STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365077	A. Building B. Wing	11/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monterey Care Center	3929 Hoover Road Grove City, OH 43123

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42728 Based on observations, interviews, and record reviews, the facility failed to ensure resident dignity was maintained during dining experiences. This affected two residents (#35 and #103) observed for dining during the annual survey. The facility census was 108. Findings include: Observation on 11/20/24 at 8:05 A.M. revealed Resident #35 and Resident #103 were lying in bed and did not have breakfast meal trays. A newly admitted resident residing in the room with Resident #35 and Resident #103 was sitting up in bed consuming breakfast from a meal tray set up in front of her. Resident #35 and Resident #103 both confirmed they were hungry and would like a meal tray. Observation on 11/20/24 at 8:19 A.M. revealed Resident #35 and Resident #103 had still not been served a breakfast meal tray. Three unknown facility employees were standing at the end of the hall by the breakfast meal cart discussing who was responsible for Resident #103. All three employees stated the resident was not on their assignment and walked away. Observation on 11/20/24 at 8:29 A.M. revealed Registered Nurse (RN) #198 entered the room of Resident #35 and Resident #103 to provide care. RN #198 confirmed Resident #35 and Resident #103 had yet to receive their breakfast meal but would find out why. Observation on 11/20/24 at 8:40 A.M. revealed Certified Nurse Assistance (CNA) #133 entered the room of Resident #35 and Resident #103 and served the residents the breakfast meal. CNA #133 confirmed he was assisting another CNA to get a resident ready for dialysis and had not had time to serve the breakfast meals to the two residents. CNA #133 confirmed the newly admitted resident residing in the same room as Resident #35 and Resident #103 had already been served and eaten her breakfast meal.

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023 Based on record review and interview, the facility failed to provide residents with a bed hold notification prior to hospital stay. This affected two (Residents #15 and #39) of four residents reviewed for notification of bed hold. The facility census was 108. Findings include: 1. Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including epilepsy, clavicle fracture, humerus fracture, dysphagia, Alzheimer's disease, dementia, Lennox-Gastaut Syndrome, convulsions, idiopathic progressive neuropathy, anxiety, depression, cervical vertebrae fracture, and nontoxic thyroid nodule. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had severe cognitive impairment. Resident #15 was sent to the hospital on 08/30/24 following a fall with a laceration to her forehead. Review of the Notification of Bed Hold form with this resident's name written at the top revealed the form did not provide the total amount of bed hold days left. Interview with the Administrator on 11/21/24 at 2:18 P.M. verified by the actual bed hold days were not captured at the time of the notice. 2. Review of the closed medical record for Resident #39 revealed an admitted [DATE] with diagnoses including hallucinations, cognitive communication deficit, obesity, Hepatitis B and C, hypertension, asthma, irritable bowel syndrome, anemia, restless leg syndrome, constipation, anxiety, depression, fibromyalgia, and rheumatoid arthritis. Review of the quarterly MDS revealed Resident #39 had minimal cognitive impairment. Resident #39 was sent to the hospital on 11/12/24 due to abnormal lab work and complications to her PICC line. Review of the Notification of Bed Hold form with this resident's name written at the top revealed the form did not provide the total amount of bed hold days left. Interview with the Administrator on 11/21/24 at 2:18 P.M. verified by the actual bed hold days were not captured at the time of the notice.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, interview, and record review, the facility failed to accurately complete Minimum Data Set (MDS) assessments for residents. This affected six residents (#1, #22, #69, #91, #95, #99) of six residents reviewed for MDS accuracy. The facility census was 108. Findings include: 1. Review of Resident #99's medical record revealed an admitted [DATE] with diagnoses including dementia, neuromuscular dysfunction of bladder, dysphagia, encephalopathy, anxiety disorder, chronic diastolic heart failure, cognitive communication deficit, and edema. Review of Resident #99's quarterly MDS assessment dated [DATE] revealed two sections of the assessment, Section C, Cognitive Patterns and Section D, Mood were not completed. All areas including resident and staff interviews were marked as 'not assessed.' Interview on 11/20/24 at 5:33 P.M. with MDS Coordinator #242, Licensed Social Worker #204, and MDS Coordinator #256 verified the MDS assessments were not being completed as they should have been. If a resident refused to complete a section of MDS a staff interview should still be completed. 2. Review of Resident #69's medical record revealed an admitted [DATE] with diagnoses including senile degeneration of the brain, unspecified dementia, anorexia, major depressive disorder, anemia, cognitive communication deficit, osteoarthritis, and anxiety disorder. Review of Resident #69's quarterly MDS assessment dated [DATE] revealed two sections of the assessment, Section C, Cognitive Patterns and Section D, Mood were not completed. All areas including resident and staff interviews were marked as 'not assessed.' Interview on 11/20/24 at 5:33 P.M. with MDS Coordinator #242, Licensed Social Worker #204, and MDS Coordinator #256 verified the MDS assessments were not being completed as they should have been. If a resident refused to complete a section of MDS a staff interview should still be completed. 3. Review of Resident #95's medical record revealed an admitted [DATE] with diagnoses including protein-calorie malnutrition, bilateral age-related nuclear cataracts, Alzheimer's disease, anxiety disorder, adult failure to thrive, cognitive communication deficit, depression, and bilateral sensorineural hearing loss. Review of Resident #95's quarterly MDS assessment dated [DATE] revealed two sections of the assessment, Section C, Cognitive Patterns and Section D, Mood were not completed. All areas including resident and staff interviews were marked as 'not assessed.' Interview on 11/20/24 at 5:33 P.M. with MDS Coordinator #242, Licensed Social Worker #204, and MDS Coordinator #256 verified the MDS assessments were not being completed as they should have been. If a resident refused to complete a section of MDS a staff interview should still be completed. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	4. Review of Resident #91's medical record revealed an admitted [DATE] with diagnoses including moderate protein-calorie malnutrition, Alzheimer's disease, adult failure to thrive, aphasia, rheumatoid arthritis, fibromyalgia, pick's disease, anorexia, and depression, Review of Resident #91's quarterly MDS assessment dated [DATE] revealed she had a short term and long-term memory problem. It was indicated she had no range of motion impairment to her upper extremities. Observation on 11/18/24 at 10:03 A.M. revealed Resident #91 had bilateral hand contractures. Interview on 11/24/24 at 9:20 A.M. with the Director of Nursing (DON) verified Resident #91 had an upper extremity impairment that was not indicated in the assessment. 42728 5. Record review for Resident #1 revealed the resident was admitted to the facility on [DATE] and had diagnoses including schizophrenia, legal blindness, and muscle wasting and atrophy. Review of the quarterly MDS assessment dated [DATE] revealed Section C of the assessments was coded as not assessed. Interview with the Director of Nursing (DON) on 11/24/24 at 1:10 P.M. confirmed the MDS assessment for Resident #1 was not completed accurately as Section C had not been completed. 6. Record review for Resident #22 revealed the resident was admitted on [DATE] and had diagnoses including anxiety disorder, schizoaffective disorder, and chronic obstructive pulmonary disease. Review of the annual MDS assessment dated [DATE] revealed Section C0100 was coded as yes, the interview should be conducted, but all the questions after, had been marked as not assessed. Interview with the DON on 11/24/24 at 1:10 P.M. confirmed the MDS assessment for Resident #22 was not completed accurately as Section C had not been completed in its entirety.

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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** 43064 Based on observation, interview, and medical record review, the facility failed to ensure nail care was provided for dependent residents. This affected four residents (#75, #91, #95, #104) of six residents reviewed for activities of daily living (ADL). The facility census was 108. Findings include: 1. Review of Resident #104's medical record revealed an admitted [DATE] with diagnoses including bipolar disorder, secondary parkinsonism, schizoaffective disorder, mild cognitive impairment, and disorientation. Review of Resident #104's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had intact cognition. She required partial to moderate assistance with personal hygiene. Review of Resident #104's care plan dated 08/01/24 revealed she had an Activity of Daily Living (ADL) self-care deficit related to decreased mobility, use of assistive device, need of staff assistance, weakness, and diagnoses. Interventions included assisting with daily hygiene as needed, therapy evaluation as needed, and adjusting level of care as needed. Review of Resident #104's monthly summary dated 10/24/24 revealed she was disoriented. Observation on 11/18/24 at 10:09 A.M. revealed Resident #104 had long dirty nails. On 11/20/24 at 1:10 P. M. and 1:47 P.M. her nails were noted to remain long and appeared to be caked in food. Observation on 11/21/24 at 10:56 A.M. revealed Resident #104's fingernails remained long and dirty. Interview attempts on 11/18/24 at 10:09 A.M. and on 11/20/24 at 1:47 P.M. revealed Resident #104 was unable to answer questions. Interview on 11/21/24 at 10:56 A.M. with Certified Nurse Assistant (CNA) #197 verified Resident #104's nails were long and dirty. She indicated the resident required assistance and did not refuse nail care. 2. Review of Resident #95's medical record revealed an admitted [DATE] with diagnoses including protein-calorie malnutrition, bilateral age-related nuclear cataracts, Alzheimer's disease, anxiety disorder, adult failure to thrive, cognitive communication deficit, depression, and bilateral sensorineural hearing loss. Review of Resident #95's quarterly MDS assessment dated [DATE] revealed his cognition was not assessed. He required supervision or touching assistance with personal hygiene. Review of Resident #95's plan of care dated 11/13/23 revealed the resident had an ADL self-care performance deficit related to cognitive status, decreased mobility, and weakness. Interventions included adjusting care level as needed, assisting with ADLs as needed, and encouraging the resident to participate in activities. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #95's monthly summary dated 10/24/24 revealed he was disoriented. Observation on 11/18/24 at 11:31 A.M., 11/20/24 at 8:16 A.M., and 11/21/24 at 10:09 A.M. of Resident #95 revealed he had long nails extending past the end of his fingertips, and they appeared to be dirty. Interview on 11/21/24 at 10:56 A.M. with CNA #197 verified Resident #95's nails were long and dirty. She indicated the resident required assistance and did not refuse nail care. 3. Review of Resident #91's medical record revealed an admitted [DATE] with diagnoses including moderate protein-calorie malnutrition, Alzheimer's disease, adult failure to thrive, aphasia, rheumatoid arthritis, fibromyalgia, pick's disease, anorexia, and depression, Review of Resident #91's quarterly MDS assessment dated [DATE] revealed she had a short term and long-term memory problem. The resident was dependent on staff for personal hygiene. Review of Resident #91's plan of care dated 07/21/23 revealed she had an ADL self-care performance deficit related to disease process, weakness, and need for staff assistance to maintain safety at times. Interventions included approaching in a calm manner, collaborating with hospice, discussing any concerns related to decline in function, monitor for decreased activity tolerance, assisting with ADLs as needed and providing one person assistance with personal hygiene and encouraging nail care as needed. Observation on 11/18/24 at 10:03 A.M. and 11/21/24 at 10:56 A.M. revealed Resident #91 had contracted hands in a tight fist. Her nails were observed to be long with some of them having dirt underneath them. Interview on 11/21/24 at 10:56 A.M. with CNA #197 verified Resident #91's nails were long and dirty. She indicated the resident required assistance and did not refuse nail care. 4. Review of Resident #75's medical record revealed an admitted [DATE] with diagnoses including Alzheimer's disease, bilateral nuclear cataracts, cognitive communication deficit, dementia, alcohol use, anxiety disorder, depression, and tremor. Review of Resident #75's comprehensive MDS assessment dated [DATE] revealed the resident was rarely or never understood. He required supervision or touching assistance with personal hygiene. Review of Resident #75's plan of care dated 02/19/23 revealed the resident had an ADL self-care performance deficit related to his diagnoses. Interventions included assisting with ADLs as needed and providing one person assistance with personal hygiene. Observation on 11/18/24 at 10:00 A.M., 11/19/24 at 8:12 A.M., and 11/21/24 at 9:32 A.M. and 10:56 A.M. revealed Resident #75 had long dirty fingernails. Resident #75's nails were so long they could be seen from across the dining room. Interview on 11/21/24 at 10:56 A.M. with CNA #197 verified Resident #75's nails were dirty and long enough that they could be seen from a distance. She indicated the resident required assistance and did not refuse nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy, Nail Care, dated 04/16/23 revealed it was the responsibility of nursing staff to provide appropriate nail care as needed.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on interview and record review, the facility failed to ensure there were sufficient activities in the memory care unit especially in the evening and weekend. This affected four residents (#75, #91, #95, and #99) of four residents reviewed for activities and had the potential to affect all 25 residents residing in the memory care unit. The facility census was 108. Findings include: 1. Review of Resident #95's medical record revealed an admitted [DATE] with diagnoses including protein-calorie malnutrition, bilateral age-related nuclear cataracts, Alzheimer's disease, anxiety disorder, adult failure to thrive, cognitive communication deficit, depression, and bilateral sensorineural hearing loss. Review of Resident #95's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed his cognition was not assessed. Review of Resident #95's plan of care dated 06/10/24 revealed the resident was sometimes dependent on staff for cognitive stimulation related to cognitive deficits. The resident could make their own decisions as to which programs they would like to attend. Review of Resident #95's recreational assessment dated [DATE] revealed the resident had interest in arts and crafts, cards, bingo, puzzles, cooking, exercise, music, outside, pet therapy, reading, writing, and watching television. He was somewhat interested in spiritual activities. He wished to attend group activities, special events, one on ones, and independent activities. Review of Resident #95's monthly summary dated 10/24/24 revealed the resident was disoriented. Review of Resident #95's activities from 10/20/24 to 11/17/24 revealed he had no independent activities. His intellectual activities included sensory stimulation on 10/25/24, and current events on 11/04/24 and 11/11/24. He had no physical activities. His social activities included snacks on 11/06/24 and 11/08/24, bingo on 11/07/24, and arts and crafts on 11/13/24. He had no spiritual activities. His special activities included holiday parties on 11/11/24, special events on 10/31/24, pet visits on 10/22/24, 10/29/24, 11/05/24, and 11/12/24, music therapy on 10/21/24, 11/04/24, 11/05/24, 11/14/24, 11/18/24, and entertainment on 11/15/24. There were no activities listed on the weekend. Observation on 11/18/24 at 10:01 A.M., 10:51 A.M., 11:41 A.M., 2:19 P.M., 3:10 P.M., and 4:18 P.M. revealed Resident #95 sitting in the dining room. The television was on but the volume was down very low. Observation on 11/19/24 at 9:59 A.M. and 2:55 P.M. revealed Resident #95 in the lounge with the television on, he was not paying attention to the television. At 4:17 P.M. he was in the dining room and again the television was on but the volume was down low. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/20/24 at 8:16 A.M. revealed activities was passing out the daily chronicle. Resident #95 shuffled the papers but did not read them. Observations at 9:21 A.M., 1:10 P.M., and 1:47 P.M. revealed Resident #95 in the lounge with the television on, he did not appear to be watching it. 2. Review of Resident #91's medical record revealed an admitted [DATE] with diagnoses including moderate protein-calorie malnutrition, Alzheimer's disease, adult failure to thrive, aphasia, rheumatoid arthritis, fibromyalgia, pick's disease, anorexia, and depression, Review of Resident #91's MDS assessment dated [DATE] revealed she had a short term and long-term memory problem. Review of Resident #91's plan of care dated 03/22/24 revealed the resident was encouraged to engage in leisure preferences to promote socialization and provide physical and mental stimulation. Interventions included honoring music and hobby preferences, introducing to other residents with similar interests, provide with assistance during programing if needed, and provide one on one programming. Review of Resident #91's recreational assessment dated [DATE] revealed the resident liked music, outside or gardening, reading or writing, watching television, and bible study. She wished ot have independent activities, one on ones, and group activities. Review of Resident #91's activities from 10/20/24 to 11/17/24 revealed her independent activities included a one on one visit, with a room visit and winding down on 10/24/24 and one on one on 11/11/24. Her intellectual activities included current events on 11/04/24, and sensory stimulation on 11/07/24 and 11/12/24. She had no physical activities. Her social activities included arts and crafts on 11/06/24, games and snacks on 11/07/24, and snacks on 11/08/24. Her spiritual activities included bible study and spiritual services on 10/23/24 and 10/30/24. Resident #91's special activities included pet therapy on 10/22/24, 11/05/24, 11/12/24, music therapy on 11/05/24 and 11/15/24, and entertainment on 11/15/24. There were no activities listed on the weekend. Observation on 11/18/24 at 11:41 A.M. and 2:19 P.M. revealed Resident #91 in the lounge, she was at a table facing the wall. Observation on 11/20/24 at 8:16 A.M. revealed Resident #91 facing the wall, the chronicle was passed out by activities and she did not get one. Observations of the resident at 9:19 A.M., 1:10 P.M., and 1:47 P.M. revealed the resident was now facing the television. 3. Review of Resident #75's medical record revealed an admitted [DATE] with diagnoses including Alzheimer's disease, bilateral nuclear cataracts, cognitive communication deficit, dementia, alcohol use, anxiety disorder, depression, and tremor. Review of Resident #75's comprehensive MDS assessment dated [DATE] revealed the resident was rarely or never understood. Review of Resident #75's plan of care dated 03/14/24 revealed he was dependent on staff for some cognitive stimulation due to cognitive deficits. Interventions included assisting off unit for strolls or special events, assisting with radio or television in room as needed, assuring activities are compatible with capabilities, encouraging participating in groups, monitoring for changes in activities, and providing with one on one as needed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #75's activities assessment dated [DATE] revealed he had interest in cards, bingo, puzzles, listening to music (used to play guitar), going outside, gardening, pet therapy, light reading, watching television and bible study. He had interest In group activities, independent activities, and one on ones. Review of Resident #75's activities from 10/20/24 to 11/17/24 revealed the resident had no independent, intellectual or physical activities. He had one spiritual service on 10/30/24. His social activities included games, reminiscing, and snacks on 11/07/24, arts and crafts on 11/13/24 and 11/15/24, and music groups on 11/15/24. He had no activities on the weekends. 4. Review of Resident #99's medical record revealed an admitted [DATE] with diagnoses including dementia, neuromuscular dysfunction of bladder, dysphagia, encephalopathy, anxiety disorder, chronic diastolic heart failure, cognitive communication deficit, and edema. Review of Resident #99's quarterly MDS 3.0 assessment dated [DATE] revealed her cognition was not assessed. Review of Resident #99's plan of care dated 03/06/24 revealed the resident was dependent on staff for activities, cognitive stimulation, social interaction due to cognitive deficits. The family was involved in Resident #99's care. Interventions included assisting off the unit for strolls or special events, assisting with radio or television in room as needed, assuring that activities were compatible with physical and mental capabilities, attempting to redirect when the resident becomes tearful, introducing to peers near resident, place close to the facilitator, one on one as needed, redirect when yelling out, and redirect as needed when distracted. Review of Resident #99's recreational assessment dated [DATE] revealed her only activity interest was listening to music. Activities needed to be modified to accommodate her cognitive deficits and she required cueing and assistance with activities. Review of Resident #99's activities from 10/22/24 to 11/17/24 revealed her spiritual activities included spiritual service and bible study on 10/30/24. Special activities included pet therapy on 11/05/24 and 11/12/24, special events on 10/29/24, music therapy on 11/15/24, and entertainment on 11/15/24. Her social activities included arts and crafts and music group on 11/15/24. Her independent activities included one on one or room visits on 10/23/24, 10/24/24, 11/05/24, 11/11/24, 11/13/24, and 11/14/24, watching television on 11/11/24 and 11/14/24, and winding down on 10/23/24, 10/24/24, 11/11/24, and 11/13/24. She had no intellectual or physical activities. She had no weekend activities. Review of Resident #99's monthly summary dated 11/19/24 revealed the resident was disoriented. Interview on 11/20/24 at 1:57 P.M. with State tested Nursing Assistant (STNA) #162 verified that the television was not catching all the residents' attention. She reported the residents really liked music however, they no longer had a way to play it on the unit. She reported Resident #75 was especially interested in music. She revealed occasionally there were activities in the afternoon. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/21/24 at 3:31 P.M. and 11/24/24 at 10:58 A.M. with Activities Director #231 revealed they had activity staff that came in on the weekends and a part-time staff member who did some activities in the evening. She reported activities in the memory care unit varied in length but she would like each activity to last over a half an hour. She was unaware they did not have a radio on the unit. She verified there had not been many evening activities in October and November. Activities Director #231 verified that some activities were documented twice under different areas. [NAME] down was something done during one on ones. Activities Director #231 was unable to provide evidence Residents #75, #91, #95, and #99 received activities on the weekends. Review of the activity calendar in the memory care unit for October 2024 revealed activities only occurred after 2:00 P.M. on 10/02/24, 10/09/24, 10/16/24, 10/23/24, and 10/29/24. The Sunday activities for 10/06/24, 10/13/24, 10/20/24, and 10/27/24 included one activity at 1:00 P.M. called word searches, coloring pages, and sensory stimulation. Saturday activities on 10/05/24, 10/12/24, 10/19/24, and 10/26/24 included two activities at 12:00 P.M. and 2:00 P.M. Review of the activity calendar in the memory care unit for 11/01/24 to 11/17/24 revealed activities only occurred after 2:00 P.M. on 11/06/24 and 11/13/24. The Sunday activities for 11/03/24, 11/10/24, and 11/17/24 included one activity at 1:00 P.M. called word searches, coloring pages, and sensory stimulation. Saturday activities on 11/02/24 and 11/09/24 only included two activities at 12:00 P.M. and 2:00 P.M. The activities on Saturday 11/16/24 included activities at 9:00 A.M. and 10:30 A.M.

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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** 42728 Based on observations, interviews, and record reviews, the facility failed to ensure Thrombo-Embolic Deterrent (TED) hose were applied as ordered by the physician. This affected one resident (#57) of the eight residents reviewed for skin conditions during the annual survey. Additionally, the facility failed to timely collect urine and treat a urinary tract infection (UTI) for Resident #86. This affected one resident (#86) of one reviewed for UTI. The facility census was 108. Findings include: 1. Record review for Resident #57 revealed the resident was admitted to the facility on [DATE] and had diagnoses including history of venous thrombosis and embolism, chronic pain, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was assessed to be rarely/never understood. Review of the active physicians order dated 06/25/24 revealed the resident was to have knee high TED hose applied every morning and removed at bedtime for edema. Observation on 11/19/24 at 8:25 A.M. revealed Resident #57 was up in his wheelchair in the dining room eating the breakfast meal. The resident did not have TED hose applied as ordered. Observation on 11/20/24 at 8:12 A.M. revealed Resident #57 was up in his wheelchair in the dining room eating the breakfast meal. The resident did not have TED hose applied as ordered. Observation on 11/20/24 at 11:00 A.M. revealed Resident #57 was up in his wheelchair in his room. The resident did not have TED hose applied as ordered. Interview with Unit Manager #144 at the time of the observation confirmed Resident #57 did not have TED hose applied as ordered. 43064 2. Review of Resident #86's medical record revealed an admitted [DATE] with diagnoses including Alzheimer's disease, dysphagia, dementia, type two diabetes mellitus, cognitive communication deficit, depression, and insomnia. Review of Resident #86's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was rarely or never understood. Review of Resident #86's plan of care dated 04/15/24 revealed she was at risk for alteration in elimination related to incontinence of bowel and bladder due to impaired cognition. Interventions included assisting with toileting and hygiene as needed, incontinence care per protocol, and monitoring for signs of UTI. Review of Resident #86's progress note dated 10/02/24 revealed Psych 360 had given new orders to obtain a urinary analysis with culture and sensitivity. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #86's progress notes dated 10/02/24 to 10/04/24 revealed no evidence there had been attempts to collect urine. Review of Resident #86's progress note dated 10/05/24 revealed the nurse obtained a urine sample via straight catheter. Review of Resident #86's progress note dated 10/07/24 revealed the initial urinary analysis had been received indicating trace amounts of blood and protein in the urine and a moderate amount of bacteria. They were awaiting the culture and sensitivity. Review of the culture and sensitivity dated 10/09/24 revealed the presence of Klebsiella pneumoniae in the urine and the susceptibility of the specimen was verified on 10/09/24. Review of Resident #86's progress note dated 10/14/24 revealed a new order was given for Keflex 500 milligrams (mg) for seven days for UTI. Interview on 11/21/24 at 10:15 A.M. and 1:44 P.M., the Director of Nursing (DON) was unable to explain why the urine was not collected until 10/05/24. She reported the urine was not collected until 10/07/24 because the lab did not pick up samples over the weekend. She verified the delay in treatment. She reported she believed the laboratory had been having a glitch and that they received the culture back by 10/10/24 but not the sensitivity.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on observations, resident and staff interviews, medical record review, and facility policy review, the facility failed to ensure staff assisted one resident (#13) with the placement of bilateral hearing aids daily as ordered. This affected one resident (#13) of one reviewed for hearing services. The facility census was 108. Findings include: Review of the medical record for Resident #13 revealed an initial admitted on 04/25/17 and a readmitted on 09/25/23. Medical diagnoses included dementia without behavioral disturbance, unspecified bilateral hearing loss, anxiety disorder, depression, and chronic obstructive pulmonary disease (COPD). Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13's cognition had not been assessed for the assessment. Resident #13 had minimal difficulty hearing and used hearing aids. Resident #13 required a varied amount of assistance from staff ranging from supervision to partial/moderate assistance to complete Activities of Daily Living (ADLs). Review of the care plan revised 10/11/23 revealed Resident #13 had impaired sensory perception related to hearing loss. Interventions included ensure adaptive equipment is accessible and monitor/report any changes or abnormal findings to the physician. Review of the current physician orders revealed Resident #13 had an order that stated, Assist resident with placement of hearing aids every day shift and document compliance with hearing aids. Resident keeps at bedside. The order was dated 02/23/24. Review of the progress notes dated from 02/23/24 through current revealed there was no evidence Resident #13 was non-compliant with accepting assistance with placement of hearing aids. Review of the current patient care Kardex revealed there were not instructions to assist Resident #13 with placement of hearing aids. Observations and interviews on 11/18/24 at 4:24 P.M., 11/19/24 at 1:12 P.M., and 11/20/24 at 9:40 A.M. revealed Resident #13 did not have bilateral hearing aids in place. Resident #13 requested surveyor stand close to the bedside and raise voice in order to be able to hear this surveyor's questions. Resident #13 stated there was only one nurse and one aide who knew how to properly place his hearing aids in his ears. Resident #13 stated the staff did not offer to place the hearing aids in his ears every day as ordered. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 11/20/24 at 9:47 A.M. with Licensed Practical Nurse (LPN) #126 and Certified Nurse Assistant (CNA) #193 in Resident #13's room revealed LPN #126 was able to place the resident's hearing aid in his right ear with proper functioning. Resident #13 stated, She's the only nurse who knows how to do it. However, CNA #193 was not able to properly place the resident's hearing aid properly into his left ear. CNA #193 attempted to put the hearing aid in twice and Resident #13 stated, No, it's not in. LPN #126 instructed CNA #193 to push the hearing aid in further into the ear canal. CNA #193 was able to do so after instructions from LPN #126. However, Resident #13 was not able to hear anything out of the left hearing aid. CNA #193 then asked LPN #126 how to turn the hearing aid on as she did not know how to do this. LPN #126 instructed CNA #126 again but the left hearing aid still was not working. Resident #13 stated, I'm not hearing anything out of the left one. The right one is good. This surveyor asked LPN #126 who would be responsible for ensuring the nurses and aides who cared for Resident #13 were educated on placing the resident's hearing aids and how to properly turn them on. LPN #126 stated, I don't know. Review of the facility policy, Additional Services and Fees, dated 02/14/13, revealed the policy did not address the proper placement and use of hearing aids for residents who required them. There was no other facility policy provided.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observations, interviews, record reviews, and review of facility policy, the facility failed to ensure pressure ulcer prevention interventions were in place per the plan of care, failed to ensure pressure ulcers were comprehensively evaluated upon admission, and failed to ensure staff were educated on the appropriate settings for Low Air Loss (LAL) mattresses. This affected two residents (#43 and 362) out of the five residents reviewed for pressure ulcers during the annual survey. The facility census was 108. Findings include: 1. Record review for Resident #43 revealed the resident was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparalysis following cerebral infarction affecting the left non-dominant side, presence of pressure ulcers, and contracture of the muscle of the left hand. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed to have moderately impaired cognition. The resident was assessed to have three unstageable pressure ulcers present. Review of the care plan revised 08/27/24 revealed the resident had areas of unavoidable impairment of skin integrity including current breakdown of the skin of the left great toe. Interventions included a bariatric extended bed with an air mattress. Observation on 11/19/24 at 1:40 P.M. revealed Resident #43 was lying in a regular size bed watching television. Pool noodles were secured in place to the footboard at the end of the bed to prevent pressure against the residents feet. Interview with the Director of Nursing (DON) at the time of the observation confirmed the bed the resident was lying on was not a bariatric extended bed. The DON confirmed the bariatric extended bed had been provided by hospice and was removed when the resident ceased receiving hospice services and had not been replaced. Interview with the DON on 11/24/24 at 1:10 P.M. confirmed the bariatric, extended mattress was added to the resident's plan of care to reduce the likelihood of pressure to the resident's feet. 41266 2. Review of the medical record for Resident #62 revealed an admitted on 07/05/24. Medical diagnoses included multiple sclerosis, pressure ulcer of other site stage IV (10/30/24), pressure ulcer of other site unstageable (09/09/24), mild protein-calorie malnutrition, other chronic osteomyelitis other site (07/05/24), schizoaffective disorder, pressure ulcer of lower back unstageable (07/05/24), pressure ulcer of sacral region stage IV (07/05/24), and pressure ulcer of right lower back stage IV (07/05/24). Review of skin assessments since admission revealed on 07/05/24, there was a skin grid completed for Resident #62 which showed a circle around the buttocks areas with a written note, multiple open areas. There was no further information provided on the skin grid. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes since admission revealed there was not an admission note entered on 07/05/24 for Resident #62. There was no evidence of a comprehensive wound assessment on any open areas had been completed upon admission. Review of the wound note (completed by a contracted wound physician) dated 07/08/24 (three days after admission) revealed Resident #62 presented with wounds on his right ischium, left ischium, right hip, coccyx, right thigh, and scrotum. Review of the physician orders revealed Resident #62 had an order that stated, monitor low air-loss mattress, check that settings are appropriate for the patient, dated 07/09/24. Observation on 11/19/24 at 9:00 A.M. of Resident #62 in his room revealed the resident was in bed with low air loss mattress in place. Interview on 11/19/24 at 4:35 P.M. with Unit Manager (UM) #144 confirmed the only skin assessment complete of Resident #62's wounds upon admission was the skin grid dated 07/05/24 which was not a comprehensive assessment of the resident's wounds. UM #144 stated Resident #62 was admitted over a weekend and the floor staff do not assess wounds so the resident's wounds were not fully assessed until Monday when the wound physician evaluated the resident on 07/08/24. UM #144 also confirmed there was no admission progress note entered for Resident #62 to address the resident's wounds. Interview on 11/20/24 at 1:45 P.M. with Licensed Practical Nurse (LPN) #126 confirmed Resident #62 had an order to monitor the settings on the resident's low air loss mattress for appropriateness. LPN #126 stated the Durable Medical Equipment (DME) provider that delivered the bed also set the bed up with the settings. LPN #126 stated she did not know what the settings were supposed to be on Resident #62's mattress. LPN #126 stated she was not educated on what the settings on the mattress were supposed to be and was not aware the settings were supposed to be monitored. LPN #126 stated, I usually look to make sure the mattress is plugged in and functioning but I do not look at the settings. Interview on 11/20/24 at 4:30 P.M. with Regional Nurse (RGN) #251 confirmed Resident #62's wounds were not comprehensively assessed by the facility staff upon admission and the wounds should have been assessed. Interview on 11/21/24 at 8:35 A.M. with the Director of Nursing (DON) confirmed the facility's nursing staff had not been educated on the appropriate settings for Resident #62's low air loss mattress for monitoring. Review of the facility policy, Skin and Wound Guidelines, revised 03/20/24, revealed the policy stated, skin alterations and pressure injuries are evaluated and documented by the licensed nurse using the Admission & Re-admission Evaluation UDA upon admission with a head-to-toe skin evaluation and completion of the Braden Scale for Predicting Pressure Sore Risk UDA.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observations, interviews, and record reviews, the facility failed to ensure care and services to prevent the development or worsening of contractures were timely and appropriately implemented. This affected two residents (#43 and #91) out of two residents reviewed for limited range of motion during the annual survey. The facility census was 108. Findings include: 1. Record review for Resident #43 revealed the resident was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparalysis following cerebral infarction affecting the left non-dominant side, presence of pressure ulcers, and contracture of the muscle of the left hand. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed to have moderately impaired cognition. The resident was assessed to have an impairment in functional range of motion present on one side of the upper body. Review of the active care plans for the resident revealed no plan of care had been implemented to address care and services required related to the resident's contracture. Review of the Occupational Therapy (OT) Evaluation and Plan of Treatment dated 10/08/24 revealed the resident had a contracture of the muscle of the left hand present. The resident declined receiving occupational therapy services at the time of the assessment. Splint/orthotic recommendations included a carrot. Review of the physicians orders for the resident revealed no order for a carrot or other splint/orthotic device were in place. Observation with the Director of Nursing (DON) on 11/19/24 at 1:40 P.M. revealed the left hand of Resident #43 was severely contracted and there were no splints, orthotics, or other devices in place to the resident's left hand. Interview with Occupational Therapist (OT) #255 on 11/21/24 at 10:46 A.M. confirmed Resident #43 was evaluated for OT services on 10/08/24 but declined them. OT #255 confirmed recommendations for a carrot to be in place to the residents left hand were made due to the presence of a contracture. Interview with the DON on 11/24/24 at 1:10 P.M. confirmed there was no plan of care in place to address interventions necessary to prevent worsening of the resident's contracture. The DON confirmed recommendations for a carrot made by OT #255 had not been implemented. 43064 2. Review of Resident #91's medical record revealed an admitted [DATE] with diagnoses including moderate protein-calorie malnutrition, Alzheimer's disease, adult failure to thrive, aphasia, rheumatoid arthritis, fibromyalgia, pick's disease, anorexia, and depression, (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #91's quarterly MDS assessment dated [DATE] revealed she had a short term and long term memory problem. Review of Resident #91's plan of care revealed it did not address contractures. Review of Resident #91's physician's orders revealed no orders related to contractures. Review of Resident #91's progress notes revealed no indication she had contractures. Observation on 11/18/24 at 10:03 A.M. of Resident #91 revealed both hands were contracted into tight fists without intervention. Interview on 11/21/24 at 10:56 A.M. with Certified Nurse Assistant (CNA) #197 verified Resident #91's hands were contracted. She reported generally there was no splint or anything to address the contractures. She reported occasionally they put washcloths in them. Interview on 11/21/24 at 11:00 A.M. with Unit Manager #144 verified there was no intervention for Resident #91's contractures. She reported that the resident's husband did not want hand rolls or washcloths, however, she verified this might not be indicated in the medical record. Interview on 11/24/24 at 9:20 A.M. and 11:30 A.M. with the Director of Nursing (DON) verified Resident #91 had hand contractures since admission.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observations, interviews, record reviews, and review of facility policy, the facility failed to ensure fall interventions were in place per the plan of care. This affected one resident (#57) of the four residents reviewed for falls during the annual survey. The facility census was 108. Findings include: Record review for Resident #57 revealed the resident was admitted to the facility on [DATE] and had diagnoses including muscle weakness, unsteadiness on feet, and dementia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/05/24, revealed the resident was assessed to be rarely/never understood. Review of the care plan, initiated 08/01/23, revealed the resident was at risk for falls and potential injury. Interventions included grip strips to the floor in front of the bed. Observation on 11/20/24 at 11:00 A.M. revealed there were no grip strips present on the floor by Resident #57's bed. Interview with Unit Manager #144 at the time of the observation confirmed there were no grip strips present on the floor by the residents bed. Review of the facility policy titled, Fall Management Guidelines, dated 12/13/23, revealed facility staff, with input of the attending physician, will implement a resident-centered care comprehensive care plan that addresses the fall management program, the goal for fall management, individualized interventions to address the residents modifiable risk factors, interventions to try to minimize the consequences of risk factors that are not modifiable, and the plan for reduction and or risk for injury related to falls.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on medical record review, resident interview, and staff interview, the facility failed to complete timely follow up to obtain sleep study results for one resident (Resident #13). This affected one (Resident #13) of four residents reviewed for respiratory care. The facility census was 108. Findings include: Review of the medical record for Resident #13 revealed an initial admitted on 04/25/17 and a readmitted on 09/25/23. Diagnoses included dementia without behavioral disturbance, anxiety disorder, depression, obstructive sleep apnea, and chronic obstructive pulmonary disease (COPD). Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13's cognition had not been assessed for the assessment. Resident #13 required a varied amount of assistance from staff ranging from supervision to partial/moderate assistance to complete Activities of Daily Living (ADLs). Review of the Order Summary Report dated February 2024 revealed Resident #13 had an order to place Sleep Study Machine at bedtime dated 02/24/24. The resident also had an order to remove sleep study machine daily dated from 02/24/24 through 02/27/24. The orders were marked as administered as ordered. Review of the progress notes dated from 02/23/24 through 11/18/24 revealed on 02/23/24 at 3:51 P.M., Resident #13 returned from an outside pulmonologist appointment with a new order to place a sleep study device at night and remove in the morning. There was no evidence of the sleep study results and no evidence of any further follow up completed by the facility to obtain the results of the sleep study results for Resident #13. Interview on 11/18/24 at 4:16 P.M. with Resident #13 revealed he was supposed to receive a Continuous Positive Airway Pressure (CPAP) machine a long time ago but the facility lost the results of his sleep study test. Resident #13 stated he had not received any further follow up from the facility. Resident #13 reported having a diagnosis of sleep apnea and stated the physician had ordered a CPAP machine for him. Interview on 11/21/24 at 8:38 A.M. with the Director of Nursing (DON) confirmed Resident #13 did complete a sleep study in the facility in February 2024. The DON stated the sleep study device was mailed back to the pulmonologist provider who ordered it to interpret the results. The DON confirmed the facility never received any results from the resident's sleep study and there was not any evidence of routine follow up with the outside provider who ordered the sleep study to obtain the results of the study. The DON confirmed there should have been additional follow up to determine the results of the sleep study and/or receive additional instructions for Resident #13.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023 Based on record review and staff interview, the facility failed to ensure a resident with Post Traumatic Stress Disorder (PTSD) was appropriately assessed to identify the cause of the resident's PTSD and minimize triggers and/or re-traumatization. This affected one (#46) of three resident identified by the facility as having PTSD/trauma. The facility census was 108. Findings include: Record review for Resident #46 revealed the resident was admitted to the facility on [DATE]. Diagnoses included anxiety, cognitive communication deficit, depression, and suicidal ideations. Resident #46 was assessed to have an active diagnosis of PTSD initiated on 08/28/24. Review of the Minimum Data Set (MDS) assessment, dated 10/28/24, revealed Resident #46 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 14. Review of the active care plans for Resident #46 revealed no plan of care was in place addressing the cause of PTSD, triggers which may cause re-traumatization, or interventions to reduce the risk of re-traumatization and provide care for PTSD. Resident #46 was receiving psychiatric services for multiple mental health issues including PTSD in relation to a history of physical abuse (step-brother) and sexual abuse (in a group home). There was no comprehensive social history of assessment of asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event. Interview with the Director of Nursing (DON) on 11/18/24 at 2:24 P.M. verified Resident #46 did not have a plan of care that addressed individual triggers or current plan of care to address those triggers. The DON verified there was no assessment of triggers that may be stressors or may prompt recall of a previous traumatic event.

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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** 43064 Based on staff interview and medical record review, the facility failed to ensure Resident #69's blood pressure was monitored as ordered. This affected one (#69) of five residents reviewed for unnecessary medications. The facility census was 108. Findings include: Review of Resident #69's medical record revealed an admitted [DATE] with diagnoses including senile degeneration of the brain, dementia, and hypertension. Review of Resident #69's quarterly Minimum data Set (MDS) 3.0 assessment dated [DATE] revealed her cognition was not assessed and staff was not interviewed. Review of Resident #69's plan of care dated 09/29/22 revealed the resident had tendency for fluctuation in blood pressure related to hypertension, orthostatic blood pressure, cardiac medications, anemia, pain, and anxiety. Interventions included administering medications as ordered, diet as ordered, monitoring blood pressure as ordered, and monitoring for signs of hypotension. Review of Resident #69's physician order dated 08/03/24 revealed an order for Amlodipine Besylate five milligrams (mg) one tablet by mouth one time a day for hypertension. The medication was to be held for a systolic blood pressure below 110 millimeters of mercury (mmHg). Review of Resident #69's Medication Administration Record (MAR) for 11/01/24 to 11/18/24 revealed the Amlodipine Besylate was administered daily, however, Resident #69's blood pressure had not been assessed. Interview on 11/20/24 at 2:32 P.M. with the Director of Nursing (DON) verified Resident #69's blood pressure was not monitored as ordered.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation,staff interview, and review of medical record, the facility failed to ensure Resident #29 was served his meal as physician ordered. This affected one resident (#29) of 25 residents in the memory care unit. The facility census was 108. Findings include: Review of Resident #29's medical record revealed an admitted [DATE]. Diagnoses included dementia, cognitive communication deficit, schizoaffective disorder, anxiety disorder, dysphagia, and hypertension. Review of Resident #29's physician order dated 08/09/24 revealed the resident was to receive a regular diet with double entree portions. Observation on 11/18/24 at 12:07 P.M. of Resident #29 revealed his lunch tray included one sandwich. Review of Resident #29's tray ticket for lunch revealed he was on a regular diet. No double entrees were indicated on his tray ticket. Interview on 11/18/24 at 12:07 P.M. with State tested Nursing Assistant (STNA) #162 verified Resident #29's physician order indicated he was to receive double entree portions, and verified Resident #29 did not receive double entree portion at lunch.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observations, interviews, record reviews, and review of facility policy, the facility failed to ensure resident received appropriate set up assistance and adaptive equipment during meals necessary to maintain adequate nutrition. This affected one resident (#43) out of the five residents reviewed for nutrition during the annual survey. The facility census was 108. Findings include: Record review for Resident #43 revealed the resident was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparalysis following cerebral infarction affecting the left non-dominant side, muscle weakness, and contracture of the left hand. Review of the significant change Minimum Data Set (MDS) assessment, dated 10/08/24, revealed the resident was assessed to have moderately impaired cognition. Review of the care plan, revised 10/12/24, revealed the resident had a history of declined intake with liberated diet and appetite had improved. Interventions included to provide feeding and set up assistance as needed. Review of the active physicians order, dated 08/17/23, revealed the resident was to have a cup with lid for all liquids. Observation on 11/20/24 at 7:45 A.M. revealed a facility Certified Nurse Assistant (CNA) entered Resident #43's room carrying the breakfast meal tray. Two bowls with lids and a sippy cup containing orange juice were present on the tray. The breakfast meal tray was placed on the over-the-bed table to the right side of Resident #43's bed. The CNA did not remove the lids from the bowls or place the over-the-bed table over the resident's bed for ease of reach. Resident #43 reached over the rail on the side of the bed to attempt to remove the lids from the bowls and knocked a knife off the table onto the floor. The CNA picked up the knife and exited the room. Resident #43 continued trying to remove the lid from one of the bowls with his right hand as his left hand was contracted and not able to assist, but was unsuccessful. Resident #43 ceased trying to remove the lid and picked up the sippy cup of orange juice and began drinking it. Once the orange juice was consumed, Resident #43 tried again to remove the lid from one of the bowls on his tray and was successful. The resident reached into the bowl with his right hand and began consuming one of the two fried eggs from the bowl. Lights in the residents room were not turned on throughout the observation and the room was dark with the exception of minimal light coming from the television and the hallway. Observation on 11/20/24 at 8:15 A.M. revealed Resident #43 was lying in bed reaching over the right side of the bed attempting to remove the lid from the second bowl on the meal tray without success. One fried egg was lying on the floor under the over-the-bed table. The residents sippy cup was empty as was his water pitcher. The resident confirmed he was still hungry and thirsty but did not have any fluids to drink and could not get the lid off the second bowl by himself. The resident further confirmed he had dropped one of the two fried eggs on the floor while trying to pick it up out of the bowl with his hand. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Registered Nurse (RN) #198 on 11/20/24 confirmed the over-the-bed table for Resident #43 was placed in a hard to reach location for meal consumption. Observation on 11/21/24 at 8:31 A.M. revealed Resident #47 was lying in bed with the breakfast meal tray in front of him. An empty coffee cup and two small plastic cups were present on the tray. None of the cups had lids on them. The residents gown was noted to be wet. The meal ticket located on the residents tray contained instructions for a sippy cup or cup with lids for all meals. Resident #47 confirmed he had not received lids on his cups and had spilled liquids onto his gown. Resident #47 denied being burnt. Interview with Registered Dietitian #250 on 11/21/24 at 9:08 A.M. confirmed Resident #47 was to receive set up assistance with meals and sippy cups or cups with lids to promote good nutrition and hydration. Registered Dietitian #250 confirmed sippy cups often disappeared and a new shipment was scheduled to arrive at the facility that day. Review of the facility policy titled, Meal Acceptance, dated 04/16/13, revealed patients/residents needing assistance in eating must be assisted upon being served. Adaptive equipment must be provided to those who need assistance, with a Physician's order.

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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. 43064 Based on observation and staff interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner. This had the potential to affect all residents who received food from the kitchen. The facility identified one resident (#60) who consumed nothing by mouth. The facility census was 108. Findings include: Observations and interview on 11/18/24 at 9:30 A.M. with Dietary Manager (DM) #118 revealed an area in the center of the kitchen was about an inch lower than the rest of the kitchen. This area contained cooking equipment such as the oven, fryer, and soup kettle. In this area, the floor (which was supposed to be a red tile) had a thick black build up, and had a large amount of food and other debris including a dome lid, plastic utensils, and French fries. There was a large amount of dirt-like material behind and around the soup kettle. DM #118 verified the observation. Subsequent observations on 11/18/24 from 11:05 A.M. to 11:35 A.M. revealed the area in the center of the kitchen, that was about an inch lower than the rest of the kitchen, had been somewhat cleaned. It was clear someone had started to get the unidentifiable black residue up. However, there were still large sections of the black residue and some of the food debris remained and the pile of dirt-like material behind the soup kettle remained. Continued observations and interview on 11/18/24 from 11:05 A.M. to 11:35 A.M. with DM #118 revealed the ceiling had multiple spots throughout the kitchen with a thick build up of dust-like particles and spots of food splatter. Additionally, there were two racks of three to four shelves that had a large amount of dust-like particles stuck to them and hanging from them. These racks had items including bowls, lids, stainless-steel cooking containers and a variety of other food service items. At 11:35 A.M., DM #118 verified the observation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 42728 Based on record reviews, staff interview, review of the Centers for Disease Control and Prevention, and review of the facility policy, the facility failed to ensure the Water Management Program was timely and appropriately implemented to prevent the spread of Legionella. This had the potential to affect all 108 residents residing in the facility. Findings include: Review of the facilities Water Management Program logs revealed no evidence of testing or interventions to prevent Legionella were present prior to 10/2024. Interview with the Administrator on 11/19/24 at 10:27 A.M. confirmed there was no record of water testing, flushing, or any other Legionella prevention measures being conducted prior to 10/2024. The Administrator stated there was a new Maintenance Director in place who had begun implementing the Water Management Plan in 10/2024. Review of the facility policy titled Legionella Policy/Procedure - Environmental, reviewed 12/26/23, revealed the facility would implement control measures to reduce the potential for the growth and spread of Legionella as identified int he Legionella Management Plan. Control measures would include, but were not limited to routine testing of chlorine levels, routine testing of water temperature levels, monitoring and flushing pipes in rooms and/or areas of the building that were not in use, monitoring decorative fountains and water fountains for use and evidence of debris and biofilm, and monitoring for conditions that may increase the risk of Legionella. Review of the CDC guidance titled Overview of Water Management Programs, dated 03/15/24, revealed water management programs identify hazardous conditions and take steps to minimize the growth and transmission of Legionella and other waterborne pathogens in building water systems. Developing and maintaining a water management program is a multi-step process that requires continuous review. Further review revealed the seven key elements of a Legionella water management program included: establish a water management program team, describe the building water systems, identify areas where Legionella could grow and spread, decide where control measures should be applied and how to monitor them, establish ways to intervene when control limits are not met, ensure the program runs as designed and is effective, and document and communicate all the activities.