STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325037	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ladera Center	5901 Ouray Road NW Albuquerque, NM 87120

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to conduct an in-depth investigation and correct the grievance allegation for 2 (R #13 and 14) of 2 (R #13 and 14) residents reviewed for the outcomes and resolutions of their grievances. This deficient practice could likely result in the facility not considering the needs of the residents or adequately resolving their grievances and could likely lead to a decrease in resident quality of life. The findings are: A. Record reveiw of the facility's policy dated 10/15/24 regarding resident grievances. The policy stated in brief: -Resident/patients have the right to voice grievances to the center or other agency without fear of discrimination or reprisal. Service location (the facility residence of the resident/patient) will inestigate, document and follow up on all concerns and grievances registered by any patient or patient representative. Social services personnel will serve as patient advocates. The facility administrator will serve as the Grievance Officer who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion, leading any necessary investigations, maintaining confidentiality . issuing written grievance decisions to the patient. The policy further stated the following: -Concerns may be registered by telephone, mail, office visit or direct outreach to staff . -Upon receipt of the grievance/concern the Grievance/Concern Form will be initiated by the staff member receiving the concern. Patients or patient representatives may complete the Grievance/Concern Form and sumbit the completed form to a staff member. -Upon receipt of the Grievance/Cocnern Form the administrator or designee will document the grievance/concern. -When logged, the Administrator and appropriate department manager will be notifed. -The department manager will contact the person filing the grievance to acknowledge receipt, investigate the grievance, take corrective actions if needed, Engage the support of the Ombudsman if warranted and notify the person filing the grievance of resolution in a timely manner. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Written resolution for grievances will be offered per resident's rights and will include date grievance was received, summary statement of the grievance, steps taken to linvestigate the grievance, summary of the pertinent findings or conclusions regarding the grievance, statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken and date the written resolution was issued. B. Record review of R #13's face sheet dated 05/28/25 revealed she was admitted to the facility on [DATE] with multiple diagnoses. C. Record review of R #13's Minimum Data Set (MDS:a review of a resident's needs, abilities and history) dated 04/13/25 section C-Cognitive Patterns (a section of the MDS which indicates a resident's mental status) Brief Interview for Mental Status (BIMS: a brief test which measures a resident's memory and mental ability) revealed a score of 15 out of 15 which indicated R #13 is alert and able to recall recent events clearly. D. Record review of R #14's face sheet dated 05/28/25 revealed she was admitted to the facility on [DATE] with multiple diagnoses. E. Record review of R #14's MDS dated [DATE], section C, BIMS revealed a score of 15 out of 15. F. Record review of a grievance/concern form dated 04/2/25 revealed a grievance submitted by R #14. The grievance form indicated it was assigned 04/03/25 and resolved 04/04/25. The form does not indicate if this grievance was investigated, the results of the investigation, the outcome of the investigation or if/when R #14 was notified of the resolution of the grievance. G. Record review of a grievance/concern form dated 05/05/25 revealed a grievance submitted by R #13. The grievance form indicated it was assigned 05/06/25 and resolved 05/06/25. The grievance form indicated R #13 was missing a gown, sheets, purple dress, pants and that a night gown had returned. The form indicated the purple dress was found. The form does not indicate if other grievances were investigated, the results of the investigation, the outcome of the investigation or if/when R #13 was notified of the resolution of the grievance. H. Record review of the facility's grievance log dated March 2025 revealed four grievances being submitted and investigated. I. Record review of the facility's grievance log dated April 2025 revealed three grievances being submitted and investigated. J. Record review of the facility's grievance log dated May 2025 revealed two grievances being submitted and investigated. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	K. On 05/27/25 at 11:30 am during interview with R #13, she stated that she has submitted multiple complaints during her stay at the facility. She stated that she submitted a grievance in March 2025 about clothes missing and torn. She stated she did not hear anything about this grievance. She stated that in early May, she resubmitted her complaint on a Grievance Form and she is still waiting to hear about the outcome of her missing items. R #13 stated that her roommate often asked and expected her (R #13) to press a call light and call staff in to help her (roommate). R #13 further stated she had also told the Social Services Director (SSD) of this concern sometime in early May 2025. She stated she has heard nothing of this grievance and knows nothing of any investigation or result. R #13 stated that she felt this was a common problem, that grievances are submitted to staff and nothing comes of the grievance. L. On 05/27/25 at 12:20 pm during interview with the SSD, she stated that often residents come to her office and voice their concerns. She stated she generally does not consider these concerns to be grievances or complaints. She stated that she often tries to resolve these cocnerns without filing a formal grievance form. SSD further confirmed that she had met with R #13 and they had talked about R #13's roommate and her concerns. SSD offered no investigation or resolution of this concern. M. On 05/27/25 at 1:55 pm during interview with R #14, she stated she has filed grievances in the past. She could not recall dates. She stated she had not heard anything about any investigation or conclusion of her grievance. N. On 05/27/25 at 2:10 pm during interview with Licensed Practical Nurse (LPN) #10, she stated she had been approached by residents who voiced concerns to her. She stated she would consider if the resident was capable of completing a grievance form. If so, she would offer the resident the form and ask them to fill it out and give the completed form to the office. She stated she generally did not complete a grievance form for residents unless she felt them unable to complete the form themselves. O. On 05/27/25 at 2:20 pm during interview with the Director of Nursing (DON), she stated that residents are encouraged to fill out their own grievance forms. She stated if a resident is unable to do so alone, then staff are expected to help. She stated that staff continue to work with residents to hear and respond to their grievances and concerns. She stated this is usually done informally. P. On 05/27/25 at 2:30 pm during interview with the facility Administrator (ADM), he stated that residents are asked to fill out their grievance forms and if they choose not to fill out the form then staff will continue to try to resolve their grievance informally.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to provide showers, eating assistance, skin assessments and grooming care for 1 (R # 5) of 1 (R #5) resident when the facility failed to assist resident with ADL (Activities of Daily Living) care in accordance with Physician approved POC (Plan of Care). This deficient practice is likely to affect the dignity, health and comfort of the residents. The findings are: A. Record review of R #5's face sheet revealed R #5's was admitted on [DATE]. B. Record review of R #5's plan of care dated 04/03/25, revealed R #5 requires assistance/is dependent for ADL care. Dependent care includes: bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting. Facility interventions are: -Provide resident with substantial/maximal assistance for personal hygiene. -Provide resident with substantial/maximal assistance for showering/bathing. -Provide resident with substantial/maximal assistance for oral hygiene. -Provide R #5 with substantial/maximal assistance for dressing. -Provide R #5 with substantial/maximal assistance for toileting. -Provide R #5 with partial/moderate assistance for eating. C. Record review of R #5's physician orders revealed the following: -Perform weekly skin checks, fingernail checks and toe nail checks. Dated 01/02/25 - Clobetasol Propionate External Cream 0.05 % (eczema [dry, itchy, bumpy skin condition] cream) once per day. Order dated 02/19/25. -Ketoconazole external crème (psoriasis [Skin disease causing scaly patches, rash and itchy skin condition] cream) once per day. Order dated 02/19/25. D. On 05/01/25 at 3:44 pm during an interview with Certified Nurse Aide (CNA) #1, she stated she is not always capable of getting her residents showers completed because she has multiple duties. She stated moving residents like R #5 on the hoyer lift (resident moving device) requires two staff to operate and takes more time. CNA #1 confirmed she doesn't have enough time in her shift to complete all her work. CNA #1 confirmed the nail care and grooming does not occur on busy days. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. On 05/01/25 at 4:33 pm during an interview with CNA #2, she stated she cannot finish all of her duties during a regular shift. CNA #2 confirmed that the resident showers and grooming do get missed. CNA #2 stated that night shift does not help with showers and sometimes CNA #2 will come to work and find R #5 soiled in feces or urine. CNA # 2 stated this only has happened once or twice. F. On 05/02/25 at 4:37 pm during an interview with CNA #3, she stated residents will go five days without a shower/bath. CNA # 3 stated that she has 11 scheduled showers and only has done three showers, (on the day of the interview). CNA #3 confirmed resident care is missed or late due to being short staffed. G. On 05/05/25 at 11:44 am during an interview with Licensed Practical Nurse(LPN) #2, she confirmed the CNAs are responsible for clipping fingernails, grooming and showering of the residents. She confirmed clipping fingernails is important for cleanliness. LPN #2 confirmed R #5 nails were longer than they should be. LPN #2 stated sometimes she cannot find a CNA to help her because they are always so busy with their tasks. Showers H. Refer to F677 for related findings. I. On 05/01/25 at 11:35 am during a phone interview, R #5's brother stated that the facility is not bathing R #5 as often as they're supposed to. R #5's brother stated the facility staff are supposed to be applying medicated cream to R #5's face, scalp, arms, and they are not. R #5's brother stated R #5's skin condition has become worse due to lack of medicated cream and showers. J. On 05/01/25 at 2:50 pm during an interview with R #5, he confirmed that the nurses are supposed to apply medicated cream to his face for his skin condition and they are not. R #5 stated they have only applied face cream twice in the last month. R #5 stated he has to ask facility staff for help to eat during mealtimes. R #5 stated he only get his clothes changed when they give him a shower, which was twice in the last month. K. On 05/01/25 at 2:50 pm during an observation of R #5, revealed redness on R #5's arms, and face. R #5 appeared unclean with foul odor, powder like flakes on his clothing, arms, hands and, face. He had multiple wounds on his arms in various stages of healing. R #5 had large flakes on his scalp and a scabbed sore on his face. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	L. On 05/02/25 at 12:22 pm, during a phone interview with Nurse Practitioner (NP) #1, she stated that on 11/20/24, R #5 was in her clinic, and he had no skin issues. NP #1 stated that on 03/28/25, R #5 returned for an appointment with atopical dermatitis (dry, itchy and inflamed skin), and he was smelling of feces and urine. She stated R #5's had peeling from skin and face. NP #1 discharged R #5 back to facility with new orders to shower him once every two days and apply medicated cream every day. NP #1 stated the medicated cream will not work if the skin is not clean and dry. NP #1 stated if the facility was applying his cream as prescribed (02/19/25 by facility) R #5's skin would not be in this condition. NP #1 also stated she sent new orders to the facility stating R #5 needs substantial/maximal assistance with eating. She stated she believed R #5 was being neglected when she observed him on 03/28/25 due to a rash throughout his entire body, a strong smell of urine and feces, dried feces on his lower back coming from brief, dirty clothing, skin flakes coming off his scalp, dirty and long fingernails. NP #1 stated the shower record provided to her by facility revealed multiple gaps in showers performed. She stated the shower gaps range from 12 to 14 days. Eating Assistance: M. On 05/01/25 at 12:37 pm during an observation in the dining room. R #5 did not receive assistance with eating his food. R #5 was able to finish approximately half of his meal before he said he was done. R #5 wore a clothing protector, and it had become soiled with food. N. On 05/02/25 at 12:22 pm during a phone interview with NP #1, she stated R #5 is not capable of feeding himself and requires extensive help due to his medical diagnosis. R #5 is incapable of holding spoons or fork, has loss of muscle control, and contractions (stiff, tight, structural changes) in his arms. O. On 05/02/25 at 12:52 pm during an interview with CNA #4, he stated facility has multiple feeders' (humiliating term describing residents who require assistance eating food). He stated there are only four staff members available to assist residents. CNA #4 stated he moves served food away from residents requiring assistance until he has time to help them. He stated his intention is to prevent them soiling themselves with food. Skin Care P. Record review of R #5's provider order dated 01/02/25 revealed weekly skin checks. Q. Record review of R #5's skin assessments, revealed long intervals in his documented skin assessments in resident charting program from 01/10/25 through 01/31/25, 03/20/25 through 03/28/25, and 04/10/25 through 04/24/25. R. On 05/05/25 at 11:48 am during an interview with nurse manager, she stated it is her expectation that staff document skin assessments correctly and timely in resident charting program. The nurse manager stated R #5's skin assessments are not documented in conformity with R #5's plan of care. The nurse manager confirmed R #5's skin has become worse in the last six weeks. S. On 05/05/25 at 12:14 pm during an interview, the Director of Nursing (DON) confirmed it is her expectation that an order from a Physician for weekly skin checks should be followed and documented. The DON stated if tasks are not documented appropriately, there is no way for the facility to verify they were completed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Grooming: T. On 05/01/25 at 2:50 am during an observation, R #5's fingernails were long with dirt or grime visible under the fingernails. U. On 05/01/25 at 3:44 pm during an interview, CNA #1 confirmed R #5's nails were too long and did not look clean. V. On 05/05/25 at 10:06 am during an interview with Administrator, he confirmed R #5's fingernail care is the responsibility of the CNAs. W. On 05/05/25 at 12:14 pm during an interview with DON, she confirmed the CNAs are responsible for fingernail care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) assistance for baths and showers by the facility staff for 2 (R #5 and R #12) of 2 (R #5 and R #12) residents reviewed for ADLs (activities of daily living). This deficient practice is likely to affect the dignity and health of the residents. The findings are: R #5 A. Record review of R #5's face sheet revealed R #5 was admitted on [DATE] with the following diagnoses: -Epilepsy, (a brain condition that causes recurring seizures). -Multiple Sclerosis, (the immune system attacks the protective sheath that covers nerve fibers). Symptoms include: lack of coordination, loss of muscle control, weakness, loss of bladder and or bowel control. -Hemiplegia, (paralysis of muscles of the lower face, arm, and leg on one side of the body). -Unspecified dementia, (a group of symptoms dealing with affecting memory, thinking and abilities). -Psoriasis, (overactive immune system response causing skin cells to multiply too quickly). Symptoms include: thick, red patches of scales that itch or burn, dry and cracked skin. Red patches cause itchiness, burning sensations or bleeding. -Dysphagia, (swallowing difficulties). Symptoms include coughing or choking while eating. B. Record review of R #5's plan of care dated 04/23/25 revealed the following: Focus: R #5 requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion and toileting related to diagnoses. Interventions: -Provide resident with substantial/maximal assistance for personal hygiene. -Provide resident with substantial/maximal assistance for showering/bathing. C. Record review of R #5's task sheet in facility's resident documentation program revealed R #5's shower days are scheduled on Tuesdays, Thursdays and Saturdays. D. Record review of R #5's shower tracking log revealed the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 04/01/25 through 04/30/25, R #5 had 2 showers of 13 opportunities. - 03/01/25 through 03/31/25, R #5 had 5 showers of 13 opportunities. -02/01/25 through 02/28/25, R #5 had 2 showers of 12 opportunism. E. On 05/01/25 at 11:35 am, during a phone interview with R #5's brother, brother stated that the facility is not bathing R #5 as often as they're supposed to. R #5's brother confirms reporting the issue to administration and filing a complaint. On 05/05/25 at 10:26 am administration stated he had not received any complaints from the family of R #5 that he can recall. F. On 05/01/25 at 2:50 pm, during an interview with R #5, he stated the facility has not been giving him a shower as often as they're supposed to. R #5 stated he has had 2 showers in the last month. R #5 confirmed he never denies showers from staff. R #5 stated he feels terrible when he doesn't get to shower, and it makes him depressed. R #5 confirmed he would be very happy if he could shower 3 times per week. G. On 05/02/25 at 12:22 pm, during a phone interview with NP(Nurse Practitioner) #1, she stated she reported R #5 to the New Mexico Department of Heath Improvement for neglect due to; a rash throughout his entire body, a strong smell of urine and feces, dried feces on his lower back coming from brief, dirty clothing, skin flakes coming off of his scalp, dirty and long fingernails, facility not providing assistance eating, and shower record with multiple gaps 12 -14 days at a time. NP #1 stated R #5 came to her clinic on 03/28/25 for a check up and had point of care documentation with him. This is how she reviewed the shower record and uncovered gaps in care for R #5. H. On 05/02/25 at 11:38 am, During a phone interview with Ombudsman, she stated after visiting with multiple residents, there is a common concern about showers not being completed at the scheduled times due to low staffing. She stated this was during a routine site visit. R #12 I. Record review of R #12's face sheet revealed R #5 was admitted on [DATE] with the following diagnoses: -Epilepsy, (a brain condition that causes recurring seizures). -Sepsis (systemic infection in blood or tissue) due to E. Coli (Bacteria infection). -Hemiplegia, (paralysis of muscles of the lower face, arm, and leg on one side of the body). -Neuromuscular dysfunction of bladder (disruption of nervous system control over the bladder). -Dementia (memory loss). J. Record review of R #12's plan of care dated 03/14/25 revealed the following: Focus: R #12 requires assistance/ is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion and toileting related to diagnoses. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions: -Provide resident with substantial/maximal assist for personal hygiene. -Provide resident with substantial/maximal assist for showering/bathing. K. Record review of R #12's task sheet in facility's resident documentation program revealed R #12's shower days are scheduled on Mondays, Wednesdays and Fridays. L. Record review of R #12's shower tracking log revealed the following: -04/01/25 through 04/30/25, R #12 had 4 showers of 13 opportunities. -03/01/25 through 03/31/25, R #12 had 3 showers of 13 opportunities. - 02/01/25 through 02/28/25, R #12 had 2 showers of 12 opportunism. M. On 05/01/25 at 3:10 pm, during an interview with R #12, he stated he does not get regular showers because there are not enough staff. R #12 stated he is supposed to get 3 showers per week, but the facility makes him wait. R #12 stated he wears a brief and poops a lot, and he has to sit in it for a long time. R #12 stated I poop, and no one cares. R #12 has difficulty speaking after previous stroke, and cannot articulate how often his brief was changed. R #12 stated, Grouchy is how I feel, it makes me feel terrible, angry, frustrated when I don't get showers. N. On 05/01/25 at 3:44 pm, during an interview,Certified Nursing Assistant (CNA) #1 stated they try to make R #5 a priority, but he doesn't always get showers done. CNA #1 stated R #12 is supposed to shower 3 times per week, but he never gets them on his 3 scheduled days. O. On 05/01/25 at 4:33 pm, during an interview with CNA #2, she confirmed that showers do get missed on a regular basis. P. On 05/02/25 at 4:37 pm, during an interview with CNA #3, she confirmed showers are missed on a regular basis. Q. On 05/05/25 at 10:26 am, during an interview with Administrator (Admin), he stated he cannot provide additional resident shower records. He stated he does not know what shower sheets look like and to ask the DON. R. On 05/05/25 at 11:20 am, during an interview with Licensed Practical Nurse (LPN) #1, she stated that she is new to the facility and wasn't given any instructions on cosigning shower/bath logs daily with CNAs. LPN #1 confirmed she would be concerned if residents weren't receiving scheduled showers. S. On 05/05/25 at 12:14 PM , during an interview with DON, she confirmed she does not have any other shower records for R #5 or R #12. The DON confirmed it is the expectation that CNAs correctly chart showers in the tracking software.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide quality of care for 1 (R #4) of 3 (R #'s 4, 7, and 8) residents reviewed for change in condition when care was not provided in a timely manner. This deficient practices likely resulted in worsening condition and unnecessary discomfort for the residents. The findings are: A. Record review of R #4's face sheet revealed she was admitted to the facility on [DATE] with the following diagnoses: -Cerebral Infarction (stroke). -Dysphagia (difficulty swallowing). -Epilepsy (a chronic condition that is characterized by seizures). The face sheet also confirmed that R #4's primary care provider is a Medical Doctor (MD) who is part of a local primary care service (PCS) that is not associated with the facility. B. Record review of R #4's daily care notes revealed the following: -03/01/25 at 5:26 pm, R #4 is reported to have chills, a measured body temperature of 99 degrees (normal body temperature is 98.6) and a cough. The reporting nurse indicated she contacted R #4's PCS by phone and left a message -03/02/25 at 10:34 am, R #4 was noted to have a change of her condition. She is noted to have an elevated body temperature of 99 degrees and a cough. R #4's PCS was contacted and PCS ordered Guaifenesin (a liquid cough medication) every four hours as needed. -03/02/25 2:11 pm, R #4 was reported to have a measured body temperature of 99 degrees and a cough. Guaifenesin was started and given at 10:00 am. Provider ordered test for COVID (a viral respiratory infection). Test result was negative and PCS contacted with message to call back (to facility). -03/02/25 at 4:33 pm, nurse contacted PCS to give an update and get final order. -03/02/25 at 7:09 pm, note indicated PCS was contacted at 4:55 pm and answered by identified person (IP). PCS directed R #4 to receive a nebulization (a respiratory breathing treatment in which medications are administered and inhaled directly into the lungs). IP indicated he will contact PCS provider to call back. C. Record review of R #4's provider orders revealed the following: -03/02/25 at 2:15 pm an order to test for COVID -03/04/25 at 4:32 pm an order to provide nebuliation every two hours as needed. (continued on next page)

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	325037	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ladera Center	5901 Ouray Road NW Albuquerque, NM 87120

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. On 05/02/25 at 11:30 am during phone interview with R #4's daughter, she stated that she was notified of her mother's changing condition on 03/02/25 at about 10:30 am. She stated she requested that her mother be sent to hospital immediately for evaluation. Daughter stated she was told that this would have to be approved by R #4's PCS and that the PCS had been contacted with no return call. Daughter stated that she began calling the PCS herself to discuss her mother's condition and her preference for her to be transported to hospital. She stated she got no response back from the PCS for 8 hours. Daughter stated when she did make contact with the PCS, she requested her mother be transported to hospital. E. On 05/02/25 at 4:10 pm during phone interview with Licensed Practical Nurse (LPN) #1, she stated that she recalled the incident in February 2025 regarding R #4 and her change condition. She stated that she contacted the PCS and left a message regarding R #4's change in condition on 03/02/25 at about 4:00 pm. LPN #1 stated she had been directed by R #4's daughter to send R #4 to the hospital and she was following up with this request. She stated she did not hear back from the PCS for about 12 hours. F. On 05/02/25 at 4:30 pm during interview with Director of Nursing (DON), she stated that she could recall an instance in February when PCS failed to respond to a resident's needs in a timely manner. She recalled that this affected the care of R #4. She stated that she could not recall any new incidents have occurred since.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to effectively manage pain for 1 (R #1) of 1 (R #1) resident reviewed for pain when staff did not provide pain treatment. This deficient practice likely resulted in R #1 experiencing long periods of pain without sufficient relief. The findings are: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE]. B. Record review of R #1's physician orders revealed the following: 1. 01/29/25: Acetaminophen 325 MG (milligram) every six hours as needed. Notify physician/midlevel provider if discomfort persists. 2. 01/29/25: Lidocaine External Cream 4 % (percent) every twenty four hours for pain (one patch each shoulder). 3. 04/21/25: Oxycodone 5 MG every six hours as needed for pain for two weeks (on hold as of 05/02/25) 4. 05/01/25:Acetaminophen 325 MG (milligram) every six hours. 5. 05/02/25: Excedrin Migraine Oral Tablet 250-65 MG, give two tablets by mouth only for one day. C. Record review of R #1's nursing progress notes revealed the following: 1. 03/13/25 at 11:37 pm: R #1 stated he would like a stronger pain medication to manage his pain. Nurse educated R #1 that he received Oxycodone at 9:06 pm and he could not have that again for several hours. 2. 05/01/25 at 1:39 am: Pain assessment interview results revealed R #1 that in the last five days, R #1 stated he experienced pain frequently which made it hard for him to sleep at night. R #1 rated his pain an 8 out of 10 on the pain scale. 3. 05/02/25 at 1:12 pm: R #1 stated he wants his Oxycodone and Acetaminophen every four hours, but it was explained to R #1 that the provider scheduled R #1's pain medication and the Oxycodone is as needed (PRN). R #1 stated he is having headaches. D. Record review of R #1's pain scale vitals (0: No pain, 1-3: Mild pain, 4-6: Moderate pain, 7-9: Severe pain, 10- Worst pain) revealed the following: 1. 04/01/25 through 04/30/25: R #1 experienced a pain level of 5 or greater 20 times, with 15 out of the 20 recorded pain levels being between a 7 and 9. 2. 05/01/25 through 05/02/25: R #1 experienced a pain level of 5 or greater 4 times, with 2 of the 4 recorded pain levels being an 8 and 9. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	E. Record review of R #1's facility grievance dated 04/30/25 revealed R #1 had concerns regarding his pain management and the timeliness of pain medications administered. R #1's grievance stated that he has had pain due to headaches and he feels that he is neglected due to prior instances where he had worsening pain due to a lack of pain medication provided. The facility response to this grievance stated, Physician scheduled pain medication. No other facility interventions were noted. F. On 05/02/25 at 12:47 pm during an interview with R #1, he stated that he experiences pain frequently due to him recently having a cervical laminectomy (removal of the back part of a vertebra in your neck to make more room within the spinal canal) and the staff does not adequately manage his pain. R #1 stated that he will use his call light sometimes to request pain medication, but he will not receive the requested pain medication. R #1 confirmed that he is frustrated due to his pain management and he feels like the facility staff does not like him. G. On 05/02/25 at 3:01 pm during an interview with Licensed Practical Nurse (LPN) #3, she stated that R #1 receives Acetaminophen every 6 hours and Oxycodone as needed, with a new order for Excedrin present to treat his headaches. LPN #3 also stated that if a resident is frequently experiencing pain that is greater than a 5 out of 10 on the pain scale, then that residents pain management should be addressed. H. On 05/02/25 at 3:11 pm during an interview with the Unit Manager (UM) #1, she stated that R #1 will experience pain and now head pain which she is trying to address for him. The UM #1 stated she spoke to the Nurse Practitioner (NP) about this issue yesterday (05/01/25) because R #1 is still in constant pain that needs to be addressed. The UM #1 also stated that she received a grievance for R #1 on 04/30/25 (a copy of the grievance was requested, but the facility did not provide the grievance to surveyors) which stated that R #1 was unhappy with his pain management and the timing of his pain medications. The UM #1 stated R #1 gets upset because he wants his pain medications sooner, but his pain level being above a 6 out of 10 frequently is concerning. The UM #1 confirmed R #1 should not have had to a file a grievance (04/30/25) regarding his pain management, R #1's pain should have been addressed sooner, and she should have been notified of R #1 having frequent pain above a 6 out of 10 on the pain scale. I. On 05/02/25 at 4:10 pm during an interview with LPN #4, she stated that R #1 can become aggressive when he does not receive his pain medication. LPN #4 also stated that R #1 gets constant head pain and his pain is frequently a 5 out of 10 or greater. J. On 05/02/25 at 4:39 pm during an interview with the Director of Nursing (DON), she stated that they received a grievance by R #1 on 04/30/25 that stated R #1 was not happy with his pain management and the timeliness of his pain medication administration. The DON stated the NP scheduled his Acetaminophen instead of keeping it as PRN, and they would try Excedrin for R #1's head pain/headaches. The DON also stated that frequent pain above a 7 out of 10 in concerning, and confirmed the nursing staff should made her aware of R #1's frequent pain and did not until R #1 filed a grievance.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents had a written, signed, and dated progress note from their physician after each visit for 3 (R #'s 4, 7 and 8) of 3 (R #'s 4, 7 and 8) residents reviewed for current physician progress notes and documentation. This deficient practice is likely to result in resident's records being incomplete and resident care not being documented and reviewed. The findings are: R #4 A. Record review of R #4's face sheet dated 05/05/25 revealed she was admitted to the facility on [DATE] with the following diagnoses: -Cerebral Infarction (stroke). -Dysphagia (difficulty swallowing). -Epilepsy (a chronic condition that is characterized by seizures). The face sheet also states that R #4's primary care provider is a Medical Doctor (MD) who is part of a local primary care service (PCS) that is not associated with the facility. The face sheet further revealed that R #4 was discharged on 03/06/25 due to her death. B. Record review of R #4's electronic medical record EMR revealed R #4's Electronic Medical Record (EMR) reviewed between 02/04/25 and 05/05/25 has no documentation of a PCS provider visiting or giving care to R #7. R #7 C. Record review of R #7's face sheet dated 05/05/25 revealed she was admitted to the facility on [DATE] with multiple diagnoses including: -Dementia (a chronic progressive disease that affects the mind and memory) Severe -Hemiplegia (partial or complete muscle weakness on one side of the body) and Hemiparesis (partial or complete paralysis on one side of the body) following Cerebral (brain) Infarction (stroke). The face sheet also states that R #7's primary care provider is a Medical Doctor (MD) who is part of a local primary care service (PCS) that is not associated with the facility. Record review of R #7's EMR reviewed between 01/01/25 and 05/05/25, revealed the EMR did not contain any documentation of a PCS provider visiting or giving care to R #7. R #8 (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Record review of R #8's face sheet dated 05/05/25 revealed she was admitted to the facility on [DATE] with multiple diagnoses including: -Dementia Moderate. -Dysphagia (difficulty swallowing). -Parkinson's Disease (a chronic, progressive disease of the nervous system that body movement). The face sheet also states that R #8's primary care provider is a Medical Doctor (MD) who is part of a local primary care service (PCS) that is not associated with the facility. E. Record review of R #8's EMR reviewed between 04/10/25 and 05/05/25 revealed the EMR did not contain any documentation of a PCS provider visiting or giving care to R #8. F. On 05/05/25 at 11:00 am during interview with Director of Nursing (DON), she stated that R #4, 7 and 8's medical record did not contain PCS documentation of the medical care provided or of any visits from the PCS provider.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation and interviews, the facility failed to ensure the facility had sufficient staff to meet the needs of all 110 residents who resided in the facility when staff failed to: 1. Offer baths or showers to the residents as scheduled and per residents' preference. 2. Offer substantial/maximal eating assistance for residents that require activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) assistance. 3. Maintain fingernail length and cleanliness for residents who are dependent on the facility for ADL's. 4. Maintain dignity of residents who are dependent on the facility for ADLs. These deficient practices are likely to affect the comfort, dignity and health of the residents. The findings are: A. Refer to F0658 and F0677 for related findings. B. On 05/01/25 at 3:44 pm during an interview with Certified Nursing Assistant (CNA) #1, she stated the facility needs extra staff to complete daily tasks. She stated there isn't always enough staff to help with the Hoyer (resident moving device) lift which requires 2 staff to use safely. CNA #1 confirmed Hoyer residents must wait longer for transfers. CNA #1 confirmed she doesn't have enough time in her shift to complete all her work. C. On 05/01/25 at 4:33 pm during an interview with CNA #2, she confirmed that she cannot finish all of her duties during a regular shift. CNA # 2 confirmed short staffing affects quality of care. D. On 05/02/25 at 4:37 pm during an interview with CNA #3, she stated that she has 11 scheduled showers and only 3 have been completed (on the day of the interview). CNA #3 confirmed resident care is missed or late due to being short staffed. CNA #3 stated We are stretched too thin, for the amount of work the facility want her to do. CNA #3 stated she has too many residents and she cannot perform the level of care she would like to. Showers E. On 05/01/25 at 10:06 am during an interview with R #13, she stated that often she is told she cannot have a shower because they do not have the staffing to sit with the residents. R #13 stated bed baths won't happen either if the facility is short staffed. F. On 05/01/25 at 10:31 am during an interview with R #11, He stated there is not enough staff to meet his daily needs. R #5 stated the facility is short staffed and the CNA's do not always answer the call lights quickly. He confirmed staff tell him there are not enough staff, often due to staff calling off work. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	G. On 05/01/25 at 12:54 pm during an interview with R #9, she stated she is supposed to be bathed 3 times per week. R #9 confirms she only gets 2 showers per week. R #9 stated she is not allowed more than 2 showers per week. R #9 stated she doesn't think they have enough staff to cover more than 2 baths. R #9 confirmed she would love more than 2 baths per week. R #9 stated her biggest complaint is waiting for call light to be answered. H. On 05/01/25 at 2:50 pm during an interview with R #5, he stated he has maybe been showered twice in the last month. R #5 confirmed the facility is not showering him as often as they should. R #5 confirmed he never denies showers from staff, and he only changes his clothes when he gets a shower. I. On 05/01/25 at 3:10 pm during an interview with R #12, he stated that he is missing showers and is supposed to be getting 3 per week. R #12 stated he wants a shower every day. R #12 stated Grouchy is how I feel. It makes me feel terrible. Angry, it makes me frustrated. That I don't get showers. J. On 05/02/25 at 2:21 pm during an interview with R #10, he stated he gets 1 shower per month, but what can I do? R #10 stated there is no point in asking for anything because the staff will say, yeah yeah, and then he won't get anything. R #10 stated they (the facility) don't have enough staff to give me 3 showers per week. Eating Assistance K. On 05/01/25 at 12:40 pm during a dining room observation at lunch time, R #5 wore a clothing protector, sat at a table with other residents, and waited for his meal. After the meal arrived, R #5 tried to eat by himself. R #5's plate was half gone when he stopped eating. R #5's clothing protector was soiled with food and drink from his eating attempts. Staff never offered to assist R #5. L. On 05/01/25 at 2:50 pm during an interview with R #5, he stated Nurse Practitioner (NP) #1 told him he needs maximal eating assistance. R #5 stated he has to ask staff for help eating or it won't happen. M. On 05/02/25 at 1:02 pm during an observation at lunch time, R #14 sat at the table with a clothing protector on and a full plate of food in front of her. R #14 stated I need help, as she pointed to her plate of food. R #14 then placed her hands over her face and lowered her head N. On 05/02/25 at 1:03 pm during an interview, CNA #4 stated there are 10 residents in the dining area who need assistance eating and 4 staff members who can assist. CNA #4 stated We try to keep our eye on the feeders (humiliating term for residents requiring eating assistance), and he will remove resident food tray after it was served to them until he has time to assist them. CNA #4 confirmed the residents must wait to eat with their food right in front of them. CNA #4 confirmed the term feeders is a common term in the facility. Resident Grooming O. On 05/01/25 at 3:10 pm during an observation and interview, R #12's finger nails were uncut with dirt or grime underneath the nails on both hands. R #12 stated he dosen't know his nailed aren't clipped. He stated the nurse or CNA will cut his nails once in a while. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	P. On 05/02/2025 at 10:23 am during an observation, R #12's fingernails were in the same condition as the day prior. Q. On 05/01/25 at 2:50 pm during an observation and interview, R #5's fingernails were uncut with dirt or grime underneath the nail. R #5 stated that the facility does not cut his fingernails regularly. R. On 05/02/25 at 3:34 pm during an observation, R #5's fingernails in the same condition as the day prior. Resident Dignity R. On 05/02/25 at 1:03 pm during an interview with CNA #4, he used the term feeders at a full table of residents while assisting R #5 with his meal. CNA #4 confirmed the term feeders was used in reference to residents who need assistance with eating. CNA #4 confirmed this is a common term used in the facility. S. On 05/05/25 at 11:48 am during an interview with LPN #3, she used the term feeders when asked about residents who need assistance with eating. T. On 05/05/25 at 11:48 am during an interview with Nurse Manager, she stated I am not familiar with staffing schedule, It's not what I do here. U. On 05/05/25 at 10:26 am during an interview with the administrator, he stated, it's easy to assume that showers aren't being completed. V. On 05/05/25 at 12:14 pm, during an interview with DON, she stated CNAs have so many showers to do per day other staff should be helping. She stated the expectation is that showers are documented daily in the resident documentation software. The DON confirmed CNA complaints of night shift not helping with showers. The DON confirmed staffing needs are adjusted according to resident census and budget.

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. Based on observation and interview the facility failed to ensure that meals were served to residents at the posted serving times (Breakfast 7:30 am, Lunch 12:30 pm and Dinner 5:30 pm). This deficient practice is likely to result in the disruption of residents' dining experience. The findings are: A. On 05/01/25 at 9:49 am during initial walkthrough of the dining room and kitchen, lunch time was posted to be served at 12:30 pm. B. On 05/01/25 at 10:06 am during an interview with R #13, she stated that breakfast, lunch and dinner trays are always late. C. On 05/01/25 at 11:03 am during an interview, R #13 stated breakfast comes out late, sometimes at 9:00 am. Lunch comes to the rooms at 1:45 pm and dinner comes to the rooms at 6:45 pm. D. On 05/01/25 at 12:36 pm during an observation of lunch time in the dining room, the first resident meal tray was served at 12:51 pm. The last resident meal tray was served at 1:11 pm. E. On 05/01/25 at 1:15 pm during an observation of lunch time, the first lunch trays were delivered to north hall from kitchen. The Certified Nurse Aid (CNA)'s started to deliver the lunch trays to the resident rooms. F. On 05/01/25 at 1:27 pm during an observation of lunch time, the first lunch trays were delivered to south hall from kitchen. The CNAs started to deliver the lunch trays to the resident rooms. G. On 05/01/25 at 3:44 pm during an interview with CNA #1, she confirmed residents get upset because staff never know when the food trays are going to come out. H. On 05/02/25 at 12:45 pm during an observation of lunch time in the dining room, the first resident meal tray was served. I. On 05/02/25 at 1:03 pm during an observation of lunch time in the dining room, the last resident meal tray was served. J. On 05/02/25 at 1:23 pm during an observation of lunch time, the first lunch trays were delivered to north hall from the kitchen. The CNAs started to deliver the lunch trays to the resident rooms. K. On 05/02/25 at 1:44 Pm during an observation of lunch time, the first lunch trays were delivered to south hall from kitchen. The CNAs started to deliver the lunch trays to the resident rooms. L. On 05/02/25 at 3:03 pm during an interview with Dietary Manager (DM), he stated the kitchen starts plating the food at 12:30 pm. He confirmed the posted lunch time is 12:30 pm. DM stated by 1:30 pm, the kitchen should be done dropping trays off in the halls.