STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275124	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer Care and Rehabilitation	200 N Oregon St Dillon, MT 59725

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 14005 Based on interview and record review, the facility failed to address the timely completion or implementation of treatment wishes, specifically related to the Provider Orders for Life-Sustaining Treatment (POLST) forms, and ensure the forms were complete so the document would not be voided, for 3 (#s 9, 16, and 20) and failed to ensure a resident's code status was consistently correct for 1 (#22) of 17 sampled residents. Findings include: 1. Review of resident #9's care plan showed the resident was admitted on [DATE]. Review of resident #9's POLST (Physician Orders for Life-Sustaining Treatment) showed the form did not have a printed name, signature, or date in the mandatory section identifying the person making the decision for life sustaining treatment. The POLST form was signed by a physician on [DATE], without verification of who was making life sustaining choices for resident #9. Resident #9's POLST showed the resident was a full code. The lack of the resident's or responsible party's signature may void the form. 2. Review of resident #16's POLST showed the physician did not print their name on the form and did not fill in the mandatory date when the form was signed. Resident #16 signed and dated the form on [DATE]. 3. Review of resident #20's care plan showed the resident was admitted on [DATE]. Review of resident #20's POLST showed the resident wished to have no CPR and for comfort focused treatment. Resident #20 signed the POLST on [DATE] to make those wishes known. The section of the form reflecting the date and person completing the form was blank. The mandatory physician signature and date section on the POLST was blank, therefore, in Montana the form would be invalid. During an interview on [DATE] at 3:31 p.m., with staff members A and I, staff member I stated when the resident was admitted the POLST was completed by the Social Services Supervisor. The Social Services Supervisor would request assistance from a nurse or the Director of Nursing when needed. Staff member I said the POLST was held at the facility and would be signed next time the physician was at the facility. Staff member A said the time lapse for signature could be up to a month time frame. Staff member I said the POLST was considered effective even without a physician signature. Staff member I said there was an audit process as staff member C checked all POLSTs to ensure the forms are complete. Staff member A said the process had recently changed and the admission staff person would be taking over this process. Staff member A said the admission person was a nurse and will be able to assist residents and their families. (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 - Some	46400 4. Review of resident #22's POLST, dated [DATE], showed the patient had elected and signed a DNR status. Review of resident #22's physician orders, dated [DATE], showed the resident was a, full code supported by durable power of attorney for healthcare. Review of an informal document titled, Nursing Report/Tasks, printed daily, and present on all nursing workstations and referenced by staff, showed each resident's room, name, code status, and special tasks or notes. Resident #22 was documented as a DNR on the document. During an interview on [DATE] at 3:56 p.m., staff member B stated resident #22 had just returned from the hospital, and on his admission paperwork the resident representative had selected for him to be a full code. Resident #22's physician stated the resident was not competent to make his own decisions and changed the ordered code status. A request for resident #22's healthcare power of attorney was made on [DATE]. Provided was a document titled, Durable Power of Attorney, dated [DATE]. Review of the document showed the representative was named a financial POA. The document failed to show any instances where healthcare decisions could be made or reversed by the representative who had signed the form. The National Polst document, which provides information related to the POLST forms and required signatures, shows Montana does require a patient and physician signature for a POLST to be valid in the State of Montana. Refer to: https://polst.org/wp-content/uploads/[DATE].02.28-Signature-Requirements-by-State.pdf, for the current state by state listing of signature requirements. The Montana Department of Health and Human Services participates in a POLST program, and on the DPHHS website, provides information related to the POLST forms and process. The website included information such as, the POLST must be, Completed by a health care professional based on patient preferences and medical indications, and: - Provider signature must be a Montana licensed physician, advanced practice registered nurse or physician assistant. - Patient (or legal decision-maker, if patient unable to make medical decisions), must sign to be valid. - Verbal orders are acceptable with follow-up signature by provider in accordance with organization. This information may be located at: https://dphhs.mt.gov/publichealth/emsts/polst.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 14005 Based on interview and record review, the facility failed to report an allegation of residen to resident abuse, as it was not identified as abuse for 2 (#s 47 and 53); and failed to report two injuries of unknown origin for a resident, one of the injuries was a major injury, for 1 (# 10) within 24 hours of the incidents of 17 sampled residents for abuse reporting. Findings include: 1. Review of resident #10's nurse progress notes, dated 4/25/25 at 12:56 a.m., showed, resident continues with fading bruising scattered purple/blue in color to left lower back. Voiced c/o pain to area. Review of nursing progress notes, from 4/18/25 through 5/25/25, showed resident #10 did not have any falls or sustain injuries. The cause of the bruising was unknown and not identified by the facility. During an interview on 5/7/25 at 4:57 p.m., staff member A said she was not aware of any bruising on resident #10. Staff member A said there was no investigation completed into the cause of the bruising of unknown origin, which is reportable to the State Survey Agency. Staff member A said the facility tried to read the progress notes every day, but we were stretched too thin (staff available for the task). Staff member A said she was still investigating to see if more information was available for the bruising. Review of resident #10's nursing notes, dated 5/7/25 at 4:39 p.m., showed, RN walked past resident's room and he was lying on his left side in bed. When RN and CNA met at 100/200 nurses station, yelling out was heard coming from the resident's room. All available staff were called to come to the resident's room for assistance. Vital signs obtained. Neuro checks started. ROM was provided to all extremities. Resident c/o increased pain to LLE with range of motion. Upon transferring him from the floor to his bed resident expressed increased pain to L hip . Review of resident #10's nursing notes, dated 5/7/25 at 7:00 p.m., showed resident #10 sustained a fractured hip. During an interview on 5/8/25 at 7:52 a.m., staff member A said resident #10 fell and fractured his hip. Staff member A said the fall with injury, which was not witnessed, and the resident was an unreliable reporter, but sustained a fractured hip, was not reported to the State Survey Agency as an injury of unknown origin. 2. Review of resident #53's nursing note, dated 3/28/25, showed resident #53 was agitated and threatening physical harm to her roommate, resident #47. The nurse's note showed, according to roommate, the resident had already hit her at this point. This was not witnessed by staff. However, the roommate was laughing and taunting resident #53 despite being reprimanded. The intervention put into place was to remove the roommate. During an interview on 5/6/25 at 2:20 p.m., staff member A said the event on 3/28/25 involving residents #47 and 53 was not abuse. The event was investigated as abuse, and it was determined there was no abuse. Staff member A said the investigation revealed no abuse, so the allegation was not reported. Staff member A said she was not alerted by staff member M when this incident occurred. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/25 at 3:25 p.m., resident #47 said she did not remember if her roommate got physical and hit her, but her roommate did get verbally aggressive, and she was going through her things. Resident #47 said she did not like roommates yelling or going through her property. Review of the State Survey Agency abuse portal did not show the facility reported the incident between resident #53 and her roommate resident #47 on 3/28/25, and did not report the bruise of unknown origin for resident #10 on 4/25/25. Review of the facility's policy titled, Abuse, Neglect and Exploitation Policy undated and taken from the Compliance Store with a 2024 Copyright, showed, alleged violation is a situation or an occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. The abuse policy showed all allegations would be reported to the administrator, to the State Survey Agency, and other required agencies.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41952 Based on interview and record review, the facility failed to ensure the required elements of education, physician and management notifications, and documentation of an AMA discharge, were completed for 1 (#55) of 17 sampled residents. Findings include: Review of a closed record EHR for resident #55 showed discharge on 3/8/25 as AMA. The resident had admitted on [DATE]. Resident #55's care plan did not have discharge planning until 3/5/25. The care plan only showed the resident wished to go back to the community. No other discharge planning was documented. No information on education and the risks was documented for an AMA discharge, other than they could not give him medications, to take with him on discharge. No notifications were in the EHR of the provider being notified. There was no recapitulation of the residents stay from the provider, or documentation of the facility contacting other entities related to the resident leaving AMA due to risks with the discharge. Review of resident #55's discharge evaluation, dated 3/12/25, showed, Resident left facility AMA and had a friend pick him up. Facility was called after a few days and advised resident was looking for placement again. Facility will not accept resident back after leaving AMA. Review of a form titled, Against Medical Advice release form, dated 3/8/25, showed predefined text and signature of the nurse and resident, no second witness signature. A hand written note of, Going to Belgrade. Friend [friends name] coming to pick. He left at 0900 [9:00 a.m.]. [sic] During an interview on 5/8/25 at 11:38 a.m., staff member B stated resident #55 had come to her upset and wanting to leave earlier in the week of his AMA discharge. She stated she educated resident #55 on needing to stay until a safer place was found, due to conversations with family, that his prior living situation was not suitable. She told resident #55 his provider would be there to see him the next week to evaluate the resident and make a plan. Staff contacted her on the day of the resident's AMA, and she directed them to educate and sign the AMA paperwork. Staff member B stated all of the education and contact with family should have been documented. Review of a facility provided policy titled, Transfer and Discharge (including AMA), listed as Copyright 2025 The Compliance Store LLC, showed: 11. Discharge Against Medical Advice (AMA) . b. The resident and family/legal representative should be informed of the risks involved, the benefits of staying at the facility, and the alternatives to both. Under no circumstances will the facility force, pressure, or intimidate a resident into leaving AMA. c. The physician should be notified of the intended AMA discharge and be encouraged to speak with the resident to encourage them to stay at the facility. d. Documentation of this notification should be entered in the nurses' notes by the nursing department . (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Notify Adult Protection Services, or other entity as appropriate, if self-neglect is suspected. Document accordingly.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41952 Based on interview and record review, the facility failed to ensure residents transferring or discharging to the hospital were provided the transfer discharge notice and bedhold for 1 (#3) of 17 sampled residents. Findings include: During an interview on 5/8/25 at 7:57 a.m., staff member A stated the facility did not have the transfer discharge notice for resident #3. Staff member A stated the transfer discharge notices and bedholds were a problem they were working on. Review of resident #3's census showed a hospitalization from [DATE] to 3/4/25. There was no documentation of a transfer discharge notice or bedhold form in the resident's record or provided.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14005 Based on interview and record review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours after admission to reflect the resident's care needs, for 1 (#10) of 17 sampled residents. This increased the risk of staff not providing necessary care and services due to the lack of the baseline care plan. Findings include: Review of resident #10's baseline care plan evaluation showed the resident was admitted on [DATE]. Resident #10's baseline care plan failed to identify the resident's code status. Section F, active diagnoses contributing to the resident's admission were left blank. Resident #10's base line care plan did not identify his risk associated with dementia, weakness, and the use of psychotropic medications. Resident #10's baseline care plan showed the resident had no history of falls. There was no date for completion of the care plan. Section 5. B, on the baseline care plan form, showed a signature and date line for the resident and the representative to sign. This section was blank. Section seven of the care plan showed it was to have a signature, title, and date of the staff completing the care plan. Section seven was blank. During an interview on 5/6/25 at 4:31 p.m., staff member A, I, and Q were present for the interview. Staff member A said the care plan process was an interdisciplinary process that began at the resident's admission. Staff member I said there was an evaluation assessment which was completed by each discipline. Staff member A said this evaluation was the base line care plan. Staff members A, I, and Q were unsure if the baseline care plan assessment sent information to a Kardex or care plan that was accessible by the certified nursing assistants. Staff member Q said the CNAs could always ask the nurse how to take care of the resident. During an interview on 5/7/25 at 8:40 a.m., staff member H said resident #37's base line care plan was not completed because the evaluation was not completed, and there were no staff signatures on the care plan. During an interview on 5/7/25 at 9:08 a.m., staff member K said he was not aware of how to look at the resident's baseline care plan. Staff member K said the only care information available to him was the sheet of paper the DON completed with information about the resident.

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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. 41952 Based on observation, interview, and record review, the facility failed to review and provide the needed ADL assistance for dining for 1 (#3) of 17 sampled residents. Findings Include: During an interview on 5/6/25 at 9:59 a.m., resident #3 was in her room sitting in her wheelchair, and she was clearing her throat and coughing, and stated the facility staff 'don't feed me right.' Resident #3 stated she had a hard time with a regular fork and spoon, and she had tried built up (adaptive) silverware in the past, but they had not been tried in a while. Resident #3 stated she was to get a walled (adaptive plate) plate but it did not always happen. During an observation on 5/7/25 at 12:37 p.m., resident #3 was in the assisted dining room at a table with another resident, and a staff member facing away from resident #3. Resident #3 had a large bowl with a mix of food and dinner roll on top. There were three drinks with straws in double handled sippy cups, without lids. Resident #3 was trying to grab the dinner roll from the bowl and could not get her hand to turn the correct way to grasp the roll. She openly stated to she could not grab it, but no one responded. The dinner roll was not eaten. Resident #3 was observed through the meal attempting to feed herself by holding her right hand steady with her left hand to try to bring a regular spoon to her mouth. Resident #3 was observed only getting two bites of food from the bowl during the meal. Resident #3 was also observed leaning towards the cups on the table, and she was trying to grab the straws with her mouth (as the straws kept moving around) to get a drink, because there were no lids on the cups, to hold the straws in place. During an interview on 5/7/25 at 4:46 p.m., staff member D stated resident #3 used to have a high wall plate, and they had attempted a heavy spoon, but resident #3 needed more assistance so staff were to feed her. When resident #3 came back from her hospitalization she did not have orders for the adaptive equipment, and there had not been any new orders written for adaptive meal equipment. The facility staff had not yet identified and addressed the issue with the resident's struggles when eating to ensure she was able to fully eat and drink at her meals safely. During an observation on 5/8/25 at 9:24 a.m., resident #3's breakfast was left on a table in the assisted dining room. A divided plate with two English muffins, cut in half, two sausage patties cut in chunks, and scrambled eggs, all not eaten, all were left on the plate. There were three sippy cups with straws, with no lids. There was a bowl with a straw that was empty. During an interview on 5/8/25 at 9:32 a.m., staff member R stated the last time therapy worked with resident #3 for meals and eating was before her hospitalization (when she had orders for adaptive equipment) when she was having a lot of behavioral problems and refusing to participate if she did not get her wheelchair back. At the time resident #3 attempted the long utensils, the kind that wrapped around her arm, but the resident did not like them. Resident #3 was to have a walled plate, and sippy cups with the concave lids, with straws. This was because she could not hold the cups. Resident #3 was to be fed by staff due to her decline. Review of resident #3's care plan for ADL self-care performance showed a revision on 1/29/25, with the intervention of, Eating: [Resident #3] needs assist of 1 with eating.

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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. 14005 Based on interview and record review, the facility failed to identify and implement beneficial interventions to prevent further falls for a resident with dementia, limited safety awareness, and who was at risk for falls. The resident used psychotropic medications and the care plan contained only minimal fall interventions and the resident had an unwitnessed fall and had head lacerations. The resident had subsequent falls and sustained a fractured hip for 1 (#10) of 17 sampled residents. Findings include. Review of resident #10's nursing note, dated 4/28/25 at 7:06 p.m., showed: - found resident sitting on his floor at 1700 (5:00 p.m.). Assessed for injury. ROM provided. No pain or discomfort noted. - The nursing note included another fall, within the same note, - .RN went to assist another resident. While walking down the hallway, RN noted blood on the floor and on the door jam of resident's (#10's) room. Resident was laying on this left side in bed. It appears resident is strong enough to get up off the floor on his own. Upon further assessment, resident was noted to have 2 small head lacerations to the back of his head. Resident assessed for further injuries . [sic] Review of resident #10's fall event report, dated 4/28/25, showed the facility investigated the cause of the fall, but did not take into consideration the recent increase in the resident's Ativan dose. Review of resident #10's 5/2025 medication administration record showed a physician's order on 4/17/25, which was to give Ativan 1 mg, given every 24 hours as needed, for anxiety. On 4/28/25, Ativan was ordered every 8 hours. The first routine dose of Ativan was given at approximately 3:00 p.m., on 4/28/25, approximately 2 hours before resident #10 sustained his first fall. Review of resident #10's eINTERACT SBAR summary note, dated 5/6/25 at 1:06 a.m., showed the resident fell due to general weakness. The note did not show the cause, or situation surrounding the fall. Review of resident #10's nursing notes, dated 5/6/25 at 2:32 p.m., showed the resident had increased falls since starting the lorazepam 1 mg every 8 hour dose. Review of resident #10's nursing notes, dated 5/7/25 at 4:39 p.m., showed, RN walked past resident's room and he was lying on his left side in bed. When RN and CNA met at 100/200 nurses station, yelling out was heard coming from the resident's room. All available staff were called to come to the resident's room for assistance. Vital signs obtained. Neuro checks started. ROM was provided to all extremities. Resident c/o increased pain to LLE with range of motion. Upon transferring him from the floor to his bed resident expressed increased pain to L hip . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of resident #10's nursing notes, dated 5/7/25 at 7:00 p.m., showed resident #10 sustained a fractured hip. During an interview on 5/8/25 at 12:07 p.m., staff member B said the Ativan contributed to resident #10's falls, and the medication was not appropriate for him. Staff member B said resident #10 said he was scared, but he wanted company or comfort and didn't need that much Ativan. The Ativan dose decreased on 5/6/25, but was too late to help prevent the last fall that caused resident #10 to sustain a hip fracture. Staff member B said if it wasn't for the psychotropic medication, resident #10 would not have fallen and fractured his hip.

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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. 46400 Based on observation, interview, and record review, the facility failed to accurately monitor a resident's meal intake, feeding abilities, and address suspected scale errors in relation to a resident's severe weight loss, although the weight loss was desireable, for 1 (#22) of 17 sampled residents. Findings include: During an interview on 5/7/25 at 1:00 p.m., NF3 stated resident #22 had been losing weight and was looking a lot thinner. NF3 stated the resident usually ate in the dining room. During an observation on 5/7/25 at 1:08 p.m., resident #22 was lying in bed, wearing only a brief, when his lunch tray was delivered to his room. It was placed on the side table next to his bed and left by the staff member without further setup or assistance provided to the resident. Resident #22 was reaching from a lying position, all the way across the top of his body, to the tray, which was not in front of him, but it was placed on his right side. He struggled to get food onto his utensil from this angle. During an observation on 5/7/25 at 1:36 p.m., resident #22's tray was in the same place with only one potato piece missing. He was sleeping and no longer attempting to feed himself. Review of resident #22's EHR documentation of the meal amount eaten, dated 5/7/25, showed the resident was documented as having eaten 76-100% of the lunch meal, which was contradictory to what was observed by the surveyor. Review of resident #22's EHR documentation of the meal amount eaten, dated 4/29/25 - 5/7/25, showed the resident was marked as eating 76-100% of all his meals during this time span. Review of resident #22's reentry functional abilities and goals assessment, dated 5/6/25, showed resident #22 needed supervision or touching assistance for eating. This assessment was completed after the resident returned from his second hospitalization in two months, and was a change from his previously independent abilities. Review of resident #22's weights, dated December 2024 - May 2025, showed the resident had been steadily losing weight. This represented a 11.59% severe weight loss over three months from February 2025 - current. - 12/6/24, and the resident's weight was 283 lbs. - 12/24/24, and the resident's weight was 283.4 lbs. - 1/18/25, and the resident's weight was 276 lbs. - 2/22/25, and the resident's weight was 271 lbs. - 3/1/25, and the resident's weight was 263 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 4/20/25, and the resident's weight was 262 lbs. - 5/3/25, and the resident's weight was 244 lbs. Review of resident #22's nutrition notes, dated December 2024 - May 2025, showed: - 12/11/24 value 283 . likely in error. Will reweigh to verify correct weight. - 12/30/24 value 283.4 . weight on 12/6 and 12/24 may be in error. - 3/5/25 value 263 . weight on 3/1 may be in error d/t possibly weight discrepancy. Will reweigh to verify correct wt. - 5/6/25 value 244 . wt. on 5/3 likely in error, will reweigh to verify correct wt. The facility failed to address and correct the potential error over a six month period. During an interview on 5/7/25 at 3:15 p.m., staff member O stated resident #22's weight loss was being monitored in the weekly nutrition meetings by both dietary and his physician. Staff member O stated resident #22 had been overweight, and the recent weight loss was desirable for his BMI. Staff member O stated while they did want him to lose weight, they also wanted him to still be eating, so they requested the dietary manager review his meal plates for the documentation of amount eaten to ensure it was accurate.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46400 Based on interview and record review, the facility failed to get immediate physician orders for a resident experiencing chest pain and respiratory concerns, who was three days later sent emergently to the hospital, for 1 (#44) of 17 sampled residents. Findings include: During an interview on 5/7/25 at 12:43 p.m., resident #44 stated he had been recently hospitalized for difficulty with breathing. Review of resident #44's EMR showed he was hospitalized from 4/19/25 - 4/30/25. Review of resident #44's nursing progress notes, dated 4/17/25 - 4/19/25, showed: - 4/17/25 at 5:20 p.m., RT and unit manager expressed concerns about resident c/o CP . phone call placed to [physician call center name] . awaiting call back from Dr. - 4/18/25 at 2:29 a.m., . No new orders at this time . - 4/18/25 at 11:09 a.m., PT notified RT of resident destating down to 86% while on his prescribed 3L [liters] of o2, with little exertion. RT into assess resident and he does continue to have a wet/loose cough and has a pleural rub sounds on his Left side of his lungs. Sats are only 91% on 3L. [sic] - 4/18/25 at 2:40 p.m., [physician call center name] was phone on 4/17/25 for treatment orders for residents. This RN asked for return call and or CXR. No follow up phone call . [sic] - Review of the resident's physician orders showed 19 hours after the initial concern with chest pain was noted, orders for steroids and breathing treatments were entered into the EHR. - 4/19/25 at 9:40 a.m., res, c/o SOB and chest discomfort, having difficulty breathing and speaking . ambulance called for transfer. Review of resident #44's oxygen saturation documentation showed it fell to 79% while on oxygen via nasal cannula on 4/19/25, the day he was sent to the hospital. Review of resident #44's hospital notes, dated 4/19/25 - 4/30/25, showed, . presents from skilled nursing facility with 3 days of difficulty breathing, cough, upper abdominal discomfort, and chest discomfort. Patient is very hard of hearing and currently on BIPAP for acute on chronic hypoxic respiratory failure . Review of resident #44's discharge summary, dated 4/30/25, showed for hospital course: - Acute on chronic hypoxic respiratory failure, - Coronary artery disease had troponin leak on admission suspect demand ischemia in the setting of hypoxic respiratory failure. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/25 at 2:53 p.m., staff member B stated if they called the physician close to or after 5:00 p.m., they would either not get an answer or be told to call the on-call provider. During an interview on 5/8/25 at 10:54 a.m., staff member N stated they had been concerned with resident #44's complaints of chest pain, and that it could have been a cardiac issue or a pleural effusion. Staff member N stated they were communicating these concerns but felt the information, just kind of sat there. The resident was transferred to the hospital several days later, which was on the weekend.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41952 Based on observation, interview, and record review, the facility failed to provide effective pain management and monitoring for a resident which resulted in her getting more medication than prescribed for 1 (#35) of 17 sampled residents. Findings include: During an observation and interview, on 5/7/25 at 2:48 p.m., staff member K provided the current narcotics log book from the cart. The narcotics log book only had nine total fentanyl patches entered into the log for resident #35, two documented as given on 4/25/25 and 4/27/25, and there was documentation of a destruction date of 5/4/25 for seven fentanyl patches. Staff member K stated he was not the person to ask any specific questions due to being new, and he had not had training for the facility's specific medication management process. He was going off what he had done in prior positions. During an interview on 5/8/25 at 11:38 a.m., staff member B stated resident #35 was having complaints of pain being unmanaged, so the provider was notified, who then discontinued all the resident's Norco and switched the resident to a fentanyl patch. The dose was 12 mcg every 72 hours. Resident #35 complained the new patch was not working. A one-time additional patch was ordered of 12 mcg the next day, for 72 hours. Staff member B stated the first patch was taken from the facility emergency kit, and the nurse on the floor added it to the narcotics log. The next day, the second fentanyl patch was placed as a one-time order from the patches delivered for the resident. Staff member B stated it would now be part of the process for nurses to visibly check the patch placement on anyone with a patch because a medication aide did not take the second patch off resident #35. Resident #35 then got another fentanyl patch and also switched to hydrocodone. Staff member B stated she did not know how the medication was switched again but resident #35's family was a nurse and heavily suggested changes. Review of resident #35's April 2025 MAR showed: -Hydrocodone/Acetaminophen Oral Tablet 5-325 MG give one tablet by mouth five times a day for pain 12/30/24 to 4/24/25. Given five times a day 4/1/25 - 4/23/25, and 4/24/25 given 3 times a day. -fentanyl Transdermal Patch 72 hour 12 MCG/hr apply every 72 hours for pain with a start date of 4/24/25 to 4/28/25. Documented as given on 4/24/25 to the rear left shoulder and 4/27/25 rear left shoulder. There were no orders or documentation in place to ensure the fentanyl patch was in place for the duration of the order, and the resident had no reaction and it was effective, or removed at the ordered times. -fentanyl Transdermal Patch 72 hour 12 MCG/hr apply transdermally one time only for pain until 4/28/25 with a start date of 4/25/25 and discontinue of 4/28/25. Given on 4/25/25 to the right rear shoulder. There were no orders or documentation to ensure the fentanyl patch was in place for the duration of the order, that the resident had no reaction and if it was effective, or removed at the ordered times. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Tylenol Oral Tablet 325 MG (Acetaminophen) give two tablets by mouth every 4 hours as needed for pain do not exceed 3 grams in 24hrs ordered from 4/25/25 to 5/4/25 given nine times, five of those times on 4/26/25, exceeding the 3 grams limit on the order. -Hydrocodone/Acetaminophen Oral Tablet 10-325 MG give one tablet by mouth every 6 hours as needed for pain from 4/28/25 - 5/4/25. This was documented as given twice on 4/30/25 for a pain level of 4 each time. Review of resident #35's May 2025 MAR from 5/1/25-5/6/25 showed: - Tylenol Oral Tablet 325 MG (Acetaminophen) give two tablet by mouth every 4 hours as needed for pain do not exceed 3 grams in 24hrs, not given. - Hydrocodone-Acetaminophen Oral Tablet 10-325 MG give one tablet by mouth every 6 hours as needed for Pain, with a start date of 4/28/25, which was held on 5/2/25 and 5/3/25, with a discontinue date of 5/4/25. This was given twice on 5/1/25 and once on 5/4/25. - Hydrocodone-Acetaminophen Oral Tablet 5-325 MG give one tablet by mouth every 6 hours, as needed for pain, with a start date of 5/4/25. This was given once on 5/4 and 5/6, and twice on 5/5/25. Review of resident #35's nursing progress notes, from 4/25/25 - 5/6/25, showed she was progressively getting more lethargic, unable to swallow, unarousable, and cold to the touch. Resident #35 was sent to theER on [DATE] and 5/3/25, after pain medications were held, and she was still declining. Resident #35 was also completing a round of antibiotics for a UTI. The 5/2/25 ER visit was noted to show the hospital determined resident #35 most likely had a 'reaction to medication' and recommended decreasing her pain medications to the original dose.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 14005 Based on interview and record review, the facility failed to ensure a licensed pharmacist sufficiently addressed and documented the monthly medication regimen reviews for 1 (#10) of 17 sampled residents, and the resident received medications for anxiety and depression which fell into the classification of a psychotropics per CMS; and failed to complete the monthly medication regimen reviews with recommendations to ensure residents were provided the appropriate medications and doses to treat their diagnoses, for 4 (#s 3, 22, 24, and 35) of 17 sampled residents. Findings include: 1. Review of resident #10's medication administration record for May 2025 showed the following: - Olanzapine, an atypical antipsychotic, 2.5 mg by mouth, every day, which was ordered on 7/11/24. - Ativan, an benzodiazapine, 1 mg by mouth, every 24 hours as needed, which was ordered on 4/17/25 and discontinued on 4/28/25. - Ativan 1 mg by mouth, every eight hours, was ordered 4/28/25. - Buspirone, an anxiolytic, 5 mg three times a day, for anxiety, which was ordered on 8/16/24, - Escitalopram, an antidepressant, 20mg daily, for anxiety and depression, was ordered 12/21/24. A request was made on 5/6/25 for the facility's gradual dose reduction requests for resident #10 for one year, but the GDR's were not received by the end of the survey. Review of the facility's Monthly Medication Reviews, for resident #10, dated May 7, 2025, showed a form that included: - Note to attending physician/prescriber. The pharmacy identified the resident as taking: Lexapro (Escitalopram), Buspar (Buspirone) and olanzapine. The pharmacy did not identify the Ativan on the document. The pharmacy requested a gradual dose reduction, or a risk versus benefit analysis or rationale, for recommendations. The physician checked a box showing the GDR was clinically contraindicated, and the continued use was in accordance with the current standard of practice. A GDR attempt was likely to impair the individual's function. There was no documentation to identify what function would be impaired for the resident. There were no risks versus benefits for the medication(s) addressed for resident #10. Resident #10 had been on Buspar for nine months with no gradual dose reductions attempted. The physician signed a declination on 4/21/25, without documenting why resident #10 needed to continue taking the psychotropic medications. During an interview on 5/8/25 at 12:07 p.m., staff member B said the Ativan contributed to resident #10's falls, and the medication was not appropriate for him. Staff member B said resident #10 said he was scared, but he wanted company or comfort and didn't need that much Ativan. The Ativan dose decreased on 5/6/25, but it was too late to help prevent the last fall that caused his hip fracture. Staff member B said if it was not for the psychotropic medication, resident #10 would not have fallen and fractured his hip. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the State Operations Manual, Appendix PP, shows: A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. 41952 2. A request was made on 5/6/25 for monthly pharmacist reviews for the last year for resident #'s 3, 24, and 35. The monthly pharmacist medication regimen reviews were not provided by the end of the survey for the three residents. During an interview on 5/8/25 at 7:33 a.m., staff member A stated the facility was having issues with the prior pharmacy locking them out of the system utilized and not providing the information, including pharmacy reviews, and recommendations. They had no historical documentation to provide. Staff member A stated the facility started with a new pharmacy provider 4/1/25 and were still working things out. a. Review of resident #3's current physician orders showed: - Duloxetine HCL delayed release particles 60 mg, one time a day for depression, with a start date of 3/1/25. - Mirtazapine 30 mg at bedtime, for depression, with a start date of 2/28/25. - Depakote delayed release 500 mg two times a day, for aggression, with a start date of 2/28/25 - Hydroxyzine 25 mg as needed every 8 hours for itching with a start date of 2/28/25 b. Review of resident #24's current physician orders showed: - Fluoxetine HCL oral tablet 40 mg for major depressive disorder with a start date of 1/25/25 - Zyprexa Oral tablet 10 mg at bedtime for paranoid delusional disorder with a start date of 1/21/25 - Zyprexa oral tablet 2.5 mg one time a day for paranoid delusional disorder with a start date of 1/22/25 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Depakote Sprinkles delayed release 125 mg give two capsules by mouth three times a day for mood stabilizer with a start date of 1/21/25 c. Review of resident #35's current physician orders showed: - Duloxetine HCL delayed release sprinkles 60 mg one capsule one time a day for depression with a start date of 12/31/24 - Buspirone HCL 5 mg one tablet two times a day for depression with a start date of 3/4/25 46400 d. A request was made on 5/6/25 for all monthly pharmacist medication reviews for the last four months for resident #22. Nothing was received by the end of the survey. During an interview on 5/7/25 at 2:40 p.m., staff member B stated [Pharmacy Provider] had been with the facility until March 31 (2025), before the contract was terminated, and a new provider sought. Staff member B stated they were unable to access any of the past reviews.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 46400 Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 (#12) of 17 sampled residents. Findings include: Review of resident #12's nursing progress note, dated 2/25/25, showed the resident had been more confused, including not knowing who her husband was, and putting jelly on her omelet at mealtime. The med tech noticed the resident had two 50mcg Fentanyl patches on. Review of resident #12's medication administration record, February 2025, showed the following orders: 1. fentanyl patch 72-hour 25mcg/hr. apply 2 patch transdermally every 72 hours related to pain . place patches onto the skin Q 72 hours as needed (in the event that 50mcg patches are not available to dispense). - This order was only documented as given on February 22, 2025. All other opportunities were marked as n/a. 2. fentanyl patch 72-hour 50mcg/hr. apply 1 patch transdermally every 72 hours for chronic bilateral lower back pain. During an interview on 5/8/25 at 10:27 a.m., staff member B stated they had put the medication orders in with the expectation the order for two 25mcg patches was understood to only be used if the original 50mcg patches [referenced in the second order] were out of stock. Staff member B stated they knew someone was going to mess it up. Staff member B stated the nurse who made the med error was no longer passing medications and had received education.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46400 Based on observation, and interview, the facility licensed staff failed to ensure the medication carts were secured and locked when the carts were unattended. This failure increased the risk of drug diversion, or the medication may be taken by a resident as packets of pills were hanging from a cart. This failure could affect any resident at the facility who had medications stored in the unsecured carts. During an observation on 5/6/25 at 5:00 p.m., the med cart in front of the main nursing desk was unlocked. During an observation on 5/7/25 at 8:57 a.m., the med cart in the dining room was unlocked. The nurse was away from the cart giving medications, with the cart behind a pillar, out of sight. During an observation on 5/7/25 at 8:59 a.m., there was a med cart on the 100-hallway unlocked, with the top drawer open, Pill packets were hanging out. There were no staff in the hallway. During an observation on 5/7/25 at 2:04 p.m., two of four medication carts were unlocked with no staff present. During an observation and interview on 5/7/25 at 2:43 p.m., the 300/400 hall medication cart was unlocked while the nurse was behind the nurses station. Staff member K was asked to show the narcotics log book, and he asked if he could grab a controlled medication out first to document. Staff member K opened the unlocked cart, and he unlocked the controlled substance drawer. Staff member K then documented a controlled medication in the narcotics log book, and then handed the narcotics log book to the surveyor to review. Staff member K asked if the surveyor could watch the open cart and controlled medication drawer for a minute to give the controlled medication. The surveyor requested staff member K lock the cart and controlled substance drawer prior to leaving the cart to take care of the medication administration.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 14005 Based on interview and record review, the facility failed to ensure the medical director effectively coordinated medical care for 1 (#20) of 17 sampled residents. The medical director was not responsive to the nursing staff when direction was needed regarding resident care issues. The medical director was also an attending physician for numerous residents in the facility. There was no process to ensure there were no concerns with the individuals' performance as a physician. The facility failed to have a process for how to address concerns with the medical directors' care of residents. This deficient practice had the potential to affect all residents residing in the facility. Findings include: During an interview on 5/6/25 at 9:39 a.m., resident #20 said he had a bad headache, and he was sick to his stomach all day, yesterday. Resident #20 said he still had a headache and was tired. Review of resident #20's vital signs from 5/6/25, showed the resident's pulse was 45 beats per minute at 11:57 a.m. Review of resident #20's vital signs from 5/1/25 through 5/7/25 showed resident #20's pulse was as low as 44 beats per minute. Resident #20's pulse documentation showed 5/7/25 the resident was exhibiting symptoms of bradycardia, with a pulse below 50 beats per minute. During an interview on 5/7/25 at 2:21 p.m., staff member B said the medical director came to the facility on ce per month, but she was primary physician for many of the residents. Staff member B said you could call the medical director's clinic in Texas, but you did not talk to the same person very often. Staff member B said the calls made to the medical director concerning a residents' medical condition were not always addressed timely and the facility may not get a return call for several days. Staff member B said she called the medical director on 5/6/25, and again today, regarding resident #20's slow pulse. Staff member B said she was only able to leave a message, and the physician had not called back to address the slow pulse. Staff member B said with the medical director not being from here, the residents do not get the care they need. Staff member B said the medical director's practice had a nurse practitioner on staff, but if the time was close to 5:00 p.m., she sends a response back in all capital letters to call the call center and leave a message. Review of resident #20's nurses notes from 5/7/25, showed resident #20 went to the local emergency room and was provided care. Resident #20 returned on an antibiotic for a urinary tract infection, an order to stop the Metoprolol, and an order to see a cardiologist. During an interview on 5/8/25 at 9:45 a.m., staff member A said the facility was aware of the concerns with the medical director.

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 14005 Based on interview and record review, the facility failed to have an antibiotic stewardship program, which had the potential to affect all residents who received antibiotics in the facility. The facility failed to ensure the pharmacy delivered medications and completed monthly drug regimen reviews for all residents from May 2024 through April 2025. The facility failed to ensure a current QAPI (Quality Assurance and Performance Improvement) plan was developed. The QAPI plan had not been reviewed and revised for more than two years. Goal dates on the Quality Assurance & Performance Improvement (QAPI) Plan for the facility were documented as 12/1/2022. Findings include: During an interview on 5/7/25 at 1:40 p.m., staff member A said the facility used [Pharmacy Name] for their resident medications, and their drug regimen reviews. Staff member A said the facility was not getting the medications as ordered and needed. Staff member A said the staff would hurry to the local store at the end of the day to try to get medications not available by the pharmacy. Staff member A said the drug regimen reviews were coming through a portal the facility could not access. The facility continued to use that pharmacy until another pharmacy could be contracted with. The facility was not able to get drug regimen reviews from the pharmacy and no gradual dose reductions were completed for any psychotropic medications from 4/2024 through 4/2025. During an interview on 5/8/25 at 9:00 a.m., staff member A said the past infection preventionist was not completing the required job duties. Staff member A said the facility does not have anyone certified as the infection preventionist at the time of the survey. Staff member A said a new nurse had been hired, but the nurse was not certified in infection prevention. The nurse hired as the infection preventionist had worked some shifts and was currently taking the infection preventionist training to become certified. Staff member A said QAPI activities were based on survey citations, grievances, and firsthand observations made by the QAPI team. Staff member A stated the facility was working on hiring and training, and had a plan to recruit and retain facility hired staff, in an attempt to get away from interim agency staff. The QAPI plan had 12/1/2022 as a goal date for the facility to reduce turnover from 50 percent to 20 percent by 12/1/2022. Staff member A said staff member B had worked 11 days in a row without a day off.

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	275124	A. Building B. Wing	05/08/2025

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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. 46400 Based on observation, interview, and record review the facility failed to ensure staff followed hand hygiene during medication pass; and failed to implement enhanced barrier precautions and signage for 2 (#s 21 and 44) of 17 sampled residents. Findings include: 1. During an observation on 5/6/25 at 7:30 a.m., staff member P was working with one med cart. Staff member P passed medications, including an insulin injection, without performing hand hygiene before or after the medication administration task. During an observation on 5/6/25 at 7:45 a.m., staff member K did not perform hand hygiene prior to or after a resident's medication administration. 2. During an observation on 5/6/25 at 11:45 a.m., resident #21 was hooked up to a wound vac for an Unstageable wound. There was no signage or supplies showing staff should follow enhanced barrier precautions. Review of resident #44's physician orders, dated 4/30/25, showed, Enhanced barrier precautions. During an observation on 5/6/25 at 3:21 p.m., there was no signage or supplies on resident #44's door showing staff should follow enhanced barrier precautions. During an interview on 5/6/25 at 4:04 p.m., staff member N stated if there was no sign detailing what type of precautions the resident was on, they would just wear all of the PPE supplied on the door cart. During an interview on 5/7/25 at 8:28 a.m., staff member B stated resident #21 should be on enhanced barrier precautions related to his wound. Staff member B stated resident #44's wound had healed.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 41952 Based on interview and record review, the facility failed to use antibiotics in accordance with accepted standards, identify a residents potential colonization of a specific organism causing the resident to be on almost continuous antibiotics for several months, gave two different antibiotics at the same time for the same UTI, and the resident contracted Clostridium difficile for 1 (#35) of 17 sampled residents. Findings include: During an interview on 5/8/25 at 11:44 a.m., staff member B stated resident #35 was on Macrobid antibiotic for sinusitis, currently. Staff member B stated the facility did not administer antibiotics without receiving the culture and sensitivity back for any resident. Staff member B stated the former infection preventionist did not do infection tracking as they should, and the facility did not have an infection preventionist at the time of the survey. Staff member B was unaware of resident #35 being on two different antibiotics at the same time for the same UTI. Review of resident #35's MARs, from 2/1/25 to 5/8/25, showed the following antibiotics were used: February 2025 - Bactrim DS Oral Tablet 800-160 MG, Give 1 tablet by mouth two times a day related to UTI for 7 days, until finished, with a start date of 2/23/25. It was given once on 2/23/25, then given twice a day 2/24/25 through 3/2/25, and once on 3/3/25. March 2025 - Vancomycin HCL Oral Capsule 125 MG, Give by mouth four times a day for C-Diff infections until 3/23/25, with a start date of 3/13/25. Documented as given twice on 3/13/25 and four times a day on 3/14/25 - 3/23/25. April 2025 - Bactrim DS Oral Tablet 800-160 MG, Give 1 tablet by mouth two times a day for UTI for 7 days, with start Date 4/4/25, and discontinue date 4/9/25, which was given once on 4/4/25 and 4/9, and twice 4/5 - 4/8/25. - At the same time, Ciproflaxin HCL Oral Tablet, 500 MG, by mouth two times a day, for UTI, were taken until 4/11/25. The start date of 4/4/25, and there was a discontinue date of 4/9/25. This medication was given once on 4/4 and 4/9/25, and twice on 4/5/25 - 4/8/25. There was no documentation for the rationale for discontinuing the ciproflaxin before the course was completed and switching to macrobid. - Macrobid Oral Capsule 100 MG, by mouth two times a day, for UTI, for 7 days until finished, with a start date of 4/9/25, and this was given once on 4/9/25 and twice 4/10/25 - 4/16/25. - Macrobid Oral Capsule, 100 MG, by mouth two times a day for UTI, for 7 days until finished, with a start date of 4/25/25, and this was given once on 4/25/25 and twice 4/26/25 - 5/2/25. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	May 2025 - Cefdinir Oral Capsule, 300 MG, Give 1 capsule by mouth two times a day for Sinusitis, for 14 days, and the order showed it may wait until the medication arrives from pharmacy to begin administration with a start date of 5/5/25. Review of resident #35's lab results, from 2/23/25 to 5/8/25, showed she was tested for a UTI multiple times, and they all came back as positive for Escherichia coli (e. coli)/Extended Spectrum Beta Lactamase (ESBL). Resident #35 was also was positive for Clostridium difficile on 3/15/25, and after returning from the ER visit on 5/3/25, with an order for antibiotics for sinusitis to start on 5/5/25.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 46400 Based on interview and record review, the facility failed to have a designated infection preventionist for the facility. This deficient practice had the potential to affect all residents in the facility. Findings include: Review of the requested entrance conference materials failed to show an infection preventionist certificate or person responsible for the infection control program in the facility. During an interview on 5/8/25 at 12:04 p.m., staff member A stated there was not a current staff member possessing an infection preventionist certification. Staff member A stated the previous infection preventionist was no longer at the facility, and the new hire was just finishing up infection preventionist training.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 14005 Based on interview and record review, it was identified the facility abuse education was not adequate to ensure administrative staff had necessary knowledge related to identification of abuse allegations, for a resident who had cognitive deficits, and management of the events for future prevention, for 2 (#s 10 and 53) of 17 sampled residents. Findings include: 1. Review of resident #10's nursing progress notes, dated 4/25/25 at 12:56 a.m., showed the resident had scattered bruising, that was healing, on his left lower back, and the resident had pain with the bruising. A review of nurses notes from 4/18/25 through 5/25/25 showed resident #10 did not have any falls or sustain any injuries. During an interview on 5/7/25 at 4:57 p.m., staff member A said there was no investigation completed into the cause of the bruising and she was still investigating to see if more information was available. Staff member A said she was not notified of bruising to resident #10's lower back. 2. Review of resident #53's nurse's note, dated 3/28/25, showed resident #53 was agitated and threatening physical harm to her roommate, #47. The nurse's note showed the resident hit the room mate, which was not witnessed, but the room mate was laughing and taunting the other resident. During an interview on 5/6/25 at 2:20 p.m., staff member A said the event on 3/28/25 involving resident #53 was not abuse. The event was investigated as abuse, and it was determined there was no abuse, even though a resident was hit by the other. The allegation was not reported. Staff member M did not report the abuse between the two residents appropriately. During an interview on 5/7/25 at 7:52 a.m., staff member A said staff member M had not had abuse training from the facility and she was unsure what abuse training the staffing agency provided for their staff. Review of Abuse/Neglect In-Service Acknowledgement showed the abuse coordinator to be staff member A. A form labeled Abuse/Neglect Competencies showed staff member A signed her training on 3/10/25 and the instructor training her was staff member I. An in-service training log was signed and dated 3/19/25 by staff member A. The trainer was identified on that form as staff member H. There was no documentation to show staff member H was competent to teach about abuse and neglect. The list showing the staff members that attended the training was not dated. Staff member A said all staff took the competency test and the test was reviewed by staff member A. Review of the facility's policy titled, Abuse, Neglect and Exploitation Policy undated and taken from the Compliance Store with a 2024 Copyright, showed, an alleged violation is a situation or an occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. The policy showed the allegation of abuse will be reported to the Administrator, state agency and other required agencies.