STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265807	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Home	1313 South 25th St Bethany, MO 64424

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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 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. 22445 Based on interview, record review, and facility policy review, the facility failed to notify the physician when blood pressure medication was held for 1 (Resident #41) of sampled 3 residents reviewed for notification of change. Specifically, the facility held Resident #41's blood pressure medication on three occasions when the resident's blood pressure (BP) was outside the physician-ordered parameters, with no notification made to the physician. Findings included: An undated facility policy titled, Condition Change, Resident (Observing, Recording and Reporting) (Includes Fall or Injury) revealed 6. Notify physician of condition change, need for treatment orders and/or medication order changes. A Resident Face Sheet revealed the facility admitted Resident #41 on 02/06/2023. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of essential (primary) hypertension. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/08/2024, revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #41 had active diagnoses that included hypertension and coronary artery disease and received a diuretic medication (a medication used to remove excess fluid from the body). Resident #41's Care Plan, last reviewed/revised on 05/08/2024, did not include a Problem area that addressed hypertension. Resident #41's May 2024 Medications Flowsheet revealed the transcription of the following orders: - an order started on 05/11/2023 for hydrochlorothiazide (a diuretic medication) 12.5 milligrams (mg), one tablet once a day for a diagnosis of Essential (primary) hypertension; and - an order started on 05/26/2023 to check the resident's BP twice a day and hold the BP medication if the systolic BP was lower than 120 or the diastolic BP was lower than 65. (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An untitled document revealed twice a day BP readings for Resident #41. The resident's BP values were documented as the following: 05/03/2024 AM (morning) BP 113/61, 05/09/2024 AM BP 93/51, and 05/18/2024 AM BP 87/50. Resident #41's May 2024 Medications Flowsheet revealed documentation that indicated staff held the resident's hydrochlorothiazide on 05/03/2024, 05/09/2024, and 05/18/2024. There was no documented evidence the physician was notified the resident's BP was below the ordered parameters. Resident #41's Progress Notes revealed no evidence the physician was notified when the resident's hydrochlorothiazide was held due to their BP being below the physician-ordered parameters on 05/03/2024, 05/09/2024, or 05/18/2024. Registered Nurse (RN) #4 was interviewed on 05/23/2024 at 6:19 AM. RN #4 stated if BP medications were held due to not meeting physician-ordered parameters, she expected the certified medication technician (CMT) to notify her. RN #4 reviewed Resident #41's medications flowsheet and stated she had not been notified of the resident's BP and added she would have expected to have been notified. On 05/23/2024 at 12:31 PM, a telephone interview was held with the Director of Nursing (DON). The DON stated she expected the CMTs to report Resident #41's BPs to the nurse. A telephone interview was held with the Medical Director (MD) on 05/23/2024 at 2:15 PM. He stated Resident #41's primary care physician (PCP) was out of town, but he was willing to answer questions. The MD said the order for the resident's BP medication to be held should have been followed, and if the medication was held, the resident's physician should have been notified. The MD stated he was sure the resident's PCP had no knowledge of Resident #41's BPs and would have adjusted the medications had he known. The Administrator was interviewed on 05/23/2024 at 6:24 AM. The Administrator stated she expected BP to be taken prior to the administration of BP medications and if the parameters were not met as ordered by the PCP, then the medication should not be given, and the CMT should notify the nurse. The Administrator stated the charge nurse was responsible for notifying the PCP.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 39714 Based on observation, interview, and facility document review, the facility failed to ensure residents' rooms were maintained in a homelike manner for 2 (Resident #13 and Resident #17) of 43 total residents who resided in the facility at the time of survey. Specifically, Resident #13 and Resident #17's closet doors were missing. Findings included: On 05/22/2024 at 12:43 PM, the Administrator stated the facility did not have a general maintenance policy. An observation on 05/21/2024 at 3:53 PM revealed Resident #17's closet was missing a door on the right side. During concurrent interview and observations with the Maintenace Supervisor (MS) on 05/21/2024 beginning at 5:06 PM, the MS said that for any maintenance issues, staff should report the concern to the MS or Administrator, and the MS would generate a work order. While touring the facility with the MS, an observation was made of Resident #13's room on 05/21/2024 at 5:12 PM. Resident #13's closet was missing a door on the right side, and the resident's clothing was exposed. At the time of the observation, the MS denied knowledge of the concern and said no one had reported it to him. An observation on 05/21/2024 at 5:16 PM revealed Resident #17's closet was missing a door on the right side. At the time of the observation, the MS again denied knowledge of the concern. The MS further stated he did not know if he could use a door from a room that was not in use but said he would check. A Maintenance Work Order, dated 04/04/2024 at 10:30 AM, revealed a work order for Resident #17's room. The work order indicated, Closet door is falling off barely hanging. Per the work order, maintenance staff began working on the problem on 04/08/2024 at 11:30 AM and completed the work order on 04/08/2024 at 12:10 PM. The Work done section indicated maintenance staff, Checked room for door/Went looking around for closet door cannot find the door. The MS signed as having completed the work order. During an interview on 05/22/2024 at 9:22 AM, Resident #13 stated their closet door had been gone for a while and was taken off because it was hanging, and the facility did not want it to fall. During an interview on 05/22/2024 at 9:28 AM, Certified Nurse Assistant (CNA) #5 stated she had seen missing closet doors in residents' rooms. CNA #5 further stated Resident #13's closet door had been missing for approximately a year. During an interview on 05/22/2024 at 9:47 AM, Resident #17 stated their closet door was breaking off and barely hanging when they initially moved into their room approximately seven months prior. Resident #17 further stated maintenance staff took the door off so that it would not fall but never said anything about replacing it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator (ADM) was interviewed on 05/23/2024 at 11:08 AM. The ADM stated when maintenance concerns were identified, the staff member who identified the concern should complete a work order form and leave it on the clip board at the nurses' station. Per the ADM, maintenance staff checked the clipboard for work orders every morning and started addressing any reported issues. The ADM said she expected staff to report maintenance concerns on the work order forms, maintenance staff to follow-up on the work-orders and make necessary repairs, and for maintenance staff to turn work orders into the ADM once they were completed. The ADM stated that the MS's hire date was 04/04/2024 and they were the only maintenance person in the building at that time, so she believed the signature on the 04/04/2024 work order regarding Resident #17's closet door was the MS's signature. The ADM further stated she would have expected the MS to take doors from an unoccupied resident room to replace any broken ones.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42192 Based on interview, record review, and facility policy review, the facility failed to develop a care plan addressing the use of a psychotropic medication for 1 (Resident #34) of 6 sampled residents reviewed for unnecessary medications. Specifically, the facility failed to develop a care plan addressing Resident #34's use of antipsychotic, antidepressant, and antianxiety medications, including information regarding target behaviors and monitoring for potential side effects of the medications. Findings included: An undated facility policy titled, Drug Review indicated, 5. Medications should not show unnecessary or excessive use and should have a diagnosis to support them. The section of the policy addressing Reviewing Antipsychotic Drugs, specified, 1. Antipsychotic drugs should only be given when necessary to treat a specific condition. 2. Review all charts of residents receiving the following drugs. Check for one or more specific diagnoses or conditions for antipsychotic drugs including: a. Schizophrenia b. Schizo-affective disorder c. Delusional disorder d. Psychotic and mood disorders (including mania and depression) e. Acute psychotic episodes f. Brief reactive psychosis g. Schizophrenia-form disorder h. Atypical psychosis i. Tourette's disorder j. Huntington's disease k. Organic mental syndromes (including dementia) with associated psychotic features as defined by: 1. Behavior (biting, kicking, scratching) which cause the resident to present a danger to themselves, others, and/or interfere with staff's ability to provide care. 2. Psychotic symptoms (hallucinations, paranoia, delusions) that cause the resident frightful distress. 3. Short term (seven days) symptomatic treatment of hiccups, nausea, vomiting or pruritus. 3. Review nurse's notes and/or behavior forms for charting of behavior, to assure that there is indication of more antipsychotic use: a. Simple pacing b. Wandering c. Poor self-care d. Restlessness e. Crying out, yelling or screaming f. Impaired memory g. Anxiety h. Depression i. Insomnia j. Unsociability k. Indifference to surroundings l. Fidgeting and nervousness m. Uncooperativeness n. Any indication for which the order is on a PRN [as needed] basis. 4. Develop an interdisciplinary care plan to evaluation behavior pattern in relationship to current medication administration. Resident #34's Resident Face Sheet revealed the facility admitted the resident on 04/05/2021 with diagnoses that included major depressive disorder, Alzheimer's disease, and anxiety disorder due to known physiological condition. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/2024, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS revealed the resident did not experience hallucinations or delusions and did not exhibit any behaviors during the seven-day assessment look-back period. According to the MDS, the resident was taking antipsychotic, antianxiety, and antidepressant medications, all of which had an indication for use noted. A review of Resident #34's Physician Order Report for the timeframe from 04/22/2024 through 05/22/2024 revealed the following orders: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- an active order dated 07/18/2022 for quetiapine tablet (an antipsychotic medication), 25 milligrams (mg), one-half tablet twice a day for a diagnosis of Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance; - an active order dated 07/18/2022 for sertraline tablet (an antidepressant medication), 100 mg, administer 200 mg (two tablets) orally at bedtime for a diagnosis of anxiety disorder due to known physiological condition; and - an active order dated 01/18/2023 for lorazepam tablet (an antianxiety medication), 0.5 mg, administer one-half tablet (0.25 mg) twice a day for a diagnosis of anxiety disorder due to known physiological condition. Resident #34's Care Plan revealed a Problem area, started on 10/19/2021, addressing behavioral symptoms, that indicated the resident was at high risk for elopement. Another Problem area, started on 11/19/2021, indicated the resident had a diagnosis of anxiety. An intervention started on 11/19/2021 directed staff to utilize medications as prescribed by the resident's physician. The Care Plan did not address Resident #34's use of psychotropic medications, including their ordered quetiapine, lorazepam, or sertraline, and did not include interventions related to target behaviors or potential side effects associated with the use of these medications. During an interview on 05/23/2024 at 11:46 AM, Licensed Practical Nurse (LPN) #18 stated many nurses did not know how to access the care plans in the electronic health record (EHR). During a follow-up interview on 05/23/2024 at 2:57 PM, LPN #18 stated residents' care plans should be updated with resident-specific information by the nurses ; however, she said nurses had not been trained regarding care plans. LPN #18 stated medication monitoring and target behaviors should be included in residents' care plans. During a telephone interview on 05/23/2024 at 5:17 PM, the Director of Nursing (DON) stated residents' care plans should include target behaviors related to prescribed medications. She stated she was the acting MDS Coordinator. The DON stated she would like to get the nurses involved in the care planning process, but said when she spoke with them, the nurses said they had never done them before. During an interview on 05/23/2024 at 6:19 PM, the Administrator (ADM) stated care plans should reflect the purpose of medications and the behaviors specific to the resident. The ADM stated the MDS Coordinator, currently the DON, was responsible for care plans, but any nurse could update care plans.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 22445 Based on interview, record review, and facility document and policy review, the facility failed to provide showers as scheduled/preferred for 2 (Resident #34 and Resident #37) of 5 sampled residents reviewed for activities of daily living (ADL). Findings included: An undated facility policy titled, Daily Care Needs indicated, 2. Before beginning care, check the bathing schedule and resident's care plan. Make note of special problems or special care needed by each resident. Resident care plans are individualized and give specific instructions on care. 1. A Resident Face Sheet revealed the facility admitted Resident #37 on 03/08/2023. According to the Resident Face Sheet, the resident had a medical history that included unspecified dementia, generalized muscle weakness, myocardial infarction (heart attack), and chronic obstructive pulmonary disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/17/2024, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident did not reject care during the assessment period. The MDS indicated Resident #37 required partial/moderate staff assistance (helper lifts, holds, or supports the trunk or limbs, but provides less than half the effort) with showers or bathing. Resident #37's Care Plan included a problem statement with an initiation date of 11/17/2023 that indicated the resident had socially inappropriate/disruptive behavioral symptoms and often declined care, especially on shower days. Interventions directed staff to reapproach or ask another caregiver to assist (initiated 11/17/2023). The facility's shower scheduled revealed Resident #37 was scheduled for a shower on Mondays, Wednesdays, and Fridays. A Concern/Grievance Report dated 10/11/2023 revealed Family Member (FM) #8 had filed a grievance on behalf of Resident #37. The grievance indicated that Resident #37 had not received a shower in a week. The facility follow-up indicated that the resident had a shower on 10/03/2023 and eight days later on 10/11/2023 when the grievance was received. The grievance report revealed the facility's resolution was to ensure the resident's refusals were documented on a shower sheet and if the resident refused, staff should offer to shower the resident again, or have another staff member offer a shower. A Concern/Grievance Report dated 02/23/2024 indicated FM #8 filed another grievance related to Resident #37 not receiving a shower that week. On the back of the report, the facility indicated staff assisted Resident #37 with a shower on Monday: however, there were no sheets to back it up as of this writing. According to the report, the facility needed Certified Nurse Aides (CNAs) or Certified Medication Technicians (CMTs) to complete a shower/bath sheet, which included the date they assisted the resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator stated in an interview on 05/21/2024 at 2:24 PM that the CNAs documented resident showers on the Skin Monitoring: Comprehensive CNA Shower Review forms and there was no bathing/shower documentation in residents' electronic medical records. Resident #37's 02/2024 Skin Monitoring: Comprehensive CNA Shower Review forms revealed that on 02/07/2024 Resident #37 was hospitalized . Shower review forms indicated of the possible 11 opportunities for Resident #37 to receive a shower in 02/2024, the resident received three showers during the month, 02/15/2024, 02/23/2024, and 02/28/2024. Resident #37's 03/2024 Skin Monitoring: Comprehensive CNA Shower Review forms indicated of the 13 opportunities for Resident #37 to receive a shower that month, Resident #37 only received six showers or a whirlpool bath on 03/06/2024, 03/08/2024, 03/13/2024, 03/18/2024, 03/23/2024, and 03/27/2024. Resident #37's 04/2024 Skin Monitoring: Comprehensive CNA Shower Review forms indicated of the 13 opportunities for Resident #37 to receive a shower that month, Resident #37 only received four showers or whirlpool bath on 04/07/2024, 04/12/2024, 04/21/2024, and 04/27/2024. Resident #37's 05/2024 Skin Monitoring: Comprehensive CNA Shower Review forms revealed Resident #37 had received a whirlpool bath on 05/04/2024 and a shower on 05/10/2024, one time per week, not three times as scheduled. An interview was held with Resident #37 on 05/20/2024 at 10:28 AM. Resident #37 stated they had not received many showers and stated there had been weeks when they received no showers. Resident #37 stated they had complained about not getting showers and was not given a reason why they were not provided. Resident #37 stated that when FM #8 called the facility and complained, the resident received a shower the next day. A telephone interview was held with FM #8 on 05/21/2024 at 9:12 AM. FM #8 stated that when she had concerns, the facility's response was dependent upon the staff member she spoke with. FM #8 stated the only time Resident #37 refused showers was when the weather was cold outside. FM #8 stated employees had reported that only a few residents received their showers, which was only because their family kept a check on the residents. FM #8 stated when they inquired why Resident #37 had not received showers, the answer was there was not enough staff to shower the residents. CNA #7 was interviewed on 05/22/2024 at 10:55 AM. CNA #7 stated no showers had been given that day due to the workload that morning. CNA #7 stated the night shift CNAs did not get residents up and dressed for breakfast as they should, and it put everyone in a rush. CNA #7 stated sometimes Resident #37 told family members they had not received a shower when in reality, the resident refused their shower. CNA #7 stated there was a shower book at the nurse's station that listed which days the resident was supposed to receive a shower, and most residents required a shower twice per week. CNA #7 stated that when a shower was completed, the CNA completed a shower sheet and documented in the electronic medical record. CNA #7 stated that even if a resident refused a shower, the shower sheet had to be completed and the sheet had to indicate the resident had refused. CNA #1 was interviewed on 05/22/2024 at 11:23 AM. CNA #1 stated she did not think there was enough staff and stated there was not always enough time to give showers. The CNA stated showers had not been given that day due to being busy answering call lights. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #2 was interviewed on 05/22/2024 at 11:52 AM. CNA #2 stated there were staff that came in specifically to provide residents' showers and stated the CNAs assigned to provide resident care did not complete showers. CNA #2 stated residents' showers were based on their care plans, and some residents got one shower per week and other residents received two showers per week. CNA #2 stated residents had not always received showers as scheduled and only received showers when staff were available. CNA #2 stated she had not heard Resident #37 state they were not receiving showers. Nursing Assistant (NA) #12 was interviewed on 05/23/2024 at 5:13 AM. NA #12 stated Resident #37 had not refused care on the night shift. NA #12 stated Resident #37 refused care from certain day shift staff, but she had no knowledge of Resident #37 refusing showers. CNA #17 was interviewed on 05/23/2024 at 10:32 AM. CNA #17 stated that when she worked she mostly gave showers to the residents. CNA #17 stated there was a shower schedule to follow and residents were scheduled for two showers per week but were able to get more showers if requested. CNA #17 stated that in addition to the shower sheets being completed after a shower, there was also a book with a list of resident names and staff placed a check mark by the resident's name when they assisted the resident with a shower. CNA #17 checked the book and confirmed Resident #37 had no check marks by their name. CNA #17 reviewed the shower schedule and stated she was unaware Resident #37 was scheduled for three showers per week; however, she stated other CNAs showered Resident #37. CNA #17 stated that when Resident #37 returned from the hospital, CNA #17 reminded the resident of someone at the hospital and the resident now had issues with her; subsequently, she had not provided showers to Resident #37. Licensed Practical Nurse (LPN) #6 was interviewed on 05/23/2024 at 10:26 AM. LPN #6 stated there were two shower aides who reported to the Administrator and the Director of Nursing (DON). LPN #6 stated the CNAs were no longer reporting to the nurses when a resident refused a shower. She stated there was a staff member in the front office that kept up with when showers were given. LPN #6 stated if a resident refused a shower the CNAs were to complete a shower sheet and write refused on the sheet. LPN #6 stated Resident #37 refused a lot of things, including showers. Registered Nurse (RN) #4 was interviewed on 05/23/2024 at 4:53 AM. RN #4 stated Resident #37 had not complained about lack of showers. RN #4 stated Resident #37 refused most showers due to wanting a whirlpool bath. RN #4 stated the staff person who worked the day shift could give whirlpool baths but did not know if the staff on the night shift could use the whirlpool tub. The Human Resources (HR) staff member was interviewed on 05/23/2024 at 10:52 AM. The HR staff member stated that when she received the shower sheets from the CNAs she transcribed the information to a ledger and kept track of when residents received showers. The HR staff member stated if a resident refused a shower, the CNA was expected to complete a shower sheet and document on the sheet the resident had refused. The HR staff member stated that when showers were not given, she was expected to notify the nurse on the hall. The HR staff member stated she was unaware Resident #37 was scheduled for three showers per week and was unable to recall whether she had spoken to the nurse to alert the nurse Resident #37 had not received scheduled showers. The HR staff member reviewed the shower sheets for Resident #37 and acknowledged Resident #37 had not received two showers per week. The HR staff member could not explain the lack of follow-up regarding Resident #37 having not received showers and stated she was unaware the resident's family had concerns about the resident not receiving showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was held with the DON on 05/23/2024 at 12:31 PM. The DON stated residents were scheduled for showers as the resident desired and the expectation was to give showers as the residents wished. The DON stated the nurse and CNA documented refusal of showers on the shower sheets. The DON stated she spoke with Resident #37 and the resident had not mentioned any problems with receiving showers. An interview was held with the Administrator on 05/23/2024 at 6:24 PM. The Administrator stated if a resident refused a shower, a shower sheet was completed and was given to the nurse. The Administrator stated that when the shower aides were not working, she expected the CNAs providing care to shower residents. The Administrator stated Resident #37 refused a lot of things and last fall 2023, the team planned to have the resident sign the shower sheets when the resident refused. The Administrator stated HR logged the showers for residents and the log was reviewed in the morning meeting, and HR should have reported the resident was missing showers. 42192 2. A Resident Face Sheet revealed the facility admitted Resident #34 on 04/05/2021. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disorder (COPD), major depressive disorder, muscle weakness, repeated falls, Alzheimer's disease, age-related osteoporosis, and anxiety disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/2024, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS revealed the resident did not refuse care during the assessment period. The MDS revealed the resident required partial/moderate assistance with showers/bathing. Resident #34's Care Plan, included a problem statement dated 10/03/2022 that indicated the resident had a diagnosis of Alzheimer's disease with late onset and dementia. Interventions directed staff to redirect the resident as needed and call the resident's Durable Power of Attorney (DPOA) to assist as needed. Resident #34's Care Plan did not address the resident's daily care needs for bathing or personal hygiene. The facility's shower scheduled revealed Resident #34 was scheduled for a shower on Mondays and Wednesdays. Resident #34's Skin Monitoring: Comprehensive CNA [Certified Nurse Aide] Shower Review forms for 03/2024 revealed the resident received two showers the first week of March on 03/06/2024 and 03/08/2024, two showers the second week of March on 03/12/2024 and 03/15/2024, no showers the third week of March (03/17/2024 through 03/23/2024), and one shower the fourth week of March, on 03/26/2024, which was 11 days since the last documented shower. Resident #34's Skin Monitoring: Comprehensive CNA Shower Review forms for 04/2024 revealed the resident received two showers the first week of April on 04/01/2024 and 04/05/2024, one shower the second week of April on 04/09/2024, two showers the third week of April on 04/17/2024 and 04/19/2024, one shower the fourth week of April on 04/23/2024, and no showers the week of 04/28/2024 through 05/06/2024. According to the documentation, the resident did not have a shower from 04/24/2024 through 05/06/2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #34's Skin Monitoring: Comprehensive CNA Shower Review forms for 05/2024 revealed the resident received one shower the week of 05/12/2024 through 05/18/2024, on 05/07/2023. Resident #34's Progress Notes for the timeframe from 04/24/2023 through 05/21/2024 revealed no documented evidence the resident refused showers/bathing or any additional shower/bathing documentation. During an interview on 05/20/2024 at 11:10 AM, Resident #34 stated they were unsure how often they received a shower or bath, but stated they did not get one every week. During an interview on 05/23/2024 at 10:06 AM, CNA #17 stated she worked at the facility as an agency contracted CNA and worked as the shower aide three days a week. She stated that during 02/2024 and 03/2024, she was pulled to help provide resident care and only provided resident showers approximately two days per week. She stated during that time, residents received at least one shower a week. CNA #17 stated they had a daily schedule to follow. She stated if someone's shower was not completed, she let staff know and offered to come in an extra day to complete resident showers. She stated a shower sheet was completed after each shower or bath, documenting skin concerns or any abnormalities noticed during bathing. She stated she turned her shower sheets into the nurse and told the nurse of any issues that needed attention. CNA #17 stated shower sheets should always be filled out after assisting a resident with bathing. She stated Resident #34 never refused showers and preferred two showers a week. During an interview on 05/23/2024 at 6:19 PM, the Administrator stated shower documentation should include refusals and multiple offers to assist the resident to shower by different staff. The Administrator stated the CNAs working the hallway should provide showers when a shower aide was not present. MO235269

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 42192 Based on interview, record review, review of an American Heart Association (AHA) blood pressure publication, and facility policy review, the facility failed to provide care and treatment in accordance with professional standards of practice and the comprehensive care plan for 1 (Resident #32) of 5 sampled residents whose medication regimen was reviewed. Specifically, on 04/06/2024 when Resident #32's blood pressure (BP) met the criteria for hypertensive crisis as defined by the AHA, nursing staff did not re-evaluate the resident or consult with the resident's physician. Findings included: An undated facility policy titled, Condition Change, Resident (Observing, Recording, and Reporting) (Includes Fall or Injury) indicated the purpose of the policy was To observe, record, and report and condition change to the attending physician so that proper treatment can be implemented. The policy revealed, 6. Notify physician of condition change, need for treatment orders and/or medication order changes. An AHA publication titled, Understanding Blood Pressure Readings, last reviewed 05/17/2024, revealed a Normal blood pressure was a systolic reading (upper number) less than 120 millimeters of Mercury (mmHg) and a diastolic reading (lower number) less than 80 mmHg. The AHA publication revealed a hypertensive crisis was a systolic reading higher than 180 mmHg and/or a diastolic reading higher than 120 mmHg. The AHA publication indicated, In hypertensive crisis, you need immediate medical attention. The AHA publication further indicated, In hypertensive crisis, you need medical attention. Wait five minutes after your first reading. Take your blood pressure again. If your readings are still unusually high, contact your health care professional immediately. A Resident Face Sheet revealed the facility admitted Resident #32 on 11/21/2023. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of bradycardia (slow heart rate) and essential (primary) hypertension. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/05/2024, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS revealed the resident had an active diagnosis of hypertension. Resident #32's Care Plan included a Problem area, started on 12/23/2023, that indicated the resident was at risk for a high blood pressure episode like a heart attack or stroke due to high BP and a heart arrythmia. The goal was for the resident to have no complications from high BP. Interventions started on 12/23/2023 directed staff to monitor for signs or symptoms of high BP and report to the charge nurse and to monitor vital signs and notify the physician of any abnormalities. Written documentation of daily BP checks for April 2024 revealed Resident #32's BP was being monitored daily. According to the documentation, Resident #32's blood pressure met the criteria for hypertensive crisis on 04/06/2024 when the resident's blood pressure reading was 189/113 mmHg. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #32's Progress Notes for April 2024, revealed no documentation regarding the resident's elevated blood pressure, that the resident's blood pressure was reassessed, or that the resident's physician was notified of the resident's high blood pressure reading. During an interview on 05/23/2024 at 10:06 AM, Certified Nurse Aide (CNA) #17 stated she took residents' vital signs and documented them for the nurse. She stated if a there was a significant change in a resident's vital signs, she would let the nurse know and take the resident's vital signs again. She stated in her past experience, nurses reevaluated the vital signs, and the charge nurse would report to the Director of Nursing (DON) and the physician. During an interview on 05/23/2024 at 11:46 AM, Licensed Practical Nurse (LPN) #18 stated if there was a discrepancy, a resident's blood pressure should be rechecked. She stated Certified Medication Technician (CMT) #19 had documented Resident #32's blood pressure readings and was usually pretty good about notifying a nurse when needed. During a telephone interview on 05/23/2024 at 4:21 PM, CMT #19 stated if there were no specific orders regarding BP for parameters for a resident, she still notified the nurse of any abnormal readings. During an interview on 05/23/2024 at 5:17 PM, the DON stated she expected the staff member who obtained abnormal blood pressure readings to report them to the nurse. The DON stated the nurse should review all vital signs and reassess residents with abnormal vital signs. She stated no concerns had been brought to her attention regarding Resident #32.

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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. 22445 Based on observation, record review, interview, and facility policy review, the facility failed to keep medication secure for 1 (Resident #30) of 1 sampled resident reviewed for accident hazards and failed to thoroughly investigate a fall and failed to implement fall interventions to prevent falls for 1 (Resident #28) of 1 sampled resident reviewed for falls. Findings included: 1. An undated facility policy titled, Medications, Self-Administration, Self Storage, Leave at Bedside, indicated, A physician's order will be obtained for each medication to be kept at the bedside. The policy also indicated, If the resident does not provide a locked box, the facility must provide a locked area for the medications. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/12/2024, revealed the facility admitted Resident #30 on 09/01/2020. The MDS revealed Resident #30 had active diagnoses that included hypertension, seizure disorder, anxiety, and depression. The MDS revealed Resident #30 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS revealed that Resident #30 had impaired vision and saw large print, but not regular print in newspapers or books, and the resident wore corrective lenses. Resident #30's Care Plan, last reviewed/revised on 04/15/2024, revealed it did not include information that resident had received orders to keep medications at their bedside or to self-administer medications. Resident #30's Physician Order Report, for the timeframe from 04/21/2024 through 05/21/2024, revealed an order for ciclopirox gel (an antifungal medication) 0.77 percent (%) to be applied topically to the toenail at bedtime, with a start date of 07/15/2022. The order did not indicate the medication could be kept at the resident's bedside. The Physician Order Report also included an order for clotrimazole-betamethasone lotion (a cortisone medication to treat fungal infections) 1-0.05% to be applied topically to the resident's hands three times a day as needed, with a start date of 09/19/2023. The order indicated that the medication could be kept at the resident's bedside. An observation on 05/20/2024 at 9:46 AM revealed ciclopirox gel 0.77% in Resident #30's room. During an interview at the time of the observation, Resident #30 stated the medication was used for itching everywhere except their eyes. Resident #30 stated they were unsure if the staff knew the medication was in the room. Two containers of clotrimazole-betamethasone dipropionate lotion was also observed in the resident's room at that time. Resident #30 stated the nurse had left the lotion at their bedside so the lotion could be applied before putting on compression stockings. Resident #30 stated they were shocked when the nurse left two containers of the same medication in the room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #30 was interviewed on 05/20/2024 at 10:29 AM. Resident #30 stated their physician had ordered the ciclopirox and had ordered that the medication could be kept at their bedside. Resident #30 stated they used the medication for itching on their hands. Resident #30 stated the clotrimazole-betamethasone lotion was also used on their hands and that they administered the medications independently. Resident #30 stated there was a resident that lived on the hall that tried to come into their room but so far, the resident had been stopped prior to entering the room. Resident #30 stated they had not been assessed to determine if they were safe to administer the medication and no instructions had been received to keep the medications out of sight in a dresser drawer or a locked box. Resident #30 stated they had used the medications prior to admission and had kept the medications in their room since admission. Certified Nurse Aide (CNA) #7 was interviewed on 05/22/2024 at 11:17 AM. CNA #7 stated if she saw medication left at a resident's bedside, she would notify a nurse. She stated she considered pills, creams, or any other medication that was physician-ordered and even over-the-counter cough drops as medication that should not be kept at a resident's bedside. CNA #7 stated she had seen physician-ordered medication in Resident #30's room and stated that the medication had been in the resident's room for as long as she remembered. CNA #7 stated the CNAs applied the medication when the resident requested and stated that the resident was independent and probably also applied the medication. CNA #7 stated she had not reported that Resident #30 had the medication at their bedside because she had not thought about it. CNA #2 was interviewed on 05/22/2024 at 12:20 PM. The CNA stated if she saw medications at a resident's bedside, she would ask the resident and the nurse if the medications were supposed to be at their bedside. She stated Resident #30 had a prescription cream at their bedside that the CNAs helped to apply. CNA #2 stated the medication had been at the bedside for a long time and the nurses were aware the medication was at Resident #30's bedside. Registered Nurse (RN) #4 was interviewed on 05/23/2024 at 5:00 AM. RN #4 stated she was only allowed to leave medications at a resident's bedside if the resident had been assessed and the physician had ordered the medications to be left at the bedside. RN #4 stated Resident #30 had clotrimazole-betamethasone at their bedside that was used on the resident's hands. RN #4 stated she was unsure if Resident #30 had an order for the medication to be left at their bedside and was unsure if the resident had been assessed for self-administration. RN #4 stated that previously, Resident #30's medications had been kept in the treatment cart and she had applied the medication for Resident #30. RN #4 stated she was unaware of how long the medication had been in the resident's room. A telephone interview was held with the Director of Nursing (DON) on 05/23/2024 at 12:31 PM. The DON stated medication should not be left at a resident's bedside unless the resident had an order for self-administration and no other residents were able to get to the medication. The DON stated a resident required an assessment for self-administration prior to self-administration of medications. The DON stated she was unaware of any residents whose medications were left at their bedside. The DON stated if staff saw medications at a resident's bedside, she expected the staff check to ensure the resident was allowed to have the medication at their bedside. The DON stated medications left at the bedside, on a hall with wandering residents was not safe. She stated she was used to residents having a locked box in their rooms for medications. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator (ADM) was interviewed on 05/23/2024 at 6:53 PM. The ADM stated she expected that before medications were left at a resident's bedside, staff obtained a physician's order and assessed the resident for self-administration. The ADM stated the danger of leaving medications in a room would be a wandering resident getting the medications. 2. An undated facility policy titled, Condition Change, Resident (Observing, Recording and Reporting) (Includes Fall or Injury), revealed Guidelines included Complete an incident, accident or risk management report per facility guidelines. A Resident Face Sheet revealed the facility admitted Resident #28 on 07/08/2019. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of generalized muscle weakness, vascular dementia, difficulty walking, embolism and thrombosis (blood clots) of the arteries in the lower extremities, and a right femur (a leg bone) fracture. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/26/2024, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated the resident required some help from staff with indoor mobility (ambulation). The MDS also indicated Resident #28 had a history of falling. Resident #28's Care Plan included a problem statement, with a start date of 11/26/2019, that indicated Resident #28 was at risk for falls related to impaired mobility. The Care Plan indicated that Resident #28 had an actual fall at the facility on 02/29/2024 that resulted in a fracture of the resident's right hip. Interventions directed staff to use a floor mat on the floor next to the resident's bed (initiated 08/11/2023), place the resident's bed in the lowest position (initiated 08/11/2023), and make sure all necessary personal items were within reach (initiated 08/09/2023). Resident #28's Fall Risk Assessment, dated 01/04/2024, revealed Resident #28 had sustained one or more falls in the previous six months. The assessment indicated the resident was a High Fall Risk. Resident #28's Event Report regarding a fall on 02/08/2024 at 9:30 AM revealed the resident had an unwitnessed fall in their room and was observed on the floor. The Event Report revealed Non-injury. The Event Report revealed the Event details, Possible Contributing Factors, Mental Status, Neurological Check, and the Interventions sections were not completed. The Event Report revealed, under the Notes section, the nurse documented that Resident #28 was found lying on the floor next to the resident's bed. The note indicated the resident stated that they had been fighting in their sleep again and indicated that the resident had a history of bad dreams and had thrown their self out of bed before. The note indicated a fall mat was placed by the resident's bedside and indicated that the bed was in a low, locked position, and their call light was within reach. There were no witness statements that indicated when Resident #28 was last seen or the condition the resident had been in at the time they were seen. Resident #28's Progress Notes revealed a note, dated 02/29/2024 at 12:32 PM, that revealed at 12:10 PM staff found Resident #28 lying on the floor. The note indicated that the resident was observed to have an open area to the top of their head and the resident complained of right hip pain. The note indicated the resident's right leg seemed to be shorter than the left and the resident was sent to the hospital for an evaluation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #28's Event Report regarding the fall on 02/29/2024 at 12:07 PM, created by Licensed Practical Nurse (LPN) #9, revealed that while Resident #28 was in their room the resident had an unwitnessed fall after going to the bathroom and then going to the sink. The Event Report indicated that the resident experienced severe pain, painful/limited range of motion of the upper extremities, abnormal body alignment, and a laceration/puncture. The report indicated there was rotation, deformity, or shortening of the right lower extremity. The Event Report revealed immediate interventions included immobilization or splinting of the area and direct pressure applied to the wound. The Event Report revealed preventative interventions included adjusting the bed to the lowest position, placement of a fall mat, a physical/occupational therapy consultation, shoes with non-skid soles, and instructions for staff to ensure necessary items were within reach of the resident. The Event Report indicated that Resident #28 was sent to the emergency department for an evaluation and treatment. Resident #28's Progress Notes revealed a note, dated 02/29/2024 at 2:38 PM, that revealed the hospital reported to the facility the resident had a right hip fracture. Resident #28's Progress Notes revealed a note, dated 03/05/2024 at 5:30 PM, that indicated Resident #28 was readmitted to the facility. An observation on 05/21/2024 at 10:27 AM revealed Resident #28 was lying in bed. The left side of the bed was against the wall. The bed was in the low position. There was no fall mat on the floor next to the resident's bed. On 05/22/2024 at 8:33 AM, Resident #28 was observed lying in bed. No fall mat was observed by the resident's bed. An interview was held with LPN #9 on 05/23/2024 at 3:51 PM. LPN #9 stated fall prevention interventions for Resident #28 included non-skid socks. LPN #9 stated she had been working when Resident #28 fell and fractured their hip. LPN #9 stated a certified nurse aide (CNA) found the resident and was unsure if the CNA had to write a statement of what was seen, but normally statements from witnesses were not completed for falls. LPN #9 stated there was a risk meeting held to determine why a resident fell and added the floor nurse on duty at the time of a resident's fall was not a part of the risk meetings. LPN #9 stated there had not been a fall mat used for Resident #28. LPN #9 stated the intervention of a fall mat was care planned for Resident #28 but not implemented because no one followed up and placed the fall mat. Certified Nurse Aide (CNA) #2 was interviewed on 05/22/2024 at 2:09 PM. CNA #2 stated new fall prevention interventions were communicated verbally by the nurse or a note would be left at the CNA desk. CNA #2 identified Resident #28 as being at risk for falls. CNA #2 identified the interventions for Resident #28 as an alarm, a low bed, and stated that the resident's door was left open. CNA #2 stated there was a fall mat in Resident #28's room under the bed and added that the mat should be on the floor next to the bed when the resident was in bed. Certified Medication Technician (CMT) #11 was interviewed on 05/22/2024 at 3:36 PM. CMT #11 stated she did not work on the shift when Resident #28 fell and broke their hip. CMT #11 stated fall prevention interventions were communicated by the nurse, the DON, or the Administrator (ADM). CMT #11 stated she had no knowledge of the fall prevention interventions for Resident #28 and added that she had not seen a fall mat by the resident's bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #6 was interviewed on 05/22/2024 at 2:44 PM. LPN #6 stated that when a resident fell , she was supposed to complete all needed paperwork, which included initiating an event report and initiate neurological checks. She stated that she was also expected to notify the resident's family. She stated that facility staff assessed the resident for 72 hours following a fall. LPN #6 stated nurses were expected to implement interventions to prevent further falls at the time of the fall. LPN #6 stated the new interventions were kept in a communication book at the CNA desk. LPN #6 stated it was the responsibility of the Director of Nursing (DON) to make sure the fall prevention interventions were used as care planned and stated there was no other follow-up to make sure the interventions were used. LPN #6 stated she was unaware of current fall prevention interventions in place for Resident #28. LPN #6 stated the nurses had access to the care plans for residents, but she was unsure what the fall care plan for Resident #28 included as interventions but stated that Resident #28 should have a fall mat in place. LPN #6 stated that when completing an event report, each section was expected to be completed. LPN #6 stated witnesses were listed but she had not seen witness statements. Registered Nurse (RN) #4 was interviewed on 05/23/2024 at 4:32 AM. RN #4 stated that when a resident fell , the nurses assessed the resident, an event report was initiated in the electronic medical record, and assessments were on-going for 72 hours. RN #4 stated all sections of the event report were expected to be completed but added she was unsure if an immediate intervention was expected to be placed to prevent further falls. RN #4 stated if a resident was a fall risk, a magnetic leaf was placed on the resident's door frame to their room. RN #4 identified Resident #28 as a fall risk. RN #4 stated fall prevention interventions for Resident #28 included not leaving the resident alone while using the toilet. RN #4 stated she had no knowledge where to find the interventions for Resident #28. RN #4 stated she had not seen a fall mat at Resident #28's bedside and stated a fall mat was not needed since the resident had not fallen out of bed. She stated that she had not been informed that the resident fell out of bed 02/08/2024. Nurse Aide (NA) #12 was interviewed on 05/23/2024 at 5:04 AM. NA #12 stated information about fall interventions could be found in Resident #28's care plan. NA #12 stated she had not seen a fall mat by Resident #28's bed. NA #12 stated there was not a book that included fall interventions for residents and stated any new fall interventions initiated were communicated verbally from staff to staff. A telephone interview was held with the DON on 05/23/2024 at 12:31 PM. The DON stated she expected event reports to be completed in their entirety by the nurse on duty at the time of the event. The DON stated she expected a new intervention to be placed each time a resident had a fall. The DON stated all staff were responsible for making sure fall interventions were used. The DON stated it was her opinion that a fall mat was not appropriate for Resident #28 but if a fall mat was on the care plan, then a fall mat should be in place when the resident was in bed. She stated that without the incident report being completed, there was not an adequate and complete investigation for the fall. The DON stated Resident #28's diagnosis of post-traumatic stress disorder and bad dreams were likely the root cause of the resident's fall and agreed the interventions used had not addressed the root cause. The DON stated she expected staff to meet after a fall to discuss when the resident was last seen and what had happened and expected that information to be included in a progress note. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADM was interviewed on 05/23/2024 at 6:24 PM. The ADM stated that when a resident fell , she expected an intervention to be implemented to prevent further falls. She stated the event report should be fully completed and closed. The ADM stated the DON was responsible for making sure event reports had been completed. She stated she expected any care planned interventions to be used consistently and added it was a team effort to make sure interventions were implemented. The ADM stated the purpose of a fall investigation was to determine what occurred and included the time of the fall, if the fall was observed, what happened, interviews to determine when the resident was last seen, and the condition of the resident. The AMD stated interviews should be recorded either in the event report or the nurse's notes.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 22445 Based on observation, interview, record review, and facility policy review, the facility failed to monitor and record fluid intake for 1 (Resident #28) of 3 sampled residents reviewed for nutrition, who had a physician's order for a fluid restriction. Findings included: A facility policy titled, Fluid Restriction, dated 05/2015, specified, 2. The DSM [Dietary Supervisor/Manager] or designee will consult with nursing staff to determine amounts of fluid to be given at meals, medication passes and at bedside. According to the policy, 6. Input/Output (I/O) records will be completed daily by the nursing department on all residents with fluid restriction prescriptions. A Resident Face Sheet revealed the facility admitted Resident #28 on 07/08/2019. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of end-stage renal disease and edema. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/26/2024, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had an active diagnosis of renal insufficiency, renal failure, or end-stage renal disease. The MDS indicated Resident #28 received hemodialysis services while a resident. Resident #28's Care Plan, included a problem statement dated 07/12/2022 that indicated the resident was on dialysis for renal failure. Interventions directed staff to monitor and record the resident's intake of food and fluids (initiated 07/12/2022). Resident #28's Physician Order Report for the timeframe from 04/23/2024 through 05/23/2024 indicated Resident #28 had an order for a 1500 milliliter (ml) fluid restriction that started on 04/24/2024 and was discontinued on 05/22/2024 (when the dialysis center transferred the resident to the hospital). Resident #28's medical record revealed no documented evidence the facility monitored and recorded the resident's fluid intake. An observation was made on 05/20/2024 at 1:58 PM. Resident #28 was eating lunch. On the resident's overbed table, a clear cup was observed holding 300 ml of water. An observation was made on 05/21/2024 at 1:03 PM. Resident #28 had consumed 100% of the lunch provided. On the resident's tray was an eight-ounce empty cup. Resident #28 stated the cup had contained a fruit flavored drink. Resident #28 stated they had been informed of the fluid restriction and they tried to adhere to the fluid restriction. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant (CNA) #2 was interviewed on 05/22/2024 at 2:09 PM. CNA #2 stated Resident #28 received a mechanical soft diabetic diet and had no limitation on fluids, except for orange juice. CNA #2 stated if a resident was on a fluid restriction the information should be in the electronic medical record. CNA #2 stated she was not aware that Resident #28 was on a fluid restriction. CNA #2 stated at one time, the certified medication technicians (CMT) kept track of residents' fluid consumption, but they did not keep track anymore. CNA #2 stated she was unaware how much fluid Resident #28 drank from day to day and was unable to report what the resident had consumed. Licensed Practical Nurse (LPN) #6 was interviewed on 05/22/2024 at 2:44 PM. LPN #6 stated Resident #28 went to dialysis every Monday, Tuesday, and Wednesday. LPN #6 stated she was aware that Resident #28 was on fluid restriction but was unsure how much the resident was allowed to drink per day. LPN #6 stated the facility had not kept very good track of Resident #28's fluid intake, and they had not determined the amount of fluids that dietary and nursing would provide daily. LPN #6 stated Resident #28 had a cup at their bedside, and CNAs provided ice water. LPN #6 stated there was no process in place for tracking fluids for residents on a fluid restriction and was unable to say where the fluid consumed by Resident #28 was recorded on a daily basis. In addition, LPN #6 stated it was unclear who was responsible for calculating and monitoring the resident's 24-hour fluid intake; however, she stated the nurses probably should report to the physician when the resident exceeded the ordered fluid amount. LPN #6 stated she was unaware whether the resident's physician was aware Resident #28's fluid consumption was not recorded. LPN #6 stated she had no knowledge of how much fluid the resident drank on any day. Registered Nurse (RN) #4 was interviewed on 05/23/2024 at 4:44 AM. RN #4 stated she arrived for work at 6:30 PM and put 240 ml of water in Resident #28's cup for use during the night shift. RN #4 stated the facility did not document fluid intake for Resident #28, which was a problem because she had no idea what Resident #28 had consumed on the previous shift. RN #4 stated there was no way of knowing how much fluid Resident #28 consumed in a 24-hour period. A telephone interview was held with the Dialysis Facility Administrator (DFA) on 05/23/2024 at 2:11 PM. The DFA stated the dialysis center dietician assessed Resident #28's fluids week by week and discussed fluids and laboratory results with the resident. The DFA stated the resident's laboratory results had not been good. The DFA stated they sent Resident #28 to the hospital from dialysis due to shortness of breath. The DFA added that for the past few weeks the dialysis center had issues removing fluid from the resident due to a low blood pressure. She stated Resident #28 had congestive heart failure and other co-morbidities that could impact the resident's fluid build-up. The DFA stated the facility had not provided any fluid intake records; however, the dialysis center had no concerns about Resident #28's fluid intake. The Administrator was interviewed on 05/23/2024 at 6:24 PM and stated she expected Resident #28's fluid intake to be recorded and shared between shifts. The Administrator stated she was unaware there was no documentation of the resident's fluid intake.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 22445 Based on interview, record review, and facility policy review, the facility failed to communicate with a dialysis provider for 1 (Resident #28) of 1 sampled resident reviewed for dialysis services. Findings included: An undated facility policy titled, Dialysis, Care of A Resident Receiving, indicated, Communication between the Facility and Dialysis Unit included, The Dialysis Communication Record will be sent with the resident on each dialysis visit. All care concerns in the last 24 hours will be addressed, including last medications given and facility contact person. The dialysis unit will complete the lower portion of the report to include weight prior to and after dialysis, any labs completed, medication given, follow up information and any new physician orders. The lower portion will be signed by the dialysis nurse and returned to the facility. These records will be maintained in the medical record. A Resident Face Sheet revealed the facility admitted Resident #28 on 07/08/2019. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of end-stage renal disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/26/2024, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated active diagnoses included end-stage renal disease. The MDS indicated Resident #28 received dialysis services while a resident. Resident #28's Care Plan included a problem statement initiated 07/12/2022, that indicated the resident had renal dialysis for renal failure. The care plan included approaches that informed staff the resident attended dialysis on Mondays, Wednesdays, and Fridays (initiated 09/16/2022). Resident #28's Physician Order Report, for the timeframe from 04/23/2024 through 05/23/2024, indicated an order for Resident #28 to attend dialysis three times a week, Mondays, Wednesdays, and Fridays, with a start date of 04/17/2024 and an end date of 05/22/2024. Licensed Practical Nurse (LPN) #6 was interviewed on 05/22/2024 at 2:44 PM. LPN #6 stated Resident #28 attended the dialysis clinic on Mondays, Wednesdays, and Fridays, leaving the facility around 10:00 AM and returning between 1:00 PM and 2:00 PM. LPN #6 stated that prior to that day there had been no communication report that was sent to dialysis and added she had been given the report on 05/22/2024 to start using. A telephone interview was held with the Director of Nursing (DON) on 05/23/2024 at 12:31 PM. The DON stated communication between the facility and the dialysis center was completed with a form that was filled out and sent to the dialysis center and then the dialysis center sent the form back. The DON stated if an emergent situation arose, she expected the parties to call each other. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was held with the Dialysis Facility Administrator (DFA) on 05/23/2024 at 2:11 PM. The DFA stated that every once in a while, the dialysis center received a form requesting Resident #28's weight, but not often. The DFA stated she had received a communication form the day prior and stated that it was a surprise. The DFA stated that the center usually called the facility and verbally relayed what had occurred in dialysis. The DFA stated she spoke with LPN #6 on 04/23/2024 about monitoring the resident's heart rate and reviewed medications with the LPN. The DFA stated that when the resident's blood pressure was low, she called and request the resident's blood pressure medication be held. The Administrator (ADM) was interviewed on 05/23/2024 at 6:24 PM. The ADM stated communication between the facility and the dialysis center was expected to be documented in the progress notes or include any fax in the medical record.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 42192 Based on interview, record review, and facility policy review, the facility failed to ensure residents' medication regimen was free of unnecessary medications for 2 (Resident #34 and Resident #41) of 6 residents reviewed for unnecessary medications. Specifically, the facility failed to specify the target behaviors for which antipsychotic medications were prescribed, failed to monitor for potential adverse drug reactions, and failed to complete behavior tracking for Resident #34 and Resident #41 to ensure continued use of an antipsychotic was indicated. Findings included: An undated facility policy titled, Drug Review indicated, 5. Medications should not show unnecessary or excessive use and should have a diagnosis to support them. The section of the policy addressing Reviewing Antipsychotic Drugs, specified, 1. Antipsychotic drugs should only be given when necessary to treat a specific condition. 2. Review all charts of residents receiving the following drugs. Check for one or more specific diagnoses or conditions for antipsychotic drugs including: a. Schizophrenia b. Schizo-affective disorder c. Delusional disorder d. Psychotic and mood disorders (including mania and depression) e. Acute psychotic episodes f. Brief reactive psychosis g. Schizophrenia-form disorder h. Atypical psychosis i. Tourette's disorder j. Huntington's disease k. Organic mental syndromes (including dementia) with associated psychotic features as defined by: 1. Behavior (biting, kicking, scratching) which cause the resident to present a danger to themselves, others, and/or interfere with staff's ability to provide care. 2. Psychotic symptoms (hallucinations, paranoia, delusions) that cause the resident frightful distress. 3. Short term (seven days) symptomatic treatment of hiccups, nausea, vomiting or pruritus. 3. Review nurse's notes and/or behavior forms for charting of behavior, to assure that there is indication of more antipsychotic use: a. Simple pacing b. Wandering c. Poor self-care d. Restlessness e. Crying out, yelling or screaming f. Impaired memory g. Anxiety h. Depression i. Insomnia j. Unsociability k. Indifference to surroundings l. Fidgeting and nervousness m. Uncooperativeness n. Any indication for which the order is on a PRN [as needed] basis. 1. Resident #34's Resident Face Sheet revealed the facility admitted the resident on 04/05/2021 with diagnoses that included major depressive disorder, Alzheimer's disease, and anxiety disorder due to known physiological condition. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/2024, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS revealed the resident did not experience hallucinations or delusions and did not exhibit any behaviors during the seven-day assessment look-back period. According to the MDS, the resident was taking an antipsychotic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #34's Care Plan revealed a Problem area, started on 10/19/2021, addressing behavioral symptoms, that indicated the resident was at high risk for elopement. Another Problem area, started on 11/19/2021, indicated the resident had a diagnosis of anxiety. An intervention started on 11/19/2021 directed staff to utilize medications as prescribed by the resident's physician. The Care Plan did not address Resident #34's use of an antipsychotic medication and did not include interventions related to target behaviors or monitoring for potential adverse drug reactions associated with the use of an antipsychotic medication. A review of Resident #34's Physician Order Report for the timeframe from 04/22/2024 through 05/22/2024 revealed an active order dated 07/18/2022 for quetiapine tablet (an antipsychotic medication), 25 milligrams (mg), one-half tablet twice a day for a diagnosis of Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance. The order did not specify any targeted behaviors for which the medication was prescribed. The Physician Order Report did not include an order for behavior tracking or monitoring for adverse drug reactions. Resident #34's Medications Flowsheets and Treatment Flowsheets for March 2024, April 2024, and May 2024 revealed no documentation regarding any target behaviors associated with the use of quetiapine, no behavior tracking information, and no monitoring for adverse drug reactions related to the use of quetiapine. Resident #34's Progress Notes for the timeframe from 04/24/2023 through 05/21/2024 revealed there was no documentation of routine, ongoing behavior tracking. Resident #34's Nuse TAR [treatment administration record] Flowsheet for May 2024 revealed the transcription an order started on 05/10/2024 for behavior monitoring every shift, that included monitoring for yelling, hallucinations, hitting, biting, pacing, crying, rejection of care, disrobing, wandering, rummaging, sexual inappropriateness, exit-seeking, sleep disturbances, isolating self, delusions, crawling out of bed, disruptive noises, cursing, paranoia, and OTHER/DESCRIBE. However, the Nurse TAR Flowsheet contained no documentation of the completion of behavior monitoring each shift as ordered. During an interview on 05/23/2024 at 5:32 AM, Registered Nurse (RN) #4 stated she had worked at the facility since the end of March 2024. She stated she was familiar with Resident #34. She stated the resident wandered and could be vocally assertive if they felt their needs were not being met. RN #4 said she had not seen the resident's Nurse TAR Flowsheet with information about behavior monitoring and interventions prior to 05/23/2024. During an interview on 05/23/2024 at 11:46 AM, Licensed Practical Nurse (LPN) #18 stated behaviors were not tracked very well at the facility. She stated nursing staff did not have time to complete behavior documentation. She stated Resident #34's Nurse TAR Flowsheet with information about behavior monitoring and interventions was not in their chart until the morning of 05/23/2024. LPN #18 confirmed the resident had been receiving quetiapine since July 2022. LPN #18 further stated she had never completed any behavior monitoring for the resident and was unsure why the resident was receiving an antipsychotic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 05/23/2024 at 2:15 PM, the Medical Director (MD) stated Resident #34's primary physician was out of town, but he was willing to answer questions. The MD stated dementia with agitation or anxiety was not an appropriate indication for use of an antipsychotic medications and said wandering was not a behavior that warranted the use of an antipsychotic mediation. The MD further stated he expected staff to monitor and document all behaviors exhibited by residents. During a telephone interview on 05/22/2024 at 12:31 PM, the Director of Nursing (DON) stated if a resident received an antipsychotic medication, behavior monitoring should be documented on the medication flowsheets and reflect anytime a behavior occurred. The DON said there should also be a progress note related to any behaviors exhibited by residents. The DON said a diagnosis of dementia with anxiety was not sufficient to warrant the use of an antipsychotic medication. She further stated a target behavior was a behavior a medication was being used to stop or reduce and indicated target behaviors should be specified. During a follow-up telephone interview on 05/23/2024 at 5:17 PM, the DON stated Resident #34 received medication that required behavior monitoring. The DON confirmed there was no behavior monitoring for Resident #34 until she printed out the forms after the concern was brought to her attention. 22445 2. A Resident Face Sheet revealed the facility admitted Resident #41 on 02/06/2023. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of unspecified dementia with agitation, unspecified altered mental status, and anxiety disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/08/2024, revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #41 had delusions and wandered four to six days during the seven-day assessment look-back period. According to the MDS, the resident received an antipsychotic medication. Resident #41's Care Plan included a Problem area, started on 05/08/2024, that indicated the resident received a psychotropic medication. The Problem area identified the psychotropic medication as an antipsychotic medication but did not specify which one or why the medication was prescribed. An approach dated 05/08/2024 directed staff to Assess/record effectiveness of drug treatment. Monitor and report signs of sedation, anticholinergic and/or extrapyramidal symptoms. Other Problem areas, started on 02/06/2024, indicated the resident had cognitive loss/dementia and anxiety disorder. Resident #41's Physician Order Report contained an order, started on 04/18/2023, for quetiapine tablet (an antipsychotic medication) 25 milligrams (mg), give one-half tablet (12.5 mg) at bedtime for a diagnosis of Unspecified dementia, unspecified severity, with agitation. According to the Physician Order Report, this order was discontinued on 03/07/2024. Resident #41's Progress Notes contained a Nurses note, dated 03/07/2024 at 6:31 PM, that indicated the resident's physician rounded and provided a new order to increase Resident #41's quetiapine to 25 mg at bedtime for dementia with agitation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #41's April 2024 and May 2024 Medications Flowsheets revealed transcription of the order for Resident #41 to receive 25 mg of quetiapine at bedtime, started on 03/08/2024. The Medications Flowsheets reflected documentation that indicated the resident received the medication daily as ordered, but there was no documentation regarding any target behaviors associated with the use of quetiapine, no behavior tracking information, and no monitoring for adverse drug reactions related to the use of quetiapine. An observation was made on 05/21/2024 at 1:05 PM. Resident #41 was in the assisted dining room moving food around on a plate with a fork. Licensed Practical Nurse (LPN) #13 stated Resident #41 had been drowsy throughout the meal. Certified Nurse Aide (CNA) #7 was interviewed on 05/22/2024 at 11:13 AM. CNA #10 stated that recently it seemed Resident #41 was sleeping more. CNA #10 said she had wondered if the resident had been given a new medication. CNA #10 further stated the only behavior she was aware Resident #41 exhibited was wandering. CNA #1 was interviewed on 05/22/2024 at 11:38 AM. CNA #1 stated the only behavior exhibited by Resident #41 was wandering. CNA #1 stated she had noticed Resident #41 recently slept more during the day, but she had not reported the increased sleep to anyone because she had not thought much about the resident sleeping more. CNA #2 was interviewed on 05/22/2024 at 12:13 PM. CNA #2 stated Resident #41 wandered into other resident's rooms and even opened closed doors during care for other residents. CNA #2 stated Resident #41 was not aggressive and had no other behaviors. CNA #2 stated she had noticed the resident was sleeping more but she had not reported the increased sleep to anyone, adding the nurses could see the resident was sleeping more just as she had noticed. Nursing Assistant (NA) #12 was interviewed on 05/23/2024 at 5:19 AM. NA #12 stated Resident #41 had no aggressive or threatening behaviors and indicated the only behavior she had observed from Resident #41 was wandering. Registered Nurse (RN) #4 was interviewed on 05/23/2024 at 5:23 AM. RN #4 stated any behaviors exhibited by residents were either recorded on the medication flowsheets or in the nursing progress notes. RN #4 stated Resident #41 was not aggressive and had not exhibited any behaviors that could harm themself or others. RN #4 reviewed Resident #41's record for 05/2024 and stated the only behavior documented for the resident was wandering. The SSD was interviewed on 05/23/2024 at 9:42 AM. The SSD stated she was not familiar with the term target behaviors. The SSD stated antipsychotic medications were used for residents that exhibited delusions, hallucinations, and psychosis. The SSD stated Resident #41 had been prescribed an antipsychotic for dementia and had to be redirected. The SSD stated the nurses were expected to monitor for behaviors and document any behaviors exhibited by the resident in the progress notes or the medication flowsheets. The SSD added Resident #41 had no aggressive behaviors and had no threatening behaviors toward themself or others. The SSD reviewed the progress notes and care plan for Resident #41 and stated she found no documentation of behaviors for Resident #41 that supported the increase in the resident's antipsychotic medication and agreed there was no target behavior specified. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #6 was interviewed on 05/23/2024 at 2:44 PM. LPN #6 stated behaviors were either documented by the nurses on the medication flowsheets or in the progress notes. During a telephone interview on 05/22/2024 at 12:31 PM, the Director of Nursing (DON) stated if a resident received an antipsychotic medication, behavior monitoring should be documented on the medication flowsheets and reflect anytime a behavior occurred. The DON said there should also be a progress note related to any behaviors exhibited by residents. She further stated a target behavior was a behavior a medication was being used to stop or reduce and indicated target behaviors should be specified. During a telephone interview on 05/23/2024 at 2:15 PM, the Medical Director (MD) stated Resident #41's primary physician was out of town, but he was willing to answer questions. The MD stated dementia with agitation or anxiety was not an appropriate indication for use of an antipsychotic medications and said wandering was not a behavior that warranted the use of an antipsychotic mediation. The MD further stated he expected staff to monitor and document all behaviors exhibited by residents. The Administrator was interviewed on 05/23/2024 at 6:24 PM. The Administrator stated that all resident behavior needed to be documented so the physician had an accurate picture of what was going on with a resident. The Administrator stated if Resident #41's antipsychotic medication was increased in the absence of behaviors, the charge nurse should have discussed the issue with the DON.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39714 Based on observation, interview, and facility policy review, the facility failed to ensure staff stored food for residents in a sanitary manner. Specifically, the facility failed to label, date, and discard left over food. This had the potential to affect 43 of 43 residents who received nourishment from the facility kitchen. Findings included: A facility policy titled, Food Safey Requirements, undated, indicated, Proper Labeling and Dating of all foods. All foods will be considered as leftovers unless in the original container with an expiration date. Leftovers will be discarded after the third (3rd) storage day. An observation of the kitchen was conducted on [DATE] at 9:37 AM with the Dietary Supervisor (DS). More than 50 heavily frosted freezer storage bags that contained left over food items were observed in the facility's deep freezer. Forty-two of the freezer storage bags were dated ranging from [DATE] to [DATE] with no description of the contents. Ten of the freezer storage bags did not contain a proper date or description of the contents. During an interview on [DATE] at 9:41 AM, the DS stated she was aware of the problem and said the Dietary Manager Assistant (DMA) had come to work to assist in discarding the items. The DS confirmed there were over 50 freezer storage bags that needed to be discarded. The DS stated it was her expectation for all stored left-over items to contain a description and date. During an interview on [DATE] at 10:31 AM, Dietary Aide (DA) #15 stated left over food items should be labeled with a time, date, and description of the contents. DA #15 further stated that left over items should be discarded if not used within three or four days. During an interview on [DATE] at 10:55 AM, the DMA stated that all stored leftovers should contain a date, label, and a use by date in which the item should be used. The DM further stated that all staff members were responsible for discarding expired items. A follow-up kitchen observation was conducted on [DATE] at 11:04 AM. During this observation, the following items were observed in the walk-in deep freezer: One freezer storage bag of French toast sticks labeled with no date, one freezer storage bag of pancakes with no description or date, one freezer storage bag of sliced apples labeled with no date, four freezer storage bags of diced green peppers labeled and dated [DATE], and one freezer storage bag of rib meat patties with no description or date. The following was observed in the walk-in refrigerator: One freezer storage bag of cooked bacon with no description or date and one freezer storage bag of shredded cheese with no description or date. The Administrator (ADM) was interviewed on [DATE] at 11:08 AM. The ADM stated their expectation was that left over food be labeled and dated when stored. The ADM said the facility had a three-day storage policy and any food stored beyond that time should be discarded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265807	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Home	1313 South 25th St Bethany, MO 64424

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 42192 Based on interview and facility document review, the facility failed to maintain a water management program to minimize the risk of Legionella in the facility's water supply. This had the potential to affect all 43 residents who resided in the facility. Findings included: During an interview on 05/22/2024 at 11:15 AM, the Administrator stated the facility did not have a policy for general maintenance. The facility's Monthly Water Management Checklist, dated 05/06/2024, revealed, the date of the last annual cleaning and control measure checks were on 05/06/2024 and included the following systems and fixtures: showerheads/hoses, water heaters, hot tubs/saunas, pipes, valves, and fittings, ice machines, eye wash stations, aerators, and heating and air conditioning units. The checklist revealed a visual inspection of the areas showed no signs of biofilm or sediment. The checklist revealed no documented evidence the electric and manual faucets, hot and cold-water storage tanks, or the water on closed wings/halls had an annual cleaning or monthly control measure checks. In addition, the checklist revealed no documented evidence the facility had a system to assess the water systems using text and flow diagrams. During an interview on 05/22/2024 at 3:24 PM, the Maintenance Supervisor stated he had been with the facility for approximately one month. He stated he completed the monthly checklist but had received no training regarding Legionella. He stated an Independent Environmental Consultant was in the facility recently to show him the facility's sprinkler systems but did not share anything with him regarding the facility water system or the water flow of the facility. During a telephone interview on 05/23/2024 at 4:29 PM, the Independent Environmental Consultant stated he trained the facility Maintenance Supervisor. He stated he went over every line item on the Monthly Water Management Checklist with the Maintenance Supervisor the previous month, and the water checks that had to be done monthly. He stated that during the visual checks he looked for scale and build-up. He stated there was no test kit used to check for biofilm; the pipes had to be cleaned and monitored for calcium build-up. He stated he had never seen a map of the facility pipes, but the facility was supposed to have one. He stated he did not think there was a place where water could stand but without a map it would be hard to know for sure. During a telephone interview on 05/23/2024 at 5:17 PM, the Director of Nursing (DON), who was also the facility's Infection Preventionist, stated she had been the DON since March 2024 and had not discussed Legionella during infection control meetings. She stated she knew what Legionella was and that it could develop in standing water. During an interview on 05/23/2024 at 1:37 PM, the Administrator stated she believed the Maintenance Supervisor monitored the facility water for Legionella. She stated the facility's Independent Environmental Consultant completed the checklist to monitor for Legionella and trained the facility's Maintenance Supervisor on how to monitor the water system.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 42192 Based on interview and record review, the facility failed to provide pneumococcal vaccine to 1 (Residents #8) of 5 residents reviewed for vaccinations. Findings included: A Resident Face Sheet revealed the facility admitted Resident #8 on 08/01/2019 and readmitted the resident on 03/04/2022. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of acute upper respiratory infection. Resident #8's Pneumococcal Immunization Informed Consent revealed the resident's responsible party (RP) gave consent for the resident to receive a pneumococcal vaccine on 09/26/2022. The Pneumococcal Immunization Informed Consent was signed and dated by the resident's RP on 09/26/2022. Resident #8's Immunization: Consent or Refusal form revealed the resident's RP gave consent for the resident to receive a pneumococcal vaccine 09/18/2023. The Immunization: Consent or Refusal form was signed and dated by the resident's RP on 09/18/2023. Resident #8's Preventative Health Care vaccination record revealed no evidence the resident had received a pneumococcal vaccination. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/08/2024, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was not up to date on their pneumococcal vaccine. During an interview on 05/23/2024 at 6:48 PM, Resident #8 stated they could not recall if they had received or been offered a pneumococcal vaccine. During a telephone interview on 05/23/2024 at 5:17 PM, the Director of Nursing (DON) stated pneumococcal vaccinations were offered upon admission and if accepted were then ordered and administered. She stated the pneumococcal vaccine should be offered to all residents unless their physician determined it was contraindicated. The DON said she was unaware of any residents who requested a vaccination that had not received it. During an interview on 05/23/2024 at 6:19 PM, the Administrator stated she was unable to find any records that a pneumococcal vaccination was administered to Resident #8. She stated the consent was present, but the vaccination had never been administered. The Administrator stated she meant to review the pneumococcal consents in November of 2023 but had failed to follow up and provide the vaccinations. She stated the former DON, who was responsible for the coordination of the vaccination program, did not follow through with the vaccinations during their employment.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 39714 Based on observation and interview, the facility failed to ensure essential kitchen equipment was maintained in a safe operating condition. The deficiency affected 2 of 3 ovens, 1 of 2 freezers, and 1 of 1 food steamers in the kitchen. Findings included: The Administrator was interviewed on 05/22/2024 at 12:43 PM. The Administrator stated that the facility had no general maintenance policy. 1. An observation of the kitchen was conducted on 05/20/2024 at 9:48 AM with the Dietary Supervisor (DS). During this observation, a drip pan was observed inside of the walk-in freezer, positioned under the motor fan, and filled with ice. The pipes attached to the freezer's motor fan were covered with ice. During an interview at the time of the observation, the DS stated that staff had to throw away the drip pan about every day and replace it with a new one to catch the dripping water. An observation of the walk-in freezer was conducted with the Maintenance Supervisor (MS) on 05/21/2024 at 4:55 PM. The observation revealed ice build-up around the top of the door, across the ceiling, and on the pipes attaching to the fan motor. A plastic drip pan was observed positioned under the fan motor half filled with ice. The right-side of the walk-in freezer floor was covered with frost. During an interview at the time of the observation, the MS stated that he was unaware of an ice buildup in the freezer and confirmed that it was a safety hazard. He stated that someone looked at the freezer but was not sure what they were doing about it. An Invoice dated 01/14/2024 revealed a vendor serviced the facility's walk-in cooler/freezer, indicating that adjustments were made to the thermostat for the walk-in freezer. The Invoice indicated Found No Other Apparent Issues. During an interview on 05/21/2024 at 10:31 AM, Dietary Aide (DA) #15 confirmed that there had been ice buildup on the floors and boxes of the walk-in freezer. DA #15 stated that he did not think it had not been fixed. During an interview on 05/21/2024 at 10:55 AM, the Dietary Manager Assistant (DMA) confirmed that there was a slow drip in the deep freezer. The DMA further stated that the ice buildup on the floors of the deep freezer was from staff neglecting to empty the drip pan. 2. An observation on 05/21/2024 at 11:37 AM, revealed the door of Oven 2 was observed hanging from the hinges and unable to close correctly. During an interview at the time of the observation, the Dietary Manager Assistant (DMA) stated that the door was broken, and they were just using the oven to keep food warm. An observation of Oven 2 was conducted on 05/21/2024 at 4:53 PM with the Maintenance Supervisor (MS). The observation revealed the door was unable to close/function properly. During an interview at the time of the observation, the MS stated he was unaware that the door of Oven 2 was not functioning as designed. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/21/2024 at 10:31 AM, Dietary Aide (DA) #15 stated the facility only had one of their three ovens working properly. DA #15 stated Oven 1 stopped working the day prior and a maintenance staff told them not to use it and the door handle for Oven 2 was broken and was rarely used. During an interview on 05/21/2024 at 10:55 AM, the DMA confirmed an oven was not working due to a faulty on/off switch. During an interview on 05/23/2024 at 1:48 PM, the Dietary Supervisor (DS) stated that one of the ovens was not heating correctly, so they only used it to warm the food. 3. During an observation on 05/21/2024 at 4:51 PM, the steamer in the kitchen was not in working order. During an interview at the time of the observation, the Maintenance Supervisor (MS) stated that no one had reported to him that the steamer was broken, and he did not know what was wrong with it. He stated that he heard it broke over a year ago, but he had only worked at the facility since April (2024). During an interview on 05/21/2024 at 10:31 AM, Dietary Aide (DA) #15 stated that the kitchen steamer broke about a month ago and it was reported to the DS, but he did not think it had not been fixed. During an interview on 05/21/2024 at 10:55 AM, the Dietary Manager Assistant (DMA) stated a quote to repair the steamer was received but nothing had been done to fix it. The Administrator (ADM) was interviewed on 05/23/2024 at 11:08 AM. The ADM stated that the staff member who identified an issue with equipment needed to complete a work order. The ADM further stated that the expectation was for staff to complete work orders for maintenance, and for the maintenance staff to follow up with repairs and to turn in work orders when completed. The ADM stated that a vendor had looked at the fan in the walk-in freezer. She stated that when she talked to the vendor the day prior, he did not know about the ice or frost on the floor and door but thought it may be due to the door not being shut.