STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275119	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Logan Health - Conrad	805 Sunset Blvd Conrad, MT 59425

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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. 47752 Based on observations, interviews, and record review, the facility failed to provide dignity and respect for residents when staff failed to knock and announce theselves prior to entering the resident rooms, causing frustration, for 2 (#s 2 and 190), and their family members, of 22 sampled residents. Findings include: 1. During an observation and interview on 4/23/24 at 8:54 a.m., resident #2 was lying in bed visiting with family members. Staff member M walked into the room without knocking. Resident #2 stated, I have no privacy, staff just walk in whenever they want. It is frustrating. NF2 stated, The staff do that all the time. I am here frequently, and it is rare to have a staff member knock before they enter [Resident #2's] room. It is frustrating that I can not even have a conversation with [Resident #2] with out someone just walking in. This is [Resident #2's] home. During an interview on 4/23/24 at 8:58 a.m., staff member M stated staff were to knock and get permission before entering a resident's room. During an observation on 4/23/24 at 9:00 a.m., staff member M walked into resident #2's room with out knocking. 2. During an observation and interview on 4/22/24 at 3:18 p.m., resident #190 was lying in bed. Staff member M walked into resident #190's room without knocking. NF4 stated, Some staff knock, but most staff do not. NF4 stated it bothered her that staff walked into the room without knocking, and it was frustrating. During an observation on 4/23/24 at 1:50 p.m., resident #190 was lying in bed with her eyes closed. Staff member L walked into resident #190's room with out knocking or asking if it was ok to enter. During an interview on 4/23/24 at 1:43 p.m., staff member L stated staff were supposed to knock prior to entering a resident's room. Staff member L stated if there was not a response by the resident staff could ask if it was ok to come in. Staff member L stated she should have knocked prior to entering resident #190's room. A review of a facility policy titled, Resident Rights and Responsibilities, BHSS907, with a revision date of 1/2023, showed: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. 1. While at [name of another facility] skilled nursing facility, a resident has the right to: A. Exercise of rights ., . F. Privacy .

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 47752 Based on observations, interviews, and record reviews, the facility failed to assess a resident for self-administration of medications for 1 (#31) of 22 sampled residents. Findings include: During an observation and interview on 4/24/24 at 7:55 a.m., staff member O was performing the morning medication pass. Staff member O stated she provided all of resident #31's medications to her. During an observation and interview on 4/24/24 at 8:05 a.m., staff member O took resident #31 her morning medications. On resident #31's bedside table was a bottle of Systane eye drops. Resident #31 stated she gave herself the eye drops, when she needed them. Resident #31 could not verbalize correct administration instructions or if there were any side effects of the Systane. During an interview on 4/24/24 at 8:09 a.m., staff member O stated she did not have any residents that were able to self-administer medications. During an observation on 4/24/24 at 9:10 a.m., resident #31 was sitting on the side of her bed. On the bedside table was a bottle of Systane eye drops, the lid was not on the bottle of eye drops. Resident #31 picked up the bottle of eye drops and administered two drops of the Systane eye drops into each eye. Resident #31 dropped the bottle of eye drops on to the floor, picked the bottle of eye drops up, and placed it on the bed side table. A request was made on 4/24/24 at 11:33 a.m., for resident #31's assessment for the self administration of medications, but this was not received prior to the end of the survey. During an interview on 4/24/24 at 1:40 p.m., staff member B stated resident #31 did not self-administer any of her medications. A Review of resident #31's physician orders, with a last order review date of 3/13/24, showed: - No physician's order for eye drops, and no order for resident #31 to self-administer her medications. A review of resident #31's Significant Change MDS, with an Assessment Reference Date of 4/1/24, showed a BIMS score of 9; moderate cognitive impairment. A review of a facility policy titled, Resident Administration of Medications Following Set-Up, with a revision date of 6/2023, showed: . PROCEDURE: 1. All residents will be assessed upon admission and quarterly thereafter for their right to self-administer medications if they choose. 2. Any resident can ask if they may self-administer medications at any time during their stay. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The Resident Care Coordinator will assess each resident for appropriateness and safety, primarily based on BIMS score, assessment of visual acuity, actual demonstration of medication administration, knowledge of physician/provider orders, dosage and frequency, as indicated on the Self Administration Assessment Form.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 48261 Based on observations, interviews, and record review, the facility failed to support and assist 2 residents, (#s 33 and 35) who were spouses, and the couple wished to share bed space but couldn't due to the lack of staff assistance, of 22 sampled residents. Findings include: During an observation and interview on 4/23/24 at 9:38 a.m., resident #35 stated she and resident #33 (a married couple) were told they could have a double bed in their shared room, or the single beds could be put together. Resident #35 stated she had asked the floor staff several times about the double bed but had not received a double bed or assistance with having the beds pushed together. Resident #35 began to cry, and she stated there was no reason she and her husband (#33) should not be allowed to share a bed. Resident #33 stated his bed was too short, and his feet dangled off the end. This surveyor observed the single beds, in separate sections of the room, and they were across from one another. The room was a double occupancy room. Therefore, the two were unable to share the same bed. The couple made the request for sharing the bed(s) on 2/12/24. Review of the facility's Maintenance log, no date, reflected a maintenance request by staff member B, completed on 2/12/24, and it showed: - Wider/Longer bed family request, it was initialed by NH, The request showed no completion date or comments in the awaiting parts, delays, comments column. During an interview on 4/23/24 at 10:35 a.m., staff member E stated he notified staff member B the facility did not have longer or wider beds, and the only option was to put the beds together and lock the wheels. Staff member E did not know why the task was not completed in the maintenance log book. During an interview on 4/23/24 at 11:00 a.m., staff member B stated she had put the request in the maintenance book and expected maintenance to complete the task. Staff member B stated she did not follow-up on requests placed in the book and did not know why the beds had not been addressed. Staff member B stated she had not received a complaint from resident #33 and #35 regarding the beds, except at the care conference, when she placed the maintenance request, which was on 2/12/24.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48261 Based on observations, interviews, and record review, the facility failed to ensure the staff and residents had access to the grievance process forms, were able to complete grievance forms for concerns voiced by residents, investigate grievances, and maintain evidence demonstrating the results of all grievances for 3 (#s 16, 21, and 35) of 22 sampled residents. This practice had the potential to affect anyone wanting to file a grievance or who had filed a grievance. Findings include: 1. During an interview on 4/22/24 at 2:46 p.m., resident #16 stated she had many complaints regarding staffing, the quality of the food, a wound on her ankle, not getting ice water throughout the day, and not receiving food as ordered on her meal ticket. Resident #16 stated she had notified staff member A of her concerns, but did not hear anything back on how her concerns were addressed, and many of her concerns had not been addressed at all. Resident #16 stated her husband and her both wrote letters to the administrator regarding their concerns, and they called her sometimes as well. NF3 stated he had also written letters of concern to the administrator and stated he did not know of a grievance process or a form for grievances. During an interview on 4/22/24 at 6:40 p.m., staff member B stated the grievance forms are in (at) the nurses' station, and the nurses provides them to residents if they request one. Staff member B stated the facility did not complete a grievance form for many of the concerns received, because the facility addressed them in the moment, so she did not feel a grievance form was warranted. During an interview on 4/22/24 at 6:43 p.m., staff member I stated, Good question, I have no idea. when asked where to find a grievance form. During an interview on 4/22/24 at 6:44 p.m., staff member U stated, That seems to be the question of the day, I haven't seen those forms in a long time, when asked where to find a grievance form. 2. During an interview on 4/23/24 at 9:38 a.m., resident #35 stated she had complained about the room being cold for weeks, and no one had fixed it. It was cold by the bed because there was a draft. Resident #35 stated she had complained to staff on the unit about not receiving the double bed as discussed at their first care conference. Resident #35 resided with her husband in one room and was told by the management she could have a double bed or push the beds together, when they attended a care conference on 2/12/24. Resident #35 stated, The food is always cold and we (residents #33 and #35) are tired of the same things over and over. Resident #35 stated she and her husband did not know of a grievance form they could use and did not know there was a grievance process. Resident #35 stated she would notify the floor staff of concerns and hoped they would fix it. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/24 at 2:00 p.m., staff member V stated the grievances had been processed through the previous administrator up until a month ago. Staff member V stated she received the book with only two grievances in it, and was not aware of where the other grievances were previously filed. Staff member V stated she was now responsible for processing grievances; however, the staff had not notified her of any grievances, and she had not received any grievance forms. Staff member V stated all grievances should have a form completed, including documentation of the complaint, the investigation notes, the resolution, and the follow-up to be sure the problem was addressed. Staff member V stated the facility was in the process of placing grievance boxes with grievance forms today, after surveyors questioned where they were located. Review of the facility's Grievance Log, 2023 - 2024, reflected two grievances in 2024. The concerns voiced by resident #16, NF3, and resident #35 were not in the grievance log. During an interview on 4/23/24 at 4:02 p.m., staff member A provided a spreadsheet of concerns reported to her by resident #16, not included in the grievance log. The spreadsheet reflected a column for the grievance, and a comments column that gave feedback on the grievance, some with resolutions and others with no comments. The spreadsheet failed to show any investigation process or follow-up regarding the effectiveness of any resolutions provided. Staff member A stated this was the only grievance spreadsheet not included with the grievance log, originally. 50245 3. During an interview on 4/22/24 at 3:50 p.m., NF7 stated she did not know about the grievance process. She would notify administration about any problems or concerns that she had about resident #6. During an interview on 4/23/24 at 10:32 a.m., resident #21 stated, No, never heard of it (grievances or the grievance process). During an interview on 4/22/24 at 6:44 p.m., staff member U stated the residents can put any comment, concern, or grievance in a box located outside of the administrator's door. When asked how a resident in a wheelchair would access this box, as it was located at shoulder level while standing. Staff member U stated residents would not be able to reach the box. Staff member U stated a resident could fall trying to reach the box. During an interview on 4/22/24 at 6:45 p.m., staff member A stated the facility did not have any more grievances than what was located in the grievance book. During an interview on 4/22/24 at 6:46 p.m., staff members I and U both stated they did not know where to find grievance forms at the nursing station.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 50245 Based on interview and record review, the facility failed to thoroughly investigate and report findings following a facility reported incident of injury of unknown origin for 1 (#11) of 22 sampled residents. Findings include: Review of a facility reported incident submitted to the State Survey Agency on 11/22/23, showed an incident of unknown origin occurred with resident #11 on 11/21/23 at 12:30 p.m. In the report, resident #11 complained of pain to the right shoulder. The facility's assessment of resident #11's shoulder showed redness as well as a bruise to the left upper arm. An area was measured but no location was specified as showed in the report: Resident stated she had not fallen and could not recall what happened . The bruise was approx 10x6 cm. A request for the complete investigation and root cause analysis related to the event was requested on 4/22/24 at 1:40 p.m., and was not recieved prior to the end of the survey. No findings were submitted to the State Survey Agency within the required reporting timeline of five working days from when the incident occurred as the cause was unknown, it was unwitnessed, and the resident was not able to state the cause. During an interview on 4/25/24 at 4:36 p.m., staff member A stated she was not able to locate any findings or documentation of the incident being submitted to the State Survey Agency. Staff member A stated she was new to the position and was now responsible for reporting and submitting findings for the facility reported events.

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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. 47752 Based on observations, interviews, and record review, the facility failed to revise a resident care plan to show effective interventions following multiple falls with injury for 1 (#12) of 22 sampled residents. Findings include: During an observation on 4/22/24 at 3:26 p.m., resident #12 was pacing up and down the hallway, in the secure care unit. Resident #12 was wearing regular socks, and no shoes. Resident #12 had a large yellow and purple bruise noted to her left eye and forehead area. During an interview on 4/22/24 at 3:29 p.m., staff member J stated resident #12 fell all the time. Staff member J stated it was not unusual for residents on the secure care unit to fall and be bruised. Staff member J stated, I had asked staff member A about the bruise on resident #12, and staff member A did not give me any information. Staff member J stated she believed all staff have access to resident care plans. When asked by the surveyor about the use of shoes or non-skid socks, Staff member J stated, The interventions are never updated so most of us (staff) don't bother looking anymore. During an interview on 4/24/24 at 10:58 a.m., staff member G stated she was responsible for updating and revising resident care plans. Staff member G stated she updated and revised care plans when there were any changes and as needed. A review of resident #12's incident reports showed resident #12 had fallen on 3/1/24, 3/9/24, 3/28/24 and 4/15/24. A review of resident #12's care plan, with a revision date of 4/16/24, showed no revision of the care plan after the falls on 3/1/24, 3/9/24, and 3/28/24. No new interventions were implemented following the falls. Review of a facility document titled, Care Planning, with a revision date of 6/2023, showed: . 5. Each service reviews and revises plan of care for which it is responsible . Review of a facility document titled, Fall Prevention and Management, AGN469, wiht a revision date of 2/2024, showed: . 5. Post Fall Event . 6. Modify the fall prevention plan of care .and any unit specific interventions to prevent repeat fall. [sic]

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 50245 Based on observations, interviews, and record reviews, the facility failed to ensure the resident had access to his hearing aids for necessary communication, and the hearing aids were kept by the nursing staff when not in use, and instructions for use were provided to staff on his care plan, for 1 (#6) of 22 residents. Findings include: During an interview on 4/22/24 at 3:50 p.m., NF7 stated she came to the facility almost every morning, and resident #6's hearing aids were never put in her ears until she specifically asked for the hearing aids to be placed. During an observation and interview on 4/24/24 at 1:04 p.m., resident #6 did not have his hearing aids in, and he was was having a hard time hearing the conversation with the staff. Staff member M stated the hearing aids were typically located in resident #6's room, on a hook, near the sink. Staff member M stated, I could not find them (the hearing aids) this morning. Staff member M stated, I could not find them yesterday either. During an interview and observation on 4/25/24 at 10:51 a.m., staff member I stated hearing aids were located in the medication room, so they could be charged every night. Staff member I stated her specific discipline typically placed hearing aids on residents, as they were usually locked in the medication room. Staff member I stated the hearing aids were supposed to be put on the resident once the daughter was at the facility, and requested the hearing aids to be placed. Resident #6's daughter was observed to be in the building earlier that day (4/25/24) at 8:56 a.m., but the hearing aids were observed to be placed at 11:32 a.m. , on 4/25/24. During an interview on 4/25/24 at 11:58 a.m., staff member B stated a lot of residents can hear without the hearing aids. During an interview on 4/25/24 at 2:03 p.m., NF6 stated, We have asked for them (the hearing aids) to be put in first thing in the morning. NF6 stated the hearing aids were needed because resident #6 liked to watch the television, and he could not hear the television without the hearing aids. NF6 stated he had never seen resident #6 take his own hearing aids out. Record review of resident #6's care plan, initiated 11/7/23, showed: - . hearing aids are to be put in in the am Record review of resident #6's EHR facesheet, showed: - . special instructions: Daughter would like Hearing Aids on every day. Kept in Med Rm. [sic]

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47752 Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision on a secure dementia unit, resulting in 1 (#34) of 22 sampled residents ingesting odor eliminator; and failing to keep chemicals secure and inaccessible to residents with cognitive impairment; and failed to provide adequate supervision for fall prevention, for 2 (#s 6 and 15). Findings include: 1. During an interview on 4/25/24 at 11:17 a.m., staff member R stated she was uncomfortable working on the secure care unit by herself, and asked not to be assigned back there (secure care unit) unless there was another staff member with her. Staff member R stated there were too many incidents that happened on the secure care unit, and only having one staff member on duty during the day was unsafe. During an observation on 4/25/24 at 11:27 a.m., two residents were sitting in the dining room, and two residents were wandering around the dining room, of the secure care unit. No staff were present in the dining room. Staff member O came into the dining room at 11:37 a.m. The four residents were left unsupervised for 10 minutes. During an interview on 4/25/24 at 11:40 a.m., staff member N stated she was aware resident #34 had drank odor eliminator spray. Staff member N stated, The shower room was not locked, and [resident #34] walked in and was found drinking the odor eliminator. [Resident #34] will drink anything that is left around and unattended. She will try to drink anything and everything. Staff member N stated the only intervention she knew about was the sign that was posted in resident #34's room, reminding her to call staff for something to drink. Staff member N stated, Most of the doors (on the unit) do not have locks on them, and we really need to have them (locks) for resident safety. I have mentioned that to [Staff Member B] a couple of times. [Resident #34] needs one-on-one care, but we cannot do that, there is only one staff member back here (Secure Care Unit) during the day. I knew there were residents in the dining room, but I had to care for another resident. During an observation and interview on 4/25/24 at 11:45 a.m., the shower room door was closed, but unlocked. In the shower room the following chemicals were found: - two (2) purple top sani-wipe disinfectant cloths, located on a counter, - one (1) bottle of odor eliminator spray, located on a counter, - one (1) opened, undated bottle of vinegar, located in an unlocked cabinet, - two (2) plastic spray bottles labeled with a printed-out piece of paper labeled, Quat-Stat 5-deluted. There were no directions or indications for use on the bottle; and, - one (1) Plastic spray bottle with Sani-T-10 plus written in black marker. There were no directions or indications for use on the bottle. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Staff member N stated she was not sure what kind of chemicals they were, but they were used to clean the shower after it was used. Staff member N stated she did not know where the chemicals came from or who maintained and refilled them. Staff member N stated she thought there was a binder in the soiled utility room, or in the clean linen closet, that had SDS information in it. Staff member N could not find the SDS information. During an interview on 4/25/24 at 11:51 a.m., staff member B stated the SDS binder is located at the nursing station. During an interview on 4/25/24 at 11:56 a.m., staff member B stated it was a team effort to update the SDS binder, which included staff member E, and staff member F. During an interview on 4/25/24 at 12:16 p.m., staff member M stated he was the staff member on the secure care unit when resident #34 ingested the odor eliminator. Staff member M stated he was doing resident care prior to lunch. Staff member M stated, I was walking down the hallway, saw [resident #34] sitting in the shower room, and she had the bottle of odor eliminator in her hand with the lid off, and the bottle was almost empty. I did not notify the nurse right away, but I should have. Staff member M stated he was not 100 percent positive that resident #34 had ingested the odor eliminator but felt she had ingested a least some of the contents of the odor eliminator bottle. During an interview on 4/25/24 at 12:23 p.m., staff member K stated staff member M did notify nursing staff of the incident with resident #34 on 4/20/24 at 3:00 p.m. Staff member W did the resident assessment and notified all the appropriate staff and resident #34's spouse. Staff member K stated poison control was contacted. Staff member K stated if the SDS sheets were not in the binder, she was not sure where they would be. Staff member K stated all the SDS sheets are to be in the binder. During an interview on 4/25/24 at 12:30 p.m., a call was placed to staff member W, who was the staff member on duty when resident #34 ingested the odor eliminator. No call back was received prior to the end of the survey. During an interview on 4/25/24 at 12:46 p.m., staff member F stated there were three staff members working together to get the SDS sheets together. Staff member F stated if there was not an SDS sheet in the binder, if one was not readily available, she would look it up online, print it out, and put it in the binder. Staff member F stated all cleaning chemicals were to have labels and directions for use. Staff member F stated, All of our spray bottles that have chemicals in them are properly labeled. During an interview on 4/25/24 at 12:51 p.m., staff member E stated the SDS binder is a collaborative effort (for the upkeep of it). Staff member E stated there was primarily three staff members responsible for maintaining the SDS binder. Staff member E stated, I have done a lot of education and training for the staff in this building regarding SDS information. As we get new chemicals, new SDS sheets are placed in the binder. Staff member E stated there should not be any chemicals in the secure unit unlocked. Staff member E stated, Those chemicals should not be back here at all, I am not even sure what that chemical is used for (plastic spray bottle with Sani-T-Plus written in black marker). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 4/25/24 at 2:05 p.m., the following chemicals were observed in the secure care unit dining area and bathroom. - two (2) plastic spray bottles of Quad-Stat chemicals, located in the cupboard above the sink, with no lock, - eight (8) bottles of odor eliminator spray, in the bathroom off the main dining room, in the secure care unit, - 1 plastic bottle of eye glass cleaner, located in the bathroom off the main dining room, in the secure care area, - two (2) bottles of x-effect bowl cleaner located in an unlocked cupboard in the bathroom off the main dining room, in the secure care area; and, - one (1) half full gallon container of perineum cleaner, sitting on the paper towel dispenser, next to the toilet, in the secure care area. Staff member N stated, There are several residents who wander in and out of this bathroom all day, every day. Staff also use this bathroom to perform check and changes on the residents. The residents back here (secure care unit) can absolutely get into the drawers and cupboards in that bathroom. [Resident #34] is constantly in and out of this bathroom. The bathroom is located within the main dining area of the secure care unit. During an observation on 4/25/24 at 2:15 p.m., one bottle of perineum spray and one bottle of odor eliminator spray was on the shelf in resident #34's room. During an interview on 4/25/24 at 2:36 p.m., staff members A and B stated one of the interventions for resident #34 was not to have any kind of chemicals in her room, and a sign was placed (in the resident's room) reminding resident #34 to call staff for something to drink. A review of resident #34's Admission MDS, with an ARD of 2/27/24, showed resident #34 was severely cognitively impaired. - .Section C1000, Cognitive skills for Daily Decision Making. - .3. Severely impaired-never/rarely made decisions. Was checked by staff. A review of a facility binder titled, LTC SDS, showed: - no SDS sheets for the odor elimination spray, eye glass cleaner spray, Quad-Stat chemicals, x-effect bowl cleaner, or the Sani-T-Plus cleaner. A review of a facility policy titled, Hazardous Materials/Waste Management Program, EC290, with a revision date of 2/2024, showed: - . Policy (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. The program applies to all employees, patients, visitors, and departments of [Facility Name], . 4. The Program and related policies address Hazardous Material: chemicals . identification, handling, use, storage . and regulatory requirements, . 9. Responsibilities to ensure compliance with this policy are as follows: A. Environmental Services Manager . 3. Ensures compliance with the Program relative to all local, state, and federal regulations governing the use, storage, and disposing of hazardous materials and wastes . [sic] . 1. Maintains and updates electronic master file of all SDS. 50245 2. During an observation on 4/24/24 at 12:58 p.m., resident #15 was ambulating in her room, without her walker. The walker was turned away from her, and resident #15 was using the furniture to stabilize herself, as she walked from her nightstand, to the end of her bed. Record review of resident #15's care plan showed: - .I transfer with supervision and my 4WW . - . I am not to have a bedside table in my room so that I don't lean on it and fall . During an interview on 4/24/24 at 1:00 p.m., staff member K stated resident #15 was not a high fall risk resident. Staff member K stated resident #15 would be safe to walk without her walker outside of her room, without assistance. Staff member K stated resident #15 only fell when putting her shoes on herself, in the morning, as resident #15 would fall forward and lose her balance. Staff member K was not aware resident #15 was falling during the day. During an interview on 4/24/24 at 1:10 p.m., staff member M stated resident #15 was a high fall risk, and she had a bed alarm at night. Staff member M was not aware of resident #15 falling during the day. During an observation on 4/24/24 at 3:37 p.m., resident #15 ambulated by herself to the bathroom with her walker. During an observation on 4/24/24 at 3:41 p.m., resident #15 was ambulating in the hallway by herself, without her walker. Review of resident #15's nursing progress notes, dated 1/31/24 - 3/18/24, showed falls on the following dates: - 1/31/24 at 1:45 p.m., (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- 1/31/24 at 5:00 p.m., witnessed fall in the dining room where resident #15 fell lost balance, and fell backwards from her walker, - 2/3/24 at 12:45 p.m., - 3/6/24 at 11:00 a.m., unwitnessed fall resulting in injury, and - 3/18/24 at 12:54 a.m., resident walking in room without walker, next to her closet which was located across the room from resident #15's bed. 3. During an interview on 4/25/24 at 8:56 a.m., NF7 stated she was upset the facility did not have foot pedals on the wheelchair for resident #6. During an interview on 4/25/24 at 9:11 a.m., staff member U stated there were three falls last night. One of the witnessed falls was resident #6, who had been wheeled down the hallway by a staff member, and his feet caught the floor, causing him to fall head-first out of the wheelchair. Resident #6 had to be sent to the ER for a head laceration requiring four stitches. Staff member U stated, We have had so many falls. During an interview on 4/25/24 at 10:51 a.m., staff member I stated staff would always assist resident #6 back and forth to his room. Staff member I stated resident #6 did not usually use his feet to propel himself, in his wheelchair. Staff member I stated, I don't know, when asked why the foot pedals were not used on resident #6's wheelchair. During an observation on 4/25/24 at 11:42 a.m., staff member P brought resident #6 back to his room in his wheelchair. Foot pedals were not observed to be on resident #6's wheelchair. Resident #6 was not observed self-propelling down the hallway by himself. Once in resident #6's room, staff member P asked staff member Y, Why are these [foot pedals] not on his chair? Staff member Y stated, I don't know. Staff member Y attempted to put the leg rests on resident #6's wheelchair, but they were too short for resident #6. Staff member Y took the foot pedals off and placed them back in the closet During an interview on 4/25/24 at 11:49 a.m., staff member Y stated resident #6 is too weak to propel himself in the wheelchair down the hallway. During an interview on 4/25/24 at 11:54 a.m., staff member Y later stated, resident #6 does self-propel himself down the hallway in his wheelchair, which staff member Y found out about after she spoke with staff member K. During an interview on 4/25/24 at 12:42 p.m., when considering resident #6's tall height, staff member B stated she did not know why a larger wheelchair or longer foot pedals were not ordered sooner for resident #6. Record review of the Fall Investigation Form, dated 4/24/24, showed: . Action plan: Educate staff to use foot pedals when transporting/pushing resident in w/c. Remove foot pedals after transfer d/t resident able to self propel .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48261 Based on interview and record review, the facility failed to ensure a registered nurse was on staff at least eight consecutive hours a day, seven days a week. This practice had the potential to affect any resident needing RN services when one was not available. Findings include: Review of the CMS [NAME] Payroll-based Journal for this facility, with a run date of 4/16/24, showed the facility triggered for not having RN coverage for eight consecutive hours each day on 39 days between the dates of 10/8/23 and 12/31/23. Review of the facility's nursing schedules, dated 10/8/23 - 12/31/23, reflected the facility did not have RN coverage for eight consecutive hours on 10/29/23. During an interview on 4/23/24 at 3:35 p.m., staff member B reviewed the schedule with the surveyor, and stated the facility did not have a registered nurse on 10/29/23. Staff member B did not know why a registered nurse was not scheduled.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 48261 Based on observations, interviews, and record review, the facility failed to post the nurse staffing information on a daily basis, at the beginning of each shift. This practice had the potential to affect anyone who wanted to review the nurse staffing levels in the facility. Findings include: During an observation on 4/22/24 at 6:30 p.m., the facility nurse posting was found on a clipboard on a wall hanger. The posting dated 4/22/24 had not been filled out for the morning shift. The posting dated 4/18/24 was not filled in for the evening and night shifts. During an interview on 4/23/24 at 6:44 p.m., staff member B stated the nurses on the units complete the posting after their shift. Staff member B did not know why the postings on 4/18/24 and 4/22/24 had not been completed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48261 Based on observations and interviews, the facility failed to provide palatable food at an appetizing temperature for 4 (#s 10, 16, 21, and 33) of 22 sampled residents. Findings include: 1. During an interview on 4/22/24 at 2:46 p.m., resident #16 stated the quality of the food was a concern for her. Resident #16 stated the food was consistently cold, and often not what she ordered. Resident #16 stated she had voiced her concerns to the management staff regarding the food temperature and spicy food. 2. During an interview on 4/23/24 at 9:38 a.m., resident #35 stated, The food is always cold, and we (resident's #33 and 35) are tired of the same things over and over. During an interview on 4/23/24 at 2:00 p.m., staff member V stated the management receives test trays from the kitchen throughout the month. The management staff then complete a questionnaire on the food's quality, appearance, taste, and temperature. Staff member V stated, The temperature continues to be an issue and residents do complain about it, with good reason. During an observation on 4/24/24 at 12:05 p.m., surveyors received test trays from the buffet line, delivered by kitchen staff to the conference room. Two trays contained Ham with gravy, rice, asparagus, and a piece of strawberry/vanilla cake. One tray contained a handmade pot pie, rice, asparagus, and a piece of strawberry/vanilla cake. The surveyors tasted all items and noted the following: - The ham with gravy was not at an appetizing temperature. - The pot pie was spicy with heavy black pepper. - The asparagus was not at an appetizing temperature and was mushy. - The rice was not at an appetizing temperature. During an observation and interview on 4/24/24 at 12:15 p.m., resident #16 was on the phone asking someone to bring food in so she could eat. Resident #16 started to cry and stated, I can talk and get mad, but I can't do anything about it, and they know it, so they just don't care. That pot pie is so spicy, and there is only one piece of meat in it. I've told them over and over that I cannot eat that spicy food. Now my mouth is on fire. Resident #16 stated she had called her husband to bring in food. Resident #16's tray was sitting next to her with the pot pie cut open and no other side dishes. During an observation on 4/24/24 at 1:30 p.m., the white board posted in the main kitchen showed resident #16 was not to receive spices or spicy foods. 50245 3. During an interview on 4/22/24 at 5:23 p.m., resident #10 stated the food was always served fifteen minutes late, and it was not always hot. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an interview on 4/23/24 at 10:32 a.m., resident #21 expressed concern about hot food being cold, and stated, The food was often cold. During an observation on 4/24/24 at 8:22 a.m., staff member K brought resident #33's breakfast to his room. At 8:24 a.m. The temperature of resident #33's eggs measured 100 degrees Fahrenheit. The potatoes measured 90 degrees Fahrenheit. Resident #33's plate had a cover but did not have a food warmer underneath the plate. References: According to the Centers for Disease Control and Prevention, food items served are required to be at least 140 degrees Fahrenheit or higher (Centers for Disease Control and Prevention, 2023). Centers for Disease Control and Prevention. (2023, November 13). Food Safety for Buffets and Parties. Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/foodsafety/serving-food-safely.html#:~:text=Use%20a%20food%20thermometer%20to,within%202%20hours%20of%20cooking.

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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. 48261 Based on observations, interviews, and record review, the facility failed to ensure food was stored off the floor in the cooler and freezer; that staff wore beard covers appropriately; cleaned thermometers before use; and ensured proper hand hygiene was used and followed when serving food. These practices had the potential to affect all residents who received food from the kitchen. Findings include: 1. During an observation on 4/22/24 at 1:25 p.m., there was a stack of 13 food filled boxes on the floor of the freezer. One crate of 2% Milk was on the floor of the cooler. During an interview on 4/23/24 at 10:05 a.m., NF5 stated, food in coolers and freezers should be six inches off the floor, as a standard practice. 2. During an observation on 4/25/24 at 8:10 a.m., staff member X was wearing a beard cover, only covering his chin and mouth, not covering his full beard. Staff member X repeatedly touched his beard, beard cover, and nose while serving breakfast food at the buffet line in the main dining room. Staff member X pulled at his beard cover adjusting it 14 times in six minutes, from 8:10 a.m. to 8:16 a.m. Staff member X did not perform hand hygiene after touching his face, beard, and beard cover. This surveyor notified the kitchen supervisor, who removed staff member X from the buffet service to re-educate the employee. 50245 3. During an observation on 4/24/24 at 8:07 a.m., the thermometer was not cleaned by NF8 before it was used to take the temperature of the foods on the buffet. NF8 had not cleaned the thermometer in between taking the temperature of different foods. During an interview on 4/25/24 at 10:57 a.m., NF5 stated staff was expected to clean thermometers before use when taking the temperatures of foods.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48261 Based on interview and record review, the facility failed to electronically submit accurate and complete direct care staffing information to CMS. This practice had the potential to affect all residents. Findings include: Review of the CMS [NAME] Payroll-based Journal for the facility found the facility triggered concerns for licensed nurse staff on 66 days, between 10/7/23 and 12/31/23. The facility also triggered for not having RN coverage for eight consecutive hours each day on 39 days between 10/8/23 and 12/31/23. Refer to F727 for the RN staffing. Review of the facility's nursing schedules, dated 10/8/23 - 12/31/23, reflected the facility did have licensed staff 24 hours a day on the dates in question, and did have RN coverage for eight consecutive hours each day except on 10/29/23. The findings were inconsistent with the PBJ submittals. During an interview on 4/23/24 at 3:32 p.m., staff member A stated the facility had noted the errors in the PBJ when she took over her position. Staff member A stated she corrected the data moving forward by including the addition of a significant number of missing job codes to the system to report the staff who were working.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47752 Based on observations, interviews, and record review, the facility failed to address the use of resident refrigerators sufficiently, and in a manner to promote safety, for the prevention of food borne illnesses and having expired food disposed of timely, for 1 (#2) of 22 sampled residents. Findings include: During an observation on [DATE] at 3:04 p.m., resident #2 had a refrigerator in his room. No refrigerator temperature logs were visualized by the surveyor. During an interview on [DATE] at 4:08 p.m., staff member B stated the temperature checks for the refrigerators are documented in the resident's electronic medical record, under tasks, for each resident with a refrigerator. During an observation and interview on [DATE] at 8:54 a.m., resident #2's personal refrigerator in his room was observed to have a sticky substance stuck to the bottom, on the inside of the refrigerator. There were two open containers of vanilla yogurt, with a use by date of [DATE] and [DATE], a small, open container of milk with an expiration date of [DATE], and a facility dessert dish covered with aluminum foil. The food in the dessert dish was not identifiable. There were no dates noted on the yogurt, milk, or dessert dish from when they were opened. Resident #2 stated he was not sure how long the food had been in the refrigerator. During an interview on [DATE] at 8:58 a.m., staff member M stated the refrigerator was checked by staff daily. A request for the policy on personal refrigerators and refrigerator temperatures was requested on [DATE] at 9:20 a.m., and it was not received prior to the end of the survey. During an interview on [DATE] at 4:08 p.m., staff members A and B both stated the refrigerator temperature checks were documented in the electronic medical record, and they had no policy for the personal refrigerators, but followed a policy from another facility. Review of an alternate facility document titled, [Facility Name] Policy/Procedure, with a revision date of , d+[DATE], showed: - . It is the responsibility of the employee (either Nursing or Dietary) placing the item in the refrigerator to assure that it is properly labeled and dated. Any item not labeled and dated will be discarded.