STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265669	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warrensburg Manor Care Center	400 Care Center Drive Warrensburg, MO 64093

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46519 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) was accurate for two sampled residents (Resident #1 and #2) out of 14 sampled residents. The facility census was 43 residents. Review of the facility's policy titled MDS Completion and Submission Timeframes dated July 2017 showed the MDS Coordinator or designee was responsible for ensuring that resident assessments were submitted in accordance with current federal and state guidelines. 1. Review of Resident #2's face sheet showed he/she admitted to the facility with the following diagnoses: -Chronic Obstructive Pulmonary Disease (COPD-a disease process that decreases the ability of the lungs to perform ventilation). -Chronic Ischemic Heart Disease (heart problems caused by narrowed heart arteries that supply blood to the heart). -Sleep Apnea (a sleep disorder in which breathing repeatedly stops and starts). -Acute Respiratory Failure (impairment of gas exchange between the lungs). Review of the resident's quarterly MDS dated [DATE] showed: -The resident was cognitively intact. -The resident was not on oxygen therapy. Review of the resident's Physician Order Sheet (POS) dated September 2024 showed an order for the charge nurse to check the placement of oxygen at 3 liters (L the measured amount of the flow of oxygen) per minute by nasal cannula (a device that delivers extra oxygen through a tube and into your nose) at night to ensure the resident was wearing to keep oxygen saturation (the amount of oxygen in the blood with normal levels between 96-100 percent or typically for people with COPD 88-92 percent) about 90 percent while in bed/sleeping. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan dated 9/16/24 showed the resident wore oxygen Pro Re Nata (PRN- as needed). During an interview on 9/17/24 at 12:53 P.M. the resident said he/she wore his/her oxygen every night at 3 L per minute. During an interview on 9/19/24 at 8:39 A.M. Licensed Practical Nurse (LPN) A said: -The MDS Coordinator completed the MDS assessments. -The nurses would occasionally help with the MDS assessments by reviewing care with the MDS Coordinator. -The resident's MDS assessment should indicate that the resident wore oxygen at night. During an interview on 9/19/24 at 10:03 A.M. the MDS Coordinator said: -The MDS assessment should indicate if a resident used oxygen therapy. -He/She was unsure if the resident's most recent MDS assessment indicated the resident was on oxygen therapy. During an interview on 9/19/24 at 11:17 A.M. the Director of Nursing (DON) said: -He/She expected the MDS assessments to be accurate. -Any resident who received oxygen therapy should have that indicated in their MDS assessment. 21003 2. Review of Resident #1's Face Sheet showed he/she was admitted on [DATE], with diagnoses including COPD, heart failure, Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), Anemia (low iron), Vitamin D deficiency, Dysphagia (difficulty swallowing), need for assistance with personal care and deficiency of other vitamins. Review of the resident's Nutrition/Dietary Note dated 4/23/24 showed: -The Registered Dietician (RD) documented he/she reviewed the resident's weights and it showed the resident's weight in April was 128 pounds (down 2 pounds in one month, down 3 pounds in 3 months, and down 13 pounds in 6 months). The resident's appetite varied. He/She ordered 2 cal (a protein and calorie supplement) 60 milliliters (ml) twice daily. The Registered Dietician recommended changing the order to health shakes three times daily due to the resident's weight loss trend. Review of the resident's Nursing Notes showed on 6/4/24, the resident was having episodes of choking at meals more frequently and choking while drinking thin liquids. The resident started a 3 day trial of nectar thickened liquids (liquids were easily pourable and were comparable to heavy syrup found in canned fruit). Dietary and the resident's responsible party were notified. (continued on next page)

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Care Plan dated 6/26/24, showed: -The resident had a self-care performance deficit related to left sided weakness from a previous stroke. -The resident ate independently with set up assistance from staff. -The resident was on a restorative eating and swallowing program (this was not defined nor were there any additional interventions showing how staff was supporting the resident in this area) Review of the resident's Nursing Notes showed: -On 7/12/24, the resident was sent to the hospital due to increased weakness, persistent pneumonia, crackles throughout the lungs, and irregular heartbeats. -On 7/19/24, the resident was readmitted to the facility and would receive skilled rehabilitative services (physical, occupational and speech therapies). The resident was now on a pureed diet. He/She did not like it and preferred to chew foods. Review of the resident's daily Skilled Nursing Notes showed: -On 7/20/24, Nutrition: the resident had difficulty swallowing at times. Fluids encouraged. Complaints of thirst: No. Mucous membranes were moist. -From 7/21/24 to 7/24/24, the nursing staff documented the resident was taking nutrition and hydration orally. He/She had no complaints of thirst. There were no signs/symptoms of a swallowing disorder. His/Her mucous membranes were moist. Review of the resident's Nursing Note dated 7/24/24 at 9:43 A.M., showed: -The resident began coughing uncontrollably at breakfast after taking a drink of nectar thick water. -The resident had extensive nasal dripping. -This nurse changed the resident to a 3-day trial of Honey thickened liquids (liquids are similar to honey or a milkshake) at this time. -This nurse spoke to the resident regarding the change and the resident agreed to try Honey thickened liquids. Review of the resident's Nursing Note dated 7/24/24 at 10:22 A.M., showed: -The resident was in the facility for COPD with exacerbation and diabetes. -The resident was alert and oriented with occasional confusion but was easily redirectable. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had difficulties in the hospital and his/her diet was changed to pureed with nectar thickened liquids. -The resident was recently observed to have coughing and difficulty swallowing at times. -The Speech Therapist evaluated the resident for oropharyngeal strengthening (a major method of swallowing training) and appropriate diet. The resident was started on a 3 day trial of honey thickened liquids as of this date. -The resident's lungs were diminished throughout and had occasional coughing following oral intake. Review of the resident's Nursing Note dated 7/25/24 showed the resident continued monitoring for 3-day trial of Honey thickened liquids. The resident had no episodes of coughing at breakfast and he/she tolerated increased thickened liquids well. No nasal dripping was noted. Review of the resident's quarterly MDS dated [DATE] (Assessment Reference Date (ARD) 7/24/24) showed: -The resident did not have any chewing or swallowing issues during the 7 day lookback period. -The resident had no choking or coughing during meals during the 7 day lookback period. Observation on 9/17/24 at 12:38 P.M., showed the resident was sitting in his/her wheelchair in the dining room waiting to be served lunch. He/She received a mechanical soft diet of ground turkey with gravy, mashed potatoes with gravy, broccoli, chocolate cake with water, a red beverage, and tea. The resident's meal was served in a divided plate. He/She was able to independently feed himself/herself and began eating and drinking without assistance. He/she did not receive a supplement at this meal. During an interview on 9/19/24 at 9:33 A.M., Certified Nursing Assistant (CNA) E said: -The facility staff had concerns with his/her weights and he/she had past weight loss and choking issues. -They were still observing him/her during meals due to his/her past weight loss history and low intake at meals. -The resident fed himself/herself and tended to eat about the same amount at each meal, but he/she was eating better. During an interview on 9/19/24 at 10:03 A.M., the MDS Coordinator said: -He/She was responsible for completing the MDS and would update regarding significant change, annuals and quarterlies. -The resident had swallowing/choking issues and weight concerns when he/she came into the facility. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She updated the care plans quarterly. -He/she tried to update any significant changes as soon as they occurred, but he/she did not always get to all of them. During an interview on 9/19/24 at 11:16 A.M., the DON said: -He/She would expect the MDS to reflect the resident's nutritional status within the 7 day lookback period. -If the nurse documented the resident had chewing or swallowing problems or if the resident had indications of being treated for choking or swallowing issues, it should be indicated on the MDS and care plan.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50579 Based on observation, interview, and record review, the facility failed to ensure a person-centered, individualized care plan describing care and services furnished by the facility to treat a resident for edema (swelling due to the retention of fluid) was developed for one sampled resident (Resident #8)and failed to complete a comprehensive care plan that included nutritional status for one sampled resident (Resident #1) out of 14 sampled residents. The facility census was 43 residents. 1. Review of Resident #8's care plan, dated 2/1/24, showed: -A focus of decreased cardiac output related to congestive heart failure (a disease in which the heart functions at a reduced capacity). -An intervention to evaluate the resident for edema with no specific schedule on when to do so. -No information regarding the resident's active edema including interventions or goals. -No information regarding the resident's orders for compression pumps or compression wraps. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 8/4/24, showed: -Diagnoses including non-traumatic brain dysfunction (damage to the brain by internal factors, such as a lack of oxygen, exposure to toxins, or pressure from a tumor) and Congestive Heart Failure (CHF a serious condition that occurs when the heart is unable to pump blood efficiently, resulting in fluid buildup in the body). -The resident needed moderate assistance with lower body dressing. Review of the resident's Physician Order Sheet (POS) dated 9/18/24, showed orders for: -Compression pumps to both legs for one hour twice per day for edema. -Compression wraps applied to both legs each morning and removed each evening for edema. During an interview on 9/18/24 at 12:29 P.M., the MDS Coordinator said: -He/She was responsible for creating care plans for residents that reflected the care and services they were provided by the facility. -Orders for compression pumps and wraps should have been reflected in the resident's care plan, otherwise staff may not have known how to operate the devices or why the devices were in place. 21003 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #1's Face Sheet showed he/she was admitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD a group of lung diseases that block airflow and make it difficult to breathe), CHF, Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), Anemia (low iron), Vitamin D deficiency, Dysphagia (difficulty swallowing), need for assistance with personal care and deficiency of other vitamins. Review of the resident's Nutrition/Dietary Note dated 4/23/24 showed: -The Registered Dietician (RD) documented he/she reviewed the resident's weights and they showed the resident's weight in April was 128 pounds (down 2 pounds in one month, down 3 pounds in 3 months, and down 13 pounds in 6 months). The resident's appetite varied. -He/She ordered 2 cal (a protein and calorie supplement) 60 milliliters (ml), twice daily. -The Registered Dietician recommended changing the order to health shakes three times daily due to the resident's weight loss trend. Review of the resident's Nursing Notes showed on 6/4/24, the resident was having episodes of choking at meals more frequently and choking while drinking thin liquids. The resident started a 3 day trial of nectar thickened liquids (liquids are easily pourable and are comparable to heavy syrup found in canned fruit). Dietary and the resident's responsible party was notified. Review of the resident's Comprehensive Care Plan dated 6/26/24, showed: -The resident had a self-care performance deficit related to left sided weakness from a previous stroke. -The resident ate independently with set up assistance from staff. -The resident was on a restorative eating and swallowing program (this was not defined nor were there any additional interventions showing how staff was supporting the resident in this area). -There was no documentation showing the resident had a problem area regarding his/her nutritional status to include the resident's history of weight loss, chewing and swallowing difficulties, diet, and it did not show any nutritional interventions that were implemented to address his/her dysphagia and weight loss concerns. Review of the resident's Mini Nutrition assessment dated [DATE], showed: -The resident had no decrease in food intake in the last 3 months and had no weight loss in the last 3 months. --This assessment was incorrect according to the RD's evaluation. -The resident was able to get out of bed/chair but did not go out. -The resident had not suffered psychological stress or acute disease in the past 3 months. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had mild dementia. -The resident's Mini Nutrition Score was 9.0 (a score of 9.0 meant the resident was at risk for malnutrition). Review of the resident's daily Skilled Nursing Notes showed: -On 7/20/24, Nutrition: The resident had difficulty swallowing at times. Fluids encouraged. Complaints of thirst: No. Mucous membranes are moist. -From 7/21/24 to 7/24/24, Nutrition: The resident was taking nutrition and hydration orally. No complaints of thirst. No signs / symptoms of a swallowing disorder. Mucous membranes moist. Review of the resident's Nursing Note dated 7/24/24 at 9:43 A.M., showed: -The resident began coughing uncontrollably at breakfast after taking a drink of nectar thick water. -The resident had extensive nasal dripping. -This nurse changed the resident to a 3-day trial of Honey thick liquids at this time. -This nurse spoke to the resident regarding change and the resident agreed to try Honey thick liquids. Review of the resident's Nursing Note dated 7/24/24 at 10:22 A.M., showed: -The resident was in the facility for COPD with exacerbation and diabetes. -The resident was alert and oriented with occasional confusion but was easily redirectable. -The resident had difficulties in the hospital and his/her diet was changed to pureed with nectar thickened liquids. -The resident was recently observed to have coughing and difficulty swallowing at times. -The Speech Therapist evaluated the resident for oropharyngeal strengthening (a major method of swallowing training) and appropriate diet. The resident was started on a 3 day trial of honey thickened liquids as of this date. -The resident's lungs were diminished throughout and had occasional coughing following oral intake. -The resident was pleasant and cooperative with cares and able to voice needs/wants most of the time. Review of the resident's Physician's Telephone Order showed the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 8/27/24 a Speech Therapy clarification order to re-certify skilled Speech Therapy 10 times in 30 days for dysphagia, to include oral exercises, therapeutic feedings, diet texture analysis, develop and train compensatory techniques. -On 8/29/24 a physician's order to upgrade the resident's diet to Mechanical Soft (soft foods with ground meat) and to continue with nectar thickened liquids. Review of the resident's POS dated [DATE], showed a physician's order for a Mechanical Soft diet with nectar thickened liquids dated 8/9/24. Review of the resident's Nutrition/Dietary Note dated 8/31/24, showed: -The RD completed another nutrition evaluation (due to a recent hospitalization readmission). -The RD documented the resident was receiving a consistent carbohydrate diet that was Mechanical Soft in texture, with nectar thickened liquids and 2 cal supplement twice daily. -The resident ate between 50 to 100 percent at meals and required staff supervision. -The resident was still slightly underweight. -The recommendation was to continue the current plan of care and Speech Therapy was to make recommendations for texture advancement. Monitoring would continue as needed. Observation on 9/17/24 at 12:38 P.M., showed the resident was sitting in his/her wheelchair in the dining room waiting to be served lunch. He/She received a mechanical soft diet of ground turkey with gravy, mashed potatoes with gravy, broccoli, chocolate cake with water, a red beverage, and tea. The resident's meal was served in a divided plate. He/She was able to independently feed himself/herself and began eating and drinking without assistance. He/she did not receive a supplement at this meal. Observation on 9/18/24 at 10:38 A.M., showed the resident was sitting in his/her wheelchair in the dining room. He/She was served oatmeal for breakfast (at his/her request) and beverages. The resident also received a 2 cal supplement. He/She was able to eat and drink independently without assistance. No issues were noted. During an interview on 9/19/24 at 9:28 A.M., Certified Nursing Assistant (CNA) E said: -The facility staff had concerns with his/her weights, past weight loss and choking issues. -They were still observing him/her during meals due to his/her past weight loss history and low intake at meals. -The resident received 2 cal supplements for weight loss. -The resident fed himself/herself and usually ate about the same amount at each meal, but he/she was eating better. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Usually they were informed about any changes in the resident's cares through the nurse. They did not have access to the resident's care plan. -The MDS Coordinator or the nurse completed and updated the resident's care plan. 3. During an interview on 9/19/24 at 9:48 A.M., The Assistant Director of Nursing (ADON) said: -They normally left notes for the MDS Coordinator to update the care plan as needed. -If they had an immediate intervention they needed to implement for a resident, they could update the care plan in those instances, but then they would also communicate with the MDS Coordinator. -Every shift had a matrix that was updated daily and all of the CNA staff were required to sign it as did the Charge Nurse. -The matrix was a form with all of the resident's primary information on it (diet, continence level, ambulation level, if they are on oxygen or any specialized equipment and what it is used for) that informed them of how the staff was to take care of the resident and it was updated per shift as needed. During an interview on 9/19/24 at 10:03 A.M., the MDS Coordinator said: -He/She was responsible for completing the MDS and care plans. -The resident had swallowing/choking issues and weight concerns when he/she came into the facility. -He/She updated the care plans quarterly. -Sometimes the Charge Nurses updated care plans with interventions, and notified him/her, but he/she tried to get the care plans updated as needed within a week of new interventions being implemented. -Sometimes he/she did not get to them in a week and tried to at least update them within a 30 day period. -Any new interventions were updated on the resident matrix for the CNA staff at the time the intervention was implemented. He/She said the matrix was updated daily. -He/she tried to update any significant changes as soon as they occurred, but he/she did not always get to all of them. During an interview on 9/19/24 at 11:16 A.M., the Director of Nursing (DON) said: -Comprehensive care plans should show the current care needs of the resident. -The care plan should be updated as the resident's condition changed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She would expect the care plan to include the nutritional status of a resident with nutritional concerns, weight loss, swallowing or chewing problems and interventions related to it. -He/She would expect a resident with any concerns with chewing, swallowing and weight loss to be on the resident's care plan. -Compression hose and wraps should be reflected on the resident's care plan.

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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. 33409 Based on interview and record review, the facility failed to complete a thorough investigation to determine the root cause and fall follow-up report of a resident's fall, failed to update the resident's care plan with appropriate interventions and monitor the effectiveness of interventions to prevent additional falls for one sampled resident (Resident #33) out of 14 sampled residents. The facility census was 43 residents. Review of the facility's Fall Assessing and their Cause revised 10/2010 showed: -The purpose of this procedure was to provide guidelines for assessing after a fall and to assist staff in identifying causes of the fall. -Incident report must be completed for resident falls; The incident report form should be completed by nursing supervisor on duty at the time and submitted to the Director of Nursing Services no later than 24 hours after the fall occurs. -Within 24 hours of the fall, the nursing staff will begin to identify possible likely cause of the incident. They will refer to resident -specific evidence including medical history, known functional impairment, etc -When a resident had fallen the following documentation should be recorded in the resident's medical record to include not limited to appropriate interventions taken to prevent future falls, completion of a fall risk assessment. Review of the facility's Fall Clinical Protocol revised 9/2012 showed: -Cause (root cause) refers to factors that are associated with or that directly result in a fall. -For an individual who has fallen, staff will attempt to define possible cause with in 24 hours of the fall -The staff with physician guidance, will follow-up on any falls associated injury until the resident stable and delayed complication such subdural hematoma (swelling or bleeding under skin) have been ruled out or resolved. -Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and address risk of serious consequences of falling. -If intervention have been successful in preventing falling, the staff will continue with current approaches or reconsider whether these measures are still needed in fall prevention. 1. Review of Resident #33's Admission Face-Sheet showed he/she had diagnoses of: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses). -Major Depression (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living). Review of the resident's Care Plan dated 7/1/24 showed he/she had: -Had impaired cognitive function/dementia or impaired thought processes. -At risk for Harm related to Self- Directed or Other-Directed due to diagnosis of Dementia. -At risk for unilateral neglect with poor safety awareness at times, related to not using call light for assistance with transfers. -Nursing care staff were to ensure a safe environment for the resident. Review of the resident's most recent Fall Risk Evaluation dated as completed on 7/8/24 showed he/she was at risk for falls. Review of the resident's Annual Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning), dated 7/9/24, showed the resident had: -Diagnoses including Dementia and Depression. -Moderate cognitive impairment. -Disorganized thinking that changed in severity. Review of the resident's Fall incident/investigation dated 8/24/24 at 1:38 A.M., showed: -The resident had an unwitnessed fall in his/her room. -Nursing description of the incident: The resident was found by care staff sitting on the floor beside his/her bed. He/she was bleeding from his/her head. -The resident's description of the incident: The resident said he/she was attempting to close his/her door, due to the light in hallway and on the way back to bed he/she slipped and fell . -Immediate Action taken by facility staff was the resident was assessed, vital signs taken, and a towel was applied to the area that was bleeding. The facility staff had contacted the Assistant Director of Nursing (ADON) and then 911 was called. The resident was taken to the hospital for evaluation and treatment. -Injuries observed at the time of the incident was a hematoma (bleeding) on top of his/her scalp (head). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warrensburg Manor Care Center	400 Care Center Drive Warrensburg, MO 64093

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-His/her reported pain level was 8 out of 10 on a scale of 1 to 10 with 10 being the worst pain. The resident was alert and ambulatory without staff assistance. -Predisposing factors included poor lighting, gait imbalance, and ambulated without assistance from staff members. -Documented under other information: the resident was not wearing non-skid socks, or shoes and the resident was not using a walker. -The facility had contacted the resident's family emergency contact on 8/24/24 at 1:14 A.M. and the resident's physician at 1:40 A.M. -NOTE: The report did not have documentation related to the root cause and any interventions in place prior to fall and put into place after the fall. The facility did not provide Registered Nurse post fall follow-up investigation with findings and additional interventions put in place after the resident injury fall. Review of the resident's Transfer to Hospital Summary note dated 8/24/24 at 2:04 A.M., showed: -The resident was found by staff around 1:05 A.M., on the floor beside his/her bed surrounded by blood. -The resident had fallen and hit his/her head on an unknown item while attempting to self-transfer back into bed, after shutting his/her bedroom door. -The resident said the light from the hallway was too bright and he/she wanted to close the door. -The resident was found by Certified Nursing Assistant (CNA) staff and was quickly assessed by Licensed Nursing staff. -The resident was bleeding a large amount of blood from his/her head. -The nurse applied a towel to the resident's head to help stop the bleeding. -After assessment the decision was made to send the resident out to the hospital for evaluation and treatment. -The ADON was notified at 1:05 A.M., the resident's family member was notified at 1:15 A.M., and the resident's primary care physician was called and made aware of the resident's fall at 1:40 A.M., -The resident was taken to the hospital via ambulance. Review of the resident's Nursing Note dated 8/24/24 at 5:28 A.M. showed: -The resident returned from hospital via his/her family member. -The resident was given a discharge packet stating that he/she had been seen for a fall with head injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was given a Computed Tomography scan (CT scan, is a medical imaging technique used to obtain detailed internal images of the body) of his/her head and spine without contrast with no abnormal findings noted while at the hospital. -The resident had one staple placed on the back side of his/her head, with instructions to have it removed by his/her primary care physician in 10-14 days. -The resident's vital signs were taken upon his/her return from the hospital. -The resident was awake and sitting in his/her recliner. -NOTE: no indication or documentation of any new fall prevention interventions were put in place after fall injury on 8/24/24. Review of the resident's medical record under the assessment tab showed there was no updated Fall Risk Evaluation completed after his/her fall on 8/24/24. Review of the resident's Fall Care Plan showed: -There was no documentation related to the fall on 8/24/24. -There were no new interventions put in place after fall on 8/24/24. During an interview on 9/16/24 at 11:34 A.M., the resident said: -He/she had a recent fall and hit his/her head. -The night shift staff left the door open and he/she went to shut the door and had fallen trying to shut the door. -He/she was able to transfer himself/herself and used a wheeling walker. During an interview on 9/17/24 at 2:55 P.M., Agency Certified Nursing Assistant (CNA) A said: -He/she has been at the facility for the past week. -The facility provided CNA's with resident care cards on how to transfer a resident and any fall prevention measures. -He/she was not aware of any fall prevention measures for the resident. During an interview on 9/17/24 at 3:01 P.M., CNA B said: -He/she was not aware of any recent fall precautions for the resident. -Nursing staff would be responsible for completing any documentation related to the resident fall. During an interview on 9/18/24 at 11:55 P.M., Licensed Practical Nurse (LPN) A said: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When a resident was found on the floor, the CNA's would alert the nurse. Nursing would assess the resident to include vital signs, neuro check, if there were any injuries nursing would send the resident out for evaluation and treatment of the injury. -He/she would ask the resident what happened if the resident was able to answer and obtain witness statements if it was an observed fall. -Nursing staff would complete the fall risk assessment, fall incident report/risk management report and notify the Administrator, physician, families and Assistant Director of Nursing and the Director of Nursing. -He/she was not aware of the RN follow-up fall investigation. -He/She was not working when the resident fell . -He/she was not aware if the care plan was updated. -Fall interventions would have been reviewed and updated as part of the nursing morning meetings. -The MDS Coordinator would be responsible to ensure the resident's fall care plan was reviewed and updated. During an interview on 9/18/24 12:32 P.M., the ADON said: -The nurse assessed the resident who had fallen to include vital signs, neuro checks if possible, head injury unwitnessed fall or witness fall hit head. -Nursing staff would complete the fall risk report and notified the physician, Administrator, ADON, DON and the resident's family member. -Nursing would document and complete monitoring assessment of the resident every shift for 72 hours. -He/she was not aware if the fall risk report or the follow-up by the RN included interventions and the root cause of fall. -The fall incident report would be discussed during the morning meeting and final review during the monthly interdisciplinary team (IDT) meetings for any root cause for the resident fall and fall interventions needed. -RN staff would be part of the IDT monthly meeting and sometimes the morning meeting. -The MDS coordinator would be responsible for any care plan updates. -He/she was not sure if Resident #33's fall care plan was updated after the fall on 8/24/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #33's fall plan was discussed to have night care staff check on the resident often, to ensure his/her door was closed at night and to ensure the resident had shoes on when up in his/her room. -The facility had not documented the proposed plan in the medical records at that time. -The resident did have Dementia and was forgetful at times, he/she required reminders. -The root cause of the resident's fall was he/she ambulated without shoes. -RN review -not sure if he/she had access to fall follow-up reports. -Resident falls were reviewed during the monthly IDT meeting. -The facility had not had an IDT meeting yet to review Resident #33's fall on 8/24/24, the IDT had not completed the final review to include final fall care plan and any potential root cause. During an interview on 9/19/24 at 10:03 A.M. the MDS Coordinator said: -He/she was responsible for updating and reviewing the residents care plans every 3 months and as needed. -Nursing staff were able to update care plans when needed, such as after a fall for immediate interventions that were put in place. -He/she would expect the fall care plan to have been updated as soon as possible. -He/she was not sure if he/she had updated the resident care plan after the fall on 8/24/24. During an interview 9/19/24 at 11:16 A.M., the Interim DON said: -Care plans should be comprehensive and show the current needs of the resident. -As resident needs changed, he/she would expect those needs to be added to the care plan. -He/she would expect the resident care plans to be updated or reviewed for new preventive fall interventions. -He/she would expect the care plan to be updated after a fall within 48 hours or less, -He/she would expect immediate fall interventions put in place by nursing staff and documented in nursing notes or on the fall risk incident report. -The fall investigation/incident or risk reports should be reviewed by a RN or the DON after completed. -He/she would expect the root cause to be included in the fall investigation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she would expect nursing documentation every shift, for 72 hours, to include fall follow-up, root cause and any interventions that were put in place. -He/she attended daily morning meetings and monthly IDT meetings. -Falls and other incidents were reviewed at both daily morning meetings and monthly IDT meetings.

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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** 21003 Based on observation, interview, and record review, the facility failed to ensure oxygen equipment was stored and changed using proper infection control practices when not in use and in a timely manner for three sampled residents (Resident #1, #40,and #37) out of 14 sampled residents. The census was 43 residents. Review of the facility's policy titled Oxygen Administration dated 1/1/24 showed: -The resident's care plan should identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: --The type of oxygen delivery system. --When to administer, such as continuous or intermittent and/or when to discontinue. --Equipment setting for the prescribed flow rates. --Monitoring of oxygen saturation levels (the amount of oxygen in the blood with a normal range of 96% to 100%) and/or vital signs as ordered. --Monitoring for complications associated with the use of oxygen. -Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. -Change humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer. -Keep delivery devices covered in plastic bag when not in use. 1. Review of Resident #1's Face Sheet showed the resident was admitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD a group of lung diseases that block airflow and make it difficult to breathe), heart failure, and Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions). Review of the resident's Care Plan dated 6/26/24 showed the resident had oxygen therapy related to respiratory failure and wore continuous oxygen at 2 liters via nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help). The resident ambulated to the restroom in his/her room and required longer oxygen tubing. Interventions showed staff would: -Change oxygen tubing and water concentrator per facility protocols. -Review the resident's Treatment Administration Record (TAR) for the most up to date physician's orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Keep extra oxygen tubing up and out of the resident's way during ambulation. -Monitor for signs and symptoms of respiratory distress and report to the physician as needed. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning), dated 7/26/24 showed the resident: -Was alert with confusion. -Needed moderate assistance with bathing, dressing, toileting, transfers and used a wheelchair for mobility. -Received oxygen therapy. Review of the resident's Physician's Order Sheet (POS) dated September 2024, showed physician's orders for continuous oxygen at 2 liters per minute (via nasal cannula) for COPD. Observation on 9/16/24 at 2:11 P.M., showed the resident was sitting in his/her recliner, dressed for the weather without odor, with glasses on and oxygen on reclined with a newspaper in his/her lap. He/She was wearing oxygen via nasal cannula that was connected to his/her oxygen concentrator (a medical device that gives you extra oxygen). His/Her eyes were closed and he/she was resting comfortably. There was a portable oxygen tank sitting across from the resident by the closet and the oxygen tubing was coiled around the top of it and was not in a plastic bag/covering. Observation on 9/17/24 at 9:33 A.M., showed the resident was sitting in his/her recliner with oxygen on via nasal cannula that was connected to his/her oxygen concentrator. The portable oxygen tank was on the back of his/her wheelchair which was sitting across from him/her and the oxygen tubing was coiled up and around the portable tank without a plastic storage bag or covering. Observation on 9/17/24 at 10:01 A.M., showed the resident was in his/her wheelchair in the dining room participating in a large group exercise activity. He/She was wearing his/her portable oxygen via nasal cannula. During an interview on 9/18/24 at 11:59 A.M., Certified Medication Technician (CMT) A said: -When oxygen nasal cannulas, tubing and facemasks were not in use they were supposed to be stored in plastic bag and labeled with the resident's name and date. -The night shift nursing staff was supposed to provide the bags and they also were responsible for changing out the tubing and humidifier bottles. -He/She was not sure how often the tubing and other oxygen supplies were supposed to be replaced. During an interview on 9/19/24 at 9:28 AM Certified Nursing Assistant (CNA) E said: -The resident's oxygen equipment (nasal cannulas, face masks and tubing) was supposed to be stored in a plastic bag when not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The CNA staff provided the bags for storage. -They were supposed to check to ensure the oxygen nasal cannulas and face masks were stored every time they completed cares due to some residents removing the nasal cannulas themselves. -The CNA staff were responsible for dating the tubing and humidifier bottles and were supposed to change them out every week. During an interview on 9/19/24 at 9:45 A.M., the Assistant Director of Nursing (ADON) said: -They normally kept the oxygen equipment (nasal cannulas, face masks mouth pieces) in bags when not in use and they were changed weekly -Humidifier bottles and tubing were also changed weekly or as needed. The CNA's can change the humidifier bottles. The weekly change was done on the night shift by the nurses. During an interview on 9/19/24 at 10:21 A.M., the MDS Coordinator said: -Oxygen tubing should be stored in plastic bags when not in use. -Night staff were responsible for providing the bags, but there was a period where the bags were being thrown away. -The night shift CNA staff were responsible for changing the oxygen tubing and oxygen equipment weekly and as needed. They also labeled the humidifier bottles. -The charge nurses were responsible for following up to ensure it was completed. -Nasal cannulas and tubing should not be coiled around the portable oxygen tank. -She/he did expect the oxygen orders to be on the physician's order sheets and the Medication Administration Record (MAR) and Treatment Administration Record (TAR), but not the care plans. During an interview on 9/19/24 at 11:16 A.M., the Director of Nursing (DON) said: -There should be an order for oxygen on the POS and it should be documented on the MAR/TAR. -The oxygen tubing and humidifier should be changed every week by the nurses. -He/She expected oxygen equipment to be labeled/dated at the time it was changed out. -Oxygen tubing should not be coiled around concentrators, canisters and the tubing should be stored in a plastic bag when not in use. 46519 2. Review of Resident #40's face sheet showed he/she admitted to the facility with the following diagnoses: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Unspecified Asthma (when a person's airways become inflamed, narrow, swell, and produce extra mucus, which makes it difficult to breathe. -Coronary Artery Disease (CAD-plaque build-up in the wall of arteries that supply blood to the heart). Review of the resident's quarterly MDS dated [DATE] showed: -The resident was cognitively intact. -The resident did not use any type of oxygen therapy. Review of the resident's POS dated September 2024 showed an order for oxygen at 2 liters per minute via nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a person) at night for low oxygen. Review of the resident's care plan dated 9/17/24 showed no focus, goal, or intervention related to the use of oxygen therapy. Observation on 9/16/24 at 11:13 A.M. showed: -The resident's oxygen tubing was wrapped around his/her bed rail. -The resident's oxygen tubing was dated 8/2/24. During an interview on 9/17/24 at 9:38 A.M. the resident said he/she wore oxygen at night. Observation on 9/17/24 at 9:40 A.M. showed: -The resident's oxygen tubing was wrapped around his/her bed rail. -The resident's oxygen tubing was dated 8/2/24. Observation on 9/18/24 at 8:09 A.M. showed: -The resident's oxygen tubing was wrapped around his/her bed rail. -The resident's oxygen tubing was dated 8/2/24. Observation on 9/19/24 at 8:44 A.M. showed: -The resident's oxygen tubing was wrapped around his/her bed rail. -The resident's oxygen tubing was dated 8/2/24. During an interview on 9/18/24 at 12:39 P.M. CNA A said: -Oxygen tubing should be stored in a bag when not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She thought the night shift changed out the oxygen tubing weekly. -If he/she were to walk into Resident #40's room and find oxygen tubing wrapped around the bed rail, then he/she would put the oxygen tubing in a bag or get new oxygen tubing. -If he/she saw oxygen tubing labeled 8/2/24 he/she would double check with the nurse that it would need to be changed out. -He/She was unaware that the resident's oxygen tubing was dated 8/2/24 and that it should have been changed out by that point in time. -The MDS Coordinator was in charge of the care plans. -He/She did not look at care plans but would ask the nurse if he/she had questions about a resident's care. During an interview on 9/19/24 at 8:40 A.M. Licensed Practical Nurse (LPN) A said: -Oxygen should be stored in a labeled bag when not in use. -Resident #40 only wore oxygen at night. -Resident #40 was usually up and out of bed before starting his/her shift, so he/she thought night shift would be responsible for the residents oxygen tubing storage. -If he/she were to walk into the resident's room and saw tubing wrapped around the bed rail or dated 8/2/24, then he/she would get new oxygen tubing and a new bag for the tubing to be stored in. -He/She was unaware that the resident's oxygen tubing was dated 8/2/24. -The oxygen tubing should have been changed out by that point in time. During an interview on 9/19/24 at 11:16 A.M. the DON said: -Resident #40's oxygen tubing should not have been wrapped around the bed rail. -The staff should have noticed that the resident's tubing was dated 8/2/24 and it should have been changed before that point in time. -Resident #40's care plans should include the use of oxygen therapy and include the orders of the oxygen use. 51305 3. Review of Resident #37's face sheet showed he/she admitted to the facility with the following diagnoses: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Congestive Heart Failure (CHF disorder that impairs the ability of the heart to fill with or pump a sufficient amount of blood throughout the body). -COPD. Review of the resident's TAR dated August 2024 showed: -Oxygen at 2 liters per minute as needed for Shortness Of Air (SOA). -Obtain pulse oximeter (SPO2 measures the amount of oxygen in the blood and the pulse) every shift for SOA. Review of the resident's current physician orders dated September 2024 showed: -Obtain SPO2 every shift for SOA. -Oxygen at 2 L per minute as needed for SOA. Review of the resident's TAR dated September 2024 showed: -Obtain SPO2 every shift for SOA. -Oxygen at 2 L per minute as needed for SOA. Review of the resident's care plan dated September 2024 showed: -The resident was at risk for impaired gas exchange. -The resident would not require continuous or as needed oxygen use during the review period. -Staff were to monitor the resident's respiratory rate and effort. -Staff were to monitor for changes in the resident's respiratory rate or shallow breathing. Observation on 9/16/24 at 12:02 P.M. showed the resident: -Had an oxygen concentrator in his/her room unplugged with a water bottle dated 7/31/24. -Had oxygen tubing bagged and dated 7/31/24. Observation on 9/16/24 at 12:45 P.M. showed the resident: -Was awake sitting in his/her recliner watching television with a blanket on. -Was not wearing oxygen. Observation on 9/17/24 at 9:10 A.M. showed the resident: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Had an oxygen concentrator in his/her room unplugged with the water bottle dated 7/31/24. -Had oxygen tubing bagged and dated 7/31/24. Observation on 9/17/24 at 9:22 A.M. showed the resident: -Was sitting in a recliner with no oxygen. -Had no difficulty breathing and no respiratory distress noted. Observation on 9/17/24 at 12:55 P.M. showed the resident: -Had an oxygen concentrator in his/her room unplugged with the water bottle dated 7/31/24. -Had oxygen tubing bagged and dated 7/31/24. Observation on 9/18/24 at 8:52 A.M. showed the resident: -Was sitting in his/her wheelchair, appropriately dressed for the weather he/she was not wearing oxygen. -Had an oxygen concentrator in his/her room unplugged with the water bottle dated 7/31/24. -Had oxygen tubing bagged and dated 7/31/24. During an interview on 9/19/24 at 9:15 A.M. CNA C said: -The night shift CNA's usually changed the oxygen water bottles and the oxygen tubing at the first of every month. -All shifts would change the water bottle if it was empty. -Oxygen tubing was changed if it became dirty or hit the floor. -Resident #37 used oxygen as needed. -Resident #37 had an oxygen concentrator in his/her room. -Resident #37 slept in the recliner in the main common area. -The staff would bring out the oxygen concentrator if needed. -The facility had two different kinds of water bottles available for oxygen concentrators. -He/she believed the resident had the refillable bottle. -The oxygen tubing and the disposable water bottle should have been changed at least twice since the 7/31/24 date on the tubing and water bottle. (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 9/19/24 at 9:30 A.M. CNA D said: -The CNA's, CMT's, and Nurses were responsible for changing the oxygen water bottle and tubing. -Oxygen tubing was changed weekly. -The oxygen water bottles were changed when empty. -Resident #37 did not use oxygen. -Resident #37 had an oxygen concentrator in his/her room. -Resident #37 was very rarely in his/her room and that oxygen tubing and water bottle could easily be missed. -The oxygen tubing and water bottle should have been changed since 7/31/24. During an interview on 9/19/24 at 9:44 A.M. LPN A said: -The CNA's were responsible for changing the oxygen tubing and water bottles on Saturday night shift. -The oxygen water bottle should be changed when it was empty or monthly. -The oxygen tubing should be changed weekly and as needed. -Resident #37 used oxygen as needed but had not used it recently. -Resident #37 had an oxygen concentrator in his/her room. -The staff kept an oxygen concentrator in his/her room to know where it was when needed. -He/she was told today the oxygen tubing and water bottle needed to be changed and he/she changed it. -The oxygen tubing and water bottle should have been changed well before today. -The tubing should have been changed and dated for Saturday. During an interview on 9/19/24 at 10:30 A.M. the ADON said: -He/she expected all oxygen tubing and water bottles to be changed weekly on night shift by the licensed nurses. -He/she expected the resident's Medication Administration Record (MAR) or the TAR to be marked when the oxygen tubing and water bottles were changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she expected the residents who used oxygen as needed consistently to have the oxygen tubing and water bottle set up and ready to go. -He/she expected the residents who did not use oxygen consistently to have the oxygen tubing and water bottle available with the concentrator in his/her room. -Resident #37 did not use oxygen consistently, he/she should have the oxygen tubing and water bottle available in his/her room unopened and not dated. -Staff should bag and date all open oxygen tubing and date water bottles that were connected to the oxygen concentrator. -The oxygen tubing and water bottle were attached to the concentrator so they should have been changed and dated later than 7/31/24. -The oxygen tubing and water bottle should have been dated 9/16/24. During an interview on 9/19/24 at 11:16 A.M. the DON said: -The night shift charge nurses were responsible, but the CNA's could change the oxygen tubing and water bottles and then notify the nurses. -Oxygen tubing and water bottles should be dated when they were changed. -Resident #37's oxygen tubing and water bottle should not have been dated 7/31/24. It should have been dated in September. -Staff should have noticed the oxygen tubing and water bottle were out dated for Resident #37.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 33409 Based on interview and record review, the facility failed to ensure the services of a Registered Nurse (RN) were utilized eight hours per day, seven days per week and failed to ensure a Director of Nursing (DON) or interim DON was onsite full -time 8 hours a day for a minimum of 40 hours a per week. The facility census was 43 residents. Review of the facility Policy for Nursing Services-RN revised 1/1/24 showed: -It is the intent of the facility to comply with RN staffing requirements. -The facility will utilize the services of a RN for at least 8 consecutive hours per day, seven days a week. -The facility will designate a RN to serve as the DON on a fulltime basis. -The DON may serve as a charge nurse only when the facility has a average daily occupancy of 60 or fewer residents. -The facility was responsible for submitting timely and accurate staffing data through the CMS Payroll-Based Journal (PBJ staffing data submitted to Center of Medicare & Medicaid services by long term care facilities)) system. Review of the facility's policy for DON Services revised on 8/2006 showed: -The DON manages the nursing services department at the facility. -The DON is a RN, in licensed in state employed. -The DON is employed full-time (40-hours per week). 1. Review of the Facility Assessment for staffing revised on 1/6/24 showed the facility: -Was to have one DON, RN full time during the weekdays (Monday -Friday). -One RN staffed during the dayshift on the weekends (Saturday and Sunday). -Two licensed nursing staff, a RN and/or Licensed Practical Nurse (LPN) as the charge nurse for the day shift and two licensed staff for the evening shift. -One LPN staffed for night shift. -One RN instructor onsite three days a week. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's PBJ, report for the Fiscal Year (FY) 2024 for Quarter 3 from 4/1/24 to 6/30/24 showed the facility PBJ report RN hours triggered due to four or more days within the quarter with no RN hours reported. Review of facility's RN's and Interim DON time sheet from 4/1/24 to 5/31/24 showed: -On 4/27/24, 4/28/24 and 5/4/24 had no time recorded for the facility RN on those days. -The facility documented on the time sheet that the corporate nurse had worked those days, but was not included in the PBJ report submitted for that quarter. Review of the Interim DON's time sheet dated 9/1/24 to 9/15/24 showed a total of 52 hours in the two week pay period. During an entrance conference interview on 9/16/24 at 8:50 A.M., the Administrator said: -The facility had an interim DON, (who also was the training nurse) who was working less than 38 hours a during the week. -The facility Corporate RN assisted with RN and DON duties. During an interview on 9/17/24 at 9:29 A.M., Certified Medication Technician (CMT) B said: -The facility did not have a full time DON for over a year. -He/she would report any concerns to the Assistant Director of Nursing (ADON). During an interview on 9/17/24 at 9:36 A.M., CMT A said: -The facility normally had a RN onsite during the weekday on the dayshift. -The facility corporate nurse was onsite at the facility when needed. -The ADON had been acting DON with oversight by the facility RN staff. During an interview on 9/17/24 at 9:48 A.M., Certified Nursing Assistant (CNA) B said: -The facility did not have a DON at that time, only a ADON/LPN for at least 6 months. -He/she would report to the ADON and RN trainer with any issue or concerns. During an interview on 9/17/24 at 10:18 A.M., Licensed Practical Nurse (LPN) A said the acting DON, was normally at the facility during the dayshift for 8 hours or less a day, it would depend on the day. During an interview on 9/18/24 at 10:45 A.M., the Staffing Coordinator/Human Resource staff said: -He/she completed the daily staffing sheet and ensured there was coverage needed. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The Administrator would ensure there was licensed nurse coverage for that shift or day. -The facility last hired a full time 40 hours a week DON on 9/22/23 and his/her last day of work was 11/22/23. -The ADON/LPN assisted with the DON duties. -The interim DON normally worked less than 40 hours a week. -The facility ADON had been acting as DON with oversight by the RN staff. -The Corporate RN would also assist in weekend RN staffing coverage and as acting DON when needed. -He/she did not track or obtain the Corporate RN hours. -The Corporate RN hours would not be included in PBJ reports. -On 4/27/24, 4/28/24 and 5/4/24 the corporate RN was listed as scheduled that day. He/she would not report those RN hours in PBJ reports. During an interview on 9/18/24 at 11:27 A.M., the Administrator said: -The facility did not have waiver for DON or RN coverage currently. -The facility Interim DON worked four days a week, not full time at 40 hours week. -The ADON/LPN was in the office as acting DON, with RN oversight one day a week or as needed. -The facility Corporate RN had been assisting with onsite RN coverage for weekends and when the Interim DON was not available for fulltime 40-hour a week. -The RN weekend staffing, was normally covered by the Corporate RN and some of the facility RN staff. -The facility should have a RN working at least eight consecutive hours every day. During an interview on 9/18/24 at 12:00 P.M., the ADON/LPN said: -He/she worked as a charge nurse four days a week and in his/her office one day a week. -He/she was the ADON with DON assigned tasks under the supervision of a RN, to include infection control, shower sheet review, quarterly assessments, and as weekend nurse on-call every weekend. -The facility did not always have RN coverage for 8 hours a day, 7 days a week. -The facility did not always have a RN on site on weekends. The RN could be reach by phone on weekends. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The facility was having difficulty maintaining RN and DON coverage/staff. During the Quality Assurance (QA) interview on 9/18/24 at 1:30 P.M., the Administrator said: -The corporate office reviewed the PBJ reports and they had not communicated the results to him/her. -It was possible that the information the corporate office had input regarding staffing was not correct. -He/she was aware of an instance where the information regarding their staffing did not get pulled over correctly into the PBJ. -He/she did not look at PBJ reports. -The facility was having a challenge with maintaining the DON position. -He/she had not been documenting the corporate nursing hours. -The HR staff would be responsible and should have documented the hours of the Corporate Nurse (the facility doesn't pay Corporate Nurse directly). -The corporate office said they were trying to assist the facility in getting a full time DON. -The ADON was a semester away from becoming a RN so they were supporting the ADON in his/her education process. During an interview on 9/19/24 at 8:54 A.M., Interim DON said: -He/she was currently the interim DON and was teaching the CNA class. -He/she did not always work a full 40 hours per week. -He/she was normally at the facility for four days a week, hours varied during the week. -The facility did not always have RN coverage each day, but thought the Corporate RN filled in as RN when RN hours were short or would be acting DON.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 33409 Based on observation, interview and record review, the facility failed to ensure safe secure storage of cleaning chemicals including liquid laundry soap and a liquid bleach bottle for one sampled resident (Resident #33) out of 14 sampled residents. The facility census was 43 residents. Review of the facility's undated Chemical Storage policy showed: -Chemicals should never be left within reach of a resident and must always be properly stored. -Residents may not have personal chemicals stored in their rooms. Review of the facility's undated Important information for residents and families showed items that cannot be brought into the nursing home due to State and Federal regulations included but was not limited to: Bleach and Laundry detergents provided by facility. 1. Review of Resident #33's face-sheet showed he/she had diagnoses of: -Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses). -Major Depression (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living). Review of the resident's Care Plan dated 7/1/24 showed he/she was: -At risk for harm: self directed or other-directed related to diagnosis of Dementia. -At risk for increased Depression with current diagnosis of Depression. -At risk for unilateral neglect with poor safety awareness at times. -The facility staff were to ensure a safe environment. Review of the resident's Annual Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning), dated 7/9/24, showed the resident had: -Diagnoses including Dementia and Depression. -Moderate cognitive impairment. -Disorganized thinking that changed in severity. Observation on 9/16/24 at 11:39 A.M., of the resident's room showed: (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was a plastic wash basin under the sink with a medium sized bottle of bleach and a green bottle of laundry soap. -The resident was in the room sitting in a recliner and did not have roommates at that time. Observation on 9/16/24 at 11:34 A.M., showed: -The resident was able to ambulate with a rolling walker throughout the facility. -The resident went to his/her closet to get his/her laundry. During an interview on 9/16/24 at 11:34 A.M., the resident said: -The facility did his/her laundry. -He/she was not sure why he/she had laundry soap and bleach in his/her room other than just in case they were needed. Observation on 9/17/24 at 9:18 A.M. of the resident's room showed: -He/she had a plastic wash basin under the sink with a medium sized bottle of bleach half full and a green bottle of laundry soap. -The resident was in the room in a recliner with his/her eyes closed. During interview on 9/17/24 at 9:29 A.M., Certified Medication Technician (CMT) B said: -The resident provided most of his/her own care, staff assisted with bathing. -He/she was not aware the resident had laundry soap or bleach in his/her room. -He/she was not aware of any reason why the resident would have chemicals in his/her room. -The resident should not have any cleaning chemicals including laundry soap and bleach in his/her room. During an interview on 9/17/24 at 9:36 A.M., CMT A said: -He/she was not aware the resident had cleaning chemicals in his/her room. -If staff found the chemicals they should have removed them from the resident's room and taken them to the charge nurse. During an interview on 9/17/24 at 9:41 A.M., Housekeeper A said: -He/she had seen the bleach and laundry soap under the sink in the resident's room. -He/she thought all care staff knew about the chemicals in the resident's room. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she did not notify nursing staff or his/her supervisor of the chemicals in the resident's room. -Normally resident's would not keep cleaning supplies stored in their room. During interview on 9/17/24 at 9:46 A.M., Laundry Aid A said: -The resident did not require any special laundry soap. -He/she was not aware of the resident having laundry soap and bleach in his/her room. -The facility provided laundry services for the resident. During an interview on 9/17/24 at 10:18 A.M., Licensed Practical Nurse (LPN) A said: -He/she was not aware the resident had laundry soap and bleach stored under his/her sink. -He/she would expect all staff to monitor for safety hazards when providing cares and when entering and exiting the resident room. -He/she would expect care staff and housekeeping staff to remove the chemicals from the resident room, give them to the charge nurse to lock up and then talk with the resident's family about bringing laundry and cleaning products into the facility. During an interview on 9/18/24 at 12:00 P.M., the Assistant Director of Nursing (ADON)/LPN said: -He/she was not aware the resident had laundry soap and bleach stored under his/her sink. -The resident was not allowed to keep cleaning chemicals in his/her room. During an interview on 9/19/24 at 8:54 A.M., Interim Director of Nursing (DON) said: -He/she would not expect any cleaning chemicals to be left in the resident's room. -If cleaning chemicals were found, they should have been removed from the resident's room immediately. -He/she would expect staff to monitor the resident rooms for any safety concerns or hazards to include cleaning supplies when entering a resident room. -All cleaning supplies and other chemicals should be stored in a secure locked storage area, not accessible to residents.