STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265693	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center of Independence, The	1800 S Swope Drive Independence, MO 64057

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45108 Based on observations, interviews, and record review, the facility failed to ensure a resident's right to a dignified existence, including being treated with respect during all care interactions for three (3) of three (3) residents observed for dignity (Resident #66, Resident #82 and Resident #39). The findings included: Review of the facility's policy titled Adaptive Equipment-Feeding Devices with a revision date of 12/2020 noted: Adaptive feeding equipment is used by residents who need to improve their ability to feed themselves and in order to enable residents with physically disabling conditions to improve their eating functions. 1. Resident #39 was admitted to the facility on [DATE] with diagnoses which included Diffuse Traumatic Brain Injury with Loss of Consciousness, Cerebral Infarction due to Occlusion of Stenosis of Small Artery, Morbid Obesity, Muscle Weakness and Repeated Falls. Record review of Resident #39's Admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) summary score of 13 which indicated the resident's cognition was intact. Resident #39 was coded as requiring setup or clean-up assistance for eating. Record review of Resident #39's Physician's Orders with no initiation date and a revision date for 12/30/24, revealed an Occupational Therapy order: Pt to trial built-up utensil daily for meals as he tolerates. [sic] In an observation on 1/8/25 at 12:43 p.m. Resident #39 was seated at a table in the large dining room, with three (3) other residents. Resident #39 requested assistance with his/her meal and staff moved the resident to the area for residents who required assistance with meals. An unknown staff member sat down with the resident and provided aid. In an observation on 1/9/25 at 1:30 p.m. Resident #39, was in bed with his/her meal tray and not eating. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/9/25 at 1:30 p.m. with Resident #39, the resident reported being frustrated that staff were not available to assist him with his meals. Resident #39 stated he could not grasp the utensils to eat his meal independently. Resident #39 reported he/she did not like the way staff treated him/her when it came to providing assistance with eating his/her meal. In an interview on 1/9/25 at 1:33 p.m. Restorative Nursing Aide (RNA) AA, stated that Resident #39, .for the most part he feeds himself. [sic] 2. Resident #66 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease, Other Fracture of T11-T12 Vertebra, Chronic Systolic (Congestive) Heart Failure, Thoracic Aortic Aneurysm without Rupture, Obstructive Sleep Apnea, Non-Pressure Chronic Ulcer of Unspecified Part of Right Lower Leg with unspecified severity and Acquired Absence of Left Leg Below Knee. Record review of Resident #66's Annual MDS dated [DATE], revealed a BIMS summary score of 15 which indicated the resident's cognition was intact. Resident #66 was coded as having occasional incontinence of bladder and frequent incontinence of bowel. Record review of Resident #66's Care Plan with an initiation date of 1/21/24 and a revision date of 1/2/25 revealed interventions that documented the resident preferred to sleep in a recliner and, . typically independent with toileting but at times may require additional assistance. Monitor for increased need . Resident #66's Care Plan did not address whether the resident needed assistance with transferring from the rocking recliner. An observation on 1/9/25 at 11:22 a.m. of Resident #66's room, revealed the resident did not have a bed in his/her room, and other than the manual wheelchair the resident was sitting in, the resident only had a rocking recliner. An interview on 1/9/25 at 11:22 a.m. with Resident #66, revealed that Resident #66 was sleeping in his/her manual wheelchair. The resident reported that he/she had difficulty getting in and out of bed in his/her current room, due to the side that the bed controls were located. The resident stated that the facility suggested the recliner. Resident #66 also reported that due to the fact that the recliner was also a rocking chair, he/she was unable to get up from the chair without assistance. The resident said he/she felt that it was easier for him/her to sleep in the manual wheelchair. Resident #66 further reported that he/she could only sleep for two (2) hours at a time in the wheelchair, and that he/she did not like the rocking recliner and wanted a bed to sleep in. Resident #66 said when he/she told the facility about his/her issue with the rocking recliner that it was suggested to have his/her family member purchase a different recliner. In an interview on 1/9/25 at 11:50 a.m. with Certified Medication Aide (CMA) CC reported that the resident had been without a bed, .a week or two (2). In an interview on 1/9/25 at 11:55 a.m. with Licensed Vocational Nurse (LVN) Treatment Nurse DD confirmed that the resident was sleeping in the manual wheelchair, that the resident reported difficulty with the rocking recliner, and it was suggested to the resident to have a family member purchase a different recliner for the resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident # 82 was admitted to the facility on [DATE] with diagnoses which included Ventricular Tachycardia, Overactive Bladder, Major Depressive Disorder and Chronic Pain Syndrome. Review of Resident #82's Admission MDS dated [DATE] revealed the resident had a BIMS summary score of 14 which indicated the resident was cognitively intact. The MDS further revealed Resident #82's functional abilities were coded as dependent on staff for toileting hygiene; and coded the resident as frequently incontinent of bladder and always incontinent of bowel. An observation on 1/9/25 at 3:33 p.m. of Resident #82's perineal care revealed RNA AA, engaged in inappropriate behavior by using profane language directed at Certified Nursing Aide (CNA) BB in the presence of Resident # 82. This behavior occurred at the bedside while performing intimate perineal care, compromising the resident's right to a dignified and respectful environment. In an interview on 1/9/25 at 4:12 p.m. with the Administrator, Director of Nursing, Regional Director and Regional Nurse it was reported that RNA AA would be suspended pending an investigation and a safe survey with trauma assessments would be provided for Resident #82. In an interview on 1/10/25 at 3:07 p.m. with Resident #82, when asked about the incident with RNA AA, he stated .I don't like it at all. That was rude and disrespectful.

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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. 37927 Based on interviews and facility policy, the facility staff failed to protect the rights of a resident whose room was changed without notice prior to the change for one (1) of one (1) resident reviewed for room changes. Resident #65 left the facility for an appointment and returned to learn his/her belongings had been moved to another room. The findings include: Review of facility policy titled Room or Roommate Change Version 1.0, Revised 8/2020 revealed the policy's Purpose -To ensure that a resident is able to exercise their right to change rooms or roommates .Procedure -III. Prior to changing a room assignment, the resident, the resident's representative (if available), the resident's new roommate, will be given timely advance notice of such change according to state and federal regulations. 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 the change. B. Social Services Staff will assist in orienting the resident to his or her new room and/or roommate. 1. Resident #65 was admitted to the facility 10/2/24 with diagnoses including diabetes, kidney failure, repeated falls, hypokalemia, hypomagnesemia, hypertensive heart without heart failure, hyperlipidemia, atrial fibrillation, anxiety disorder, muscle weakness and arthritis. In an interview on 1/7/25 at 12:15 p.m., Resident #65 stated that the facility moved his belongings to a new room when he/she was out for an appointment without notifying the resident before the move. Resident #65 stated that it caused a misunderstanding between him/her and his/her former roommate as each thought the other had asked for the move. In an interview on 1/10/25 at 7:50 a.m., the Social Worker (SW) reported that it was a clinical decision to move Resident #65. SW also acknowledged that Resident #65 had only left the building for an appointment. SW also confirmed that the move was not discussed with the resident. In an interview on 1/10/25 at 5:00 p.m., the Administrator stated that staff were expected to implement policy correctly.

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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. 45108 Based on observation, interviews and record review, the facility failed to appropriately address and resolve grievances raised during previous resident council meetings. Residents voiced specific concerns regarding food, missing laundry items, and not receiving showers over numerous monthly meetings. This deficient practice had the potential to affect all residents who resided in the facility. The census on the first day of survey entrance was 96 residents. The findings included: 1. Record review of Resident Council Meeting Minutes dated 7/3/24, revealed that residents reported they were not receiving showers. Record review of Resident Council Meeting Minutes dated 9/4/24, revealed that residents reported they were not receiving showers and reported that the Dietary department ran out of milk and yogurt. Record review of Resident Council Meeting Minutes dated 10/2/24, revealed that residents reported that they were not getting their clothes back from the laundry department in a timely fashion and residents were running out of clothing. Record review of Resident Council Meeting Minutes dated 11/6/24, revealed that residents reported that not all resident rooms were cleaned daily, and residents were not getting their clothes back from the laundry department. Record review of Resident Council Meeting Minutes dated 12/4/24 revealed that residents reported that resident rooms were not being cleaned daily, residents were not getting their clothing back from the laundry department, and the Dietary department was running out of condiments. There was no evidence in the meeting minutes that the residents' reported concerns had been addressed by facility leadership. An observation during the Resident Council meeting on 1/10/25 at 2:00 p.m., revealed residents reported having lost and/or damaged laundry; the facility ran out of paper towels and hand soap; resident rooms were not being cleaned daily; and meal trays were not matching the dining tickets due to the dietary department running out of food items. An interview with the Administrator and the Director of Nursing (DON) on 1/10/25 at 5:30 p.m., revealed that facility leadership met with the Activity Director who conveyed the residents' concerns in a leadership meeting. The Administrator also mentioned that Resident Council meetings were discussed in Interdisciplinary Team meetings. Per the DON, each department gave a response to the issues brought up in resident council. Neither the Administrator nor the DON provided a response as to why the concerns had not been addressed by the facility.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42070 Based on observation, interviews and record review, the facility failed to ensure appropriate notification following a fall during a transfer for one (1) of 36 residents sampled (Resident #39). Resident # 39 reported falling while being transferred from a wheelchair to the bed by Restorative Nursing Aide (RNA) AA and Maintenance Supervisor. The staff involved did not notify the nurse or physician of the incident, as required. This deficient practice compromised the resident's right to prompt assessment and care and potentially placed the resident at risk for unrecognized or untreated injuries. The findings included: 1. Record review of Resident #39's Admission Minimum Data Set (MDS) dated [DATE], revealed an admitted [DATE], and a Brief Interview for Mental Status (BIMS) summary score of 13 which indicated the resident was cognitively intact. Resident #39 was coded as dependent for a chair/bed to chair transfer. Continued review revealed diagnoses which included Diffuse Traumatic Brain Injury with Loss of Consciousness, Cerebral Infarction due to Occlusion of Stenosis of Small Artery, Morbid Obesity, Muscle Weakness and Repeated Falls. Record review of an undated Visual Bedside Kardex Report revealed that Resident #39 required the mechanical aid of a Hoyer lift with two (2) staff members assisting for transfers. Review of Resident's #39's Care Plan revealed there was an intervention with an initiated date of 12/26/24 that the resident required mechanical aid Hoyer lift with two (2) staff assisting for transfers. There was no evidence in the Progress Notes that a fall with Resident #39 had been reported. In an observation on 1/9/25 at 1:00 p.m. of a skin assessment on Resident # 39 with Licensed Vocational Nurse Treatment Nurse (LVN) DD revealed that Resident # 39 had two (2) closed abrasions, that were red and scabbed over below the resident's left knee. LVN DD cleaned the abrasions and applied skin prep, without a written order for the treatment. In an interview with Resident # 39 on 1/8/25 at 1:29 p.m., the resident reported that on the date of admission 12/24/24, he/she fell during a staff assisted transfer from the wheelchair to the bed. Resident # 39 was only able to recall one of the staff members who assisted during the transfer. The resident stated that had he/she sustained an injury to his/her left leg. The first day here, they dropped me trying to transfer. A couple guys dropped me when my legs gave out. Took a gash out of my left leg. [sic] In an interview on 1/9/25 at 11:00 a.m. with LVN DD, he/she stated that no staff member notified her of the two (2) red scabbed over abrasions to the resident's left leg, and was not aware that a fall had occurred with the resident (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/9/25 at 5:00 p.m. with the Maintenance Supervisor, revealed that he/she and the RNA AA were the staff members who assisted the resident with the transfer. The Maintenance Supervisor stated that the resident's admission paperwork did not list that the resident was to be transferred via a mechanical Hoyer lift. The Maintenance Supervisor reported that Resident # 39 during transfer started to slip out of their wheelchair but did not fall. RNA AA was unavailable to be interviewed due to being recently suspended earlier in the day.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 37927 Based on interview and record review, the facility failed to provide documentation of appropriate notification of pending benefit changes to Medicare services for one (1) of three (3) residents sampled for beneficiary notices (Resident #90). The findings include: 1. The 1/10/25 review of the notices given to three (3) residents selected from the form entitled Beneficiary Notice - Residents discharged Within the Last Six Months (provided to the facility during the Entrance Conference) revealed none was available for 1 of 3 sampled residents, Resident #90. In an interview, the Social Worker (SW) on 1/10/25 at 2:28 p.m. reported not being in the position until August 2024 and the SW was unable to provide proof of notification letters sent to Resident #90.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42070 Based on interviews and record review, the facility failed to notify the resident and the resident's representative of a facility-initiated emergency transfer to an acute care hospital. This deficient practice affected one (1) of two (2) residents reviewed for hospitalization s from a total of 36 residents sampled (Resident #101). The findings include: The facility's policy governing resident transfer and discharge processes was reviewed. The policy, titled Transfer and Discharge was dated 10/24/22. The policy directed staff from Social Services (or a designee) to prepare a written transfer notice to send with the resident in the event of an emergency transfer. 1. A review of Resident #101's medical record revealed an admitted [DATE]. His/her medical history included metabolic encephalopathy, hemiparesis affecting his/her left side, and history of CVA. A comprehensive minimum data set (MDS) was not completed as the resident was admitted on [DATE] and discharged on [DATE]. Resident #101 did not return to the facility after hospitalization . A Recapitulation of Stay Resident Discharge Summary dated 10/30/24 revealed that Resident #101 was transferred to the hospital on 10/29/24 at 4:00 p.m. due to a change in medical condition. The electronic form was signed by the Director of Nursing (DON). Continued review of Resident #101's medical record revealed no evidence of a written notice of transfer having been sent to the resident or the resident's representative. On 1/9/25 at 12:10 p.m., an interview was conducted with Licensed Practical Nurse (LPN) FF regarding the facility's practices for transferring residents to acute care settings. According to LPN FF, the nurse that transferred the resident to the hospital would be expected to complete the notice of transfer and send it with the resident at the time of transfer, as part of the transfer paperwork. LPN FF added that a copy of the notice should be kept in the resident's medical record. On 1/10/25 at 5:01 p.m., an interview was conducted with the facility's Administrator and the DON. During the interview, the DON confirmed that a written notice of transfer was not sent with Resident #101 at the time of his/her transfer nor was it sent to the resident's representative. The DON added that the nurse transferring the resident to the hospital should have completed the notice of transfer. When reminded that he/she signed Resident #101's discharge summary, the DON stated he/she was unable to recall whether a notice of transfer was sent.

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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** 42070 Based on interviews and record review, the facility failed to provide the resident and the resident's representative with a written notice of the facility's bed-hold policy upon transferring a resident to an acute care hospital. This deficient practice affected one (1) of two (2) residents reviewed for hospitalization s from a total of 36 residents sampled (Resident #101). The findings included: The facility's policy governing resident transfer and discharge processes was reviewed. The policy, titled Transfer and Discharge was dated 10/24/22. The policy directed staff to provide a resident and a resident representative with a written notice which specified the duration of the resident's bed-hold at the time of transfer. 1. A review of Resident #101's medical record revealed an admitted [DATE]. His/her medical history included metabolic encephalopathy, hemiparesis affecting his/her left side, and history of CVA. A comprehensive minimum data set (MDS) was not completed as the resident was admitted on [DATE] and discharged on [DATE]. Resident #101 did not return to the facility after hospitalization . A Recapitulation of Stay Resident Discharge Summary dated 10/30/24 revealed that Resident #101 was transferred to the hospital on 10/29/24 at 4:00 p.m. due to a change in medical condition. The electronic form was signed by the Director of Nursing (DON). Continued review of Resident #101's medical record revealed no evidence of a written notice of the facility's bed-hold policy having been sent to the resident or the resident's representative. On 1/9/25 at 12:10 p.m an interview was conducted with Licensed Practical Nurse (LPN) FF regarding the facility's practices for transferring residents to acute care. According to LPN FF, the nurse that transferred the resident to the hospital was expected to complete the notice of bed-hold and send it with the resident at the time of transfer as part of the transfer paperwork. LPN FF added that a copy of the notice should be kept in the resident's medical record. On 1/10/25 at 5:01 p.m. an interview was conducted with the Administrator and the DON. During the interview, the DON confirmed that a written notice of bed-hold policy was not sent with Resident #101 at the time of his/her transfer nor was it sent to the resident's representative. The DON added that the nurse transferring the resident to the hospital should have completed the notice of bed-hold.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45108 Based on observation, interviews and record review, the facility failed to ensure the accuracy of a skin assessment when the corresponding assessment did not reflect the actual condition of the skin for one (1) of 36 residents sampled (Resident #39). Inaccurate documentation compromised the facility's ability to provide appropriate and timely care, potentially putting the resident at risk for further complications. The findings included: 1. A review of Resident #39's electronic health record revealed an admitted [DATE], with diagnoses that included Diffuse Traumatic Brain Injury with Loss of Consciousness, Cerebral Infarction due to Occlusion of Stenosis of Small Artery, Morbid Obesity, Muscle Weakness and Repeated Falls. A further review of Resident #39's Admission Minimum Data Set (MDS) dated [DATE], noted a Brief Interview for Mental Status (BIMS) summary score of 13, which indicated the resident's cognition was intact. Section M of the MDS noted Moisture Associated Skin Damage (MASD), and no other skin problems were present. A review of a Skin/Wound note dated 12/25/24 at 9:25 p.m. created by Licensed Vocational Nurse Treatment Nurse (LVN) DD, documented that LVN DD assessed Resident #39, and the resident had no skin issues noted. There was no evidence of any other documentation that noted Resident #39's skin issues. In an observation on 1/9/25 at 11:00 a.m. of a skin check/assessment on Resident # 39 conducted by LVN DD revealed that Resident # 39 had two (2) closed abrasions that were red and scabbed over located below the resident's left knee. LVN DD cleaned the abrasions and applied skin prep. In an interview with Resident #39 on 1/8/25 at 1:29 p.m. the resident reported that on his/her date of admission 12/24/24, Resident #39 fell during a transfer from the wheelchair to the bed and sustained an injury to his left leg. Resident #39 said, The first day here, they dropped me trying to transfer. A couple guys dropped me when my legs gave out. Took a gash out of my left leg. [sic] In an interview on 1/9/25 at 11:00 a.m. with LVN DD, the nurse stated that no staff member notified him/her of the two (2) red scabbed over abrasions to the residents left leg of Resident #39, he/she was not aware of an injury or a fall and had not documented them. In an interview on 1/9/25 at 5:00 p.m. with MS, revealed that he/she and the RNA AA were the staff members who assisted the resident with the transfer. MS stated that the resident's admission paperwork did not list that the resident was to be transferred via a mechanical Hoyer lift. MS reported that Resident # 39 during transfer started to slip out of their wheelchair but did not fall. RNA AA was unavailable to be interviewed due to being recently suspended earlier in the day.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42070 Based on interviews and record review, the facility failed to obtain a physician ordered urinalysis (UA) sample in a timely manner for Resident #5, one (1) of one (1) resident reviewed for laboratory results from a total of 36 residents sampled. The findings include: 1. Resident #5 was admitted to the facility on [DATE] with diagnoses including but not limited to cellulitis, heart disease, anemia, morbid obesity, infection of unspecified joint, pain and diabetes with diabetic neuropathy. Review of the clinical health record for Resident #5 revealed a physician's order dated 1/3/24 for a UA. On 1/9/25 the laboratory results were requested from the Director of Nursing Services (DON) with reminders provided as other requests were completed. In an interview on 1/10/25 at 5:10 p.m., the DON reported that the 1/3/25 physician's order was executed on 1/10/25 and the sample was earlier that day. There was no reason provided for the delay in obtaining the sample.

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	265693	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center of Independence, The	1800 S Swope Drive Independence, MO 64057

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 20005 42070 Based on observations, interviews and record review, the facility failed to ensure residents received the necessary nursing care and services for activities of daily living by failing to 1) Provide residents with showers in accordance with bathing schedules for two residents (Resident #2 and Resident #58) and 2) Provide residents requiring assistance with toileting the necessary care and services to transfer on and off the toilet for one (1) of six (6) residents reviewed (Resident #70), and 3) Ensure that two (2) of 36 residents sampled (Resident #39 and Resident #82) were provided with personal hygiene care and/or adaptive eating equipment in accordance with their preference and Care Plans. The findings included: Cross-Reference to F725 Sufficient Nursing Staff Review of the facility policy, Showering a Resident, undated, documented Purpose: A shower bath is given to the residents to provide cleanliness, comfort and to prevent body odors. Policy: Residents are offered a shower at a minimum of once weekly and given per resident request. 1. Resident #2 was admitted to the facility on [DATE] with diagnoses including cerebral palsy, depression, anxiety, non-weight bearing, spastic diplegic, and obesity. The most recent Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) was conducted and the resident was coded as 15 indicating the resident had intact cognition. The MDS also coded the resident as having upper and lower impairment in range of motion and coded the resident as being dependent on staff for showers, transfers, and hygiene. The resident 's care plan, initiated 7/5/17, documented under Focus that the resident required assistance with activities of daily living (ADL) due to weakness and cerebral palsy. The goal listed the resident was to maintain their current level of functioning through the next review date. The intervention was for the resident to receive substantial/maximal assistance by staff for showering, bed mobility and transfers. The care plan documented the resident was to receive a shower two (2) times weekly and as needed. An intervention was a Hoyer lift for transfers with the assistance of two staff. On 1/7/25 at approximately 11:00 a.m., in an interview with Resident #2, she /he stated that the staff was short, and they (the staff) asked them to stay in bed and take a shower another day. She/he said that when they were short staffed, they often asked her/him to do that. She /he didn ' t know what happened, but the facility seemed to be short staffed a lot recently. Resident #2 said they used to get showers two times per week but now they was lucky if she /he got a shower one (1) time per week. She /he stated they thought some of the staff were scared to move her/him due to being a two-person assist. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/10/25 at 10:30 a.m., in an interview with CNA EE, she/he stated that when they were short staffed, they (the staff) asked Resident #2 to change their shower day and sometimes asked the resident to stay in bed. CNA EE stated that Resident #2 had a diagnosis of obesity along with cerebral palsy and this made her difficult to transfer. Review of the Skin Monitoring: Comprehensive CNA shower Review sheets from October 2024 through December 2024 revealed the following: October - the resident received 5 showers, November - the resident received 4 showers, December - the resident received 5 showers. On 1/10/25 at approximately 2:30 p.m., in an interview with the LVN DD, who monitored the skin on bath days, she/he stated that if the residents refused a shower, they were supposed to sign the form. She /he also stated that she/he wasn ' t familiar with Resident #2 refusing showers recently. There was no record of Resident #2 refusing showers. 2. Resident #58 was admitted to the facility on [DATE] with the following diagnoses: seizure, atrial fibrillation and chronic obstructive pulmonary disease. The most recent MDS, dated [DATE], revealed a BIMS was completed and coded the resident as a 15, indicating intact cognitive status. The MDS also coded the resident as needing partial assistance with bathing. The resident ' s care plan, updated 10/24, documented under Focus that the resident had a Activity of Daily Care deficit due to generalized muscle weakness, heart failure, alcohol dependence, lymphedema, muscle wasting and atrophy. The resident had a need for assistance with personal care. The interventions listed included: The resident required supervision/ set up assistance with bathing/showering two (2) times weekly and as needed or desired and that the resident was dependent on staff for personal hygiene and oral care. On 1/8/25 at approximately 10:00 a.m., Resident #58 complained about not getting showers two (2) times weekly like he used to. He stated the facility was usually understaffed and often times the staff would ask him to take a shower on a different day because of this. Resident #58 stated they needed more help, especially on the weekends. He /she stated he usually got a shower one (1) time per week. He /she stated he usually asked staff when he could take a shower. He /she stated he tried to get on the [showering] list. Review of the Skin Monitoring: Comprehensive CNA Shower Review sheets from October 2024 through December 2024 revealed the following: October - the resident received four showers, November - the resident received four showers. December - the resident received five showers. On 1/10/25 at approximately 2:30 p.m., in an interview with the LVN DD, who monitored the skin on bath days, he/she stated that if residents refused a shower, they were supposed to sign a form. She/he also stated that she wasn ' t familiar with Resident #58 refusing showers lately. There was no record of Resident #58 refusing showers. On 1/10/25 at approximately 5:15 p.m., in an interview with the Director of Nursing, she /he acknowledged that the residents should have at least two (2) showers per week. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy governing call light responses was reviewed. The policy was titled Answering the Call Light, and had a revision date of March 2021. The policy's purpose was to ensure timely responses to residents' requests and needs. Step 2 of the procedure instructed staff to identify themselves and politely respond to the resident by name. Subsection B of Step 2 required staff to notify another staff member if the resident's request necessitated assistance. Subsection C instructed staff to complete the task within five minutes if possible. 3. A review of Resident #70's medical record revealed an initial admitted [DATE]. The resident's medical history included hemiparesis affecting the right dominant side, morbid obesity, chronic obstructive pulmonary disease, and fatigue. A quarterly minimum data set (MDS) assessment conducted on 11/12/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 possible points. This suggested that the resident's cognition was not impaired. The assessment also noted that Resident #70 used a wheelchair for mobility and was completely dependent on staff for toileting assistance. A review of Resident #70's plan of care revealed a focus area for ADL self-care performance deficit. An intervention dated 10/7/24, directed staff to provide Resident #70 with substantial/maximal assistance with toileting. On 1/9/25 at 11:05 a.m., the flashing call light in room [ROOM NUMBER]-B indicated a call for assistance from the restroom. An audible alert from the nurse's station was heard. From 11:05 a.m. to 11:18 a.m., the call light continued to flash, and the beep from the call light panel at the nurse's station persisted. During this time, Licensed Practical Nurse (LPN) GG was observed at the nurse's station, using a computer to document in the electronic medical record system. Continued observation on 1/9/25 revealed: At 11:18 a.m., Resident #70 was seen sitting on the toilet in their restroom with the door open. When asked if they needed assistance transferring back to their wheelchair, the resident responded, Yes, please! I've been sitting here forever! At 11:20 a.m., two maintenance employees passed by Resident #70's room but failed to acknowledge the call light or respond to the call for assistance. At 11:22 a.m., a Certified Occupational Therapy Assistant (COTA) approached the door of room [ROOM NUMBER], looked up at the flashing call light, turned around, and walked back down the hallway. The COTA did not return to assist Resident #70. At 11:23 a.m., the Administrator walked past the 300 hallway, glanced down the hallway, and proceeded to the Director of Nursing's office. At 11:24 a.m., a maintenance employee entered the room across from 303. The employee did not acknowledge the call light or respond to Resident #70's call for assistance. At 11:26 a.m., a surveyor informed Certified Medication Technician (CMT) HH that Resident #70 needed assistance. CMT HH responded to Resident #70's room and helped him/her back to their wheelchair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/25 at 12:42 p.m., an interview was conducted with Resident #70. Resident #70 confirmed that they required physical assistance from staff for transfers to and from the toilet due to weakness in both lower extremities. Resident #70 mentioned that Restorative Nursing Assistant (RNA) AA had assisted them to the toilet around 11:00 a.m. and instructed them to pull the cord when you're done. However, Resident #70 expressed frustration that RNA AA had not responded to the call request. Resident #70 stated that this was typical of most of the people that work here. When asked if they had brought this concern to facility leadership, Resident #70 responded, What's the use? On 1/9/25 at 1:13 p.m., an interview was conducted with CMT HH to discuss Resident #70's care requirements. CMT HH confirmed that Resident #70 needed physical assistance for transfers to and from the toilet. CMT HH also mentioned that while assisting Resident #70 off the toilet at 11:26 a.m., Resident #70 had expressed concern about the time it took to receive toileting assistance. An interview with RNA AA was not possible because they were suspended from employment by facility leadership on 1/9/25 at approximately 4:00 p.m., for an unrelated allegation. On 1/9/24 at 5:01 p.m., an interview was conducted with the Administrator and the Director of Nursing (DON). During the interview, the Administrator and DON were asked about their expectations regarding the facility staff's response to call lights. The DON clarified that every employee should respond to a call light or a resident's request for assistance. If an employee was unable to provide the necessary assistance, they were expected to report the resident's request to an appropriate staff member and follow up to ensure proper care was provided. The Administrator also emphasized the importance of a reasonable response time to call lights, stating that waiting over 20 minutes for assistance with transferring off the toilet was excessive. Review of the facility's policy titled, Showering a Resident, undated, revealed that residents should be offered a minimum of one (1) shower per week and given if requested by the resident. A shower schedule was reviewed and based on the resident's room number he/she is provided a shower on both Mondays and Thursdays or Tuesdays and Fridays. Review of the facility's policy titled, Adaptive Equipment-Feeding Devices, revised 12/2020, revealed, Adaptive feeding equipment is used by residents who need to improve their ability to feed themselves and in order to enable residents with physically disabling conditions to improve their eating functions. 4. A review of Resident #39's electronic health record revealed an admitted [DATE], with diagnoses that included Diffuse Traumatic Brain Injury with Loss of Consciousness, Cerebral Infarction due to Occlusion of Stenosis of Small Artery, Morbid Obesity, Muscle Weakness and Repeated Falls. Review of Resident #39's Admission Minimum Data Set (MDS) dated [DATE], noted a Brief Interview for Mental Status (BIMS) summary score of 13, indicating the resident was cognitively intact. According to the assessment, the resident was dependent on staff for assistance with shower/bathe self. Resident #39 was coded as requiring setup or clean-up assistance for eating. Review of Resident #39's Care Plan with an intervention initiation date of 12/26/24 documented that the resident was dependent on staff for bathing and personal hygiene care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #39's Physician's Orders with no initiation date and a revision date for 12/30/24, revealed an Occupational Therapy order: Pt to trial built-up utensil daily for meals as he tolerates. [sic] Review of Shower documentation revealed Resident #39 was documented to have received a shower on 12/29/24, 12/31/24 and on 1/10/25. In an observation on 1/8/25 at 12:43 p.m. Resident #39 was seated at a table in the large dining room, with three (3) other residents. Resident #39 requested assistance with his/her meal and staff moved the resident to the area for residents who required assistance with meals. An unknown staff member sat down with the resident and provided aid. In an observation on 1/9/25 at 1:30 p.m. Resident #39, was in bed with his/her meal tray and not eating. In an interview with Resident #39 on 1/8/25 at 1:29 p.m., the resident reported that he had received one (1) bed bath and no showers since being admitted on [DATE]. He stated that staff would keep him clean by changing his bedding and clothes. In an interview on 1/9/25 at 1:30 p.m. with Resident #39, the resident reported being frustrated that staff were not available to assist him with his meals. Resident #39 stated he could not grasp the utensils to eat his meal independently. Resident #39 reported he/she did not like the way staff treated him/her when it came to providing assistance with eating his/her meal. In an interview on 1/9/25 at 1:33 p.m. Restorative Nursing Aide (RNA) AA, stated that Resident #39, .for the most part he feeds himself. [sic] 5. Resident # 82 was admitted to the facility on [DATE] with diagnoses that included Ventricular Tachycardia, Overactive Bladder, Major Depressive Disorder and Chronic Pain Syndrome. Review of Resident #82's Admission MDS dated [DATE] revealed the resident had a BIMS summary score of 14, indicating intact cognition. The MDS further revealed Resident #82's functional abilities indicated the resident was dependent on staff for assistance with toileting hygiene and shower/bathe self. Review of Shower documentation for Resident #82 revealed, was the resident was documented to have received a shower 12/26/24, 1/2/25, and 1/9/25. In an interview with Resident #82 on 1/8/25 at 1:09 p.m., Resident #82 reported that he was not receiving showers. Resident #82 stated, .it's embarrassing, because I smell bad. In an interview with the Administrator and the Director of Nursing (DON) on 1/10/25 at 5:30 p.m., DON stated that residents were supposed to get two (2) showers a week. The DON also said, . staff, or bath aides, or anyone can give a bath. Some prefer the bath aides. [sic] 45108

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20005 Based on observation, interview and policy review, the facility did not provide meaningful activities on the weekends for two (2) residents (Resident #58 and Resident #78), and did not get one (1) resident out of bed for activities that they wanted to attend (Resident #39) out of 36 residents sampled. The findings include: The facility's policy Activities Program, revised 6/2020, documented under Purpose: To encourage residents to participate in activities to make life more meaningful, to stimulate and support physical and mental capabilities to the fullest extent, and to enable the resident to maintain the highest attainable social, physical and emotional functioning. Listed under Policy: The facility provides an Activity Program designed to meet the needs, interests, and preferences of residents. The activities are varied and work to address the needs and interests identified through the assessment process. The Activity Program may address areas including but not limited: A. Social Activities: B. Indoor ad Outdoor activities: C. Activities away from the facility: D. Religious programs: E. Opportunity for resident involvement for planning activities: F. Creative activities: G. Educational activities: and H. Exercise activities. II. A Variety of activities should be offered on a daily basis, which includes weekends and evenings. 1. Resident #39 was admitted to the facility on [DATE], with diagnoses including diffuse traumatic brain injury with loss of consciousness, status unknown other cerebral infarction, due to occlusion or stenosis of small artery, muscle weakness, mild cognitive impairment of uncertain or unknown etiology other idiopathic peripheral, autonomic neuropathy, chronic obstructive pulmonary disease, chronic kidney disease, and Bipolar 1. The most recent Minimum Date Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) and the resident was coded as 15, which indicated the resident's cognition was intact. The MDS also documented under section F (Preferences for Customary Routine and activities) the resident preferred group activities, animals (pet therapy) and doing their favorite activities was very important to them. Further review of Resident #39's medical record revealed a Care Plan, dated 12/24/24, documented under activities as a Focus area that the resident was dependent on staff for cognitive stimulation and social interaction. The goal was for the resident to participate/attend activities of choice two (2) to three (3) times per week by next review. The interventions listed were for the resident to be invited to activities, groups, music groups, and special events. Also, the facility was to provide a program that was of interest and empowered the resident by encouraging /allowing choice, self-expression, and responsibility. On 1/8 /25 at 1:29 p.m., Resident #39 stated that since he/she couldn't get out of bed by himself, that staff were not getting him up for activities. I would like to go to bingo, but nobody comes to get me. I'm a smoker, but they say because I can't function, they don't take me. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #58 was admitted to the facility on [DATE] with the following diagnoses: seizure, atrial fibrillation and chronic obstructive pulmonary disease. The most recent MDS dated [DATE], revealed a BIMS was completed and coded the resident as a 15, indicating intact cognitive status. The F section of the MDS (Preferences for customary routine and activities) documented music, books, news, outside activities, and religious activities were very important to him. Further review of the medical record revealed a Care Plan, updated on 10/30/24, documented under activities that the resident didn't care for group activities due to physical mobility/limitation issues and listed under Goals: the resident would express satisfaction with the type of activities and level of activity involvement through the next review date. The interventions were to invite the residents to activities, thank the residents for attendance at bingo, music, and social events. The resident liked to socialize with peers and watching programs on T.V. In an interview with Resident #58 on 1/7/25 at 3:45 p.m., the resident complained of having no activities to participate in for the weekends. He /she stated he was here for two years, and they have never had activities on the weekends. He /she stated they liked Bingo, but it was rarely offered on weekends, and he /she gets bored. Reviews of the activity attendance records for the months of October 2024 through December 2024 revealed Resident #58 attended two bingo activities on Saturday in the past three months. 3. Resident #78 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, obesity, and cerebral infarction. The most recent MDS dated [DATE] revealed a BIMS was conducted, and the resident was coded as 13, indicating intact cognitive status. The most recent annual MDS dated [DATE] documented under section F (Preferences for customary routine and activities) that it was very important for him to participate with groups of people, religious activities, listen to music, and participate in his favorite activities. Review of the Care Plan, updated on 12/9/24, documented as a concern that Resident #78 had little or no activity involvement due to eating in the dining room. Resident #78 preferred to eat in his /her room/bed especially in the morning. Listed under goals was that resident would express satisfaction with type of activities and level of activity involvement when asked through the next review date. Interventions included that the resident enjoyed playing Bingo, Farkle, and attending special events in the lobby. On 1/9/25 at 9:40 a.m, in an interview with Resident #78, the resident stated the facility really didn't have weekend activities. The resident stated that he/she got bored on the weekends. He stated he /she liked Bingo but it was not always offered on the weekends. He /she stated they would also like their church to come to the facility on Sundays. Review of the activity attendance records for the months of October 2024 through December 2024, revealed that Resident #78 attended two (2) activities on the weekend within the three months: Farkle and Wellness Walk was attended on 10/5/24. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/22 at 10:02 a.m., in an interview with the Activity Director (AD), she stated that the residents would start card games with other residents on the weekend; however, the [activity] staff weren't there to observe what was done on the weekends, except for Bingo. When questioned about the church services, the AD stated they weren't aware of the churches not coming. However, they weren't in the facility to observe. On 1/10/25 at 10:02 a.m., in a follow-up interview with the AD with the Assistant AD present, they explained that they don't staff the Sunday weekend activities. The AD said that they leave out materials, such as board games and cards, so the residents can do things independently. On Saturdays they come in and staff Bingo, but that's the only weekend activity that was staffed by the Activity department. Bingo for the past three months had been done every other Saturday, due to the holidays and having other activities going on. However, the only available activities listed on Saturdays and Sundays were coloring sheets, card games, table games, fell owship church, chat with coffee, and South Christian Church. They only supervise the activities during the week. The Activity Director stated that starting in the month of January 2025 they will be offering Bingo every Saturday. On 1/10/25 at 5:00 p.m. in an interview with the facility's Administrator, he /she acknowledged that the activities were a concern, and stated he /she knew how to correct the situation. 45108

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42070 Based on interviews and a review of medical records, the facility failed to identify and implement the necessary care and services to address the needs of diabetic residents. Specifically, facility staff failed to: 1. Recognize and appropriately respond to signs and symptoms of hyperglycemia, such as changes in mental status, feelings of anger, excessive hunger, excessive thirst, and frequent urination. 2. Implement blood glucose monitoring as ordered by the medical provider. Failed to transcribe and/or verify insulin orders and blood glucose monitoring with the physician upon admission. 3. Administer insulin as ordered by the medical provider resulting in the resident becoming physically and verbally combative, excessively hungry, resulting in hypoglycemia and a blood sugar of 541. This deficient practice contributed to the subsequent hospitalization of one (1) of two (2) residents reviewed for hospitalization from a total of 36 residents sampled (Resident #101). The findings include: According to Mayo Clinic (accessed 1/9/25 https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631), High blood sugar, also called hyperglycemia, affects people who have diabetes. Several factors can play a role in hyperglycemia in people with diabetes. They include food and physical activity, illness, and medications not related to diabetes. Skipping doses or not taking enough insulin or other medication to lower blood sugar also can lead to hyperglycemia. It's important to treat hyperglycemia. If it's not treated, hyperglycemia can become severe and cause serious health problems that require emergency care, including a diabetic coma. Hyperglycemia that lasts, even if it's not severe, can lead to health problems that affect the eyes, kidneys, nerves and heart.' Hyperglycemia usually doesn't cause symptoms until blood sugar (glucose) levels are high - above 180 to 200 milligrams per deciliter (mg/dL), or 10 to 11.1 millimoles per liter (mmol/L). 1. A comprehensive review of Resident #101's medical record revealed an initial admitted [DATE]. The resident's medical history included metabolic encephalopathy and diabetes. A comprehensive minimum data set (MDS) was not completed, as Resident #101 was admitted on [DATE], and discharged to acute care on 10/29/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident #101's discharge medication list from the hospital dated 10/28/24, was reviewed. The medication list contained a note indicating Resident #101 as having a recurrent trend of low Accu-Checks [blood sugars]. A review of the discharge medications revealed an order for insulin lispro 1-6 units to be injected subcutaneously four (4) times daily with meals and nightly. A second order was noted for insulin aspart sliding scale 0-14 units to be injected subcutaneously three times daily before meals. A third order was noted for insulin glargine 10 units to be injected subcutaneously nightly. Additional instructions on the medication list directed nursing staff to monitor Resident #101's blood glucose every two (2) hours for two (2) episodes and then every four (4) hours for two (2) episodes. A review of the medications transcribed to Resident #101's medical record revealed that as of 1/10/25,-date fixed neither the order for insulin lispro nor the order for insulin aspart were transcribed. An order was noted for insulin glargine 10 units to be injected subcutaneously at bedtime. A review of Resident #101's administration record for October 2024 revealed the insulin glargine injection was not administered the night Resident #101 was admitted to the facility. An indication on the administration record directed the reader to refer to progress notes. A subsequent review of the nursing progress notes revealed no documentation that indicated why the insulin glargine was not administered. Continued review of Resident #101's medical record revealed one (1) blood sugar assessment dated [DATE] at 5:42 p.m. The result was 290 milligrams per deciliter (mg/dL). There was no evidence that additional blood sugar monitoring was conducted at two (2) and four (4) hour intervals as directed by the hospital discharge instructions. A nursing progress note dated 10/28/24 at 5:30 p.m. indicated Resident #101 arrived at the facility in a wheelchair. The note described Resident #101 as being nonverbal at the time of admission but responded to yes or no questions appropriately. Additionally, the note identified Resident #101 as being a diabetic. A narrative in the progress note read, Doctor will look at insulin orders tomorrow when come as the orders from the Hospital are not clear. BS [blood sugar] 290 . The note did not indicate how facility staff planned to monitor and treat Resident #101's abnormal blood sugars until the insulin orders were reviewed by the medical provider. A nursing progress note dated 10/29/24, at 10:02 a.m. noted that at 8:30 a.m., Resident #101 was observed lying on the floor adjacent to their bed. The resident was assisted with dressing and then transferred to their wheelchair, being subsequently taken to the dining room. The progress note did not specify whether Resident #101's blood sugar levels were assessed or whether Resident #101 was evaluated for signs or symptoms of hypoglycemia or hyperglycemia. A progress note dated 10/29/24, at 10:09 a.m. documented Resident #101's disruptive behaviors in the dining room. Resident #101 engaged in combative actions, threw a bowl of oatmeal onto the table, and knocked orange juice out of the Certified Nurse Aide (CNA)'s hand when the CNA offered it to Resident #101. The note further described Resident #101's behavior as sitting near the nurse's station, where he/she began hollering and sliding out of the wheelchair. Resident #101 was subsequently provided with a peanut butter sandwich and orange juice, which appeared to have a calming effect on the resident temporarily. The progress note did not indicate whether Resident #101's blood sugar levels were assessed or whether Resident #101 exhibited any signs or symptoms of hypoglycemia or hyperglycemia at that time. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A progress note dated 10/29/24 at 1:09 p.m. indicated that the nurse practitioner was in the building and ordered depakote sprinkles 125 milligrams (mg) to be given by mouth every 12 hours for restlessness and agitation. The progress note failed to indicate whether Resident #101's insulin orders were reviewed by the nurse practitioner at the time of their visit. A progress note dated 10/29/24 at 3:58 p.m. by Licensed Practical Nurse LPN FF documented that the resident ate a total of two peanut butter and jelly sandwiches and a meat sandwich. Afterward, the resident was assisted to his/her room where the resident became combative. The note further described the resident's persistent hunger. The note indicated the resident's blood sugar at 12:00 p.m. was 389. The resident was assisted to the dining room where he/she ate a full meal and still wanted more. Resident #101 became upset when he/she was taken out of the dining room and started sliding himself/herself out of the wheelchair. The resident calmed down when given a piece of bread but continued to get upset after eating. The resident was then allowed to sit on the floor. Additional behaviors were described as kicking and hitting. The Administrator responded to the room and directed staff to send the resident to a psychiatric hospital. The note indicated the resident's blood sugar was 541 at 2:55 p.m. The NP was informed and an order was given for 20 units of insulin. However, the medical record did not contain evidence that the 20 units of insulin were administered. A Recapitulation of Stay Resident Discharge Summary dated 10/30/24 at 4:13 p.m. was reviewed. The summary was signed by the Director of Nursing and indicated Resident #101 was transferred to the hospital on 10/29/24 at 4:00 p.m. due to noncompliance with care along with verbal and physical aggression toward staff. The summary did not contain vital signs (to include blood glucose). On 1/10/25 at 5:01 p.m. an interview was conducted with the Administrator and the Director of Nursing (DON). Both the Administrator and DON recalled Resident #101 and the circumstances of his/her transfer to the hospital. The Administrator explained that the resident became verbally and physically aggressive with staff due to psych issues and thus was transferred to the hospital for that reason. When asked about whether facility staff were aware that the resident's blood glucose levels had gone unmonitored since shortly after admission, the DON stated, No, we sent [him/her] to the hospital for the behaviors. The DON explained he/she was not aware that Resident #101 was admitted to the facility with insulin and blood glucose monitoring orders that had not been carried out as ordered and subsequently discharged from the facility with a blood glucose level of 541 at last check. The DON acknowledged that the resident's symptoms of anger, excessive hunger, excessive thirst, and frequent urination were indicative of uncontrolled hyperglycemia but that this was not recognized or considered at the time of his/her hospital transfer. When asked how facility staff ensured physician's orders were accurately transcribed from the hospital discharge reconciliation, the DON explained that a checklist had been developed to facilitate the review of new admissions. However, when asked to produce the checklist for Resident #101's admission, the DON was unable to provide it. When asked what the expectation of a nurse would be in the event that a resident's blood glucose was continuously trending upward with orders for insulin, the DON stated the nurse would be expected to notify the medical provider immediately and acknowledged the notification had not occurred for Resident #101.

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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** 42070 Based on observations, interviews, and record review, the facility failed to ensure the environment was as free from accident hazards by failing to 1) Ensure residents smoked only in the areas designated by the facility's safety committee in accordance with the facility's policy; and 2) Supervise residents while they smoked in accordance with the facility's policy. This deficient practice affected two (2) of four (4) residents reviewed for accident hazards related to smoking from a total of 36 residents sampled (Resident #13 and Resident #20). The findings include: The facility's policy governing practices for residents who smoke was reviewed. The policy, titled Smoking by Residents contained a revision date of November 2023. The policy's purpose read, To respect resident choice to smoke and to maintain a safe healthy environment for both smokers and non-smokers. Section II of the policy read, The facility permits smoking only in the area(s) designated by the Facility's Safety Committee. Line X of the procedure read, All smoking sessions will be supervised by Facility Staff members. 1. A review of Resident #13's medical record revealed an initial admitted [DATE]. The resident's medical history included chronic obstructive pulmonary disease and hemiparesis affecting the resident's left side. A quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/20/24 revealed a brief interview for mental status (BIMS) score of 14 out of 15 possible points indicating the resident's cognition was not impaired. Resident #13 required supervision or touching assistance to walk distances greater than ten (10) feet. On 1/7/25 at 10:00 a.m., Resident #13 was observed smoking near the facility's front door. There were no staff supervising Resident #13 as he/she was smoking. Signs were observed on the columns of the facility's front awning which directed staff to smoke only in designated areas. On 1/7/25 at 3:25 p.m., Resident #13 was observed smoking immediately to the right of the facility's front door. There were no staff supervising Resident #13 as he/she smoked. On 1/8/25 at 1:30 p.m., Resident #13 was observed smoking near the facility's front door. There were no staff supervising Resident #13 as he/she smoked. On 1/8/25 at 1:50 p.m., an interview was conducted with Resident #13. When asked whether he/she had received directions about the facility's smoking procedures, Resident #13 explained that he/she had but that they don't ever take us on time, so I just go myself. Resident #13 went on to explain that, at some point in the past, he/she voiced concerns about facility staff not adhering to the established smoking times and that he/she was told just sign out and go out to the street. 2. A review of Resident #20's medical record revealed an initial admitted [DATE]. Resident #20's medical history included hemiparesis affecting the left side and tobacco use. An annual MDS assessment with an ARD of 10/16/24 revealed a BIMS score of 15 out of 15 possible points indicating the resident's cognition was not impaired. The assessment identified Resident #20 as currently using tobacco. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 9:55 a.m., Resident #20 was observed attempting to exit the facility through the front door. The receptionist stated, [Resident #20], you have to sign out before you go out there to smoke. Resident #20 proceeded to sign out using a binder that was in the facility's lobby before exiting onto the front walkway near the facility's entrance. At 10:00 a.m., Resident #20 was observed lighting and smoking a cigarette with Resident #13. There were no staff supervising Resident #13 or Resident #20 as they smoked. On 1/7/25 at 1:33 p.m., an interview was conducted with Resident #20 regarding the facility's practices for smoking. Resident #20 explained that facility staff were always late assisting residents to the designated smoking area. Resident #20 went on to explain that facility maintenance staff had not cleared the designated smoking area from a recent snowstorm and that residents were not able to use that area. On 1/7/25 at 1:45 p. m., an observation of the designated smoking area confirmed the patio area was covered with snow. A letter signed by the Administrator, dated 10/24/24, was posted near the patio door. The letter indicated that the only designated smoking area for residents was the rear outside patio. The letter added that no other area on this property may be used for resident smoking. In addition, resident smoking may only occur in this designated area under staff supervision. On 1/7/24 at 2:55 p.m., an interview was conducted with Licensed Practical Nurse (LPN) FF regarding the facility's practices for monitoring residents who smoked. LPN FF confirmed he/she was familiar with the care needs of both Resident #13 and Resident #20. LPN FF added that Resident #20 had some functional range of motion limitations in his/her upper extremities and would likely have difficulty extinguishing a cigarette if it fell into his/her lap. LPN FF also confirmed that both Resident #13 and Resident #20 should have staff supervision when smoking and that the designated smoking area was the facility's rear patio. When asked how he/she monitored residents' whereabouts to ensure smoking safety, LPN FF stated, You know, we try hard but there's only so many of us. On 1/10/25 at 5:01 p.m., an interview was conducted with the Administrator and the Director of Nursing (DON). During the interview, the Administrator and the DON were asked about the facility's practices for monitoring residents who smoked. The Administrator confirmed that the only designated smoking area was the facility's rear patio. Additionally, the Administrator confirmed that all residents required staff supervision while smoking. When asked how facility leadership ensured residents smoked only in the designated smoking areas, and received supervision in accordance with the facility's established policy, the Administrator shook his/her head No and did not elaborate.

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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** 45108 Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure that perineal care was provided in a manner to prevent urinary tract infection for one (1) of 36 residents sampled (Resident #82). The finding included: Review of the facility policy titled, Perineal Care revised 6/2020 revealed the procedures for performing Perineal care, as follows: .A. For female residents: i. Separate the labia. Wash with soapy washcloth/cleansing wipe, moving from front to back, on each side of the labia and in the center over the urethra and vaginal opening, using a clean washcloth/cleansing wipe for each stroke. ii. Rinse area, moving from front to back, using clean washcloth/cleansing wipe for each stroke. iii. Dry area moving from front to back, using a blotting motion with towel. 1. Resident #82 was admitted to the facility on [DATE] with diagnoses that included Ventricular Tachycardia, Overactive Bladder, Major Depressive Disorder and Chronic Pain Syndrome. Review of Resident #82's Admission Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) summary score of 14, which indicated the resident was cognitively intact. The MDS further revealed Resident #82's functional abilities were coded as the resident being dependent on staff for toileting hygiene and the resident was frequently incontinent for bladder and always incontinent for bowel. Review of Resident #82's Care Plan with a revision dated 1/3/25, documented that the resident had a behavior problem related to incontinence care and/or brief changes. Resident #82's Care Plan stated, . claims staff are not performing peri care correctly d/t [due to] her wanting to be wiped a specific way/direction/speed/order. In an observation on 1/9/25 at 3:33 p.m. of Resident #82's perineal care revealed Restorative Nursing Aide (RNA) AA, did not spread Resident #82's knees apart in a manner that allowed the resident to be cleaned properly. During an interview at this time, RNA AA stated that because the resident was contracted, she could not open the resident's legs. Certified Nurse Aide (CNA) BB was present during the resident's perineal care, and verbalized disagreeing with RNA AA. CNA BB stated that the RNA AA did not clean the resident properly and could have done better. In an interview with Resident #82 on 1/10/25 at 3:07 p.m., when asked about the perineal care that was provided to him/her by the RNA AA on 1/9/25, he/she stated that .He didn't change me right, and he didn't wipe me very good. He put the brief on me wrong. [sic]

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42070 Based on observations, interviews, and record review, facility staff failed to ensure residents fed by enteral means receive the appropriate treatment and services to maintain the resident's nutritional status by failing to monitor the resident's intake and administer supplemental tube feedings for meal intakes less than 50%. This deficient practice affected one (1) of two (2) residents reviewed for tube feeding from a total of 36 residents sampled. (Resident #73) The findings included: 1. A review of Resident #73's medical record revealed an initial admitted [DATE]. His/her medical history included dementia and presence of a gastrostomy tube. An admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/24 revealed a Brief Interview for Mental Status (BIMS) score of 02 from a total of 15 possible points indicating the resident's cognition was severely impaired. The assessment identified the presence of a feeding tube. On 1/8/25 at 1:44 p.m. Resident #73 was observed during the lunch meal sitting in his/her wheelchair at a table in the memory care dining room. Resident #73 was able to feed him/herself and ate approximately 25% of his/her lunch meal before facility staff took the meal tray for return to the kitchen. A preliminary review of Resident #73's physician's orders revealed an order dated 12/30/24 for Glucerna 1.5 240 milliliters (ml) per hour (hr) via feeding tube over a two hour period with 100 ml water flush before and after administration if he/she resident eats less than 50% of meals. Continued observation of Resident #73 through 1/8/25 3:00 p.m. revealed facility staff did not administer Glucerna 1.5 to Resident #73 in accordance with his/her physician's orders. A review of Resident #73's progress notes revealed a nutrition note dated 1/8/25 at 10:47 a.m. and authored by the Dietitian revealed recommendations to continue the PRN enteral feeding order. A review of the resident's administration records for January 2025 revealed no documented administration of PRN (as needed) Glucerna 1.5 on 1/8/25 in accordance with the Resident #73's physician orders. A review of the resident's care flow records for January 2025 revealed that the resident ate 0-25% of his/her lunch on 1/1/25 and 0-25% of his/her breakfast on 1/3/25. Additionally, Resident #73 ate 25-50% of his/her dinner on 1/2/25 and 25 to 50% of his/her lunch on 1/3/25. A review of the resident's administration records for January 2025 revealed no documented administration of PRN Glucerna on 1/2/25 or 1/3/25 in accordance with the Resident #73's physician's orders. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/25 at 4:57 p.m. an interview was conducted with the Director of Nursing (DON) regarding the facility's processes for monitoring Resident #73's meal intakes and administering PRN enteral feedings to supplement his/her nutritional needs. The DON explained that the assigned nursing staff were expected to make sure they check and see how much [he/she] eats and should be administering the Glucerna when it needs to be given.

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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. 42070 Based on interviews, and record review, facility leadership failed to maintain adequate nursing staffing, as established by the facility's leadership, to provide appropriate nursing care and services to meet the needs of residents. This deficient practice had the potential to affect all residents living in the facility. The findings included: 1. Due to the scope and severity deficient practice found during the survey, facility leadership was asked to produce daily staffing hours for the month of December 2024. A review of the facility's daily staffing hours revealed: - On 12/8/24, the facility's census was 95. Actual nursing staff hours worked was 2.68 PPD. - On 12/9/24, the facility's census was 95. Actual nursing staff hours worked was 2.57 PPD. - On 12/10/24, the facility's census was 95. Actual nursing staff hours worked was 2.54 PPD. - On 12/11/24, the facility's census was 96. Actual nursing staff hours worked was 2.72 PPD. - On 12/12/24, the facility's census was 96. Actual nursing staff hours worked was 2.70 PPD. - On 12/13/24, the facility's census was 92. Actual nursing staff hours worked was 2.56 PPD. - On 12/14/24, the facility's census was 95. Actual nursing staff hours worked was 2.42 PPD. - On 12/15/24, the facility's census was 95. Actual nursing staff hours worked was 2.30 PPD. - On 12/16/24, the facility's census was 95. Actual nursing staff hours worked was 2.59 PPD. - On 12/17/24, the facility's census was 96. Actual nursing staff hours worked was 2.48 PPD. - On 12/18/24, the facility's census was 95. Actual nursing staff hours worked was 2.61 PPD. - On 12/19/24, the facility's census was 97. Actual nursing staff hours worked was 2.34 PPD. - On 12/21/24, the facility's census was 99. Actual nursing staff hours worked was 2.03 PPD. - On 12/22/24, the facility's census was 99. Actual nursing staff hours worked was 2.23 PPD. - On 12/23/24, the facility's census was 99. Actual nursing staff hours worked was 2.22 PPD. - On 12/24/24, the facility's census was 97. Actual nursing staff hours worked was 2.25 PPD. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- On 12/25/24, the facility's census was 98. Actual nursing staff hours worked was 2.34 PPD. - On 12/26/24, the facility's census was 100. Actual nursing staff hours worked was 2.19 PPD. - On 12/27/24, the facility's census was 101. Actual nursing staff hours worked was 2.40 PPD. - On 12/28/24, the facility's census was 101. Actual nursing staff hours worked was 2.23 PPD. - On 12/29/24, the facility's census was 101. Actual nursing staff hours worked was 2.24 PPD. - On 12/30/24, the facility's census was 101. Actual nursing staff hours worked was 2.13 PPD. - On 12/31/24, the facility's census was 99. Actual nursing staff hours worked was 2.38 PPD. During an interview with the Administrator and Director of Nursing (DON) on 1/10/25 at 5:10 p.m. the Administrator was asked whether the facility had established a minimum nursing staffing level to ensure residents received necessary care and services. The Administrator explained that the minimum nurse staffing expectation to meet the needs of residents was 2.8 nursing staff hours per patient per day (PPD) and acknowledged that the facility was routinely failing to meet that established benchmark. 45108

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 20005 Based on observation and interview, it was determined the facility failed to ensure the pureed diets were followed according to the menu. This failed practice affected two (2) residents with pureed diets out of 93 residents who received meals from the kitchen. The findings include: Review of the facility policy, Therapeutic Diets, with a revision date of 12/2020, documented under Purpose,- To ensure that the Facility provides therapeutic diets to residents that meet nutritional guidelines and physicians' orders. The policy listed under Procedure, - IV. The Nutrition Services Manager and Dietitian will observe meal preparation and serving to ensure that: A. Each food item, served separately in the regular diet, is pureed and served separately for a pureed diet per the menu spreadsheet and pureed diets. 1. Review of the noon menu, dated 1/9/25, revealed residents with pureed diets were supposed to receive pureed BBQ meatballs, mashed potato and gravy, pureed buttered peas, pureed brownie, and pureed buttered white bread with a beverage. Observation of the preparation of the noon meal at 12:00 p.m., on 1/9/2025 revealed the following: The [NAME] prepared the meat in the robocoupe, sanitized the robocoupe, then pureed the peas. The mashed potatoes were already prepared. The [NAME] was not observed to puree bread. During the tray line meal service, Which started at approximately 12:30 p.m., it was observed that the two pureed trays received pureed meat, peas and mashed potatoes. The pureed trays also had pureed dessert. Puree bread was not served to them. On 1/9/25 at 1:45 p.m., in an interview with the Food Services Manager, she acknowledged that the two residents who received pureed diets were to include the bread and that the menu was not followed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20005 Based on resident interviews, a resident council meeting, observations, and an observation of a test tray meal evaluation, the facility failed to provide palatable foods per resident preferences for taste and temperature as evidenced by improper temperatures. This deficient practice had the potential to affect residents residing on four (4) out of five (5) units eating meals from the kitchen. The findings include: 1. During the initial tour of the facility on 1/7/25 at approximately 10:00 a.m., through 1:00 p.m., the following residents verbalized a concern with the quality of the food and food temperatures: Resident #12 was admitted to the facility on [DATE] with diagnoses including anemia, hemiplegia and heart failure. The most recent Minimum Data Set (MDS), dated [DATE], Revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #12 stated at 10:30 a.m., that the food was usually cold. She /he didn't think it was dietary's fault. The resident said that the trays sat in the hallway for too long due to the facility being short staffed. Resident #58 was admitted to the facility on [DATE] with a diagnosis that included diabetes. The most recent MDS, dated [DATE] coded the resident as having a BIMS score of 15, indicating the resident's cognition was intact. 2. Resident #58 stated at 10:50 a.m., that the food was usually cold to lukewarm, and the meals came out later than the posted times. The resident usually skipped breakfast and ate lunch and dinner in the dining room. Often times, he /she stated they ordered out due to not liking the food. 3. Resident #78 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder, hypertension, and hyperlipidemia. The most recent MDS, dated [DATE], coded the resident as having a BIMS score of 15, indicating intact cognition. Resident #78 stated at 11:10 a.m., that oftentimes the food was cold, and the trays were late. The resident said that any day of the week the dinner was served at 7:00 p.m. He/she stated that sometimes when the kitchen was short staffed, they used plastic, and the food was usually cold. 4. Resident #82 was admitted to the facility on [DATE] with diagnoses including ventricular tachycardia, unspecified severe protein calorie malnutrition, major depressive disorder, recurrent, chronic pain syndrome, hypotension, and gastro esophageal reflux. The most recent MDS, dated [DATE], coded the resident as having a BIMS score of 14, indicating intact cognition. On 1/7/25 at 12:49 pm, Resident #82 stated. Food is horrible, it is nasty, served cold. They don't know how to cook here. 5. Residents made the following comments regarding the food on 1/8/25: (continued on next page)

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	265693	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center of Independence, The	1800 S Swope Drive Independence, MO 64057

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #37 was admitted to the facility on [DATE] with a diagnosis of multiple sclerosis. The most recent MDS, dated [DATE], coded the resident as having a BIMS score of 14, indicating the resident's cognition was intact. Resident #37 stated at 1:15 p.m., that he didn't care for the food. It's often late and cold. 6. A review of Resident #63's medical record revealed an initial admitted [DATE]. Resident #63's medical history included chronic obstructive pulmonary disease and chronic kidney disease. A quarterly MDS assessment with an assessment reference date (ARD) of 10/10/24 revealed a BIMS score of 14 out of 15 possible points, which indicated that Resident #63's cognition was not impaired. On 1/8/25 at 11:33 a.m. an initial interview was conducted with Resident #63 regarding the care and services he received in the facility. When asked about nutrition and food, Resident #63 described most meals as just not good. When asked to expand on his food concerns, Resident #63 explained that food temperatures were always cold and that the food tastes like slop. When asked whether he voiced his food concerns to facility staff, Resident #63 stated, I think we all have. It don't get any better. 7. Resident #88 was admitted to the facility on [DATE] with diagnoses including renal failure, diabetes, and hypertension. The most recent MDS, dated [DATE], coded the resident as having a BIMS score of 14, indicating intact cognition. Resident #88 stated at 10:00 a.m. that the food was always late and cold. The resident said that facility staff want the residents to go to the dining room for breakfast at 7:00 a.m., and they don't serve the food until 8:30 a.m. Resident #88 stated at 12:49 p.m., Food is usually late and cold. Residents made the following comments regarding the food on 1/9/25: Resident #58 stated at 11:00 a.m., that the coffee was cold again, but the breakfast was better than normal. On 1/10/25, Resident #88 was observed in the dining room at 8:00 a.m., he /she stated the posted time for breakfast was 7:30 a.m. and that the trays had not come out yet. 8. Review of the Resident Council Meeting Minutes revealed the following: 8/8/24- Dietary: Hamburgers were very dry being cooked for too long. Ran out of milk several times this month. Staff served tacos without salsa, no sour cream. Staff served brown gravy with biscuits and the gravy was horrible. Resident would like dietary to order chicken noodle soup. Residents would like to have salt and pepper shakers at the table. 9/4/24- New Business- CNAs are not asking the residents what they want to eat, the CNA's are just filling out the meal tickets. Dietary: Still running out of milk and yogurt. Still no sour cream. Still no salt and pepper. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dietary Response: Yogurt is going by fast because everyone eats it and nursing comes and asks for it for meds. Can only order so much due to budget. Salt and pepper shakers waiting for them to get added to my order guide. 10/2/2024- New Business: Meals are late daily. 11/6/2024-New Business- Meals are late daily. 12/4/2024- New Business: Lunch and dinner are still always late. Dietary: Too much fruit cocktail, meals always late. Dietary keeps running out of sugar, ketchup, cream, sweetener. French fries always cold. Resident do not like the turkey bacon. Residents' plates come and have no silverware. Dietary Response: Explained a few condiments weren't ordered due to the budget, explained that fries are difficult to keep hot once they leave the kitchen but will try harder. Ordered regular and turkey bacon, when we run out of regular bacon, we utilize turkey bacon. On 1/10/2025 at 2:00 p.m., during a Resident Council meeting, the residents stated they were still getting late meals, and the dietary department was still running out of condiments. The always available menu that included daily substitutes, wasn't always available. They don't always get silverware with their meals. They stated that they don't always get juice with their breakfast, and their food preferences don't always get honored. They used to get chocolate milk all the time and now they don't. The food temperatures were still a concern for them. There were five months of food complaints in the Resident Council Meeting Minutes and the residents were still complaining about the food on 1/10/25. 9. An observation of the breakfast meal dining service occurred on 1/10/25 at 7:00 a.m. A test tray was requested to be sent out on the last food cart for the 500 hall. The test tray left the kitchen at approximately 9:28 a.m. The food trays were served on open carts with plastic covering. The test tray temperatures were as follows: Eggs - 93 degrees ( ) Fahrenheit (F); meat - 93 F; hot cereal 129 F; and milk - 44.7 F. The Food Service Supervisor was present, and she stated the food was too cold and that it sat in the hallway for too long. On 1/10/25 at 6:00 p.m., in an interview with the Administrator, he /she acknowledged that the food complaints were a concern. 42070

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. 37927 Based on interviews, credential review and review of facility policy, the facility failed to employ a qualified social worker as mandated for facilities with greater than 120 beds. This failure affected 96 of 96 residents at the facility. The findings include: 1. Review of the provided Job Description for position 7001 Social Worker, Revised December 2023, revealed License Qualification: LSW, LCSW or LMSW [Licensed Social Worker, Licensed Clinical Social Worker or Licensed Master of Social Work]: Qualifications * Certified, licensed, or registered in the state of practice, required. * Bachelor's Degree in Social Work or a bachelor's degree in Human Services field including but not limited to Sociology, Special Education, Rehabilitation Counseling and Psychology from an accredited school of social work, required. * One year of supervised social work experience in a healthcare setting working directly with geriatric individuals. Review of credentials for the Social Worker (SW) revealed that he/she held a Bachelor of Arts in Human Services. The SW was not a licensed by state as required in the Qualifications listed on the job description provided by the facility. In an interview on 1/10/25 at 7:50 a.m. the SW confirmed they did not have a license and also confirmed not having the required year of supervision.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 37927 Based on interviews and record review, the facility was unable to provide documentation of regular Quality Assurance Performance Improvement Plan (QAPI) meetings and evidence of participation by the required parties. This affected all facility residents. The findings include: During an interview on 1/10/25 at 12:20 p.m., the Administrator reported the committee's plan was to meet monthly, but he/she could not locate all the verification of attendance for the QAPI meetings held since the last survey in June of 2023. The Administrator provided QAPI verification of attendance records, and a documentation review was completed for meetings held June 2024, August 2024, September 2024, and October 2024. There was no additional evidence of required meetings, and no additional documentation regarding those in attendance at the required meetings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42070 Based on observation, interview, record review and review of the facility policy, the facility failed to ensure that residents received wound care in a manner to prevent infections for two (2) of two (2) residents observed for wound care (Resident #26 and Resident #82), and 2) Failed to implement Enhanced Barrier Precautions as indicated by the resident's plan of care for one (1) of three (3) residents reviewed from a total of 36 residents sampled. The findings included: 1. Review of the facility's policy titled, Hand Hygiene revised 6/2020, revealed the purpose of the policy was to ensure that all individuals used the appropriate hand hygiene while in the facility. The hand hygiene policy did not address when to wash hands or don gloves prior to providing care. Review of the facility's policy titled, Dressing-Application and Technique revised 6/2020, revealed, .C. Wash hands before and after each procedure, and put on gloves. Resident # 82 was admitted to the facility on [DATE] with diagnoses that included Ventricular Tachycardia, Overactive Bladder, Major Depressive Disorder and Chronic Pain Syndrome. Review of Resident #82's Admission MDS dated [DATE] revealed the resident had a BIMS summary score of 14, indicating intact cognition. The MDS further revealed Resident #82's was coded for having a stage three (3) pressure injury. During the observation on 1/9/25 at 11:09 a.m. the Licensed Vocational Nurse Treatment Nurse (LVN) AA did not perform hand hygiene before donning gloves and subsequently touched the curtain and Resident #82's bedside table prior to starting the wound care for the resident. 2. Resident #26 was admitted to the facility on [DATE] with diagnoses that included Acute Transverse Myelitis in Demyelinating Disease of Central Nervous System, Complete Traumatic Amputation at level between left hip and knee, Paraplegia. Review of Resident #26's Significant Change Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) summary score of 10, indicating the resident was moderately cognitively impaired. The MDS further revealed Resident #26's was coded to have a stage four (4) pressure injury. During the observation on 1/9/25 at 12:06 p.m., the Licensed Vocational Nurse Treatment Nurse (LVN) AA did not perform hand hygiene before donning gloves and subsequently touched the curtain and Resident #26's bedside table prior to starting the wound care for the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the facility policy, Standard and Enhanced Precautions, implemented 4/1/24, documented under Purpose: To ensure the use of appropriate personal protective equipment to improve infection control as required in the care of residents . V. Enhanced Barrier Precautions [EBP] - A. EBP should be used for any residents who meet the above criteria, wherever they reside in the facility. B. For residents of whom EBP are indicated, EBP should be used when performing the following high-contact resident care activities: 1. Dressing; 2. Bathing/showering; 3. Transferring; 4. Providing hygiene; 5. Changing linens; 6. Changing briefs or assisting with toileting; 7. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator; [and] 8. Wound care: any skin opening requiring a dressing. C. EBP are intended to be in place for the duration of a residents stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at high risk. Resident #37 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis and chronic kidney disease. The resident had a pressure injury on their sacral area and had a suprapubic catheter in place. The most recent Minimum Data Set (MDS) assessment dated [DATE] revealed that there was a Brief Interview for Mental Status (BIMS) which coded the resident as a 14, indicating the resident ' s cognition was intact. Review of the Care Plan, initiated 11/7/24, documented as a focus area that the resident was on Enhanced Barrier Precautions due to wounds and catheter care. The goal listed was to reduce the transmission of pathogens. The intervention listed was for staff members to wear a clean gown and gloves while performing high contact resident care activities to include Dressing, Bathing/Showering, transferring, providing hygiene, changing linens, changing briefs or toileting assistance, and/or caring for indwelling medical devices like central lines, catheters, feeding tubes, tracheostomy/ventilator. Observations of Resident #37 revealed the following: 1/7/25 at 11:30 a.m. - Observed resident in room: there was no signage outside the door that indicated precautions were in place and there was no PPE [personal protection equipment] inside or outside the room. There was a hazardous waste container inside the room. 1/8/25 at 10:15 a.m. - Observed resident inside their room, no signage posted for enhanced barrier precautions. PPE was not available. 1/9/25 at 9:30 a.m. - no signage posted outside or inside the room for enhanced barrier precautions. Observations on 1/8/25 at 10:15 a.m. of Resident #37 ' s room revealed that there was no signage outside the resident ' s room indicating the resident was on enhance barrier precautions. There was no PPE outside or inside the resident ' s room for staff to use. There was a box in the room marked hazardous waste, but no PPE could be found. This was observed on all days of the survey. On 1/10 /25 at approximately 5:15 p.m., in an interview with the Director of Nursing (DON), she /he acknowledged that the resident should be on enhanced barrier precautions, and acknowledged a sign should have been posted to let the staff know. The DON stated they would service the staff on the correct precautions for Resident #37. 45108