STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295041	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens of Green Valley	100 Delmar Gardens Drive Henderson, NV 89074

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on observation, interview, and document review, the facility failed to ensure residents have a right to make choices about aspects of their life in the facility which are significant to the resident for 1 of 35 sampled residents and 3 unsampled residents (Residents #126, 14, 118 and 41). The failure to accommodate the residents' preferences and choices had the potential risk to cause psychosocial distress to the residents. Findings include: The facility is located off a minor street which leads to an entrance to the facility parking lot where the facility has a large, covered portico which joins a large wrap around porch area before the entrance to the facility. In this porch area before the facility's main entrance are numerous park benches to sit and enjoy the quiet view of the front flower garden of the facility. Resident 126 (R126) R126 was admitted to the facility on [DATE] with diagnosis of hypertension and chronic kidney disease. R126 had a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. R126 had an Elopement Risk Evaluation completed which revealed the resident was not at risk for eloping from the facility. On 09/25/2024 in the afternoon, R126 stated R126 was easy going person. R126 stated would like one thing to be changed so the residents would be allowed to go out and sit in the front porch area of the building. R126 compared the facility to being in a prison. R126 stated has degrees in mining and air conditioning and yet still must ask at the reception desk to be let outside to which the receptionist says no you can't go out front without a chaperone. Resident 14 (R14) R14 was last admitted to the facility on [DATE] with diagnosis of cerebral palsy and atherosclerotic heart disease. R1 had a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. R1 had an Elopement Risk Evaluation completed which revealed the resident was not at risk for eloping from the facility. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the Resident Council Meeting on 09/25/2024 at 1:00pm, R1 stated the residents were not permitted to go outside in the front of the building. Residents had been instructed had to go to the gazebo area in the courtyard. This is also the smoking area. No facility rationale was offered to the resident. Resident 118 (R118) R118 was last admitted to the facility on [DATE] with diagnosis of cellulitis and myelodysplastic syndrome. R2 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. R2 had an Elopement Risk Evaluation completed which revealed the resident was not at risk for eloping from the facility. During the Resident Council Meeting on 09/25/2024 at 1:00pm, R2 stated residents were not permitted to go outside in the front of the building. Residents had been instructed had to go to the gazebo area in the courtyard. This is also the smoking area. No facility rationale was offered to the resident. Resident 41 (R41) R41 was last admitted to the facility on [DATE] with diagnosis of type 2 diabetes mellitus with diabetic neuropathy and atherosclerotic heart disease. R3 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. R3 had an Elopement Risk Evaluation completed which revealed the resident was not at risk for eloping from the facility. During the Resident Council Meeting on 09/25/2024 at 1:00pm, R3 stated the residents were not permitted to go outside in the front of the building. Residents had been instructed had to go to the gazebo area in the courtyard. This is also the smoking area. No facility rationale was offered to the residents. On 09/25/2024 at 3:33 pm. the receptionist stated if a resident comes to the desk and wants to go outside in the front of the building, the resident must be accompanied by a staff member or a family member. If the resident does not have a staff member or a family member with them, staff would redirect the resident to the gazebo area in the courtyard. The receptionist explained can also try to find a staff member for the residents if one is available. On 09/26/2024 in the afternoon, observed R126 ask the receptionist if it would be possible to go out to sit in the front. The receptionist advised the resident without a staff person to accompany them, the resident would have to go out to the gazebo in the courtyard. The resident was not given the option of the facility finding a staff person to go with them. On 09/25/2024 at 2:35 pm, the Administrator stated would want a family member or staff member to accompany the resident. The administrator explained the facility has protective oversite of the residents in the facility and this administrator would not be comfortable allowing residents to go out in front of the facility without someone accompanying them. The Administrator stated this Administrator would be more comfortable if the Inter-disciplinary team met, and the team agreed it was okay for the resident to go out in front of the building unaccompanied. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/26/2024 at 8:40 am, the Social Services Director (SSD) stated if a resident wants to go outside to sit out front of the building, the resident would need to have staff, or a family member accompany them, even if the resident had a higher BIMS score and an Elopement Assessment indicating no elopement risk. The SSD explained the residents here can choose for themselves within reason. The SSD also explained the facility has protective oversite, which is the safety of the residents in all situations, at the facility where the weight of safety may outweigh the resident's self-determination. The SSD also stated it would not surprise this SSD some residents say this facility is a prison because some residents have told this SSD this same thing. The Administrator revealed the facility had no policy restricting the residents from going out the front door to sit in the front porch area, nor did the facility have a policy requiring the residents to have a chaperone to access the front porch area to sit on the benches. In reviewing the Resident Rights Document (regarding dignity, self-determination, and freedom of choice) located within the Admissions Packet, the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The resident has the right to be treated like an individual and assisted in getting the most out of the programs and services they offer. The residents have the right to surroundings which are safe, clean, comfortable, and homelike. Lastly, the residents have the right to make independent and informed decisions regarding their health and wellbeing.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review and document review, the facility failed to ensure assessments were accurate, specifically for vision, hearing, and functional status impacting activities of daily living for 1 of 35 sampled residents (Resident 96). The deficient practice potentially deprived the resident of a person-centered plan of care ensuring the resident received adequate level of assistance with care needs. Findings include: Resident 96 (R96) R96 was admitted on [DATE] and readmitted on [DATE], with diagnoses including chronic vision loss, chronic hearing loss, Parkinson's disease and weakness. On 09/24/2024 at 8:38 AM, R96 laid in bed with eyes opened, an untouched breakfast tray was in front of the resident. After introduction, R96 requested surveyor to come closer and speak louder due to difficulty hearing. As the surveyor walked around the resident's bed to come closer to left side, the resident maintained frontal gaze and did not follow the surveyor's movement. R96 asked surveyor if breakfast had been served? The surveyor responded, it's right in front of you. The resident explained being blind and needed help with meals. The resident's meal ticket did not document R96 needed assistance with meals and there were no staff members in the room to help R96 with breakfast. On 09/24/2024 at 8:40 AM, a Certified Nursing Assistant (CNA) entered the room and responded to R96's request for assistance with breakfast. After consuming 25 percent (%) to 50% of the meal, the CNA verbalized R96 required full assistance with meals but this was not reflected in the resident's meal ticket. The CNA indicated not being steadily assigned to R96 and the CNA was not advised to provide R96 with one-on-one (1:1) feeding assistance. The annual minimum data set (MDS) dated [DATE], documented R96 had adequate vision. Adequate vision was defined as being able to see in fine detail, such as regular print in newspaper and books. The quarterly MDS dated [DATE], documented R96 had adequate vision and adequate hearing. Adequate hearing was defined as having no difficulty in normal conversation, social interaction and listening to the television. R96 required set-up or clean up assistance with eating defined as helper sets up and cleans up while resident completed the activity with helper assisting only prior to and following the activity. A hospital discharge summary dated 06/07/2024, documented R96 was clinically blind with chronic hearing loss and was transferred to the hospital on 06/05/2024 due to poor oral intake and generalized weakness. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/25/2024 at 12:16 PM, the Licensed Practical Nurse (LPN) steadily assigned to R96, indicated the resident was blind being able to see only shadows. The LPN indicated the resident was hard of hearing and one would have to come very close to the resident and speak in a loud voice to converse with R96. The LPN explained the resident used to be able to read with eyeglasses and magnifying lens when first admitted in 2021 and would dine with late spouse in the main dining room. The LPN reviewed R96's MDS assessments and verbalized the assessments were not accurate since R96 had been clinically blind since last year, had always been hard of hearing and had been totally dependent on staff for ADLs since the death of spouse in February 2024. The LPN indicated MDS nurses were required to lay eyes on the resident and interview direct care staff when completing assessments. The LPN emphasized the MDS Coordinator who completed R96's assessment most likely did not visit with R96 and did not interview the LPN who was R96's primary nurse. On 09/25/2024 at 2:09 PM, the MDS Coordinator confirmed completing R96's annual assessment in November 2023 and the most recent quarterly assessment in August 2024. The MDS Coordinator explained when a resident's assessment was coming due, the MDS nurse would get information required to complete the resident assessments. Depending on the section being completed, the MDS nurse verbalized needing to meet with the resident, interview direct care staff and review medical record. The MDS Coordinator emphasized the importance of accurate assessments since it drove the resident's plan of care. The MDS Coordinator could not recall when a visit with R96 occurred or could not identify which nurse was interviewed regarding R96. The MDS Coordinator indicated not being aware R96 was blind, hard of hearing and totally dependent on staff for activities of daily living (ADLs). The MDS Coordinator explained being responsible for the MDS assessments of many residents and the inaccurate entries made to R96's assessments, particularly, vision, hearing and functional status for ADLs was a mere oversight. On 09/25/2024 at 3:49 PM, the Director of Nursing (DON) indicated being familiar with R96 who resided in the facility with late spouse since 2021. The DON indicated R96 used to be able to read with eyeglasses and magnifying lens, but the resident's vision loss continued to progress, and the resident was now currently blind. The DON indicated R96 had always been hard of hearing, and one would have to come closer and speak louder to converse with R96. The DON explained R96 had started to decline after the death of spouse in February 2024. The DON reviewed R96's MDS assessments and confirmed the entries were inaccurate particularly with vision, hearing and functional status related to ADLs. On 09/25/2024 at 4:00 PM, the DON indicated MDS nurses were expected to gather information by visiting with the resident and/or family, interviewing direct care staff and reviewing medical record. The DON verbalized it was likely the MDS Coordinator did not pay R96 a visit when completing the resident's assessment nor interview the resident's primary nurse which should have been done. The DON emphasized the importance of accurate MDS assessments for more appropriate person-centered care plans and to ensure appropriate level of care was provided to residents. On 09/27/2024 at 9:15 AM, R96's family member corroborated the LPN and DON's recollection regarding R96's use of eyeglasses and magnifying lens in the past. However, due to glaucoma and macular degeneration, the resident had been diagnosed by a specialist last year as being completely blind in the left eye and seeing only shadows from the right eye. The family member indicated R96 had always been hard of hearing and started to steadily decline with functional status after the death of late spouse in February 2024. The family member expressed the facility had not made adequate accommodations with the changes in the resident's health status and family requests to provide R96 with meal assistance fell on deaf ears resulting in a 25-pound weight loss and a hospitalization in June 2024. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Center for Medicare/Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual Version 3. 0 dated October 2023, revealed steps for conducting vision assessment (Section B) included: -ask family, caregivers and direct care staff about the resident's vision patterns during the seven-day look back period -ask the resident about visual abilities -test accuracy of your findings by asking the resident to look at regular-size print in a book or newspaper then ask the resident to read aloud. -Code 4, severely impaired if the resident had no vision, sees only light, colors or shapes and does not appear to follow objects with eyes. The CMS RAI Manual Version 3.0 dated October 2023, documented steps in performing hearing assessment included: -interview the resident about hearing function. -observe the resident during verbal interactions. -review the medical record -interview family, direct care staff, activities personnel and speech and hearing specialists. - Code 2, moderate difficulty if speaker has to increase volume and speak distinctly. The CMS RAI Manual Version 3.0 dated October 2023 revealed steps for conducting functional assessment (Section GG). Functional status was based on need for assistance when performing self-care and mobility activities. Steps for assessment included interviewing the resident or their family and reviewing medical records. Code 1 (dependent) if the helper completed the activities for the resident, or the assistance of two helpers was required to complete the activities. Complaint #NV00072063

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418 Based on observation, interview, record review, and document review, the facility failed to complete a Preadmission Screening and Resident Review (PASRR) Level 2 evaluation for displayed behavioral activity or diagnosis for 3 of 35 sampled residents (Resident 99, 135, and 72). The deficient practice had the potential to place residents at risk of not being evaluated for appropriate determination of necessary behavioral health services. Findings include: Resident #99 R99 was admitted on [DATE], with diagnoses including psychosis and bipolar. The PASRR level 1 utilized for R99's admission was dated 09/28/2020, documented diagnoses of dementia and Alzheimer. On 09/24/2024 at 9:30 AM and 09/26/2024 at 10:20 AM, R99 was observed lying in bed with day clothing. R99 was awake and would answer simple questions. R99 was noticed to mumble words to self when not spoken to. R99's care plan problem with a start date of 03/28/2023 documented: Resident is at risk for adverse consequence related to receiving psychotropic medications. - Buspirone and Escitalopram for diagnosis of anxiety and depression. - Depakote for diagnosis of Bipolar. - Quetiapine for diagnosis of psychosis. R99's nursing progress notes documented the following behaviors: - Resident combative and aggressive with difficulty to redirect. Time out of 30 minutes provided by certified nursing aide (CNA) and nurse for delivery of personal care but still unable to redirect resident and unable to provide care. - Resident difficult to redirect and nurse pulled medications, but resident refused. Another nurse tried to give resident medications, but still refused to take medications. - Resident in bed awake, talking to self with nonexistent person in the room the whole night with periods of delusions and confusion. - The resident refused medications, very aggressive. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- During provision of care/ADLs resident was physically combative and verbally aggressive in a way not to comply with procedure. Redirections provided with some effect. Safety of resident guarded high risk for fall. Resident 135 (R135) R135 was admitted on [DATE] with diagnoses including bipolar disorder and schizophrenia. The PASRR level 1 utilized for R135's admission was dated 04/13/2022, documented diagnoses of dementia and Alzheimer. The physician admission note dated 08/08/2024, listed a diagnosis of major neurocognitive disorder with behavioral changes and agitation. Past medical history of schizophrenia, dementia, anxiety and bipolar. R135's nursing progress notes documented the following behaviors: - Continues to walk unit throughout shift will stop to take bites of meal and drink beverages - Resident pushes on exit doors. - Resident redirected away from kissing other residents. - Resident assisted away from kissing and holding hands. - Taking sugar packs putting closed packets in mouth and pocket. - Resident walking around unit entire shift. - Continues to put shoes on and take off continuously. - Redirected away from other patients trays and service area sink throughout the shift. - Exit seeking, pushing on unit doors On 09/26/2024 at 10:03 AM, the Director of social services (SS) indicated the resident was admitted with a diagnosis of Alzheimer's and dementia and the resident does not need to have a PASRR level 2 completed. The Director was not sure if a resident exhibiting behaviors and a psychiatric diagnosis with medication management would require a PASRR level 2. The Director was not aware a PASRR level 2 was to determine if a resident was still suited to be in the facility and if determined to be appropriate, certain recommended interventions will be recommended by the evaluations. The Director indicated the facility does not have a PASRR policy. On 09/26/24 at 10:51 AM, the Director provided one of the sampled resident's (R99) progress note from the previous facility dated 07/27/2021. The progress note documented the resident had a diagnosis of bipolar. The Director was informed the PASRR used for resident's admission was 09/28/2020, and the resident was admitted on [DATE]. The Director acknowledged the presence of psychiatric diagnosis on the resident's medical records and admission PASRR lacked the diagnosis and recommendations. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50289 Resident 72 (R72) R72 was readmitted on [DATE], with diagnoses including schizophrenia, dementia with psychotic disturbance, mental disorder, delirium due to known physiological condition, and anxiety disorder. On 09/24/2024 in the afternoon, R72 was observed sitting in the wheelchair on the patio. During a conversation with R72, the resident made the following statements: there is someone trying to take over my identity. This person's name is [NAME]. But this person lives in Russia. This person is having sex with men all day. This person has been doing this for years already. R72 continued to verbalize can't participate in activities because of the person who is trying to impersonate them. The impersonator was born May 26, 1941. R72 stated the impersonator is trying to kill them by placing drugs around the room. R72 stated the impersonator is trying to give the drugs to them to kill them. A PASARR level one document dated 07/29/2020, revealed R72 did not have dementia, mental illness (MI), intellectual disability, (ID) mental retardation (MR) or any related condition (RC) and was deemed appropriate for nursing facility placement. A review of the patient's medical record revealed R72's schizophrenia was diagnosed on [DATE], anxiety disorder on 08/30/2024, dementia with psychotic disturbance on 12/14/2023, mental disorder not otherwise specified on 12/14/2023, and delirium due to known physiological condition on 04/25/2024. On 09/25/2024 at 09:44 AM, the Admissions staff stated Social Services were who takes care of the PASARR's for residents who are already in the facility. On 09/25/2024 at 10:00 AM, the Social Services Director (SSD) explained Social Services would look for a PASARR 2 when the resident needs more services. The SSD also explained if the Inter-disciplinary team met and concluded the resident needed more services, then Social Services would initiate the PASARR LEVEL 2 PROCESS. The SSD verified should have started the PASARR level 2 process for this resident after resident was admitted . The medical record lacked documented evidence R72 was referred for a PASARR level two screening. Facility's policy titled Behavioral Assessment, Intervention and Monitoring, documented new onsets or changes in behavior which indicate newly evident or possible serious mental disorder, intellectual disability, or a related disorder will be referred for a PASARR Level II evaluation. The Division of Health Care Financing and Policy- Medicaid Services Manual- for Nursing Facilities Policy dated 05/01/2015, documented when an individual has been identified with possible indicators of mental illness, intellectual disabilities or related condition, a PASARR Level II screening must be completed to evaluate the individual and determine if nursing facility services and/or specialized services are needed and can be provided in the nursing facility. Examples include: a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting a presence of a mental disorder (where dementia is not the primary diagnoses), or an intellectual disability or related condition was not previously identified and evaluated through PASARR. Social services would be responsible for keeping track of each resident's PASARR screening status and referring to appropriate authority.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418 Based on observation, interview, record and document review, the facility failed to ensure comprehensive care plans were created for the management of sleep apnea devices for 2 of 35 sampled residents (Resident 64 and 390). The deficient practice had a potential for staff not to provide person centered care for a resident. Findings include: Resident 64 (R64) R64 was admitted on [DATE] with diagnoses including open wound lower back and pelvis and hemiplegia after cerebral infarction. On 09/24/2024 at 1:43 PM, at R64's bedside table was breathing equipment. R64 indicated it was a CPAP (Continuous Positive Airway Pressure) machine (a device that helps treat sleep-related breathing disorders, such as sleep apnea, by keeping airways open while you sleep). R64 indicated using the CPAP at night and self manages the equipment and does the self-application of the nasal mask. R64 indicated bringing the equipment from home upon admission. Physician and nursing progress notes lacked documented evidence R64 was using the breathing apparatus at night to aide breathing status during the duration of sleep. R64 lacked documented evidence a comprehensive care was created for the use, and the care and maintenance of the breathing apparatus. Resident 390 (R390) R390 was admitted on [DATE], with diagnoses including obstructive sleep apnea and amyotrophic lateral sclerosis. On 09/24/24 at 12:01 PM, at R390's bedside table was breathing equipment. R390 indicated it was a BiPAP (Bilevel Positive Airway Pressure) machine (a noninvasive ventilator that helps people breathe by delivering pressurized air into the upper airway). R390 indicated using the BiPAP at night and self manages the equipment and does the self-application of the nasal mask. R390 indicated bringing the equipment from home upon admission. R390 care plan dated 03/17/2023, documented a medical diagnosis of obstructive sleep apnea (adult). Problem: Resident uses BiPAP machine. Target Date: 09/29/2024 (Long Term Goal) Resident will have no respiratory issues and/or complications related to use of BIPAP. The comprehensive care plan lacks any care interventions and the space allotted was left blank. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/26/2024 12:11 PM, the Director of Nursing (DON) reviewed the care plans and confirmed R390's care plan for the use of the BiPAP did not have any care interventions and R64 did not have any care plan for the use of the CPAP machine. The DON indicated residents using respiratory devices should have a care plan indicating the problem, a set goals and care interventions. Care plans were a requirement to ensure care provisions were provided to a resident at an individual approach. The facility policy titled Care Plans, Interdisciplinary revised 05/2021, documented care plans are completed on the resident assessment instrument (RAI) section of the electronic healthcare record.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure a deep tissue injury in a high risk resident was treated, and appropriate interventions were implemented and the weekly skin assessment was completed as scheduled for 1 of 25 sampled residents (R52). This deficient practice had the potential to lead to worsening of the pressure injury, increased risk of infection, delayed healing, further tissue damage, and a higher likelihood of complications such as sepsis or hospitalization . Findings include: Resident 52 (R52) R52 was admitted on [DATE], with diagnoses including diabetes mellitus, urinary tract infection, dysphagia (difficulty swallowing), and gastrostomy. The Braden Scale for Predicting Pressure Sore Risk dated 07/20/2024, documented a score of 10, which indicated a high risk for developing a pressure sore. The Admission Skin assessment dated [DATE], documented R52 had a left heel, old wound. The Care Plan dated 07/14/2024 documented R52 was at risk for skin breakdown/pressure ulcers due to immobility, general weakness, shortness of breath with exertion, oxygen use, acute respiratory failure with hypoxia, acute bronchitis, wheezing, and status post PEG placement (Percutaneous endoscopic gastrostomy [a tube placed through the skin into the stomach for nutrition and hydration]) on 07/11/2024 (prior to admission). The interventions included turning and repositioning, conducting daily systematic skin inspections, providing pressure-reducing devices for the bed and chair, and reporting any signs of skin breakdown (such as soreness, tenderness, redness, or broken skin). The Nursing Progress Notes dated 07/18/2024, documented both heels were assessed with no skin redness. On 09/24/2024 at 11:28 AM, R52 complained of pain in the left heel. R52's heels were not elevated. A Licensed Practical Nurse (LPN) responded to R52's room and confirmed there was skin redness, tenderness, and the presence of a blackish, dime-sized deep tissue injury (DTI) on the left heel with a scab. The LPN explained the CNA was responsible for performing daily skin assessments and reporting any skin concerns to the nurse, who would then notify the wound nurse. The LPN indicated a wound consult would be requested to follow up on R52's left heel DTI. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/24/2024 at 1:00 PM, the Wound Care Treatment Nurse (WCTN) indicated the LPN requested a wound consult for R52 regarding the left heel DTI. The WCTN explained after assessing R52's left heel, a dark skin discoloration on the left heel with 75% (percent) epithelialization and 25% granulation. The WCTN indicated the DTI appeared to be several weeks old and measured 4 x 4 centimeters (cm). The WCTN indicated R52's wound was cleansed with saline, treated with Povidone Iodine, covered with a gauze pad, and secured with rolled gauze. The WCTN indicated both heels should have been elevated while R52 was in bed. The WCTN explained this was the first encounter with R52 and would refer the case to the Wound Nurse Practitioner (WNP) during the weekly rounds on Wednesdays and was scheduled the next day. On 09/24/2024 at 3:03 PM, Certified Nursing Assistant 1 (CNA1) who was assigned to R52's care, indicated previously about weeks ago a skin discoloration on R52's left heel had been observed when R52 complained of pain. CNA1 explained had completed the skin assessment form and reported it to the assigned LPN. Certified Nursing Assistant 2 (CNA2) confirmed R52 had a pre-existing pressure injury prior to transfer to this unit. Both CNAs explained the process involved checking residents' skin during care and showering, completing the form, and immediately reporting any concerns to the assigned nurse. CNA1 explained the skin assessment was completed at the time. R52's medical records lacked documented evidence the skin assessment was completed as scheduled, the DTI was treated, and offloading was implemented. On 09/25/2024 at 9:10 AM, during wound care observation, the WNP assessed R52's heel and confirmed it was a pressure injury or DTI. The WNP indicated R52's DTI was avoidable with proper offloading. The WNP demonstrated the offloading techniques on both of R52's heels and clarified the pillow should have been placed beneath R52's calf, not beneath the heels. The WNP recommended R52 wear bunny boots to alleviate pressure on both heels and Venelex, aiding in wound healing and reducing pain. The WNP indicated R52's DTI on the left heel was referred for consultation for the first time today and never seen previously. The Skin Wound Progress Notes dated 09/25/2024, which documented the initial exam by WNP, revealed R52 had a DTI on the left heel with no exudate. There was 100% epithelialization, cleansed with saline, treated with Povidone iodine, covered with gauze pad, and secured with rolled gauze. Bunny boots were ordered for use while in bed. They were positioned on two pillows to prevent the heel from hitting the bed. On 09/26/2024 at 11:00 AM, the LPN indicated was familiar and assigned to R52 most of the days but did not receive a report for R52's skin concerns on the left heel previously. On 09/26/2024 at 12:00 PM, the Clinical Care Coordinator (CCC), indicated R52 had an old wound with a dry scab on the left heel, as documented on 07/12/2024. The intervention plan included elevating the heel, referring the wound for treatment, and applying bunny boots. The CCC indicated although R52 was first seen on 09/25/2024, R52 should have been assessed from the onset of the DTI or preventions implemented like turning and repositioning, and offloading. The CCC indicated bunny boots should have been ordered. The CCC indicated the skin assessment was scheduled twice a week during shower days or during provision of care. R52's medical records lacked documented evidence that interventions for the left heel pressure injury were consistently assessed, treated, and that offloading was implemented, and weekly skin assessments were completed as scheduled. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/27/2024 at 12:49 PM, the Director of Medical Records (DMR) confirmed there was only one skin assessment completed for the month of September, and it was dated 09/23/2024. The DMR explained the skin assessment should have been completed twice a week. The DRM confirmed the skin assessment was not completed as scheduled. A facility policy titled Skin Monitoring dated May 2021, documented to identify residents who were at risk for skin breakdown and to initiate immediate treatment when skin breakdown occurred. The plan of care was to initiate and document preventive measures based on the assessed risk. Bath skin reports were given to the nursing assistants with shower assignments and returned to the charge nurse as soon as they were completed. The charge nurse identified, assessed, and documented the areas of concern. A facility policy titled Pressure Ulcer Care and Documentation dated May 2021, documented to prevent pressure injuries and/or prevent deterioration of existing pressure injuries. Observe the signs on a daily basis, including tenderness, redness, or a darker, deeper bruise-like color, pain, discomfort, excessive dryness, or abrasions. Inform the charge nurse about any alterations in the patient's condition. The prevention strategy involved the application of anti-pressure devices.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review, and document review, the facility failed to ensure a resident who was clinically blind was provided assistance with food and fluids for 1 of 35 sampled residents (Resident 96). The deficient practice potentially contributed to the resident's significant weight loss and hospitalization . The resident was sent to the hospital on 06/05/2024 due to poor oral intake and weakness and on 09/27/2024 due to dehydration. Findings include: Resident 96 (R96) R96 was admitted on [DATE] and readmitted on [DATE], with diagnoses including chronic vision loss, chronic hearing loss, weakness, abnormal weight loss and nutritional deficiency. On 09/24/2024 at 8:38 AM, R96 laid in bed with eyes opened, an untouched breakfast tray was in front of the resident. After introduction, R96 requested surveyor to come closer and speak louder due to difficulty hearing. While the surveyor walked around the resident's bed to come closer to left side, the resident maintained frontal gaze and did not follow the surveyor's movement. R96 asked surveyor if breakfast had been served? The surveyor responded, It's right in front of you. The resident explained being blind and needed help with meals. The resident indicated not being able to see the meal tray which consisted of a bowl of oatmeal, cup of coffee, scrambled eggs, chopped sausage, pureed biscuit, two glasses of white cranberry juice and a glass of milk. The resident expressed being very thirsty. On 09/24/2024 at 8:40 AM, a Certified Nursing Assistant (CNA) entered the room and responded to R96's request for assistance with breakfast. After consuming 25 percent (%) to 50% of the meal, the CNA verbalized R96 required full assistance with meals, but this was not reflected in the resident's meal ticket. The CNA indicated not being steadily assigned to R96 and the CNA was not advised to provide R96 with one-on-one (1:1) feeding assistance. The CNA verbalized R96 was appropriate for 1:1 assistance with meals due to blindness. On 09/24/2024 at 10:37 AM, the Licensed Practical Nurse (LPN) steadily assigned to R96, explained the resident used to eat in the main dining room with late spouse and the resident had started to decline both in vision and functional status since R96's spouse passed in February 2024. According to the LPN, the inter-disciplinary team (IDT) had discussed the resident's weight loss and supplements were added to R96's diet but providing the resident with feeding assistance was not discussed. The LPN who indicated had witnessed part of this morning's breakfast observation, verbalized R96 was appropriate for 1:1 feeding assistance. The annual minimum data set (MDS) dated [DATE], documented R96 had adequate vision. Adequate vision was defined as being able to see in fine detail, such as regular print in newspaper and books. R96 required supervision or touching assistance with eating wherein helper provided verbal cues as resident completed the activity and assistance may be provided intermittently throughout the activity. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS dated [DATE], documented R96 had adequate vision and adequate hearing. Adequate hearing was defined as having no difficulty in normal conversation, social interaction and listening to the television. R96 required set-up or clean up assistance with eating defined as helper sets up and cleans up while resident completed the activity with helper assisting only prior to and following the activity. A hospital discharge summary dated 06/07/2024, documented R96 was clinically blind with chronic hearing loss and was transferred to the hospital on 06/05/2024 due to poor oral intake and generalized weakness. A dietary note dated 07/08/2024, revealed R96 had a 25-pound (lb.) weight loss or 15.2 percent (%) for one month, 19-lb weight loss or 12.2 % over three months and a 20-lb weight loss or 13% weight loss over six months. Body mass index (BMI) 21.41 low for age. Laboratory tests ordered, supplement added, family notified of significant weight loss. A quarterly nutrition assessment dated [DATE], revealed R96 had a 26-lb or 16% weight loss over three months and BMI 21.18 low for age. Discontinue Glucerna, offer 2CalHN three times a day, soup with lunch and dinner and super cereal with breakfast. A speech therapy (ST) evaluation dated 08/09/2024, documented R96 required feeding assistance due to highly impaired vision and being at risk for aspiration, malnutrition and weight loss. The medical record lacked documented evidence the ST's recommendations to provide R96 with 1:1 assistance with meals was communicated to the IDT and reflected on the resident's meal ticket. A dietary note dated 09/13/2024, documented R96 was being provided assistance with meals due to blindness. On 09/25/2024 at 3:49 PM, the Director of Nursing (DON) indicated being familiar with R96 who resided in the facility with late spouse since 2021. The DON indicated R96 used to be able to read with eyeglasses and magnifying lens, but the resident's vision loss continued to progress, and the resident was now currently blind. The DON reviewed the resident's medical record and confirmed R96 had significant weight loss and the consultant Registered Dietitian (RD) who came to the facility twice a week appeared to be under the impression the resident was being provided full assistance with meals based on dietary notes. The DON indicated due to inaccurate entries to the resident's MDS assessments, the resident was deprived of a more appropriate level of care, particularly with eating. The DON indicated the facility did not require a physician's order for 1:1 feeding assistance, but the dietary team was expected to discuss these items in weekly meetings. The DON verbalized R96 should have been provided 1:1 feeding assistance sooner and failing to do so may have contributed to the resident's weight loss and hospitalization . On 09/26/2024 at 10:24 AM, the Director of Food Services (DFS) explained weekly meetings were held among the dietary team who consisted of the DFS, RD and Speech Therapist (ST). The team discussed which residents were to be upgraded or downgraded in terms of diet and assistance needed. The DFS indicated there was a breakdown in communication since the DFS had not been informed of R96's significant weight loss and blindness requiring full assistance with meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/27/2024 at 7:47 AM, R96 laid in bed with eyes opened, an untouched breakfast tray was on the bedside table on the right side of the resident's bed. A CNA entered the room and started to inform the resident of the meal tray's contents. R96 verbalized being very thirsty but the water tumbler was almost empty and out of reach from the resident. The CNA asked the LPN to bring in fresh water, upon arrival of which the resident was observed drinking the 8-ounce cup of fresh water within minutes. The CNA indicated hydration passes were not done at start of shift but rather when the satellite kitchen opened which was the only time the ice water dispenser became available to staff and residents. On 09/27/2024 at 8:04 AM, the LPN indicated the Nurse Practitioner (NP) just made rounds and ordered to send R96 to the hospital for dehydration and weakness and the family member had just been informed. On 09/27/2024 at 8:05 AM, the NP indicated not being aware feeding assistance was not being provided to R96 routinely. The NP indicated being under the impression R96 was being provided with 1:1 feeding assistance with all meals due to blindness. The NP conveyed the resident appeared dehydrated, weak and had new onset diarrhea and would be transferred to the hospital. On 09/27/2024 at 8:39 AM, the RD indicated being a consultant and came to the facility twice a week and as needed. The RD could not recall R96 and explained nutritional assessments were based on interviews with nurses, CNAs and reviewing medical record. The RD verbalized identifying R96's significant weight loss but the RD was under the impression the CNAs were steadily providing 1:1 feeding assistance to R96. The RD indicated not being aware the resident was being sent out to the hospital due to dehydration. On 09/27/2024 at 9:15 AM, R96's family member corroborated the LPN and DON's recollection regarding R96 use of eyeglasses and magnifying lens in the past. However, due to glaucoma and macular degeneration, the resident had been diagnosed by a specialist last year as being completely blind on the left eye and seeing only shadows from the right eye. The family member indicated R96 had always been hard of hearing and started to steadily decline with functional status after the death of late spouse in February 2024. The family member expressed the facility had not made adequate accommodations with the changes in the resident's health status and family requests to provide R96 with meal assistance fell on deaf ears resulting in a 25-pound weight loss and a hospitalization in June 2024. The family member indicated the facility had not invited the family member to any care plan meetings and expressed being upset over being notified earlier of R96's transfer to the hospital due to dehydration. The Weight Loss and Intervention policy dated 2014, documented the physician and IDT team would identify conditions and medications which may be causing anorexia, weight loss or an increase in weight loss with careful consideration to functional factors which may inhibit independent eating. The Feeding a Resident policy reviewed June 2021; documented residents unable to feed self would receive assistance with each meal to promote adequate oral intake. Staff would talk to the resident to explain what foods were being offered from the main plate. Complaint #NV00072063

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure the physician orders for bolus tube feeding, water flushes, and gastrostomy tube care were obtained for 1 of 35 sampled residents (Resident 52). This deficient practice had the potential to result in improper nutrition, dehydration, increased risk of infection, gastrointestinal complications, delayed healing, and potential hospital readmission. Findings include: Resident 52 (R52) R52 was admitted on [DATE], with diagnoses including dementia, diabetes mellitus, urinary tract infection, dysphagia (difficulty swallowing) and gastrostomy. The Admission Skin assessment dated [DATE], documented R52 had Percutaneous Endoscopic Gastrostomy (PEG) (a feeding tube inserted into the stomach through the abdomen for nutrition) tube in place. A Care Plan dated 07/14/2024, documented R52 received nutritional support through a feeding tube with a risk of aspiration. Interventions included assessing tolerance, verifying tube placement before feedings, flushes, or medication administration, and providing tube flushes as ordered. On 09/24/2024 at 10:59 AM, R52 was observed in bed, alert and verbally responsive with the PEG site covered by a dry dressing dated 09/24/2025. An unopened Glucerna 1.2 tube feeding (1000 milliliters bottle) was on top of the dresser, not connected, and labeled with a date of 08/30/2024. R52 indicated the TF was provided directly to the PEG tube once in a while. R52 medical records lacked documented evidence the physician orders for bolus feeding, water flushing, placement verification and PEG tube site care or monitoring were in place. On 09/24/2024 at 11:00 AM, a Licensed Practical Nurse (LPN) explained R52's bolus feeding had been started previously to provide 237 ml of Glucerna, intended only if meal intake was less than 75%. The LPN indicated R52 was on a soft mechanical diet and had consumed more than 75%. On 09/24/2026 at 12:30 PM, R52 was eating lunch independently with soft mechanical diet. The CNA indicated R52 had a good appetite and consumed an average of 75-100%. On 09/25/2026 at 1:30 PM, the LPN indicated the bolus was not given because R52 had eaten more than 75% and TF formula was readily available at bedside if needed. The LPN explained administering the bolus feeding and managing the PEG tube required a physician's order, which had not been obtained. The LPN explained was familiar with R52's care, and confirmed the orders should have been in place for proper monitoring and continuity of care. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/26/2024 at 12:00 PM, the Clinical Care Coordinator (CCC) explained the use of a PEG tube required a physician s order and specific care instructions for its management. The CCC stated R52 was on an oral diet and received bolus feeding if meal intake was less than 75%. The CCC confirmed there should have been both bolus and care orders in place to manage the bolus feeding, PEG tube, and insertion site. The CCC explained the facility had transitioned from one electronic health record (EHR) system to another. The new EHR system was fully implemented, and a third party was hired to ensure everything was successfully transferred over. The CCC confirmed responsibility for auditing and ensuring the necessary orders were in place, as the direct care staff no longer had access to the previous system. The CCC explained the PEG tube insertion site should have been monitored regularly, including checking PEG placement and flushing. The CCC explained R52 maintained a stable weight without significant changes. The CCC indicated the Registered Dietitian was on vacation and unavailable for an interview. A facility policy titled Gastrostomy Tube Placement Check dated June 2021, outlined the procedure for verifying physician orders to ensure proper GT placement in the resident's stomach. The policy required checking the tube's position before each feeding and medication administration.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review, and document review, the facility failed to ensure care orders were obtained, transcribed and carried out for a peripherally inserted central catheter (PICC) line for 1 of 35 sampled residents (Resident 96). The deficient practice placed the resident at risk for infection. Findings include: Resident 96 (R96) R96 was admitted on [DATE] and readmitted on [DATE], with diagnoses including urinary tract infection (UTI). On 09/24/2024 at 8:38 AM, R96 laid awake in bed with breakfast tray in front. Two intravenous (IV) ports were observed dangling from underneath the resident's right arm with sleeve covering the insertion site. On 09/24/2024 at 10:28 AM, the Licensed Practical Nurse (LPN) pulled up R96's right sleeve and removed a beige kerlix wrapped around R96's right upper arm which revealed a transparent dressing labeled 08/29/2024 PICC, a gauze pad covered the insertion site. The LPN explained PICC line dressing changes were performed weekly and as needed but there should not be any gauze covering the insertion site to allow nurses to monitor the site every shift. The LPN indicated needing to review R96's medical record to determine when antibiotic therapy was completed and whether the physician had ordered to maintain R96's PICC line. A laboratory report finalized on 08/29/2024, revealed R96's urine was positive for a UTI and the organism was susceptible to Meropenem (antibiotic). A physician's order dated 08/29/2024, documented to insert a PICC line for UTI. A diagnostic report dated 08/29/2024, revealed a PICC line was inserted in R96's right upper arm for antibiotic therapy. A physician's order dated 09/01/2024, documented to administer Meropenem IV reconstituted solution one gram every eight hours for UTI. A nurse's note dated 09/13/2024, revealed pharmacy reached out to R96's primary nurse regarding the stop date for R96's antibiotic therapy. The nurse reached out to the physician, left a voice message and was awaiting call back. The Medication Administration Record (MAR) for September 2024, revealed R96's last IV antibiotic dose was administered on 09/13/2024. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record lacked documented evidence the nurse followed up with the physician regarding R96's antibiotic stop date and clarification orders were obtained on whether to maintain or discontinue R96's PICC line. The medical record lacked documented evidence care orders for R96's PICC line such as site monitoring, flushes and dressing changes were obtained since insertion on 08/29/2024. On 09/25/2024 at 3:28 PM, the Director of Nursing (DON) reviewed R96's medical record and confirmed there were no care orders entered for R96's PICC line which should include site monitoring and flushing every shift and dressing changes weekly and as needed. The DON indicated there should not have been any gauze pad covering R96's insertion site but the diagnostic vendor who performed the PICC line insertion may have been the ones to place the gauze dressing. The DON confirmed R96 received antibiotics until 09/13/2024 but there was no documentation any nurse followed up with a physician regarding next steps which may include repeat testing, a stop date for antibiotic therapy or maintenance or removal of the resident's PICC line. According to the DON, lack of routine PICC line care placed R96 at risk for another infection. On 09/27/2024 at 8:06 AM, the Nurse Practitioner (NP) indicated ordering the removal of R96's PICC line on 09/24/2024. The NP verbalized not getting a phone call from the facility regarding R96's antibiotic therapy otherwise the NP would have reached out to infectious disease and possibly order repeat testing prior to stopping antibiotic therapy and ordering the removal of R96's PICC line. The NP verbalized not being aware there were no care orders entered for the resident's PICC line such as flushing, site monitoring and dressing changes. The IV policy and procedure manual dated 11/28/2017, documented flushing was performed to maintain catheter patency and flush orders were obtained from a physician. Site assessments may occur during dressing changes, routinely for signs and symptoms of infection and every shift when catheter was not in use. Transparent dressings were changed every five to seven days and labeled with date, time and nurse's initials.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure physician orders were obtained for the use of Oxygen (O2) and monitoring of O2 saturation for 1 of 35 sampled residents (Resident 155), and for the use of a CPAP machine (a device used to treat sleep-related breathing disorders, such as sleep apnea, by keeping the airways open during sleep) for 1 of 35 sampled residents (Resident 64). This deficient practice could have led to potential adverse health outcomes, including inadequate oxygenation and compromised respiratory management. Resident 155 (R155) R155 was admitted on [DATE], with diagnoses including pneumonia, respiratory tuberculosis, acute and chronic respiratory and dependence of supplemental O2. The Observation Report dated 08/28/2024, documented R155 had O2 flowing via nasal cannula and had experienced shortness of breath. On 09/24/2024 at 3:30 PM, R155 was in bed, breathing through the mouth. O2 was flowing at 5 liters per minute (LPM) via nasal cannula, with no signs of shortness of breath. On 09/25/2024 at 9:21 AM, R155 was in bed with eyes closed, and O2 was flowing at 5 liters LPM via nasal cannula. On 09/25/2024 at 12:33 PM, R155 was seated on the edge of the bed, eating lunch. The O2 was on and flowing at 5 LPM via nasal cannula. R155 indicated being dependent on continuous O2 at 2 LPM, even prior to admission and it was administered by facility staff. R155's medical records lacked documented evidence of physician orders for the administration and management of O2, and no O2 saturation monitoring was recorded. On 09/25/2024 at 12:44 PM, a Licensed Practical Nurse (LPN) confirmed R155's O2 was flowing continuously at 5 LPM via nasal cannula. The LPN explained a physician order was necessary for O2 use, along with a schedule for cannula changes and O2 saturation monitoring. The LPN confirmed there was no order in place, no care orders, and no monitoring of O2 saturation. On 09/26/2024 at 12:00 PM, the Clinical Care Coordinator (CCC) indicated O2 use required an order, and O2 saturation should have been monitored. The CCC explained without an order, there was a risk of administering too much O2 or the resident not needing it. The CCC explained the admission nurse or direct care nurse was responsible for assessing and obtaining the O2 orders. The CCC confirmed R155 had been assessed on 08/28/2024, and Oxygen was already in place. The CCC indicated the O2 orders should have been obtained. A facility policy revised in May 2021, indicated a physician's order was required to apply O2. 39418 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 64 (R64) R64 was admitted on [DATE] with diagnoses including open wound lower back and pelvis and hemiplegia after cerebral infarction. On 09/24/2024 at 1:43 PM, at R64's bedside table was breathing equipment. R64 indicated it was a CPAP machine (a device that helps treat sleep-related breathing disorders, such as sleep apnea, by keeping airways open while you sleep). R64 indicated using the CPAP at night and self manages the equipment and does the self-application of the nasal mask . R64 indicated bringing the equipment from home upon admission. R64 lacked documented evidence of a physician's order for the use, and the care and maintenance of the breathing apparatus. Physician and nursing progress notes lacked documented evidence R64 was using the breathing apparatus at night to aide breathing status during the time of sleep. On 09/26/2024 12:11 PM, the Director of Nursing (DON) indicated residents using CPAP machines should have a physicians' order. The DON indicated once an order is placed onto the electronic healthcare records (EHR) an order set will be generated for the care and maintenance. The facility policy titled CPAP/Bi-Level Respiratory Care revised 07/2021, documented any/all use of CPAP or Bi-Level respiratory care procedures requires specific physician's order.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 40142 Based on interview, record review and document review, the facility failed to ensure annual performance appraisals were completed for 4 out of 10 sampled employees (Employees 6, 7, 9 and 10). The deficient practice placed the residents at risk for receiving substandard quality of care from certified nursing assistants (CNAs). Findings include: The Personnel Records Checklist dated 09/26/2024 revealed the following: -Employee 6 was hired as a CNA on 06/23/2022. A review of the employee's file revealed there was no annual performance evaluation completed for Employee 6 for Year 2023 and Year 2024. -Employee 7 was hired as a CNA on 07/07/2022. A review of the employee's file revealed there was no annual performance evaluation completed for Employee 7 for Year 2023 and Year 2024. - Employee 9 was hired as a CNA on 08/19/2021. A review of the employee's file revealed there was no annual performance evaluation completed for Employee 9 for Year 2022, Year 2023 and Year 2024. -Employee 10 was hired as a CNA on 11/04/2021. A review of the employee's file revealed there was no annual performance evaluation completed for Employee 10 for Year 2022 and Year 2023. On 09/27/2024 at 10:33 AM, the Human Resources (HR) Coordinator confirmed there were no annual performance appraisal forms completed for Employees 6, 7, 9 and 10 since their respective hire dates. The HR Coordinator explained being responsible for initiating the process by putting the CNA's name and date of hire on the Annual Performance Appraisal form and this would be placed in the Director of Nursing's (DON) box. According to the HR Coordinator, the DON was responsible for completing the annual evaluations for all nursing staff and the forms were to be returned to the HR Director after completion. The HR Coordinator indicated issuing reminders to the DON but the forms for Employees 6, 7, 9 and 10 had not been returned to HR. On 09/27/2024 at 12:11 PM, the DON explained being responsible for completing annual appraisal forms for CNAs, a task which used to be shared with the former staff development coordinator (SDC). The DON explained the purpose of annual evaluations were to conduct performance reviews, ensure staff were able to deliver quality care and areas for improvement would be reviewed and addressed. The DON indicated delegating this task occasionally to the former SDC who was authorized to complete the forms as well. The DON indicated the forms may have not been completed because both the SDC and DON assumed the appraisal forms had been completed by the other. On 09/27/2024 at 1:12 PM, the Administrator indicated CNA annual appraisals were expected to be completed by the DON or SDC. The Administrator indicated not being aware the annual appraisals were not completed for Employees 6, 7, 9 and 10 since date of hire. The Administrator indicated the annual appraisals were used as an opportunity to discuss areas for improvement and ensure delivery of quality care. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Annual Performance Appraisal form dated 2007, revealed the annual appraisal was an important feedback tool when used appropriately. The form would provide the staff member with a clear picture of their performance and discuss areas where improvement was needed. Approximately 30 days prior to the employees' anniversary date, managers would begin to gather information to complete the form, meet with the staff member to discuss appraisal and return completed form to the Administrator for review and provide staff a copy prior to filing in the employee's file.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure the residents' behavior was monitored and documented for residents receiving psychoactive medications for 6 of 25 sampled residents (Residents 44, 102, 5, 161, 4, and 99). This deficient practice could have increased the risk of adverse side effects, ineffective medication management, missed signs of worsening conditions, and compromised resident safety. Findings include: A facility policy titled Medication Monitoring and Management revised in November 2014, indicated the resident's medication regimen required monitoring for significant negative changes from baseline. Medications were to be ruled out as the cause of these changes, following the policy on detecting and preventing adverse consequences. Resident 44 (R44) R44 was admitted on [DATE], with diagnoses including depression, dementia with behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A Physician Order dated 09/01/2024, documented Donepezil Hydrochloride (HCL) oral tablet milligrams (mg) to give 1 tablet by mouth at bedtime related to dementia. A Physician Order dated 09/01/2024, documented Sertraline HCL tablet 25 mg to give 1 tablet by mouth daily for depression due to verbalization of sadness over health condition. A Physician Order dated 09/01/2024, documented Risperidone tab 0.5 mg to give one tablet by mouth two times daily for psychosis manifested by (MB) yelling and swinging at staff and others. R44's medical record lacked documented evidence there were orders to monitor target behaviors and side effects for the use of psychoactive medications. On 09/26/2024 at 12:00 PM, the Clinical Care Coordinator (CCC) explained the facility had transitioned from one electronic health record (EHR) system to another. The new EHR system was fully implemented, and a third party was hired to ensure everything transferred successfully. The CCC took responsibility for auditing and ensuring the necessary orders were in place, as direct care staff no longer had access to the previous system. The CCC confirmed Licensed Nurses were expected to monitor residents' behavior and adverse effects of psychoactive medications, documenting either in the progress notes or on the printed medication administration record. The CCC acknowledged inconsistent monitoring of residents' behaviors and side effects related to psychoactive medications. 37718 Resident 102 (R102) (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R102 was admitted on [DATE] with diagnoses including Wernicke's Encephalopathy (a type of dementia). A physician order dated 08/31/2024, documented Xanax (a sedative) 0.5 mg give 1 tablet by mouth three times a day for anxiety. A physician order dated 08/27/2024, documented Lamictal (an anticonvulsant) 25 mg to give 1 tablet by mouth daily for depression. A physician order dated 08/27/2024, documented Risperidone tab 2 mg one tablet by mouth at bedtime for psychosis. A physician order dated 08/27/2024, documented Zoloft tablets, 25 mg, give three tablets by mouth at bedtime for depression. The September 2024 Medication Administration Record indicated all medications were given as ordered. R102's medical record included nurse progress notes documenting R102's exit-seeking behavior and verbalizing of delusional statements. These notes were documented at irregular intervals. R102's medical record lacked physician orders for the monitoring of behaviors and for side effects of the psychoactive medications. On 09/27/24 at 10:16 AM, the Licensed Practical Nurse (LPN) verbalized caring for R102 today and on a regular basis. The LPN reported R102's behavior and medication side-effects were assessed and then documented in the progress note section of the electronic health record (EHR). The LPN verbalized the facility had recently changed to a different EHR system. Under the former EHR system, monitoring of medication side effects and of behaviors was ordered by the physician and the licensed nurse documented monitoring was carried out on the MAR. The LPN revealed the new EHR system was in transition, and documenting on the MAR was not available in the new system. The LPN revealed they had been instructed to document side effect and behavior observations in the progress note section of the new EHR. 40142 Resident 5 (R5) R5 was admitted on [DATE], with diagnoses including unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. A physician's order dated 08/29/2024, documented to give Seroquel Oral Tablet 25 mg, one tablet by mouth at bedtime for psychosis. The medical record lacked documented evidence there were orders to monitor target behaviors and side effects for R5 's Seroquel use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 08/29/2024, documented to give Prozac 10 mg (anti-depressant), three capsules by mouth one time a day for depression. The medical record lacked documented evidence there were orders to monitor target behaviors and side effects for R5 's Prozac use. 50289 Resident 161 (R161) R161 was readmitted on [DATE], with diagnoses including generalized anxiety disorder and dementia. R161 physician's orders listed the following psychotropic medications: 1) SEROquel Oral Tablet 25 MG (Quetiapine Fumarate), Give 1 tablet by mouth at bedtime for psychotic disturbance, order date: 08/24/2024. R161's ordered psychotropic medications were marked by the EHR system with a black box warning (serious adverse reactions or special problems occur, particularly those which may lead to death or serious injury). R161's September medication administration record (MAR) lacked documented evidence psychotropic medication adverse reaction monitoring was completed. R161's nurses progress notes revealed no entries for the monitoring of psychotropic medication side effects. 39418 Resident 4 (R4) R4 was admitted on [DATE], with diagnoses including delusional disorder and psychosis. R4 physician's orders listed the following psychotropic medications: 1) FLUoxetine Hydrochloride Oral Capsule 20 milligrams (MG) (Fluoxetine HCl), Give 1 capsule orally one time a day for major depression, as evidenced by (AEB) self-isolation, order date: 8/24/2024. 2) ZyPREXA Oral Tablet 5 MG (Olanzapine), Give 1 tablet by mouth one time a day for schizophrenia, order date: 08/24/2024. R4's comprehensive care plan for Problem documented: Risk for adverse consequence related to receiving psychotropic medications Zyprexa for schizophrenia and Prozac for depression. Category: psychotropic Drug Use dated 07/07/2024, documented a listed intervention of monitor and report signs of sedation, anticholinergic and /or extrapyramidal symptoms (group of side effects that can occur as a result of taking certain medications, especially antipsychotics. Resident 99 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R99 was admitted on [DATE], with diagnoses including psychosis and bipolar. R99 physician's orders listed the following psychotropic medications: 1) busPIRone HCl Oral Tablet 7.5 MG (Buspirone HCl), Give 1 tablet by mouth three times a day for anxiety, order date: 8/28/2024. 2) Escitalopram Oxalate Oral Tablet 5 MG (Escitalopram Oxalate), Give 1 tablet by mouth one time a day for Depression, order date: 8/28/2024 3) Depakote extended release (ER) Oral Tablet Extended Release 24 Hour 250 MG (Divalproex Sodium), Give 1 tablet by mouth two times a day for Bipolar, order date: 8/28/2024. 4) SEROquel Oral Tablet 50 MG (Quetiapine Fumarate), Give 1 tablet by mouth at bedtime for psychosis, order date: 8/28/2024. R99's comprehensive care plan for Care Plan documented: Problem: Resident is at risk for adverse consequence related to receiving psychotropic medication buspirone and escitalopram. diagnosis: anxiety and depression. Depakote diagnosis: Bipolar. quetiapine diagnosis: psychosis. R4 and R99's ordered psychotropic medications were marked by the EHR system with a black box warning (serious adverse reactions or special problems occur, particularly those that may lead to death or serious injury). R4 and R99's, September medication administration record (MAR) lacked documented evidence psychotropic medication adverse reaction monitoring was completed. R4 and R99's, nurses progress notes revealed no entries for the monitoring of psychotropic medication side effects. On 09/26/2024 at 2:06 PM, the 300 Hall nurse indicated documentation of the side effect of any psychotropic medication would be placed on the MAR. On 09/26/2024 at 2:15 PM, the Unit 4 nurse indicated the new electronic healthcare record (EHR) does not have the side effects monitoring and for now documentation of monitoring would be on the progress notes. On 09/27/2024 at 9:59 AM, the 300 Hall nurse indicated with the previous EHR, side effect monitoring was completed on the MAR on a shift-to-shift basis. With the new EHR switch over, migration of the orders for side effect monitoring did not occur. The nurse indicated directives where side effects monitoring should be documented on the progress notes. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/27/24 at 10:26 AM, the Clinical Care Coordinator (CCC) indicated facility was aware of some of the order sets did not migrate over to the new EHR. The CCC indicated the regional nurse prior to the implementation of the new EHR, had printed the MAR and the nurses were expected to chart on it or enter side effect monitoring onto the progress notes. The CCC acknowledged nurses were not too keen into charting into paper MAR and the progress notes. The CCC indicated nursing staff is still pending for training into entering the orders sets into the HER, preventing an updated side effect monitoring for the side effects. The CCC acknowledged without the consistent side effect monitoring charted into the MAR, there was lack of monitoring documentation for the side effects of psychotropic medication and the side effects monitoring was essential for the physician and pharmacist for the resident drug review. The facility policy titled Medical Regimen Review Policy (undated), documented Medication Review: will be conducted monthly. The medical regimen review should consider the potential drug interactions, side effects, and any adverse reactions. The facility policy titled Medication Monitoring and Management revised 11/2014, documented to optimize the therapeutic benefit of medication therapy and minimize or prevent adverse consequences, facility staff, the attending physician/prescriber, and the consultant pharmacist perform ongoing monitoring for appropriate, effective and safe medication use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on observation, document review and interview, the facility failed to ensure stored foods were labeled and dated, food items were discarded prior to the expiration date, nourishment refrigerators were keeping the proper temperature, and safe food handling was occurring during meal service. This deficient practice posed a potential risk to safety and health standards which could lead to contamination, inadequate storage, and place residents at risk of foodborne illness. Findings include: On [DATE] in the morning, round scrambled egg patties were open in the walk-in cooler. These egg patties were not labeled or dated as to when the box was opened. The Food Service Manager explained the open boxed items should have been dated as to when the box was opened and then placed back in the freezer. On [DATE] in the morning, one open corn muffin mix, and one unopened corn muffin mix, were being stored in the dry storage area had expired in ,d+[DATE]. The Food Service Manager verified the items in the dry storage area should have been thrown away one year from the manufacturers date. The Food Services Manager verified the corn muffin mixes with a manufacture's date of ,d+[DATE] should have been thrown away on ,d+[DATE]. On [DATE] in the morning, five unlabeled and undated, previously baked pies were being stored in the freezer. The Food Service Manager explained the previously baked pies should have been labeled as to what kind of pie they were and dated as to when they were baked and placed in the freezer for storage. On [DATE] in the morning, there were two unlabeled and undated cups of a scooped frozen substance with plastic wrap over each of them. The Food Service Manager explained the previously scooped ice cream should have been labeled as to what kind of ice cream they were and dated as to when they were scooped and placed in the freezer for storage. On [DATE], in the afternoon, in the unit one dining room, an uncovered plate of food was observed being brought to a resident. The plate was set down on the table, however, before the staff member let go of the plate the Speech therapist clarified the next texture for the resident being served. The staff member then took the plate back to the steam table and set it on top. When another resident came into the dining room with texture of diet, the plate was then served to the new resident. On [DATE], in the afternoon, the CNA verified the plate of food was taken to the resident by mistake due to the incorrect food texture. The plate was brought back to the steam table and set on top. They served the same plate of food to another resident who needed the correct texture. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], in the afternoon, the Food Services Manager confirmed when food is taken from the steam table to a resident, if the plate of food is wrong for any reason, the plate of food should be discarded and a new plate of alternatives should be brought to the resident. The Food Service Manager stated the plate is not supposed to go back to the steam table to wait for another resident due to possible cross contamination. On [DATE] at 3:46pm, the unit one refrigerator temperature was 50 degrees Farenheit (F) and on [DATE] at 9:17am, the unit one refrigerator temperature was 48 degrees F. The Food Services Manager initially explained it may have been the cause of the staff leaving the refrigerator door open during meal service. However, after further review the unit one refrigerator was found to not be holding the proper temperatures. This refrigerator held resident milk, juice, yogurt, and salads. A document titled Food Storage (Dry/Refrigerated/Frozen) 2014 Edition documented: All foods items will be labeled, and the labeling must include the name of the food and the date by which it should be sold, consumed, or discarded. Discard food which has passed the expiration date and discard food which has been prepared in the facility after seven days of storing under proper refrigeration. Keep foods out of the temperature danger zone (41 degrees F to 135 degrees F).