STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265856	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair View Health Care Center	1714 W 16th Street Sedalia, MO 65301

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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 0567 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to manage his or her financial affairs. 39644 Based on interview and record review, facility staff failed to ensure residents have appropriate access to their trust fund account to include on the weekends. The facility census was 53. 1. Review of facility's Resident Trust Policy, dated 02/02/24, showed the facility shall allow the residents access to their personal possessions and funds during regular business hours, Monday through Friday. Review of the facility's Admission Packet, undated, showed the facility shall allow the residents access to their personal possessions and funds during regular business hours, Monday through Friday. During an interview on 08/28/24 at 9:40 A.M., the Corporate Business Office Manager said the corporation policy states resident access to funds is during business hours Monday through Friday. The business office manager said, she was unsure exactly what regulation says about access to funds outside of business hours. During an interview on 08/29/24 at 5:00 P.M., the Administrator said she has never had access to money on the weekends ever arise, but if a nurse was to cover money for a resident, she would pay them back later from the petty cash kept at the facility. The administrator said she is aware of what the regulation says about residents' access to funds.

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 39644 Based on interview and record review, facility staff failed to check the Employee Disqualification List (EDL) (a list of individuals who have been determined to have abused or neglected a resident or misappropriated funds or property belonging to a resident), criminal background check (CBC), and Family Care Safety Registry (FCSR) prior to hire in accordance with their facility policy for nine (Registered Nurse (RN) E, Nurse Aide (NA) D, Certified Medication Technician (CMT) F, Dietary Aide G, laundry aide H, housekeeping aide I, maintenance J, Certified Nurse Aide (CNA) K, and CNA L) out of ten sampled employees. The facility census was 53. 1. Review of the Facility's Screening- Applicant, Employee, Volunteer and Vendor (Missouri) policy, Revised May 2024, showed: -HR staff will conduct the following screens on potential employees prior to hire; -Criminal history- Using the request for Criminal Record Check, a criminal background check should be done through Missouri Highway Patrol's Missouri Automated Criminal History Site; -FCSR; -EDL list. 2. Review of RN E's personnel record showed the employee with a hire date of 11/27/23. The personnel record did not contain documentation staff completed a FCSR or CBC/ EDL check prior to his/her hire date. 3. Review of NA D's personnel record showed the employee with a hire date of 01/31/24.The personnel record did not contain documentation staff completed a FCSR or CBC/ EDL check prior to his/her hire date. 4. Review of CMT F's personnel record showed the employee with a hire date of 09/28/23. The personnel record did not contain documentation staff completed a FCSR or CBC/ EDL check prior to his/her hire date. 5. Review of Dietary aide G's personnel record showed the employee with a hire date of 11/07/23. The personnel record did not contain documentation stafff completed a FCSR or CBC/ EDL check prior to his/her hire date. 6. Review of Laundry aide H's personnel record showed the employee with a hire date of 08/18/23. The personnel record did not contain documentation staff completed a FCSR or CBC/ EDL check prior to his/her hire date. 7. Review of Housekeeping aide I's personnel record showed the employee with a hire date of 11/17/23. The personnel record did not contain documentation staff completed a FCSR or CBC/ EDL check prior to his/her hire date. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Review of maintenance J's personnel record showed the employee with a hire date of 01/05/24. The personnel record did not contain documentation staff completed a FCSR or CBC/ EDL check prior to his/her hire date. 9. Review of CNA K's personnel record showed the employee with a hire date of 07/26/23. The personnel record did not contain documentation staff completed a FCSR or CBC/ EDL check prior to his/her hire date. 10. Review of CNA L's personnel record showed the employee with a hire date of 06/13/23. The personnel record did not contain documentation staff completed a FCSR or CBC/ EDL check prior to his/her hire date. 11. During an interview on 08/26/24 at 3:30 P.M., Human Resources (HR) said he/she has been in this position for two weeks. He/She said he/she is responsible for doing the on-boarding of all new employees. He/She does the new employee criminal background checks and EDL's. He/She said the regional staff does all new empoyee FCSR's because he/she does not currently have access to do them yet. He/She said he/she will be responsible for doing them in the future. He/She said he/she is not sure about any employees hired prior to his/her start date. He/She said the previous business office manager (BOM) was responsible for the new employee CBC and EDL checks but he/she is no longer employed at the facility and his/her position was eliminated when the facility was bought out as of June 1, 2024. He/She knows all FCSR/EDL/CBC's should be completed before hire. He/She said he/she was not aware that any the staff previous to his/her employment did not have the CBC/ FCRS/EDLS completed prior to starting. During an interview on 08/28/24 at 1:51 P.M., the Director of Nursing (DON) said HR is responsible for ensuring all backgrounds are completed before someone is hired. He/She said he/she does the interview and then walks them over to HR to complete the paperwork if he/she decided to hire them. He/She said he/she was not aware there were staff who had not completed the required background screenings prior to hiring them. He/She said hiring staff without having the background screenings completed first, puts the residents at risk for being exposed to people who are on the disqualifying list. During an interview on 08/29/24 at 4:03 P.M., the Administrator said before new ownership in June, he/she and the BOM would collaborate on completing the EDL/CBC/FCSR checks with new hires. He/She said with new ownership it is HR's responsibility to ensure EDL/CBC/FCSR's are completed. He/She said he/she was unaware both the EDL and CBC or the FCSR had to come back prior to hire. He/She said he/she thought it was okay to hire as long as the EDL was completed. He/She was unaware the EDL/CBC/FCSR's were not being completed on time before hire.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39644 Based on interview and record review, facility staff failed to provide written information to the resident and/or the resident's representative of the bed hold policy at the time of transfer to the hospital for three (Resident #22, #36, and #47) out of three sampled residents. The facility's census was 53. 1. Review of the facility policies showed staff did not provide a policy for bed hold notification. 2. Review of Resident #22's medical record showed the resident discharged from the facility on 07/10/24 and readmitted to the facility on [DATE]. The record did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy. 3. Review of Resident #36's medical record showed the resident: -discharged on [DATE] and readmitted to the facility on [DATE]; -discharged on [DATE] and readmitted to the facility on [DATE]; -discharged on [DATE] and readmitted to the facility on [DATE]; -Did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy. 4. Review of Resident #47's medical record showed the resident discharged from the facility on 06/09/24 and readmitted to the facility on [DATE]. The record did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy. 5. During an interview on 08/28/24 at 9:30 A.M., the Social Services Director (SSD) said he/she is responsible for this process, but only does the bed hold information at admission and not when a resident discharges for therapeutic leave or hospital stay. The SSD said he/she was not aware he/she was supposed to do this each time a resident discharged . During an interview on 08/28/24 at 4:16 P.M., Licensed Practical Nurse (LPN) C said he/she does not know about the bed hold policy, but believes it is the SSD who takes care of that. During an interview on 08/29/24 at 5:52 P.M., the administrator said the nurse who discharges the resident should be completing the bed hold, they have been in-serviced to do this when a resident leaves. The administrator said she did not know it was not being done.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on interviews and record review, facility staff failed to ensure Level I Pre-Admission Screening (used to evaluate for the presence of psychiatric conditions to determine if a Pre-admission Screening and Resident Review (PASRR) level II screen is required) were completed for two residents (Resident #8, and #26) out of two sampled residents. The facility census was 53. 1. Review of the facility's policies showed staff did not provide a policy for PASRR. 2. Review of the Central Office Medical Review Unit (COMRU) website, https:// health.mo. gov/seniors/nursinghomes/pasrr.php, dated 09/04/24, showed the PASRR is a federally mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability related diagnosis who apply or reside in Medicaid Certified beds in a nursing facility regardless of the source of payment. The screening assures appropriate placement of persons known or suspected of having a mental impairment(s) and also the individual needs of mentally impaired persons can be and are being met in the appropriate placement environment. 3. Review of Resident #8's annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/30/24, showed staff assessed the resident as: -admitted [DATE]; -Unit is Medicare and/or Medicaid Certified; -Did not contain an evaluation with PASRR; -Moderate cognitive impairment; -Diagnosis of Anxiety Disorder, Depression (other than bipolar), and Schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves); -Received antipsychotic, antianxiety, and antidepressant medications in the seven day look back period (period of time used to complete assessment). Review of the resident's medical record showed the record did not contain a level I Pre-Admission Screening or PASRR level II screen. 4. Review of Resident #26's annual MDS, dated [DATE], showed staff assessed the resident as: -admitted on [DATE]; -Did not contain an evaluation with PASRR; -Unit is Medicare and/ or Medicaid Certified; -Cognitively intact; (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnosis of Anxiety Disorder, Depression (other than bipolar), and Post-Traumatic Stress Disorder (PTSD); -Received antianxiety and antidepressant medications in the seven day look back period. Review of the resident's medical record showed the record did not contain a level I Pre-Admission Screening or PASRR level II screen. 5. During an interview on 08/29/24 at 4:35 P.M., the Director of Nursing (DON) said he/she was unsure of who was responsible to complete PASRR evaluations for residents. During an interview on 08/29/24 at 4:46 P.M., the administrator said he/she was responsible for completing PASRR evaluations on residents, but he/she could not locate the completed PASRRs for Resident #8 and #26.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39644 Based on observation, interview and record review, facility staff failed to ensure acceptable standards of practice when staff failed to complete neurological assessments (evaluation completed by staff for early detection of nervous system damage following head trauma) for two of four sampled residents (Resident #3, and #18). Ensure pressure relieving devices were in place for two out of three sampled residents (Resident #20, and #22). Staff failed to provide wound care treatment per physician orders for one out of one sampled resident (Resident #40). The census was 53. 1. Review of the facility's Head Injury policy, revised 05/18/2024, showed staff are directed as follows: -Assess resident following a known, suspected or verbalized head injury. The assessment shall include, at a minimum: a. Vital signs. b. General condition and appearance. c. Neurological evaluation for changes in: Physical functioning, Behavior, Cognition, Level of consciousness, Dizziness, Nausea, Irritability, and Slurred speech or slow to answer questions; -Preform neuro checks as indicated or as specified by the physician; -Continue monitoring for 72 hours following the incident or until the resident is asymptomatic for a period of time specified by the physician. 2. Review of Resident #3's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 06/06/24, showed staff assessed the resident as follows: -Severe cognitive impairment; -Required maximal assistance from staff for toileting, moderate assistance with transfers and sit to stand. -Diagnosis of Dementia. Review of the resident's nurse's notes, dated 07/20/24 at 6:30 A.M., showed staff documented a fall with discolored area on forehead. Review of the resident's nurse's notes, dated 08/05/24 at 6:35 A.M., showed staff documented a fall with a hematoma on the forehead. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed the medical record did not contain documentation of a neurological assessment, with continuous monitoring of the resident or notification of the physician for the fall on 07/20/24 and did contain documentation of a neurological assessment, or continuous monitoring of the resident for the 8/05/24 fall. 3. Review of Resident #18's Quarterly MDS, dated [DATE], showed facility staff assessed the resident as: -Severe cognitive impairment; -Resident is dependent on staff for all Activities of Daily Living (ADL). Review of the resident's nurse's notes, showed on 07/19/24 at 3:40 P.M., staff documented the resident was found on the floor on the left side of bed. Review of the resident's medical record, showed staff did not document a neurological assessment, or continuous monitoring of the resident. During an interview on 08/29/24 at 4:15 P.M., Licensed Practical Nurse (LPN) C said nurses are responsible for assessing the resident after a fall first. The nurses are to start neurological checks when there is an unwitnessed fall, if the resident hit their head, or if they have an obvious head injury. The LPN said the neurological checks sheets are filled out and placed on the residents chart. LPN C said if they are not in the residents chart the only other place would be the Director of Nursing could have them. During an interview on 08/29/24 at 4:40 P.M., Director of Nursing (DON) said the expectation is for neurological checks to be done and on the chart. The DON said if a resident has an unwitnessed fall or if they hit their head then a neurological check should be done. The DON said if the neurological checks were not found on the chart he/she does not know where they are, he/she does not have the neurological assessments for the residents. During an interview on 08/29/24 at 5:00 P.M., the administrator said unwitnessed or falls where a resident hit their head, neurological checks should be done. She said these are a paper form and should be on the resident's chart. 4. Review of the facility's Transcription of Orders/Following Physician's Orders Policy, revised 05/18/24, showed: -The purpose of this policy is to outline procedures in accurately transcribing physician's orders and to ensure that all physicians' orders are followed. To ensure a process is in place to monitor nurses in accurately transcribing and following physicians orders; -The Nurse or Certified Medication Technician (CMT) in charge of medication administration must review all their designated Medication Administration Record (MAR) and Treatment Administration Record (TAR) prior to the end of their shift to ensure that all medications/treatments scheduled to be given on their shift were administered according to the physicians order and that all necessary interventions were taken in the event of an omission. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #20's annual MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Upper extremity impairment on both sides. Review of the resident's plan of care, updated 06/26/24, showed the resident with hand contractures and treatment for therapy carrots to be placed bilateral hands, and new order for medication to help with contractures. Review of the resident's Physician Order Sheet (POS), dated 08/01/24 thru 08/29/24 showed therapy carrots for both hands daily . Observation on 08/26/24 at 12:14 P.M., showed the resident in a broda chair (positioning wheel chair) with leftand righthand contractures, without therapy carrots in either hands. Observation on 08/27/24 9:35 A.M., showed the resident in a broda chair without therapy carrots in either hand. Observation on 08/28/24 3:19 P.M., showed the resident in his/her bed without therapy carrots in either hand. Observation on 08/29/24 at 4:05 P.M., showed the resident in his/her bed without therapy carrots in either hand. 6. Review of Resident #22's annual MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Upper extremity impairment on both sides; Review of the resident's plan of care, dated 07/30/24, showed staff are directed: -Provide treatment to bilateral hands daily as ordered; -Be gentle and explain to resident when trying to alleviate the pressure being caused by the contractures; -Ensure whatever the physician has ordered to apply between fingers and palms is being done daily. Review of the resident's POS, dated 08/01/24 - 08/28/24, showed: -Diagnosis: Contracture of unspecified hand, left forearm, left upper arm, left wrist, right wrist; -Treatment: Hand rolls bilateral daily; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Treatment: Keep pillows between arm and chest. Observation on 08/26/24 at 11:40 A.M. and 2:25 P.M., showed the resident in bed, with both hands contracted towards the chest, without hand rolls in place, and without pillows between arm and chest. Observation on 08/27/24 at 11:18 A.M., showed the resident in bed, with both hands contracted towards the chest, without hand rolls in place. Observation on 08/28/24 11:28 A.M., showed the resident in bed, with both hands contracted towards the chest, without hand rolls in place, and without pillows between arm and chest. Observation on 08/29/24 at 10:49 A.M., showed the resident in bed, with both hands contracted towards the chest, without hand rolls in place, and without pillows between arm and chest. During an interview on 08/28/24 at 11:51 A.M., Occupational Therapist (OT) V said therapy staff only performs Passive Range of Motion (PROM) exercises and hygiene to the resident's hands Monday-Friday, but the charge nurse would be responsible for the treatment (s) ordered by the physician. During an interview on 08/29/24 at 1:32 P.M., CMT U said the charge nurse is responsible to place hand rolls in the resident's hands for his/her contractures. During an interview on 08/29/24 at 4:01 P.M., LPN R said the charge nurse is responsible to put the rolls in the resident's hands daily. The LPN said he/she had not gotten the chance to do the treatment and place the hand rolls yet. During an interview on 08/29/24 at 4:41 P.M., DON said the expectation is all physician orders should be followed. The DON said he/she does not believe the resident with carrots has them for use, so the doctor should be notified and the order changed. The DON said it is his/her responsibility to follow up with physician orders, to make sure they done and are appropriate. During an interview on 08/29/24 at 5:01 P.M., the administrator said physician orders for treatments should be done per the order. The administrator said if an order is not being done for some reason, she would expect the nurse to document this, or call to have the order changed or discontinued. 7. Review of Resident #40's Significant Change MDS, dated [DATE], showed staff assessed the resident as follows: -Severely Cognitively Impaired; -No impairment to upper or lower extremities; -Dependent with ADLS; -Two unstageable pressure ulcers. Review of the resident's care plan, dated 08/19/24, showed staff were directed to administer treatments as ordered and monitor for effectiveness. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's wound clinic order, dated 08/07/24, showed treatment to right pressure ulcer as follows: -Cleanse wound with Hypochlorous acid (a disinfectant and antimicrobial); -Apply santyl (an FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal) to wound bed; -Apply calcium alginate (a highly absorbent wound dressing made from seaweed that can help treat moderate to heavily draining wounds) to wound base; -Cover with bordered gauze. Review of the resident's Hospice orders, dated 08/07/24, showed treatment to right pressure ulcer as follows: -Clean with Dakins solution (a topical antiseptic that's used to treat and prevent infections in wounds); -Apply Santyl to wound; -Cover wound with calcium alginate; -Secure with island dressing. Review of the resident's TAR, dated 08/07/24, showed treatment to right pressure ulcer as follows: -Cleanse wound with Hypochlorous; -Apple Santyl; -Place calcium alginate in wound bed; -Cover with island dressing. Observation on 08/29/24 at 11:28 A.M., showed LPN M performed a dressing change to right pressure ulcer and used iodoform packing strips (a sterile, single-use wound dressing that is used to treat open wounds, bedsores, and infected wounds) to pack the ulcer. During an interview on 08/29/24 at 12:00 P.M., LPN M said he/she packed the ulcer because that's what the hospice nurse had done previously and that's how he/she thought it was ordered. During an interview on 08/29/24 at 4:31 P.M., the Director of Nursing (DON) said that he/she would absolutely expect the nurses to follow physician's orders. He/She said he/she was unaware that the orders were different, and the order should have been clarified. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/29/24 at 4:51 P.M., the Administrator said nurses should follow the physician's orders. He/She said he/she would expect the orders to be clarified to ensure the correct treatment is being done. 50422

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Fair View Health Care Center	1714 W 16th Street Sedalia, MO 65301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation, interview and record review, facility staff failed to provide adequate baths/showers to maintain proper hygiene for four residents (Resident #15, #26, #37, #38) out of seven sampled residents, and one additionally sampled resident (Resident # 35), who required assistance from staff to complete their Activities of Daily Living (ADLs) (bathing, showering, dressing, transfers, toileting, etc.). The facility census was 53. 1. Review of the facility's Resident Showers Policy, revised 06/26/24, showed the purpose is to assist residents with bathing to maintain proper hygiene, and directed staff as follows: -Resident will be provided showers as per request or as per facility schedule protocols and based upon resident safety; -Partial baths may be given between regular shower schedules as per facility policy; -Assist the resident with showering as needed. 2. Review of Resident #15's annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 06/04/24, showed staff assessed the resident as follows: -Cognitively intact; -Did not reject care; -Lower extremity (hip, knee, ankle, foot) impairment on one side; -Able to shower/bath self Review of the resident's plan of care, last updated 06/04/24, showed staff are directed to assist with ADLs, with transfers when needed, and with showering. Review of the facility's shower schedule showed the resident will be assisted with a bath/shower on Mondays and Thursdays by facility staff. Review of the resident's shower sheets, from 06/01/24 to 06/30/24, showed staff did not document they assisted the resident with a bath/shower on 06/06/24, 06/13/24, 6/20/24, and 06/24/24 (four of the eight scheduled days in June), and did not document the resident refused any baths/showers. Review of the resident's shower sheets, from 07/01/24 to 07/31/24, showed staff did not document they assisted the resident with a bath/shower on 07/08/24, 07/11/24, 07/15/24, 07/18/24, and 07/25/24 (five of the eight scheduled days in July), and did not document the resident refused any baths/showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's shower sheets, from 08/01/24 to 08/25/24, showed staff did not document they assisted the resident with a bath/shower on 08/01/24, 08/08/24, 08/12/24, 08/15/24, 08/19/24, and 08/22/24 (six of the seven scheduled days in August), and did not document the resident refused any baths/showers. During an interview on 08/26/24 at 1:45 P.M., the resident said he/she is scheduled to have a shower twice per week but he/she had not received a bath/shower for about four weeks, and it would feel good to have one. 3. Review of Resident #26's annual MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact; -Occasionally rejected care; -Lower extremity impairment on both sides; -Dependent on staff to shower/bathe self -Refused to get in and out of tub/shower. Review of the resident's plan of care, updated 06/08/24, showed staff is directed to assist with ADLs, and bed baths (per the resident's request) three times per week. Review of the facility's shower schedule, showed the resident will be assisted with a bath/shower on Wednesdays (once per week) by facility staff. Review of the resident's shower sheets, from 06/01/24 to 06/30/24, showed staff did not document they assisted the resident with a bed bath on 06/05/24, 06/12/24, 06/19/24, and 06/26/24 (none of the four scheduled days in June), and did not document the resident refused any baths. Review of the resident's shower sheets, from 07/01/24 to 07/31/24, showed staff did not document they assisted the resident with a bed bath on 07/03/24, 07/10/24, 07/17/24, 07/24/24, and 07/31/24 (none of the five scheduled days in July), and did not document the resident refused any baths. Review of the resident's shower sheets, from 08/01/24 to 08/26/24, showed staff did not document they assisted the resident with a bed bath on 08/07/24, and 08/21/24 (two of the three scheduled days in August), and did not document the resident refused any baths. Observation on 08/26/24 at 1:05 P.M., showed the resident in bed with unkempt hair. During an interview on 08/26/24 at 1:13 P.M., the resident said he/she prefers to take a bed bath but often struggle to get staff to assist him/her with a bed bath at least once per week, and therefore uses a lot of air freshener to help minimize the smell of any body odor in his/her room. 4. Review of Resident #35's quarterly MDS, dated [DATE], showed staff assessed the resident as follows: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Severe cognitive impairment; -Did not reject care; -Upper (shoulder, elbow, wrist, hand) and lower extremity impairment on one side; -Dependent on staff for personal/toileting hygiene, transfers, and to shower/bathe self. Review of the resident's plan of care, dated 05/01/24, showed staff is directed to assist with all ADLs, with transfers, and provide either a bed bath or shower. Review of the facility's shower schedule, showed the resident will be assisted with a bath/shower on Tuesdays and Fridays by facility staff. Review of the resident's shower sheets, from 06/01/24 to 06/30/24, showed staff did not document they assisted the resident with a bath/shower on 06/14/24, 06/18/24, and 06/28/24 (three of the eight scheduled days in June), and did not document the resident refused any baths/showers. Review of the resident's shower sheets, from 07/01/24 to 07/31/24, showed staff did not document they assisted the resident with a bath/shower on 07/09/24, 07/12/24, 07/16/24, 07/19/24, 07/23/24, 07/26/24, and 07/30/24 (seven of the nine scheduled days in July), and did not document the resident refused any baths/showers. Review of the resident's shower sheets, from 08/01/24 to 08/26/24, showed staff did not document they assisted the resident with a bath/shower on 08/02/24, 08/06/24, 08/13/24, 08/16/24, 08/20/24, and 08/23/24 (six of the seven scheduled days in August), and did not document the resident refused any baths/showers. Observation on 08/27/24 at 11:48 A.M., showed the resident awake in bed with unkempt hair. 5. Review of Resident #37's admission MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact; -Did not reject care; -Partial/moderate assist with toileting hygiene, and to shower/bathe self. Review of the resident's plan of care, dated 07/12/24, showed staff is directed to assist with hygiene after incontinent episodes, and assist with showers. Review of the facility's shower schedule, showed the resident will be assisted with a bath/shower on Mondays and Thursday by facility staff. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's shower sheets, from 07/05/24 to 07/31/24, showed staff did not document they assisted the resident with a bath/shower on 07/11/24, 07/15/24, 07/18/24, 07/25/24, and 07/29/24 (five of the seven scheduled days in July), and did not document the resident refused any baths/showers. Review of the resident's shower sheets, from 08/01/24 to 08/26/24, showed staff did not document they assisted the resident with a shower on 08/01/24, 08/05/24, 08/12/24, 08/19/24, and 08/22/24 (five of the seven scheduled days in August), and did not document the resident refused any baths/showers. Observation on 08/26/24 at 1:10 P.M., showed the resident in his/her room with greasy hair. During an interview on 08/26/24 at 1:10 P.M., the resident said he/she is occasionally incontinent, and staff does not assist him/her with a bath/shower as often as he/she would like, which makes him/her feel pretty filthy. 6. Review of Resident #38's quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Did not reject care; -Dependent with personal hygiene, toileting, shower/bathe self. Review of the resident's plan of care, dated 06/01/24, showed the resident dependent on staff for all ADLs except eating, and directed two staff to assist with transfers and showers. Review of the facility's shower schedule, showed the resident will be assisted with a bath/shower on Mondays and Thursday by facility staff. Review of the resident's shower sheets, from 06/01/24 to 06/30/24, showed staff did not document they assisted the resident with a bath/shower on 06/06/24, 06/13/24, 06/17/24, 06/24/24, and 06/27/24 (five of the eight scheduled days in June), and did not document the resident refused any baths/showers. Review of the resident's shower sheets, from 07/01/24 to 07/31/24, showed staff did not document they assisted the resident with a bath/shower on 07/04/24, 07/08/24, 07/11/24, 07/15/24, 07/18/24, and 07/29/24 (six of the nine scheduled days in July), and did not document the resident refused any baths/showers. Review of the resident's shower sheets, from 08/01/24 to 08/26/24, showed staff did not document they assisted the resident with a bath/shower on 08/01/24, 08/05/24, 08/08/24, 08/12/24, 08/15/24, 08/19/24, and 08/22/24 (none of the seven scheduled days in August), and did not document the resident refused any baths/showers. Observation on 08/29/24 at 11:20 A.M., showed the resident in his/her bed with greasy hair. Any observation of the resident up and presented unclean/unkept hair? (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/28/24 at 3:00 P.M., Nursing Assistant (NA) P said the resident is dependent on staff for almost all ADLs. 7. During an interview on 08/28/24 at 3:25 P.M., NA Q said facility staff have a shower list/schedule located at the nurses' station, that directs staff which residents are to be assisted with a bath/shower on specific days. The NA said staff document they assist a resident with a bath/shower on the resident's shower sheet, turn in the completed shower sheet to the charge nurse, who then submits to the administrator for filing. During an interview on 08/29/24 at 4:01 P.M., Licensed Practical Nurse (LPN) R said the Certified Nursing Assistants (CNAs) and NA's are expected to document a shower sheet for each resident on their scheduled shower days, give the sheet to the charge nurse for review/action, who then submits them to the administrator. The LPN said the CNA's and NA's should document a shower sheet for a resident even if the resident refused his/her bath/shower. The LPN said if there is not a completed shower sheet for a specific resident, staff likely did not attempt/assist the resident with a bath/shower on that day. During an interview on 08/29/24 at 8:35 A.M., the adminstrator said if there was not a shower sheet for a specific resident, then staff did not assist with a shower as scheduled. During an interview on 08/29/24 at 4:35 P.M., the Director of Nursing (DON) said staff should assist residents with a bath/shower when scheduled. The DON said if staff did not document a completed shower sheet for a specific resident, staff likely did not assist the resident with a bath/shower as scheduled.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 39644 Based on interview and record review, facility staff failed to provide an ongoing activity program to meet the needs, interests, and physical, mental, and psychosocial well-being for four (Resident #23, #44, #48, and #58) out of 14 sampled residents on weekends. The facility staff failed to post an activities calendar for residents to view. The facility census was 53. 1. Review of the facility's policy titled, Activities, dated 07/23, showed the facility will provide an ongoing program of activities designed to meet, in accordance with comprehensive assessment, their interests and their physical, mental and psychosocial well-being. Review showed staff were directed to: -Activities will be designed with the intent to promote and enhance the emotion health, self-esteem, pleasure, comfort, education, creativity, success, and independence for all residents, based on interview and assessing the residents like and dislikes; -The activities calendar will be posted on each unit and will include activities that are appropriate for the general therapeutic milieu population that meets the specific needs, cognitive impairments, interests and supports the quality of life while enhancing self-esteem and dignity. 2. Review of the facility's activity calendar, dated July 2024, did not contain scheduled activities on: -Saturday, 07/20/24; -Sunday, 07/21/24; -Saturday, 07/27/24; -Sunday, 07/28/24. Review of the facility's activity calendar, dated August 2024, did not contain scheduled activities on: -Saturday, 08/03/24; -Sunday, 08/04/24; -Saturday, 08/10/24; -Saturday, 08/17/24; -Sunday, 08/18/24; -Saturday, 08/24/24; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Saturday, 08/31/24. 3. Observation on 08/26/24 at 12:00 P.M., showed staff did not post an activity calendar for residents to view. Observation on 08/27/24 at 1:00 P.M., showed staff did not post an activity calendar for residents to view. Observation on 08/28/24 at 9:56 A.M., showed staff did not post an activity calender for residents to view. Observation on 8/29/24 at 12:45 P.M., showed staff did not post an activity calender for residents to view. During an interview on 08/26/24 at 12:30 P.M., Resident #23 said there has not been any activities over the last couple months. He/She said the activitity director went on vacation and never came back. He/She would love to go to activities if they had them, he/she likes to play Bingo and Yahtzee. He/She said there has not been an activities calendar in his/her room for couple of months. During an interview on 08/27/24 at 1:35 P.M., Resident #44 said the facility does not have activities since the person who was doing activities left. He/She wishes there was activities. During an interview on 08/27/24 at 12:10 P.M., Resident #48 said there has not been activities because there is no activity person. The resident likes to go to activities and wishes there were things to do. During an interview on 08/27/24 at 1:48 P.M., Resident #58 said they don't have any activities. The facility has not done any activities since the director left. He/She wants to go to activities and wishes they had some to go to. During an interview on 08/29/24 at 3:56 P.M., Certified Nurses Aide (CNA) N said he/she is unsure who does activities currently. He/She said there are not any activities on the weekends. He/She said activities happen occasionally and at random times if there is someone here to help with them. During an interview on 08/29/24 at 2:20 P.M., Licensed Practicial Nurse (LPN) R said the facility does not have an activities person right now. He/She said if there is an activity it is at a random time. He/She said there hasn't been very many activities recently due to not having anyone to do them. During an interview on 08/29/24 at 4:31 P.M., the Director of Nursing (DON) said an activity director left and another person stepped up to do activities, but also left end of July/beginning of August. He/She said since they do not have an activity director, they have not had any activities. He/She said they have random activities if someone is able to help, but nothing consistently. He/She said she expects an activity calendar to be posted for the residents to see but has not seen an activities calendar recently. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/29/24 at 4:41 P.M., the administrator said one activity director was fired and they hired someone else who went on vacation and then did not come back. He/She said there has not been consistent activities since they do not have an activities director. He/She said an activity calendar should be in the resident's room to view, but he/she does not think there has been one posted this month. 50422

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47193 Based on observation, interview, and record review, facility staff failed to maintain a medication error rate of less than 5%. Out of 29 opportunities observed, six errors occurred, resulting in a 20.69% error rate, which effected four residents (Resident #23, #26, #31, #58) out of ten sampled residents. The facility census was 53. 1. Review of the Facility's Medication Errors policy, dated [DATE], showed the facility shall ensure medications will be administered as follows: -According to physician orders; -In accordance with accepted standards and principles which apply to professionals providing services; -The facility must ensure that it is free of medications error rates of 5% or greater as well as significant medication error events; -The facility will consider factors indicating error in medication administration, including, but not limited to, the following: -Medication administered not in accordance with prescriber's order. Examples include but not limited to incorrect dose, route of administration, dosage form, time of administration. Review of the Facility's Administration of Insulin policy, dated [DATE], showed: -All insulin will be administered in accordance with physician's orders; -Prepare insulin dose. Before administering insulin, perform two nurse verification of correct resident, dose, calculations, and correct route of administration; -Insulin pens must be clearly labeled with the resident name, physician name, date dispensed, type of insulin, amount to be given, frequency, and expiration date; -If the label is missing, the pen will not be used; a new pen must be ordered from pharmacy; -Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation; -Check expiration date on the pen. Discard if expired. Review of the Facility's Medication Administration policy, dated [DATE], showed: -Ensure the six rights of medication administration are followed, right dose; -Identify expiration date. If expired, notify nurse manager; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Multi-dose vials will be re-labeled with beyond use date, 28 days after vial is opened or punctured (unless otherwise specified by the manufacturer). Follow the manufacturer's label to verify the beyond use date as some MDVs expire sooner than 28 days after opening. The beyond use date rule will begin on the first day the multi-use vial is opened or punctured; -Visually inspect the vial before use to double check the expiration date, beyond use date if previously opened, and ensure there is no visible contamination; -Unit manager will perform random checks of opened multi-dose vials for appropriate dating. 2. Review of Resident #23's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated [DATE], showed staff documented the resident diagnosis of Diabetes Mellitus and received insulin injections seven days of the seven days in the look back period. Review of the resident's physician's order sheets (POS), dated [DATE], showed an order for Lispro (Rapid-acting insulin) inject per sliding scale for a blood sugar of ,d+[DATE] inject two units (u) subcutaneously (under the skin) for a diagnosis of type 2 diabetes mellitus. Observation on [DATE] at 7:57 A.M. and 11:29 A.M., showed the resident's vial of Lispro had an open date of ,d+[DATE] and did not have a beyond use date. LPN B prepared and administered Lispro two units subcutaneously to the resident. 3. Review of Resident #26's Annual MDS, dated [DATE], showed staff documented the resident diagnosis of Diabetes Mellitus and received insulin injections seven days of the seven days in the look back period. Review of the resident's POS, dated [DATE], showed an order for Aspart (rapid-acting insulin) inject per sliding scale for a blood sugar of ,d+[DATE] inject two units (u) subcutaneously for a diagnosis of type 2 diabetes mellitus. Observation on [DATE] at 11:01 A.M., showed the resident's Aspart pen had an illegible open date and did not have a beyond use date. LPN B prepared and administered Aspart two units subcutaneously to the resident. During an interview on [DATE] at 11:08 A.M., Licensed Practical Nurse (LPN) B said he/she was not sure what the open date said. He/She said it might say ,d+[DATE], but it is smeared and hard to read. 4. Review of Resident #31's Quarterly MDS, dated [DATE], showed staff documented the resident diagnosis of Diabetes Mellitus and received insulin injections seven days of the seven days in the look back period. Review of the resident's POS, dated [DATE], showed the following orders: -Glargine-YFGN (long-acting insulin) inject seven units subcutaneously for a diagnosis of type 2 diabetes mellitus; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Fiasp (Rapid-acting insulin) inject as per sliding scale for blood sugar of ,d+[DATE] inject two units subcutaneously for a diagnosis of Type 2 diabetes mellitus. Observation on [DATE] at 7:54 A.M., showed the resident's Glargine pen did not have an open date or have a beyond use date. LPN B prepared and administered glargine seven units subcutaneously to the resident. Observation on [DATE] at 11:23 A.M., showed the resident's vial of Fiasp had an open date of [DATE] and did not have a beyond use date. LPN B prepared and administered fiasp two units subcutaneously to the resident. During an interview on [DATE] at 11:35 A.M., LPN B said he/she checked the vials expiration date before he/she gave the insulin. He/She said he/she was not aware insulin expired sooner once opened. He/She said he/she was not educated regarding open dates and use beyond dates. He/She said he/she was not aware the insulin was expired before he/she gave the insulin. He/She said he/she was not sure who oversees checking insulin expiration dates in the medication cart. During an interview on [DATE] at 3:10 P.M., LPN B said he/she is not sure what the expectation of staff is when and expired insulin is given to resident. He/She said the concern for giving expired insulin is it may be ineffective. 5. During an interview on [DATE] at 1:51 P.M., the Director of Nursing (DON) said pharmacy usually prints on the insulin vials/pens, how long the insulin is good for once opened and they also provide a cheat sheet with each individual insulin expiration date. He/She said some insulins are only good for 28 days while others last 48 days once opened. He/She said it is his/her expectation staff check the open and expiration date prior to administering the insulin. He/She said he/she would consider it a medication error because the nurse failed to implement one of the rights of medication administration. He/She said it is the responsibility of the charge nurse to ensure the medication carts are free of expired insulin daily and the responsibility of the nurse to check before administration of the insulin. During an interview on [DATE] at 4:03 P.M., the administrator said it is his/her expectation staff mark all insulin vials and pens with the open date and beyond use date. He/She said staff should not administer any insulin that is beyond the date listed on the vial or pen. He/She said insulin vials and pens expire 28 days after opening/puncturing. He/She said some insulins expire longer than the 28 days and should be checked against the insulin cheat sheet provided by pharmacy. He/She said charge nurses are responsible for maintaining medication carts and the insulin vials/pen beyond use dates. He/She said he/she also expects staff who are administering the medications/insulins to check them before the administer them. He/She said he/she considered administering expired insulin as a medication error. 5. Review of Resident #58's Admission MDS, dated [DATE], showed staff documented the resident diagnosis of Diabetes Mellitus and received insulin injections seven days of the seven days in the look back period. Review of the resident's POS, dated [DATE], showed an order for Aspart insulin (a rapid acting medication used to lower blood sugar) six units per sliding scale for a blood sugar of ,d+[DATE]. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 11:12 A.M., showed LPN B prepared and administered only four units out of the six units of insulin subcutaneously to the resident, for a blood sugar of 283 as ordered. During an interview on [DATE] at 11:18 A.M., LPN B said after looking at the POS he/she should have given the resident six units of insulin instead of four units. He/She said he/she would fix his/her mistake by giving two more units of insulin. During an interview on [DATE] at 1:51 P.M., the DON said when a medication error sheet should be filled out by the nurse and the nurse initiate the physician's interventions. He/She said he/she plans to do further education regarding insulin administration. During an interview on [DATE] at 4:03 P.M., the administrator said if the wrong dose of insulin was given to a resident, he/she would the nurse to also notify the DON and fill out an incident report.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 39644 Based on interview and record review, facility staff failed to develop a detailed facility assessment, to include the overall number of facility staff needed to ensure sufficient number of qualified staff are available to meet each resident's needs during day-to-day operations and emergencies. The facility census was 53. 1. Review of the facility policies showed staff did not provide a policy for the facility assessment. 2. Review of the Facility Assessment Tool, dated 01/20/24, showed the following: -Special Treatments and Conditions: Oxygen therapy 5; Tracheostomy Care 1; Bilevel positive airway pressure (BIPAP)/Continuous positive airway pressure (CPAP): 3; Behavioral Health care needs 12; Injections 8; Dialysis 1; Ostomy Care 1; Hospice Care 2. -Assistance with Activities of Daily Living was left blank; -Number of licensed Nurses per resident was left blank; -Direct care staff per resident was left blank; During an interview on 08/29/24 at 5:00 P.M., the Administrator said it is her responsibility to update the facility assessment. She said she did not know the facility assessment wasn't update, but the corporation that just took over has a new assessment that will be put into place.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation, interview, and record review, facility staff failed to perform hand hygiene and/or wash hands to prevent the spread of infection during medication pass for five residents (Residents #3, #20, #29, #41, and #48) of six sampled residents, and during perineal care for two residents (Resident #22 and #38) of two sampled residents. Facility staff failed to follow infection control protocols for cleaning/disinfecting the glucometer (a device used to measure blood sugar levels) when staff tested four residents (Resident #23, #26, #31, and #58) of four sampled resident blood sugar levels. Facility failed to ensure the two-step purified protein derivative ((PPD) skin test for Tuberculosis (TB)) was completed in accordance with their policy and on file for six employees (Registered Nurse (RN) E, Nurse aide (NA) D, housekeeping aide I, Maintenance J, Certified nurse aide (CNA) K, and Licensed Practical Nurse (LPN) S) out of ten employee files reviewed. Facility staff failed to have and maintain transmission-based precautions for one resident (Resident #56) in order to prevent the transmission of clostridium difficile ((C-diff) a germ that causes diarrhea and an inflammation of the colon) infection and failed to post guidance on contact precaution actions for staff and visitors. Facility staff failed to implement the Enhanced Barrier Precautions (EBP) policy when they did not educate, or alert staff/other providers of residents who required EBP, and failed to place appropriate personal protective equipment (PPE) in close proximity for three (Resident #22, #35, and #38) of three sampled residents. Facility staff failed to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's cooling tower to inhibit the growth of waterborne pathogens and reduce the risk of an outbreak of Legionnaire's Disease (LD-a serious type of pneumonia (lung infection) caused by Legionella bacteria). Failure to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems has the potential for the failure of staff to identify and mitigate the presence of waterborne pathogens, which places all residents of the facility at risk of exposure which could lead to illness. The facility census was 53. 1. Review of the Facility's Hand Hygiene policy, dated June 2024, showed: -Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice; -Alcohol based hand rubs with 60-95% alcohol is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom; -Soap and water: -When hands are visibly dirty; -Exposure to c. diff. is suspected or likely; -Either soap and water or alcohol-based hand rub (ABHR is preferred): -Between resident contacts; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-After handling contaminated objects; -Before applying and after removing PPE, including gloves; -Before preparing or handling medications; -For conditions involving a resident, or the resident's environment, who is isolated for c diff or other infectious diarrhea, handwashing with soap and water is required. Review of the facility's Peri-Care Policy, dated 06/29/23, showed staff are directed as follows: -Ensure resident genital area is kept clean and proper techniques are used to prevent skin breakdown, infections, or any other impairments that can be caused from not using proper aseptic technique; -Peri-care prevents skin breakdown, itchning burning, odor, and infections; -Always wear gloves when giving peri-care to protect yourself and the resident; -Wash hands and put gloves on; -Remove and dispose of gloves, and wash hands. 2. Observation on 08/26/18 at 11:20 A.M., showed Certified Medication Technician (CMT) A did not perform hand hygeine after he/she prepared and administered medication to Resident #41 or before he/she adminsitered medication to Resident # 3. Observation on 08/26/18 at 11:23 A.M., showed CMT A did not perform hand hygeine after he/she prepared and administered medication to Resident #3 or before he/she adminsitered medication to Resident #20. Observation on 08/26/18 at 11:28 A.M., showed CMT A did not perform hand hygeine after he/she prepared and administered medication to Resident #20 or before he/she adminsitered medication to Resident #29. Observation on 08/26/18 at 11:35 A.M., showed CMT A did not perform hand hygeine after he/she prepared and administered medication to Resident #29 or before he/she adminsitered medication to Resident #48. Observation on 08/26/18 at 11:45 A.M., showed CMT A prepared Resident #48's medication and took the medication to the resident. CMT A did not wash his/her hands and returned to the medication cart to. CMT A did not perform hand hygiene in a manner to prevent the spread of infection while administering medication. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 08/28/23 at 10:34 A.M., CMT A said he/she knows he/she should perform hand hygiene after each resident. He/She said he/she was not sure why he/she did not use hand sanitizer after passing resident medication. He/She said he/she just forgot because of nerves. He/She said he/she typically uses hand sanitizer between residents but washes his/her hands after the second or third resident. He/She said to his/her knowledge the facility does not provide any other reeducation for medication pass other than the new employee education. During an interview on 08/28/24 at 11:01 A.M., the infection Preventionist (IP) said it is his/her expectation staff use hand sanitizer from one resident to the next during medication pass. He/She said staff should be educated on hand hygiene during new employee training and yearly. During an interview on 08/28/24 at 1:51 P.M., the Director of Nursing (DON) said it is his/her expectation that staff perform hand hygiene between each resident's medication pass to prevent the spread of infections. He/She said he/she was not aware staff were not performing hand hygiene during medication pass. He/She said staff are educated on hand hygiene and should know the policy. During an interview on 08/29/24 at 4:05 P.M., the administrator said it is his/her expectation staff perform hand hygiene before entering and exiting resident rooms and between each resident's medication pass. He/She said he/she expects staff to perform hand hygiene when removing gloves. He/She said he/She was not aware staff were not performing hand hygiene between passing resident medications. 3. Review of Resident #22's annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/29/24, showed staff assessed the resident as severe cognitive impairment, had an indwelling catheter, dependent with personal hygiene, and toileting. Observation on 08/28/24 at 12:09 P.M., showed CNA W and CNA X entered the resident's room to provide care. CNA W and CNA X did not wash his/her hands before he/she applied gloves.CNA X cleaned the bowel movement (BM) from the resident's buttock, provided peri-care/catheter care, changed gloves, cleaned BM from the resident's hip, placed a clean disposable pad underneath the resident, and both CNAs removed gloves. The CNAs did not perform appropriate hand hygiene before or during, peri-care to prevent the spread of infection. During an interview on 08/28/24 at 12:20 P.M., CNA X said he/she should have washed his/her hands before peri-care, and after removing his/her gloves, and he/she just did not. 4. Review of Resident #38's quarterly MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment, had an indwelling catheter, dependent with personal hygiene, and toileting. Observation on 08/28/24 at 3:06 P.M., showed NA P and NA Q entered the resident's room, retrieved gloves from their pockets, put gloves on, transferred the resident via hoyer lift from chair to bed, and removed his/her brief. Observation showed the resident incontinent of BM. NA P performed incontinence care, wiped the catheter tubing and assisted NA Q to place a clean brief on the resident, both NAs removed their gloves, and transferred the resident back to his/her chair from the bed via mechanical lift. NA Q secured the resident's catheter bag to his/her chair and propelled him/her out the room. The NAs did not perform appropriate hand hygiene during, or after peri-care to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 08/28/24 at 3:25 P.M., NA P said he/she should have sanitized or wash his/her hands after cares. The NA said he/she should have changed gloves and at least sanitize hands after cleaning the resident's bowel movement, but he/she just forgot. The NA said he/she carried the gloves in his/her pockets because gloves are usually stored on walls outside the residents' rooms, and not always available inside a resident's room. During an interview on 08/29/24 at 4:35 P.M., the DON said it is not appropriate for staff to transport gloves in their pockets because of the risk for contamination, and he/she was not aware staff was transporting gloves in their pockets for use. The DON said staff should wash hands/sanitize after glove changes, and between clean and dirty tasks. 5. Review of the Facility's Glucometer Disinfection policy, dated April 2024, showed: -The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use; -The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against Human immunodeficiency virus (HIV), Hepatitis C and Hepatitis B virus; -Procedure:Retrieve two disinfectant wipes from container,using first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer,after cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions. Allow the glucometer to air dry. Review of the facility glucose monitoring system manual, undated, showed the manual directs staff as follows: -To clean meter, use a moist (not wet) lint-free cloth dampened with a mild detergent. Wipe all external areas id the meter or lancing device including both front and back surfaces until visibly clean; -To disinfect your meter, clean the meter with one of the validated disinfecting wipes listed below. Other Environmental Protection Agency (EPA) registered wipes may be used for disinfecting the system, however these other wipes have not been validated and could affect the performance of your meter; i.Dispatch hospital cleaner disinfectant towels with bleach; ii. Medline Micro-Kill+ Disinfecting, Deodorizing, Cleaning Wipes with Alcohol; iii.Clorox Healthcare Bleach Germicidal and Disinfecting Wipes; iv. Medline Micro-Kill Bleach Germicidal Bleach Wipes; -Wipe all external areas of the meter or lancing device including both front and back surfaces until visibly clean. Allow the surface of the meter or lancing device to remain wet at room temperature for the contact time on the wipe's directions for use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Super Sani-Cloth Germicidal Disposable Wipes General Guidelines for use, dated 2021, showed staff are directed to disinfect nonfood contact surfaces only: Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for full two minutes. For heavily soiled surfaces, use wipe to pre-clean prior to disinfecting. Let air dry. 6. Observation on 08/27/24 at 7:57 A.M., showed LPN B entered Resident #23's room and obtain his/her blood sugar. LPN B did not clean/disinfect the glucometer before he/she placed the glucometer back in the top drawer of the medication cart. Observation on 08/27/24 at 11:01 A.M., showed LPN B did not clean the glucometer with an approved EPA registered healthcare disinfectant after he/she obtained Resident #26's blood sugar or before he/she obtained Resident #58's blood sugar. Observation on 08/27/24 at 11:23 A.M., showed LPN B did not clean the glucometer with an approved EPA registered healthcare disinfectant after he/she obtained resident #31's blood sugar or before he/she obtained resident #23's blood sugar. During an interview on 08/27/24 at 8:05 A.M., LPN B said he/she wipes down the glucometer with an alcohol wipe to clean after each resident. He/She said the facility does not provide any other wipes. He/She said he/she should have wiped it down after use and before he/she put it away. He/She said he/she just forgot. During an interview on 08/28/24 at 11:01 A.M., Infection Preventionist (IP) said the facility's policy is for staff to clean glucometers with a Sani-wipe, place it on a barrier or clean napkin and let it air dry for 5 minutes in between residents. His/She expectation is that staff follow the policy for cleaning the glucometer. He/She said he/she used to oversee new employee education, but the process has changed since the new company has taken over. He/She is not sure who is providing the new employee infection control education upon hire. During an interview on 08/28/24 at 1:51 P.M., the DON said it is his/her expectation staff are cleaning glucometers in between residents. He/She said staff should be cleaning glucometers with Sani-cloths and placing them on a clean barrier while they dry for three minutes. He/She said he/she was not aware staff were using alcohol wipes to clean the glucometers. He/She said disinfecting the glucometer is important for ensuring there is not cross contamination of blood. During an interview on 08/29/24 at 4:05 P.M., the administrator said it is his/her expectation staff clean/disinfect glucometers after each use, with a sani-wipe. He/She said staff should wipe down the glucometer thoroughly then allow it to dry for five minutes or until dry. He/She said alcohol wipes do not kill blood borne pathogens and should not be used to disinfect glucometers. He/She said he/she was not aware staff were using alcohol wipes to clean glucometers. 7. Review of the Facility's Tuberculosis Testing policy, dated June 2023, showed upon hire, a new employee will receive a 2-step purified protein derivative skin test. Review of the Center for Disease Control and Prevention's, Clinical Testing Guidance for TB: TB Skin Tests, Dated May, 14, 2024, showed: -Two-Step testing; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-If the first skin test is negative, a second TB skin test should be done 1to 3 weeks later; -If the second TB skin test result is positive, it is probably a boosted reaction; -Interpreting test results; -The skin test reaction should be read between 48-72 hours after administration by a health care worker trained to read TB skin results. 8. Review of RN E's employee file showed: -Hire date of 11/27/23; -The file did not contain documentation staff administered the first step PPD and second step PPD test. Review of NA D's employee file showed: -Hire date of 01/31/24; -The file did not contain documentation staff administered the first PPD and second PPD test. Review of Housekeeping I's employee file showed: -Hire date of 11/17/23; -Staff documented the first step PPD administered on 11/17/23 and read on 11/20/23; -Staff documented the second step PPD administered on 11/28/23 five days after the 24-72 time. Review of maintenance J's employee file showed: -Hire date of 01/05/24; -Staff documented the first step PPD administered on on 01/02/24 and read on 01/04/24; -Second step PPD was administered on 01/04/24. Staff did not wait seven-21 days after the first dose, before administering the second step PPD. Review of CNA K's employee file showed: -Hire date of 07/26/23; -Staff documented the first step PPD administered on 07/26/23 and read on 07/29/23; -The file did not contain documentation a second step PPD dose administered. Review of LPN S's employee file showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Hire date of 06/30/23; -Staff documented the first step PPD administered on 03/03/23 and read on 03/06/23; -The file did not contain documentation a second step PPD dose administered. During an interview on 08/28/24 at 11:01 A.M., the IP said he/she oversees new employee TB's along side human resourses (HR). He/She said HR notifies him/her when they hire a new employee and he/she gives them their TB and directs them to return to have them read in two-three days. He/She said they require two step TB's upon hire. He/She said staff are directed to return to him/her in two-three weeks from the first TB, to get the second step. He/She said if staff do not return for their TB, he/she tries to reach out to the person. He/She said if he/she cannot get ahold of the staff member he/she notifies HR. He/She said he/she is not aware of any active staff members who did not receive the two step TB's. He/She said the second step should never be given the day the TB is read. He/She was not aware there were any staff who received the second step the same day the first step was read. During an interview on 08/28/24 at 1:51 P.M., the DON said the IP and HR work together to make sure all new employees have the two step TB's completed. He/She said the IP gives a list to him/her weekly of staff who need TB's read or given with deadlines. He/She tries to reach out to those staff members if he/she sees them. He/She said he/she was not aware there were staff who did not complete the two step TB's or who had them too close together. He/She said he/she is new and just started at the end out July. He/She said not having TB's completed puts their resident population at risk for TB expose due to their susceptibility. During an interview on 08/29/24 at 4:05 P.M., the administrator said when someone comes in for an interview and they have decided to hire them either the infection preventionist, DON or himself/herself perform the initial TB test. He/She said it is the responsibility of the IP to make sure staff complete the first step and the second step TB. He/She said TB's should be read between 48-72 hours and there should be 2-3 weeks in between the first and second step. He/She said he/she is not sure why the staff member was given the second step the same day as the first step was read. 9. Review of facility's Management of C-Difficile Infection Policy, dated 05/14/24, showed the purpose is to implement facility-wide strategies for the prevention and spread of Clostridioides difficile infections. Facility staff were directed as follows: -Contact precautions shall be implemented in accordance with a physician's order and facility policy for transmission-based precautions; -All staff are to wear gloves and a gown upon entry into the resident's room and while providing care for the resident with C. difficile infection; -Hand hygiene shall be performed by handwashing with soap and water; -Maintain contact precautions for the duration of illness, but no less than 48hrs after diarrhea has resolved; -A private room with a dedicated toilet is preferred. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility's policy Transmission-Based Isolation Precautions, dated 06/26/24, showed: -Contact precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment; -Transmission based precautions refer to actions implemented in addition to standard precautions that are based upon the means of transmission (airborne, contact, and droplet) in order to prevent or control infections; -Facility staff will apply Transmission-based precautions, in addition to standard precautions, to resident who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission; -Signage that includes instructions for use of specific PPE will be places in a conspicuous location outside the resident's room, wing, or facility wide; -The CDC category of transmission-based precautions or instructions to see the nurse before entering will be included in the signage; -The Facility will have PPE readily available near the entrance of the resident's room and will don appropriate PPE before or upon entry into he environment of a resident on transmission-based precautions; -Healthcare professional caring for residents on contact precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment; -Donning PPE upon entry and discarding before exiting the room is done to contain pathogens, especially those that that been implicated in transmission through environmental contamination (e.g. C. difficile). 10. Review of Resident #56's Temporary Care Plan, dated 08/20/24, showed the following: -Cognitively intact; -Diagnosis of C-Diff; -Independent with transfers and ADLS. Review of the resident's nurses admission assessment, dated 08/20/24, showed the resident is being treated for C-Diff and has seven days of antibiotic left to take. Observation on 08/26/24 at 9:27 A.M., showed the resident's room did not contain precaution signage, PPE inside or outside of the room. Observation on 08/27/24 at 8:09 A.M., showed the resident's room did not contain precaution signage, PPE inside or outside of the room. (continued on next page)

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	265856	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair View Health Care Center	1714 W 16th Street Sedalia, MO 65301

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 08/27/24 at 10:34 A.M., showed LPN M did not wear a gown when he/she entered the residents' room to administer the resident's intravenous (within a vein) antibiotics. The resident room did not contain precaution signage, PPE inside or outside the room. During an interview on 08/27/24 at 10:43 A.M., LPN M said resident has red bin outside of door because resident is on C-Diff precautions. He/She said make sure and wear gloves going in and hand wash after removing gloves. He/She said no gown or goggles are needed, just gloves and handwashing. Observation on 08/28/24 at 9:19 A.M., showed CNA O did not wear a gown or gloves when he/she changed the resident's bed sheets. The resident room did not contain precaution signage, PPE inside or outside the room. During an interview on 08/29/24 at 10:50 A.M., CNA O said the resident has red bin outside of door for C-Diff precautions. He/She said to make sure and wear gloves going in room and to wash hands after removing gloves. He/She said he/she is unsure if there should be a sign outside of door due to privacy, but maybe a sign that says see charge nurse before entering resident room. He/She said he/she failed to wear gloves when changing bed sheets because, he/she was busy and honestly can't think of why he/she did not wear gloves, he/she should have worn gloves. He/She said not wearing gloves is a risk of getting sick and transferring the infection to another resident. During an interview on 08/29/24 at 8:50 A.M., CMT A said resident is on precautions for C-Diff. He/She said they were told to wear gloves when entering the room and remove gloves, put in red bin, and wash hands. He/She said he/she was not told he/she needed a gown. He/She would expect a sign on the door that says please see charge nurse before entering due to privacy. During an interview on 08/29/24 at 11:01 A.M., the Infection Preventionist said resident was admitted with C-Diff and was finishing up antibiotic here in facility. He/She said PPE for C-Diff should be gloves and hand washing or sanitizing after leaving room. He/She was not aware that gowns should be worn as a precaution for C-Diff when entering the room. He/She said there should have been a sign on the door to alert staff/visitors on precautions, but he/she just forgot. During an interview on 08/29/24 at 4:31 P.M., the DON said the resident was admitted with C-Diff from hospital. He/she said the resident should have proper PPE outside of resident's room to use when entering room. He/She said he/she expects a sign on door to ask nurse about precautions before entering the room. He/She said C-Diff precautions should be gloves and gown when caring for resident. He/She said gloves should be removed and hands should be washed and not sanitized when leaving the room. During an interview on 08/29/24 at 4:41 P.M., the administrator said he/she was not aware of resident's diagnosis upon admission that day until he/she saw the red bin outside of his/her door. He/She said he/she expects a sign outside of door to see the charge nurse before entering room. He/She expects PPE to he gloves, gown, and hand washing with soap and water. He/She said not using appropriate PPE is a risk for spreading infection to other residents. 11. Review of the facility's Enhanced Barrier Precautions Policy, dated 05/18/24, showed staff are directed as follows: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-EBP uses PPE and recommends gown and glove use for certain residents during specific high-contact resident care activities associated with multidrug-resistant organisms (MDRO) transmission; -EBP (gown and gloves) must be used for high-contact resident care activities with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO; -High-contact resident care activities include, but are not limited to, dressing, transferring, providing hygiene, changing briefs, indwelling device care or use; -Indwelling medical devices include, but are not limited to, central lines, urinary catheters, feeding tubes, and tracheotomies; -Make gowns and gloves available immediately near or outside of the resident's room; -All staff receive training on EBP upon hire and at least annually, and are expected to comply with all designated precautions; -The Infection Preventionist (IP) will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education; -EBP are intended to be placed for the resident's entire stay in the facility or until discontinuation of the indwelling device that placed them at higher risk; -Facility should ensure all staff and other health care providers (doctors, therapy providers, etc.) know which residents require EBP; -The facility's IP is responsible for the enforcement of the policy. 12. Review of Resident #22's annual MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Upper extremity (shoulder, elbow, wrist, hand) impairment on both sides; -Uses a feeding tube for nutrition; -Has a trach (a catheter inserted into the windpipe to help a person breathe); Observation on 08/26/24 at 11:35 A.M., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room. Observation 08/27/24 at 9:22 A.M., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 08/27/24 at 12:21 P.M., showed LPN B did not wear a gown when he/she administered the resident's medications, water flushes, and feeding via peg tube. The LPN re-entered the resident's room and did not wear a gown or gloves when he/she administered a nebulizer treatment via the resident's trach mask. The LPN did not use appropriate PPE as an EBP during cares. Observation on 08/28/24 at 11:51 A.M., showed Occupational Therapist (OT) V did not wear a gown when he/she performed hand exercises with the resident. The OT did not use appropriate PPE as an EBP during the therapy session. During an interview on 08/28/24 at 11:51 A.M., OT V said he/she has not been notified or made aware of any extra precautions or requirements to use additional PPE/EBP during therapy sessions with the resident. 13. Review of Resident #35's quarterly MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment, and uses a feeding tube for nutrition. Observation on 08/26/24 at 11:35 A.M., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room. Observation 08/27/24 at 9:22 A.M., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room. Observation on 08/27/24 at 11:48 A.M., showed LPN B did not wear a gown when he/she administered the resident's medications, feeding, and water flushes via peg tube. The LPN did not use appropriate PPE as an EBP during care. During an interview on 08/27/24 at 2:40 P.M., LPN B said he/she was not aware of any protocol to use EBP for residents with medical devices such as a peg tube or trach. 14. Review of Resident #38's quarterly MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment, had an indwelling catheter, dependent with personal hygiene, and toileting. Observation on 08/28/24 at 3:06 P.M., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room. NA P and NA Q did not wear a gown when they transferred the resident via mechanical lift, performed incontinence care and catheter care. The NAs did not use appropriate EBP during transfers and incontinence/catheter care. During an interview on 08/28/24 at 3:25 P.M., NA P said he/she was not aware of any extra PPE such as gowns required for use with catheter care. During an interview on 08/28/24 at 12:32 P.M., the IP said he/she was not officially made aware of a CDC recommendation/guideline regarding EBP. The IP said he/she was told by a friend, and he/she consulted with the Administrator, but did not implement a policy. The IP said the facility did not currently have a protocol for EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 08/29/24 at 4:35 P.M., the DON said he/she was aware of EBP required PPE for residents with wounds/devices such as peg tube, catheter, and trach from a previous job. The DON said he/she noticed there were residents in the facility that met the criteria, and he/she spoke with the IP regarding implementing a policy, but they just did not get to it yet. During an interview on 08/29/24 at 4:46 P.M., the administrator said he/she knew of EBP requirements for catheters/peg tubes but was not fully aware previously for extra PPE to be used with a trach or wound. The administrator said the facility had a policy for EBP, but staff did not implement it. The administrator said the policy should have been implemented prior to help with infection control. 15. Review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 17-30, dated 06/02/17 and revised on 06/09/17; showed: -The bacterium Legionella can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least [AGE] years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as shower heads, cooking towers, hot tubs, and decorative fountains; -Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water; -CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of legionellosis was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the Centers for Disease Control and Prevention (CDC) and its partners developed a toolkit to facilitate implementation of this ASHRAE Standard (https://www.cdc.gov/legionella/maintenance/wmp-toolkit.html). Environm[TRUNCATED]

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50422 Based on observation, interview, and record review, facility staff failed to ensure call lights were within reach for three residents (Resident #10, #27, and #40) out of 14 sampled residents. The facility census was 53. 1. Review of the facility's policy titled, Call Light Accessibility and Timely Response, dated 4/30/24, showed all staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. All residents will be evaluated on how to call for help by using the resident call system. Staff will ensure the call light is within reach of resident and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. The call system should be accessible to a resident lying on the floor. 2. Review of Resident #10 Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/28/24, showed staff assessed the resident as follows: -Severely Cognitively Impaired; -Upper extremity impairment on one side, impairment on both lower extremities; -Dependent for Activities of Daily Living (ADL's) and transfers. Review of the resident's care plan, dated 05/28/2024, showed staff is directed to make sure the resident has his/her call light at all times, remind and encourage to use call light. Observation on 08/26/24 at 12:16 P.M. and 2:38 P.M., showed the resident in his/her bed, with the call light on the floor not within reach. Observation on 08/28/24 at 9:28 A.M., showed the resident in his/her bed, the call light hung on the wall behind bed not within reach. Observation on 08/29/24 at 8:00 A.M., showed the resident in his/her bed, with the call light on the floor not within reach. Observation on 08/29/24 at 11:00 A.M., showed the resident in his/her recliner, with the call light on the floor not within reach. 3. Review of Resident #27's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Severely Cognitively Impaired; -Legally blind; -No impairment to upper or lower extremities; (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Substantial/Maximal assist with transfers and ADLS. Review of the resident's care plan, dated 06/16/2024, showed staff is directed to make sure the resident has his/her call light when in his/her room and remind resident to use the call light and wait for help. Observation on 08/26/24 at 9:24 A.M., showed the resident in his/her wheelchair, with the call light on bed not within reach. Observation on 08/28/24 at 9:30 A.M., showed the resident in his/her wheelchair, the call light hung on wall above bed not within reach. 4. Review of Resident #40's Significant Change MDS, dated [DATE], showed staff assessed the resident as follows: -Severely Cognitively Impaired; -No impairment to upper or lower extremities; -Substantial/Maximal assist with transfers; -Dependent with ADLS. Review of the resident's care plan, dated 08/19/24, showed staff is directed to make sure resident's call light is within reach at all times when in his/her room. Observation on 08/26/24 at 9:23 A.M.,12:08 P.M. and 2:31 P.M., showed the resident in his/her bed, with the call light on the floor beside bed not within reach. Observation on 08/27/24 at 9:35 A.M. and 1:58 P.M., showed the resident in his/her bed, with the call light on the floor beside bed not within reach. Observation on 08/28/24 at 8:47 A.M., showed the resident in his/her bed, with the call light on the floor beside bed not within reach. Observation on 08/29/24 at 8:02 A.M., showed the resident in his/her bed, with the call light on the floor beside bed not within reach. 5. During an interview on 08/29/24 at 3:54 P.M., Certified Nurses Aide(CNA) N said call lights should be within reach of resident at all times. He/She said if call light is not within reach, it is a risk for them fall if they can not ask for help. During an interview on 08/29/24 at 3:50 P.M., Lisenced Practical Nurse (LPN) M said call lights should be within reach of resident. He/She said if call light is not within reach the resident can not ask for help and it is a risk for them falling. He/She said he/she is unsure why the above residents did not have their call light within reach, it should have been within reach. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/29/24 at 4:31 P.M., the Director of Nursing said call lights should always be within reach or clipped to the resident. He/She said that if call light is not within reach, it is a risk of the resident falling out of bed or trying to get up on their own. He/She said he/she expects the above residents to have their call light within reach even if they aren't able to use them. He/She said it is the aides or any staff in the room to ensure call lights are within reach. During an interview on 08/29/24 at 4:51 P.M., the administrator said he/she expects call lights to be within reach of residents. He/She said if call lights are not within reach, it is a risk that the residents won't be able to ask for help if they need it. He/She said he/she expects the above residents and all residents to have their call light within reach at all times. He/She said any staff can put the call light within reach.