STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275080	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cooney Healthcare and Rehabilitation	2555 E Broadway Helena, MT 59601

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51133 Based on interview and record review, the facility failed to ensure the current Do Not Resuscitate order was reflected in the code status of the electronic health record and care plan for 2 (#49 and #57) of 31 sampled residents. This deficient practice increased the risk of the individual choices not being honored for the Do Not Resuscitate. Findings include: 1. A review of resident #57's Montana Provider Orders for Life-Sustaining Treatment (POLST), dated [DATE], showed, YES CPR: Attempt Resuscitation. A review of resident #57's care plan showed: . Patient has an advance Directive as evidenced by: Do not Resuscitate, Date Initiated: [DATE], Patient's wishes will be honored, Target date: [DATE], . Follow facility protocol for identification of code status, Date Initiated [DATE] . Review code status quarterly, Date Initiated [DATE] . A review of resident #57's EHR dashboard showed, Code Status: POLST Do Not Resuscitate (DNR: No CPR). Resident #57's current POLST did not match the code status in the care plan or the resident's EHR dashboard. 2. A review of resident #49's, Montana Provider Orders for Life-Sustaining Treatment (POLST), dated [DATE], showed, YES CPR: Attempt Resuscitation. A review of resident #49's EHR dashboard showed, Code Status: (Advance Directives) POLST: DNR/Comfort Treatment/No artificial nutrition. A review of resident #49's physician orders dated, [DATE] showed, . Description: DNR/Comfort Treatment/No artificial nutrition . A review of resident #49's care plan, last reviewed on [DATE], showed no advance directive or code status. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:33 p.m., staff member N stated she looked at #49's EHR dashboard for the current code status. During an interview on [DATE] at 3:45 p.m., staff member I stated the POLST was done on admission, was found in PCC under 'code status,' and reviewed quarterly at every care plan meeting. During an interview on [DATE] at 4:22 p.m., staff member I stated she, or her assistant, entered the advance directives in the medical record, and stated, Any of us can do it as long as the doctor is aware. The change is put in as a verbal and doctor signs .typically it is tasked to social services to deal with. A review of the facility's policy, Advance Directives, revised [DATE], showed: If the Resident Has an Advance Directive . . 2. The director of nursing services (DNS) or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the residents medical record and plan of care. . 4. The plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49554 Based on observation, interview, and record review, the facility failed to revise individualized comprehensive care plans to reflect the bathing preference for 1 (#132) of 3 sampled residents for baths and to reflect current transfer methods for 2 (#s 35 and 55) of 3 sampled residents for transfers. Findings include: 1. During an observation and interview on 8/12/24 at 11:12 a.m., resident #132's hair was greasy, and she stated she doesn't get baths on a regular basis. Review of resident #132's Social Services note, dated 8/12/24, showed the resident, prefers bed baths. Review of resident #132's care plan failed to show bathing preferences and how often she prefers to be bathed. During an interview on 8/15/24 at 7:46 a.m., staff member O stated, Resident preferences for bathing should be in the care plan, and it is also on the bath schedule. During an interview on 8/15/24 at 7:51 a.m., staff member P stated, We do not add bathing preferences to the care plan unless it is an extenuating circumstance, such as refusing to shower. 2. During an interview on 8/12/24 at 11:45 a.m., resident #35 stated, The staff don't use the Hoyer (mechanical) lift with me anymore. During an interview on 8/14/24 at 10:28 a.m., staff member L stated, We use three to four people to transfer resident #35, and we do a stand pivot transfer. A stand pivot transfer was not completed using any mechanical device. Review of resident #35's care plan showed: Transfer assistance of (Hoyer lift); utilize Hoyer with 700 lb weight capacity. The resident's care plan was not being followed by staff, per the interviews with L and #35. 3. During an interview on 8/12/24 at 2:25 p.m., resident #55 stated, The Hoyer lift scares me, so staff use the sit-to-stand lift (mechanical lift). Review of resident #55's care plan showed, . Hoyer lift with XXL sling for transfers. When interviewed, the resident stated a different type of mechanical lift was used. A Hoyer lift does not allow a resident to bear weight, and it completely lifts a resident's entire body. A sit-to-stand lift allows the resident to bear some weight during transfers. If an improper lift is used, injury may occur to the resident.

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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. 50245 Based on observation, interview, and record review, the facility licensed nursing staff failed to follow physician wound care orders; failed to complete wound treatments; and failed to document the wound status/severity sufficiently, for 1 (#23), and failed to follow physician orders; complete wound dressing changes properly; licensed nursing staff used improper aseptic technique with a dressing change; and licensed nursing staff failed to follow the facility policy and procedures for wound care services, for initialing wound dressings, adding times, or dates, for 1 (#32) of 3 sampled residents requiring wound care. These failures made it more difficult to accurately determine the status of wounds, locations of wounds, and severity, for ongoing treatment/needs to be met, for both residents who had wounds being treated. Findings include: 1. Review of resident #23's EHR showed an increasing size wound throughout time, missed weeks of documentation in the Weekly Wound Reviews, missed wound treatments, and reports from the [Clinic Name] showing wound care dressings were not completed by the physician's orders. Review of resident #23's MAR showed in the month of July 2024, two opportunities were missed for a dressing change for the right gluteal fold wound, which was on 7/6/24 and 7/27/24. Review of resident #23's EHR showed a Visit Report from [Clinic Name], with the date of service of 7/3/24 and 7/31/24, that showed, Patient has shown up to the [Clinic Name] multiple times without prescribed dressings on. Please make sure that you are following provider orders. Review of resident #23's EHR showed a Physician's Telephone Order from [Clinic Name], which showed: Pt again was noted to not have prescribed dressing in place when he arrived. All wound dressings are the same. [sic] Below shows the review of resident #23's Weekly Wound Review documentation of the right gluteal fold: 2/14/24 - The wound was documented as Pressure (not staged) with measurements of 0.4 cm x 1.1 cm x 1.0 cm 5/19/24 - Pressure ulcer Stage III no measurements documented. Wound measurements difficult to obtain due to lack of help with positioning resident . 7/18/24 - Pressure Stage IV with measurements of 0.9 cm x 0.25 cm x 0.2 cm 8/1/24 - Pressure Stage IV 0.8 cm x 0.4 cm x 0.7 cm - no and yes were both documented for odor 8/8/24 - This document was blank and was in progress 2. Review of resident #32's EHR showed documentation was completed for the assessments shown below, but the wound location was not specified, measurements or specific wound characteristics were not always provided, and there were instances (ex: 6/25/24) where no skin issues were noted, but the week prior there were skin issues documented with no resolution (ex: 6/20/24). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of resident #32's EHR wound assessment documentation, from 6/20/24 - 8/1/2024, showed: 6/20/24 Weekly Skin Check - Right 2nd toe - wound - Left 1st and 4th - toes have wounds - In the Weekly Heel Check section of this assessment, no identifiable heel skin issues were charted 6/25/24 Weekly Skin Check -No was selected which showed the resident did not have any skin issues 7/2/24 Weekly Head to Toe - Showed a skin issue to the Toes on bilateral feet - In the Weekly Heel Check section of this assessment, no identifiable heel skin issues were charted 7/12/24 Weekly Wound Review - Left heel 5.2 cm x 3.9 cm x 0.1 cm - Unstageable 7/12/24 Weekly Skin Check - Left heel - pressure ulcer (not staged) 5.3 cm x 3.9 cm x 0. 1cm - Left 2nd toe - 0.5 cm x 0.5 cm x 0.1 cm - Left 4th toe - 0.9 cm x 0.6 cm x 0.1 cm - Right 3rd toe - 0.6 cm x 0.5 cm x 0.1 cm 7/19/24 Weekly Wound Review - Left heel blister - 3.8 cm x 4.6 cm x 0.3 cm -2nd left toe trauma - 0.6 cm x 0.5 cm x 0.1 cm 7/28/24 Weekly Head to Toe - Left heel - mentioned in documentation but no wound measurements or characteristics of wound. - Right 3rd toe - healing (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Left great toe - healing - Left 2nd toe - small - Left 5th toe - small 7/30/24 Weekly Head to Toe - showed: no skin issues 8/1/24 Weekly Wound Review - Left heel - pressure ulcer Stage III - 3.5 cm x 6.3 cm x 0.5 cm - Left toe (location not specified) - trauma Stage II - 0.4 cm x 0.5 cm x 0.1 cm - Right toe (location not specified) - skin tear and N/A stage - 0.7 cm x 0.5 cm x 0.1 cm - Right toe (location not specified) - pressure ulcer Stage II - 0.8 cm x 0.4 cm x 0.1 cm During an observation on 8/14/24 at 12:43 p.m., resident #32's wound dressing did not have any initials, date, or time. Staff member E and N removed the majority of the dirty wound dressing from the left heel but left the old hydrofera blue dressing on. Staff members E and N doffed gloves, cleaned hands, and donned new gloves. Staff member E removed the hydrofera blue dressing, cleaned the left heel wound with a cleaning solution, painted the wound with betadine, then placed a new hydrofera blue pad on the heel. Next, staff member E wrapped the area with kerlix then coban. Gloves were not changed after removing the dirty dressing before placing the new dressing on the wound. Review of resident #32's physician order showed, Left Heel: betadine paint, hydrofera blue, ABD, kerlix, coban. During the observation (on 8/14/24 at 12:43 p.m.), no ABD pad was applied to the wound dressing. The left heel wound bed was slightly larger in size and circumference than a half dollar coin, with both sides of the wound bed also extending outward medially and laterally, about an inch and a half. The wound bed was pink in color with intermittent red areas. The entire heel was calloused and yellow along with the surrounding tissue around the wound bed. During an observation on 8/14/24 at 1:01 p.m., staff member E placed the following dressings on #32's left 2nd toe: betadine, hydrofera blue, 4 inch kerlix (doubled), then coban. Review of #32's physician order for the left 2nd toe showed: Left 2nd toe: betadine paint, kling, coban. When asked why staff member E was applying kerlix instead of kling, staff member E stated, I've went to the appointments with him and [the physician] is okay with it. During an observation on 8/14/24 at 1:08 p.m., staff member E applied the following dressing to #32's 3rd and 4th right toes: betadine, four inch kerlix (doubled), and coban. The 3rd and 4th toes were noticeably pushed apart from one another due to the doubled kerlix material. No dates, times or staff initials were written on any of the observed dressings. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of #32's physician orders showed, Right 4th toe: clean with wound cleanser, betadine, conforming gauze, coban one time a day. R third toe: betadine paint, hydrofera blue, kling, coban. [sic] Review of a facility provided document titled, Wound Care, revised October 2010, showed: .10. Follow Physicians orders for cleansing and dressing the wound . 13. [NAME] tape with initials, time, and date and apply to dressing.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49554 Based on interview and record review, the facility failed to provide a safe environment while using a lift, and anticipate and assess the residents needs related to transfers, for 1 (#35) of 3 sampled residents. This resulted in the resident being transferred with the wrong lift and the lift failing, and the resident was dropped from the lift to the bed. Findings include: During an interview on 8/12/24 at 11:45 a.m., resident #35 stated, . staff were transferring me recently with the Hoyer lift, and the lift gave out, and dropped me. Thankfully, I was over the bed when this happened. I'm not sure why it happened; the staff member that was assisting me said they just pushed the down button and it dropped. During an interview on 8/14/24 at 10:28 a.m., staff member L stated, . when the lift gave out with (resident #35), staff were using the smaller Hoyer lift with the scale on it. I hadn't seen the 700-pound lift before until that incident happened. I think it was stored downstairs. It looks old. Review of resident #35's progress notes showed this incident happened on 7/19/24. Review of resident #35's care plan with a revision date of 8/7/24 showed: Transfer assistance of (Hoyer lift); utilize Hoyer with 700-pound weight capacity.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 50245 Based on observation, interview, and record review, the facility failed to provide sufficient hydration for 1 (#50) of 31 sampled. This failure had the potential to affect all of the residents with a BIMS less than 7 in the facility and required encouragement from staff to drink a sufficient amount of fluids throughout the day. Findings include: During an observation and interview on 8/12/24 at 12:19 p.m., resident #50 had dried lips, and when asked if he was getting enough water throughout the day, resident #50 reached for the cup of water and stated, Oh yeah, I do need this (the water). Resident #50 then took three big gulps of water and laid back down on the bed. Review of resident #50's EHR showed a readmission on 7/31/24 after being hospitalized for a small bowel obstruction on 7/26/24. During an observation on 8/14/24 at 9:27 a.m., resident #50 was laying in his bed sleeping with no fluids at the bedside. During an interview on 8/14/24 at 10:56 a.m., staff member F stated if a resident had a history of a small bowel obstruction, she would encourage fluids if she was concerned about constipation or a bowel obstruction for a resident. During an observation on 8/14/24 at 11:16 a.m., resident #50 did not have any fluids at the bedside. During an observation and interview on 8/14/24 at 11:20 a.m., resident #50 came out of his room and asked two staff members for juice. The staff walked by resident #50 and did not address his need for something to drink. Resident #50 asked the surveyor to get him juice. Resident #50 had dry lips and stated he was thirsty. During an interview on 8/14/24 at 12:15 p.m., staff member N stated to prevent constipation, fluids and laxatives were important. During an observation on 8/14/24 at 1:17 p.m., resident #50 did not have any fluids at the bedside. Review of resident #50's MDS, with an ARD of 8/4/2024, showed a BIMS of 2. A BIMS of 0 to 7 showed severe cognitive impairment. Review of resident #50's EHR showed a Nutritional Assessment with an effective date of 8/2/24 which recommended resident #50 received 2,632 ml of fluids per day. This Nutritional Assessment was completed by staff member H who also noted fluids to be Encouraged to resident #50.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 50245 Based on observation, interview, and record review, the facility failed to provide adequate staffing resulting in residents not recieving scheduled showers for 1 (#132) of 31 sampled residents, call lights not answered in an adequate timeframe for 5 (#s 11, 12, 27, 37, 132) of 31 sampled residents, increased risk of dehydration in residents, and negative impact on resident's wound treatments and services. These failures increased the risk of negative outcomes of psychosocial harm due to residents feeling embarrassed and their needs not being met from missed showers and long call light wait times. Findings include: During an interview on 8/12/24 at 12:09 p.m., resident #12 stated the facility was . always short of help at night. During an interview on 8/13/24 at 12:50 p.m., resident #27 stated she can wait up to 45 minutes for help. Resident #27 stated, This is very dependent on the CNAs that are on. During an interview on 8/13/24 at 1:04 p.m., resident #132 stated she can wait as long as 30 minutes for a staff member to answer her call light, and this can occur as often as three times a week. Resident #132 stated mornings, bedtimes, and late nights were the worst wait times. Resident #132 stated, Sometimes I don't make it to the bathroom . (from waiting she is then incontinent and) it makes me feel uncomfortable. Resident #132 stated, Sometimes you call, and no one comes at all. And you know they are down there because you can hear them laughing at the nurse's station. Resident #132 stated she did not receive her scheduled showers. She stated, Sometimes I get promised one, and it doesn't happen so another day goes by. Review of resident #132's EHR scheduled shower task showed No Data Found in the last 30 days. No refusals were documented. Showers completed in the months of June and July 2024 were requested; bathing ability was the only information provided. During an interview on 8/13/24 at 1:22 p.m., resident #11 stated, I will wait 30-45 minutes for a call light to be answered. And it is definitely worse at night, and I don't make it to the bathroom. I hate it. I pee on the floor. During an interview on 8/13/24 at 2:01 p.m., NF3 stated, My (family member) does not get enough showers, and if they miss her one day then she has to wait a bunch of days to get it. During an interview on 8/13/24 at 2:30 p.m., resident #37 stated, Sometimes it (a call light being answered) takes forever. Sometimes I'm on the potty for 30 minutes. During an interview on 8/13/24 at 2:48 p.m., staff member S stated when they are fully staffed, the (unit) runs smoothly, but when the facility is short staffed or only has three CNAs work is stressful. Staff member S stated, The fifth person acts as a float to help with showers and lifts. Staff member S stated showers were getting done when they were fully staffed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/13/24 at 3:01 p.m., staff member T stated some halls have quite a few residents that require lifts that can take up to 30 minutes to complete all of the cares needed. Staff member T stated when the facility was short staffed, another staff member was taken from their hall to help. Staff member T stated, This can put us both behind, especially with call lights. When asked about showers, staff member T stated, I know the showers are getting done on my shift because I stay after and do them. When asked if staff member T gets breaks or lunch, staff member T stated, No, I don't know (how) I'd keep up if I did. During an interview on 8/14/24 at 8:31 a.m., NF4 was tearful and stated, I didn't go (to the facility) for two days because it was heartbreaking. It is tough to see your loved one not get the care that he deserves. NF4 stated the facility often seems understaffed. NF4 stated she was worried the facility was not reminding her family member to drink enough fluids throughout the day. She stated, It is totally concerning. Dehydration happens with elderly. During an interview on 8/14/24 at 10:56 a.m., staff member F stated the shifts were from 6 a.m. to 6 p.m. They stated on a busy day, they can leave as late as 9:00 p.m. Review of resident #23's Weekly Wound Review Assessment, dated 5/19/24, showed concern for staffing with wounds and positioning: Wound measurements difficult to obtain due to lack of help with positioning resident . Review of staffing data submitted via the PBJ system revealed the facility had a one-star staffing quality rating and excessively low weekend staffing.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45448 Based on interview and record review, the facility failed to ensure medication regimen reviews were completed monthly and documented in the electronic health record for 2 (#42 and 74) of 3 sampled residents for medication review. Findings include: Record review of resident #74's medical record showed an admitted [DATE]. Review of resident #74's progress notes showed a medication review was performed on 5/28/24, with no irregularities found. No other medication reviews were located in the EHR or medication review documents, or provided. Record review of resident #42's medical record showed an admitted [DATE]. Review of resident #42's progress notes showed a review was completed on 2/21/24, 4/11/24, 5/21/24, and 6/26/24. No medication review was found or provided for 2/7/24 (on admission), March 2024, or July 2024. During an interview on 8/15/24 at 8:01 a.m., staff member A said a medication regimen review was done monthly by the pharmacy. The pharmacist sends the review to the facility in batches, they are reviewed by QAPI and the physician. Staff member A said he had only been at the facility since July 2024 and could not speak to the process prior to his arrival. Staff member A said there were no staff assigned to oversee the completion of the medication review. Record review of a facility document, Medication Regimen Reviews, revision dated May 2019, showed: . 2. Medication regimen reviews are done upon admission (or as close to admission as possible) and at least monthly, thereafter, or more frequently if indicated.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45448 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%. The observed error rate was 20.69% for 3 (#s 73, 74, and 101) of 4 residents sampled for medication administration. Findings include: 1. During an observation and interview on 8/14/24 at 7:59 a.m., staff member J removed single dose medication cards for resident #101. Staff member J compared the medication order on the EHR medication administration record (MAR). Staff member J did not verify the physician admission order with the order listed in resident #101's MAR when a discrepancy was found with resident #101's provided medication. The order was: Aripiprazole 2 mg, physician order; give 2 tablets per day. Medication label on card; give 3 tablets per day, (the card only had one tablet remaining), staff member J dispensed 1 tablet into the medication cup for the resident. Losartan 100 mg, physician order; give 1, 50 mg tablet per day. Medication label on the card; Losartan 100 mg, give 1 tablet per day. Staff member J was going to break the unscored pill in half to give the appropriate dose. Staff member J then pulled up the third medication card, was about to dispense the third medication into the resident's medication cup, and noticed the medication was not listed on the MAR with an order to be given. Staff member J collected all of resident #101's medication and gave it to staff member FF to be checked for accuracy. Staff member J stated she was trained by the facility to always go by the order that was listed on the MAR and not on the cards provided by the pharmacy. The medication cards were not always correct because the order may have changed, and the facility was trying to use up the medication that had already been provided from the previous order. Staff member J said resident #101 was a new admit to the facility, and the medication should have been checked by the nurse prior to being placed in the medication cart. During an interview on 8/14/24 at 8:19 a.m., staff member FF said the medication cards were received from the hospital when resident #101 was admitted to the facility. Staff member FF said all of the medications provided were incorrect, and she would be dispensing medications from facility stock based on the physician admission orders, until she was able to verify the medications and dosages. She was not aware of how the incorrect medication was dispensed to the medication cart. 2. During an observation on 8/14/24 at 8:08 a.m., staff member J removed single dose medication cards for resident #74. Staff member J compared the medication order on the EHR medication administration record (MAR). Staff member J did not verify the physician order with the order listed in resident #74's MAR when a discrepancy was found with resident #74's single dose medication card. The order was: (continued on next page)

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	275080	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cooney Healthcare and Rehabilitation	2555 E Broadway Helena, MT 59601

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Gabapentin 400 mg, physician order; give 1 capsule by mouth TID (three times daily). Medication label on the card; Gabapentin 100 mg, give 2 capsules by mouth TID. The administration card was observed to contain 2 capsules in each bubble for dispensing. Staff member J said she was instructed to use up the card, and when the card was empty, the new dosage would be correct. Staff member J dispensed 4 capsules to resident #74. Insulin Aspart Flex Pen 100 UNIT/ml, physician order; inject 10 units subcutaneously with meals, related to Type II diabetes. Medication Label on the pen; inject 4 units in a.m. subcutaneously with meals. Staff member FF removed resident #74's insulin pouch and removed his insulin pen. She immediately discarded the pen in the sharps container and returned from the medication room with a new pen. Staff member FF stated the pen was almost empty. The facility was using up the insulin they had on hand for resident #74, and the order from the physician was for 10 units. Staff member FF said the order on the MAR was correct and did not need to be checked against the physician order when a discrepancy was found. 3. During an observation and interview on 8/14/24 at 8:37 a.m., staff member F said she did not usually dispense medications for the residents she was assigned for the day. Staff member F was dispensing medication for resident #73 from the stock medication within the medication cart. The order was: Tylenol 1000 mg, 325 mg tablets, give 3 TID (three times daily). Staff member F said she was going to have to check the order, 3 tablets of 325 mg was only 975 mg and the order was for 1000 mg. Staff member F dispensed 2, 500 mg tablets from the stock medication to resident #73. Staff member F did not verify the order prior to dispensing the medication. Staff member F said she was instructed to go by the order in the computer, they were up to date, and the cards may be incorrect. If the orders are different from the cards, she will pull medication from the stock medication and verify the orders. During an interview on 8/14/24 at 11:10 a.m., staff member B said the facility should not be using cards that have come to the facility from another facility. Medication should be dispensed from the stock medication or ordered from a satellite pharmacy until the medication can be received from the pharmacy. Staff member B said if a medication order has been changed, the remaining medication should be removed from the medication cart and destroyed. Staff member B said it would be an expectation that the medication ordered match the medication label on the medication card. Record review of a facility policy, Administering Oral Medications, revision dated October 2010, showed: . 6. Check the label on the medication and confirm the medication name and dose with the MAR.

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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 label and date food items in the refrigerator located in the A-hall; and failed to ensure food stored in the walk-in freezer was stored at a temperature to keep the food frozen solid. This deficient practice increased the risk of residents receiving contaminated food due to improper food storage. Findings include: 1. During an observation on 8/14/24 at 2:27 p.m., the following items were found in the A-Hall refrigerator: - a rectangle shaped container with a blue lid, which contained a red colored food item, labeled, misty 102, undated, - a round container with a blue lid containing an unknown food substance, not labeled or dated, - a ripped, brown paper bag, with a 'Subway' logo, and it contained a food item wrapped in paper, not labeled or dated, - one Sysco Imperial Med Plus NSA 1.7 Vanilla Nutritional Drink, opened and half empty, not labeled or dated; and, - one Premier Protein high protein shake, not labeled or dated. During an interview on 8/14/24 at 2:29 p.m., staff member K stated perishable food items kept by residents were, .labeled, dated, and stored in the nourishment refrigerator. A review of the facility's policy, Foods Brought by Family/Visitors, revised March 2022, reflected, .b. Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. 2. During an observation on 8/13/24 at 12:45 p.m., there was an unknown substance stored in black garbage bags in the facility's walk-in freezer, and it was not labeled or dated. The food was frozen to the touch. During an interview on 8/13/24 at 12:47 p.m., staff member BB stated there was ice stored in the black garbage bags in the walk-in freezer and normally they are labeled and dated. Staff member BB said, The ice is used for emergencies. Staff member BB said she would remove the ice stored in the black bags from the walk-in freezer. During an observation on 8/14/24 at 2:21 p.m., the temperature gauges in the walk-in freezer read 20 degrees Fahrenheit, 18 degrees Fahrenheit, and 24 degrees Fahrenheit. The black garbage bags where the ice was stored were gone. The sliced zucchini in the walk-in freezer was bendable when touched, a package of meat, resembling bacon, was pliable when touched, and a food item with breading, stored in a clear plastic bag, was soft and broke in half when touched. The food touched was not frozen solid. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Work Order #916 showed the due date for the freezer maintenance was 8/3/24, and the priority was indicated as High. A review of the facility's document, RECORD OF REFRIGERATION TEMPERATURES, revised 4/11/2016, showed: Code for adequate temperature: Freezer: Not greater than 0 degrees or food maintained solid Report to Supervisor when recorded temperatures are not adequate.

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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. 49554 Based on observation, interview, and record review, the facility failed to maintain proper infection control practices while in a COVID-19 outbreak for 3 (#s 21, 70 and 74) of 31 sampled residents; failed to provide notification and a screening process for visitors entering the facility; failed to train staff on the proper PPE process for transmission based precautions; failed to encourage residents to wear facemask's while out of their rooms; and failed to properly dress a wound with aseptic technique for 1 (#32) of 1 sampled resident. The facility was in Covid-19 outbreak status during the survey with 10 active resident cases of Covid-19. Findings include: A. During an observation on 8/12/24 at 9:44 a.m., upon entering the facility, no signage was noted on the entry doors notifying visitors the facility was experiencing a COVID-19 outbreak. The facility had hand sanitizer and masks located on the entry desk. A resident, when asked, informed the surveyors of the outbreak status. During an interview on 8/12/24 at 1:42 p.m., staff member A said the facility did not currently have a process in place for screening visitors for COVID-19 as they enter the building. The facility outbreak began on 8/1/24. Staff member A said he had the N95 masks removed from the PPE boxes and replaced with procedural masks. The staff had no had been fit tested for using N95 masks. Staff member A said he did have KN95 masks available. During an observation on 8/12/24 at 9:53 a.m., an air conditioner was observed running outside of a resident's room on B hall. The air conditioner was blowing air down the hall. During an interview on 8/12/24 at 10:09 a.m., staff member Q stated, I think this outbreak started on August 5th. Residents and staff are both sick, and I think there are ten residents in isolation. During an observation and interview on 8/12/24 at 10:17 a.m., staff member Z was standing in the hallway next to the housekeeping cart. Staff member Z lifted their mask to take a drink from their water bottle. Staff member Z was wearing a procedure mask, and lifted it to take another drink and replaced the mask over their face. Staff member Z placed their water bottle in the protective covering where the trash is stored on the housekeeping cart. Staff member Z stated, I'm not sure when this outbreak started. Staff know when a resident is in isolation when there is a cart of PPE outside of their door, and a sign on their door. I shouldn't have touched my mask, and I know that is not a good place for my water bottle. During an interview on 8/12/24 at 10:30 a.m., staff member R stated, Enhanced respiratory precautions mean to use caution when entering the residents room. The residents' rooms are open because they (residents in the rooms) have tested negative (for COVID-19). Staff should still use caution when entering the rooms, but the resident has tested negative. During an interview on 8/12/24 at 2:04 p.m., staff member D stated, The facility conducts PPE training upon hire. For droplet precautions, you should wear a gown, gloves, a face shield, and a mask. A surgical mask is okay to wear when a resident is on droplet precautions. (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 observation and interview on 8/13/24 at 10:48 a.m., resident #21's room door was open with a sign on the door to alert staff and visitors that the resident was on droplet precautions. Staff member EE stated, The door should be closed, and the resident should stay in their room. Any resident on droplet precautions should remain in their room, and the door should be closed. Staff should be wearing full PPE to include gown, gloves, face sheild, and a KN95 mask or higher. Resident #21's room was at the end of the hallway, and numerous rooms were observed with the doors open. Staff member EE stated, None of those residents (with open doors) have tested positive for Covid-19. During an interview on 8/13/24 at 2:29 p.m., NF1 stated she had been to the facility to visit her husband for lunch on 8/12/24 and was not aware there was COVID-19 in the building. She had been coming to visit him almost daily and did not receive a notification or information from the facility or staff about a facility outbreak. During an observation on 8/14/24 at 7:32 a.m., resident #21 was sitting in his wheelchair by the front entrance with no mask on. Resident #21 was greeting people as they came into the facility and sounded like his nose was stuffy. During an observation on 8/14/24 at 8:35 a.m., resident #21 was sitting in the dining room eating breakfast. Other residents were eating in the same dining room. Review of resident #21's electronic health record showed resident #21 tested for COVID-19 as follows: 8/3/24 - Negative 8/9/24: Positive: First signs of symptoms 8/11/24 - Positive 8/12/24 - Negative: A progress note in the electronic health record showed resident #21 tested positive on this date, while the assessment showed the test was negative. Review of the facility's infection control binders showed three of the binder's staff member EE was using as guidance were dated 2018. Review of a facility document titled, Covid-19 Plan 2023 with a revision date of 9/30/2022, showed: . -Empiric use of Transmission Based Precautions (TBP) or Quarantine is no longer recommended unless: - Resident is symptomatic - Currently on Quarantine or has not met criteria to discontinue precautions due to recent Covid-19 Infection Source Control options for HCP include: -N95 mask (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-KN95 mask -Symptomatic Residents should be placed on Transmission Based Precautions (NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or face shield that covers the front and sides of the face) and Symptomatic Employees should be restricted from work pending test results. Source control should be used by symptomatic resident if possible. [sic] 45448 During and observation on 8/14/24 at 8:08 a.m., staff member J was observed passing medication to a COVID-19 positive resident (#74) with a transmission-based precaution sign posted on the resident door, without wearing eye protection. 50245 During an interview on 8/13/24 at 9:06 a.m., staff member N stated resident #70 was in droplet precautions because he was covid negative but was still in precautions to prevent the spread of the disease. Staff member N stated resident #21 was in enhanced respiratory precautions as he actively had covid. Staff member N was asked why the room next door had both airborne and droplet precaution signs; but staff member N stated, I'm not sure. Review of resident #70's EHR showed two negative covid test results. During an interview and observation on 8/14/24 at 3:47 p.m., staff member K stated, He's (resident #70) not on precautions. He tested negative. Resident #70 had a droplet precaution sign on his door, and a PPE cart outside of his room. Staff member K stated she had not been wearing PPE because the nurse told her he was covid negative. Staff member K shrugged and said she did not know why the sign was still up if resident #70 was no longer in precautions. During an observation on 8/14/24 at 3:50 p.m., staff member DD walked into resident #70's room without any PPE on. Outside of resident #70's door was a droplet precaution sign and cart for PPE. B. During an observation on 8/14/24 at 12:43 p.m., staff member E and staff member N completed a left heel, left 2nd toe, right 3rd toe, and right 4th toe wound dressing change for resident #32. Staff member E removed all but the hydrofera blue pad off of the previous dressing. Staff member E and N doffed gloves, washed hands, and donned a new pair of gloves. Staff member E then removed the hydrofera blue, cleaned the wound with a cleanser, then dressed the wound with clean dressings. Staff member E did not change gloves with aseptic technique to prevent wound infection in between cleaning the wound and touching the clean dressing.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 49554 Based on interview and record review, the facility failed to ensure the designated infection preventionist was qualified through an approved certification program, prior to assuming the role, of the infection preventionist. The deficient practice increased the risk of infection control concerns not being identified or addressed for all residents and staff within the facility. Findings include: During an interview on 8/13/24 at 10:48 a.m., staff member EE stated, I have been in this position for about one month. I have started the CDC training, but I haven't completed it. I know that we have issues with infection control. I was aware of that when I was hired. We are working on them. Review of staff member EE's training record showed only three modules out of fifteen had been completed prior to the start of survey. Review of staff member EE's job description showed, . Education and Experience Required: Certification in Infection Control and Epidemiology . Refer to F880, Infection Control, for overall failures identified related to COVID-19.

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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. 45448 Based on observation, interview, and record review, the facility failed to place the call light button within reach for 2 (#18 and #46) of 31 sampled residents. This deficient practice caused resident #18 to call out for help and resident #46 to feel panicked and afraid. Findings include: 1. During an observation and interview on 8/12/24 at 2:51 p.m., resident #46 was observed to be lying in her bed with the call light across the room, draped on a pedal exercise device on the floor. Resident #46 was on Transmission Based Precautions for testing COVID-19 positive. She was dozing off during conversation and said she was very tired and weak from COVID-19 symptoms. During an observation and interview on 8/14/24 at 3:16 p.m., resident #46 was lying in bed and stated she was feeling much better. Resident #46 said she felt a little panicked and scared the night of 8/13/24. The call light had been over the foot of the bed, lying on the floor, she was unable to reach the device. Resident #46 said she had attempted to reach for the device several times and was unable. Resident #46 said staff had dropped off her dinner tray at 5:15 p.m., and staff had not checked on her again until 8:45 p.m., when they removed the dinner tray. Resident #46 said she was scared and had called her sister for comfort. During an interview on 8/14/24 at 4:34 p.m., staff member F said staff try and check on the residents every hour or two. Staff member F said she knows resident #46 was checked on frequently during day shift on 8/13/24. Resident #46 had frequent assessments completed for nutrition, dentures, and hydration. Staff member F said the staff were expected to check on residents and make sure the call lights were within reach at all times. The staff were provided training by the facility. 2. During an observation on 8/14/24 at 4:40 p.m., resident #18 was calling out for help when this surveyor, who was in the hall outside the room, was passing by. She asked if her call light was on. Resident #18 was informed her call light (alert light) was not on in the hallway. Resident #18 then asked her room mate to activate her call light, she wanted help. Resident #18's call light was located behind her recliner, lying in the top drawer of her bedside table, and the drawer was partially closed. During an interview on 8/15/24 at 11:04 a.m., staff member Q said call lights should be placed near the resident and within reach, and it should be placed on their strong side (of body) if they have weakness. Staff member Q stated, We have received training on call lights and placement by the facility. Record review of a facility document, Answering the Call Light, with a revision date of July 2023, showed: . 5. Ensure the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.