STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275079	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wibaux County Nursing Home	712 Wibaux St S Wibaux, MT 59353

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 14005 Based on interview and record review, the facility failed to refer a resident with a newly evident or possible serious mental disorder or related condition for a Level II review, for 1 (#3) of 16 sampled residents. This failure put the resident at risk for not receiving services necessary for mental health. Findings include: Review of resident #3's care plan, last updated on 1/22/25, showed a diagnosis of . unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and other bipolar disorder . Review of resident #3's telehealth psychiatric progress notes showed diagnoses of .bipolar affective disorders or recurrent manic episodes, anxiety disorder, insomnia and unspecified dementia without behavioral disturbances . The psychiatric progress notes also showed, 1/27/25 resident #3 was receiving Seroquel due to impulsivity. On 2/17/25, the resident's psychotropic medications were changed due to delusions. Seroquel was changed from twice a day, to just be given at bedtime, but Zyprexa Zydis 12 mg was added at noon. During an interview on 3/11/25 at 10:19 a.m., staff member C said she was responsible to make sure the Level I and Level II were completed. Staff member C said she did not complete resident #3's Level I. Review of resident #3's Level I showed a new Level I was initiated 3/10/25. A completed Level I was requested but was not provided by the end of the survey.

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14005 Based on observation, interview, and record review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours after admission to reflect the residents' care needs, for 4 (#s 20, 23, 24, 77) of 16 sampled residents. This increased the risk of staff not providing necessary care and services due to the lack of the baseline care plan. Findings include: During an interview on 3/11/25 at 10:19 a.m., staff members A, B, and C were present. Staff members B and C said the care plans are done by the two of them, as they were the IDT (interdisciplinary team), with help from staff member N. Staff member C said the facility has an MDS nurse, but she does not complete care plans. Staff members B and C said an attempt is made to start the baseline care plan on the day of admission, but sometimes care planning doesn't get completed. Staff members A, B, and C said they knew about the requirement for a baseline care plan. Staff member B said the computer system had a template which could be used to complete care plans. During an interview on 3/11/25 at 2:00 p.m., staff member B said there were two admissions on 2/12/25, and resident #23 was admitted later in the day. Staff member B said it was busy that day, and she had to work later that night. Staff member B said the individual baseline care plan's didn't get started. 1. Review of resident #20's MDS, with an ARD date of 1/10/25, showed, resident #20 was admitted on [DATE]. Resident #20's baseline care plan was initiated 1/7/25, when nutrition concerns were added to the plan. 2. Review of resident #23's baseline care plan, with a review date of 2/26/25, showed, resident #23 was admitted on [DATE]. Psychotropic drug use was initiated on the baseline care plan on 2/12/25, however no interventions for the psychotropic drug were included for the care plan problem area. Resident #23 was at risk for eloping, and the elopement risk was not addressed on the care plan until 2/23/25. 3. Review of resident #24's nursing progress notes, dated 2/14/25, showed the resident was admitted to the secured unit on 2/14/25. The baseline care plan only included the resident's wishes for her advance directives. The only other problem addressed in the first forty-eight hours on the baseline care plan was the risk of skin issues, due to the resident refusing care at times, which was added on 2/16/25. 51111 4. During an observation on 3/10/25 at 3:34 p.m., resident #77 was lying in bed resting on the top of the blanket, with a sneaker on one foot but not on the other. A wheelchair was in resident #77's room next to a wall, not beside the bed and within reach. A record review of the resident's baseline care plan showed no information about the use of a wheelchair or assistance needed for resident #77. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/13/25 at 8:37 a.m., staff member B stated nurses can view a pocket care plan for residents, and staff member B usually starts putting care plan information in for newly admitted residents. Staff member B stated other staff members, including staff members C and N, enter information into resident care plans, and they update the care plans when needed. Review of resident #77's baseline care plan showed the diagnoses of Alzheimer's disease and Disorientation, and a single problem was documented on the baseline care plan, which showed, Start Date: 3/03/2025, Category: Advance Directives Resident Rights-Code Status . I am a DNR . Last Reviewed/Revised: 3/03/2025 by [staff member B]. [sic] Review of resident #77's fall risk assessment, completed on 3/5/25, by staff member B, showed a score of 19, showing the resident was a high fall risk. The fall risk was not included on resident #77's baseline care plan. Review of resident #77's admission elopement evaluation, completed on 3/5/25, by staff member B, showed resident #77 was at risk for eloping, and an elopement care plan should be initiated. There was no information documented or added to the baseline care plan for resident #77's increased elopement risk. Review of resident #77's March 2025 medication administration record showed an admitted [DATE], and a physician order for: .sertraline tablet 50 mg . 1 tab QAM; oral . Monitor for target behaviors of sadness and crying. The information to monitor for behavioral signs and symptoms was not included on resident #77's baseline care plan. A review of #77's baseline care plan showed the risk for falls was not added to the plan until 3/11/25, and this was completed by staff member C. Review of a facility policy titled, Baseline Care Plan, revised 9/29/2022, showed: . The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including . i. Initial goals based on admission orders. ii. Physician orders . The admitting nurse, or supervising nurse on duty shall gather information from the admission physical assessment . b. Interventions shall be initiated that address the resident's current needs including: i. Any health and safety concerns to prevent decline or injury, such as elopement, fall . (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ii. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living . A supervising nurse shall verify within 48 hours that a baseline care plan has been developed .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 14005 Based on observation, interview, and record review, the facility failed to develop and implement individualized comprehensive care plans for 2 (#s 12 and 24) of 16 sampled residents. Findings include: Review of resident #12's comprehensive care plan, with a problem dated 4/12/23, showed the resident was an elopement risk. The care plan did not show the resident lived on the secure unit. The interventions on the care plan failed to identify what approaches should be used to prevent elopements. Resident #12 was observed in the secured unit every day of the survey. During an interview on 3/11/25 at 2:59 p.m., staff member G said resident #24, sometimes listens and will come out to the dining room. Other than that, she sits in her room and cries. Staff member G said he was unaware of what activities the resident prefers. Review of resident #24's current comprehensive care plan showed resident #24 should be encouraged to attend activities. The care plan was not individualized to identify the type of activities resident #24 was interested in. The care plan failed to identify the problem of resident #24's frequent crying and did not direct staff in how to help the resident during episodes of tearfulness. During an observation on 3/12/25 at 12:10 p.m., resident #24 was sitting at the dining room table with her lunch meal in front of her. Resident #24 was talking about what her family had done to her and asking why they abandoned her. Resident #24 did not eat any food or drink any fluids. Staff member I approached her and encouraged her to eat and tried to engage her by talking about planting flowers. When staff member I did not get a response, staff member I then shrugged her shoulders and walked off as she was unsure of what approaches might be effective to help resident #24. Review of nurse's notes, dated 3/7/25 showed, the resident's [family member] and [family member] (neither POA or guardian) were going to take resident #24 out of the facility against medical advice. The nursing note showed the family member's believed resident #24 was capable of making her own decisions. The notes showed the physician was called, and the physician directed the staff to call the police for kidnapping if those family members took resident #24 out of the facility. Review of resident #24's comprehensive care plan failed to identify family dynamics and the potential for family removing the resident from the facility as a problem. There were no directions for the staff in the event the family tried to take resident #24 out of the facility against medical advice. During an interview on 3/11/25 at 10:19 a.m., staff members B and C said they completed and updated all comprehensive care plans with assistance and oversight by staff member N.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 14005 Based on observation, interview, and record review, the facility failed to provide meaningful activities, designed to meet the individual resident preferences and interests, for 2 (#s 20 and 23) of 16 sampled residents. Findings include: 1. During an observation on 3/10/25 at 1:17 p.m., resident #20 was observed standing at the exit door while pushing the door handle. Resident #20 stood there for 3-4 minutes, then turned around, and paced up and down the hall several times. There were no staff interventions offered to the resident, in an attempt to alter the resident's behavior of trying to open the door, or engage resident #20 in any way. During an observation on 3/10/25 at 2:57 p.m., resident #20 was observed pacing up and down the hall. Resident #20 came into the TV room and sat next to the surveyor. When the surveyor talked to resident #20, he relaxed and listened to the surveyor for five minutes. During an interview on 3/10/25 at 3:17 p.m., staff member H said the CNAs try to put out coloring books and puzzles on weekends, but they don't do any activities. There is only one CNA, and that CNA needs to do 15 minute checks on a different resident [#23], and complete personal cares for other residents on the unit. During an observation on 3/11/25 at 1:40 p.m., resident #20 was observed pacing in the hallway on the secured unit. Staff were in the dining room visiting with the residents and each other. Resident #20 was not approached or invited to attend or participate in the conversation, in an attempt to intervene in the pacing behavior. Review of resident #20's MDS (minimum data set), with an assessment reference date of 1/10/25, showed the resident scored a 99 on the BIMS, which shows the resident was unable to complete the interview. Review of resident #20's activity assessment section, on the 1/10/25 MDS, showed books, magazines, music, and news were somewhat important to resident #20. Review of resident #20's comprehensive care plan dated 1/14/25 showed resident #20 had one intervention related to activities. The care plan showed resident #20 will be reminded of activities. The care plan did not address resident #20's preference of music, or what type of books or magazines he enjoyed reading. Review of resident #20's comprehensive care plan dated 1/14/25, showed resident #20 had elopement risk identified as a problem. The care plan showed staff will attempt to redirect, distract, take to an activity, offer a snack/drink or offer conversation for resident #20. During an observation on 3/12/25 at 12:30 p.m., resident #20 was observed going through the secured unit door into the main part of the facility. Staff members K and M saw resident #20 going out of the secured unit door. Staff members K and M turned him around and allowed him to continue pacing in the secured unit hall. Staff members K and M were not observed to follow the care plan and did not engage or offer diversional activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an observation on 3/10/25 at 1:29 p.m., staff member I was observed sitting at the table in the secured unit dining room. Resident #23 sat watching staff member I paint a car. Resident #23 got up from the table and left the room. Staff member I asked the residents sitting around the table if they would like to paint a car. There were two female residents sitting at the table. One resident was sleeping, and the other resident was folding her Kleenex facial tissues. Neither resident answered staff member I, nor were they engaged in any way with the activity. During an interview on 3/10/25 at 3:30 p.m., staff member G said the working on the secured unit were to monitor resident #23 every 15 minutes. In addition to that, the CNA staff are expected to run activities on the secured unit. Staff member G said there is usually only one CNA on the secure unit during the day shift, but there bay be a an employee who works as a float sometimes later in the day. During this interview, there were no activities being done with the residents on the secured unit. During an interview on 3/12/25 at 12:18 p.m., with staff members I and K, staff member I said she interviews the residents and then completes a sheet that has the same exact questions as the MDS questions. Staff member I was unable to answer how individualized resident information would be obtained. Staff member I said she did not put individualized resident preferences onto the care plan. Staff member I said she is also a CNA (certified nurse assistant) and gets pulled to the floor occasionally. Staff member I admitted to assisting daily with CNA tasks, such as assisting in the dining rooms during meals, helping with transferring residents, and providing cares. Staff member K said she does not always know what individual residents prefer for activities. Staff member K said she figures out what residents like by trial and error.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14005 Based on observation, interview, and record review, the facility failed to timely identify elopement risks, and implement sufficient preventative interventions for residents with elopement(s), for 2 (#s 20 and 23) residents of 2 sampled for elopements who lived on the secure unit. There continued to be elopement hazards, and it was identified necessary staff were not aware of how to identify an elopement, staff failed to use interventions to prevent elopements, and one resident had repeated elopements and was at high risk of eloping. The overall elopement system was not adequate to ensure resident safety. Findings include: A review of the State Operations Manual, Appendix PP, F689 - Accidents and Hazards shows: A situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary, would be considered an elopement. This situation represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. Facility policies that clearly define the mechanisms and procedures for assessing or identifying, monitoring and managing residents at risk for elopement can help to minimize the risk of a resident leaving a safe area without the facility's awareness and/or appropriate supervision . 1. Review of resident #23's current MDS, dated [DATE], showed resident #23 had a BIMS of 4, reflecting severe cognitive impairment. Review of resident #23's nursing progress notes, dated 2/16/25, showed resident #23 had opened a dining room window and climbed out of the window. Resident #23 had obtained a shovel, and when found, he was already shoveling snow in the courtyard. Resident #23 was wearing a jacket, a baseball hat, and medical gloves. Resident #23 refused to return to the facility until he was finished shoveling and staff remained with him. The facility did not assess the resident for injuries following this elopement. Review of resident #23's nurses notes, dated, 2/23/25 at 1:37 p.m., showed, CNA alerted this nurse 10 minutes ago that resident had crawled through his window and was headed toward the facility garage. Resident #23 was returned to the facility by staff, and had no injury. Review of resident #23's nursing note, dated 2/27/25, showed the CNA alerted the nurse at 10:50 a.m., that resident #23's window was open, and he was missing. All staff were notified, and a search was started. Resident #23 was located behind the nursing home, at the clinic, unharmed. Review of resident #23's elopement evaluation, with an observation date of 2/23/25 at 8:14 p.m., was completed on 3/10/25 at 5:15 p.m., by staff member B. Review of resident #23's elopement evaluation, with an observation date of 2/27/25, was also not completed until 3/10/25. The assessments were not completed until all three elopements occurred. No other elopement assessments were located in the resident's medical record. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/10/25 at 2:39 p.m., NF1 said the [Clinic Name] called him and alerted him about the resident being at the clinic, and the clinic was trying to figure out where he belonged. NF1 said that was the only elopement he was aware of for resident #23. NF1 said he was not aware of what the facility was doing to prevent any more elopements for the resident. Resident #23 was at the clinic long enough for him to give his phone number to the clinic staff. Review of resident #23's baseline care plan showed elopements were not initially identified as a problem, and there were no interventions to prevent elopements. The baseline care plan was to be completed within the required 48 hours of the resident's admission, which would have been by 2/14/25. Interventions for elopements were implemented after the second elopement on 2/23/25. The care plan directed the staff to do a window audit to ensure the windows were secured. Although this intervention for the window security was implemented, resident #23 climbed out the window again on 2/27/25. Review of resident #23's care plan approach, dated 2/27/25 showed, the facility initiated an Apple air tag to be placed for monitoring the resident, however resident #23 had removed the tag, so it was not beneficial at the time of resident #23's third elopement. During an observation on 3/10/25 at 1:20 p.m., the secure unit's sitting room window was observed to have a Velcro device attached to it. The device would prevent the window from opening to far, in an attempt to prevent elopements. This same device, was attached to a different window, and it was removed by resident #23, and then he eloped out the window on three occasions. The sitting room was not observed 100% of the time, so it created a risk for this resident if he removed the device in an attempt to elope. During an interview on 3/10/25 at 2:57 p.m., staff member F said resident #23 went out the dining room window, the one that had the air conditioner in it, and he got into the courtyard. Staff member F said no stops were put on the windows in the dining room because it wasn't identified as a potential problem. Staff member F said following resident #23's first elopement, he went around and put in child proof stoppers on the windows where the exit was to the non-secured courtyard. Staff member F said the next time resident #23 eloped, staff assumed he took off the stop, because the stops were only secured by Velcro. After that incident, the facility bought new locks that clamped onto the side of the windows, and a tool was needed to get the stops off the window. The TV room and some of the courtyard windows were not secured yet because the facility was waiting on the order of the devices to arrive. The devices initially received were too small and did not fit the windows. Staff member F stated he monitors the windows every day, but it had not been done yet that day. Staff member F stated if resident #23, took the stops off once, he could do it again. Based on observations on 3/10/25 3:10 p.m., staff member F and this surveyor were able to open the windows to a level of 16 inches on the secure unit for rooms [ROOM NUMBER]. The Velcro closure was screwed into the window incorrectly in room [ROOM NUMBER], and the other windows had the Velcro stops removed. During an interview on 3/10/25 at 3:17 p.m., staff member H said resident #23 had gone into a different resident's room, shut the door, and went through the window. Staff member H said resident #23 went out the window twice during one of her shifts. He was found in the courtyard both times, but one time he was back around the courtyard by the back door. Staff member H said it was snowing the day he eloped through the window, but staff member H was unable to remember when the elopement occurred, and said it was maybe two weeks ago. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/10/25 at 3:30 p.m., staff member G said resident #23 is on 15-minute observations for monitoring his location, which was implemented after the 2/27/25 elopement, which was his third one. Staff member G said due to only one staff person caring for the ten residents on the secured unit, resident #23 is left unsupervised for longer periods of time, therefore, the 15-minute checks were not always timely. Review of resident #23's nursing progress notes, did not show any documentation of the times resident #23 left through the window twice in one day. During an interview on 3/11/25 at 10:19 a.m., staff members A, B, and C did not identify the resident breaking through a window screen and crawling out the window in attempt to leave the facility as an elopement. The staff said he was still on the property and in a courtyard, so they did not think of this as an elopement. The three staff members (A, B, and C) were unable to identify if climbing through a window was authorization to leave and if supervision was necessary. Review of the facility policy titled, Elopement and Wandering Residents, dated 9/3/24, showed the definition of elopement as, Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. The policy showed a systematic approach to monitoring and managing residents at risk for elopement, to include the identification and assessment of risk, implementing interventions to reduce hazards and risks, and monitoring for effectiveness. The policy showed residents were to be assessed for risk of elopement on admission and throughout their stay. The policy included a procedure for post-elopement that included having the nurse complete a physical assessment and documentation of the assessment. The policy included details for how the social services designee will re-assess the resident and make referrals for counseling or consults; and, documentation in the medical record will include findings from nursing and social service assessments, physician and family notification, care plan discussion, and consultant notes. Review of resident #23's IDT progress notes did not include any social services notes to reflect a social services re-assessment was completed after the elopements, or the need for referrals for counseling. During and interview on 3/12/25 3:50 p.m., staff member D said the first time resident #23 eloped, the CNA was on the unit, and staff member D was on the main hall. The CNA saw resident #23 walking toward the garage, so resident #23 was out just a few minutes. Staff member D said the second time resident #23 eloped, the CNA and staff member D had both just checked on him, and within a minute or two of the CNA and staff member D checking on him, he got out the window. Resident #23 was probably gone 15 minutes or more the second time. 2. Review of resident #20's elopement assessment showed an observation date of 1/3/25, however it was not completed until 1/17/25, 14 days after his admission. The assessment identified the resident as being at risk for eloping. Review of resident #20's baseline care plan failed to identify elopement as a problem. Resident #20's care plan did not include the risk of elopement until 1/14/25, and the interventions were minimal, to include, resident #20 resides on a secure unit and the staff will attempt to redirect resident and distract him when upset and wanting to leave. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/10/25 at 1:17 p.m., resident #20 was observed standing at the exit door, pushing on the door handle. The resident stood at the door for 3-4 minutes, then turned around, and began pacing up and down the hall several times. There were no staff observed attempting to redirect the resident from the door or engage him in to intervene in the behavior. During an observation on 3/11/25 at 4:14 p.m., resident #20 was wandering up and down the hallway of the secure unit, which he did several times. Resident #20 came to the exit door of the unit, and pushed against the door that had wallpaper the resembled a library. Resident #20 walked from the door into the TV room, located right next to the exit door, and pushed up against the unsecured window. Resident #20 then sat in a recliner, located next to the window, and stared out of the TV room window. During an observation on 3/12/25 at 12:30 p.m., resident #20 was observed going out the secured unit door into the main area of the facility. Staff member K and M observed the resident exiting the door, stopped him, and returned him to the secure unit. Staff members K and M turned the resident around and allowed him to continue pacing in the hall. No staff were observed to follow the care plan interventions identified and implemented for the prevention of elopements, or try to engage the resident when he was exit seeking. 51111 During an observation on 3/12/25 at 4:10 p.m., resident #20 was in the TV room of the secure unit, sitting in the recliner next to the unsecured window. No other residents or staff were in the room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275079	A. Building B. Wing	03/13/2025

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 14005 Based on observation, interview, and record review, the facility failed to review the risks and benefits of using grab/assist bars attached to the bed, for 2 residents (#s 4 and 12) of 16 sampled residents. Findings include: During an observation on 3/10/25 at 1:10 p.m., a grab bar was observed on the left side of resident #12's bed. During an observation on 3/10/25 at 1:15 p.m., a grab bar was observed on both sides of resident #4's bed. 1. During an interview on 3/12/25 at 12:10 p.m., staff member K said resident #4 does not use his side rails during personal cares. Staff member K said he does not use them to help turn himself in bed at all. Staff member K said resident #4 may occasionally grab onto the assist bar when he is being transferred while he is sitting on the edge of the bed. Staff member K said resident #12 doesn't use the grab bars every time he gets up and out of bed. During an interview on 3/13/25 at 9:56 a.m., staff member H said resident #4 does not use his grab bars at all when she provides care or when she transfers him in or out of bed. Review of resident #4's MDS with an ARD date of 9/16/24, showed resident #4 had a BIMS (Brief Interview for Mental Status) score of 1. A score from 0-7 suggests severe cognitive impairment. The observation detail list report completed on 3/17/24 showed the resident was: - not expressing a desire to use a restraint, - cognitively impaired with fluctuations in level of consciousness, - resident has visual impairments, - resident has problems with balance and trunk control, - takes psychotropic medication, which would require safety precautions. Review of resident #4's care plan, with an intervention date of 3/27/24, showed resident #4 gets restless if he is left in bed too long. Review of resident #4's side rail assessment and consent dated 7/16/24, showed the resident was using bilateral turn and repositioning bars. The assessment failed to show detail related to the consideration of the increased risk his restlessness could have on his safety in relationship to the grab bars. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview on 3/12/25 at 10:47 a.m., staff member B said resident #12 asked for her side rails to be put back on the bed after the rails had been removed. Staff member B said the staff did not consider entrapment hazards due to the resident's weakness when assessing resident #12. Staff member B said she was unaware of any scheduled maintenance on the bed and grab bars. Staff member B said there were no safety measurements completed by nursing when the resident's grab bar assessment was completed on 7/16/24. Staff member B said no alternative interventions were attempted before using the grab bar. Review of resident #12's bed rail safety assessment, completed on 7/10/24, showed: - resident #12 had a fluctuation in levels of consciousness or a cognitive deficit, - received medication that would require safety precautions, - had a BIMS of 6; severe cognitive impairment. Review of resident #12's restraint assessment, completed on 7/16/24, showed, negative outcomes were a possibility, however, entrapment and death were not considered a risk for resident #12. Review of resident #12's medication administration record for February 2025, showed resident #12 took clonazepam for anxiety, Prozac for depression, and Zyprexa for schizophrenia. The effects of these psychotropic medications were not documented as being taken into consideration when the assessment for side rails was completed.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 14005 Based on observation, interview, and record review, the facility failed to ensure the dietary manager completed a certification program approved by a national certifying body or had higher education in a related field. This had the potential to affect residents and their nutritional status or meal safety for those who consumed food prepared and served by the facility. Findings include: During the initial tour of the kitchen, on 3/10/25 at 11:50 a.m., no documentation of advanced training for the dietary manager was posted. During an interview on 3/13/25 at 9:47 a.m., with staff members A, B, C, and N, staff member N stated one of the issues the facility continued to review monthly had to do with staff member M's lack of certification as a dietary manager. Staff member N stated she received weekly email reports from staff member M about progress on completing the dietary manager certification. Staff member N stated staff member M worked full-time and was still not certified in the role. Staff member N stated this process was ongoing since the last plan of correction was started after last year's survey process, which was on 2/29/24. During an interview on 3/13/25 at 11:07 a.m., staff member M said she did not have the CDM certificate, but she was enrolled in an online program titled, Certified Dietary Manager/Certified Food Protection Professional, and was only on the third lesson. She did not identify when she would have the course completed. 51111 Review of a facility document titled, Facility Assessment For [Facility Name], dated 8/8/2024, showed: . Food and Nutrition Services . having a Dietary Manager who is working on her CDM who has a vast knowledge and experience of food and nutrition .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 14005 Based on interview and record review, the facility failed to maintain medical records which were accurately documented, dated, labeled, and completed in their entirety, for 5 (#s 4, 14, 18, 20 and 23) of 16 sampled residents. Findings include: 1. The following incomplete records were located in resident #4's medical records: a. A review of resident #4's hard-copy POLST form and alternate medical records, dated 3/17/20, showed: - In the section for the resident's full name, date of birth, and sex, the form had been altered by blocking out information with white out. Resident #4's name had been added to the form in the area which had been altered with white out. - In the mandatory section, where there should be a medical provider signature, the date, the time, and the providers phone number, was incomplete. The POLST form would be invalid due to the altered and missing information. b. Resident #4's staff assessment of daily and activity preference, completed on 3/12/25, was incomplete. c. Resident #4's consent for Zoloft and Zyprexa was incomplete. The observation information included the creator, the date of the observation, the date recorded, completion date, and who completed the form was incomplete. The consent was obtained by verbal consent on 12/13/24 and had not been signed by the POA by 3/13/25. 2. The following records were found to be incomplete for resident #23: - Resident #23 had an elopement evaluation with an observation date of 2/23/25. The form was incomplete until 3/10/25, the first day of the survey. - Resident #23 had an elopement assessment initiated on 2/27/25 at 6:15 p.m., and the date the record was completed was 3/10/25. During an interview on 3/11/25 at 10:19 a.m., staff member B said completing assessments later than the observation date would not be the normal practice. Staff member B said the assessments should be completed at the time of the observation. Staff member B said the elopement assessments for resident #23, dated 2/23/25 and 2/27/25, were completed on 3/10/25. 3. Resident #20 had an elopement evaluation which had an observation date on 1/3/25 that was not completed until 1/17/25. 51111 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of resident #18's POLST form, dated 6/20/24, showed the form was left blank in the required fields of: the signature of provider, provider printed name, date and time signed by provider, and provider phone number. During an interview on 3/13/25 at 10:43 a.m. with staff members A, B, C and N, staff member C stated admission forms, including advance directives and POLSTs should be filled out completely. A request was made for a facility POLST policy on 3/12/25, and no specific POLST document was received by the end of the survey. 5. Review of resident #14's care plan showed a short term goal associated with the mood state that included, Target Date: 04/12/2025 kkk [sic] and the associated approaches for the goals showed, Approach Start Date: 01/22/2025 [Male name] loves [staff member C] [sic] and Approach Start Date: 01/22/2025 [Male name] loves [staff member B] [sic] During an interview on 3/13/25 at 10:59 a.m., staff member A stated the information in resident #14's care plan was something she had never seen in a medical record before. Staff member A stated she would check on how the information was added in to the medical record, and stated, Hopefully it's not because of a virus. It's weird though because that's staff member B's husband's name, and the other name is staff member C's husband's name. Staff member A returned to provide information on the documentation seen on the care plan. Staff member A stated staff member N added the information in to the care plan as a way to have staff members B and C notice the care plans needed updated. The information did not pertain to the resident's care or needs. Review of a facility policy titled, Confidentiality of Personal and Medical Records, revised 7/11/2024, showed: . [Facility Name] staff should exercise caution . in using medical record information for documentation purposes .