STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265765	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Nursing Home	202 South West Street Concordia, MO 64020

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to conduct quarterly Criminal Background Checks for eight out of 10 sampled employees (Employees AA, BB, CC, DD, EE, FF, GG and HH). The facility census was 70 residents. Review of the facility Background Screening Investigations policy dated 8/23/24 showed: -The Employee Disqualifications List (EDL) is maintained through the Department of Health and Senior Services (DHSS).-The EDL is checked prior to date of hire and quarterly thereafter.1. Review of Employee AA's personnel record showed:-His/her hire date was 1/13/25.-His/her EDL check date was 1/13/25.-His/her quarterly EDL checks were due in April 2025 and July 2025 and were not completed.2. Review of Employee BB's personnel record showed:-His/her hire date was 2/17/25.-His/her EDL check date was 2/12/25.-His/her quarterly EDL check was due in May 2025 and was not completed.3. Review of Employee CC's personnel record showed:-His/her hire date was 3/31/25.-His/her EDL check date was 3/27/25.-His/her quarterly EDL check was due in June 2025 and was not completed.4. Review of Employee DD's personnel record showed:-His/her hire date was 9/30/24.-His/her EDL check date was 9/27/24.-His/her quarterly EDL checks were due in December 2024, March 2025 and June 2025 and were not completed.5. Review of Employee EE's personnel record showed:-His/her hire date was 8/19/24.-His/her EDL check date was 8/9/24.-His/her quarterly EDL checks were due in November 2024, February 2025 and May 2025 were not completed.6. Review of Employee FF's personnel record showed:-His/her hire date was 2/3/25.-His/her EDL check date was 1/30/25.-His/her quarterly EDL checks were due in April 2025 and July 2025 and were not completed. 7. Review of Employee GG's personnel record showed:-His/her hire date was 8/5/24.-His/her EDL check date was 8/2/24.-His/her quarterly EDL checks were due in November 2024, February 2025 and May 2025 and were not completed8. Review of Employee HH's personnel record showed:-His/her hire date was 11/21/24.-His/her EDL check date was 11/22/24.-His/her quarterly EDL checks were due in February 2025 and May 2025 and were not completed.9. During an interview on 7/31/25 at 2:20 P.M. the Human Resources (HR)/ Business Office Manager (BOM) said:-He/she did not have any employee records of quarterly EDL checks.-The only time the facility did EDL checks was at the time the employee was hired.10. During an interview on 8/1/25 at 11:35 A.M. the Administrator said:-EDL checks were to be done upon hire and quarterly.-The BOM was responsible for completing EDL checks both upon hire and quarterly.-No one had been monitoring to ensure that quarterly EDL checks were completed.

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

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

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F 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** Based on interview and record review, the facility failed to ensure one sampled resident's (Resident #9) urine sample was picked up by the laboratory according to acceptable standards of practice and failed to ensure effective coordination with the lab, thereby delaying necessary treatment, out of 18 sampled residents. The facility census was 70 residents.Review of the facility's Urinary Tract Infection/Bacteriuria - Clinical Protocol procedure, revised April, 2018, showed:-The physician and staff will identify individuals with a history of symptomatic Urinary Tract Infection (UTI - an infection of one or more structures in the urinary system), those with risk factors for UTI, and those with possible signs and symptoms of a UTI.-The physician will help nursing staff interpret any signs, symptoms, and lab tests and will order appropriate treatment for verified or suspected UTIs and/or urosepsis based on pertinent assessment.Review of the American Society of Microbiology (ASM) website showed:-Once a urine sample has been collected it must be transported to the laboratory.-Urine samples should be plated (transferring a measured amount of urine onto [NAME] plates to cultivate and identify microorganisms that may be causing a UTI) within two hours of collection. Boric acid or refrigeration can extend the time between collection and plating to 24 hours.-Plates are typically incubated at 35 - 37 degrees Celsius for 24 to 48 hours.-It usually takes a day for bacteria from a urine sample to grow to a sufficient quantity they can be detected and identified using standard clinical microbiology lab techniques. If the urine from a person with UTI symptoms confirms a likely UTI, a doctor can start antibacterial treatment based on the most likely causative organisms while waiting for the culture results to tailor therapy.1. Review of Resident #9's admission Record showed the resident was admitted to the facility on [DATE] with diagnoses that included a UTI.Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 6/12/25, showed the resident:-Did not have a urinary catheter (device to drain urine from the bladder).-Was cognitively intact.-Was frequently incontinent of urine.-Had no UTI within the past 30 days.Review of the resident's nursing note, dated 7/17/25 at 3:16 P.M., showed:-The resident complained of burning while urinating. -An order was received to obtain a urinalysis (UA) with culture and sensitivity (a two-part laboratory test used to diagnose and guide treatment for UTI) for signs and symptoms of UTI per physician.-The lab order was entered into resident's record and in laboratory.Review of the resident's Nurse Practitioner (NP) note, dated 7/22/25 showed:-The resident reported dysuria (discomfort, pain, or burning while urinating).-Order for a UA to see if resident has a UTI and would wait for results. -Would order antibiotic therapy (ABT) if indicated. The resident verbalized understanding.-The physician was notified and aware. -The physician expressed concerns that that UA was collected on 7/17/25 and there were still no results.Review of the resident's nursing notes dated 7/24/25 showed:-At 1:36 P.M. the nurse followed up with the lab for the UA that was collected on 7/23/25. The person gave the number for the representative in the area because the lab was not found. The order had been placed for the lab. The urine was collected and in the hazardous refrigerator on 7/23/25 and was not in the refrigerator on 7/24/25. Phone number for the representative was given to the Director of Nursing (DON).-At 2:09 P.M. the nurse attempted unsuccessfully three times to reach the representative. He/She contacted the laboratory direct number and the specific location of the urine within the company could not be determined.Review of the resident's Urine Culture (laboratory test to detect and identify bacteria or other organisms in a urine sample) Partial Report, dated 7/25/25 showed:-Urine was collected on 7/23/25.-White blood cell counts in urine were abnormally high.-Microbiology tests to follow in a separate report.-No specific organism was identified as being abnormally numerous on the partial report.Review of the resident's nursing notes dated 7/25/25 showed:-At 10:13 A.M. urine was picked up this morning in route to the lab.-At 2:36 P.M. an order for Macrobid oral capsule 100 milligram (mg). Give one capsule (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by mouth two times daily for UTI for five days.-At 2:38 P.M. an order for Pyridium oral tablet 100 mg by mouth every 12 hours as needed for UTI for three days.Review of the resident's Order Summary Report (OSR) and Medication Administration Record (MAR) dated July 2025 showed the resident started on Macrobid 100 mg on 7/26/25.Review of the resident's nursing note dated 7/27/25 at 11:43 A.M. showed the resident started on ABT on 7/26/25 and had not wanted Pyridium for discomfort.Review of the resident's NP note, dated 7/29/25 showed:-The resident started on Macrobid 100 mg by mouth for five days on 7/26/25.-The resident reported feeling much better since he/she started the ABT.Review of the resident's Urine Culture Final Report, dated 7/29/25, showed:-The specimen was collected 7/23/25.-Results showed Proteus Mirabilis (a common cause of bacterial infection) of over 100,000 colony forming units (CFU)/ml (indicative of a significant UTI).During an interview on 7/28/25 at 12:15 P.M. the resident said:-He/She was finally being treated for a UTI.-It took a week and a half to start treatment for a UTI because nobody knew what happened with the first two urine samples. -Staff ended up taking three different urine samples. During an interview on 7/30/25 at 11:10 A.M. the resident said:-He/She was still taking an antibiotic but didn't know the name of the medication.-He/She felt much better after starting the treatment and had been very weak with the UTI.During an interview on 7/31/25 at 2:08 P.M. Certified Nurse Assistant (CNA) C said:-The resident first complained about pain during urination a couple of weeks ago. -He/She reported the complaint to the nurse at the time.-The resident complained of urinary pain three or four times since then and he/she always reported it to whoever the nurse was at the time, which was the facility protocol for CNAs. During an interview on 7/31/25 at 2:33 P.M. Licensed Practical Nurse (LPN) C said: -The resident first started complaining of pain during urination on 7/17/25. The resident's family was in the room when he/she reported it. The resident was lying in bed and said his/her back and tummy also hurt. -Two or three hours later around supper time the resident said he/she felt better and his/her back pain had stopped. -The CNAs also reported the resident said he/she felt better. -A UA was ordered on 7/17/25 when the resident first complained of pain while urinating and the lab was notified. -On 7/17/25 he/she placed the urine in the refrigerator and filled out a label for the urine sample cup. -The resident asked him/her about lab results on 7/22/25.-He/She found the same urine sample with the same label in the refrigerator on 7/22/25, so it apparently never got picked up. -The urine should have been picked up the early morning hours of 7/18/25.-Urine should be collected and placed in the refrigerator and picked up in time for the culture to be started within 24 hours.-The urine culture was reordered that same day. -The resident wasn't able to produce a urine sample into a urine hat (a container designed to fit on a toilet seat used to collect urine samples) before 6:00 P.M. on 7/22/25 so it was collected on the following shift and got picked up by the lab in the early morning hours of 7/23/25. The urine was gone when he/she returned to work at 6:00 A.M. on 7/23/25, but there were no results from the lab by 7/24/25 so he/she called the lab on 7/24/25 to follow up. He/She was told the lab order was not found. -The DON followed up with another order. -The resident's urine was collected again the evening of 7/24/25. -He/She worked only three days a week but read a nursing note that showed the urine was picked up on 7/25/25. -The resident had started ABT when he/she returned to work on 7/29/25. During an interview on 8/1/25 at 9:03 A.M. LPN B said:-He/She worked three days a week, with days off varying.-He/She and LPN C were the main nurses working the resident's side of the facility.-The resident was good about telling staff when something was bothering him/her.-From nurses' notes he/she could see the resident complained of a burning sensation when urinating and that a urine sample was collected on 7/17/25. He/She didn't know when it was picked up.-A note on 7/23/25 showed the lab lost the urine. The nurse was given the lab representative's contact information.-Sometime towards the beginning of last week, maybe around 7/25/25, a CNA reported the resident complained of burning while urinating.-Nursing notes showed another urine sample was picked up the morning of 7/25/25. All he/she needed to do was wait for the urine results.-The resident started on an antibiotic on 7/26/25.-He/She didn't think the nine-day wait from the time the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urine was first collected to the resident eventually starting ABT on 7/26/25 was standard of practice. The longest they should have to wait was 72 hours to give time for the urine to be picked up and for the culture to grow. The resident should be able to get any needed antibiotic once the lab results were back. -The lab courier came daily Monday through Friday and didn't come on the weekends. -Management informed nurses that the lab specimens wouldn't be picked up on the weekend. -Nurses could do STAT (quick turn-around time) orders but the lab courier wouldn't come on the weekend. If nurses put in an order one day the lab courier would come early the next morning except for Saturday and Sundays.-He/She thought lab specimens should be picked up seven days a week. There shouldn't be more than 24 hours between collecting the sample and the lab picking it up for testing.During an interview on 8/1/25 at 10:05 A.M. CNA A said:-The resident complained about a week and a half ago to multiple CNAs that he/she was urinating more frequently and felt urgency to urinate and that he/she wasn't feeling good and felt weak. Several days ago, the resident said he/she wasn't going to make it through the night because of the symptoms. -He/She reported it to the nurse along with another CNA that the resident had complained. The resident complained several times throughout the day and he/she and the other CNA told LPN C each time. -LPN C told him/her and the other CNA to collect the resident's urine in a urine hat while the resident sat on the toilet. -They couldn't get a sample that day before they left at 6:00 P.M. The nurse told the oncoming nurse and he/she and the other CNA told the oncoming CNA for the next shift to keep trying to get a UA sample.-He/She heard there was an issue where the lab didn't pick the sample up or they lost it and they had to get another one. -He/She heard nursing talking about the sample having been in the refrigerator too long and they had to get another sample.During an interview on 8/1/25 at 11:20 A.M. the DON said:-The facility got three urine samples from the resident.-He/She thought the lab had deleted the resident's order completely the first time. -The second time they picked it up, but the lab couldn't find the results. The nurse made sure it got picked up then. -He/She ordered the lab for a third time STAT and was told it would be picked up the same day. -The urine sample should have been picked up the first time it was ordered, and results should have been available within 3 days and an antibiotic started.-The lab didn't pick up specimens on Saturday or Sunday mornings or normally do STAT orders. -A weak or more was too long of a turnaround. -Once urine was picked up the facility should have results within 72 hours and antibiotics should be started within 3 or 4 days. -Another option was to send the resident to the emergency room on the weekends.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #12) received timely vision services out of 18 sampled residents. The facility census was 70 residents. Review of the facility's policy titled Visually Impaired Resident, Care of dated March 2021 showed:-Assistive devices to maintain vision included glasses, contact lenses, magnifying lens, and any other device used by the resident to assist with visual impairment.-It was not required of the facility to provide devices to assist with vision, but it was their responsibility to assist the resident and representatives in locating available resources, scheduling appointments, and arranging transportation to obtain needed services.-Residents who have lost or damaged their devices would be assisted in obtaining services to replace the devices.1. Review of Resident #12's admission Record showed he/she was admitted to the facility on [DATE] with a diagnosis of End Stage Renal Disease (ESRD- a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis (a medical procedure that filters and cleanses the blood).Review of the resident's Not Seen Visit Report dated 4/14/25 showed:-The resident was supposed to be seen by an eye doctor.-The resident was out of the facility at the time of the visit.-Note: This date aligned with a day that the resident would have been at dialysis.Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 5/15/25 showed:-The resident was cognitively intact.-The resident used corrective lenses.Review of the resident's care plan dated 7/3/25 showed no care plan related to the resident's vision needs.During an interview on 7/29/25 at 10:44 A.M. the resident said:-He/She was missing his/her glasses.-He/She had not seen an eye doctor recently.-He/She had poor vision without his/her glasses.-He/She utilized reading glasses at that point in time because they were better than not having glasses at all.Observation on 7/29/25 at 10:44 A.M. of the resident's room showed the resident only had a pair of reading glasses at his/her bedside.During an interview on 7/30/25 at 12:32 A.M. the Social Services Designee (SSD) said:-The resident had not complained to him/her about missing glasses.-The Business Office Manager (BOM) was the person who set up vision services at the facility.-He/She was unaware that the resident was not seen by the eye doctor when they last came to the facility.During an interview on 7/30/25 at 1:24 P.M. the BOM said:-He/She was not aware that the resident was not seen by the eye doctor when they were last at the facility.-The resident was most likely at dialysis when the eye doctor came to the facility.-There was not an eye appointment that had been scheduled after the resident missed seeing the eye doctor due to being at dialysis.-The eye doctor came to the facility quarterly.-The facility did not choose the dates in which the eye doctor came to the facility.-There were always residents who missed their quarterly appointments due to being out of the facility when providers came to the facility.-He/She was unaware the resident was missing his/her glasses.-If an emergency were to arise in which any resident needed to be seen by an eye doctor, then an appointment could be set up outside of the quarterly visits.-He/She was unsure what exactly counted as a vision emergency, or if it included missing glasses.During an interview on 8/1/25 at 9:15 A.M. Certified Nursing Assistant (CNA) A said:-The SSD was responsible for setting up eye appointments.-The resident would not have had to ask to be seen by the eye doctor because the resident would have been seen by the eye doctor that came to the facility.-When the eye doctor came to the facility to see residents, management would give the nurses and CNAs a list of residents to be seen.-The CNAs and nurses were responsible for ensuring that the residents were ready and taken to wherever the provider had set up at the facility to be seen -If a resident was not at the facility when the provider came to the facility the CNAs were responsible for reporting that to the charge nurse.-The resident usually came back from dialysis around lunch time.-The providers that come to the building were usually at the facility all day, so he/she was unsure why the resident would not have been (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seen.-He/She was unaware that the resident had not seen the eye doctor when they last came to the facility.-The resident wore glasses.-He/She was unaware that the resident was missing his/her glasses.-He/She thought the resident's reading glasses were the resident's normal pair of glasses.-The resident had not complained to him/her about missing glasses.-He/She was unsure if there was a specific facility policy or procedure related to missed quarterly appointments.-Care plans should be up to date and reflect the resident's current status to include vision needs.During an interview on 8/1/25 at 9:39 A.M. Licensed Practical Nurse (LPN) A said:-The SSD was responsible for setting up eye appointments.-The SSD would go around and ask residents if they wanted to be seen by the eye doctor.-When the eye doctor came to the facility, the SSD or BOM would give the list of residents to be seen by the provider.-The nurses were responsible for ensuring that the listed residents were ready and taken to wherever the provider had set up in the facility.-If the resident was at dialysis when the eye doctor came to the facility, then the facility could ask the doctor to stay until the resident returned or set up a different appointment for the resident.-He/She was not aware that the resident had missed his/her eye doctor appointment.-He/She was unaware that the resident used prescription lenses.-The resident had never asked him/her to be seen by the eye doctor.-He/She was unaware that the resident was missing his/her glasses.-Care plans should be up to date and reflect the resident's current status to include vision needs.During an interview on 8/1/25 at 9:55 A.M. the Assistant Director of Nursing (ADON) said:-The SSD was responsible for setting up eye doctor appointments.-For residents who qualified, there was an eye doctor that came to the facility to see the residents.-Residents needed to ask if they wanted to be seen by the eye doctor.-A list of the residents that were to be seen was sent to the facility and the date of when the provider would be at the facility was sent ahead of time.-The nurses and CNAs were responsible for ensuring that the residents were ready and taken to wherever the provider set up in the facility.-If a resident was not at the facility when the eye doctor came to the building, then they would be seen the next time the eye doctor came.-He/She thought a family member had provided the resident with a different pair of glasses.-If the resident was out of the facility due to being at dialysis when the eye doctor came to the facility, then the facility would need to set up an appointment with an outside source.-The facility could have tried to find out who the resident saw in the past and set up an appointment at that practice.-The resident should have seen an eye doctor by that point in time.-Care plans should be up to date and reflect the resident's current status to include vision needs.During an interview on 8/1/25 at 11:19 A.M. the Director of Nursing (DON) said:-The BOM set up the vision services at the facility.-The BOM would assist the resident in putting them on the correct insurance to be able to be seen by the eye doctor that came to the building.-Once the resident was on the correct insurance, they could be placed on the list to be seen by the eye doctor when they next came to the facility.-The facility was given a list of the residents that were to be seen by the eye doctor and that list was given to each nursing station.-The nurses would then be responsible for ensuring that the residents were ready and taken to where the provider had set up in the facility.-Missing glasses would count as something emergent if the resident depended on them to see.-He/She was unsure what would need to be done for the resident if they could not see the eye doctor on the day that they came to the facility.-He/She thought the resident's glasses were taken home by a family member due to being broken prior to the DON working for the facility.-Care plans should be up to date and reflect the resident's current status to include vision needs.-He/She was unsure of when the resident last saw an eye doctor.

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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. Based on observations, interview, and record review, the facility failed to ensure appropriate care for one sampled resident (Resident #2) with a Gastrostomy (G-Tube- an opening into the stomach from the abdominal wall, made surgically for the introduction of food) out of 18 sampled residents. The facility census was 70 residents.Review of the facility's policy titled Enteral (involving or passing through the intestine, either naturally via the mouth and esophagus, or through an artificial opening) Feeding-Safety Precautions dated November 2018 showed:-The purpose of the policy was to ensure the safe administration of enteral feeding.-Change administration sets for open-system enteral feedings at least every 24 hours, or as specified by the manufacturer.-Check the enteral nutrition label against the order before administration and check for the following information:--Resident name, ID, and room number.--Type of formula.--Date and time formula was prepared.--Route of delivery.--Access site.--Method.--Rate of administration.-Elevate the head of bed (HOB) at least 30 degrees during tube feeding and at least one hour after the feeding.1. Review of Resident #2's admission record showed he/she admitted to the facility with the following diagnoses:-Cerebral Infarction (ischemic stroke- occurs as a result of disrupted blood flow and restricted oxygen to the brain) Due to Thrombosis (clotting of the blood) of Right Middle Cerebral Artery.-Dysphagia (difficulty or discomfort in swallowing) Following Cerebral Infarction.-Cognitive Communication Deficit (a communication impairment resulting from difficulties with cognitive processes like attention, memory, and problem-solving, rather than primary speech or language problems).-Other Symptoms and Signs Involving Cognitive Functions and Awareness.-Gastrostomy (G-Tube- an opening into the stomach from the abdominal wall, made surgically for the introduction of food) Status. Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 6/5/25 showed:-The resident had severely impaired cognition.-The resident was fully dependent on staff with rolling from side to side.-The resident had a feeding tube.Review of the resident's care plan dated 7/9/25 showed:-The resident had a feeding tube due to his/her dysphagia.-The following interventions were in place:--Administer tube feeding as ordered per the Physician Order Sheet (POS), which indicated that the resident received Jevity (calorically dense, fiber-fortified therapeutic nutrition for tube feeding) -Assure the head of bed (HOB) was elevated 30 to 45 degrees.-Clean and change all equipment used for the resident's tube feeding per facility policy.Review of the resident's POS dated July 2025 showed:-An order for staff to change the tube feeding bag daily, ensure to date and initial when new a bag was placed in the morning with a start date of 7/29/25.-Elevate HOB 30 degrees or more at all times, as tolerated by the resident, for shortness of breath while lying flat.-Isosource (a nutritionally complete, calorically dense tube feeding formula that contains fiber to help support digestive health and bowel function) 1.5 Cal, to run at 50 milliliters (ml)/hour for 22 hours a day, on at 8:00 A.M. and off at 6:00 A.M.Review of the resident's Medication Administration Record (MAR)/Treatment Administration Record (TAR) dated July 2025 showed:-No order in place for HOB elevation 30 degrees or more related to the tube feeding.-No order in place for the staff to change the tube feeding bag daily, ensure to date and initial when new bag was placed in the morning prior to 7/29/25.Observation on 7/28/25 at 10:24 A.M. showed:-The resident's HOB was not at a 30-to-45-degree angle.-The resident's tube feeding bag was not labeled with the resident's name, date, hang time, rate of administration, and the nurse's initials.Observation on 7/29/25 at 9:31 A.M. showed:-The resident's HOB was at a 30-to-45-degree angle, but the resident had slid down in bed and was lying at a less than a 30-degree angle.-The resident's tube feeding bag was not labeled with the hang time or the nurse's initials.Observation on 8/1/25 at 7:51 A.M. showed the resident's HOB was not at a 30-to-45-degree angle.During an interview on 8/1/25 at 9:22 A.M. Certified Nursing Assistant (CNA) A said:-Residents who received tube feeding needed to have their HOB elevated at a 30-degree angle.-Nurses and CNA's ensured the resident was in the correct (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	position while the tube feeding was running.-The resident was unable to position himself/herself independently.-Care plans should be up to date and reflect the resident's current status.-The resident's care plan should include all tube feeding orders.During an interview on 8/1/25 at 9:43 A.M. Licensed Practical Nurse (LPN) A said:-Residents who received tube feeding needed to have their HOB elevated at a 45-degree angle.-When tube feeding was hung the nurse needed to put the date and time of when the tube feeding was hung on the label.-Nurses and CNA's ensured the resident was in the correct position while tube feeding was running.-The resident's current tube feeding order was Isosource 1.5 Cal, but when the resident first admitted to the facility, he/she had an order for Jevity.-The resident was fully dependent on staff for positioning.-The MDS Coordinator was responsible for making and updating care plans.-The resident's care plan should be up to date and reflect their current status.-The resident's care plan needed to be updated.-The resident's care plan should include all of the resident's current tube feeding orders.During an interview on 8/1/25 at 10:02 A.M. the Assistant Director of Nursing (ADON) said:-Residents who received tube feeding needed to have their HOB elevated at least to 45 degrees.-Tube feeding bottles and bags needed to be labeled with date, time hung, rate, and initialed by the nurse.-If he/she were to find the resident's tube feeding bag unlabeled or mislabeled, he/she would notify the doctor and re-hang new tube feeding.-The resident was fully dependent on staff for positioning.-Nurses were responsible for ensuring residents were in the correct position while tube feeding was running.-If he/she were to observe the resident not in the correct position, he/she would stop the tube feeding, assess the resident, and notify the doctor.-He/She thought the resident had Jevity ordered as the resident's tube feeding formula.-The MDS coordinator was responsible for making and updating care plans.-The resident's care plan should be up to date and reflect the resident's current status.-The resident's care plan needed to be updated to include all of the resident's current tube feeding orders.During an interview on 8/1/25 at 11:19 A.M. the Director of Nursing (DON) said:-Residents who received tube feeding needed to have their HOB elevated to 30-degrees.-The facility policy indicated that the resident's HOB should be at 30-degrees.-The resident's tube feeding bag should be labeled daily with the date, time, and nurse's initials.-The nurse should have labeled the tube feeding bag on 7/28/25.-If staff were to observe the resident's tube feeding bag unlabeled or mislabeled, he/she expected staff to dispose of the tube feeding that was hanging and start a new tube feeding.-The CNA's and nurses ensured the resident was in the correct position while the resident's tube feeding was running.-The CNA's were to inform the nurse that the resident needed to be repositioned if the resident was not in the correct position.-The resident was unable to position himself/herself independently.-He/She thought the resident had Jevity ordered as the tube feeding formula.-Care plans were completed and updated by the MDS coordinator.-The resident's care plan needed to be updated.-The resident's care plan needed to include all of the resident's current tube feeding orders.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify, assess and provide supportive interventions for two sampled residents (Resident #11 and #40), with a diagnosis of Post-Traumatic Stress Disorder (PTSD a mental health condition triggered by a terrifying event either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event) out of 18 sampled residents. The facility census was 70 residents.Review of Trauma-Informed Care Implementation Center (https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/) copyright 2021 showed:-Trauma-informed care shifts the focus from What's wrong with you? to What happened to you?-A trauma-informed approach to care acknowledges that health care organizations and care teams need to have a complete picture of a patient's life situation - past and present - in order to provide effective health care services with a healing orientation.-Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness. It can also help reduce avoidable care and excess costs for both the health care and social service sectors.-Trauma-informed care seeks to:--Realize the widespread impact of trauma and understand paths for recovery.--Recognize the signs and symptoms of trauma in patients, families, and staff.--Integrate knowledge about trauma into policies, procedures, and practices; and--Actively avoid re-traumatization. Review of facility policy titled Trauma-Informed and Culturally Competent Care revised [DATE], showed:-Guided staff when providing care that was culturally competent and trauma-informed in accordance with professional standards of practice.-Addressed the needs of trauma survivors that minimized triggers and/or re-traumatization.-All staff were guided in evidence-based organizational and interpersonal strategies that supported trauma-informed and culturally competent care. -Developed an individualized care plans that addressed past trauma in collaboration with the resident and family, as appropriate.-Identified and decreased exposure to triggers that might have re-traumatize the resident. -Recognized the relationship between past trauma and current health concerns. -Developed individualized care plans that incorporated language needs, culture, cultural preferences, norms, and values. 1. Review of Resident #11's admission Record showed the resident admitted to the facility on [DATE] with a diagnosis of PTSD.Review of the resident's Level One Pre-Admissions Screening and Resident Review (PASRR-federally mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability related diagnosis who apply or reside in Medicaid Certified beds in a nursing facility regardless of the source of payment) dated [DATE] showed the resident had a diagnosis of PTSD. Review of the resident's care plan dated as revised on [DATE] showed:-He/She had PTSD. -He/She had a history of abuse. -The resident's triggers were not addressed.-The resident's interventions were not addressed. Review of the resident's Trauma Informed Care assessment dated [DATE] showed:-The resident had trauma in the past.-Had nightmares about the event.-Tried hard not to think about the event or went out of the way to avoid situations that reminded him/her of the event.-Felt numb or detached from people, activities, or surroundings. Review of the resident's Quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated [DATE] showed:-The resident was cognitively intact. -The resident had PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:17 A.M. the resident said:-He/she had a diagnosis of PTSD.-He/She had not been asked about what his/her triggers were or interventions to the triggers During an interview on [DATE] at 8:59 A.M., Certified Nursing Assistant (CNA) A said: -He/She knew the resident had a diagnosis of PTSD.-The only trigger he/she knew of was resident's door to his/her room being left open. -He/She would look on the care plan for the triggers and interventions. -He/She would have expected triggers and interventions to be in the care plan.-He/She was unsure if triggers or interventions were listed in the care plan.-If the interventions and triggers were not in the care plan, he/she would have informed the nurse. During an interview on [DATE] at 8:59 A.M., Licensed Practical Nurse (LPN) B said:-He/She was familiar with the resident.-He/She knew the resident had a diagnosis of PTSD.-He/She was unfamiliar with the residents' triggers or interventions.-The resident's triggers and interventions should have been listed in the care plan.-He/She was unfamiliar if the triggers and interventions were listed in the care plan.-The MDS Coordinator was responsible for care plans.-He/She would tell the MDS Coordinator if there were not triggers or interventions listed in the care plan. During an interview on [DATE] at 9:18 P.M., the MDS Coordinator said:-The resident had a diagnosis of PTSD.-When a resident had a diagnosis of PTSD the triggers and interventions would have been listed in the care plan.-The event that caused the PTSD would be addressed in the care plan.-PTSD should not have been listed with other diagnosis but in it's own place in the care plan. -He/She audited the care plans. During an interview on [DATE] at 11:26 A.M., the Director of Nursing (DON) said:-The MDS Coordinator was responsible for the care plans.-The resident had a diagnosis of PTSD.-When a resident had a diagnosis of PTSD there would be triggers and interventions listed in the care plan.-He/She did not know the resident's triggers or interventions. -The information of the resident's triggers and interventions should have been in the care plan. -Care plans were audited by the MDS Coordinator and the Inter-Disciplinary Team (IDT). 2. Review of Resident #40's admission Record showed the resident was admitted to the facility on [DATE] with diagnoses that included:-PTSD-Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety).-Major depression (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living).-Bipolar disorder, unspecified (a mental health condition characterized by severe shifts in mood and energy levels). Review of the resident's Trauma Informed Care Assessment – PTSD, dated [DATE] showed the resident:-Had experienced an unusually frightening, horrible, or traumatic experience.-Had nightmares within the past month about the events that were especially frightening or traumatic.-Tried hard not to think about the events or avoided situations that reminded him/her of the events.-Had been constantly on guard or easily startled. Review of the resident's medical record showed:-No further PTSD or Trauma Informed Care assessments were available in the resident's medical record. -No further PTSD or Trauma Informed Care assessments were provided when requested. Review of the resident's most recent PASRR Level II (a comprehensive evaluation for individuals who screen positive on the initial Level I PASRR screening to determine the need for specialized services and care), dated [DATE], showed the resident: -Had a long history of depressive symptoms beginning at the approximate age of 16, history of a suicide attempt at age [AGE], and cutting approximately (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seven years ago. The resident reported persistent symptoms of feeling down, depressed, worthless, irritable, and anxious, and having difficulty with concentration, coping, excessive worry, and motivation. -Had a spouse whom the resident felt very close to and who was a significant source of support, but the spouse passed away in [DATE]. He/she also used to like to spend time with his/her pet when he/she lived at home.-Had a very supportive family member (Family Member A) whom he/she talked with frequently.-Required a high level of care and supervision where his/her cognitive, physical, and psychiatric needs could be managed effectively, ensuring his/her safety.-Recommendations were for therapeutic counseling due to his/her history of visual and auditory hallucinations, grief over his/her spouse's death, and feelings of isolation. He/she would benefit from regular therapy sessions given his/her openness to exploring this option and the potential to improve coping skills and emotional regulation.-Required ongoing assessment of mood, thought processes, and behaviors for intervention purposes. His/her behavioral plan may include discussion of feelings, coping mechanism identification, problem solving techniques, providing resources for support, and clinical interventions.-Should have a crisis intervention plan with clear steps to be taken with the resident during a crisis due to his/her history of suicidal ideations/attempts. Review of the resident's admission MDS dated [DATE], showed the resident: -Was moderately cognitively impaired.-In the past two weeks:--Had little to no interest 12 to 14 days.--Felt down, depressed, or hopeless two to six days.--Had difficulty falling asleep, staying asleep or slept too much 12 to 14 days.--Had trouble concentrating 12 to 14 days.-It was very important for the resident to be around animals and participate in religious services and somewhat important for him/her to go outside for fresh air.-Was diagnosed with PTSD, anxiety, depression, and bipolar disorder. Review of the resident's quarterly MDS, dated [DATE] showed the resident:-Was cognitively intact.-Felt down, depressed, or hopeless two to six days within the past two weeks.-Experienced hallucinations (perceptions in the absence of real external stimuli) and delusions (firmly held beliefs contrary to reality). Review of the resident's Comprehensive Care Plan, revised [DATE], showed:-A trauma informed care plan was initiated [DATE]. It showed the resident would have fewer episodes due to trauma over the next quarterly review period. The resident was sexually abused prior to admission. The psychiatric Nurse Practitioner (NP) was to follow up. The trauma informed care plan did not show how staff were to know when the resident's trauma was triggered, what the resident's triggers were, or what they should do to lessen the likelihood of triggering the resident. -A PASRR care plan, revised [DATE], showed the resident was in need of specialized services due to his/her mental health needs. Goals were for the psychiatrist to evaluate the residents' response to psychotropic medications and the need for other services. No counseling services were mentioned on the care plan.-A Mood care plan, initiated [DATE], showed the resident had problems related to bipolar, depression, and PTSD. Nursing was to assist the resident, family, and caregivers in identifying strengths and coping skills and to reinforce these. No specific strengths or coping techniques were mentioned. Staff were to monitor, record, and report to the physician any increased anger, mood changes, agitation, feelings of being threatened, thoughts of harm, or possession of objects that could be used as weapons. -A psychological well-being care plan, initiated [DATE], showed the resident had problems related to depression, bipolar, anxiety, and PTSD. Nursing was to provide opportunities for the resident and family to participate in the resident's cares. When conflicts arise, remove the resident to a calm and safe environment and allow him/her to vent feelings. Approach resident in a calm manner, calling the resident by name. If physically or verbally aggressive assure resident is safe and leave him/her alone for five or 10 minutes before reattempting or have another staff member reattempt cares.-A PTSD (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plan, initiated [DATE], showed:--The resident was diagnosed with PTSD and had a history of childhood abuse and fearfulness of being outside his/her living quarters. The goal was for the resident to verbalize feelings related to emotional triggers and have fewer incidents of emotional discomfort related to PTSD through the quarterly review date. The plan didn't show how staff were to tell if the resident was experiencing discomfort related to PTSD. --Interventions were for staff to allow the resident to verbalize feelings and to increase communication with the resident; explain treatments, procedures, and labs; monitor and document the resident's feelings relative to triggering events and allow a safe space to voice fears, frustrations, and concerns; create a plan for a healthy response to stress; psychiatry and mental health counseling as indicated/ordered; and remove the resident to a calm, safe environment. ---Note: There was no plan for what the resident or staff should do in the event the resident was triggered or documentation of the resident's triggers. The plan didn't specify if there were any restrictions on who provided personal cares to the resident. The plan didn't specify if counseling services would be offered or show how staff were to know if counseling services were indicated.---Note: The intervention to have a staff member accompany the resident to medical appointments was not in the resident's care plan.-There was no crisis intervention plan with clear steps to be taken with the resident during a crisis related to his/her history of suicidal ideation/attempts as was recommended in the resident's most recent PASRR. Review of the resident's electronic medical record on [DATE] showed no documentation the resident received or was offered counseling services. Observation on [DATE] at 11:35 A.M. showed the resident was lying awake in bed. The resident's affect was flat when he/she spoke. During an interview on [DATE] at 11:38 A.M. the resident said:-He/She told the physician a couple of days ago he/she thought his/her depression medication needed to be increased and the doctor agreed.-Nobody at the facility had ever asked him/her about PTSD.-Staff almost always knocked and announced themselves before entering his/her room, but when they enter quickly it triggered his/her anxiety and PTSD. -He/She avoided certain shows that triggered his/her PTSD.-He/She was still bothered by past traumas, but nobody at the facility had asked him/her about them or if he/she wanted counseling. He/she was open to counseling, but didn't trust many people. It would have to be the right counselor that he/she trusted.-He/She didn't know if he/she had a PTSD care plan. Nobody had ever mentioned it to him/her or asked him/her what he/she needed related to PTSD. Observation on [DATE] at 10:45 A.M. showed the resident was lying awake in bed. During an interview on [DATE] at 10:47 A.M. the resident said:-The physician increased his/her depression medication, but he/she wasn't sure what the medication was. -Family Member A was his/her main support system and visited or spoke with the resident on the phone daily.-He/She had a diagnosis of PTSD since he/she was [AGE] years old which was caused by sexual and physical abuse and he/she still experienced emotional trauma from that. He/She had been abused as a young child as well. Someone had pulled out his/her hair when he/she was quite young.-He/She was open to counseling and thought it could be helpful, but it had to be a good match, or it would stress him/her out. -Going outside or going places sometimes triggered his/her PTSD. It was bad going to the doctor's office. It made his/her PTSD and anxiety go way up. When he/she went to the doctor's the facility let his/her CNA go with him/her. His/her anxiety would be worse if they didn't. During an interview on [DATE] at 2:08 P.M. Certified Nursing Assistant (CNA) C said:-He/She thought the resident had depression because he/she would sleep during the day or withdrawal. -He/She didn't (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	know if the resident had anxiety.-He/She didn't know if the resident had a history of depression and didn't know he/she had been diagnosed with PTSD.-He/She didn't know what the resident's PTSD triggers were or what staff were supposed to do to lessen the likelihood of triggering the trauma.-He/She knew the resident preferred female caregivers.-Trauma Informed Care meant being informed of the resident's past trauma and included how staff should respond to the resident. -An emotional trigger could be loud noises or anything that set someone off. Watching something on TV could trigger a response or seeing someone else being abused. -He/She didn't know the resident's triggers. -It would be helpful to know who was diagnosed with PTSD and what their triggers were to avoid an adverse reaction.-Staff's approach to residents mattered and this was especially true of Resident #40. He/she tried to joke around and approach residents with an upbeat mood to keep the residents' moods and attitudes more positive in general. -He/She reviewed the resident's electronic medical record to see the residents' care plans and charted on each resident daily. -The resident's care plan showed he/she was at risk for changes in mood and staff should report this to the nurse. Staff were to reattempt care or have another staff reattempt cares.-His/Her TIC plan didn't show what CNAs were to do to avoid triggers.-His/Her Mood care plan showed staff were to report increasing anger, agitation, or possession of items that could be used as weapons.-The resident's PTSD care plan showed staff were to remove the resident to a safe area and allow him/her to share feelings, but didn't show what might trigger the retraumatization. During an interview on [DATE] at 9:40 A.M. CNA A said:-Some days the resident needed encouragement to come out of his/her room, to bathe, change clothes, and go to the bathroom. He/she would get a little down and tended to stay quiet and to himself/herself. -The resident was more open with staff after he/she got to know them. -The resident was diagnosed with depression and anxiety. -The resident would bounce his/her leg or leave activities and wanted to be by himself/herself.-He/She read the resident's care plan and thought he/she had a PTSD diagnosis. -When the resident was at the hospital a short time back he/she had increased agitation and threw his/her shoe, but he/she was out of his/her typical routine. The resident was in significant pain at the time. -The resident mentioned he/she had a rough childhood and was physically and sexually assaulted over a period of time. The resident mentioned a few events, but nothing very specific.-He/She only wanted three specific staff members to help him/her with bathing. -He/She didn't think the resident was working with the facility social worker or with a counselor to work through his/her PTSD. At least the resident never mentioned that.-The resident never mentioned his/her triggers. -He/She didn't remember triggers being in the resident's care plan. They probably should be. -He/She normally offered to do the resident's shower when the agency staff worked.-He/She didn't know how the resident would react if his/her PTSD was triggered. -The resident needed staff to assist him/her in getting dressed. -There should be direction in the care plan to specify what staff needed to know to not to trigger any PTSD symptoms. During an interview on [DATE] at 10:25 A.M. Family Member A said:-He/She was the resident's main support. The resident also had a close bond with his/her spouse, but the spouse died about a year ago and that had been very hard for the resident.-It was also very hard for the resident to go from living for years independently in his/her own home with his/her spouse and pet to living in a facility alone. The resident had a lot of losses within the past year and he/she had medical concerns he/she worried about a lot as well.-The resident had a long history of physical and sexual abuse since childhood and was diagnosed with PTSD. -He/She thought the resident could benefit from counseling if it was with the right therapist. -He/She definitely shouldn't have a male counselor and it would likely be three months or longer for the resident to feel comfortable with any therapist.-He/She told the facility the resident should never have male staff providing any personal cares such as changing his/her briefs, showering, or dressing, and they should not enter his/her room to provide cares.-The (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had told him/her multiple times since he/she has been at the facility that he/she had thoughts of harming himself/herself. The resident said he/she would never act on those urges since he/she promised Family Member A he/she wouldn't, but those urges were still there. During an interview on [DATE] at 10:47 A.M. the Social Services Designee (SSD) said: -He/She knew very little about the resident's past trauma. What he/she knew was through Family Member A.-He/She had never spoken to the resident about his/her past trauma. The resident's family said he/she was happy and doing better at the facility. When he/she was new to the facility the resident wouldn't come out of his/her room, but was doing better with that.-He/She thought counseling might be more triggering. The resident only spoke to Family Member A about his/her past traumas.-Family Member A reported the resident verbalized in the past he/she felt like harming himself/herself. He/she wasn't aware the resident felt that way since he/she had been at the facility.-The resident should have a care plan that addressed his/her urge to harm himself/herself.-He/She wasn't sure if the resident was ever offered any counseling services since he/she had been at the facility.-The nursing staff or family should bring it to his/her attention they think counseling might help.-He/She was responsible for arranging counseling services.-He/She and the MDS Coordinator had access to the resident's Level II PASRR which should show the supports he/she needed. -He/She wasn't aware of any specific Level II PASRR recommendations.-He/She was responsible for talking with the family or resident about any mental health concerns and bringing them up with all Department heads in daily morning meetings.-He/She wasn't aware that there were any specific staff who should not provide cares. -The care plan should specify who should provide certain cares for the resident depending on his/her comfort level. The charge nurse was responsible for seeing what the resident felt comfortable with related to his/her cares. If the resident didn't feel comfortable then he/she (SSD) should have a conversation with the resident. -He/She had a good relationship with the resident so he/she would be the best person to talk with the resident about it. -The MDS Coordinator was responsible for the PTSD care plan. -He/She did the Trauma Informed Care assessment which the MDS Coordinator could see in the medical record. -He/She worked closely with the MDS Coordinator to contribute to the PTSD care plan. During an interview on [DATE] at 11:20 A.M. the Director of Nursing (DON) said:-The PTSD care plan should identify the resident's triggers and show how staff can mitigate triggers that might retraumatize the resident.-Staff should know what to do to mitigate triggers. They should be able to find that information in the care plan.-Involved family members and the resident should absolutely be part of the PTSD care planning to provide information on the resident's history. The best person to work with the resident and family on that was someone the resident felt close to and safe with.-The MDS Coordinator was responsible for the PTSD care plan with input from other staff.

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	265765	A. Building B. Wing	08/01/2025

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility failed to ensure two sampled Nursing Assistants (NA) (NA B and NA C) had completed the state approved Certified Nursing Assistant (CNA) training program within four months of his/her facility employment. The facility census was 70 residents.Review of the facility Nursing Assistant Qualifications and Training Requirements policy dated August 2022 showed:-The facility would not employ any individual as a Nursing Assistant for more than four months unless that individual had completed a training program and competency evaluation approved by the state.1. Review of NA B's personnel file showed:-His/her hire date was 2/17/25.-He/She had worked at the facility for over five months.-There was no record of the employee having completed CNA training.2. Review of NA C's personnel file showed:-His/her hire date was 8/19/24.-He/She had worked at the facility for over eleven months.-There was no record of the employee having completed CNA training.3. During an interview on 7/31/25 at 2:20 P.M. the Human Resources (HR)/ Business Office Manager (BOM) said:-He/she did not yet have any paperwork to show that NA B and NA C were CNAs.-NA B and NA C were still working at the facility as NAs.During an interview on 8/1/25 at 11:26 P.M. the Director of Nursing (DON) said:-An NA can only work in the facility for four months.-NAs must become CNAs within 16 weeks of their hire date.-The Administrator was responsible for ensuring the four month time frame was met for NAs becoming CNAs.During an interview on 8/1/25 at 11:35 A.M. the Administrator said:-NAs were to become CNAs within 16 weeks of their date of hire.-He/she tracked the NAs to ensure they were CNAs within four months of their hire date.-He/she had not been aware that NA B and NA C had not become CNAs within four months of their hire date.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure appropriate follow-up was completed for pharmacy recommended gradual dose reductions (GDR- stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or medication can be discontinued) for two sampled residents (Resident #2 and #6) out of 18 sampled residents. The facility census was 70 residents.Review of the facility's policy titled Tapering Medications and Gradual Drug Dose Reduction dated July 2022 showed:-Tapering that is applicable to psychotropic medications are referred to as GDRs.-Residents who use psychotropic medications should receive GDRs and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.-The physician would order appropriate tapering of medications, as indicated.-Residents who use psychotropic medications should receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue the use of such drugs.-During the first year in which a resident was admitted on a psychotropic medication, or after the facility has initiated such medication, the facility would attempt to taper the medication during at least two separate quarters, unless clinically contraindicated.-After the first year, tapering would be attempted at least annually, unless clinically contraindicated.-The tapering may be considered clinically contraindicated if:--The continued accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.--The resident's target symptoms returned or worsened after the most recent attempt at tapering the dose within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.1. Review of Resident #2's Physician Order Sheet (POS) dated March 2025 showed:-Mirtazapine Oral Tablet (used to treat depression) 7.5 milligrams (mg), give one tablet via Gastrostomy (G-Tube- an opening into the stomach from the abdominal wall, made surgically for the introduction of food) in the evening related to Major Depressive Disorder (MDD- a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).-Paroxetine HCl Tablet (used to treat multiple different mental health conditions) 20 mg, give one tablet via G-Tube one time a day related to MDD.-Bupropion HCl Oral Tablet (used to treat depression) 75 mg, give one tablet via G-Tube two times a day related to MDD.-Risperidone Tablet (an anti-psychotic medication used to treat different mental health conditions) 0.25 mg, give one tablet via G-Tube two times a day related to Anxiety Disorder (any group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats), Unspecified and restlessness/agitation.-Lorazepam Oral Tablet (used to treat anxiety) 0.5 mg, give one tablet via G-Tibe three times a day for anxiety. Review of the resident's medication regimen review dated 3/5/25 showed:-The resident had been receiving Risperidone 0.25 mg, Lorazepam 0.5 mg, Bupropion 75 mg, Mirtazapine 7.5 mg, and Paroxetine 20 mg.-The pharmacist recommended a GDR for the medications.-The provider check marked the box disagree and did not give a rationale for continuing the current dosages of the medications.Review of the resident's POS dated May 2025 showed:-Mirtazapine Oral Tablet 7.5 mg, give one tablet via G-Tube in the evening related to MDD.-Paroxetine HCl Tablet 20 mg, give one tablet via G-Tube one time a day related to MDD.-Bupropion HCl Oral Tablet 75 mg, give one tablet via G-Tube two times a day related to MDD.-Risperidone Tablet 0.25 mg, give one tablet via G-Tube two times a day related to Anxiety Disorder, Unspecified and restlessness/agitation.-Lorazepam Oral Tablet 0.5 mg, give one tablet via G-Tibe three times a day for anxiety. Review of the resident's medication regimen review dated 5/7/25 showed:-The resident had been receiving Risperidone 0.25 mg, Lorazepam 0.5 mg, Bupropion (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	75 mg, Mirtazapine 7.5 mg, and Paroxetine 20 mg.-The pharmacist recommended a GDR for the medications.-The provider check marked the box disagree and did not give a rationale for continuing the current dosages of the medications.2. Review of Resident #6's POS dated April 2025 showed:-An order for Brexpiprazole Oral Tablet (Rexulti- an atypical anti-psychotic medication used to treat multiple mental health conditions and agitation with dementia) 2 mg, give one tablet by mouth one time a day related to Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses) Unspecified Severity, With Agitation.Review of the resident's medication regimen review dated 5/7/25 showed:-The resident had been receiving Rexulti 2 mg.-The pharmacist recommended a GDR be completed.-The provider check marked the box disagree and did not provide a rationale for continuing the current dose.3. During an interview on 8/1/25 at 9:48 A.M. Licensed Practical Nurse (LPN) A said:-The nurses and nurse management ensure the completion of monthly medication regimen reviews.-The doctor needed to put the rationale of why he/she did not want the GDRs completed for Resident #2 and Resident #6 on the recommendation sheet.During an interview on 8/1/25 at 10:13 A.M. the Assistant Director of Nursing (ADON) said:-The Director of Nursing (DON) was responsible for completing the monthly pharmacy recommendations.-The doctor needed to provide the rationale of why he/she did not want the GDRs completed for Resident #2 and Resident #6 on the recommendation sheet.-GDRs needed to be completed as part of the regulation for psychotropic medication.During an interview on 8/1/25 at 11:19 A.M. the DON said:-He/She was responsible for ensuring the appropriate follow-up was completed for the monthly medication reviews.-The doctor needed to provide the rationale of why he/she did not want the GDRs completed for Resident #2 and Resident #6 on the recommendation sheet.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #12) was referred to an oral surgeon in a timely manner out of 18 sampled residents. The facility census was 70 residents.Review of the facility's policy titled Dental Services dated December 2016 showed:-Social Service representatives would assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible.-All dental services provided were recorded in the resident's medical record. 1. Review of Resident #12's admission Record showed he/she was admitted to the facility on [DATE] with a diagnosis of End Stage Renal Disease (ESRD- a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis (a medical procedure that filters and cleanses the blood).Review of the resident's care plan dated 4/4/25 showed:-The resident had upper and lower dentures.-The goal for the care plan was for the resident to be free of oral pain and lesions over the next review period.-An intervention that was put in place by the facility included:--Assure the resident received dental consults as needed.Review of a dental summary report dated 4/29/25 showed:-The resident had a chipped tooth.-The dentist was only able to perform a limited exam due to the resident's dental pain.-The resident needed to be referred to an oral surgeon.-The resident was seen due to broken teeth on his/her right side of the mouth.-The resident reported that the broken teeth to his/her right side of the mouth had been a problem for about a month prior to the exam.-The resident needed multiple teeth removed in four to six areas of the oral cavity.-The resident thought that he/she already had a referral to an oral surgeon in place and was awaiting to hear back about an appointment.Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 5/15/25 showed:-The resident was cognitively intact.-The section for oral/dental status was not completed.During an interview on 7/29/25 at 10:42 A.M. the resident said:-He/She had recently seen the dentist.-Nothing had really been done by the dentist during the exam.-He/She needed to see an oral surgeon because he/she needed some teeth to be removed.-To his/her knowledge an appointment had not been set up with an oral surgeon.-His/Her mouth felt really uncomfortable.Observation on 7/29/25 at 10:42 A.M. of the resident's mouth showed that he/she had missing teeth.During an interview on 7/30/25 at 12:32 P.M. the Social Services Designee (SSD) said:-The business office manager (BOM) set up the resident's dental services.-He/She did not know that the resident needed to be referred to an oral surgeon.-There was a chance that the referral could have been completed by a nurse.-If a nurse had completed a referral, then the nurse would have filled out a transportation sheet.-He/She had not received any transportation sheets related to the resident seeing an oral surgeon.During an interview on 7/30/25 at 1:26 P.M. the resident said:-He/She had seen dentist twice since his/her admission to the facility. -He/She thought he/she had been told that the facility was having a hard time finding an oral surgeon that accepted the resident's insurance and that was why he/she had not seen an oral surgeon yet.-His/Her mouth pain was usually ranked as a five out of ten on a numerical pain scale (a tool used to quantify pain intensity, typically using a scale from zero to ten, where zero represents no pain and ten represents the worst pain imaginable).-He/She had gotten used to the pain because it had been so long since he/she last saw the dentist.-He/She just felt terrible about the whole situation because the problem was only getting worse especially to the back of his/her mouth.During an interview on 7/30/25 at 1:35 P.M. the BOM said:-The SSD would have been the person responsible for sending the resident's oral surgeon referral.-The facility had the dentist come to the facility quarterly.-If there had been questions related to a dental note, then the SSD should have reached out to the dentist to get clarification.-He/She was unaware that the resident needed to be seen by an oral surgeon.During an interview on 8/1/25 at 9:15 A.M. Certified Nursing Assistant (CNA) A said:-He/She was not sure when the resident was last seen (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by the dentist.-He/She was unsure of who reviewed dental notes to ensure referrals and follow-ups were completed.-He/She was unaware that the resident needed to be seen by an oral surgeon.-The resident had complained of mouth pain in the past.-The resident would tell CNA A that the food that was served to him/her was too hard to chew and requested something else to eat.-The SSD would have been the person responsible for sending out the oral surgeon referral.-The referral should have been completed by that point in time.During an interview on 8/1/25 at 9:51 A.M. Licensed Practical Nurse (LPN) A said:-He/She was unsure when the resident last saw the dentist.-The resident had not complained of any oral pain to him/her.-He/She was unaware the resident had chipped/broken teeth.-The Assistant Director of Nursing (ADON) and/or the Director of Nursing (DON) reviewed the dental notes after the dentist came to the facility.-The ADON and/or the DON would have told the SSD that an oral surgeon referral needed to be completed.-The ADON and/or the DON should have ensured that a referral had been sent to an oral surgeon.-There should have been the same day and up to 72 hours follow-up completed after the dental notes were sent to the facility.-A referral should have been completed by that point in time.During an interview on 8/1/25 at 10:21 A.M. the ADON said:-He/She was unsure when the resident last saw a dentist.-The BOM was responsible for reviewing and uploading dental notes to residents' electronic medical records (EMR).-The BOM should have given the dental note to the SSD, so the SSD could complete the oral surgeon referral.-He/She was unaware that the resident needed to be seen by an oral surgeon.-He/She was unsure of why no follow-up had been completed after the dental note was received by the facility.-He/She was unsure if the resident had complained of any mouth pain.-CNA A should have reported the mouth/chewing pain to the nurse.-The referral should have been completed within a week of the facility receiving the dental note.-The referral should have been completed by that point in time.During an interview on 8/1/25 at 11:19 A.M. the DON said:-He/She was unsure when the resident last saw a dentist.-He/She was unaware that the resident needed to be seen by an oral surgeon.-The BOM and the SSD reviewed notes after residents were seen by providers to ensure appropriate follow-up was completed.-He/She was unsure if the resident had any mouth pain.-The BOM would have been responsible for giving the dental note to the SSD.-The SSD would have been responsible for completing the referral to the oral surgeon. -The referral should have been completed within a week of receiving the dental note.