revealed the facility assessed R51 to have a Brief Interview for Mental Status (BIMS) score of nine out of 15 which indicated the resident was moderately cognitively impaired. Review of R51's admission MDS with an ARD of 09/28/23 located in the resident's EMR under the MDS tab revealed it was very important to have books, newspapers, and magazines to read, to be around animals/pets, to keep up with the news, and to do favorite activities. Review of R51's Activities CAA [Care Area Assessment] Worksheet part of the MDS with an ARD of 09/28/23 dated and provided by the Activity Director (AD) revealed the care area of activities was triggered due to little interest or pleasure in doing things. R51 preferred group activities and the narrative read, [R51] enjoys playing cards, and spending time with family . [R51] enjoys talking to other residents in the building as well. No other interests were identified. The CAA indicated activities would be addressed in the care plan. Review of R51's EMR revealed no documented evidence of quarterly activity progress notes. Review of R51's comprehensive Care Plan, initiated on 09/26/23 located in the resident's EMR under the Care Plan tab revealed the care plan did not address activities for R51. There was no additional assessment of R51's activity participation or activity plan. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/08/24 at 10:01 AM, R51 was asked about the activity program and stated, It is not so good. R51 stated she went to bingo a couple days a week and that was basically it. R51 stated there was music and church offered occasionally. R51 stated she received activity calendars but there was not much to do. R51 stated she stayed in her room a lot. R51 was in her room and both hers and her roommate's television (TVs) were turned on different channels. R51's TV volume was turned off and her roommate's TV volume was turned on. R51 could not see her roommate's TV with the curtain pulled between the beds. Observations revealed: -On 04/08/24 at 10:44 AM, R51 wheeled herself in her wheelchair to the nursing station, then turned around and wheeled back down hall to her room. -On 04/08/24 at 11:55 AM, R51 wheeled herself-past nursing station and down the 300 hall. -On 04/08/24 at 12:49 PM, R51 was sitting in her wheelchair in her room without activity. -On 04/08/24 at 1:48 PM, R51 was in her wheelchair in her room with the TV on. -On 04/09/24 at 10:01 AM, R51 was sitting in her wheelchair in her room without activity waiting for breakfast. -On 04/09/24 at 12:59 PM, R51 was on her side in the room with the curtain pulled and the lights were out. The TV was not turned on. -On 04/11/24 at 3:43 PM, bingo was taking place in the main dining room. R51 was in her room with the TV on. She stated she had attended bingo for a while but got short of breath and returned to her room so she could utilize the oxygen concentrator. During an interview on 04/09/24 at 2:10 PM, the AD was asked where the activity participation records were located. She stated she did not document residents' attendance at activities. The AD stated the main activity was bingo and most residents attended. She stated bingo was offered every other Monday and every Thursday. The AD stated on the opposite Mondays, she did nails (painted fingernails). During an interview on 04/12/24 at 10:23 AM, the AD stated she was a certified nursing assistant (CNA) and had been in her current role of AD for about a year and a half. The AD stated she completed the Activity CAAs with the full MDS assessments but did not complete quarterly assessments of activities for residents. The AD verified there were no activity participation records for R51 or quarterly activity notes. The AD stated she filled out Section V on the MDS which indicated care planning would or would not occur. The AD stated she did not develop or write activity care plans and did not attend the care plan meetings. The AD stated R51 usually attended bingo or parties, played cards, and went to groups or laid on her bed in her room. The AD stated she was the only activity employee in the facility for 82 residents who currently resided 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	During an interview on 04/12/24 at 10:40 AM, the AD described the activity program. She stated on the third Thursday of the month at 6:30 PM, Christian church came and offered a church service. The Catholic church came every Friday at 10:00 AM; however, there were no church services offered on Sundays/weekends. The AD verified there was a lack of scheduled activities on the weekends. The AD verified there were no outings being offered currently. The AD stated she was the van driver in addition to being the AD. She stated she drove the van for doctor's appointments. The AD stated she offered a sit to fit exercise program twice a week and she left games and cards for residents to play in the evenings. During an interview on 04/09/24 at 6:29 PM, CNA2 stated R51 left the room to go to the dining room for dinner but he had not seen her participate in any activities. CNA2 stated that when he started his shift at 3:00 PM, most of the activities were already over for the day. 2. Review of R5's quarterly MDS with an ARD of 03/01/24 located in the EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R20's annual MDS with an ARD of 02/09/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R18's quarterly MDS with an ARD of 03/01/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R224's significant change MDS with an ARD of 01/09/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 10 out of 15 which indicated the resident was moderately cognitively impaired Review of R41's annual MDS with an ARD of 12/22/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R70's quarterly MDS with an ARD of 01/05/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of the Activity Calendars for February 2024 through April 2024 and provided by the facility revealed one or two scheduled activities were offered per day Mondays through Fridays. Scheduled activities on the weekends were not found on the calendars and outings were absent. A resident council group interview was held on 04/10/24 at 2:30 PM with R70, R5, R18, R224, R41, and R20. The residents stated they liked the AD and the activities that were offered but would like more activities to be scheduled. Their comments included: -R20, R224, R41, and R5 stated they would like more bingo. -R224 stated, We sit here day after day and need something to do besides TV. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-R18 stated there used to be music that played during meals which was enjoyable. R5 stated there used to be a radio in the dining room but it had been removed. R224 stated they had an activity once a month in which singers would come and she enjoyed that. -All the residents stated activities typically occurred between 2:00 PM and were over around 4:00 PM. All the residents verified there was a lack of activities on the weekends. -R20, R18, and R5 stated there was no one to take them on outings; they used to go to Walmart and they enjoyed that. Currently there are no outings scheduled.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 15406 Based on interview, policy review, and job description review, the facility failed to ensure there was a qualified Activity Director (AD) to oversee the activity program. This created the potential for the activity program to not be administered effectively and to not meet the needs, interests, and preferences of all 82 residents who resided in the facility. The facility census was 82. Findings include: Review of the facility's policy titled, Activities Program dated 10/24/22 revealed, The Facility provides an Activity Program designed to meet the needs, interests, and preferences of residents .an individualized Care Plan will be developed and implemented for each resident .The resident's activity plan will be reviewed and updated at least quarterly . No less than quarterly, the Director of Activities or his or her designee will make a progress note .The Activity Department will maintain accurate records of each resident's participation in group, independent and room visit involvement. Participation will be documented daily . Review of facility's Activity Director (AD) job description provided by the facility revealed the AD's responsibilities included assessing residents' interests, strengths and limitations to create individualized activity plans that promote engagement and enjoyment .Collaborate with community organizations, volunteers, and local resources to enhance the activity program and expand opportunities for residents to participate in community-based activities and events . Maintain documentation and reporting requirements as outlines by regulatory agencies . Qualifications: .previous experience in activity programming or recreational therapy, preferably in a long-term care of healthcare setting. Certified Activity Director . During an interview on 04/12/24 at 10:47 AM, the Administrator verified the AD had no credentials. During an interview on 04/09/24 at 2:10 PM, the Activity Director (AD) stated she did not record or maintain activity participation records. The AD stated she was not aware of the requirement to maintain records as directed by the facility policy. During an interview on 04/12/24 at 10:23 AM, the AD stated she was a certified nursing assistant (CNA) and had been in her current role of AD for about a year and a half. She stated the previous Administrator had instructed her regarding what the role entailed. The AD verified she previously worked in the facility as a CNA and had not worked in an activity department elsewhere. The AD stated she had taken an activity course online but did not take the test to become certified. The AD stated no one had asked her to become certified. The AD verified she did not document activity progress in quarterly notes and did not develop activity care plans as directed by the policy. During an interview on 04/12/24 at 4:38 PM, the Administrator stated he had been in his position less than a month with the change in ownership. He stated he was aware not all of the responsibilities of the AD were being fulfilled, such as completion of activity participation records. The Administrator stated it was a slow process and he was observing and evaluating staff, including the AD, to ensure a good fit for the position.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, record review, and facility policy review, the facility failed to ensure Resident #16 was offered a smoking apron to prevent accidents while smoking, per her care plan. Additionally, the facility failed to care plan what staff should do if the resident refused the smoking apron and failed to ensure all staff were aware of the resident's assessed need for the smoking apron for safety. This affected one of two sampled residents reviewed for smoking out of a sample of 28 residents. The facility census was 82. Findings include: Review of the facility's policy titled, Smoking by Residents, revised 10/24/22, revealed, . Residents who are not able to smoke independently and safely will be accompanied by Facility Staff while smoking . Resident who smoke shall wear a smoking apron if they are found not to be safe (i.e., drop lit cigarettes or do not handle the ashes properly.) . If clothing is found to have cigarette burn holes the smoker must wear an apron to protect themselves from burns regardless of whether the resident is assessed as independent for smoking . Review of R16's Admission Record, provided by the facility, revealed R16 was admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy, need for assistance with personal care, contracture of the left hand, and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following cerebral infarction (stroke) affecting left dominant side. Review of R16's Alert Note, dated 09/16/23 at 2:10 PM, and located under the Progress Notes tab of the electronic medical record (EMR), revealed, . Notified by CNA [Certified Nurse Aide] that while she had residents out for their smoking break this resident asked another resident to put out a cigarette for her and handed her a lit butt. The other resident took the lit butt and dropped it into her walker basket and the tissue caught on fire. The staff member immediately put out the flames. While this was happening, the other resident dropped her own cigarette into her lap where there were tissues and these tissues caught on fire. The staff member immediately put out theses [sic] flames also. The other resident was wearing her smoking apron. This resident was asked to also wear a smoking apron from now on for safety. There were no injuries to either of these residents . Smoking assessment to be updated and education provided to residents about properly extinguishing cigarettes . Review of R16's N Adv - Smoking and Safety, dated 09/16/23 at 7:27 PM, and provided by the facility, revealed R16 was observed to have balance problems while sitting or standing; had limited or no range of motion in arms or hands; burned skin, clothing, furniture or other; dropped ashes on herself; and was unable to extinguish tobacco safely. It was recorded on the assessment, . Have noted holes in clothing and noted resident drop ashes on her clothing or in her belongings per other staff and other residents . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R16's Care Plan, dated 09/16/23 and located under the Care Plan tab of the EMR, revealed a problem, . I am no longer an independent smoker. Unable to extinguish cigarette safely . The goal was recorded as, Resident will not suffer injury from unsafe smoking practices. Interventions included, . Resident to wear smoking apron during smoking sessions . Review of R16's care plan revealed no documentation R16 refused to wear a smoking apron. Review of R16's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/10/24 and located under the MDS tab of the EMR, revealed R16 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated R16 was cognitively intact. Review of R16's Incident Note, dated 01/25/24 at 10:11 AM and located under the Progress notes tab of the EMR, revealed, . This nurse was made aware that resident had a blister on left upper thigh and upon assessment resident has a dime sized fluid filled blister on left thigh. Upon asking resident what happened she said she burned herself a few days ago with her cigarette while smoking. This nurse asked the resident if she told anyone and she said no. Upon asking why she didn't tell anyone she said she didn't know . Review of R16's N Adv - Smoking and Safety, dated 03/07/24 at 8:47 AM and provided by the facility, revealed, . Smoking safety note: Resident does not wear her apron during smoking . Review of R16's Care Plan, Progress Notes, and Misc [Miscellaneous] tabs of the EMR revealed no documentation staff were educated on interventions to take if R16 refused to wear a smoking apron, that R16 had been educated on the facility's smoking policy, or that any steps had been taken to address R16 not wearing a smoking apron. There was no documentation of any incidents where R16 refused or was resistant to wearing a smoking apron. Review of R16's N Adv - Smoking and Safety, dated 03/12/24 and provided by the facility, revealed R16 continued to require a smoking apron while smoking. During an observation on 04/09/24 at 9:04 PM, R16 was observed on the patio smoking. R16 did not have a smoking apron on. Licensed Practical Nurse (LPN) 1, R16's assigned nurse, was observed supervising the smokers. During an observation on 04/10/24 at 5:08 PM, R16 was observed on the patio smoking. R16 did not have a smoking apron on. During an interview on 04/11/24 at 10:31 AM in R16's room, R16 stated that she smoked without a smoking apron on at times. R16 stated sometimes staff would ask if she wanted to wear an apron and sometimes, she would take one. R16 stated she had informed the Assistant Director of Nurses (ADON) a long time ago that she would wear an apron when smoking. R16 confirmed she had dropped a cigarette onto her leg causing a burn blister. R16 was asked if she had burned herself at any other time. R16 stated she did not remember if she had burned herself at any other time. R16 stated she could not hold a cigarette in her right hand safely any more due to an injury. R16 stated, Sometimes I forget, and it will slip out of my fingers, and I will drop it. During an interview on 04/11/24 at 10:35 AM, R4, a resident who sometimes smokes, stated R16 was supposed to wear a smoking apron but she did not. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/11/24 at 10:36 AM, Nurse Aide (NA) 1, R16's assigned aide, confirmed she supervised smokers at times. NA1 was asked which residents required the use of a smoking apron. NA1 did not identify R16 as requiring a smoking apron. During an interview on 04/11/24 at 10:46 AM, LPN1, who was assigned to R16, confirmed she supervised the smokers at times. LPN1 was asked which residents required the use of a smoking apron. LPN1 did not identify R16 as requiring a smoking apron. During an interview on 04/11/24 at 10:51 AM, the Administrator stated his expectation was for staff to follow facility policy related to smoking. During an interview on 04/11/24 at 7:20 PM, Regional Nurse Consultant (RNC) 1 stated R16's care plan and progress notes recorded R16 refused to wear her smoking apron. RNC1 was asked to provide that documentation. No further documentation was provided by the end of the survey.

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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** 16752 Based on observation, interview, record review, and review of facility's policy, the facility failed to ensure residents' indwelling catheters were properly positioned and secured to promote adequate drainage and prevent reoccurring urinary tract infections for one of two residents (Resident (R) 173) reviewed for catheters out of a total sample of 28 residents. The facility census was 82. Findings include: Review of facility's policy titled Care of Catheters revised 10/24/22 revealed, .Take care to ensure the collection bag does not touch the floor at any time .Collection bags should always be kept below the level of the bladder, including during transport .The catheter and collection tubing should be free of obstruction and kinking. Catheter tubing should be secured to prevent dependent loops .Anchor the catheter with a leg strap to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter . Review of R173's undated Admission Record located in the resident's electronic medical record located in the resident's (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included malignant bladder cancer. Review R173's five day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/25/24, located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a Brief Interview of Mental Status (BIMS) score of six out of 15 which indicated the resident was severely cognitively impaired. The resident was assessed to be totally dependent on staff for activities of daily living and had an indwelling catheter. Review of R173's Care Plan initiated on 03/22/24 and located in the resident's EMR under the Care Plan tab directed the staff to irrigate the catheter if occlusion occurred, change as needed if leakage occurred, position catheter bag and tubing below the level of the bladder and away from door entrance, and to check the catheter tubing for kinks. Observation 04/09/24 at 10:57 AM revealed R173 was lying in bed with her eyes closed. The resident's urinary drainage bag was attached to the siderail with the bottom of drainage bag touching the fall mat on the floor. The tubing was clamped to the bed's side rail. Observation on 04/10/24 at 2:30 PM revealed R173 was lying in bed with her eyes closed. The resident's urinary drainage bag was resting on the floor mat. Observation on 04/11/24 at 3:45 PM revealed R173 was lying in bed with her eyes closed. The resident's urinary drainage bag inside the dignity bag was touching the floor and the drainage bag's tubing was resting on the floor. (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 04/12/24 at 9:27 AM with Licensed Practical Nurse (LPN) 7 revealed R173's urinary catheter drainage bag was in a dignity bag resting on floor mat and the drainage tubing was lying on the floor. LPN7 performed hand hygiene and applied a pair of gloves. LPN7 repositioned the tubing, so it was no longer on the floor. LPN checked the securement device on the resident right upper thigh and found that the adhesive backing was folded over on itself and not attached to the resident's thigh. LPN7 stated the resident would need a new securement device to properly anchor the catheter tubing to the resident's thigh. LPN7 elevated the resident's bed slightly so that drainage bag no longer touched the floor mat. LPN7 stated the privacy covering protected the drainage bag, so it did not matter if it touched the floor or the fall mat. However, LPN7 acknowledged the drainage tubing needed to be repositioned to promote proper drainage.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, and facility policy review, the facility failed to offer/provide adequate fluids such as ice water and other beverages to two of 28 sampled residents (Resident (R)13 and R20) and to four of five supplemental residents (R70, R18, R41, R224) attending the resident council group interview. An initial nutritional assessment was not completed by the Registered Dietitian for R13; R13 was not offered and was not documented as consuming adequate fluids. The facility census was 82. Findings include: Review of the facility's policy titled, Nutrition/Hydration Management dated 10/24/22 revealed, The concept of nutrition management is an interdisciplinary process. The key components of this system are: Maintaining nutritional status as indicated by clinical measures such as body weight, biochemical measure, and hydration .Within seven (7) days of admission, a registered dietitian completes a thorough nutritional assessment providing a more detailed profile of the resident's overall nutritional status . 1. Review of R13's undated Admission Record located in the resident's electronic medical record (EMR) under the Profile tab revealed R13 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, anxiety disorder, and cerebral infarction (stroke). Review of R13's significant change in status Minimum Data Set (MDS) with an assessment reference date (ARD) of 01/23/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated the resident was moderately cognitively impaired. The MDS also revealed R13 was 65 (5'6) tall and weighed 148 pounds. R13 was dependent on staff for transfers, did not walk during the assessment period, and required supervision with eating/drinking. Review of R13's Care Plan dated 11/14/23 located in the resident's EMR under the Care Plan tab revealed a focus of, Nutritional Status General- regular [diet]- thin [liquids]. The goal was, Will maintain weight through the next review. Interventions in full were: House supplement TID [three times a day], modify diet as appropriate according to resident's food tolerances and preferences. Review of R13's physician Orders dated 04/03/24 located in the resident's EMR under the Clinical tab revealed, Resident is at risk for malnutrition r/t [related to] Parkinson, HTN [hypertension/high blood pressure], CKD [chronic kidney disease], A Fib [atrial fibrillation], GERD [gastrointestinal reflux disease. House supplements, 90 ml (milliliters) or three ounces had been prescribed three times a day, initiated on 10/01/23. Review of 13's Dietary Profile dated 01/07/24 located in the resident's EMR under the Assessment tab revealed the sections for fluid comments, fluid likes, and fluid dislikes were blank/not filled out. Under Fluid Intake, eight cups per day was documented. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R13's EMR revealed the Registered Dietitian (RD) had not completed a nutritional assessment since R13 was admitted . A request for all nutrition assessments and progress notes was made to administration on 04/12/24. No nutrition assessments were provided prior to the survey team's exit. There was no evidence R13's calorie, protein, or fluid needs had been determined or that a thorough nutritional assessment had been completed. Review of R13's Nutrition - Amount Consumed & Fluids from 03/09/24 through 04/09/24 located in the resident's EMR under the Task tab revealed no fluid intake was recorded from 03/09/24 until 04/04/24. R13's fluid intake for 04/04/24 was 1300 ml, on 04/05/24 was 1180 ml, on 04/06/24 was 440 ml, on 04/08/24 was 500 ml, averaging 855 ml per day, equal to 3 1/2 cups per day. Observations during the survey, confirmed by interview, revealed R13 did not have ice water available in her room or other beverages on 04/08/24 and on 04/09/24 as follows: -On 04/08/24 at 1:50 PM R13 was observed in her room. Her ice water pitcher was observed to be empty and there were no beverages observed in her room. -On 04/09/24 at 10:02 AM R13 was observed sitting in her room. There was no ice water observed in her plastic water pitcher. It was empty. R13 stated she had asked the staff to fill it three times that morning but it had not been filled. R13 stated she was thirsty and unable to get ice water herself due to physical limitations. There were no beverages observed in her room. -On 04/09/24 at 1:00 PM, R13 was sleeping in bed. There were no drinks on her overbed table and the water pitcher was empty. -On 04/09/24 at 2:54 PM, R13 stated she was served nothing to drink for lunch and had only been served orange juice for breakfast. R13 stated she was thirsty and wanted something to drink. There was one empty disposable cup on the overbed table and R13 stated that was her nutritional supplement given to her with medications and she had consumed it (three ounces of nutritional supplement per the Physician's orders.) R13's call light was activated at this time and R13 requested ice water. -On 04/09/24 at 6:26 PM R13 stated she had consumed the water provided to her earlier in the day and she was still thirsty. Certified Nurse Assistant (CNA) 2 was present in the room. -During an interview on 04/10/24 at 1:49 PM, R13 stated she had not been served beverages for lunch. R13's lunch meal was on the overbed table. No beverage cups were observed to be present. During an interview on 04/09/24 at 6:30 PM, CNA2 stated he filled R13's water pitcher earlier that day per her request. 2. A resident council group interview was held on 04/10/24 at 2:30 PM with R70, R5, R6, R18, R224, R41. Five of the six residents (R20, R70, R18, R41, R224) attending expressed concerns regarding the availability of ice water in their rooms and beverage availability. Comments included: -R20 stated if you are not in your room, you will not be provided ice water. -R70, R18, R224 all stated they were rarely provided ice water in their rooms. (continued on next page)

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	265589	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-R20, R18, R41, R224 stated they did not like the drinks that were served. They stated they were routinely served Kool-Aid to drink. The facility ran out of drinks they preferred such as coffee, juice, and milk; additionally, iced tea was not available. Review of R20's annual MDS with an ARD of 02/09/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R18's quarterly MDS with an ARD of 03/01/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R224's significant change MDS with an ARD of 01/09/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 10 out of 15 which indicated the resident was moderately cognitively impaired. Review of R14's annual MDS with an ARD of 12/22/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R70's quarterly MDS with an ARD of 01/05/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. 3. Review of Resident Council Minutes dated 12/22/23 revealed: Dietary: . Not giving patients [the] right tray or not bringing drink. 4. During an interview on 04/09/24 at 6:29 PM, CNA2 stated he was supposed to check the water pitchers at the start of his shift and every two hours. During an interview on 04/11/24 at 12:44 PM, Licensed Practical Nurse (LPN)4 stated the CNAs were supposed pass ice water in the mornings and throughout the day. She stated the nurses monitored this. LPN4 stated R13 was unable to get water herself and required staff assistance. During an interview on 04/11/24 at 11:23 AM, the Registered Dietitian (RD) stated she had been employed less than a month and had made three visits. The RD stated she was not aware of residents' concerns about the lack of availability of ice water in their rooms or beverages in general. The RD stated she was aware the previous RD had not completed full nutritional assessments. The RD verified she had not assessed R13 yet; all residents would be assessed at least quarterly. The RD stated all residents should have ice water in their rooms and beverage choices. During an interview on 04/11/24 at 1:51 PM, the Director of Nursing (DON) and Regional Nurse Consultant (RNC)2 stated the expectation was to ensure residents had ice water available in their rooms.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on observation, interview, record review, and review of facility's policy, the facility failed to maintain oxygen therapy equipment for one of three residents reviewed for oxygen (Resident (R) 46) out of a total sample of 28 residents. R46's oxygen tubing and humidifier bottle were not changed and not dated. Additionally, the oxygen concentrator filter had a heavy accumulation of gray dust debris. The facility census was 82. Findings include: Review of the facility's policy titled, Oxygen Administration revised 10/24/22 read in part .All oxygen tubing, humidifiers, masks, and cannulas used to deliver oxygen will be changed weekly and when visibly soiled or as indicted by the state regulations . Review of R46's undated Admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia. Review of R46's Physicians Orders for the month of April 2024 located in the resident's EMR under the Orders tab revealed an order to change O2 tubing and humidifier weekly and clean the concentrator filter every week. Date all tubing and place in a bag when not in use. Observation on 04/08/24 at 9:45 AM revealed R46 was lying in bed with the head of bed (HOB) elevated to 45 degrees. The resident was wearing an oxygen nasal cannula with oxygen (O2) set at two liters per minute (lpm). There was no date on the oxygen tubing. The oxygen concentrator had dust debris. The humidifier bottle was labeled with the date of 03/29/24. The filter on the concentrator had a heavy coating of gray dust. Observation on 04/09/24 at 1:10 PM revealed R46 in bed sleeping wearing nasal O2 cannula. The setting was two liters. There was no date on the oxygen tubing and the humidifier bottle contained 20 milliliters (ml) of water and was dated 03/29/24. The filter on the side of the concentrator had a heavy collection of gray dust debris. Observation on 04/12/24 at 9:47 AM revealed R46 was lying in bed with the HOB elevated at 45 degrees. The resident was wearing nasal cannula, and the flow of oxygen was set at two (lpm) and the tubing remained unlabeled. The resident's pulse oximeter reading was at 96% saturation. The oxygen concentrator at the bedside remained unchanged as the filter had a heavy accumulation of gray dust debris. The humidifier bottle was empty and had a tape dated 4/10/24 over the old date of 03/29/24. During an observation and interview on 04/12/24 at 9:52 AM, the Certified Medication Technician (CMT) 2 stated the night shift nurse was responsible for changing and dating the oxygen tubing, dating and changing the humidifier bottle, and cleaning the concentrator's filter. CMT2 confirmed the condition of the equipment and stated she was unaware it was in this condition. The CMT cleaned the concentrator filter and attempted to change the humidifier bottle when he/she discovered the central supply was out of the humidifier bottles. The CMT refilled the humidifier bottle with bottle with water. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/12/24 at 2:30 PM, the Central Supply Clerk (CS) stated the current supply of humidifier bottles did not fit the oxygen concentrators and she would have to order the correct bottles from another company.

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F 0697 Level of Harm - 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** 25225 Based on interview, record review, and facility policy review, the facility failed to provide pain management for one of four sampled residents (Resident (R) 20) reviewed for pain out of a total sample of 28 residents. R20 was without pain medication for three days. R20's pain was not assessed, the Director of Nursing (DON) was not notified, and non-pharmacological interventions to help relieve the resident's pain during the three-day period were not attempted. This failure resulted in actual harm for R20. The facility census was 82. Findings include: Review of the facility's policy titled, Pain Management, revised 10/24/22, revealed, . Facility Staff is responsible for helping the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain . The Licensed Nurse will assess the resident for pain and document results on the MAR each shift . Review of R20's Admission Record, provided by the facility revealed R20 was admitted to the facility on [DATE] with diagnoses that included poly osteoarthritis, polyneuropathy, chronic pain, and fibromyalgia. Review of R20's Physician Orders, dated 12/01/22 and located under the Orders tab of the electronic medical record (EMR), revealed R20 was to receive hydrocodone-acetaminophen (Norco, an opioid analgesic) 10/325 milligrams (mg) two tablets by mouth every six hours as needed (prn) for moderate pain, not to exceed five tablets in a 24-hour period. Review of R20's Care Plan, dated 12/29/23 and located under the Care Plan tab of the EMR, revealed a focus related to pain medication therapy. The goal was R20 would be free of any discomfort or adverse side effects from pain medication. Interventions included administering analgesic medications as ordered by the physician. Review of R20's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/09/24 and located under the MDS tab of the EMR, revealed R20 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated R20 was cognitively intact. It was recorded R20 was on a scheduled pain medication regimen, did not receive prn pain medications, was frequently in pain, her pain occasionally interfered with day-to-day activities, and R20 rated her pain at a 9 on a zero to 10 scale, with zero being no pain and 10 being the worst pain imaginable. Review of R20's physician Encounter Note, dated 02/19/24 and located under the Progress Notes tab of the EMR, revealed, . Patient states that her chronic pain is better with the 2 Norco at noon, she states at night she tends to have pain when she wakes up, she is in some pain, she was asking if something else could be done . I will change the Norco from 2 of the 10/325 at noon to 2 tablets at noon and 1 tablet at bedtime . (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of R20's Physician Orders, dated 02/19/24 and located under the Orders tab of the EMR, revealed R20 was to receive hydrocodone-acetaminophen 10/325 mg, two tablets by mouth in the afternoon for pain and one tablet by mouth at bedtime for pain. R20 continued to have the above referenced prn medication order. Review of R20's Progress Notes, dated 03/28/24 at 12:21 PM through 03/30/24 at 4:27 PM and located under the Progress Notes tab of the EMR, revealed the following: 03/28/24 at 12:21 PM - . HYDROcodone-Acetaminophen Oral Tablet 10-325 MG Give 2 tablet by mouth in the afternoon for pain medication unavailable no script [prescription] for refill cant [sic] pull from ekit [emergency kit] . 03/28/24 at 6:51 PM - . HYDROcodone-Acetaminophen Oral Tablet 10-325 MG Give 1 tablet by mouth at bedtime for pain Unavailable. Awaiting new prescription. Request sent per day nurse . 03/29/24 at 1:11 PM - . HYDROcodone-Acetaminophen Oral Tablet 10-325 MG Give 2 tablet by mouth in the afternoon for pain No Script, pharmacy and office for [physician name withheld] contacted for new script . 03/30/24 at 4:27 AM - . HYDROcodone-Acetaminophen Oral Tablet 10-325 MG Give 1 tablet by mouth at bedtime for pain not available on med [medication] cart rx [pharmacy] called, awaiting prescription, per rx md [physician] was contacted . 03/30/24 at 11:54 AM - . HYDROcodone-Acetaminophen Oral Tablet 10-325 MG Give 2 tablet by mouth in the afternoon for pain on order, pharmacy aware, script is needed from MD . Review of R20's Medication Administration Records, dated 03/28/24 through 03/30/24, located under the Orders tab of the EMR revealed no documented evidence R29 received her hydrocodone/acetaminophen as ordered by the physician from 03/28/24 through 03/30/24. This was a total of six missed doses. There was no documented evidence R20's pain level was assessed from 03/28/24 through 03/30/24; during the time she did not receive her ordered hydrocodone/acetaminophen. There was no documentation of any non-pharmacological interventions that were attempted during that time to help with R20's pain. There was no documentation the Director of Nursing (DON) was notified R20 was without her pain medication. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of R20's Care Plan, dated 04/09/24 and located under the Care Plan tab of the EMR, revealed a focus related to acute/chronic pain. The goal was R20 would verbalize adequate relief of pain or ability to cope with incompletely relieved pain. Interventions included administering analgesia as per orders. During an interview on 04/08/24 at 12:25 PM, R20 stated her pain could be bad. R20 stated the pain was located in her shoulders; right leg, especially the knee; and she had rods in her legs. R20 stated when she received her pain medication, it would bring her pain down to about a 6, but when the pain medication wore off, it would get higher and higher. She stated her pain would be at a 9 or 10 when she woke up, but the pain medication did help to make the pain tolerable. R20 stated the pain kept her from sleeping or doing activities at times. R20 stated at the end of March 2024, there was a time when her pain medication was not available for some reason, and it was rough when that happened. R20 stated staff did not do anything different when she was without her pain medications, and she was not offered anything else. R20 stated she would just sit if she did not have her medication or if the pain level was too high. She stated it was too painful to move without her pain medication. R20 stated she did take a muscle relaxer and gabapentin for nerve pain, but it required all the medications to keep her pain tolerable. During an interview on 04/09/24 at 1:00 PM, Nurse Aide (NA) 1 was asked if R20 had pain. NA1 stated yes. She stated when R20 was experiencing increased pain, she would tell the nurse. NA1 stated R20 had been without pain medication not long ago, and R20 had not done much during that time, because she was hurting too bad. During an interview on 04/12/24 at 9:10 AM, the Director of Nursing (DON) reported that agency staff were assigned to R20's hall on this day. The DON stated the process for reordering narcotic medications was to fax the request to the pharmacy, and if a new prescription was required, the pharmacy would contact the physician. During an interview on 04/12/24 at 2:00 PM, the DON and Regional Nurse Consultant (RNC) 2 were asked if they were aware R20 had been without her pain medication from 03/28/24 through 03/30/24. The DON stated, No. They were asked what they would have expected staff to do. The DON stated, Call the doctor, and if he could not get that, give her something else, and notify me. The DON stated she would have called the doctor on the direct number she has for him. The DON confirmed R20 should not have gone three days without her pain medication. The DON was asked what staff did to help relieve R20's pain during that time. The DON stated she would have to research and get back to the surveyor with that information. No further information was provided before the end of the survey.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, facility policy review, and staffing schedule review, the facility failed to ensure there was adequate competent nursing department staffing, in adequate numbers to meet the needs of five of 28 sampled residents (Resident (R) 20, R13, R14, R4, and R16) and six supplemental residents (R5, R70, R6, R118, R224, and R41). Residents did not receive medications; did not have their call lights answered timely and/or they had unmet needs; activities of daily living (ADLs) were not provided for residents requiring assistance; and residents were not provided ice water in their rooms or sufficient beverages. Weekend staffing and agency staff were common problems expressed by the residents. The facility census was 82. Findings include: Review of the facility's policy titled, Nursing Department - Staffing, Scheduling & Postings dated 10/24/22 revealed, Purpose: To ensure an adequate number of nursing personnel are available to meet resident needs. The Facility will employ sufficient nursing staff on a 24 hour basis that meet the appropriate competencies, skill set, and required qualifications to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being for each resident . Non-permanent caregivers are expected to meet competency, knowledge, and skill requirements to the same extent as permanent personnel . 1. A resident council group interview was held on 04/10/24 at 2:30 PM with R70, R5, R18, R224, R41, and R20. Their comments included: a. Medications were not passed on 04/08/24 in the evening/at bedtime: -R20, R18, R5, and R224 stated there were not enough nursing staff to pass medications. They stated on 04/08/24 there was an unfamiliar/inexperienced person passing evening shift medications (Certified Medication Technician (CMT) 2) on the 100, 200, and 300 halls and residents were not administered their bedtime medications. -R5 stated she had a pain pill that she waited for and did not receive. R5 stated she was not able to go to sleep until 4:00 AM. -R20 stated CMT2 did not know what medications to administer and asked her what medications she was supposed to get. -R224 stated she was supposed to take blood pressure medication and was concerned she might have a heart attack due to missing the medication. R224 stated CMT2 signed off that she had administered the medications when she had not. R224 stated CMT2 left at 10:00 PM without administering the medications. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-R70, R18, R5 and R224 all stated they did not receive their medication on the evening/bedtime shift on 04/08/24. They stated they reported the failure to receive their medications to the oncoming nurse on night shift (Registered Nurse (RN)2), but the oncoming nurse would not administer the medications because they had been signed out as being given. -R18 stated she had an order for Bio freeze (ointment) for pain and it must be rubbed into her skin. R18 stated the staff would not rub it in and told her to go to a massage therapist. b. Residents reported concerns with agency nursing staff: -R5, R70, R20, and R18 all stated the staff told them, That is not my job when they requested care/treatment. R18 stated it made her feel angry when staff said it was not their job. R224 stated the nurses acted like they did not care. -R18 stated the agency nursing staff were, bad. R20, R5, R18, and R224 stated the staff were wearing earbuds and talking on their phones when providing care. They stated they had reported this numerous times in resident council meetings, but it continued to be a problem. -R18 and R5 stated the agency staff did not introduce themselves and they had to ask them for their names. They stated this had been brought up in resident council meetings and it had not improved. -R20 stated there were times when it took three hours for the staff to see what you wanted. -R5 stated the staff did not know what to do when they answered the light; they were not trained. c. Residents reported concerns with weekend staffing and getting residents up early when they did not want to get up: -R20, R18, R224, and R41 all stated weekend staffing was poor and one time there were only two aides for the whole building. -R5 stated she needed help to get to the bathroom and there had been times when she waited up to four hours to be toileted. R5 stated, I will get up and do it myself. I need help and they do not come. They all say wait. -R224, R20, and R5 stated Easter night was especially bad for staffing. They stated the managers did not come in during staffing shortages to assist. -R20 stated she waited so long for her call bell to be answered, she had fallen back asleep. She stated then later when she was awake the staff told her they came in but she was sleeping so the light was turned off and no care provided. -R18 stated the staff snuck in the room and turned the call light off and did not provide help. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-R20 and R5 stated the staff came in and got their roommates up and dressed before 6:00 AM when the residents did not want to get up that early. They stated the staff did this to residents who could not speak up for themselves. One resident remained up in her wheelchair until 11:00 PM. R18 stated they did this to her roommate, got her up, put her in the back of the dining room and she was left there without having her brief changed. Review of R5's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/01/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. Review of R20's annual MDS with an ARD of 02/09/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R18's quarterly MDS with an ARD of 03/01/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R224's significant change in status MDS with an ARD of 01/09/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 10 out of 15 which indicated the resident was moderately cognitively impaired. Review of R14's annual MDS with an ARD of 12/22/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R70's quarterly MDS with an ARD of 01/05/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. 2. R6 requested to speak with a surveyor. During an interview on 04/11/24 at 01:16 PM, R6 stated the facility was short staffed a lot on weekends and evenings and he received his medications late. R6 stated, on 04/08/24 he did not receive his 9:00 PM medications including Trazadone (antidepressant), diazepam (anti-anxiety medication), and Melatonin (hormone supplement) all for sleep, and his blood pressure medication. R6 stated he missed all his evening medications and as a result was up all night. He stated he could tell his blood pressure was elevated because he had a headache. R6 stated he asked the night shift nurse, (Registered Nurse (RN) 2) who came on shift at 11:00 PM if she could administer the medications that were not administered by the CMT2. RN2 stated she could not give the medications because the medications were signed out as being given, it was against the law to administer them, and it was none of her business what occurred on the prior shift. R6 stated he asked RN2 if she could call someone such as the Director of Nursing (DON) or the doctor about the missing medications so they could be administered. R6 stated if RN2 would have called, it could have been straightened out, but it was not. R6 stated he reported the incident to the Assistant Director of Nursing (ADON) the next day. (continued on next page)

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St Peters Rehab and Healthcare Center	230 Spencer Road Saint Peters, MO 63376

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R6's quarterly MDS with an ARD of 01/16/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of the untitled staffing worksheet for 04/08/24 and provided by the facility, RN2 was scheduled on night shift for the 100, 200, and part of the 300 hall; RN2 was a regular facility employee. CMT2 was scheduled on evening shift for the 100, 200, and part of the 300 hall; she was an agency employee. During an interview on 04/11/24 at 2:54 PM, the ADON stated R6 came and talked to her about the failure to receive his medications on 04/08/24 and his inability to sleep as a result. The ADON stated she told R6 that CMT2 would not be returning to the facility. The ADON verified CMT2 was an agency Medication Technician. The ADON verified many residents were not administered their medications on 04/08/24 on the evening shift; however, the medication records showed the medications were administered. The ADON stated RN2 had called and left her a message the night the incident occurred but she was sleeping and did not hear the phone. The ADON stated there was a staffing phone for on call staffing issues, but she did not have the staffing phone that night, the DON had the staffing phone. The ADON stated RN2 should have notified the physician and given him/her the information about the medications not being administered per the residents' statements even though they were signed out. The ADON stated the physician should make the decision what to do. During an interview on 04/11/24 at 2:03 PM, the DON verified she had the staffing phone the night of 04/08/24; however, she was not called. The DON verified the agency CMT2 documented residents received their medications when they did not. The physician had since been notified. The DON stated CMT2 would not be back to the facility and RN2 had been educated on what to do if a similar situation occurred in the future, indicating the person with the staffing phone should have been called and/or Physician contacted. 3. Review of Resident Council Minutes from October 2023 to March 2024 (except for February 2024 for which no minutes were provided) revealed concerns were raised repeatedly with call lights, staff not introducing themselves, staff not responding to residents' needs, and staff talking on their phones as follows: a. Review of Resident Council Minutes dated 10/25/23 revealed: Nursing . not introducing themselves . b. Review of Resident Council Minutes dated 11/28/23 revealed: Nursing . Weekends are bad. CMTs [certified medical technicians] . not introducing who they are . c. Review of Resident Council Minutes dated 12/22/23 revealed: Old business: . Nursing . weekends still not great but getting better. still not introducing themselves . d. Review of Resident Council Minutes dated 01/30/24 revealed: Old business: Aides not introducing themselves . Talking on phone outside of resident room or in resident's room . e. Review of Resident Council Minutes dated 03/25/24 revealed: Old business: Aides still not introducing themselves . New business . Nursing: Call lights - taking some time, turned off without addressing, Staff saying they can't help other, I'm not your aide . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Review of R13's undated Admission Record located in the resident's EMR under the Profile tab revealed R13 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, anxiety disorder, and cerebral infarction (stroke). Review of R13's significant change in status MDS with an ARD of 01/23/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 11 out of 15 which indicated the resident was moderately cognitively impaired. During an observation on 04/10/24 at 12:46 PM, R13 was observed sitting in her wheelchair in her room. She stated she had wanted to go back to bed since she had finished breakfast. R13 stated, I want to lay down; my butt and back hurt. R13 activated her call light at this time and CNA5 went down the hall towards R13's room. During an interview on 04/10/24 at 1:08 PM, R13 continued to sit in her wheelchair in her room. R13 stated no one answered her call light; however, it had been turned off. R13 stated she was in pain and wanted to lie down. During an interview on 04/10/24 at 1:10 PM, Certified Nurse Aide (CNA) 3 was assisting residents with their meals in the dining room for the unit and stated CNA5 was the aide assigned to R13. CNA3 stated staff could not answer call lights right now because it was lunch time and R13 would be assisted after lunch. During an interview on 04/10/24 at 1:49 PM, R13 stated CNA5 came and assisted her to lay down after the surveyor spoke with CNA3. R13 was lying in bed at this time. During an interview on 04/10/24 at 1:54 PM, CNA5 stated she worked for an agency and was not a regular facility employee. CNA5 verified she turned off R13's call light without providing care/laying her down. CNA5 stated she told the resident she would come back after lunch was finished. CNA5 denied R13 telling her earlier that day that she wanted to lay down. 5. Review of the untitled daily staffing worksheets for weekends in March 2024 through 04/07/24, provided by the facility, revealed staffing shortages of CNAs as follows: a. The daily staffing worksheet for Saturday 03/02/24 revealed six CNAs were scheduled for day shift (6:00 AM - 2:00 PM); five worked. The daily staffing sheet revealed five CNAs were scheduled for night shift (10:00 PM - 6:00 AM); four worked. b. The daily staffing worksheet for Sunday 03/03/24 revealed six CNAs were scheduled for day shift; three worked. The daily staffing sheet for afternoon shift (2:00 PM - 10:00 PM) showed six CNAs were scheduled; four worked. The daily staffing sheet for night shift revealed five CNAs were scheduled for night shift; four worked. c. The daily staffing worksheet for Saturday 03/09/24 revealed eight CNAs were scheduled for day shift; seven worked. d. The daily staffing worksheet for Sunday 03/10/24 revealed four CNAs were scheduled for night shift; three worked. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	e. The daily staffing worksheet for Saturday 03/16/24 revealed seven CNAs were scheduled for day shift; six worked. The daily staffing schedule for night shift revealed six CNAs were scheduled; five worked. f. The daily staffing worksheet for Sunday 03/31/24 (Easter) revealed six CNAs were scheduled for day shift; five worked. There were four CNAs scheduled and working the afternoon shift. g. The daily staffing worksheet for Saturday 04/06/24 revealed there were seven CNAs scheduled for the day shift; six worked. The daily staffing worksheet revealed there were seven scheduled for the evening shift; five worked. There were five scheduled on night shift; four worked. 6. Review of R14's Admission Record, provided by the facility, revealed R14 was admitted to the facility on [DATE] with diagnoses that included muscle weakness, difficulty in walking, and need for assistance with person care. Review of R14's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/30/24 and located under the MDS tab of the electronic medical record (EMR), revealed R14 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated R14 was cognitively intact. During an interview on 04/08/24 at 2:52 PM, R14 was asked if she felt there was enough staff to meet the residents' needs. R14 stated, The only thing I have to say about that is that I feel abused when they don't take care of me when I need it due to lack of staff. R14 stated the facility often did not have enough staff. R14 stated normally there was only one aide to take care of the residents on the 100 hall. R14 stated there were normally around 14 residents on the 100 hall, and almost all of the residents were dependent on staff to meet their needs. R14 stated most of the facility staff was good, but the agency staff were just there for the money. 7. Review of R4's Admission Record, provided by the facility, revealed R4 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis, type 2 diabetes mellitus, and severe obesity. Review of R4's quarterly MDS, with an ARD of 12/28/23 and located under the MDS tab of the EMR, revealed R4 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. During an interview on 04/08/24 at 3:22 PM, R4 stated, Yesterday we couldn't get out of bed because there was only one aide on each hall. R4 stated that happened often. R4 stated that on 04/05/24, staff got her out of bed at 2:00 PM and she did not get put back into bed until after 8:00 PM. R4 stated she wanted to go to bed at 6:00 or 6:30 PM, but no one was available to help her into bed. R4 stated, They have to understand what I've done to my body. With the cage in my back, it affects everything. With neuropathy, if I sit too long in the wheelchair, I have to keep my legs bent and go down slow and it hurts. R4 stated, I did get myself in bed one time by myself. R4 stated, I turned the button on, the aide came in and said she would be back and never did. R4 stated the aide turn her call light off. R4 stated, I got all the way there, from the foot to the top of the bed. R4 stated she had been waiting a long time with that episode. She stated, I'm talking an hour or more. R4 stated she had called her family member and reported what was going on. R4 stated. They let me lay in bed for six hours or longer with pee and poop and keep doing that same thing of turning the call light off. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. Review of R20's Admission Record, revealed R20 was admitted to the facility on [DATE] with diagnoses that included polyarthritis, chronic pain, and fibromyalgia. Review of R20's annual MDS, with an ARD of 02/09/24 and located under the MDS tab of the EMR, revealed R20 had a BIMS score of 15 out of 15, which indicated R20 was cognitively intact. During an interview on 04/08/24 at 12:15 PM, R20 was asked if she felt there was enough staff to meet the residents' needs. R20 stated, No. R20 stated a lot of times, there was only one aide working two halls. R20 stated that even with agency staff, there might only be one aide per hall. R20 stated, You have to wait to go to the bathroom and be changed. R20 stated that call light response times varied. She stated, I understand she [her assigned aide] doesn't have any help so I try to be considerate. 9. Review of R16's Admission Record, provided by the facility, revealed R16 was admitted to the facility on [DATE] with diagnoses that included contractures, difficulty walking, and hemiplegia and hemiparesis of the left side. Review of R16's quarterly MDS, with an ARD of 01/10/24 and located in the electronic medical record (EMR) under the MDS tab, revealed R16 had a BIMS score of 15 out of 15, which indicated R16 was cognitively intact. During an interview on 04/08/24 at 10:50 AM, R16 reported that on 04/07/24, during the morning hours on the day shift, she asked her aide to help her get out of bed. R16 stated the aide replied, I don't want to, but I guess I have to. R16 reported that she asked the aide if that was not her job and that the aide replied, If you want to get up, you do it. R16 reported that the aide refused to get her out of bed. R16 stated the aide was hateful and it made her angry. R16 stated that the aide would not provide her name. R16 stated she remained in bed until the evening shift when LPN1 and an unidentified CNA helped her get out of bed. R16 stated she reported the allegation of neglect to LPN1 at that time. Cross-Reference F-600: Neglect. During an interview on 04/09/24 at 7:09 PM, Licensed Practical Nurse (LPN) 3 stated there were usually seven CNAs on the evening shift for the whole facility and five CNAs for nights. LPN3 stated there were some shortages due to staff not showing up; the existing staff split up the work. During an interview on 04/11/24 at 2:03 PM, the DON stated she was aware of residents' concerns about staff wearing earbuds while providing care and slow call bell response time. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/12/24 at 2:32 PM, the DON, ADON, and Regional Nurse Consultant (RNC) 1, stated the number of CNAs scheduled depended on the facility's census. The ADON stated with a current census of 82 residents, there would be a minimum of one CNA per 15 residents on day shift (six CNAs), one CNA per 20 residents on afternoon shift (four to five CNAs), and one CNA per 25 residents on night shift (four). The ADON stated the usual numbers for preferred staffing was seven CNAs on days, six CNAs on evenings, and five CNAs on nights. They stated there was a staffing phone for getting shifts covered when there were no calls/no shows. They stated the weekend staffing numbers were the same but there were no wound nurse or restorative staff. They stated there was also a manager on duty each weekend day, although this was not necessarily a nurse. They stated things took longer on the weekends. If agency staff did not work scheduled shifts, they were not allowed to come back. They acknowledged receiving complaints about residents not receiving medications or getting changed (incontinence) timely. The ADON stated the staffing was adequate and she had not worked on the floor for two years. The ADON stated the facility used one agency for obtaining staff and requests were made a week ahead of time. The ADON stated they tried to use the same staff; there had been issues with competencies and that was why they used the same staff when possible. The ADON stated staff were certified by the state of Missouri and were deemed competent by the staffing agency. The ADON stated either she or the DON had the staffing phone for on call issues. During an interview on 04/12/24 at 4:18 PM, the Administrator stated he had been hired within the past month when the new ownership of the facility took place. He stated measures to improve staffing were being put into place such as increasing the percentage of facility to agency staff and he had hired a staffing coordinator. The Administrator stated there had not been enough time yet to facilitate change. The Administrator stated he was aware of the residents' concerns regarding staffing. He stated he performed random spot checks on the weekends and verified the manager on duty program for weekends. 16752 25225

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, policy review and job description review, the facility failed to provide medically-related social services to ensure residents maintained their highest practicable wellbeing for three out of 28 sampled residents (R73, R43, and R11). R43 was not provided with a room change notice prior to a room change, had only one set of clothing to wear for a week following the room change. R73 was not given the opportunity to make his own decisions regarding the possession of his phone; the SSD followed the Power of Attorney's wishes without determining what R73 wanted. R11 was not invited to his care plan meeting; the resident's family was invited and the meeting was scheduled around the family's availability. The Social Service Director was the only social services employee and she was routinely assigned to provide direct care service tasks. The facility census was 82. Findings include: Review of the Social Services Director job description revealed, The Social Services Director works closely with residents, their families, and interdisciplinary healthcare teams to ensure the social and emotional needs of residents are met. The Social Services Director plays a crucial role in advocating for residents' rights and quality of life .Counseling: Provide emotional support and counseling to resident and their families to address issues such as adjustment to long -term care, grief, and coping with illness or disability. Referral: Identify and connect residents and families with community resources and support services, such as . mental health services . Advocacy: Advocate for residents' rights and interests, ensuring they receive respectful and dignified care . Qualifications: Bachelor's or Master's degree in Social Work/Psychology . 1. Review of the facility's Room or Roommate Change policy dated 10/24/22 revealed, When the resident is being moved at the request of the Facility, the notice of a change in room assignment will be in writing and will include the reason (s) for such change . Social Services Staff will assist in orienting the resident to his or her new room . Information regarding room transfers will be documented in the resident's medical record . Review of the Privacy and Dignity policy dated 10/24/22 revealed, Residents are dressed appropriate to the time of day and season as well as individual preferences . The facility respects the resident's private space and property. Staff treats residents with respect including . speaking respectfully, listening carefully . Review of R43's undated Admission Record located in the resident's electronic medical record (EMR) under the Profile tab revealed R43 was admitted to the facility on [DATE]. Review of R43's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/15/24 located in the resident's EMR under the MDS tab revealed the facility assessed R43 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/08/24 at 11:36 AM, R43 stated she recently moved (on 04/01/24) from a different room to the current room where she resided. R43 stated she was told in the morning she would be moving to a different room and she was moved a few hours later to her new room. R43 was wearing slacks and a shirt and stated she had been wearing this outfit for three days because her possessions, including her clothing, had not been moved from her old room to this one. R43 stated she had told several staff she needed to have her possessions moved. R43 stated she was not able to get her possessions herself due to mobility issues. During an interview on 04/09/24 at 1:52 PM, the Social Service Director (SSD) The SSD stated R43 was notified verbally in the morning and moved to her new room in the afternoon, last week. The SSD verified no written notice was given to R43. The SSD verified she had not documented the reason for the move or that R43 had moved in R43's EMR. On 04/09/24 at 2:47 PM, the SSD and surveyor went to R43's room and the SSD looked in R43's closet and verified R43 had no clothes and her possessions had not been moved. The SSD asked R43 how many staff had she reported this to, who had she reported this to, and when had she reported it. During an interview on 04/09/24 at 6:17 PM, R43 stated she was concerned how the SSD talked to her about her clothing earlier that day. R43 stated the SSD's questioning about who she notified, etc. made her uncomfortable. R43 stated the SSD had not followed through with the room change and she felt like she (the resident) was being blamed for not having her clothing moved. R43 stated the SSD had been the staff member who had worked with her on her room change. R43 stated she was not given a room change notice in writing prior to the move. R43's EMR was reviewed for evidence of a room change notice and for documentation explaining the reason for the room change. No documentation was found in the EMR related to R43's room change or the behaviors that precipitated the move. 2. Review of the facility's policy titled, Resident Rights dated 05/01/23 revealed, Purpose - To promote and protect the rights of all residents at the facility .All residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the Facility . Review of R73's undated Admission Record located in the resident's EMR under the Profile tab revealed R73 was admitted to the facility on [DATE]. Review of R73's admission MDS with an ARD of 12/26/23 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 14 out of 15 which indicated the resident was cognitively intact. During an interview on 04/09/24 at 11:56 AM, Interested Party (IP) 73 stated Family Member (F) 73 was R73's Power of Attorney (POA) and authorized who R73 could and could not speak to. IP73 stated R73 had a girlfriend of approximately [AGE] years who historically spoke on the phone to R73 daily. IP73 stated when F73 took over as POA, she refused to let R73 speak to his girlfriend. IP73 said she had mailed a cell phone to R73 after the one he had when he was admitted to the facility went missing. IP73 stated the facility took the phone that they (IP73 and R73's girlfriend) mailed to R73 away from R73 and gave it to his POA without R73's permission. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/24 at 1:21 PM, the SSD stated F73 told her she would rather R73 and his girlfriend not talk. The SSD stated R73 received a phone through the mail from his girlfriend after his went missing. The SSD stated she contacted F73 and asked if R73 could have the phone. F73 instructed the SSD to get the phone and stated she would send it back to R73's girlfriend. The SSD stated F73 came and retrieved the phone from the facility. The SSD stated she did not ask R73 if he wanted to keep the phone. The SSD stated R73 never told her that he did not want to talk to his girlfriend. The SSD verified R73 was his own decisions maker. Review of a Social Services Note dated 01/04/24 in the EMR under the Progress Notes tab read, Spoke with POA [F73's name] she stated she does not want [R73's] girlfriend to call or have visitation with Resident. [POA] came to facility to get his phone on 01/03/24 [POA] stated she will not be giving the phone back to Resident. 3. Review of the facility's Care Planning policy dated 10/24/22 revealed, The Comprehensive Care Plan must be prepared by the IDT [interdisciplinary team]. The IDT team includes the following individuals . The resident and/or his/her family or legal representative . The Facility will invite the resident, if capable . to care planning meetings . Review of R11's undated Admission Record located in the resident's EMR under the Profile tab revealed R11 was admitted to the facility on [DATE]. Review of R11's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/16/24 located in the resident's electronic medical record (EMR) under the MDS tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. During an interview on 04/08/24 at 1:11 PM, R11 stated he was interested in participating in his care and would like to attend care plan meetings. R11 stated he had not previously attended the meetings. During an interview on 04/09/24 at 2:31 PM, the SSD stated, until about a month ago, she had been responsible for inviting families and residents to quarterly care plan meetings. The SSD stated R11's POA had canceled the last couple of care plan meetings. The SSD stated residents were also invited to their care plan meetings; however, indicated she did not document that R11 had been invited. Review of the Plan of Care Notes from 12/07/22 through current in the EMR under the Progress Notes tab revealed notes on 12/07/22, 02/13/23, 05/31/23, and 01/24/24 indicating R11's POA was invited to the meeting or attended the care plan meetings. There was no mention of R11 being invited to or attending any of the meetings. During an interview on 04/11/24 at 3:08 PM, the Assistant Director of Nursing (ADON) stated she regularly attended care plan meetings and she did not remember R11 coming. 4. During an interview on 04/09/24 at 1:21 PM, the SSD stated prior to becoming the SSD, she had been a Certified Nursing Assistant (CNA). The SSD stated she received her certificate in 2022 to become the SSD, which started in August of 2022. The SSD stated she was the only staff member working in the social service department. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/24 at 11:39 AM, the SSD stated she was working on this date in the kitchen because they were shorthanded. The SSD stated she also worked as a CNA when there was a need.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on interview, record review, and facility policy review, the facility failed to provide medications, as ordered by the physician, to meet the residents' needs for two of five sampled residents (Resident (R) 20 and R4) whose medications were reviewed. The facility census was 82. Findings include: 1. Review of the facility's policy titled, Pain Management, revised 10/24/22, revealed, . Facility Staff is responsible for helping the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain . Review of R20's Admission Record, provided by the facility, revealed R20 was admitted to the facility on [DATE] with diagnoses that included polyosteoarthritis, polyneuropathy, chronic pain, and fibromyalgia. Review of R20's Physician Orders, dated 12/01/22 and located under the Orders tab of the electronic medical record (EMR), revealed R20 was to receive hydrocodone-acetaminophen (Norco, an opioid analgesic) 10/325 milligrams (mg) two tablets by mouth every six hours as needed (prn) for moderate pain, not to exceed five tablets in a 24-hour period. Review of R20's Care Plan, dated 12/29/23 and located under the Care Plan tab of the EMR, revealed a focus related to pain medication therapy. The goal was R20 would be free of any discomfort or adverse side effects from pain medication. Interventions included administering analgesic medications as ordered by the physician. Review of R20's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/09/24, revealed R20 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated R20 was cognitively intact. It was recorded R20 was on a scheduled pain medication regimen, did not receive prn pain medications, was frequently in pain, her pain occasionally interfered with day-to-day activities, and R20 rated her pain at a 9 on a zero to 10 scale, with zero being no pain and 10 being the worst pain imaginable. Review of R20's physician Encounter Note, dated 02/19/24 and located under the Progress Notes tab of the EMR, revealed, . Patient states that her chronic pain is better with the 2 Norco at noon she states at night she tends to have pain when she wakes up she is in some pain she was asking if something else could be done . I will change the Norco from 2 of the 10/325 at noon to 2 tablets at noon and 1 tablet at bedtime . Review of R20's Physician Orders, dated 02/19/24 and located under the Orders tab of the EMR, revealed R20 was to receive hydrocodone-acetaminophen 10/325 mg, two tablets by mouth in the afternoon for pain and one tablet by mouth at bedtime for pain. R20 continued to have the above referenced prn medication order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R20's Progress Notes, dated 03/28/24 at 12:21 PM through 03/30/24 at 4:27 PM and located under the Progress Notes tab of the EMR, revealed the following: 03/28/24 at 12:21 PM - . HYDROcodone-Acetaminophen Oral Tablet 10-325 MG Give 2 tablet by mouth in the afternoon for pain medication unavailable no script [prescription] for refill can't [sic] pull from ekit [emergency kit]. 03/28/24 at 6:51 PM - . HYDROcodone-Acetaminophen Oral Tablet 10-325 MG Give 1 tablet by mouth at bedtime for pain Unavailable. Awaiting new prescription. Request sent per day nurse . 03/29/24 at 1:11 PM - . HYDROcodone-Acetaminophen Oral Tablet 10-325 MG Give 2 tablet by mouth in the afternoon for pain No Script, pharmacy and office for [physician name withheld] contacted for new script . 03/30/24 at 4:27 AM - . HYDROcodone-Acetaminophen Oral Tablet 10-325 MG Give 1 tablet by mouth at bedtime for pain not available on med [medication] cart, rx [pharmacy] called, awaiting prescription, per rx md [physician] was contacted . 03/30/24 at 11:54 AM - . HYDROcodone-Acetaminophen Oral Tablet 10-325 MG Give 2 tablet by mouth in the afternoon for pain on order, pharmacy aware, script is needed from MD . Review of R20's Medication Administration Record (MAR), dated 03/28/24 through 03/30/24, revealed no documentation R29 received her hydrocodone/acetaminophen as ordered by the physician from 03/28/24 through 03/30/24, for a total of six missed doses. During an interview on 04/08/24 at 12:25 PM, R20 stated at the end of March 2024, there was a time when her pain medication was not available for some reason, and it was rough when that happened. During an interview on 04/12/24 at 9:10 AM, the Director of Nursing (DON) stated nurses reorder narcotics, and the process for reordering narcotic medications was to fax the request to the pharmacy, and if a new prescription was required, the pharmacy would contact the physician. During an interview on 04/12/24 at 2:00 PM, the DON and Regional Nurse Consultant (RNC) 2 stated they were not aware R20 had been without her pain medication from 03/28/24 through 03/30/24. The DON stated she would have expected nursing staff to call the doctor, and if they could not get that, give her something else, and notify her. The DON stated she would have called the doctor on the direct number she has for him. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R4's Admission Record, provided by the facility, revealed R4 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis, type 2 diabetes mellitus, and severe obesity. Review of R4's quarterly MDS, with an ARD of 12/28/23 and located under the MDS tab of the EMR, revealed R4 scored 15 out of 15 on the BIMS, which indicated the resident was cognitively intact. Review of R4's Physician Orders, located under the Orders tab of the EMR and dated 02/26/24, revealed R4 was to receive Ozempic 1mg/dose [4mg/3 milliliters (ml)], inject 1 mg subcutaneously every week on Monday for diabetes mellitus with hyperglycemia. Review of R4's Orders-Administration Notes, dated 02/26/24 at 10:14 PM and located under the Progress Notes tab of the EMR, revealed, . Ozempic (1 MG/DOSE) Subcutaneous . On Order . Review of R4's Orders-Administration Notes, dated 03/04/24 at 11:48 AM and located under the Progress Notes tab of the EMR, revealed, . Ozempic (1 MG/DOSE) Subcutaneous . Medication unavailable, on order, unable to pull from e kit . Review of a pharmacy Pending Orders Report, dated 03/05/24 at 5:19 PM and provided by the facility, revealed R4's Ozempic was previously filled on 03/05/24 and was scheduled for the next refill on 03/18/24. The report recorded, . Status . Refill Too Soon . Review of R4's Orders-Administration Notes, dated 03/11/24 at 11:03 AM and located under the Progress Notes tab of the EMR, revealed . Pharm [pharmacy] called for update on Ozempic, informed they would not be able to send more out until March 18th [Pharmacy name withheld] Scripts send out medication on 2/26 for a month supply . Review of R4's Orders-Administration Notes, dated 03/18/24 at 8:25 AM and located under the Progress Notes tab of the EMR, revealed, . Ozempic (1 MG/DOSE) Subcutaneous . unavailable . Review of R4's pharmacy Shipping Manifest, dated 03/18/24 at 11:39 AM and provided by the facility, revealed R4's Ozempic was delivered to the facility, received by Certified Medication Technician (CMT)1, and was given to LPN6. Review of R4's entire EMR revealed no documentation R4 was administered the Ozempic after it was delivered. Review of R4's Orders-Administration Notes, dated 04/01/24 at 11:18 AM and located under the Progress Notes tab of the EMR, revealed, . Ozempic (1 MG/DOSE) Subcutaneous . reorder . Review of R4's Orders-Administration Notes, dated 04/08/24 at 9:12 AM and located under the Progress Notes tab of the EMR, revealed, . Ozempic (1 MG/DOSE) Subcutaneous . Not available on backorder . Review of R4's pharmacy Shipping Manifest, dated 04/08/24 at 11:44 AM and provided by the facility, revealed R4's Ozempic was delivered to the facility, received by CMT1, and was given to the Assistant Director of Nursing (ADON). Review of R4's entire EMR revealed no documentation R4 was administered the Ozempic after it was delivered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's Progress Notes, located under the Progress Notes tab of the EMR and dated 03/01/24 through 04/08/24, revealed no documentation that the physician was notified of R4's missed doses of Ozempic. During an interview on 04/03/24 at 3:31 PM, R4 stated she was not receiving her Ozempic as ordered by the physician. R4 stated she was supposed to receive the medication on this day, but she did not. R4 stated she had missed several doses. R4 stated, The nurse is trying to tell me there is a shortage. R4 stated she did not buy that because another resident was getting their Ozempic. During an interview on 04/12/24 at 9:04 AM, CMT1 stated the facility's policy on reordering medications was to peel the sticker off of the medication card when there were three doses left, place the stick on the reorder sheet, and then fax the sheet to the pharmacy. CMT1 stated if there were only one or two stickers on the reorder sheet, she would leave it for the evening CMT because she would have some medications due for refill as well. CMT1 stated she believed the facility's electronic charting system was now integrated with the pharmacy so that you could just click on a link to reorder medications from the pharmacy. CMT1 stated if a medication was not available, staff should check the supply room for stock medications or let the nurse know, and she would contact the nurse practitioner or physician as necessary to reorder a medication. During an interview on 04/12/24 at 9:10 AM, the DON stated agency staff who were new to the facility were assigned to R4 on this day. The DON stated medications, except for narcotics, could be reordered directly from the facility's electronic charting software now. The DON was asked why R4's Ozempic was not available. She reviewed the clinical record and stated it looked like the medication was on backorder. The DON was asked if all the missed doses were on backorder. The DON stated the documentation for the 04/01/24 dose recorded the medication was on reorder, so she would need to check with staff to make sure they did not mean backorder. The DON was asked if the physician had been notified of R4's missed Ozempic doses. The DON stated she would have to check with staff to see where their documentation was. The DON was asked what the facility's policy was on notifying the physician of missed doses of medication. She stated she would have to look at the new policy, but she would expect the nurses to document and notify the physician. The DON stated that on 03/18/24, it was documented staff had called the doctor about other things, so she was sure they had notified him of the missed medication as well. The DON stated, I will check into it. The DON stated that typically when a prescription was nearing its' end, the pharmacy would contact the physician for a new prescription. She stated, A lot of time we follow up. We can give the doctor a call and let him know also. The DON stated, Sometimes it does take a while to get the scripts. During an interview on 04/12/24 at 10:21 AM, the DON was asked why R4's Ozempic would not be available if a month's supply (one dose per week for four weeks) had been sent to the facility on [DATE] as documented in the 03/11/24 progress note. The DON stated, I would have to look into that. The DON was asked what her expectation was if R4's Ozempic had arrived at the facility after the administration time, such as on 03/18/24. The DON stated she would expect staff to call the physician and see what he wanted to do. The DON was asked if R4 should have received her Ozempic on 04/08/24 after it was delivered to the facility and given to the ADON. The DON stated the nurse should have followed up with the physician. The DON stated she would follow up with the ADON to see if she notified the physician about the missed medication. The DON was asked what her expectation was regarding informing R4 about what was happening with her medications. The DON stated the resident should have been kept informed. The DON was asked to provide the facility's policies related to ordering medication, receiving medications, and physician notification. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/12/24 at 11:53 AM, the DON reported the physician had not been informed when R4 had not received her Ozempic. No information was provided to the surveyor regarding the months' supply of Ozempic that was delivered on 02/26/24 or why R4 did not receive her medications on 03/18/24 or 04/08/24 after the medication was delivered to the facility. The requested policies were not provided by the end of the survey.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure a medication error rate below five percent. During medication administration two medication errors for Resident (R) 14 were made out of 25 opportunities. The medication error rate was 8 percent. The facility census was 82. Findings include: Review of the facility's policy titled, "Medication Administration" revised 10/24/22 read in part, Medications will be administered by a licensed nurse per the order of an attending physician or licensed practitioner or as consistent with the state law . When preparing medications. The nurse will do a three-part check. Compare the licensed practitioner prescription with the medication administration record (MAR). Compare the licensed practitioner's order with the pharmacy label on the medication package. Compare the pharmacy label and the MAR. Any discrepancy identified during the first, second and third check must be resolved prior to the administration of any medication. Whenever a medication is held for any reason, the licensed nurse will initial the appropriate area on the MAR circle, his/her her initials. The licensed nurse will document the reason the medication was held on the back of the MAR . Review of R14's Admission Record located in the resident's electronic medical records (EMR) under the Profile revealed the resident was admitted to the facility on [DATE] with diagnoses that included fecal impaction, pneumonitis, chronic kidney disease stage II, partial intestinal obstruction and diabetes mellitus. Review of R14's "Medication Administration Record" for April 2024 and located in the resident's EMR under the Orders tab revealed R14 was to receive multiple medications which included Myrbetriq Oral (overactive bladder) tablets extended release 50 milligrams (mg) and Allegra (allergy medication) 50 mg. Observation on 04/11/24 at 9:46 AM revealed Certified Medicine Technician (CMT) 1 prepared R14's medications for administration. The Myrbetriq and the Allegra were not included in R14's prepared medications. During an interview on 04/11/24 at 9:30 AM, CMT1 stated the medications Allegra and Myrbertic had not arrived from the pharmacy. CMT1 informed Licensed Practical Nurse (LPN) 1 about the missing medications. During an interview on 04/11/24 at 11:00 AM, the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) stated it was their expectation nurses would notify the pharmacy a few days in advance when a resident's medication was running low to avoid the resident missing any prescribed medications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/12/24 at 8:59 AM, CMT1 stated the R14's Myrbetriq was delivered by the pharmacy on 04/10/24 and LPN1 had signed for the receipt of the medication on 04/10/24. CMT1 stated the Myrbertiq was found on the wrong medication cart later 04/11/24 and the resident never received the medication. The CMT stated the Allegra was now a stock medication and would need to be ordered with the stock medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 16752 Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure one of five medication carts and one of two treatment carts were locked and secured on two of five resident halls. Additionally, the facility failed to ensure medication refrigerator temperature logs were maintained in one of two medication rooms. The facility census was 82. Finding include: Review of the facility's policy titled, Storage of Medications revised November 2020, read in part The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended .Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications are stored separately from food and are labeled according . 1. Observation on 04/09/24 at 11:56 AM revealed the 400 hall treatment/wound cart was left unlocked and unattended with a tube of Santyl ointment and dressing supplies on top of the cart. Continued observation revealed Licensed Practical Nurse (LPN) 4 returned to the cart five minutes later and took the cart down to the 500 hall. During an interview on 04/09/24 at 12:15 PM, LPN4 stated she did not realize the unlocked and unattended treatment cart was not being watched by the Nurse Practitioner. 2. Observation on 04/09/24 at 4:57 PM revealed the 300 Hall medication cart was unlocked and unattended. LPN3 was in R35's room across the hall administering medications. The cart was not in the line of eyesight of the LPN. During an interview on 04/09/24 at 5:05 PM, LPN3 acknowledged the medication cart was left unlocked, unattended, and not in her line of sight. 3. Observation on 04/10/24 at 10:52 AM of the medication room on the front hall revealed the following concerns: -A large amount of dried purple spillage on the floor underneath a box of wine; -The floor had dust and dirt debris, discarded break away locks, and paper trash on it. -The floor next to the white narcotic refrigerator had a light brown dried residue; -There were no temperatures recorded on the April temperature log for the freezer or the narcotic refrigerator in the medication room; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-According to the March temperature log for the medication refrigerator, no temperatures were recorded from 03/06/24 to 03/18/24 and from 03/23/24 to 03/31/24. During an interview at the time of the medication room observation, the Director of Nursing (DON) stated the dried purple color spillage probably occurred last night, and it should have been cleaned up. The DON stated she was unsure if housekeeping cleaned in the medication room. The DON was unable to explain the missing documentation on the temperature logs.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 22411 Based on observation, interview, record review, and facility policy review, the facility failed to ensure condiments were offered and served with food for three of 28 sampled residents (Resident (R) 174, R13, and R41). The facility census was 82. Findings Include: Review of the facility's policy titled, Dietary Department- General revised 10/24/22, revealed The dietary department is responsible for establishing a program that meets the nutritional needs of the residents and accounts for cultural, religious, physical, psychological, and social needs. The primary objectives of the dietary department include Preparation and provision of nutritionally adequate, attractive, well-balanced meals that are consistent with physician orders and accommodates resident allergies, intolerances, and preferences. 1. During the initial tour on 04/08/24 at 10:45 AM, an interview was conducted with R174. The resident stated she was admitted to the facility a few days ago. R174 stated no condiments were served with the meals. Observation on 04/10/24 at 9:15 AM R174 was served a breakfast tray with toast, sausage, scrambled eggs, coffee, and juice. There were no condiments on the tray such as salt, pepper, sugar, butter and/or jelly. Certified Nursing Assistant (CNA) 6 set up the resident's tray and left the room. The CNA never asked the resident if he/she needed anything else. During an interview on 04/10/24 at 10:15 AM, CNA6 stated that she usually asked the residents if they wanted anything else but did not ask the resident specifically about the condiments. CNA6 stated if the resident wanted condiments all he/she had to was asked for the condiments. 2. Review of R13's significant change in status Minimum Data Set (MDS) with an assessment reference date of 01/03/24 and located in the resident's electronic medical record (EMR) under the MDS tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated the resident was moderately cognitively impaired. During an interview on 04/10/24 at 1:49 PM, R13 stated the lunch meal she had been served was terrible. R13 was observed with a plate of meat cubes, green beans, and au gratin potatoes on her overbed table in her room. She had not eaten anything from the plate and had eaten the dessert only (cake). R13 stated she was not offered salt or pepper with her meals, adding she would like salt and pepper. R13 stated it would taste better with salt. R13 stated she was finished with the meal. 3. Review of R41's annual MDS with an ARD of 12/22/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265589	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Peters Rehab and Healthcare Center	230 Spencer Road Saint Peters, MO 63376

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A resident council group interview was held on 04/10/24 at 2:30 PM with R41 in attendance. R41 stated stated the facility did not consistently serve condiments. She stated, for instance tartar sauce was not served with fish or no butter was available. R41 stated she was served a sandwich the previous night and there was no mayonnaise available. The sandwich had mustard only. R41 stated salt and pepper were not always available. During an interview on 04/12/24 at 3:35 PM, when asked if residents were to be offered condiments such as mayonnaise, ketchup, tartar sauce, salt, and pepper with their meals, the Dietary Manager (DM) stated the residents who could have the condiments per their diet should be offered condiments.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22411 Based on observation, interview, record review, and facility policy review, the facility failed to ensure nourishment refrigerators free from grime and food residue on the inside and that temperatures were checked. These failures had the potential to affect all 82 residents. Findings include: Review of the facility's policy titled, Cleaning Scheduled, stated, The dietary staff will maintain a sanitary environment in the dietary department by complying with the routine cleaning schedule developed by the Dietary Manager. The Dietary Manager will develop a cleaning schedule that includes the frequency of which equipment, and areas are to be cleaned. The cleaning schedule is posted weekly. The cleaning schedule includes tasks assigned to specific positions within the dietary department. Dietary staff will initial next to the assigned task once it is completed. The Dietary Manager monitors the cleaning schedule to ensure compliance. Observation on 04/10/24 at 1:30 PM revealed the nourishment refrigerator in the front dining hall had spilled juice at the bottom and contained two sandwiches. Observation of the nourishment refrigerator in the back dining hallway revealed there were two three gallons of milk (1 chocolate and 2 2% milk). Neither refrigerator contained temperature logs. During an interview on 04/10/24 at 1:30 PM during the observations of the nourishment refrigerators, the DM was asked about the temperature not being recorded for the nourishment refrigerators and whose responsibility was it to check the temperature and keep them clean. The DM stated, I am not sure, my only job is to put the snacks and beverages in there.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on interview, record review, and facility policy review, the facility failed to ensure the Infection Prevention and Control Program (IPCP) was overseen by an Infection Preventionist (IP) who had completed specialized training in infection prevention and control (IPC). This had the potential to affect 82 of 82 residents who resided at the facility. The facility census was 82. Findings include: Review of the Centers for Disease Control and Prevention (CDC) website at https://www.train. org/cdctrain/training_plan/3814 revealed, . This course will provide infection prevention and control (IPC) training for individuals responsible for IPC programs in nursing homes so they can effectively implement their programs and ensure adherence to recommended practices by front-line staff. The course will include information about the core activities of an effective IPC program, with a detailed explanation of recommended IPC practices to prevent pathogen transmission and reduce healthcare-associated infections and antibiotic resistance in nursing homes. Additionally, this course will provide helpful implementation resources (e.g., training tools, checklists, signs, and policy and procedure templates) . It was recorded that 19.75 nursing continuing education credits (contact hours) would be awarded for successful completion of the course. Review of the facility's policy titled, Infection Prevention and Control Program, revised 10/24/22, revealed, . The Infection Preventionist is responsible for coordinating the development and monitoring of the Facility's established infection control policies and procedures . On 04/08/24, upon entrance to the facility, the Administrator was asked to provide information related to the IP's certification of specialized training in IPC. Review of the IP's Certificate of Attendance, dated 07/30/19, revealed the IP had successfully completed a one-day course titled, Infection Preventionist 1 Day. It was recorded that the course was presented by Pathway Health and that six contact hours had been awarded for completion of the class. No documentation was provided regarding what topics were covered or addressed in the training. The surveyor conducted an Internet search for the course attended by the IP; however, it could not be found. A course titled Infection Preventionist One Day Class, held in another state and presented by the same company, was found at https://eadn-wc01-7191210.nxedge. io/wp-content/uploads/2018/12/REVISED-Deadline-2019-Winter-Seminar-Registration-Brochure.pdf. The description of the course was recorded as, . This 1-day course will offer strategies for the Infection Preventionist on key aspects of the role necessary for the Infection Preventionist, highlighting operational tips for both quality and regulatory compliance . (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/12/24 at 3:54 PM, the IP stated she had been employed at the facility for [AGE] years and had been the IP for several years. The Certificate of Attendance was reviewed with the IP. The IP was asked why the course awarded only six hours of continuing education credit and if the training covered the topics recommended by the Centers for Medicare and Medicaid Services (CMS) and covered in the IP training provided by the Centers for Disease Control and Prevention (CDC). The IP stated it had been a long time ago, and she did not remember. The IP stated, I just did what my corporate boss told me to do. During an interview on 04/12/24 at 3:57 PM, the Director of Nursing (DON) stated she had been employed by the facility for two months and had completed the CDC IP training. The DON stated she spent 10-15 hours per week on infection control as she kept up with antibiotic stewardship, tracked infection control trends, and implemented the McGreer's protocols in the facility. The DON reported she had been working on Enhanced Barrier Precautions the previous week. The DON provided her certification of completion of the CDC's Infection Preventionist training. During an interview on 04/12/24 at 4:40 PM, Regional Nurse Consultant (RNC) 2 reported the IP had started the CDC Infection Preventionist training but had not completed it. RNC2 stated she had instructed the IP to finish the training.