STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40377 Based on record review and interview, the facility failed to ensure the proper Medicare Notice of Medicare Non-Coverage letter was completed and provided for 2 of 3 unsampled residents selected for beneficiary notification review. The deficient practice resulted in non-compliance with Medicare requirements, that could hinder the resident's ability to make informed decisions regarding their coverage and care. Findings include: Resident #231 Resident #231 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including primary generalized osteoarthritis, chronic respiratory failure with hypoxia, and chronic obstructive pulmonary disease, unspecified. Resident #231 was discharged home on 10/31/2024. Resident #231's clinical record lacked documented evidence the Centers for Medicare and Medicaid Services (CMS) Notice of Medicare Non-coverage Form (NOMNC) was provided to the resident or the resident's representative. On 03/26/2025 at 1:35 PM, the Business Office Manager (BOM) confirmed the BOM could not find the NOMNC for Resident #231. The BOM confirmed the facility follows the CMS instructions for the NOMNC, CMS-10123. Resident #231's last day of Part A service was 10/31/2024. Resident #232 Resident #232 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including type 2 diabetes mellitus with ketoacidosis without coma, chronic obstructive pulmonary disease, unspecified, and chronic kidney disease, stage 3. Review of Resident #232's CMS Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form provided by the BOM on 03/26/2025, revealed Resident #232's Medicare Part A skilled services episode started on 11/26/2024 and the last covered day for Part A services was on 12/19/2024. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #232's discharge was extended to address the resident's medical condition. Resident #232 was discharged home on 12/23/2024. The medical record lacked documented evidence the Notice of Medicare Non-Coverage letter was provided to Resident #232 for the admission extension. On 03/26/2025 at 1:35 PM, the BOM confirmed the BOM could not find the NOMNC for Resident #232 extended admission. The BOM verbalized the resident was going to discharge on 12/19/2024, but extended to 12/26/2024, due to a medical condition the resident's physician treated prior to discharge. On 03/27/2025 at 7:24 AM, the facility's Executive Director stated it was the expectation the facility followed the CMS guidelines and provide the Notice of Medicare Non-Coverage letter to resident and/or resident representative two days prior to the end of the benefits. The facility's undated policy titled Notice Instructions for the Notice of Medicare Non-Coverage (NOMNC) documented the facility would provide a NOMNC letter to eligible beneficiaries, even if they agree to terminate services. The NOMNC would be delivered at least two days before Medicare covered services end, or the last day of service if care is not provided.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40377 Based on interview and document review the facility failed to ensure Minimum Data Set (MDS) 3.0 assessments were transmitted timely for 4 of 10 months, starting June 2024. The deficient practice had the potential to impact resident care by delaying the resident care plan. Findings include: Jun 2024: 10.3% of admission assessments were completed late (11 of 107) [DATE]: 12.5% of assessments were completed late (8 of 64) 14.5% of admission assessments were completed late (9 of 64) [DATE]: 13.5% of assessments were completed late (12 of 89) [DATE]: 11.9% of assessments were completed late (7 of 59) On 03/27/2025 at 7:19 AM, the Executive Director (ED) verbalized the MDS Coordinator was responsible to submit the MDS assessments for the facility and confirmed the facility had filed the aforementioned MDS assessments late. The ED verbalized the facility had a change in MDS Coordinators which attributed to the late filings.

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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** 49557 Based on clinical record review, interview, and document review the facility failed to ensure the accuracy of a Minimum Data Set 3.0 (MDS) assessment for 1 of 19 sampled residents (Resident #4) and 1 of 3 residents sampled for closed records (Resident #79). This deficient practice had the potential to deprive residents of necessary care and services relative to current health management needs in the facility and upon discharge home. Findings include: Resident #4 Resident #4 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including other specified spondylopathies, lumbar region and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A Hospice Plan of Care for certification period 01/08/2025 through 03/18/2025, documented Resident #4 was receiving hospice services. A quarterly MDS assessment dated [DATE], Section O - Special Treatments, Procedures, and Programs included instructions to check all treatments, procedures, and programs performed. Item O0110K1 - Hospice care lacked a checkmark, X, or any other documentation indicating Resident #4 was receiving hospice care. Resident #79 Resident #79 was admitted to the facility on [DATE], with a diagnosis of fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing. A Nursing Progress Note dated 03/02/2025, documented Resident #79 was discharged home. A discharge MDS assessment dated [DATE], Section A2105 - Discharge Status documented Resident #79 was discharged to a short-term general hospital. On 03/26/2025 at 1:45 PM, the Director of Nursing (DON) verbalized the facility did not have a policy related to completion of MDS assessments and the facility followed the Resident Assessment Instrument (RAI) manual. On 03/26/2025 at 2:53 PM, the MDS Consultant explained the MDS Consultant and the MDS Coordinator were responsible to complete MDS assessments for residents and the RAI manual was used as a reference. The MDS Consultant would review and sign off on all assessments completed by the MDS Coordinator. The MDS Consultant reviewed Resident #4's clinical record and confirmed Resident #4 was receiving hospice services, the services began in 2024. The MDS Consultant verbalized the most recent MDS assessment for Resident #4 was completed on 01/17/2025. The MDS Consultant confirmed the MDS assessment did not indicate Resident #4 was receiving hospice services and was inaccurate. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS Consultant reviewed Resident #79's clinical record and verbalized the resident was discharged home on 03/02/2025. The MDS Consultant confirmed Resident #79's discharge MDS indicated the resident was discharged to the hospital and was inaccurate. The Centers for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.1.9.1, dated 10/2024, documented residents in a hospice program were to be identified in item O0110K1. Item A2105 documented the location to which a resident was being discharged . Knowing the setting to which the resident was discharging helped to inform discharge planning.

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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** 46301 Based on clinical record review, interview, and document review, the facility failed to develop a person-centered Comprehensive Care Plan for the use of insulin, for 1 of 19 sampled residents (Resident #32). This deficient practice had the potential to result in residents not receiving care and services to meet their needs related to the use of insulin. Findings include: Resident #32 Resident #32 was admitted to the facility on [DATE], with a diagnosis of type 2 diabetes mellitus. A physician's order dated 10/20/2024, documented HumaLOG Injection Solution 100 unit/milliliter (ml), inject 10 units subcutaneously with meals for type 2 diabetes mellitus. A physician's order dated 08/26/2024, documented Insulin Glargine Solution 100 unit/ml, inject 56 unit subcutaneously two times a day for type 2 diabetes mellitus with diabetic polyneuropathy. Resident #32's Medication Administration Record (MAR) dated March 2025, documented the administration of HumaLOG Injection Solution, and Insulin Glargine Solution as per the physician order. Resident #32's Care Plan lacked documented evidence of the use of insulin. On 03/27/2025 at 2:53 PM, the Director of Nursing (DON), confirmed Resident #32's Care Plan lacked documented evidence of the use of insulin. The DON verbalized, not expecting to see the care plan be insulin specific. The Resident Assessment Instrument (RAI) 3.0 manual, Chapter 2, The Care Area Assessment (CAA) Process and Care Plan Completion dated 10/2023, documented the residents' plan of care would be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. The resident's care plan would be revised based on changing goals, preferences, and needs of the resident and in response to current interventions. The RAI 3.0 manual, Chapter 4, CAA Process and Care Planning, dated 10/2023, documented the care plan should be revised on an ongoing basis to reflect changes in the resident and the care the resident was receiving.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46301 Based on interview, clinical record review, and document review, the facility failed to ensure behaviors monitored were associated with the specific condition indicated by the physician for the use of psychotropic medications for 1 of 19 sampled residents (Resident #32). The deficient practices had the potential to cause residents to use an unnecessary medication with possible adverse effects. Findings include: Resident #32 Resident #32 was admitted to the facility on [DATE] and readmitted [DATE], with diagnoses including major depressive disorder, recurrent, unspecified, and generalized anxiety disorder. Resident #32's psychotropic physician's order documented the following; -Buspirone Hydrochloride (HCL) tablet 5 milligram (mg), give 5 mg by mouth three times a day for anxiety as evidence by hyper verbalization, ordered 12/17/2024. -Clonazepam tablet 1 mg, give 1 mg by mouth three times a day for anxiety, ordered 03/13/2025. -Duloxetine HCl capsule delayed release particles 60 mg, give 60 mg by mouth two times a day for depression, ordered 02/07/2025. -Trazodone HCl Oral Tablet 100 mg, give 125 mg by mouth one time a day for depression as evidence by insomnia, ordered 08/06/2024. -Wellbutrin Sustained Release tablet extended release 12 Hour, 150 mg, give 150 mg by mouth one time a day for depression, ordered 03/12/2025 Resident #32's care plans documented the following focus areas related to psychotropic medications: -Resident #32 had chronic anxiety and depression with behavior history of demanding behavior, mood changes such as anger or irritability/impatience with staff and other, initiated 05/07/2023 and revised 02/24/2025. -Resident #32 used psychotropic medications related to chronic anxiety and major depressive disorder with behaviors of depressed mood, sleep disturbances, and feelings loss of control initiated 05/07/2023 and revised 02/24/2025. An intervention included behaviors observed were repetitive statements, crying, rapid speech, preservation, hyper-verbalization, restlessness and agitation. Resident #32's behavior monitoring in the electronic medical record (EMR) instructed the Certified Nursing Assistants (CNA) to document behavior monitoring every day and night shift related to behaviors observed on shift. The behavior monitoring was not resident specific to the behaviors to monitor for. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/2025 at 2:40 PM, the Director of Nursing (DON) verbalized the behavior monitoring was documented by the CNAs during each shift. The CNAs would input a progress note for new and escalating behaviors. The DON explained the EMR had all types of behaviors to document for the residents, which would include the behaviors to monitor for Resident #32. The facility policy titled Psychotropic Drugs, updated 10/2022, documented residents with orders for psychotropic medication were evaluated and appropriate interventions implemented. Psychotropic drugs were any drug affecting the brain activities associated with mental processes and behavior. The interdisciplinary team validated there were appropriate diagnoses of behavioral symptoms, so the underlying cause of the symptom was recognized, and the condition was treated appropriately.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311 Based on observation, interview, clinical record review, and document review the facility failed to ensure 1) temperatures were monitored and recorded on each shift for 1 of 4 medication storage refrigerators, 2) medications were not stored with food items in 1 of 4 medication storage refrigerators, 3) a multi-dose vial was discarded within 28 days of opening, and 4) a medication cart was not left unsecured and unattended. The deficient practices had the potential to contaminate medication with food products, compromise medication integrity by not maintaining and recording the daily refrigerator temperatures between ,d+[DATE] degrees Fahrenheit (F), place the residents and staff at risk of receiving expired/outdated vaccines, and to allow unauthorized access to medications on the medication cart in the 200 Hallway. Findings include: Medication Storage On [DATE], during a review of the Staff Development Coordinator (SDC) office medication storage refrigerator, the following items were found: -two mozzarella cheese sticks -two full soda cans -two small containers of yogurt -one wheel of queso [NAME] cheese -one 8-ounce bottle of sour cream -one 6-ounce jar of jalapeno stuffed olives -one vial of Tubersol Solution 5 units/0.1 milliliters (ml), with a written opened date of [DATE], and -three Fluad influenza vaccines The SDC medication storage refrigerator did not contain a temperature log for refrigerator temperature monitoring and was found unsecured. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:18 PM, the Director of Nursing (DON) confirmed the food items were stored in the same refrigerator as the biologicals/vaccines in the SDC office. The DON verbalized it would be considered an infection control issue and both the food items and the biologicals stored in the SDC medication storage refrigerator would need to be discarded for cross contamination. The DON explained the SDC was responsible for maintaining the medication storage refrigerator in the SDC office and confirmed the lack of a temperature log or temperature tracking for the refrigerator. On [DATE] at 3:38 PM, the SDC, who was also a Licensed Practical Nurse (LPN), confirmed the SDC was responsible for the medication storage refrigerator contents and monitoring in the SDC office. The SDC explained the food had belonged to the SDC and the SDC had stored the food in the medication storage refrigerator with the vaccines intended for staff and residents. The SDC confirmed the SDC had not maintained or documented the SDC office medication storage refrigerator temperatures and had left the refrigerator unlocked. The SDC confirmed food was absolutely not allowed to be stored with vaccines/biologicals. The facility policy titled Medication Storage, dated ,d+[DATE], documented medications and biologicals were stored properly, following provider pharmacy recommendations, to keep their integrity and to support safe and effective drug administration. Medication rooms and cabinets would remain locked when not in use or attended to by persons with authorized access. Medications which required refrigeration were kept between 36 F and 46 F by using a thermometer in the refrigerator. A temperature log or tracking mechanism was maintained to verify the temperature remained within acceptable limits. The temperature of any refrigerator that stored vaccines would be monitored and recorded twice daily. Refrigerated medications were to be kept in closed and labeled containers. Foods such as employee lunches and activity department refreshments should not be stored in the same refrigerator. Expired Medication On [DATE] at 12:55 PM, a multi-dose vial of Tubersol Solution 5 units/0.1 ml, with a written opened date of [DATE], was located in the SDC medication storage refrigerator. The Tubersol solution was open for 49 days and stored in the SDC medication storage refrigerator for use on staff and residents. On [DATE] at 2:59 PM, during a medication storage room inspection, a Registered Nurse (RN) confirmed a multi-dose vial would be considered expired after 28 days of opening the vial. The date of opening would be the start of the 28 days and would be indicated in writing on the vial. On [DATE] at 3:08 PM, an LPN explained a multi-dose vial should have the date of opening written on either the vial or on the box containing the vial and would be considered expired 28 days after opening. The LPN explained a medication would not work as prescribed if used past the expiration date. On [DATE] at 3:21 PM, the DON confirmed the opened date of the Tubersol Solution was [DATE]. The DON verbalized a multi-dose vial should have a date of opening written on the vial, or on the box containing the vial, and should be discarded either 28 or 30 days after opening. The DON was not sure if the vial of Tubersol Solution was considered expired and would need to review the facility policy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:26 PM, the DON verbalized a multi-dose vial was considered expired after 30 days from the date of opening. The DON confirmed the Tubersol Solution vial found in the SDC medication storage refrigerator on [DATE], was expired and should have been discarded as the efficacy would have been reduced after the expiration date. The facility policy titled Medication Administration-General Guidelines, dated ,d+[DATE], documented multi-dose vials had specific shortened end-of-use dating, once opened, to ensure medication purity and potency. Multi-dose vials were to be discarded 28 days after the opened date. The facility policy titled Medication Storage, dated ,d+[DATE], documented medications and biologicals were stored properly, following provider pharmacy recommendations, to keep their integrity and to support safe and effective drug administration. Outdated, expired, or discontinued medications were immediately removed from stock, disposed of, and re-ordered from the Pharmacy. 46301 Unsecured Medications On [DATE] at 7:22 AM, a medication cart in the 200 hall was left unattended, with the top drawer unlocked with resident medications present and could be opened when the cart was locked. On [DATE] at 7:23 AM, a RN returned to the medication cart and confirmed the top drawer remained unlocked when the rest of the cart was secured. The facility policy Medication Storage, dated ,d+[DATE], documented during administration of medication, the medication cart was to be kept closed and locked when out of sight of the medication nurse.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30748 Based on observation, interview, and document review, the facility failed to obtain cooking temperatures and holding temperatures of chicken prior to plating the chicken to serve to residents for lunch service. This deficient practice posed a potential risk to safety and health standards which could lead to contamination and place residents at risk of foodborne illness. Findings include: On 03/26/2025 at 11:30 AM, dietary staff had removed three large trays of chicken breasts from the oven. The chicken was transferred to a holding tray and placed in the steam table. The chicken was then placed on a plate and ready to be placed in a steam cart to deliver to residents. The Dietary Aide failed to obtain cooking temperatures and holding temperatures prior to plating the chicken to serve to residents. On 03/26/2025 at 11:46 AM, the Dietary Manager confirmed temperatures were not taken nor documented for the chicken prior to placing the chicken on plates to serve to residents. The Dietary Manager verbalized the chicken temperatures were taken while the chicken was cooking, however the temperatures were not documented nor observed by the inspector. On 03/26/2025 at 11:48 AM, the Registered Dietician (RD) explained the facility did not record cooking temperatures and the facility was following the facility policy. The RD acknowledged residents could get sick and get a foodborne illness related to under temped chicken if consumed. A cooking temperature log for food could not be located. On 03/26/2025 at 1:52 PM, the Executive Director explained the facility did not have a policy related to foodborne illness. The facility policy titled Preparation and Service of Foods-Safety Precautions, last updated 11/2018, documented chicken was to have a minimum cooking temperature of 165 degrees Fahrenheit. Food holding temperatures were to be at 140 degrees Fahrenheit at a minimum. The facility policy titled Food Temperature, last updated 10/2017, documented food temperatures were to be taken and documented daily prior to meal service and monitored periodically throughout the meal service.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46301 Based on observation, interview, clinical record review and document review, the facility failed to ensure resident information was not visible on an unattended computer screen facing a public area and a clinical record was complete for 1 of 19 sampled residents (Resident #8). This deficient practice had the potential for unauthorized access to residents' protected health information and for care provided to residents, resident response to care provided, and refusals of care to not be documented and available for review as necessary. Findings include: On 03/24/2025 at 7:22 AM, a computer screen on a medication cart in the 200 hallway displayed medication information for a resident. On 03/24/2025 at 7:23 AM, a Registered Nurse (RN) returned to the medication cart. The RN confirmed the computer displayed resident information and verbalized when walking away from a medication cart. The RN explained the process was to always ensure the cart was locked and the computer screen was locked to prevent access to resident protected health information. The facility policy Medication Storage, dated 01/2025, documented resident's health information needed to remain private. Medication Administration Records containing resident health information must not be visible when not in direct use. 49557 Resident #8 Resident #8 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including encounter for orthopedic aftercare following surgical amputation and basal cell carcinoma of skin, unspecified. On 03/24/2025 at 10:29 AM, Resident #8 had a clean, dry dressing in place on the resident's head. Resident #8 verbalized the resident had a wound present for approximately one year and facility staff were providing wound care. Resident #8's Treatment Administration Record (TAR) for March 2025, documented the following: -Clean scalp with wound cleanser, dab dry. Apply small amount of Bacitracin ointment and cover with dry dressing for two weeks, every night shift for surgical wound. The start date was 03/25/2025, and the scheduled administration time was 6:00 PM. The TAR had a blank space for the scheduled administration on 03/25/2025. -Nystatin powder 100,000 units/gram. Apply to groin, inner thighs, toes topically one time a day for chronic candida/fungal intertrigo. The start date was 12/02/2024, and the scheduled administration time was 8:00 PM. The TAR had a blank space for the scheduled administration on 03/25/2025. (continued on next page)

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	295067	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ormsby Post Acute Rehabilitation	3050 N Ormsby Road Carson City, NV 89703

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Wound Care - Scalp: Clean with wound cleanser and pat dry. Leave open to air. Notify provider for any changes in condition. Every day shift for lesion. The start date was 01/06/2025 and the discontinue date was 03/25/2025 at 12:24 PM. The scheduled administration time was 6:00 AM. The TAR had a blank space for the scheduled administration on 03/25/2025. -Left below the knee amputation (BKA) compression sock on at all times for shaping of stump, remove on each shift for skin integrity check for left BKA aftercare. The start date was 02/02/2025, and the scheduled administration times were 6:00 AM and 6:00 PM. The TAR had a blank space for the 6:00 PM scheduled administration on 03/25/2025. On 03/27/2025 at 7:31 AM, an RN verbalized Resident #8 had a wound on the resident's scalp. The RN explained when wound care was provided to residents, the care was to be documented in the resident's TAR. On 03/27/2025 at 9:00 AM, the Director of Nursing (DON) explained the DON's expectation of nursing staff when providing wound care to residents included following the physician's order and documenting in the resident's TAR. A blank space on the TAR could indicate missing documentation and/or an omission of the ordered care. The DON reviewed Resident #8's TAR and confirmed the blank spaces on 03/25/2025. On 03/27/2025 at 2:30 PM, the DON verbalized the blank spaces on Resident #8's TAR related to care of the wound on the resident's scalp, application of Nystatin powder, and removal of a compression sock on 03/25/2025 resulted from an omission of documentation. The facility policy titled Skin Integrity, updated 01/2025, documented if skin impairment was noted, the nurse was to notify the physician, obtain a treatment order and document on the TAR after the order was implemented. The facility policy titled Medication Administration - General Guidelines, reviewed 01/2025, documented medications were to be administered in accordance with written orders of the prescriber. The administration of medication was to be documented in the electronic health record. The nurse was to document any dose of regularly scheduled medication which was withheld, refused, or given at any time other than the scheduled time.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40377 Based on clinical record review, document review, and interview, the facility failed to ensure the coordination of hospice care between the facility and hospice agencies and ensure the activities and services detailed in the hospice agency's care plan were provided to residents, documented by the hospice agency and received by the facility for 3 of 6 residents on hospice services (Resident #230, #50, and #4). The deficient practice had the potential to compromise the overall quality of hospice care due to the lack of coordination between the facility and hospice agencies and had the potential to jeopardize the health and safety of residents under hospice care in the facility. Findings include: Resident #230 Resident #230 was admitted to the facility on [DATE], with diagnoses including multiple sclerosis, chronic diastolic (congestive) heart failure, severe protein calorie malnutrition, paroxysmal atrial fibrillation, and adult failure to thrive. Resident #230 was admitted by the hospice agency to hospice care in the facility on 03/07/2025. Resident #230's hospice care plan dated 03/07/2025, documented services would include skilled nursing two times a week, a certified nursing aide two times a week, a Social Worker every other week and as needed, and a Chaplain weekly and as needed. Resident #230's facility care plan dated 03/07/2025, documented under the Problem: Hospice - terminal prognosis related to multiple sclerosis, the following interventions: - Adjust provision of activities of daily living (ADL) to compensate for resident's changing abilities. Encourage participation to the extent the resident wishes to participate. - Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. - Work with nursing staff to provide maximum comfort for the resident. Resident #230's hospice binder at the nurse's station documented Resident #230's current hospice benefit period was 03/07/2025 through 05/05/2025. The Activities included bathing, oral care, hair care, toileting two times per week and as needed. Monitoring included: pain and symptoms as needed, vital signs weekly, symptom management as needed and bowel monitoring as needed. Resident #230's hospice binder lacked a sign-in sheet for hospice staff to document when hospice staff were in the facility and providing care to the resident. On 03/26/2025 at 2:10 PM, Resident #230's hospice communication binder and facility's electronic medical record (EMR) lacked hospice visit notes from hospice nurses and certified nursing aide (CNA) visits. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/27/2025 at 9:46 AM, the Licensed Practical Nurse (LPN) verbalized hospice visit notes from the CNA and Nursing visits would be in the resident's hospice binder. The LPN verbalized the hospice staff check in with the nurse in the facility before providing care and the documentation was sent after the visit. Hospice CNAs give a verbal report to the nurse and the facility Nurse documents the tasks completed in the resident's clinical record. The LPN confirmed the hospice CNA's task documentation was not in Resident #230's clinical record. On 03/27/2025 at 1:56 PM, the DON provided hospice visit notes report, dated 03/27/2025 at 9:36 AM, fax dated 03/27/2025 4:24 PM EST (1:24 PM PST) for the following hospice care visits for Resident #230: - Skilled Nursing on 03/24, 03/21, 03/19, 03/17, 03/13, 03/10, 03/08, and 03/07 - CNA on 03/11 and 03/14 - Chaplain on 03/24, 03/17, and 03/10 - Social Worker on 03/24 and 03/10 The DON confirmed the hospice visits were not previously documented prior to 03/27/2025 in Resident #230's chart and were not available to facility staff to coordinate hospice care for Resident #230. On 03/27/2025 at 2:33 PM, the DON verbalized hospice visit notes should be in the resident's hospice binder and scanned into the resident's record. The DON confirmed documentation for only one CNA hospice visit since the resident's admission to hospice care and confirmed the hospice plan of care documented a CNA two times per week. The contract between the facility and the hospice agency providing care to Resident #230 dated 11/05/2024, documented Section 2.6, Manner of Communication, all communication between the hospice and Skilled Nursing Facility (SNF) pertaining to the care and services provided to the Patient shall be documented in the Patient's clinical record. 46301 Resident #50 Resident #50 was admitted to the facility on [DATE], with diagnoses including peripheral vascular disease, Alzheimer's disease, and venous insufficiency, chronic. Resident #50 was admitted by the hospice agency to hospice care in the facility on 05/22/2024. Resident #50's hospice care plan dated 02/04/2025, documented services would include skilled nursing two times a week, a certified nursing aide two times a week, a Social Worker once a month and as needed, and Chaplain two times per month. Resident #50's facility care plan dated 02/27/2025, documented under the Problem: Hospice - terminal prognosis peripheral vascular disease/Alzheimer's disease, the following interventions: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. - Work with nursing staff to provide maximum comfort for the resident. Resident #50's hospice binder at the nurse's station documented Resident #50's current hospice benefit period was 02/04/2025 through 04/04/2025. The Activities included bathing, oral care, hair care, toileting two times per week and as needed. Monitoring included: pain and symptoms as needed, vital signs weekly, symptom management as needed and bowel monitoring as needed. On 03/26/2025 at 2:00 PM, Resident #50's EMR and hospice communication binder lacked hospice visit notes from skilled nursing, CNAs, Social Worker and Chaplain visits. The binder included multiple documents titled Staff Visit Sign-in Sheet. The sign-in sheets documented the following: -During the week of 02/02/2025, one aide visits was completed. -During the week of 02/09/2025, one aide visits was completed. -During the week of 02/16/2025, no visits documented. -During the week of 02/23/2025, no visits documented. -During the week of 03/02/2025, two skilled nursing visit were completed. -During the week of 03/09/2025, one skilled nursing visit was completed. - During the week of 03/16/2025, no visits documented. - During the week of 03/23/2025, one skilled nursing visit was completed. On 03/26/2025 at 2:10 PM, Resident #50's hospice binder and electronic clinical record lacked visit notes from hospice nurses and CNA visits. On 03/27/2025 at 1:56 PM, the DON provided hospice visit notes report, fax dated 03/27/2025 10:35 AM for the following hospice care visits for Resident #50: - Skilled Nursing on 02/18, 02/25, 02/27, 03/06, 03/07, 03/11, 03/13, 03/21, and 03/24 - CNA on 02/05, 02/10, 02/12, 02/18, 03/05, 03/07, 03/12, 03/19, and 03/26 The contract between the facility and the hospice agency providing care to Resident #50 dated 10/18/2021, documented Section 3.7, Coordination of Care - General, each party was responsible for documenting such communication in its respective clinical records to ensure the needs of the hospice patients were met twenty-four hours per day. 49557 Resident #4 (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #4 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including other specified spondylopathies, lumbar region and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident #4 was admitted by the hospice agency to hospice care in the facility on 05/23/2024. Resident #4's hospice communication binder, located at the nurses' station, included a hospice care plan effective from 01/08/2025 through 03/18/2025. The care plan documented ordered and accepted services included: -Skilled nursing one time a week starting 01/19/2025. -CNA two times a week for one week, then four times a week for seven weeks starting 01/19/2025. -Spiritual visit one time per month starting 01/18/2025, two times per month starting 02/01/2025, and one time per month starting 03/01/2025. Resident #4's facility care plan documented a problem of Hospice: Resident #4 had a terminal prognosis related to dementia. The date initiated was 06/29/2024, and the revision date was 08/14/2024. Interventions included to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. On 03/26/2025 at 1:52 PM, the DON confirmed the DON was the hospice coordinator for the facility. The DON explained some hospice residents' hospice communication binders had logs indicating when visits had been completed by hospice staff while others did not. The DON reviewed the binders weekly to confirm the frequency of hospice visits being completed. If hospice staff did not document the visit in the binder, the hospice agency would send the visit notes to the facility and the facility would scan the notes into the resident's EMR. On 03/26/2025 at 2:00 PM, Resident #4's EMR and hospice communication binder lacked hospice visit notes from skilled nursing, CNAs, and spiritual visits. The binder included multiple documents titled Staff Visit Sign-in Sheet and Communication Note (sign-in sheet). The sign-in sheets documented the following: -During the week of 01/19/2025, four aide visits were completed. -During the week of 01/26/2025, four aide visits and one skilled nursing visit were completed. -During the week of 02/02/2025, four aide visits and one skilled nursing visit were completed. -During the week of 02/09/2025, two aide visits and one skilled nursing visit were completed. -During the week of 02/16/2025, one aide visit and one skilled nursing visit were completed. -During the week of 02/23/2025, no visits documented. -During the week of 03/02/2025, no visits documented. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-During the week of 03/09/2025, no visits documented. On 03/27/2025 at 8:33 AM, the DON explained facility staff were made aware of hospice staff providing care to residents by coordinating directly with the hospice staff and by reviewing hospice visit notes. The DON verbalized the hospice visit notes would document the nurses' assessment, any changes to the care plan, if hospice staff contacted the physician, and any personal hygiene provided to the resident. The facility ensured a current hospice care plan and current orders were onsite by doing quality assurance (QA) audits of residents on hospice however there was no formal process or frequency for the QA audits. The DON explained the process if the facility did not have a current care plan or documentation of completed visits onsite was to contact the hospice agency, request the documents be sent to the facility, and place the documents in the binder. On 03/27/2025 at 8:48 AM, the DON confirmed the care plan in Resident #4's hospice binder concluded on 03/18/2025. The DON verbalized the DON was unsure and would have to verify if the facility had a current hospice care plan or documentation of visits completed from 01/18/2025 through 03/18/2025. On 03/27/2025 at 1:56 PM, the DON provided copies of hospice visit notes completed by CNAs. The visits notes had a fax date stamp of 03/27/2025 from 11:31 AM through 11:50 AM and documented visits for the following dates: -Two visits were completed on 01/21/2025, 01/23/2025, 01/28/2025, 01/30/2025, 02/04/2025, 02/11/2025, 02/27/2025, 03/04/2025, 03/06/2025, 03/11/2025, 03/13/2025, and 03/18/2025. -One visit was completed on 02/06/2025, 02/18/2025, 02/20/2025, and 02/25/2025. Copies of visits notes completed by hospice skilled nursing, with a fax date stamp of 03/27/2025 at 11:17 AM, documented visits were completed on 02/11/2025 and 02/21/2025. On 03/27/2025 at 2:33 PM, the DON confirmed the facility did not have documented evidence of the completed hospice visits for Resident #4, Resident #50, and Resident #230 and a current hospice care plan for Resident #4 onsite in the facility and available for staff review prior to 03/27/2025. The facility was unable to provide documentation of coordination with the hospice agency regarding weeks when frequency of visits, as documented on the hospice care plan, were not met. The DON verbalized all visit notes should have been obtained, scanned into the resident's EMR, and placed in the resident's hospice binder. On 03/27/2025 at 2:39 PM, the DON confirmed the hospice agency providing care to Resident #230 did not use a sign-in log to track hospice staff in the facility and the sign-in log for Resident #50 was incomplete. The contract between the facility and the hospice agency providing care to Resident #4, effective 04/24/2024, documented the hospice and the facility were to develop a process to exchange information regarding development and updating of the plan of care (POC) and evaluation of care outcomes to ensure the hospice patient received necessary and appropriate care. Each party was to designate one or more liaisons to facilitate cooperation and communication between the parties to assure needs were met. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled Hospice - Provision of Care by Outside Providers, updated 09/2017, documented the facility collaborated with outside providers to coordinate the provision of hospice care as directed by the physician. The hospice and the facility communicated, established, and agreed upon a coordinated plan of care. Upon arrival, hospice staff would notify the facility staff of care to be rendered.