STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275030	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Transitional Care and Rehabilitation	1500 32nd St S Great Falls, MT 59405

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 51133 Based on observation, interview, and record review, the facility failed to assist a resident with obtaining clothing that fit, and change the clothing she had regularly, are attempt to obtain clothes she could use that fit, so the resident did not need to re-wear the same shirts each day. This failure did not enhance enhance the resident's dignity as how she dressed was important to her, and she became teary discussing it, for 1 (#52) of 39 sampled residents. Findings include: During an interview and observation on 4/21/25 at 3:51 p.m., resident #52 was very tearful and stated she had few clothes of her own at the facility, and the clothes were either way too big, or way too small. Resident #52 said she had some very nice clothes at the assisted living, and she had asked staff to get clothing from the assisted living where she resided. Resident #52 was observed in a multicolored, short sleeve, floral shirt and gray sweat pants which were knotted at the waist. There were no clothes hanging in resident #52's closet. There were three items of clothing in the middle drawer of the bedside stand which she identified as her own. There was one item of clothing in the top drawer of the bedside stand which she stated was given to her by the facility and did not fit. During an interview on 4/22/25 at 3:39 p.m., staff member W stated there was a linen closet with spare clothing for residents if needed. Staff member W stated they used spare clothing for residents quite a bit because they came to the facility from the hospital. Staff member W said social services would contact the resident's family for more clothing when there was a need. During an interview on 4/22/25 at 3:47 p.m., staff member Q stated he had not requested additional clothing from resident #52's assisted living facility. During an observation on 4/22/25 at 4:04 p.m., resident #52 was observed in the same multicolored, short sleeve, floral shirt as the previous day. During an observation and interview on 4/23/25 at 8:11 a.m., resident #52 was observed in the same multicolored, short sleeve, floral shirt she wore on 4/21/25. Resident #52 stated, I don't know who brought my clothes to me, they don't fit me at all. Staff member W said, I thought someone brought you clothes, they must have brought the wrong clothes. During an interview on 4/23/25 at 10:14 a.m., staff member DD stated staff does assist with getting residents proper clothing and it is a task of the social service department. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #52's Admission MDS, with an ARD of 4/17/25, showed it was very important for resident #52 to choose what clothes to wear. Her BIMS score showed she was a 13, cognitively intact. Review of resident #52's Inventory of Personal Effects, undated, showed, 1- blouses, multi-colored short sleeve, 1- Shorts, yellow & white, - Dentures: Upper, - 02 tank & holder, - 3 - Bracelets (2 beaded) (1 grn & clear stone). Review of the facility's policy and procedure titled, Promoting/Maintaining Resident Dignity, with a revision date of 1/7/25, showed: Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: .9. Groom and dress residents according to resident preference.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 51133 Based on observation and interviews, the facility failed to provide a home like setting and correct and control odors emanating on the 400B hallway, for 2 (#s 114 and 130) of 39 sampled residents. This deficient practice affected those residents who resided on the 400B hallway and their visitors, due to the unpleasant odors. Findings include: During an observation on 4/21/25 at 3:24 p.m., there was a strong smell of urine observed in the 400B hallway. During an observation on 4/22/25 at 9:43 a.m., an overwhelming, undesirable smell of urine was present throughout the 400B hallway. During an interview on 4/23/25 at 4:20 p.m., NF4 stated resident #114 had always kept a clean and tidy home before her dementia diagnosis. NF4 stated the strong smell of hallway 400B would not have been tolerated by resident #114, but due to the diagnosis of dementia, she was not the same person. During an interview on 4/23/25 at 4:24 p.m., NF3 stated he had a concern when his mother, resident #114, was moved to the 400B hallway due to the overwhelming strength of the smell. NF3 stated a room replacement was discussed with social services, but this room was the only option. NF3 commented, You can smell it when you come down the hall. NF3 stated the facility sprayed odor ban in the room before she moved in, and they over did it and caused a negative effect of coughing for resident #114. NF3 stated he brought in a bottle of air freshener, but I can't help the whole building. NF3 further stated he brought in a fan and planned to bring an air purifier to help with the smell. During an interview on 4/23/25 at 4:40 p.m., resident #130 stated, sure stinks in here. During an observation on 4/24/25 at 8:58 a.m., the malodorous smell was again observed throughout 400B hallway.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 35356 Based on observation, interview, and record review, the facility failed to ensure residents received proper treatment, services, and assistive devices to maintain optimal visual abilities for 1 (#42) of 39 sampled residents. Findings include: During an observation and interview on 4/22/25 at 9:04 a.m., resident #42 was sitting in his room attempting to watch television. He was wearing glasses. The resident stated he could not see well even with the glasses he had on, and he was frustrated because he had been asking to see the eye doctor for over a month, and the facility told him he had to wait because they did not have a ride for him. During an observation and interview on 4/22/25 at 3:03 p.m., resident #42 was sitting in his room attempting to read his bible. The resident stated he was frustrated because he could not see well even with his glasses. The resident repeated he had been asking the facility to make an eye appointment for him, but he was frustrated because he had been asking for a while, and they still had not made him an appointment. Review of resident #42's Social Services Progress Note, created by staff member S, dated 2/6/25, showed, . Speech therapist approached me, and reported that resident is complaining about his vision, and requesting follow-up with ophthalmologist. Could you help arrange this appointment? Review of resident #42's Social Services Progress Note, dated 2/17/25, showed, . Vision and hearing adequate, wears glasses . There were no additional Social Services Notes which showed the physician requested eye exam was scheduled for resident #42. Review of resident #42's Health Status Note, dated 3/29/25, showed, . Note to social services for eye doctor appointment requested by resident. He states he doesn't have prescription glasses anymore and can't see well. This nurse did look and found only simple 'reader' glasses. Review of resident #42's Progress and Social Service notes did not show an eye appointment was scheduled for the resident from this request. Review of resident #42's Health Status Note, dated 4/3/25, showed, Resident magnifying glass has been dropped and taped several times. Contacted his sister and she is going to get him a new one as soon as she can. During an interview on 4/23/25 at 8:59 a.m., resident #42 expressed again how important it was for him to see the eye doctor because he could hardly see anything. He stated the current glasses he had were not helping. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/25 at 9:21 a.m., staff members H and P, both stated resident #42, did not have an eye appointment scheduled. Staff member H stated the eyeglasses the resident was currently wearing were magnified eyeglasses his sister brought in for him last weekend. She stated they realized that he only had readers available. Both staff members stated they were aware the resident was still having difficulty seeing even with the magnified eyeglasses provided by his sister. Staff members H and P stated staff member Q was responsible for scheduling the eye appointments for residents. During an interview on 4/23/25 at 9:24 a.m., staff member Q stated resident #42 did not have an eye exam scheduled. He stated he was aware the resident was having difficulty seeing and had spoken to staff member S about scheduling an eye exam for the resident but did not know if anything would help due to his glaucoma. A review of resident #42's Progress Notes, Physician Notes, and Provider Orders did not show any documentation to discontinue the request for obtaining an eye exam for resident #42. A referral for an eye exam was made by the provider on 2/6/25. As of 4/24/25, no eye exam had been scheduled for resident #42. During an interview on 4/24/25 at 9:36 a.m., staff member A stated it was the expectation to set up an eye appointment more often than yearly when a resident was actively having difficulty with their vision, or there was a change in the resident's visual health. A review of the facility's policy and procedure titled, Hearing and Vision Services, with a revision date of 1/14/25, reflected: . 1. The facility will utilize the comprehensive assessment process for identifying and assessing a resident's vision and hearing abilities in order to provide person-centered care. This process includes: c. Ongoing monitoring of sensory problems; . e. Evaluation. 2. Staff should refer any identified need for hearing or vision services/appliances to the social worker/social service designee. 3. The social worker/social service designee is responsible for assisting residents, and their families, in locating and utilizing any available resources (e.g. Medicare or Medicaid program payment, local health organizations offering items and services which are available free to the community), for the provision of the vision and hearing services the resident needs. 4. Once vision or hearing services have been identified, the social worker/social service designee will assist the resident by making appointments and arranging for transportation .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 32998 Based on observation, interview, and record review, the facility failed to ensure a resident admitted without a pressure ulcer did not develop a pressure ulcer for 1 (#10) of 2 sampled residents with pressure ulcers. Resident #10 was admitted with intact skin on the sacrum and developed a Stage III pressure ulcer which progressed to a Stage IV with healing not achievable. The resident did have refusals of care, and the facility implemented interventions for wound prevention, but failed to identify the wound timely and prevent further deterioration or infection, of the wound, and implement and monitor sufficient intervetnions for healing, or resolve the resident's concerns with refusals and pain management which hindered wount healing. Findings include: During an observation on 4/21/25 at 2:32 p.m., resident #10 was seated in her wheelchair. Review of resident #10's Care Plan, initiated 3/31/25, showed the resident was to be in her wheelchair for only one hour, three times daily, at meals. Review of resident #10's turn and turn and reposition task documentation, dated 3/26/25 through 4/24/25, had not shown documentation for repositioning every two hours. During an interview on 4/24/25 at 8:48 a.m., staff members H and P stated resident #10 was dependent on staff for all her care needs. Staff members H and P stated the resident's son came in daily to assist her with meals. Staff member H stated skin interventions for resident #10 were an air mattress, reposition every hour, use a wedge behind her when in bed, and a cushion in the resident's wheelchair. Staff member H stated the resident sometimes refused to be repositioned. Staff member H stated she made rounds frequently to ensure the resident was being repositioned. During an interview on 4/24/25 at 9:23 a.m., staff member EE stated resident #10 went to the wound clinic. Staff member EE stated resident #10 had refused turning and repositioning, occasionally. Staff member EE stated the resident was at higher risk for pressure ulcers because of the resident's medical co-morbities. Review of resident #10's Nursing-Clinical Admission Evaluation, dated 7/8/24, showed a scar on the resident's coccyx, a pressure wound to the right ankle, and a pressure wound to the right gluteal fold. The resident did not have a pressure wound on her sacrum, per the clinical admission evaluation. Review of resident #10's Skin and Wound Evaluations, dated 8/29/24 through 4/21/25, showed the following: - On 8/29/24 a Stage III pressure wound to the resident's sacrum was identified. Measurements were 1.3 cm x 1.5 cm x 0.2 cm (length x width x depth) - From 9/10/24 through 12/10/24 the resident's pressure wound was documented as a Stage III, which began undermining on 11/11/24, and as of 11/18/24, the Stage III pressure wound was undermining and measuring 1.5 cm and tunneling, measuring 2.0 cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- On 12/18/24, the pressure wound was classified as a Stage IV with undermining. Measurements were 2.8 cm x 1.8 cm x 2.3 cm, with 3.0 cm of undermining, showing interventions were not successful for helping prevent further deterioration of the wound, and on 12/23/24, the pressure wound was classified as a Stage IV measuring 3.0 cm x 2.4 cm x 2.0 cm with 2.8 cm of undermining. From this date to 2/24/25, the wound measurements varied, but staff were not consistent on the wound documentation related to the status, size, and tunneling. - On 4/21/25, the pressure wound measured 2.2 cm x 1.3 cm x 1.3 cm with 2.3 cm of undermining. - Review of resident #10's Skin and Wound Evaluations showed inconsistent measurements and failed to identify undermining and tunneling consistently. Review of resident #10's wound care orders and TARs showed the dressing changes were to be done either daily, or every other day, depending on the order at the time. It was found not all changes occurred as ordered by the physician. Review of resident #10's TAR showed dressing changes were not documented for 8/28/24, 8/29/24, 10/9/24, 10/19/24, 10/23/24, 10/25/24, 11/11/24, 1/7/25, 1/15/25, 1/26/25, 2/5/25, 3/14/25, 4/7/25, 4/15/25, and 4/19/25. From 8/20/24 through 11/11/24, dressing changes were to be done one time daily, but did not occur at least 6 times. The TAR reflected incomplete information related to the treatment of the wound. Review of resident #10's Skin and Wound Evaluation, dated 10/28/24 showed the provider identified an infection in the resident's wound. Review of resident #10's MAR, dated 10/2024 through 12/2024, showed the following orders for antibiotics: - 10/22/24, Bactrim DS 800-160 mg two times daily for 20 days for sacral wound with cellulitis - 10/25/24, metronidazole 500 mg three times daily for cellulitis/sacral ulcer for 14 days - 10/28/24, Ampicillin-sulbactam sodium intraveneously every six hours for cellulitis/sacral wound infection for seven days - 11/30/24, Bactrim-DS 800-160 mg two times daily for 10 days for sacral wound infection. Review of resident #10's Care Plan, with an initiation date of 10/25/24, showed the resident had a wound, but it was not identified where the wound was on the resident's body, nor was the severity of the wound. The Care Plan showed the following interventions for skin integrity and alteration in skin integrity: - Administer treatment as ordered. Initiated on 10/25/24. Revised on 10/28/24 - Air mattress. Initiated on 7/25/24. Revised on 1/20/25 - Turn and reposition every two hours. Initiated on 7/25/24. Revised on 1/20/25 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Assess, record, and monitor wound healing. Initiated on 10/25/24. Revised on 10/28/24 - Cushion in chair. Initiated on 11/14/24. Revised on 4/22/25 - Positioning wedge while in bed. Initiated on 3/25/25. - Assess the level of pain and administer pain medication prior to dressing changes, initiated on 10/25/24 and revised on 4/22/25 Review of resident #10's Progress Note, dated 3/25/25, showed the resident refused Ultramist treatments, due to pain during and after, the procedure. There were no documented pain management interventions prior to the wound treatment procedures. Review of resident #10's Physician Progress note, dated 1/27/25, showed the resident was to have hydrocodone, as needed for pain, especially with dressing changes. During an interview on 4/24/25 at 11:14 a.m., staff member Y stated resident #10 was to be repositioned every two hours. Staff member Y stated she checked on the resident at the start of every shift. Staff member Y stated the resident did not normally refuse to be turned. During an interview on 4/24/25 at 11:18 a.m., staff member Z stated she made sure the resident was turned and repositioned on time. Staff member Z stated the resident was usually turned every one to two hours. Staff member Z stated a wedge was used to keep the resident in position. Staff member Z stated the resident had an air mattress. Staff member Z stated if the resident refused it was documented and she would notify the nurse.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 35356 Based on observation, interview, and record review, the facility failed to address an indwelling catheter upon admission for discontinuation, by failing to complete an ordered urinary and cognitive assessment and failed to provide the resident with the appropriate services to maintain or restore previous bladder function for self-catheterization to ensure the resident's optimal urinary outcome and independence for 1 (#22) of 39 residents. This deficient practice had the potential to cause an increase in urinary incontinence, urinary infection, and reduce the resident's independence. Findings include: During an observation and interview on 4/21/25 at 4:13 p.m., resident #22 was sitting in a wheelchair in his room. He had urinary catheter tubing coming out of the top of his pants and a catheter bag attached to the side of his wheelchair. Resident #22 stated he was paralyzed from the waist down. He said he was recently admitted to the facility and had the indwelling catheter when he was admitted to the facility. He stated the indwelling catheter was placed when he was in the hospital. He believed it was placed due to a urinary tract infection that he had while in the hospital. He stated prior to being admitted to the hospital, and then the facility, he used to perform self-catheterizations on himself, stating it made him feel more independent when he could self-catheterize. He stated having the current indwelling catheter could be uncomfortable. Resident #22 stated he had asked the staff if he could begin self-catheterizing himself again, and he was told they did not know how to bill for the self-catheterization supplies, and he would need to keep the indwelling catheter. The resident stated he did not receive an assessment by the facility to determine his ability to perform self-catheterization. He also stated he did not have any problems with skin breakdown. Review of resident #22's Discharge Summary, dated 3/19/25, reflected: - Chief Complaint: . for unknown reasons and ran out of supplies to catheterize himself . He has a history of neurogenic bladder and he had been without supplies for three days, resulting in urinary leakage and subsequently excoriation on his genitals, perineal area, perianal area, inner thighs, and inner skin folds. The patient is wheelchair bound and is paraplegic without ability to use his legs . - Patient's Personal Goals: . [Resident #22] has a desire to be independent . Review of resident #22's Admission Note, completed by staff member S, dated 3/31/25, showed: - Date of Admission: 3/19/25. - Date of Visit: 3/28/25. - History and Present Illness: .He has neurogenic bladder as well and currently has an indwelling foley, in the past he has been able to manage with intermittent self-cath, and he is interested to try this again . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Assessment and Plan: 2. Neurogenic bladder, with indwelling foley. Resident expressed interest to transition to intermittent straight cath. I would like to have speech perform a cognitive eval to assess his level of competence with the procedure but I do think that it may be feasible . [sic] Review of resident #22's Physician Orders, dated 3/30/25: showed, I was wondering if it would be possible to have OT/Speech evaluate for his ability to perform intermittent straight cath, instead of the indwelling catheter. He states he has managed this in the past, but unsure if there has been progressive physical or cognitive disability that would affect his ability to perform this safely . During an interview on 4/23/25 at 11:12 a.m., staff member L stated she was not aware of a referral for resident #22 to assess his cognition and his ability to perform self-catheterization. During an interview on 4/23/25 at 11:15 a.m., staff member M stated she was not aware of a referral for resident #22 to assess his cognition and his ability to perform self-catheterization. During an interview on 4/23/25 at 11:20 a.m., staff member N stated there were no current or older physician orders to assess resident #22 for cognition and self-catheterization. She stated resident #22 did not have a therapy case in their charting system. She stated the expectation would be to complete any ordered assessment no later than three days after receiving the order. During an interview on 4/23/25 at 11:26 a.m., staff member H stated resident #22 had a physician order from 3/30/25, to assess for cognition and self-catheterization. She stated there was no documentation which supported this evaluation had been completed. Staff member H stated resident #22 currently had an indwelling catheter and was not performing self-catheterization. She stated when the provider entered in an order for a therapy evaluation that order would be sent to the communication board for therapy to complete. During an interview on 4/23/25 at 11:30 a.m., staff member O stated he oversaw the critical supply log for ordering resident supplies. He said there was a discussion at one point to order self-catheterization supplies for resident #22. But they did not know how to order those supplies and had inquired with the regional resource manager but had not heard anything back on how to order the self-catheterization supplies for resident #22. During an interview on 4/23/25 at 11:49 a.m., staff member N confirmed there were no orders on the facility's communication board to assess resident #22 for cognition and ability to perform intermittent self-catheterizations. During an interview on 4/23/25 at 11:56 a.m., staff member B stated it was the expectation to attempt a bladder trial and discontinue an indwelling catheter for a resident that was admitted with an indwelling catheter. He stated the provider would order the bladder trial and typically the therapy department would complete an assessment to evaluate the resident's ability depending on their diagnosis and if it was plausible to discontinue the catheter. Staff member B stated if the resident could complete intermittent self-catheterization safely and effectively the resident should be provided with the appropriate services and treatments to self-catheterize. A review of the facility's policy and procedure titled, Incontinence, with a revision date of 1/14/25, reflected: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- . 3. Residents that enter the facility with an indwelling catheter, or receives one while in the facility, will be assessed for removal of the catheter as soon as possible, unless the resident's clinical condition demonstrates that catheterization was necessary. 4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible . A review of the facility's policy and procedure titled, Indwelling Catheter Use and Removal, with a revision date of 1/21/25, reflected: - Compliance Guidelines: 2. Residents that admit with an indwelling catheter or subsequently receives one will be assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that the catheter is necessary. 3. The facility will conduct ongoing assessments for residents at risk for urinary catheterization or on residents with indwelling catheters to determine if the catheter needs to be continued or removed if the catheter is no longer necessary. 4. If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to: . b. Timely and appropriate assessments related to the indication for use of an indwelling catheter; c. Identification and documentation of clinical indications for the use of the catheter; as well as criteria for discontinuation of the catheter when the indication for use is no longer present .

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Park Place Transitional Care and Rehabilitation	1500 32nd St S Great Falls, MT 59405

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49554 Based on observation, interview, and record review, the facility failed to provide behavioral health services for 1 (#391) of 1 resident sampled for behavioral health, who showed signs of depression after a life-changing event. This deficient practice had the potential to lead to an increased deterioration in resident #391's health, mood, and behavior and failed to identify any interventions for staff to use related to improving the resident's mood or depressive symptoms. Findings include: During an observation and interview on 4/22/25 at 8:39 a.m., resident #391 was lying in his bed watching television. Resident #391 stated, I have been here since February. I am a school teacher and recently suffered a stroke. It left me unable to use my right side, and now I need dialysis as well . It really bothers me that I can't do things for myself. I was living on my own and doing everything for myself before the stroke. I don't know if I'll ever get back to doing things on my own. Resident #391 was tearful and stated, No, the facility has not spoken with me about seeing someone for mental health. I should probably start seeing a counselor or someone . I think it could help me mentally. During an interview on 4/23/25 at 4:17 p.m., staff member T stated, [Resident #391] does seem to be depressed. He has been through a lot for his age. I do think he would benefit from mental health counseling. He doesn't participate in many activities, but he does occasionally come out of his room. I think he is just tired most days . I wouldn't want to live like that, if it were me. During an observation and interview on 4/23/25 at 4:25 p.m., resident #391 was wheeling back to his room. He had a flat affect and stated he was tired and just wanted to go to bed. During an interview on 4/24/25 at 8:32 a.m. , staff member Q stated they had completed the PHQ-9 for resident #391 upon admission in February 2025. Staff member Q stated, I did speak with him about mental health therapy after he was admitted , but I do not have documentation of that conversation . Review of resident #391's PHQ-9, dated 2/27/25, showed: .B. Score and Category Interpretation: iii. In addition, PHQ-9 Total Severity Score can be used to track changes in severity over time. Total Severity Score can be interpreted as follows: 1-4: minimal depression 5-9: mild depression 10-14: moderate depression . Resident #391's PHQ-9 assessment score, dated 2/27/25, was 12, moderate depression. There were no other PHQ-9 assessments completed prior to the start of the survey period. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #391's Admission MDS, dated [DATE], showed: . Section D - Mood: D0160. Total Severity Score: 12, moderate depression . D0700. Social Isolation: 2 = sometimes. Review of resident #391's care plan, with a revision date of 3/3/25, showed: .Focus: I have a mood problem r/t PHQ2-9 assessment, self reporting feeling down, depressed or hopeless resulting in risk for difficulty sleeping, lacking energy, feeling bad about myself, difficulty concentrating and feeling lonely or isolated. Goal: I will have improved mood state (happier, calmer appearance, no s/sx of depression, anxiety or sadness) through the review date. Interventions/Tasks: Assist me in developing/Provide me with a program of activities that is meaningful and of interest. Encourage and provide opportunities for exercise, physical activity. Educate me/family/caregivers regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance. Monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills. Monitor/record/report to MD prn mood patterns s/sx of depression, anxiety, sad mood as per facility behaviour monitoring protocols. [sic] Review of resident #391's social service progress note, dated 2/27/25, showed: -Late Entry: Note Text: Admission Assessment: . Previously lived alone in [Town] plans to discharge with sister or ALF. Alert, oriented, able to make needs known, use call light appropriately. BIMS 14/15 cognitively intact. PHQ2-9 12/27 self reported moderated indication of depression. Some cognitive deficits related to stroke. No concerns with psychosocial well-being or behaviors. No psychosocial/mental health dx. [sic] Review of a facility document titled Behavioral Health Service, dated 1/14/25, showed: -It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning and well-being. -Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorders. -3. The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety . -7. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. The assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Staff will: .f. Assess and develop a person-centered care plan for concerns identified in the resident's assessment.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51133 Based on observation, interview, and record review, the facility failed to properly store, label, date, and discard food items by the use by date, in the backroom cooler in the kitchen; and failed to monitor refrigerator and freezer temperatures, in the refrigerator next to the juice dispenser, in the kitchen. These failures may affect any resident using or receiving items from the refrigerator or freezer. Findings include: 1. During an observation on 4/21/25 at 12:50 p.m., the following items were observed in the back room cooler in the kitchen: - tortillas opened and wrapped in cellophane with a use by date of 10/18/24, - a food item which resembled a potato, wrapped in aluminum foil, not labeled or dated, - a stainless-steel pan labeled beef was not dated, - mushrooms in a plastic bag were not labeled or dated, - hotdog's, in a stainless-steel pan, were opened and not covered, labeled, or dated, - a food item which resembled cooked, ground beef, stored in a stainless-steel pan, was not labeled or dated, - an item labeled deli ham stored in a stainless-steel pan was not dated, - sausages stored in a stainless-steel pan were labeled 4/7, and - a food item labeled chicken was dated 4/9 and 4/13. During an interview on 4/21/25 at 12:53 p.m., staff member V stated the use by date was seven days after the food item was opened. Review of the facility's policy and procedure titled, Food Safety Requirements, with a revision date of 1/14/25, showed: .Policy Explanation and Compliance Guidelines: . 3. Facility staff shall .ensure timely and proper storage. c. Refrigerated storage . Practices to maintain safe refrigerated storage include: . iv. Labeling, dating and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use by date, or frozen (where applicable)/discarded . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During the initial observation in the kitchen on 4/21/25 at 12:58 p.m., the refrigerator, located to the left of the juice machine, did not have a temperature log monitoring temperatures in the refrigerator and the freezer. During an interview on 4/23/25 at 12:15 p.m., staff member U said the refrigerator temperatures should be monitored for all refrigerator units. Review of the facility's policy and procedure titled, Food Safety Requirements, with a revision date of 1/14/25, showed: .Policy Explanation and Compliance Guidelines: . 3. Facility staff shall .ensure timely and proper storage.c Refrigerated storage . Practices to maintain safe refrigerated storage include: i. Monitoring food temperatures and functioning of the refrigeration equipment daily and at routine intervals during all hours of operation .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 35356 Based on observation, interview, and record review, the facility failed to ensure safe and effective blood-draw practices were utilized by contracted staff to reduce the potential for cross-contamination and contamination from blood-borne pathogens when attempting to draw a resident's blood in the dining room, for 1 (#39); failed to implement the appropriate use of TBP for droplet precautions for 1 (#7); and contact precautions for 1 (#52) of 39 sampled residents; and failed to ensure proper hand hygiene was followed related to glove use in the kitchen. These deficient practices had the potential to increase the risk of infection related to blood-borne pathogens, and the risk of spread of infection for all residents. Findings include: 1. During an observation on 4/22/25 at 8:26 a.m., resident #39 was sitting at a table in the main dining room eating his breakfast. There was another resident sitting at the table with resident #39. NF1 and NF2 were attempting to obtain a blood sample from resident #39's right arm. During an interview on 4/22/25 at 8:30 a.m., NF1 and NF2 stated they did not work for the facility. They stated they were there to draw resident #39's blood per a physician's order for blood work. NF1 stated a staff member told them they could draw the resident's blood in the dining room if the resident did not mind. They stated they had asked resident #39 if he minded if they drew his blood in the dining room, and he had told them he did not mind. NF1 and NF2 stated the concern with drawing a resident in the dining room would be related to blood-borne pathogen exposure and infection to the resident and other residents exposed. They stated they received training on blood-borne pathogen exposures from their facility but had not received any additional training at this facility. During an interview on 4/22/25 at 8:46 a.m., staff member J stated when staff from other facilities were at this facility to draw blood they were expected to follow this facility's guidelines for safe infection control practices. They were expected to check in with the staff prior to obtaining the blood sample for the resident and they were not to draw a resident's blood in a common living area such as the dining room. Staff member J stated drawing blood in the dining room had the potential for cross-contamination of blood-borne pathogens. Staff member J stated they had not provided any additional training for the contracted staff to ensure they were aware of the facility's expectations and process for drawing labs and preventing the spread of blood-borne pathogens. During an interview on 4/22/25 at 11:55 a.m., staff member B stated drawing labs on a resident in the dining room was an infection control concern and had the potential to spread blood-borne pathogens. Staff member B stated the contracted staff were expected to follow the facility's infection control guidelines and were not to draw a resident's blood in the dining room. He stated it was an issue that needed to be addressed on our side. During an interview on 4/22/25 at 3:42 p.m., staff member R stated the two lab technicians had inquired with her about finding resident #39 for his blood draw. She stated he was in the dining room and told them to ask him for permission before drawing his blood. She stated she did not realize they were going to draw his blood in the dining room. She stated she did not stay to assist them or the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Specimen Collection, with a revision date of 1/21/25, reflected: - . 2. The staff will be educated on the proper collection techniques, handling, and storage of specimens, ensuring proper infection control practices are used . 49554 2. During an observation on 4/22/25 at 8:13 a.m., resident #7's door was closed. A yellow circle was on the doorjamb. No other signage was on the door. Inside the room were protective goggles place on the back of a chair, protective goggles, and used PPE were in the trash. A hanging storage container with PPE was hanging on the bathroom door. Resident #7 was lying in his bed sleeping. During an observation and interview on 4/22/25 at 10:16 a.m., staff member CC stated, [Resident #7] is on droplet precautions for pneumonia and on EBP because he has a catheter. We use the yellow dot system for EBP. When we go into his room, we wear goggles, gowns, and gloves. All the PPE for us (staff) to use is in his room hanging on the bathroom door. We enter the room, don the PPE, and then doff the PPE before we exit the room. During an interview on 4/24/25 at 10:30 a.m., staff member J stated, There should be signage on the outside of the door if they are on droplet precautions. The PPE should also be on the outside of the room so staff can don PPE prior to entering the room. I track the infection to determine when to release them (resident) from isolation. For droplet precautions, it would be seven days from the time of symptom onset. Review of resident #7's MAR, with a revision date of 4/21/25, showed an active order for droplet precautions due to parainfluenza. Review of resident #7's discharge summary, dated 4/21/25, showed: . -Discharge Diagnosis: Parainfluenza virus pneumonia . Review of resident #7's infection progress note, dated 4/23/25, showed: Note Text: Resident shows no signs or symptoms of parainfluenza. No fever over last 48 hours. (see chart) droplet precautions ended today, Resident remains on EBP for wounds/cath. Will be moved back to his own room today as isolation for virus is complete. [sic] Review of the facility's document titled, Transmission-Based (Isolation) Precautions, dated 1/14/25, showed: - Policy: It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. For training and quick referencing purposes, a summary of precautions is contained at the end of this policy . Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Facility staff will apply transmission-based precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission. - 9. Initiation of Transmission-Based Precautions (Isolation Precautions) . e. Signage that includes instructions for use of specific PPE will be placed in a conspicuous location outside the resident's room, wing, or facility-wide. Additionally, either the CDC category of transmission-based precautions (e.g., contact, droplet, or airborne) or instructions to see the nurse before entering will be included in the signage. f. 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 the environment of a resident on transmission-based precautions. [sic] 3. During an observation on 4/21/25 at 3:51 p.m., resident #52 had a PPE caddy hanging on the bathroom door, inside the room. During an observation on 4/22/25 at 8:51 a.m., the PPE caddy was hanging on the outside of resident #52's room door. During an observation on 4/23/25 at 8:11 a.m., staff member W was in resident #52's room assisting the resident, but was not wearing PPE. During an observation and interview on 4/23/25 at 4:08 p.m., a contact precautions sign was observed on the outside of resident #52's door. Staff member X stated resident #52 was on contact precautions due to an MSSA, staph infection. Staff member X said the PPE should be donned before entering the room. During an interview on 4/24/25 at 11:21 a.m., staff member J stated resident #52 was on contact precautions due to the MSSA diagnosis. Staff member J said the contact precautions were removed today (4/24/25) from resident #52's room because she was at the end of her treatment date, and she was now on enhanced barrier precautions. Review of resident #52's medical diagnosis showed METHICILLIN SUSCEPTIBLE STAPHYLOCOCCUS AUREUS INFECTION, UNSPECIFIED SITE. It was categorized as an acute infection on admission. Review of a facility's document titled, Case detail - Quick view, showed, Resident - [#52], . admitted : 4/10/25, Status: Confirmed (P), Infection Details - Onset Date 4/10/25, .Infection Site - Breast - Left, Organism - Methicillin-susceptible Staphylococcus aureus, .Isolation and Precaution Details - Isolation Requirement Yes, Isolation Precaution Contact, Isolation Start Date 4/10/25 . Review of the facility's policy and procedure titled, Transmission-Based (Isolation) Precautions, with a revision date of 1/14/25, showed, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Policy Explanation and Compliance Guidelines: 1. Facility staff will apply Transmission-Based Precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission. .Type and Duration of Transmission-Based Precautions Recommended for Selected Infections and Conditions, Infection/Condition - Staphylococcal disease, Precaution - Contact . 10. Contact Precautions- .d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens . 4. During an observation on 4/23/25 at 12:15 p.m., staff member BB was observed using a broom to sweep the floor with gloved hands. Staff member BB was then observed picking up a head of lettuce and did not change her gloves in between sweeping with the soiled broom and touching the head of lettuce. During an interview on 4/23/25 at 12:17 p.m., staff member U stated gloves should be changed between each task (soiled to clean) in the kitchen. During an observation on 4/23/25 at 12:20 p.m., staff member AA was observed wearing gloves assembling food trays. Staff member AA used his gloved hands to pick up meat from the steam table and placed the meat on a resident's tray. Staff member AA was then observed touching a soiled piece of cardboard which covered the garbage can, to throw an item away with gloved hands. He did not change the gloves and returned to handling food from the steam table. Staff member AA, wearing the same gloves, reached into a bag of hot dog buns, grabbed a bun, then he opened a plastic container containing yellow cheese, picked up the yellow cheese with his gloved hands, and returned to the steam table. Staff member AA did not change his gloves or wash hands for the duration of the observation. Review of the facility's policy and procedure titled, Food Safety Requirements, with a revision date of 1/14/25, showed, .Policy Explanation and Compliance Guidelines: 1. Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident. Elements of the process include the following: .f. Employee hygienic practices. 7. Staff shall adhere to safe hygienic practices to prevent contamination of food from hand or physical objects . .f. Staff should maintain nails that are clean and neat, and wearing intact disposable gloves in good condition that are changed appropriately to reduce 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 - Some	.h. Gloves will be worn when directly touching ready-to-eat food and when serving residents who are on transmission-based precautions. [sic]