STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365147	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Oaks Health Center	4114 North State Route 376 NW McConnelsville, OH 43756

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of the concern log, review of personnel files, interviews, and policy reviews the facility failed to ensure residents were treated with respect and dignity by nursing staff. This affected one resident (#9) of six residents interviewed on 300 halls. Findings included: Medical record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including anxiety, depression, respiratory disease, diabetes, difficulty walking, and was currently under hospice care. Interview on 01/13/25 at 9:15 A.M., and 01/21/25 at 1:58 A.M., with Resident #9 revealed Registered Nurse (RN) #126 was rude and rough with care such as pulling on her arms when administering insulin. Resident #9 reported several residents had voiced complaints about RN #126 and she had observed RN #126 make another staff member cry. The RN works on 3rd shift. Interview on 01/13/25 at 11:10 A.M., with Resident #78 revealed there's a nurse on nightshift, but she could not recall her name, that doesn't treat her with respect and dignity. The nurse just doesn't like her and yells at her if she tries to ambulate on her own. The nurse was always in a hurry. Interview on 01/16/25 at 11:14 A.M., with Licensed Practical Nurse (LPN)/Unit Manger #177 revealed she had heard other staff members having issues with RN #126, however she had not heard anything related to residents. The LPN reported she had just started as the Unit Manager last Friday. Interview on 01/16/25 at 11:26 A.M., with LPN/Unit Manger #165 revealed RN #126 had a dry personality but was a good nurse. She had also just started as the Unit Manger last Friday and been off for a few months. LPN #165 reported she was unaware of any concerns regarding RN#126 and residents. Interview on 01/16/25 at 11:49 A.M., with the Director of Nursing (DON) revealed there had been concerns with RN#126, however she thought she had provided education to the RN and placed the education in her personnel files. The DON reported she had just recently received a complaint from a resident that RN #126 rushes when providing care. The DON reviewed the concerns forms with the surveyor and could not recall which concerns were related to RN #126 and she would have to look into them a little deeper. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/16/25 at 3:07 P.M., with the Administrator revealed the DON had found some education for RN #126 on her computer and handed the surveyor a one-page typed letter from the DON that was signed at the bottom and undated. The letter indicated on 08/23/24 and 09/11/24 RN #126 was provided verbal education accordingly. On 11/20/24 the DON had met with RN #126 and explained there had been concerns with her in the past and explained if there were any further complaints that they would result in a suspension. The Administrator reported there had been no further concerns since 11/20/24. Interview on 01/22/25 at 2:14 P.M., with Hospice RN #340 revealed she had reported on at least three occasions Resident #9's concerns regarding RN #126 to the Social Service Director (SSD) #190. The SSD #190 told her she wrote up concern forms and reported the incidents to the Administrator. The RN could not recall the dates she had reported the residents concerns to the SSD. Interview on 01/22/25 at 3:54 P.M. with SSD #190 confirmed there had been other resident besides Resident #9 that had voiced concerns regarding RN #126. SSD #190 verified that the Hospice RN #340 had reported concerns related to RN #126, however she cannot recall the dates or information, and she could not locate the concerns forms she had started regarding the concerns. The SSD reported she starts the concern form and then gives the form to the department responsible and she must have not received the form back. The SSD verified she does not document on the form in the space that indicates the resolution was communicated to the person filing the concern. Review of resident concern forms dated 08/20/24 to 01/07/25 revealed: On 07/23/24 Resident #9 had reported RN #126 the nurse was yelling and hollering. The resolution was to speak to the nurse regarding volume when speaking. There was no evidence the resident was notified of the resolution, or the nurse was educated. On 08/22/24 Resident #14 (not interviewable) was upset that the nurse (RN #126) told her to get rid of her snacks and was rude. The resident was crying. The resolution was the nurse would be addressed. There was no evidence the nurse was addressed, or the resident was notified of the resolution. On 09/10/24 a former resident reported staff (RN #126) was rude when asking for medications. The resolution was staff would be re-educated on attitude. There was no evidence the resolution was discussed with the resident or staff was re-educated. On 11/19/24 a family member had voiced concerns that she had called into the building for an update on her husband (no longer a current resident at the facility during the annual survey) and RN #126 was extremely rude. The form indicated the nurse was educated on customer service. The resolution was blank. There was no evidence the family member was notified of the outcome of the concern, or the nurse was educated. Further review of the concern log/forms dated 07/15/24 to 01/07/25 revealed no evidence there were any concerns reported, or forms completed for Resident #9 regarding RN #126. Review of RN #126's personnel file revealed the RN was hired on 09/26/23 and there was no evidence the RN had any verbal education/disciplinary actions. The surveyor had requested the file include any disciplinary actions. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Grievances/Complaints (dated 04/2017) revealed the administrator and staff would make prompt efforts to resolve grievances to the satisfaction of the resident and or representative. The resident or person filing the grievance and/or complaint on behalf of the resident, would be informed (verbally and in writing) of the findings of the investigation and the actions that would be taken to correct any identified problems. Review of the facility's policy titled Dignity (dated 08/2009) revealed each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents should be treated with dignity and respect at all times. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review, review of the probate court local rules of practice, and interview the facility failed to ensure a resident had a legal guardian when the resident no longer had the ability to maintain capacity. This affected one resident (#19) of one resident reviewed for notification. The facility census was 85. Findings Include: Review of the medical record for Resident #19 revealed an initial admitted [DATE] of secondary Parkinsonism, diabetes mellitus, aphasia, hyperlipidemia, bipolar disorder, depressive episodes, schizoaffective disorder, bipolar type, anxiety disorder, schizophreniform and dementia. Review of the letter of guardianship dated 10/03/14 revealed the resident was deemed incompetent. A family member of the resident was named the resident's guardian of person only indefinitely. Review of the removal of guardianship dated 11/14/17 revealed the resident's family member was removed as the resident's guardian for failure to file guardianship reports. Review of the resident's facehseet revealed the resident's family member was listed as emergency contact, responsible party, other legal oversight, family member responsible and primary financial contact. Review of the medical record revealed no evidence of power of attorney (POA) paperwork for the family member listed on the face sheet. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated dementia, anxiety disorder, depression, bipolar disorder and schizophrenia were active diagnoses. Review of the resident's immunization consent form dated 09/11/23 revealed the resident refused consents and signed the consent with the resident's initials. On 01/22/25 at 8:50 A.M. interview with the Business Office Manager (BOM) #132 revealed the resident was within the $200 limit and a spend down letter was not sent due to having no person in place for financial power of attorney (POA) or guardianship. She revealed the county did not have guardians at this time so they have not started trying to get the resident a guardian. On 01/22/25 at 9:36 A.M. interview with the Secretary #320 revealed the county was very limited on guardians, however a local attorney was providing guardianship. She said in the event there is not available guardians in the county then the facility would have to look outside of the facility. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/22/25 at 9:45 A.M. interview with Secretary #330 revealed the local law office was accepting skilled nursing facility residents for guardianship. On 01/22/25 at 10:15 A.M. interview with the Administrator revealed he was unaware of the local attorney providing guardianship. The Administrator revealed the required documents would be sent to the law office to begin the guardianship process.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 32654 Based on review of resident financial records and staff interview, the facility failed to notify a resident that received Medicaid benefits when the amount in the resident's account reached $200 less than the SSI resource limit for one person, and that, if the amount in the account, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This affected one of six residents whose financial records were reviewed (#19). The facility handled the funds for 52 residents. The facility census was 85. Findings Include: Review of the financial records for Resident #19 revealed the facility managed her funds. Review of the resident's quarterly resident fund statement revealed the balance in the resident's account had been greater than $1800.00 since 10/01/24. On 10/01/24 the balance was $1881.99. The current balance in the account was $1950.97. On 01/22/25 at 8:50 A.M. interview with the Business Office Manager (BOM) #132 confirmed the Resident #19 received Medicaid benefits and that the resident's balance was within the $200 of the resource limit. BOM #132 verified there had been no attempts to obtain a guardian to manage her funds.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of the code status binder, interview, and policy review the facility failed to ensure resident code status was consistent and accurate. This affected three residents (#54, #85, and #191) of three reviewed for advance directives. Findings included: 1. Medical record review revealed Resident #54 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of liver, type two diabetes, urinary tract infection, anemia, paroxysmal atrial fibrillation, congestive heart failure, cardiomegaly, hyperlipidemia, anxiety, history of acute kidney, ileus, acute pulmonary edema, conjunctival hemorrhage, severe sepsis with septic shock, sepsis, encephalopathy, bacteriuria, liver disease, diarrhea, infectious gastroenteritis and colitis, muscle weakness, difficulty walking, need for assistance with personal care. Review of Resident #54's census tab revealed the resident was admitted [DATE] and was discharged on [DATE] and no anticipated to return (short-term general hospital stay), however was readmitted [DATE]. Review of Resident #54 current orders dated ,d+[DATE] revealed the resident code status was Do-Not-Resuscitate Comfort Care-Arrest (DNRCC-A) originally dated [DATE]. Review of Resident #54 current plan of care revealed there was a social aspect plan of care dated [DATE] that indicated the resident/resident representative had chosen the following advanced directives DNRCC-A. The interventions included to have advance directives reviewed quarterly and as needed. Review of Resident #54 progress note dated [DATE] revealed the resident was admitted [DATE] for five-day respite with possibility of long-term care. The code status reviewed with resident; code status is DNRCC-A. Review of the code status binder on [DATE] revealed no evidence of a signed code directive. Review of Resident #54's medical record revealed no evidence of a signed code directive. Interview on [DATE] at 2:00 P.M., with Registered Nurse (RN) #212 revealed the resident was discharged on [DATE] and was readmitted originally for a respite stay on [DATE]. The RN confirmed the order entered in the computer was DNRCC-A. The nurse confirmed the electronic medical record, nor the code status binder had a copy of a signed DNRCC-A. The nurse reported she would have to call hospice to confirm the code status. Interview on [DATE] at 2:08 P.M., with Resident #54 revealed she doesn't want CPR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 2:22 P.M., with RN #212 revealed she called hospice, and hospice had sent over a signed code status directive and the resident was not a DNRCC-A but a DNRCC. The RN reported she was going to change the order to DNRCC and place a copy of the signed code status form in the electronic medical record and code status binder. 2. Medical record review revealed Resident #191 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, sepsis, tracheostomy, gastrostomy, hypertension, atrial fibrillation, acute kidney failure, protein-calorie malnutrition, anxiety, hyperlipidemia, and tobacco use. Review of Resident #191's hospital discharge note dated [DATE] revealed the resident's code status as DNRCC-A Further review of Resident #191's face sheet and orders revealed no evidence of orders for the resident's code status. Review of Resident #191 social aspect care plan dated [DATE] revealed the resident/resident representative had chosen the following advanced directives. There was no evidence of the resident code status/advance directive. Review of the code status binder on [DATE] revealed no evidence of the resident's code status. Interview on [DATE] at 2:05 P.M., with RN #212 confirmed the resident did not have an order for her code status, however someone had entered full code on the face sheet. RN #212 reported she doesn't know when the code status was updated on the face sheet. The RN reported she would add an order for the resident code status. Interview on [DATE] at 2:10 P.M., with Resident #191 revealed she wanted to be a full code. Review of the facility policy titled Advance Directives (dated ,d+[DATE]) revealed upon admission, the resident would be provided a written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. The social service director of designee would inquire of the resident, his/her family members and/or legal representative, about the existence of any written advance directive. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. The interdisciplinary team will review annually with the resident advance directives to ensure that such directives are still the wishes of the resident. The DON or designee would notify the attending physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. The attending physician would not be required to orders for which he or she had an ethical or conscientious. 47985 3. Record review revealed Resident #85 was admitted to the facility on [DATE] with diagnoses including vascular dementia with agitation, post traumatic stress disorder, and idiopathic gout. Review of hospital paperwork dated [DATE] revealed Resident #85 had a full code status in place. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an order dated [DATE] revealed Resident #85 had a do not resuscitate and do not intubate order in place (DNR/DNI). Review of a progress note dated [DATE] at 1:43 P.M. by Social Service Designee (SSD) #190 revealed Resident #85 admitted to the facility on [DATE] and the code status was reviewed which was a full code. Interview on [DATE] at 4:20 P.M. with Director of Nursing (DON) confirmed there was in order in place for Resident #85 to have a DNR/DNI in place but there was no signed paperwork in place. Additionally, DON stated upon admission to the facility, Resident #85's family was called to clarify code status and chose for him to be a full code status however the order was never updated. If Resident #85 were to have coded, due to the DNR order in place, Resident #85 would not have been resuscitated.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and interview, the facility failed to notify legal representatives of changes in orders or medical conditions. This affected two residents (#19, #85) of two residents reviewed for medical provider notifications. The facility census was 85. Findings include: 1. Record review revealed Resident #85 was admitted to the facility on [DATE] with diagnoses including vascular dementia with agitation, post-traumatic stress disorder, and idiopathic gout. Review of a nursing note dated 11/27/24 at 12:42 P.M. by Registered Nurse (RN) #188 revealed the provider evaluated and gave an order for an x-ray of Resident #85's right ankle. There was no evidence Resident #85's representative was made aware of the new order. Review of a nursing note dated 12/01/24 at 4:24 P.M. by Licensed Practical Nurse (LPN) #219 revealed Resident #85's temperature was 100.7, he was achy and not feeling well. A COVID test was completed and negative. There was no evidence Resident #85's representative was made aware of the new order. Review of a nursing note dated 12/06/24 at 9:49 A.M. by LPN #177 revealed a rapid COVID test was completed per protocol and the results were negative. There was no evidence Resident #85's representative was made aware of the new order. Review of a nursing note dated 01/01/25 at 1:03 P.M. by LPN #211 revealed a certified nursing assistant (CNA) informed the nurse of Resident #85's right eye being red in color. The medical provider was notified and gave an order for polytrim every four hours for seven days. There was no evidence Resident #85's representative was made aware of the new order. Review of a nursing note dated 01/02/25 at 9:54 A.M. by LPN #177 revealed new orders were received for a CBC, Chem 8, ESR, CRP and uric acid levels for Resident #85 as well as an x-ray and venous Doppler of his left lower extremity due to pain and swelling. There was no evidence Resident #85's representative was made aware of the new order. Review of a nursing note dated 01/02/25 at 5:18 P.M. by LPN #177 revealed an x-ray of Resident #85's left knee was obtained with no concerns noted. There was no evidence Resident #85's representative was made aware. Review of a nursing note dated 01/05/25 at 10:03 A.M. by LPN #211 revealed Resident #85's right foot had +1 pitting edema, minimal movement, and was grimacing when attempting to move. A new order was received for a right lower extremity venous duplex. There was no evidence Resident #85's representative was made aware of the new order. Interview on 01/13/25 at 12:10 P.M. with Resident #85' family revealed they are not ever contacted regarding new orders or for updates regarding the residents' status. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/16/25 at 4:10 P.M. with Director of Nursing (DON) confirmed there was no evidence of Resident #85's representatives being made aware of changes in orders or for medical updates about the resident. 32654 2. Review of the medical record for Resident #19 revealed an initial admitted secondary Parkinsonism, diabetes mellitus, aphasia, hyperlipidemia, bipolar disorder, depressive episodes, schizoaffective disorder, bipolar type, anxiety disorder, schizophreniform and dementia. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the resident's progress note dated 11/11/24 at 5:37 P.M. revealed new orders were received to obtain complete blood count (CBC), complete metabolic panel (CMP), lipid panel, hemoglobin A1c, vitamin D level, TSH and vitamin B12 level on next lab day. Review of the resident's medical record revealed no documented evidence the resident and/or resident representative was made aware of the new orders. Review of the resident's facesheet revealed the resident's family member was listed as emergency contact, responsible party, other legal oversight, family member responsible and primary financial contact. On 01/15/25 at 11:27 A.M., interview with the Director of Nursing (DON) verified the resident and/or the resident representative was made aware of the new order. Review of the facility policy titled, Change of Condition and Physician Notification Policy, (last revised 09/20) revealed it was the policy of the facility to promptly identify, respond to and report changes in resident condition to the resident's physician/Nurse Practitioner (NP) and resident/resident representative. A significant change is a major decline or improvement of the resident's status. The nurse will notify the physician/NP/Physician Assistant (PA) and the residents representative when there was a need to alter medications or treatments.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on observation, record review, review of the facility Abuse and Neglect policy and procedure, and interviews, the facility failed to provide adequate and necessary supervision and intervention to protect Resident #27's right to be free from sexual abuse by Resident #21. This resulted in Immediate Jeopardy and the potential for actual harm beginning on 11/16/24 when Certified Nursing Assistant (CNA) #300 observed Resident #21, who was positive for Hepatitis C engaging in non-consensual sexual intercourse with Resident #27, a cognitively impaired and non-interviewable male resident who lacked the cognition to consent to the interaction. CNA #300 reported the incident to CNA #203 and Registered Nurse (RN) #188 but no investigation was completed, and no interventions were initiated to prevent potential recurrence. On 11/21/24 staff again observed Resident #21 in Resident #27's room with her shirt lifted up in front of the resident. This affected one resident (#27) of two residents reviewed for abuse. The facility census was 85. On 01/15/25 at 4:00 P.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on 11/16/24 when the facility failed to protect Resident #27's right to be free from sexual abuse by Resident #21. In addition to failing to prevent the incident from occurring, following the incident, the facility failed to timely intervene, thoroughly investigate and implement measures to prevent additional incidents of sexual abuse from occurring. The Immediate Jeopardy was removed on 01/16/25 when the facility implemented the following corrective actions: On 01/15/25 at 4:00 P.M. the facility initiated an investigation related to the incident of sexual abuse involving Resident #27. The investigation process included speaking to Resident #21 and Resident #27 regarding the alleged incident, interviewing all residents, or assessing residents if they were not cognitively intact including skin assessments, pain assessments. The investigation process also included interviewing staff who worked on 11/16/24 for potential knowledge of any abuse incidents, as well as educating all staff on the abuse policy and procedure, notifying family and physician. On 01/15/25 at 4:35 P.M. Resident #21 was placed on one-on-one supervision. Resident #21 would remain on one-on-one services until seen by psychiatric services. Facility staff would complete the one-on-one supervision which would be tracked through documentation. On 01/15/25 at 5:15 P.M. Resident #21 and Resident #27's guardians were notified of the sexual abuse incident by the DON/Designee. On 01/15/25 at 5:30 P.M. a Quality Assurance Assessment (QAA) meeting was held which included the Administrator/Executive Director, DON, two unit managers, social worker, regional nurse consultant, and medical director. The team discussed a plan to mitigate the sexual abuse concern identified including an immediate intervention to keep all residents safe, the investigation including all education needed, interviews, assessments, discussions with all physicians, any medications that needed ordered or clarified, notifying family and the next steps including notifying the police department and filing a self-reported incident (SRI). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Oaks Health Center	4114 North State Route 376 NW McConnelsville, OH 43756

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/15/25 at 5:30 P.M. Resident #21 and Resident #27's physician was notified of the sexual abuse incident by the Administrator/Designee. On 01/15/25 at 5:30 P.M. the DON/Designee assessed Resident #21 with no negative findings. On 01/15/25 at 5:58 P.M. the Administrator/Designee notified the police department of Resident #21 and Resident #27 allegedly having sexual intercourse in November 2024 and that the facility had started an internal investigation. On 01/15/25 at 5:58 P.M. the Administrator/Designee reported the allegation of sexual abuse involving Resident #27 to the State Agency and began a thorough investigation. On 1/15/25 at 6:00 P.M. the DON/Designee assessed 23 of 23 non-interviewable residents on the memory care unit to ensure no signs or symptoms of sexual abuse were identified. On 01/15/25 at 6:10 P.M. the DON/Designee assessed Resident #27. On 01/15/25 at 6:10 P.M. Social Service Designee (SSD)/Designee #190 assessed Resident #21 for psychosocial well-being. On 01/15/25 at 6:13 P.M. a local Police Department (PD) Officer arrived at the facility to take a report. The DON informed the officer there was an allegation of (sexual) intercourse between two memory impaired residents (#27 and #21) and that the facility was investigating the allegation. On 01/15/25 at 6:15 P.M. SSD #190 spoke with Resident #21's guardian. As a result of the conversation, the guardian agreed to transfer Resident #21 to another facility that could accommodate her sexual behaviors. Discharge planning was started. Resident #21 would remain on increased supervision as recommended by psychiatric services. Supervision was changed to every 15 minutes checks on 01/16/25 at 12:30 P.M. On 01/15/25 at 6:20 P.M. SSD #190/Designee assessed Resident #27 for psychosocial well-being. On 01/15/25 at 6:30 P.M. SSD #190/Designee interviewed or assessed 89 of 89 current residents and interviewed 123 of 123 staff members with no additional allegations of sexual abuse identified. On 01/15/25 at 7:00 P.M. SSD #190/Designee assessed 23 of 23 residents on the memory care unit for psychosocial well-being. On 01/15/25 at 7:15 P.M. the DON/Designee reviewed the orders and care plans for 23 of 23 residents on the memory care unit to ensure interventions for sexually inappropriate behaviors were in place. 01/15/25 at 9:00 P.M. the Administrator/Designee educated 123 of 123 staff members on the Abuse policy including Sexual abuse and reporting and investigating abuse. On 01/16/25 at 1:30 P.M. bloodwork was drawn for a Hepatitis panel for Resident #27. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/16/25 at 8:15 A.M. the DON/Designee spoke with the Nurse Practitioner regarding Resident #21. Orders were obtained for birth control pills. The resident had been started on the medication, Tagamet (a medication used to decrease libido) on 12/26/24. The resident's guardian was notified of these orders on 01/16/25. On 01/17/25 at 11:00 A.M. Resident #21's plan of care was updated to include the following non-pharmacological interventions to deter potentially sexually inappropriate behaviors: activities of choice, offer other activities to participate in with the activities department, leave the unit with supervision to participate in other activities and socialize, going on outings when able, family trips when able and counseling with Psychiatric Nurse Practitioner. Beginning on 01/16/25 the facility implemented audits for the Administrator/Designee to interview three staff members weekly times four weeks to ensure no concerns of sexual abuse were identified, then as determined by the QAA Committee. Beginning on 01/16/25 the facility implemented audits for the DON/Designee to assess three non-interviewable residents weekly times four weeks to ensure no signs or symptoms of sexual abuse were identified, then as determined by the QAA Committee. Although the Immediate Jeopardy was removed on 01/16/25, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action and monitoring to ensure on-going compliance. Findings include: Record review revealed Resident #27 admitted to the facility on [DATE] with diagnoses including dementia, hypertension, angina pectoris, attention and concentration deficit following cerebral infarction, and personal history of a traumatic brain injury. Record review revealed Resident #27 had a court appointed legal guardian of person and estate as of 05/14/24 related to being deemed an incompetent adult in the probate court. Resident #27 resided on the facility secured memory care unit. Review of a care plan dated 07/22/24 revealed Resident #27 may demonstrate inappropriate behaviors including agitation. The care plan was not specific to what the inappropriate behaviors were and did not include evidence of sexually inappropriate behaviors for the resident. In addition, there was no evidence in the medical record or plan of care that the resident was sexually active with other residents in the facility. Review of Resident #27's Minimum Data Set (MDS) assessment dated [DATE] revealed the cognitive assessment was incomplete. The assessment revealed Resident #27 refused care one to three days of the seven-day assessment reference period. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a psychiatric consult note documented in Resident #21's medical record, dated 11/21/24 at 1:40 P. M. revealed Resident #21 was caught on 11/16/24 having sexual relations with a gentleman (identified to be Resident #27) on the unit. The note indicated staff were being diligent at trying to keep them apart. Record review revealed no documentation of this incident was included in Resident #27's medical record. Following the incident, there was no evidence Resident #27 was assessed for injury, assessed related to his ability to consent to a sexual relationship with another resident/resident #21 or evidence the resident's legal guardian was notified. Review of a nursing note dated 11/21/24 at 1:27 P.M. by RN #188 revealed Resident #27 was found with Resident #21 in his room with her shirt pulled slightly up and the female resident was redirected out of Resident #27's room. There was no evidence that the provider or legal guardian were notified of the incident. Review of a handwritten, unsigned note dated 11/21/24 revealed Resident #27's guardian was alerted of a relationship with a resident, and noted the resident does not like to be told to stay out of the female resident's room. Staff were educated to assist with socializing in the common area. Record review revealed there was no evidence Resident #27 was assessed related to his ability to consent to a sexual relationship with another resident/Resident #21 at this time. Record review revealed Resident #21 admitted to the facility on [DATE] with diagnoses including anoxic brain damage, unspecified dementia, opioid use with opioid-induced psychotic disorder, bipolar disorder, major depression, chronic viral Hepatitis C, [NAME] (an eating disorder in which a person eats things not usually considered food), and acute Hepatitis C without hepatic coma. Record review revealed Resident #21 had a court appointed legal guardian of person and estate as of 05/02/22 related to being deemed an incompetent adult in probate court. Resident #21 resided on the facility secured memory care unit. Review of a care plan dated 04/15/24 revealed Resident #21 demonstrated inappropriate behaviors including making false accusations about peers and staff. There was no evidence of a care plan related to sexually inappropriate behaviors or that the resident was sexually active with other residents in the facility. Review of a MDS assessment completed on 11/15/24 revealed Resident #21 had severe cognitive impairment. The MDS revealed the resident had no behaviors. Review of a nursing note dated 11/21/24 at 1:17 P.M. by RN #188 revealed Resident #21 was found in Resident #27's room with her shirt up. Resident #21 was redirected out of the male resident's room. There was no evidence Resident #21's physician or legal guardian were notified of the incident. In addition, there was no evidence the facility implemented additional interventions to prevent continued sexual behaviors from occurring. Review of a psychiatric consult note documented in Resident #21's medical record, dated 11/21/24 at 1:40 P. M. revealed Resident #21 was caught on 11/16/24 having sexual relations with a gentleman (identified to be Resident #27) on the unit. The note indicated staff were being diligent at trying to keep them apart. The note indicated Resident #21 was not on birth control and a pregnancy test was ordered. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of orders revealed Resident #21 had an order entered by LPN #165 dated 11/21/24 for a pregnancy test to be completed on 12/02/24. Review of a handwritten, unsigned note dated 11/21/24 revealed Resident #21's guardian was notified of sexual behaviors and stated, that's how she is. The note indicated Resident #21 was spoken to about appropriate and inappropriate behaviors. However, there was no evidence the facility implemented additional interventions to prevent continued sexual behaviors at this time. Review of the medical record revealed a progress note dated 12/22/24 at 10:46 A.M. by RN #212 that included Resident #21 wanders ad lib and is very friendly with male resident (Resident #27). Review of an addendum to a psychiatric consult note dated 12/26/24 at 1:37 P.M. revealed after speaking with staff, a pattern of Resident #21's behavior was that she tended to be more sexual with any new male resident. A recommendation for Tagamet 400 milligrams (mg) twice daily was provided in addition to a recommendation Resident #21 be placed on birth control if appropriate clinically. Record review revealed no evidence the facility implemented any additional non-pharmacological interventions and/or supervision to timely identify and/or prevent continued sexual behaviors by Resident #21 at this time. Review of orders revealed Resident #21 received an order dated 12/26/24 for Tagamet 200 mg two tablets twice daily by mouth. Interview on 01/14/25 at 10:28 A.M. with SSD #190 revealed she was involved on the memory care unit, but stated not as much as she would like to be. She stated Resident #21 had a boyfriend (Resident #27), the staff tried to keep them apart and staff were attempting interventions. However, SSD #190 did not specify what type of interventions and stated she does not document in care plans because the MDS nurse entered care plans for behaviors. She stated Resident #21 and Resident #27's families were aware of their interest in each other, and the SSD revealed she did not think they were concerned. Interview on 01/14/25 at 2:36 P.M. with RN #188 revealed there had been an incident where Resident #21 was in a room with a male resident (Resident #27) and pulled her shirt up, but the resident stated she only showed the male resident her belly button. Resident #21 was then started on Tagamet to lessen behaviors and sex drive, which the RN stated she believed were working. The RN also indicated staff were to ensure Resident #21 and Resident #27 were not alone in the same room together. Interview on 01/15/25 at 8:26 with CNA #153 revealed she believed Resident #21 and Resident #27 were boyfriend and girlfriend and stated they had been caught a few times together behind closed doors. She stated the residents were caught lying in bed together, but one time it was more than that, although the CNA stated she was not working at the time of this incident. The CNA revealed staff were to make sure the residents were not alone behind closed doors. Interview on 01/15/25 at 8:50 A.M. with CNA #202 revealed she had seen Resident #21 holding hands with and kissing Resident #27 more on the evening shift. The CNA stated she tried to redirect and separate the residents when this occurred. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 01/15/25 at 8:55 A.M. with LPN #165 revealed she had observed Resident #21 holding hands with Resident #27 but denied knowledge of any type of sexually inappropriate behaviors being reported to her. An additional interview on 01/15/25 at 9:02 A.M. with LPN #165 revealed (in November 2024) Resident #21 told Psychiatrist #305 that she needed a pregnancy test, and Psychiatrist #305 ordered the test. LPN #165 stated she just entered the test in the computer but did not inquire why it was necessary. Interview on 01/15/25 at 9:03 A.M. with Psychiatrist #305 revealed he was informed by staff (unable to state which staff) Resident #21 had sexual relations with a male resident on the unit. He stated Resident #21 still menstruated, so after being made aware of the sexual activity, a pregnancy test was ordered (the test was negative). Psychiatrist #305 revealed if the resident continued to have sex, she should be started on birth control. During the interview, Psychiatrist #305 revealed he confirmed with Resident #21 she had sex with another resident, and stated the resident was quite proud. However, there was no evidence the psychiatrist discussed with staff the other resident involved in the sexual activity to ensure the resident was able to and had consented to the sexual activity. Interview on 01/15/25 at 10:16 A.M. with Licensed Social Worker (LSW) #313 revealed she worked with Psychiatrist #305 for any consults in the facility. She stated she was contacted (unable to recall by which facility staff member) because Resident #21 had allegedly been having sex with a male resident (Resident #27). The LSW revealed since the resident still had menses, there was a possibility of her becoming pregnant, so Psychiatrist #305 ordered a pregnancy test, then eventually started her on Tagamet. However, there was no evidence the LSW discussed with staff the other resident involved in the sexual activity to ensure the resident was able to and had consented to the sexual activity. Interview on 01/15/25 at 10:26 A.M. with MDS Nurse #139 revealed social service staff were expected to develop and document care plans related to resident behaviors. Interview on 01/15/25 at 10:35 A.M. with Resident #21 revealed she had a boyfriend and identified him as Resident #27. Resident #21 stated they had already had sex (including penetration) without protection, and they got in trouble because she could still get pregnant. Resident #21 stated she sees Resident #27 every day. During the interview Resident #21 stated all the staff know about her sex life. Resident #21 stated I have tried to hide myself, but I'm not hideable due to having a loud voice and Resident #27 is able to find her. Interview on 01/15/25 at 10:39 A.M. with RN #188 revealed she had heard CNA #300 allegedly witnessed Resident #21 and Resident #27 having sex. During the interview, Resident #21 approached RN #188 and stated she needed condoms so she could have safe sex. Interview on 01/15/25 at 11:42 A.M. with SSD #190 revealed she had spoken with Resident #21 about her interactions with Resident #27 as she felt Resident #21 was able to remember a little more than Resident #27 could. SSD #190 revealed she cautioned Resident #21 about the relationship because of the age difference between the two residents and the resident's memory impairment. During the interview, she confirmed Resident #21 had a diagnosis of Hepatis C and having unprotected sex with another person would not be safe. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 01/15/25 at 1:12 P.M. with CNA #300 revealed (on 11/16/24) she was about to provide incontinence care to another resident, but there were no gloves in the room, so she went to Resident #27's room because she recalled seeing gloves in there. She stated upon entering the room, she observed Resident #21 lying with her back on the bed with her buttocks towards the edge and her legs spread while Resident #27 was standing in front of her penetrating her. Both residents were completely naked. She stated she was new to the facility and did not know what to do, and she noticed the residents became nervous with her presence as well. She stated she closed the door and walked to the nurse's station to ask what to do. She was informed by CNA #203 the residents needed to be separated, and a statement needed to be written. CNA #300 stated CNA#203 took her statement. Interview on 01/15/25 at 1:53 P.M. with Resident #21's guardian revealed the resident was very forward and talked about sex often. The resident's guardian stated the facility had not contacted her or made her aware of any type of relationship between Resident #21 and Resident #27. The guardian stated it was her preference that the resident does not have sexual interactions. She stated she wanted Resident #21 to be safe, and she did not feel Resident #21 should be sexually active due to cognition and hygiene concerns. Interview on 01/15/25 at 2:40 P.M. with Resident #27's guardian revealed at the last care conference she had with the facility she was made aware Resident #27 was having sexualized types of behaviors. However, she was not aware of actual sexual activity, the extent of the sexualized behaviors or that the resident was involved in any type of relationship with another resident. During the interview, the guardian revealed Resident #27 was not able to provide consent (to sexual activity) due to his cognitive impairment. The guardian revealed she had not been notified that the sexual activity that had occurred had placed Resident #27 at risk for contracting Hepatitis C (as the sexual intercourse was unprotected). She stated the last phone call she received from the facility was on 11/14/24. Interview on 01/15/25 at 3:09 P.M. with the DON revealed she was aware Resident #21 and Resident #27 would hold hands, and she was aware there was human contact where some upper body contact was attempted or did happen. However, she stated she was not aware of any invasive contact (eluding to sexual intercourse). The DON verified Resident #27, due to cognitive impairment would not be able to consent to sexual activity. The DON revealed she was unaware of pregnancy testing for Resident #21 until 01/13/25. The DON revealed she was aware Tagamet had been ordered for Resident #21 to decrease her libido and deter potential attempts at sex. The DON indicated it was her expectation if two residents were observed having sex that the staff would call her and the Administrator, not leave until they were interviewed, and an investigation and self-reported incident (SRI) would be completed immediately. During the interview, the DON indicated she was unaware of this incident involving Resident #27 in 11/2024 until interview with the State agency surveyor. Interview on 01/15/25 at 4:17 P.M. with CNA #108 revealed she had previously observed Resident #21 kissing Resident #27 and had observed the resident's holding hands. While the CNA did not report witnessing Resident #21 having sexual activity with Resident #27, she stated she had heard from a lot of staff that had witnessed Resident #21 having sex with Resident #27. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 01/15/25 at 4:34 P.M. with CNA #300 revealed additional staff present during the incident (on 11/16/24) included the scheduler, CNA #203, and a higher up lady. CNA #300 stated it was her second week at work, and following the incident, she placed a written statement in a folder next to the computer. She stated the incident had occurred after lunch but before 2:00 P.M. She stated, the higher up lady who shared the same name as the DON, stated there was nothing that could be done about it. Interview on 01/15/25 at 4:41 P.M. with CNA #201 revealed Resident #21 believed she was in a relationship with Resident #27 and staff had to remind them of their age gap. Interview on 01/16/25 at 8:16 A.M. with RN #188 revealed she could not recall working at the time Resident #21 and Resident #27 were observed having sex, despite being on the schedule to work on this date (11/16/24). During the interview, the RN was unable to recall information from this time period. During the interview, RN #188 revealed she was also unaware Resident #21 had Hepatitis C and the potential for spreading it during sex. Interview on 01/16/25 at 8:18 A.M. with CNA #203 revealed she was working at the facility (on 11/16/24) when CNA #300 informed her Resident #21 and Resident #27 were in Resident #27's room having sex and she was unsure what to do. CNA #203 stated she told CNA #300 the resident's needed separated, so she went to split them up, but they had already separated themselves and were getting their clothes back on. Both residents were naked at that time. CNA #203 stated she told RN #188 about the incident, but she was passing medications, so she told CNA #300 to write a witness statement and place it on the medication cart. Interview on 01/16/25 at 8:23 A.M. with SSD #190 revealed she was not clinical, so she did not think to inquire why Resident #21 needed a pregnancy test ordered. SSD #190 revealed she did not know Resident #21 had Hepatitis C and could potentially transmit it sexually. During the interview, SSD #190 provided no evidence the sexual activity between Resident #21 and Resident #27 was consensual, that Resident #27 had the ability to consent to the interaction or that the incident had been investigated as possible sexual abuse with Resident #27 being the victim. Interview on 01/16/25 at 8:34 A.M. with the DON revealed no one inquired why the pregnancy test was ordered for Resident #21 in November 2024. The DON verified the lack of written documentation of the sexual intercourse incident in the resident's medical records at the time of the incident, lack of responsible party/guardian notification and physician notification. The DON verified the incident was not reported to the State agency and/or investigated as an incident of sexual abuse. The DON also verified the lack of comprehensive assessments and care plans related to the ability to consent to sexual activity for Resident #27. During the interview, the DON denied knowledge of CNA #300 writing a statement following the observed incident on 11/16/24. Attempts to interview Resident #27 throughout the survey were unsuccessful due to the resident's impaired cognitive status. During the survey, the resident was observed on the secured memory care unit often times sweeping the carpet and participating in activities. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/16/25 the facility provided a root cause analysis indicating the incidents of sexual abuse had occurred due to Resident #21's age and being very impulsive due to medical diagnoses including memory impairment, anoxic brain damage, unspecified dementia, history of opioid use, bipolar disorder and not recognizing socially appropriate boundaries. The root cause analysis revealed a nursing home had been determined to not be the least restrictive environment for Resident #21 and that Resident #21 would likely be served in a group home setting or all female facility/unit. However, there was no evidence the facility had identified this or addressed this for the resident prior to the State agency being onsite for the annual survey. Upon further questioning of the root cause analysis, the facility updated the analysis to only note the incidents of sexual abuse had occurred due to Resident #21's age and being very impulsive due to medical diagnoses including memory impairment, anoxic brain damage, unspecified dementia, history of opioid use, bipolar disorder and not recognizing socially appropriate boundaries. During the onsite survey, staff reported their belief was that Resident #21 and Resident #27 were boyfriend and girlfriend and were aware physical contact (i.e. hand holding and kissing) between the residents had and was occurring (as noted in the staff interviews above). However, the facility failed to identify these behaviors as potentially inappropriate, failed to ensure an interdisciplinary comprehensive assessment of each resident's ability to consent to the relationship or sexual activity, or provide adequate supervision and intervention (staff reported simply re-directing when the residents were observed together) to prevent Resident #21 from engaging in unprotected sexual intercourse with Resident #27 on 11/16/24 placing Resident #27 at risk for contracting Hepatitis C and placing Resident #21 at risk for becoming pregnant. Review of a policy titled Abuse, Neglect, Exploitation & Misappropriation of Resident Property, dated 2016, revealed sexual abuse was non-consensual contact of any type with a resident. When an issue was identified, the resident involved should be protected from reoccurrence, the incident should be reported to the state, and an investigation should be completed and be thorough. All residents and witnesses should be interviewed. In the case of a resident-to-resident incident, the interdisciplinary team will determine appropriate interventions.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Oaks Health Center	4114 North State Route 376 NW McConnelsville, OH 43756

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on staff interviews, policy review, and record review, the facility failed to report an allegation of sexual abuse. This affected one resident (#27) of seven residents reviewed on the memory care unit. The facility census was 85. Findings include: Record review revealed Resident #27 was admitted to the facility on [DATE] with diagnoses including dementia, hypertension, angina pectoris, attention and concentration deficit following cerebral infarction, and personal history of a traumatic brain injury. Record review revealed Resident #27 had a court appointed legal guardian of person and estate as of 05/14/24 related to being deemed an incompetent adult in the probate court. Resident #27 resided on the facility secured memory care unit. Review of a care plan dated 07/22/24 revealed Resident #27 may demonstrate inappropriate behaviors including agitation. The care plan was not specific to what the inappropriate behaviors were and did not include evidence of sexually inappropriate behaviors for the resident. In addition, there was no evidence in the medical record or plan of care that the resident was sexually active with other residents in the facility. Review of Resident #27's Minimum Data Set (MDS) assessment dated [DATE] revealed the cognitive assessment was incomplete. The assessment revealed Resident #27 refused care one to three days of the seven-day assessment reference period. Review of a psychiatric consult note documented in Resident #21's medical record, dated 11/21/24 at 1:40 P. M. revealed Resident #21 was caught on 11/16/24 having sexual relations with a gentleman (identified to be Resident #27) on the unit. The note indicated staff were being diligent at trying to keep them apart. Record review revealed no documentation of this incident was included in Resident #27's medical record. Following the incident, there was no evidence Resident #27 was assessed for injury, assessed related to his ability to consent to a sexual relationship with another resident/Resident #21 or evidence the resident's legal guardian was notified. Review of a nursing note dated 11/21/24 at 1:27 P.M. by RN #188 revealed Resident #27 was found with Resident #21 in his room with her shirt pulled slightly up and the female resident was redirected out of Resident #27's room. There was no evidence that the medical provider or legal guardian were notified of the incident. Review of a handwritten, unsigned note dated 11/21/24 revealed Resident #27's guardian was alerted of a relationship with a resident, and noted the resident does not like to be told to stay out of the female resident's room. Staff were educated to assist with socializing in the common area. Record review revealed there was no evidence Resident #27 was assessed related to his ability to consent to a sexual relationship with another resident/Resident #21 at this time. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed Resident #21 admitted to the facility on [DATE] with diagnoses including anoxic brain damage, unspecified dementia, opioid use with opioid-induced psychotic disorder, bipolar disorder, major depression, chronic viral Hepatitis C, [NAME] (an eating disorder in which a person eats things not usually considered food), and acute Hepatitis C without hepatic coma. Record review revealed Resident #21 had a court appointed legal guardian of person and estate as of 05/02/22 related to being deemed an incompetent adult in probate court. Resident #21 resided on the facility secured memory care unit. Review of a care plan dated 04/15/24 revealed Resident #21 demonstrated inappropriate behaviors including making false accusations about peers and staff. There was no evidence of a care plan related to sexually inappropriate behaviors or that the resident was sexually active with other residents in the facility. Review of a MDS assessment completed on 11/15/24 revealed Resident #21 had severe cognitive impairment. The MDS revealed the resident had no behaviors. Review of a nursing note dated 11/21/24 at 1:17 P.M. by RN #188 revealed Resident #21 was found in Resident #27's room with her shirt up. Resident #21 was redirected out of the male resident's room. There was no evidence Resident #21's physician or legal guardian were notified of the incident. In addition, there was no evidence the facility implemented additional interventions to prevent continued sexual behaviors from occurring. Review of a psychiatric consult note documented in Resident #21's medical record, dated 11/21/24 at 1:40 P.M. revealed Resident #21 was caught on 11/16/24 having sexual relations with a gentleman (identified to be Resident #27) on the unit. The note indicated staff were being diligent at trying to keep them apart. The note indicated Resident #21 was not on birth control and a pregnancy test was ordered. Review of orders revealed Resident #21 had an order entered by LPN #165 dated 11/21/24 for a pregnancy test to be completed on 12/02/24. Review of a handwritten, unsigned note dated 11/21/24 revealed Resident #21's guardian was notified of sexual behaviors and stated, that's how she is. The note indicated Resident #21 was spoken to about appropriate and inappropriate behaviors. However, there was no evidence the facility implemented additional interventions to prevent continued sexual behaviors at this time. Review of the medical record revealed a progress note dated 12/22/24 at 10:46 A.M. by RN #212 that included Resident #21 wanders ad lib and is very friendly with male resident (Resident #27). Review of an addendum to a psychiatric consult note dated 12/26/24 at 1:37 P.M. revealed after speaking with staff, a pattern of Resident #21's behavior was that she tended to be more sexual with any new male resident. A recommendation for Tagamet 400 milligrams (mg) twice daily was provided in addition to a recommendation Resident #21 be placed on birth control if appropriate clinically. Record review revealed no evidence the facility implemented any additional non-pharmacological interventions and/or supervision to timely identify and/or prevent continued sexual behaviors by Resident #21 at this time. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of orders revealed Resident #21 received an order dated 12/26/24 for Tagamet 200 mg two tablets twice daily by mouth. Review of the Ohio Department of Health Enhanced Information Dissemination and Collection revealed no evidence the facility reported the allegation of sexual abuse between Residents #21 and #27. Interview on 01/14/25 at 2:36 P.M. with RN #188 revealed there had been an incident where Resident #21 was in a room with a male resident (Resident #27) and pulled her shirt up, but the resident stated she only showed the male resident her belly button. Resident #21 was then started on Tagamet to lessen behaviors and sex drive, which the RN stated she believed were working. The RN also indicated staff were to ensure Resident #21 and Resident #27 were not alone in the same room together. Interview on 01/15/25 at 8:26 A.M. with certified nursing assistant (CNA) #153 revealed she believed Resident #21 and Resident #27 were boyfriend and girlfriend and stated they had been caught a few times together behind closed doors. She stated the residents were caught lying in bed together, but one time it was more than that, although the CNA stated she was not working at the time of this incident. The CNA revealed staff were to make sure the residents were not alone behind closed doors. Interview on 01/15/25 at 8:50 A.M. with CNA #202 revealed she had seen Resident #21 holding hands with and kissing Resident #27 more on the evening shift. The CNA stated she tried to redirect and separate the residents when this occurred. Interview on 01/15/25 at 8:55 A.M. with LPN #165 revealed she had observed Resident #21 holding hands with Resident #27 but denied knowledge of any type of sexually inappropriate behaviors being reported to her. An additional interview on 01/15/25 at 9:02 A.M. with LPN #165 revealed (in November 2024) Resident #21 told Psychiatrist #305 that she needed a pregnancy test, and Psychiatrist #305 ordered the test. LPN #165 stated she just entered the test in the computer but did not inquire why it was necessary. Interview on 01/15/25 at 9:03 A.M. with Psychiatrist #305 revealed he was informed by staff (unable to state which staff) Resident #21 had sexual relations with a male resident on the unit. He stated Resident #21 still menstruated, so after being made aware of the sexual activity, a pregnancy test was ordered (the test was negative). Psychiatrist #305 revealed if the resident continued to have sex, she should be started on birth control. During the interview, Psychiatrist #305 revealed he confirmed with Resident #21 she had sex with another resident, and stated the resident was quite proud. However, there was no evidence the psychiatrist discussed with staff the other resident involved in the sexual activity to ensure the resident was able to and had consented to the sexual activity. Interview on 01/15/25 at 10:16 A.M. with Licensed Social Worker (LSW) #313 revealed she worked with Psychiatrist #305 for any consults in the facility. She stated she was contacted (unable to recall by which facility staff member) because Resident #21 had allegedly been having sex with a male resident (Resident #27). The LSW revealed since the resident still had menses, there was a possibility of her becoming pregnant, so Psychiatrist #305 ordered a pregnancy test, then eventually started her on Tagamet. However, there was no evidence the LSW discussed with staff the other resident involved in the sexual activity to ensure the resident was able to and had consented to the sexual activity. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/15/25 at 10:35 A.M. with Resident #21 revealed she had a boyfriend and identified him as Resident #27. Resident #21 stated they had already had sex (including penetration) without protection, and they got in trouble because she could still get pregnant. Resident #21 stated she sees Resident #27 every day. During the interview Resident #21 stated all the staff know about her sex life. Resident #21 stated I have tried to hide myself, but I'm not hideable due to having a loud voice and Resident #27 is able to find her. Interview on 01/15/25 at 10:39 A.M. with RN #188 revealed she had heard CNA #300 allegedly witnessed Resident #21 and Resident #27 having sex. During the interview, Resident #21 approached RN #188 and stated she needed condoms so she could have safe sex. Interview on 01/15/25 at 11:42 A.M. with SSD #190 revealed she had spoken with Resident #21 about her interactions with Resident #27 as she felt Resident #21 was able to remember a little more than Resident #27 could. SSD #190 revealed she cautioned Resident #21 about the relationship because of the age difference between the two residents and the resident's memory impairment. During the interview, she confirmed Resident #21 had a diagnosis of Hepatitis C and having unprotected sex with another person would not be safe. Interview on 01/15/25 at 1:12 P.M. with CNA #300 revealed (on 11/16/24) she was about to provide incontinence care to another resident, but there were no gloves in the room, so she went to Resident #27's room because she recalled seeing gloves in there. She stated upon entering the room, she observed Resident #21 lying with her back on the bed with her buttocks towards the edge and her legs spread while Resident #27 was standing in front of her penetrating her. Both residents were completely naked. She stated she was new to the facility and did not know what to do, and she noticed the residents became nervous with her presence as well. She stated she closed the door and walked to the nurse's station to ask what to do. She was informed by CNA #203 the residents needed to be separated, and a statement needed to be written. CNA #300 stated CNA#203 took her statement. Interview on 01/15/25 at 3:09 P.M. with the director of nursing (DON) revealed she was aware Resident #21 and Resident #27 would hold hands, and she was aware there was human contact where some upper body contact was attempted or did happen. However, she stated she was not aware of any invasive contact (eluding to sexual intercourse). The DON verified Resident #27, due to cognitive impairment would not be able to consent to sexual activity. The DON revealed she was unaware of pregnancy testing for Resident #21 until 01/13/25. The DON revealed she was aware Tagamet had been ordered for Resident #21 to decrease her libido and deter potential attempts at sex. The DON indicated it was her expectation if two residents were observed having sex that the staff would call her and the Administrator, not leave until they were interviewed, and an investigation and self-reported incident (SRI) would be completed immediately. During the interview, the DON indicated she was unaware of this incident involving Resident #27 in 11/2024 until interview with the State agency surveyor. Interview on 01/16/25 at 8:16 A.M. with RN #188 revealed she could not recall working at the time Resident #21 and Resident #27 were observed having sex, despite being on the schedule to work on this date (11/16/24). During the interview, the RN was unable to recall information from this time period. During the interview, RN #188 revealed she was also unaware Resident #21 had Hepatitis C and the potential for spreading it during sex. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/16/25 at 8:18 A.M. with CNA #203 revealed she was working at the facility (on 11/16/24) when CNA #300 informed her Resident #21 and Resident #27 were in Resident #27's room having sex and she was unsure what to do. CNA #203 stated she told CNA #300 the resident's needed separated, so she went to split them up, but they had already separated themselves and were getting their clothes back on. Both residents were naked at that time. CNA #203 stated she told RN #188 about the incident, but she was passing medications, so she told CNA #300 to write a witness statement and place it on the medication cart. Interview on 01/16/25 at 8:34 A.M. with the DON revealed no one inquired why the pregnancy test was ordered for Resident #21 in November 2024. The DON verified the lack of written documentation of the sexual intercourse incident in the resident's medical records at the time of the incident, lack of responsible party/guardian notification and physician notification. The DON verified the incident was not reported to the State agency and/or investigated as an incident of sexual abuse. The DON also verified the lack of comprehensive assessments and care plans related to the ability to consent to sexual activity for Resident #27. During the interview, the DON denied knowledge of CNA #300 writing a statement following the observed incident on 11/16/24. Review of a policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property (dated 2016) revealed all allegations of abuse must be reported immediately to the administrator, who reports to the State Agency immediately bot not later than two hours after the allegation is made.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on staff interviews, policy review, and record review, the facility failed to thoroughly investigate an allegation of sexual abuse. This affected one resident (#27) of seven residents reviewed on the memory care unit. The facility census was 85. Findings include: Record review revealed Resident #27 was admitted to the facility on [DATE] with diagnoses including dementia, hypertension, angina pectoris, attention and concentration deficit following cerebral infarction, and personal history of a traumatic brain injury. Record review revealed Resident #27 had a court appointed legal guardian of person and estate as of 05/14/24 related to being deemed an incompetent adult in the probate court. Resident #27 resided on the facility secured memory care unit. Review of a care plan dated 07/22/24 revealed Resident #27 may demonstrate inappropriate behaviors including agitation. The care plan was not specific to what the inappropriate behaviors were and did not include evidence of sexually inappropriate behaviors for the resident. In addition, there was no evidence in the medical record or plan of care that the resident was sexually active with other residents in the facility. Review of Resident #27's Minimum Data Set (MDS) assessment dated [DATE] revealed the cognitive assessment was incomplete. The assessment revealed Resident #27 refused care one to three days of the seven-day assessment reference period. Review of a psychiatric consult note documented in Resident #21's medical record, dated 11/21/24 at 1:40 P. M. revealed Resident #21 was caught on 11/16/24 having sexual relations with a gentleman (identified to be Resident #27) on the unit. The note indicated staff were being diligent at trying to keep them apart. Record review revealed no documentation of this incident was included in Resident #27's medical record. Following the incident, there was no evidence Resident #27 was assessed for injury, assessed related to his ability to consent to a sexual relationship with another resident/resident #21 or evidence the resident's legal guardian was notified. Review of a nursing note dated 11/21/24 at 1:27 P.M. by Registered Nurse (RN) #188 revealed Resident #27 was found with Resident #21 in his room with her shirt pulled slightly up and the female resident was redirected out of Resident #27's room. There was no evidence that the medical provider or legal guardian were notified of the incident. Review of a handwritten, unsigned note dated 11/21/24 revealed Resident #27's guardian was alerted of a relationship with a resident, and noted the resident does not like to be told to stay out of the female resident's room. Staff were educated to assist with socializing in the common area. Record review revealed there was no evidence Resident #27 was assessed related to his ability to consent to a sexual relationship with another resident/Resident #21 at this time. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage, unspecified dementia, opioid use with opioid-induced psychotic disorder, bipolar disorder, major depression, chronic viral Hepatitis C, [NAME] (an eating disorder in which a person eats things not usually considered food), and acute Hepatitis C without hepatic coma. Record review revealed Resident #21 had a court appointed legal guardian of person and estate as of 05/02/22 related to being deemed an incompetent adult in probate court. Resident #21 resided on the facility secured memory care unit. Review of a care plan dated 04/15/24 revealed Resident #21 demonstrated inappropriate behaviors including making false accusations about peers and staff. There was no evidence of a care plan related to sexually inappropriate behaviors or that the resident was sexually active with other residents in the facility. Review of a MDS assessment completed on 11/15/24 revealed Resident #21 had severe cognitive impairment. The MDS revealed the resident had no behaviors. Review of a nursing note dated 11/21/24 at 1:17 P.M. by RN #188 revealed Resident #21 was found in Resident #27's room with her shirt up. Resident #21 was redirected out of the male resident's room. There was no evidence Resident #21's physician or legal guardian were notified of the incident. In addition, there was no evidence the facility implemented additional interventions to prevent continued sexual behaviors from occurring. Review of a psychiatric consult note documented in Resident #21's medical record, dated 11/21/24 at 1:40 P.M. revealed Resident #21 was caught on 11/16/24 having sexual relations with a gentleman (identified to be Resident #27) on the unit. The note indicated staff were being diligent at trying to keep them apart. The note indicated Resident #21 was not on birth control and a pregnancy test was ordered. Review of orders revealed Resident #21 had an order entered by Licensed Practical Nurse (LPN) #165 dated 11/21/24 for a pregnancy test to be completed on 12/02/24. Review of a handwritten, unsigned note dated 11/21/24 revealed Resident #21's guardian was notified of sexual behaviors and stated, that's how she is. The note indicated Resident #21 was spoken to about appropriate and inappropriate behaviors. However, there was no evidence the facility implemented additional interventions to prevent continued sexual behaviors at this time. Review of the medical record revealed a progress note dated 12/22/24 at 10:46 A.M. by RN #212 that included Resident #21 wanders ad lib and is very friendly with male resident (Resident #27). Review of an addendum to a psychiatric consult note dated 12/26/24 at 1:37 P.M. revealed after speaking with staff, a pattern of Resident #21's behavior was that she tended to be more sexual with any new male resident. A recommendation for Tagamet 400 milligrams (mg) twice daily was provided in addition to a recommendation Resident #21 be placed on birth control if appropriate clinically. Record review revealed no evidence the facility implemented any additional non-pharmacological interventions and/or supervision to timely identify and/or prevent continued sexual behaviors by Resident #21 at this time. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of orders revealed Resident #21 received an order dated 12/26/24 for Tagamet 200 mg two tablets twice daily by mouth. Review of the Enhanced Information Dissemination and Collection revealed no evidence the facility reported the allegation of sexual abuse between Residents #21 and #27. There was no documented evidence an investigation was initiated or completed in regard to the allegation of sexual abuse to Resident #27. Interview on 01/15/25 at 3:09 P.M. with the DON revealed she was aware Resident #21 and Resident #27 would hold hands, and she was aware there was human contact where some upper body contact was attempted or did happen. However, she stated she was not aware of any invasive contact (eluding to sexual intercourse). The DON verified Resident #27, due to cognitive impairment would not be able to consent to sexual activity. The DON revealed she was unaware of pregnancy testing for Resident #21 until 01/13/25. The DON revealed she was aware Tagamet had been ordered for Resident #21 to decrease her libido and deter potential attempts at sex. The DON indicated it was her expectation if two residents were observed having sex that the staff would call her and the Administrator, not leave until they were interviewed, and an investigation and self-reported incident (SRI) would be completed immediately. During the interview, the DON indicated she was unaware of this incident involving Resident #27 in 11/2024 until interview with the State agency surveyor. Interview on 01/16/25 at 8:34 A.M. with the DON verified the incident was not reported to the State agency and/or investigated as an incident of sexual abuse. Review of a policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property (dated 2016) revealed all allegations of abuse must be reported immediately to the administrator, who reports to the State Agency immediately bot not later than two hours after the allegation is made. Once the administrator and State Agency are notified, an investigation of the allegation violation will be conducted. The investigation must be completed within five working days unless there are special circumstances causing the investigation to last longer. The resident, accused and all witnesses including those who witnessed/heard the incident, came in close contact with the resident the day of the incident, and employees who worked closely with the accused/alleged victim and perpetrator the day of the incident. Statements should be obtained, medical reports and statements should be obtained if applicable, the resident records should be reviewed, and evidence of the investigation should be documented.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, review of email correspondence to the local Ombudsman, and staff interview, the facility failed to ensure the local Ombudsman was notified of a resident's transfer to the hospital as required. This affected one resident (#88) of one residents reviewed for hospitalization . Findings include: Review of Resident #88's closed medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included nodular sclerosis Hodgkin lymphoma, metabolic encephalopathy, end stage renal disease, dependence on hemodialysis, myoclonus (sudden, involuntary muscle jerking/ spasms), hypertension, and adult onset diabetes mellitus. Review of Resident #88's progress notes revealed a nurse's note dated 10/29/24 at 8:10 P.M. that indicated the resident was sent to the emergency room for an evaluation at the request of his family. The progress note did not specify what change in condition the resident had that prompted the family to want him sent to the emergency room , but transportation had been set up with the local emergency medical service (EMS). He left the faciity on [DATE] at 8:13 P.M. Review of Resident #88's electronic medical record (EMR) noted a Notice of Transfer or Discharge observation dated 10/30/24 that was completed Social Service Director (SSD) #190 at 8:28 A.M. SSD #190 indicated the resident had been transferred to the hospital as it was necessary to meet the resident's welfare and the resident's needs could not be met in the facility. The observation detail report included the mailing address for the Long- Term Care Ombudsman and a phone number. It did not include a place to indicate whether the Ombudsman's office had been notified of the transfer, or not. Review of an email correspondence from SSD #190 to the Ombudsman's office revealed an email was sent with a subject line of the facility's October 2024 discharges. Attached to that email was a discharge summary report that was for the time period of 10/01/24 through 10/31/24. Thirteen (13) residents were indicated to have been discharged from the facility with 12 of them being a discharge to home. One pertained to a resident's discharge to an acute care hospital. None of the 13 residents were Resident #88's transfer to the hospital on 10/29/24. Findings were reviewed with SSD #190. On 01/22/24 at 1:45 P.M., an interview with SSD #190 revealed she was the employee that was responsible for notifying the Ombudsman of any discharges or transfers from the facility. She confirmed Resident #88's transfer to the hospital was not included on the discharge summary report for 10/01/24 through 10/31/24 she used to notify the Ombudsman of all transfers and discharges that month. She could not explain why Resident #88's transfer was not on that report since it fell between 10/01/24 and 10/31/24. She reported another resident's name had been included who was also sent to the hospital at the request of resident or their family member. She denied she had any other documented evidence of the Ombudsman being notified of the resident's transfer to the hospital, since it was not on that list.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review and staff interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate for two residents (#30, #38) in the area of dental and dialysis. This affected two residents (#30, #38) of 20 sampled residents. The facility census was 85. Findings Include: 1. Review of the medical record for Resident #30 revealed an initial admitted [DATE] with the latest readmission of 12/10/24 with the diagnoses including but not limited to partial traumatic amputation of left foot, osteomyelitis, sepsis, diabetes mellitus with neuropathy, hypertension, hyperlipidemia, osteoarthritis, gastro-esophageal reflux disease, constipation, edema, nausea and vomiting and anemia. Review of the resident's plan of care revealed no care plan addressing the resident's dialysis or potential for infection related to the central line. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was not assessed. The assessment indicated the resident had not received dialysis services. Review of the resident's monthly physician orders for January 2025 revealed no physician orders for offsite hemodialysis. On 01/15/25 at 3:52 P.M., interview with the Director of Nursing (DON) verified the MDS was not coded correctly to reflect the resident's hemodialysis. 2. Review of the medical record for Resident #38 revealed an initial admitted [DATE] with the latest readmission of 06/02/23 with the diagnoses including but not limited to metabolic encephalopathy, sepsis, acidosis, epilepsy, solitary pulmonary nodule right upper lobe, dementia with behavioral disturbances, esophageal thickening, diabetes mellitus, hypertension, anxiety disorder, mood disorder, insomnia, dental caries and added on 09/20/24 schizophrenia. Review of the resident's admission observation and data collection dated 02/02/23 revealed the resident had her own natural teeth. The assessment indicated the resident's teeth had no cavities or broken teeth. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care dated 02/16/23 revealed the resident had potential for mouth pain related to problems developing with natural teeth. Interventions included assess condition of oral cavity, teeth, tongue and lips as needed, assess location of pain, quality and characteristic of pain, duration, intensity and severity of pain, aggravating and alleviating factors as needed, check dentures for a proper/comfortable fit, dental evaluation and intervention as needed, encourage fluids to keep oral cavity moist, medications as ordered, observe and report difficulties, observe and report difficulties chewing/swallowing, observe for need for change diet consistency to increase ease of eating, obtain a dietary consult as needed, follow recommendations as required and offer and provide mouth care as needed. Review of the resident's quarterly observation and data collection dated 11/01/24 revealed the resident's natural teeth had no cavities or were not broken. The assessment indicated the resident had no ulcers, lesions, halitosis, dry membranes or bleeding gums. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had no obvious or likely cavity or broken natural teeth. On 01/13/25 at 9:19 A.M., observation of the resident revealed she had multiple black broken teeth with obvious caries. On 01/14/25 at 12:14 P.M., interview with the DON verified the oral assessments and MDS failed to reflect the resident's black broken teeth with obvious caries.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and staff interview the facility failed to complete a significant change minimum data set (MDS) for one resident (#40) within 14 days of the resident being admitted to hospice services. This affected one resident (#40) of 20 residents reviewed for assessments. The facility census was 85. Findings Include: Record review revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including abdominal aortic aneurysm without rupture, malignant neoplasm of prostate, and unspecified dementia. Review of a social services note dated 12/16/24 at 3:28 P.M. revealed Resident #40's family requested a referral be sent to hospice. Review of orders revealed Resident #40 admitted to hospice services on 12/17/24 for a diagnosis of senile degeneration of the brain. Review of minimum data set (MDS) assessments revealed a significant change assessment for Resident #40 was not completed within 14 days of the resident's admission to hospice. Interview on 01/15/24 at 10:27 A.M. with MDS Nurse #139 revealed if a resident has a significant change in status, including an admission to hospice services, a significant change MDS should be completed within 14 days. MDS Nurse #139 confirmed Resident #40 did not have a significant change MDS completed upon admission to hospice.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review, staff interview and facility policy review, the facility failed to ensure a significant change Pre-Admission Screening and Resident Review (PASARR) was completed when a mental health diagnosis was newly added. This affected one resident (#38) of four residents reviewed for PASARR. The facility census was 85. Findings Include: Review of the medical record for Resident #38 revealed an initial admitted [DATE] with the latest readmission of 06/02/23 with the diagnoses including but not limited to metabolic encephalopathy, sepsis, acidosis, epilepsy, solitary pulmonary nodule right upper lobe, dementia with behavioral disturbances, esophageal thickening, diabetes mellitus, hypertension, anxiety disorder, mood disorder, insomnia, dental caries and added on 09/20/24 schizophrenia. Review of the plan of care dated 11/22/24 revealed the resident suffers from schizophrenia and is at risk for change in ability, thinking, perception, behavior and personality. Interventions included assist to identify effective coping mechanisms, maintain a calm environment and approach with the resident, monitor the resident's behavior endangers self or other, intervene if necessary, obtain a psych consult/psychosocial therapy as needed, provide outlets for expression of hostility and anger, restrict access to potentially harmful items, set limits and expectations for behavior with resident, use physical/chemical restraints as last resort, administer psychotropic medications per physician orders and monitor for side effects, encourage resident to openly express feelings and reinforce appropriate expressions of these feelings, establish and maintain consistency in resident's routine when possible, let resident make own decisions as long as the decisions are not a danger to self or others, limit overstimulation of resident, notify physician of changes in resident's mood/behavior, restate resident's conversations to validate it, a gradual dose reduction (GDR) will be attempted to separate quarters with at least one month between attempts per the physician recommendation, gradual does reduction must be attempted annually thereafter unless medically contraindicated, monitor for changes in resident's functional status, monitor for effectiveness of medication, notify physician if medication is ineffective, monitor for any drug related side effects, order for as needed medications will have designated purpose for use, administration of as needed medications will be documented in the medical record and indicate prior interventions to include non-pharmacological interventions, perform an AIMS assessment on admission and quarterly to monitor for the occurrence of tardive dyskinesia. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated dementia, anxiety and schizophrenia was a current diagnoses. On 01/14/25 at 1:35 P.M., interview with the Director of Social Services (DSS) #190 verified when the diagnoses of schizophrenia was added on 09/20/24 a significant change PASARR was not completed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, PASRR, (last revised 01/20) revealed all new admission and readmissions are screened for mental health disorders (MHD) and intellectual disabilities (ID) or related disorders per the Medicaid Pre-Admission Screening and Resident Review process.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and interview, the facility failed to ensure a pre-admission screening and resident review (PASARR) assessment was correct upon resident admission to the facility. This affected one resident (#85) of four residents reviewed for PASARRs. The facility census was 85. Findings include: Record review revealed Resident #85 was admitted to the facility on [DATE] with diagnoses including vascular dementia with agitation, post-traumatic stress disorder (PTSD), and idiopathic gout. Review of a PASARR completed on 11/21/24 revealed no evidence of PTSD being listed as a serious mental illness. Interview on 01/14/25 at 1:46 P.M. with Social Services Director (SSD) #190 confirmed PTSD was not listed on Resident #85's PASARR.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and interview, the facility failed to ensure a significant change Pre-Admission Screening and Resident Review (PASARR) contained correct developmental disability diagnoses. This affected one resident (#23) of four residents reviewed for PASARR assessments. The facility census was 85. Findings include: Record review revealed Resident #23 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, altered mental status, schizophrenia, and moderate intellectual disabilities. Review of a significant change PASARR completed on 08/05/24 revealed no evidence Resident #23 had a diagnosis of moderate intellectual disabilities. Interview on 01/14/25 at 1:46 P.M. with Social Services Director (SSD) #190 confirmed moderate intellectual disabilities was not listed on Resident #23's PASARR.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, interview and facility policy review, the facility failed to develop a comprehensive plan of care for three residents (#30, #31, #38). This affected three residents (#30, #31, #38) of 20 sampled residents. The facility census was 85. Findings Include: 1. Review of the medical record for Resident #30 revealed an initial admitted [DATE] with the latest readmission of 12/10/24 with the diagnoses including but not limited to partial traumatic amputation of left foot, osteomyelitis, sepsis, diabetes mellitus with neuropathy, hypertension, hyperlipidemia, osteoarthritis, gastro-esophageal reflux disease, constipation, edema, nausea and vomiting and anemia. Review of the resident's plan of care revealed no care plan addressing the resident's dialysis or potential for infection related to the central line. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was not assessed. The assessment indicated the resident had not received dialysis services. Review of the resident's monthly physician orders for January 2025 revealed no physician orders for offsite hemodialysis. On 01/15/25 at 3:52 P.M., interview with the Director of Nursing (DON) verified the lack of a comprehensive assessment addressing the resident's hemodialysis and potential for infection related to the port used for hemodialysis. 2. Review of the medical record for Resident #38 revealed an initial admitted [DATE] with the latest readmission of 06/02/23 with the diagnoses including but not limited to metabolic encephalopathy, sepsis, acidosis, epilepsy, solitary pulmonary nodule right upper lobe, dementia with behavioral disturbances, esophageal thickening, diabetes mellitus, hypertension, anxiety disorder, mood disorder, insomnia, dental caries and added on 09/20/24 schizophrenia. Review of the resident's admission observation and data collection dated 02/02/23 revealed the resident had her own natural teeth. The assessment indicated the resident's teeth had no cavities or broken teeth. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care dated 02/16/23 revealed the resident had potential for mouth pain related to problems developing with natural teeth. Interventions included assess condition of oral cavity, teeth, tongue and lips as needed, assess location of pain, quality and characteristic of pain, duration, intensity and severity of pain, aggravating and alleviating factors as needed, check dentures for a proper/comfortable fit, dental evaluation and intervention as needed, encourage fluids to keep oral cavity moist, medications as ordered, observe and report difficulties, observe and report difficulties chewing/swallowing, observe for need for change diet consistency to increase ease of eating, obtain a dietary consult as needed, follow recommendations as required and offer and provide mouth care as needed. Review of the resident's quarterly observation and data collection dated 11/01/24 revealed the resident's natural teeth had no cavities or were not broken. The assessment indicated the resident had no ulcers, lesions, halitosis, dry membranes or bleeding gums. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had no obvious or likely cavity or broken natural teeth. On 01/13/25 at 9:19 A.M., observation of the resident revealed she had multiple black broken teeth with obvious caries. On 01/14/25 at 12:14 P.M., interview with the DON verified resident's dental care plan failed to address the resident's black broken teeth with obvious caries. Review of the facility policy titled, Comprehensive Person Centered Care Plans, (dated 12/16) revealed a comprehensive person center care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 32801 3. Medical record review revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including diffuse traumatic brain injury, hemiplegia, deformity of the head, and convulsions. Review of Resident #31's current orders dated 12/18/24 revealed the resident was to always wear a safety helmet when out of bed. Review of Resident #31's plan of care revealed no evidence of a plan of care for a safety helmet. Interview on 01/21/25 at 8:26 A.M., with Registered Nurse (RN) #139 confirmed the resident was ordered to wear a safety helmet when out of bed, however there was no plan of care for the safety helmet.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review, policy review, and interview, the facility failed to ensure comprehensive care plans were up to date. This affected two residents (#21 and #71) of three residents reviewed for care planning. The facility also failed to complete quarterly care conferences. This affected one resident (#1) of three residents reviewed for care planning. The facility census was 85. Findings include: 1. Record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage, unspecified dementia, and bipolar disorder. Review of a minimum data set (MDS) completed on 11/15/24 revealed Resident #21 exhibited no behaviors. Review of a care plan last revised on 11/18/24 revealed Resident #21 did not have a care plan for sexually inappropriate behaviors in place. Review of a nursing note dated 11/21/24 at 1:17 P.M. by Registered Nurse (RN) #188 revealed Resident #21 was found in a male resident's room with her shirt up. Resident was redirected out of the male resident's room. Interview on 01/14/25 at 10:28 A.M. with Social Services Director (SSD) #190 revealed behaviors should be listed in the care plan with interventions. SSD #190 stated the MDS nurse is responsible for completing care plans. Interview on 01/15/25 at 10:26 A.M. with MDS Nurse #139 revealed the behavior care plans should be completed by the social worker. Interview on 01/16/25 at 8:34 P.M. with Director of Nursing (DON) confirmed Resident #21's care plan was not updated to include sexually inappropriate behaviors. 2. Record review revealed Resident #71 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation, dementia, and hypertension. Review of an MDS completed on 09/30/24 revealed Resident #71 had behaviors including delusions and wandering daily. Review of a nursing note dated 10/31/24 at 7:58 P.M. by RN #188 revealed Resident #71 had his hands wrapped around a Certified Nursing Assistant (CNA)'s neck, and the CNA was red and sweating. Resident #71 was redirected and was sent to the emergency department for evaluation. Review of a nursing note dated 10/31/24 at 8:44 P.M. by RN #162 revealed Resident #71 returned to the facility with no new orders. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a care plan last reviewed on 11/13/24 revealed no care plan to address Resident #71's aggressive behaviors. Interview on 01/14/25 at 10:28 A.M. with Social Services Director (SSD) #190 revealed behaviors should be listed in the care plan with interventions. SSD #190 stated the MDS nurse is responsible for completing care plans. Interview on 01/15/25 at 10:26 A.M. with MDS Nurse #139 revealed the behavior care plans should be completed by the social worker. MDS Nurse #139 confirmed there was not a behavior care plan in Resident #71's record. 28923 3. Review of Resident #1's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included paraplegia, neurogenic bowel, colostomy status, neuromuscular dysfunction of the bladder, Stage IV pressure ulcer (full-thickness skin and tissue loss with exposed fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer) on her buttock, chronic pain syndrome, chronic peripheral venous insufficiency, chronic obstructive pulmonary disease (COPD), major depressive disorder, attention deficit and hyperactive disorder (ADHD), bipolar disorder, anxiety disorder, and muscle weakness. Review of Resident #1's annual Minimum Data Set (MDS) assessment completed on 01/01/25 revealed the resident did not have any communication issues and was cognitively intact. She was known to have verbal behaviors directed at others, but was not known to reject care. She had a functional limitation in her range of motion for her bilateral lower extremities. She was dependent on staff for bed mobility and transfers and a motorized wheelchair was indicated to be the mobility device she used. Her prior MDS assessment was a quarterly MDS assessment completed on 10/01/24. Review of Resident #1's care conference reports revealed the resident's last recorded care conference meeting had been held on 08/29/24. There was no documented evidence of a care conference meeting being held on or around 10/01/24, when the resident's last quarterly MDS assessment was completed or on or around 01/01/25, when the resident's annual MDS assessment was completed. On 01/13/25 at 10:58 A.M., an interview with Resident #1 revealed she could only recall having had one care conference meeting in the time she had been at the facility. She denied she had been invited to attend any recent care conference meetings, despite her having a quarterly MDS assessment completed on 10/01/24 and an annual MDS assessment completed on 01/01/25. She reported she would have liked to have one and would have attended if offered. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/15/25 at 4:57 P.M., an interview with SSD #190 revealed any care conference meetings held for Resident #1 would have been documented under the observation tab of the electronic medical record (EMR). She reported the resident was about due for another care conference meeting. She verified the last documented care conference meeting they had for the resident was on 08/29/24. She denied they had completed a care conference meeting for the resident since and despite a quarterly MDS assessment being completed on 10/01/24 and an annual MDS assessment being completed on 01/01/25. She acknowledged the resident was past due for a care conference meeting since she had not had one in the last 90 days (quarterly). She tried to complete them a week after their quarterly or annual MDS assessment was done, but were getting behind on them. She was still trying to play catch up on them since she took over that position in July 2024. They were trying to get them (care conference meetings) all done in one day each week, but they had so many to do she was not able to keep up. Her IDT was wanting them scheduled all on the same day, but she felt she was going to have to schedule them twice a week to be able to get them all done. It was hard to get her IDT together for the meetings for more than just once a week. A review of the facility's policy on Care Conferences (revised 01/2020) revealed the facility's care planning/ IDT was responsible for the development of an individualized comprehensive care plan for each resident. A comprehensive care plan for each resident was developed within seven days of completion of the resident assessment (MDS). Care conferences would be scheduled to include the resident, resident representative, and IDT as soon as possible after admission, routinely, and with a change in condition.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review, interview, and facility policy review, the facility failed to complete a discharge summary that included a recapitulation of the resident's stay. This affected one resident (#87) of one resident reviewed for discharge. The facility census was 85. Findings Include: Review of the closed medical record for Resident #87 revealed an initial admitted [DATE] with the diagnoses including but not limited to traumatic subdural hemorrhage, rhabdomyolysis, diabetes mellitus, hyperlipidemia, hypertension, benign prostatic hyperplasia, obesity, diverticulosis, osteoarthritis, incisional hernia, dysphagia, generalized muscle weakness and disorders of kidney and ureter, renal mass. The resident was discharged to his own home on 10/16/24. Review of the baseline care plan dated 10/11/24 revealed the baseline care plan will identify my care needs, risk, strengths and goals for the first 48 hours. Interventions included the resident will be receiving skilled care and his discharge planning, goals, community referrals, transportation, health knowledge deficits and follow-up will be discussed and planned with the resident and as needed with selected representatives. Review of the resident's five day MDS assessment dated [DATE] revealed the resident's cognition was not assessed. The assessment indicated the resident required partial/moderate assistance with ADL's. The assessment indicated the resident's goal was to discharge to the community. Review of the progress note dated 10/16/24 at 11:25 A.M. revealed the resident voiced wishes to be discharged on this day. The resident's wife was at bedside and in agreement. The resident denied any need for medical equipment or home health services. The resident was encouraged to continue with therapy in house as ordered but denied the need for therapy. The Certified Nurse Practitioner (CNP) was updated on the resident's wishes and a new order was received to discharged the resident home per his request. The discharge instructions were reviewed with the resident and his wife with no questions. The resident was encouraged to follow up with the surgeon and his primary care physician as soon as possible. The resident was encouraged to go to the emergency department (ED) if any complications should occur. The resident was discharged to home at this times and appeared to be in stable condition. Review of the discharge instructions dated 10/16/24 revealed the physician orders and a list of the resident's medications have been provided for discharge, see attached and discharge medications and physician's orders have been reviewed with the resident and/or responsible party, understanding of the medications and administration had been verbalized and confirmed. The discharge instructions provided no recapitulation of the resident's stay. Review of the medical record revealed no documented evidence of a completed discharge summary that included a recapitulation of the resident's stay. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/15/25 at 3:18 P.M., interview with Social Service Director (SSD) #190 verified the resident had no discharge summary that included a recapitulation of the resident's stay. Review of the facility policy titled, Discharge Summary and Plan, (dated 2021 and last revised 12/16) revealed when a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's current diagnoses, medical history, course of illness, treatment and/or therapy since entering the facility, current laboratory, radiology, consultation and diagnostic test results, physical and mental functional status, ability to perform activities of daily living, sensory and physical impairments, nutritional status and requirements, special treatments or procedures, discharge potential, dental condition, activity potential, rehabilitation potential, cognitive status and medication therapy. A copy of the following will be provided to the resident and receiving facility and a [NAME] will be filed in the resident's medical record, an evaluation of the resident's discharge needs, the post discharge plan and the discharge summary.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 32654 Based on record review, observation, and staff interview, the facility failed to ensure a resident who was dependent on staff for personal care received the assistance needed with nail care. This affected one resident (#57) of two residents reviewed for activities of daily living (ADL's). The facility census was 85. Findings Include: Review of the medical record for Resident #57 revealed an initial admitted [DATE] with the diagnoses including but not limited to Alzheimer's disease, dementia, chronic kidney disease, hypertension, vitamin D deficiency and dysphagia. Review of the plan of care dated 01/06/23 revealed the resident required staff assistance to complete activities of daily living (ADL) tasks completely and safely. Interventions included allow resident sufficient time to complete all or parts of task, do not rush resident, encourage resident to do as much as safely possible for self, observe the deterioration in ADL abilities and report if occurs, provide adequate resident periods between activities and therapy evaluation and treat as needed and ordered. Review of the resident's comprehensive Minimum Data Set (MDS) dated [DATE] revealed the resident had a severe cognitive deficit. On 01/13/25 at 11:02 A.M., observation of Resident #57 revealed his nails were long and jagged with brown substance under the nail. On 01/14/25 at 10:43 A.M., observation of the resident revealed his nails remained long, jagged with a brown substance under the nail. On 01/14/25 at 1:59 P.M., interview with Certified Nursing Assistant (CNA) #158 verified the resident's nails were long, jagged with a brown substance under nail.

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F 0684 Level of Harm - 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** 47985 Based on observations, record reviews, and interviews, the facility failed to monitor and administer Resident #31's vancomycin per standards of care, failed to address edema and obtain Doppler testing timely for Residents #59, #85, and #191, failed to communicate orders and care plan with hospice for continuity of care for Resident #54, and failed to address a change in condition for Resident #41 following a fall. This affected six sampled residents (#31, #41, #54, #59, #85, #191) of 20 residents reviewed for quality of care. The facility census was 85. Actual Harm occurred to Resident #41 beginning on 12/20/24 when Registered Nurse (RN) #213 documented the resident had inflammation of left foot and toes after a fall on 12/19/24, with no evidence the resident's medical provider was notified of the resident's change in condition delaying any orders for treatment of the resident's change in condition. On 12/21/24, Resident #41's left foot continued to be edematous and red, with the resident exhibiting facial grimacing with repositioning and generalized discomfort; the resident's wife verbalized he had been sleepier and had a poor appetite since his fall on 12/19/24. An order was received on 12/21/24 at 11:42 A.M. for an x-ray of the left foot and hip, and a venous Doppler to right foot. Resident #41 continued to show signs of discomfort including facial grimacing and moaning aloud with care, and as needed pain medication was administered. The left foot and hip x-rays were delayed and not completed until the following day (12/22/24) at 2:00 P.M., the x-ray results were received, the resident was transferred to the hospital for additional testing that identified the resident had an acute mildly impacted subcapital right femoral neck fracture. Findings include: 1. Record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including atherosclerotic heart disease without angina pectoris, hypo-osmolality and hyponatremia, anemia, hypertension, and heart failure. Resident #41 was recently readmitted to the facility on [DATE] after a brief stay in the hospital. Review of a nursing note dated 12/19/24 at 2:30 P.M. by RN #188 revealed Resident #41 was noted to have fallen from his wheelchair on his right side in the dining room attempting to throw away an apple core. Resident #41 was assessed with no injuries noted, he did not complain of pain or discomfort, but stated this floor is hard. Resident #41 was assisted into his wheelchair without difficulty. The resident's responsible party was notified. Review of a nursing note dated 12/20/24 at 8:00 P.M. by RN #213 revealed Resident #41 had inflammation noted to his left foot and toes. There was no evidence the resident's medical provider was notified of the resident's change in condition after his fall on 12/19/24. Review of a nursing note dated 12/21/24 at 11:42 A.M. by RN #202 revealed Resident #41's left foot was noted to be slightly edematous and red, with pedal pulses palpable and no increased warmth. Resident #41 had grimacing with positioning and generalized discomfort, and as needed Tylenol was administered. Resident's wife was present and stated he had a poor appetite and was sleepier since his fall on 12/19/24. A new order was received for an x-ray to the left hip and foot due to pain, and a venous Doppler to the right foot. Wife present and agreeable. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a nursing note dated 12/21/24 at 9:41 P.M. by RN #216 revealed the mobile imaging company called and stated the x-ray would not be able to come in as scheduled but would come sometime tomorrow. Review of a nursing note on 12/22/24 at 11:22 A.M. by RN #202 revealed Resident #41 continued to show signs of discomfort, facial grimacing and moaning aloud with care, and as needed Tylenol was administered as ordered. Review of a nursing note dated 12/22/24 at 2:00 P.M. by RN #202 revealed the mobile imaging company was in-house for exam of Resident #41. Review of a medication administration record for December 2024 revealed on 12/22/24 Resident #41 received an x-ray of his left foot and hip. Review of a nursing note dated 12/22/24 at 2:10 P.M. by RN #202 revealed x-ray results were received, and the on-call provider was notified and gave new orders to send to the emergency department for further evaluation. A squad was notified of need for transfer and family notified. Review of a nursing note dated 12/22/24 at 3:59 P.M. by RN #202 revealed Resident #41 was transported to the hospital. Review of a hospital note dated 12/23/24 revealed Resident #41 presented to the emergency department (ED) following a fall at a facility. Upon presentation, Resident #41's blood pressure was 190/71 and other vitals were within normal limits. An x-ray of the pelvis showed a previous internal fixation of the left femoral neck and due to a nondisplaced fracture of the right femoral neck, and fecal impaction. A CT scan of the pelvis showed an acute mildly impacted subcapital right femoral neck fracture. Interview on 01/16/25 at 2:43 P.M. with Director of Nursing (DON) revealed there have been concerns with the mobile imaging company not showing up to complete STAT imaging. The DON confirmed Resident #41 began to complain of pain on 12/20/24, with no new intervention in place until the imaging services were ordered on 12/21/24, which were not completed until 12/22/24. The DON stated if the company does not show up within four hours, a resident should be sent to the hospital. 2. Record review revealed Resident #59 admitted to the facility on [DATE] with diagnoses including dementia, metabolic encephalopathy, type II diabetes, and hypertension. Review of a minimum data set (MDS) completed on 10/09/24 revealed Resident #59 had impaired cognition and no behaviors. Review of a nursing note dated 11/30/24 by RN #188 revealed Resident #59 complained of discoloration to her left foot. Her foot was noted to be dark purple/black, and swelling was noted with capillary refill of less than three seconds. Resident #59 denied pain, the medical provider was notified, and new orders were received for an x-ray and a venous Doppler. The mobile imaging company stated they would not be able to complete the Doppler until next week. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a progress note dated 12/02/24 by Nurse Practitioner (NP) #315 revealed she was asked to see Resident #59 due to discoloration of the left foot. An x-ray was completed and negative and the venous duplex was not yet completed. There was one-two pitting edema to the left foot with purple discoloration to the left foot dorsal aspect, non-tender palpation and 2+ DPPT pulse. No new orders were given. Review of a note dated 12/10/24 at 2:20 P.M. revealed the mobile imaging company was in-house to complete Resident #59's ultrasound (Doppler). Results were negative. Review of a Doppler report dated 12/10/24 revealed there was no evidence of left lower extremity deep venous thrombosis. Interview on 01/16/25 at 1:47 P.M. with RN #188 revealed she entered Resident #59's order for a stat venous Doppler and she faxed the information six times before the mobile imaging completed the ultrasound. RN #188 stated she notified the NP (#315) of the situation but the Medical Director (MD) #340 came in and evaluated the resident and was not worried. Her family did not want her sent out for evaluation and were okay with waiting until the scan could be done in house. Interview on 01/16/25 at 10:56 A.M., with the Nurse Practitioner (NP) #315 confirmed her expectations would be the venous Doppler be done within 24 hours from when it was ordered. Interview on 01/16/25 at 2:43 P.M. with Director of Nursing (DON) revealed there have been concerns with the mobile imaging company not showing up to complete STAT imaging. The DON confirmed Resident #59 waited from 11/30/24 to 12/10/24 to receive the venous Doppler. The DON stated if the company does not show up within four hours, a resident should be sent to the hospital. 3. Record review revealed Resident #85 admitted to the facility on [DATE] with diagnoses including vascular dementia, post-traumatic stress disorder, and idiopathic gout. Review of a MDS completed on 11/29/24 revealed Resident #85 had moderately impaired cognition and wandered daily. Review of orders revealed Resident #85 had an order in place to receive a venous duplex (Doppler) to his left lower extremity due to pain and swelling dated 01/02/25. The order was discontinued on 01/02/25. Review of a nursing note dated 01/02/25 at 9:54 A.M. by Licensed Practical Nurse (LPN) #177 revealed new orders were received for Resident #85 for a CBC, Chem 8, ESR, CRP, and uric acid level, obtain an x-ray of left knee due to pain and swelling, and a venous duplex of the left lower extremity. Review of a nursing note dated 01/05/25 at 10:03 A.M. by LPN #211 revealed Resident #85 had +1 putting edema to the right foot with minimal movement and grimacing when attempting to move. The resident's medical provider was notified and new order was received for right lower extremity venous duplex. Review of a nursing note dated 01/05/25 at 6:40 P.M. for late entry from 9:28 A.M. by LPN #211 revealed she called the mobile imaging company to schedule a Doppler for Resident #85 and was told a face sheet and order needed sent prior to scheduling. Information was sent. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of orders revealed Resident #85 had an order in place for a venous duplex of right lower extremity dated 01/05/25. The order was discontinued on 01/08/25. Review of a nursing note dated 01/08/25 at 9:29 A.M. by LPN #211 revealed she called the mobile imaging company to ask if the venous Doppler had been completed and the scheduler requested a new order with updated symptoms. Review of orders revealed Resident #85 had an order in place dated 01/08/25 for a venous duplex of right lower extremity due to pain and edema. The order was discontinued on 01/16/25. Review of a nursing note dated 01/10/25 at 10:44 A.M. by LPN #165 revealed a face sheet and orders were faxed to the mobile imaging company for a venous duplex of the right lower extremity due to pain and swelling and will call back to schedule exam. Review of a patient report (for Resident #85) for venous Doppler dated 01/15/25 revealed there was no deep venous thrombosis evident on the right lower extremity. Interview on 01/16/25 at 10:56 A.M., with the Nurse Practitioner (NP) #315 confirmed her expectations would be the venous Doppler be done within 24 hours from when it was ordered. Interview on 01/16/25 at 2:43 P.M. with the DON revealed there have been concerns with the mobile imaging company not showing up to complete STAT imaging. The DON confirmed Resident #85 received an initial order on 01/02/25 and waited until 01/15/25 to have a venous Doppler completed. The DON stated if the company does not show up within four hours, a resident should be sent to the hospital. 32801 4. Medical record review revealed Resident #31 was admitted to the facility on [DATE] at 5:05 P.M., with diagnoses including diffuse traumatic brain injury with loss of consciousness, hemiplegia, deformity of the head, atrial fibrillation, chronic pain, and iron deficiency anemia. Review of Resident #31's hospital records dated 12/04/24 to 12/18/24 revealed the resident was admitted for a cranial wound dehiscence and purulence. The resident had a craniectomy in 2019 complicated by chronic draining scalp wound and was treated with long term antibiotics. The resident had been having ongoing purulent drainage and exposed hardware. She was taken to neurosurgery and plastics on 12/04/24 for excision of skull bone infection with craniectomy, removal of prior cranial hardware, debridement of bone and scalp and dermal tissue, and implantation of dura matrix. The infection disease was consulted to assist with intravenous antibiotics. Their recommendation at discharge included intravenous meropenem two grams every eight hours for six weeks and vancomycin (pharmacy to dose) for six weeks. The stop date would be 01/16/25. A left tunneled internal jugular central line was placed on 12/12/24. The resident will need oral antibiotics therapy at the end of the parenteral therapy based on the follow up MRI. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #31's hospital discharge orders dated 12/18/24 revealed to obtain Vancomycin tough and a basic metabolic profile (BMP) 30-60 minutes before the scheduled dose on Monday and Thursday for two weeks and then weekly on Mondays. Obtain a complete blood count (CBC) and hepatic function panel weekly on Monday. The resident's vancomycin trough range goal was 15-20 micrograms (mcg) per milliliter (ml). Fax laboratory results to the infection disease physician (name and fax number was provided on discharge paperwork). Further review revealed to administer meropenem two grams intravenously every eight hours (last dose was administered on 12/18/24 at 10:56 A.M.) and vancomycin 750 milligrams (mg) every 12 hours intravenously (last dose was administered on 12/18/24 at 5:42 A.M.). A. Review of Resident #31's current orders dated 01/2025 revealed meropenem two grams intravenous every eight hours (6:00 A.M., 2:00 P.M., and 10:00 P.M.) and vancomycin 750 mg intravenous every 12 hours (goal trough range 15-20 mcg/ml) at 8:00 A.M. and 8:00 P.M. Review of Resident #31's medication administration records (MAR) dated 12/18/24 to 01/15/25 revealed the resident didn't receive meropenem on 12/18/24 10:00 P.M., 12/19/24 at 6:00 A.M., 12/29/24 at 2:00 P.M. due to the medication was not available. The vancomycin was not administered on 12/18/24 8:00 P.M., 12/19/24 at 8:00 A.M., 12/23/24 at 8:00 A.M., 12/29/24 at 8:00 P.M., 12/30/24 at 8:00 A.M. and 8:00 P.M. and 12/31/24 at 8:00 A.M., due to the medication was not available. The physician was notified on 12/31/24 that the vancomycin was not available. The medication was on hold on 01/09/25 for the 8:00 A.M. and 8:00 P.M. awaiting trough to be drawn, however the trough (blood work to check medication level) was never collected on 01/09/25. B. Review of Resident #31's orders revealed vancomycin trough was ordered on 12/19/24 on Tuesday and Thursday for two weeks (discontinued on 12/31/24). On 12/27/24 and 01/06/25 vancomycin trough was ordered every Monday and was discontinued on 01/19/25 and 01/09/25 a vancomycin trough was ordered and discontinued the same day. Further review revealed on 12/27/24 a BMP, CBC, CMP, and hepatic function was ordered every Monday and discontinued on 01/19/25. Review of Resident #31's laboratory results revealed the only laboratory results in the medical record were dated 01/10/25. Review of Resident #31's medical record revealed no evidence the laboratory test was faxed to the infectious disease physician per the hospital discharge orders. Review of the laboratory results dated [DATE] to 1/20/25 revealed: -12/19/24 (Thursday) only the vancomycin trough was completed. There was no evidence the BMP was collected per the hospital discharge orders. The vancomycin trough was collected at 10:22 A.M. Per the MAR the resident had missed the 8:00 P.M. dose on the 12/18/24 and the 8:00 A.M., dose on 12/19/24. The trough level was 10.7 microgram (mcg)/ milliliter and the resident's goal were 15-20. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-12/23/24 and 12/26/24 (Monday and Thursday) There was no evidence laboratory results were obtained. -12/30/24 (Monday) the blood was collected at 1:45 P.M. (Vancomycin was not administered on 12/29/24 at 8:00 P.M., or on 12/30/24 at 8:00 A.M., due it was not available). The trough level was 5.5 mcg/ml. The BMP, hepatic, and CBC was collected. -01/06/25 (Monday) There was no evidence lab testing was collected. -01/07/25 (Tuesday) The trough level was 26.3 mcg/ml. The BMP, hepatic, and CBC was collected. The trough level was collected at 11:36 A.M., which would have been after the administration of the vancomycin (order was to collect 30-60 minutes prior to administration of vancomycin). New orders were to hold to hold morning dose on 01/09/25 and recollect vancomycin's trough due to the 01/07/25 bloodwork was not collected properly. -01/09/25 there was no evidence the vancomycin trough was collected; however, the resident did not receive either dose of vancomycin on 01/09/25. -01/10/25 the vancomycin trough was collected at 1:44 P.M. and the trough was 4.0 mcg/ml. The MAR indicated the 8:00 A.M., dose was held until the lab was drawn. -01/13/25 (Monday) the vancomycin trough was 13.0 mcg/ml and was collected at 1:47 P.M. The MAR indicated the vancomycin was held until the trough was collected. The other labs were obtained per orders. Review of Resident #31's progress notes dated 01/08/25 revealed the vancomycin trough was reported to pharmacy. The results were 26.3. The dose of vancomycin was administered before the labs were drawn on 01/07/25 so the trough was not a true draw. Recommendation received to redraw trough tomorrow 01/09/25 and hold the 8:00 A.M., dose of Vancomycin until after labs have been drawn. Interview on 01/21/25 at 10:53 A.M., with Licensed Practical Nurse (LPN)/Unit Manger #177 confirmed Resident #31's laboratory results were not in the resident medical record except for the laboratory testing that was completed on 01/10/25. The LPN verified she called and had the hospital fax over all the laboratory results today (01/21/25) from admission to present. The laboratory person comes to the facility on Monday and Thursday to collect labs. LPN #177 reported she called the infection disease physician office today, and they confirmed they had received the laboratory results. The LPN confirmed the troughs should have been drawn 30-60 minutes prior to administering the vancomycin, however the vancomycin troughs on 12/26/24, 12/30/24, and 01/07/25 were collected after the administration of the vancomycin. The LPN confirmed the resident had missed seven doses of the vancomycin and three doses of the meropenem because they were not available to administer from pharmacy, which has been an issue for the facility. LPN #177 confirmed the BMP was not collected on 12/19/24 nor was the trough or BMP collected on 12/23/24, or 12/26/24 per the hospital discharge orders. The laboratory staff did not come on 01/06/25 due to weather but came on 01/07/25. LPN #177 confirmed the resident lab work should have been collected via the central line by the facility's nursing staff; however, it was not collected because the facility depends on the lab to transport specimens. The labs were not done on 01/09/25 and staff should have (but did not) contacted the physician and not held the two doses. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	5. Medical record review revealed Resident #54 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of liver, type two diabetes, urinary tract infection, anemia, paroxysmal atrial fibrillation, congestive heart failure, cardiomegaly, hyperlipidemia, anxiety, history of acute kidney, ileus, acute pulmonary edema, conjunctival hemorrhage, severe sepsis with septic shock, sepsis, encephalopathy, bacteriuria, liver disease, diarrhea, gastroenteritis and colitis, muscle weakness, difficulty walking, need for assistance with personal care. Review of Resident #54's face sheet revealed the resident primary payer was hospice Medicaid. Review of Resident #54' Minimum Data Set (MDS) dated [DATE] revealed the resident was receiving hospice services. A. Review of Resident #54's current and discontinued orders dated 12/19/24 to 01/15/25 revealed no evidence of orders for hospice. Review of Resident #54's medical record revealed no evidence of hospice notes. Review of Resident #54's care plans revealed no evidence of a plan of care for hospice. B. Review of Resident #54's orders dated 12/16/24 to 01/15/25 revealed to check the resident's blood glucose twice a day and notify hospice if greater than 450 mg/dL. Review of Resident #54's MAR dated 12/2024 revealed the resident's blood glucose on 12/18/24 was 509. Review of Resident #54's medical record revealed no evidence hospice was notified of the blood glucose of 509 mg/dL on 12/28/24. C. Review of Resident #54's hospice orders dated 12/10/24 and 01/22/25 revealed the resident was ordered Humalog insulin 10 units prior to meals. Review of Resident #54's facility orders dated 12/11/24 to 01/16/25 revealed the resident was ordered Humalog 15 units three times a daily. Review of Resident #54's MAR dated 12/16/24 to 01/15/25 revealed the resident was receiving 15 units of Humalog three times daily. Interview on 01/22/25 at 9:45 A.M., with RN #139 confirmed Resident #54 did not have a plan of care for hospice. Interview on 01/22/25 at 10:59 A.M. and 2:20 P.M. with LPN #177 confirmed she had called hospice and reviewed Resident #54's medical record and there was no evidence hospice was notified of the blood sugar of 509 mg/dL on 12/18/24. LPN #177 confirmed the facility's physician had increased the resident's Humalog to 15 units on 12/10/24, however hospice was not updated. Originally LPN #177 confirmed the facility had to call hospice to obtain notes, however later reported the facility staff was not aware, however hospice confirmed there was a binder they have been leaving notes in for the staff. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 01/22/25 2:16 P.M. with Hospice RN #340 revealed there has been communication issues with the facility not notifying hospice of changes in resident conditions/orders. The night shift nurses were worse than day shift. For example, Resident #54 has been yelling out at night. No one had called and updated hospice. Hospice RN #340 stated she usually gets information from the chart during her visits, the resident, and sometimes she gets information from other residents. Resident #54 had had an as needed order for Ativan and the facility was not utilizing the as needed medication or notifying hospice. There has been concerns with medication not being administered timely as well. If medications are ordered from the facility, it may take 2-3 days before the medications are started. Hospice RN#340 reported she brings notes in every two weeks and places in the binders for staff. Review of the facility's policy titled Hospice (dated 06/2022) revealed the facility policy was to coordinate end-of-life care with hospice agency of a resident/resident representative choice. The facility would coordinate care with the hospice agency. Facility would notify hospice agency upon resident/resident representative request, or a change in resident condition. Facility would document the coordination of care and treatment that was given to the resident. 6. Medical record review revealed Resident #191 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, sepsis, tracheostomy, gastrostomy, hypertension, atrial fibrillation, acute kidney failure, protein-calorie malnutrition, anxiety, hyperlipidemia, and tobacco use. Review of Resident #191's progress note dated 01/13/25 at 9:41 A.M., revealed the resident had noted with swelling and bruising to right arm. Area noted to be warm and tender to touch. New orders received to obtain a venous duplex and laboratory testing. Review of Resident #191's progress note dated 01/14/25 revealed no evidence the venous duplex was completed. Review of Resident #191's progress note dated 01/15/25 at 11:54 A.M., revealed the resident had a Doppler completed to the right upper extremity per orders. Review of Resident #191's Doppler results dated 01/15/25 revealed the reason for the right upper extremity Doppler was for pain and swelling to the right arm. The impression included no findings of the right upper extremity deep vein thrombosis. Review of the facility's imaging services agreement (dated 10/01/22) revealed the imaging service was to respond within a reasonable timeframe to request for services, usually within a few hours. Doppler exams are scheduled services, although every effort is made to prioritize emergent venous Doppler studies to be performed within 24 hours. Interview and observation on 01/13/25 at 10:19 A.M., with Resident #191 revealed she had had swelling in her right arm/hand since admission and had not been able to move it. The resident reported she had voiced concerns to the facility staff and wanted an x-ray, but no one had gotten back to her, and she didn't know what the holdup was. At 10:28 A.M., during the interview with the resident an unknown staff member had walked into the resident's room and reported she had spoken to the Nurse Practitioner, and she had ordered a venous Doppler and blood work. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 01/15/25 at 10:16 A.M., with Resident #191 revealed the venous Doppler still had not been completed and she still had the swelling in her right arm and hand. Interview on 01/15/25 at 10:20 A.M., with Licensed Practical Nurse (LPN)/Unit Manger #177 confirmed the resident had not had the venous Doppler at this time. Interview on 01/15/25 at 10:33 A.M., with the Director of Nursing (DON) revealed she was not aware the Doppler was not done and her expectation would be the Doppler would have been done within 24 hours of the order, if not, the facility would transport the resident to the hospital to have the test completed. Interview on 01/16/25 at 10:56 A.M., with the Nurse Practitioner (NP) #315 confirmed her expectations would be the venous Doppler be done within 24 hours from when it was ordered. The NP confirmed staff did not update her that the Doppler was not completed within the 24 hours. Interview on 01/16/25 at 11:06 A.M., with LPN #177 revealed it was the facility's expectation to have a venous Doppler completed within 24 hours from the order. The LPN reported she thought the contracted company was having staff issues.

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F 0686 Level of Harm - 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** 47985 Based on observations, record reviews, and interviews, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to ensure skin assessments/skin checks were completed and to ensure skin integrity issues were reported to the medical provider. In addition, the facility failed to provide treatment to newly developed pressure ulcers for Resident #41 and failed to implement skin interventions for Resident #1 per the resident's plan of care. This affected two residents (#1 and #41) of two residents reviewed for pressure ulcers. The facility census was 85. Actual Harm occurred beginning on 01/01/25 when Resident #41, who was assessed to be at high risk for the development of pressure ulcers, was readmitted to the facility from the hospital with mushy heels and the facility failed to comprehensively assess or implement interventions to prevent pressure ulcer development. On 01/09/25 prevlon boots were ordered to both feet without documentation regarding the reason the boots were ordered. On 01/12/25 an initial assessment revealed had a pressure ulcer to his left heel that measured 4.5 (did not specify inches or centimeters) in diameter and was brown in color (with no staging included). The facility failed to implement new pressure ulcer interventions at this time resulting in a decline and identification of bilateral heel pressure ulcers that were Stage III (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss due to the eschar and coloring of the wound) pressure ulcers. Findings include: 1. Record review revealed Resident #41 admitted to the facility on [DATE] with diagnoses including atherosclerotic heart disease without angina pectoris, hypo-osmolality and hyponatremia, anemia, hypertension, and heart failure. Resident #41 recently readmitted to the facility on [DATE] after a brief stay in the hospital. Review of a care plan initiated 12/26/23 revealed Resident #41 was at risk for skin breakdown related to decreased mobility and incontinence. Interventions (all dated 06/28/24) included avoiding shearing skin during positioning, turning and transferring; conduct a weekly skin assessment and pay particular attention to bony prominences; encourage and assist to turn and reposition for comfort and as needed; floats heels as needed; keep linens clean and dry as possible, minimize skin exposure to moisture; pressure reducing cushion to chair; pressure reducing mattress to bed; use lifting device as needed for bed mobility; and use moisture barrier product to perineal area as needed. The care plan was last reviewed on 01/02/25 with no new interventions. Record review revealed no documented evidence care planned interventions, including turning and repositioning and floating the resident's heels, were implemented and completed. Review of a hospital wound care note dated 12/24/24 revealed Resident #41 had a traumatic wound to the second toe of his right foot. There were no additional wounds listed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a nursing note dated 01/01/25 at 3:42 P.M. by Licensed Practical Nurse (LPN) #211 revealed Resident #41 was readmitted to the facility, with pain noted to hip, scattered bruising to bilateral arms and right leg was yellow and purple in color. There was an incision to his right hip measuring 10 centimeters (cm) in length by 0.01 cm in width and 0 cm in depth. Review of an Admission Observation and Data Collection assessment dated [DATE] revealed Resident #41's skin color was normal, warm in temperature, normal turgor, and skin impairment was identified and to be assessed on a Wound Event Assessment. Resident #41 was determined to be at high risk for developing pressure ulcers. Review of a progress note dated 01/02/25 by Nurse Practitioner (NP) #315 revealed Resident #41's skin was warm, dry, and the dressing to the right hip was dry and intact with surrounding ecchymosis. Review of an order dated 01/09/25 revealed Resident #41 was to have prevlon boots on when in bed. Review of a nursing note dated 01/12/25 at 9:23 A.M. by Registered Nurse (RN) #213 revealed wound on Resident #41's left heel was now approximately 4.5 (did not specify inches or centimeters) in diameter and had become brown in color. There was no staging including in the note. No drainage was noted, and soft boots were in place to elevate foot and heel off the bed. Review of a nursing note dated 01/16/25 at 7:20 P.M. by RN #213 revealed the heel of Resident #41's left foot had approximately 4 centimeter (cm) area of light brown coloration, was soft to touch, and soft booties were in place to both feet. Review of a nursing note dated 01/20/25 at 11:05 A.M. by RN #213 revealed Resident #41 had a Stage I (intact skin with a localized area of non-blanchable erythema) pressure ulcer to his left heel, which was darker brown than previously noted and padded boots were in place to each foot. Review of an order dated 01/22/25 revealed Resident #41's heels should be monitored and notify nurse practitioner of any changes due to deep tissue injury. Measurements provided to the surveyor on 01/22/25 of bilateral heel pressure ulcers revealed an ulcer to the left heel was five centimeters by three centimeters and an ulcer to the right heel was three centimeters by 1.5 centimeters. Eschar noted to be present was not measured. Interview on 01/21/25 at 10:21 A.M. with Registered Nurse (RN) #188 revealed Resident #41 had a wound to his right second toe, which the resident was admitted with from the hospital, and a wound to the left and right heels. RN #188 stated the bilateral heels were hard and brown. Interview on 01/21/25 at 2:25 P.M. with Licensed Practical Nurse (LPN) #165 revealed she completes wound rounds with the NP, NP #315 when she comes in. LPN #165 stated they had not looked at Resident #41's heels during the wound rounds on 01/20/25 because the last they heard, the heels were just soft and prevlon boots had been added as a preventative measure. LPN #165 confirmed there was no documentation in the medical record regarding where the wounds to Resident #41's heels came from or information about the right heel at all. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview and observation on 01/21/25 at 2:40 P.M. with Director of Nursing (DON) revealed the wound to Resident #41's left heel was approximately the size of a fifty-cent piece, was purple and brown in color, with approximately 25% eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like). The wound to the right heel was approximately the size of a nickel, brown in color and had about 5% eschar. Resident #41's wife was present at the time of the observation and stated the resident's heels were soft upon return to the facility from the hospital (on 01/01/25). Observation on 01/22/25 at 10:36 A.M. of Resident #41's heels revealed the right heel was a healing blister the size of a nickel with blanchable skin and the skin was intact and wound edges approximate. The left heel had 30% eschar in the corner of the wound and was dry. Fascia, muscle, tendon, ligament, cartilage and/or bone were not exposed indicating a potential Stage 3 pressure injury. Interview on 01/22/25 at 11:18 A.M. with LPN #165 revealed she was unable to locate any documented evidence Resident #41 had mushy heels upon readmission to the facility on [DATE], however, LPN #165 stated the floor nurse knew but failed to document it. LPN #165 confirmed there was nothing regarding pressure ulcers/wounds to Resident #41's heels in the care plan, nursing notes, or hospital documentation to indicate the resident's heels had started to have wounds in the hospital. Interview on 01/22/25 at 11:40 A.M. with Medical Director (MD) #340 revealed he does not specialize in wound care and was not comfortable with staging the wounds to Resident #41's heels. MD #340 stated the NP took care of wounds for the facility. MD #340 stated the wounds looked like a blister, but he was not sure. He stated if new wounds arise, staff should contact the NP to let her know so she can assess and give interventions as soon as the wound is noticed. Interview on 01/22/25 at 12:53 P.M. with the DON revealed nursing notes, hospital notes, the NP note, assessments, and orders did not address potential deep tissue injuries or pressure ulcers to Resident #41's heels until 01/09/25 for the prevlon boots. The DON stated she assessed Resident #41's heels upon his return to the facility (01/01/25) but failed to document. After observing wounds on 01/21/25 (at 2:40 P.M. with the surveyor), the DON did not contact a medical provider, complete an assessment, or measure the wounds to Resident #41's bilateral heels. The DON acknowledged eschar was present in both wounds. Interview on 01/22/25 at 3:16 P.M. with RN #213 revealed she had assessed Resident #41's left heel the other day and it was about a Stage II pressure ulcer (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister), and she reported to the unit manager, LPN #165, to have the NP look at Resident #41's heels. RN #213 went to observe Resident 41's heels with surveyor present and stated the wound to Resident #41's left heel appeared to be a Stage Three (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss due to the eschar and coloring of the wound). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the National Pressure Ulcer Advisory Panel Pressure Injury Stages (dated 2018) revealed a deep tissue injury in intact or non-intact skin with localized area of persistent, non-blanchable deep red, maroon, purple discoloration or epidermal separation revealed a dark wound bed or blood filled [NAME]. If necrotic tissue (eschar), subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full-thickness pressure injury (unstageable, stage 3 or 4). A stage 3 pressure injury is full-thickness loss of skin, in which adipose is visible in the ulcer and granulation tissue and epibole are often present. Slough and eschar may be visible. If slough or eschar obscure the extent of tissue loss, it is an unstageable pressure injury. An unstageable pressure injury is when the extent of tissue damage cannot be confirmed because it is obscured by slough or eschar. If slough or eschar are removed, stage 3 or 4 will be revealed. Stable eschar (dry, adherent, intact without erythema or fluctuance) on the heels should not be removed. Review of a Pressure Ulcer/Injury Risk Assessment policy (last revised in 2017) revealed the following information should be documented in the medical record: - The type of assessment - The date, time, and type of skin care provided - The name and title (or initials) of the person completing the assessment - Any change in the resident's condition if identified - The condition of the resident's skin - How the resident tolerated to procedure - Any problems or complaints made by the residents - If treatment/assessment were refused - Initiation of a form related to the type of alteration if a new skin alteration is noted - Addressing the MD notification if new alteration is noted - And notification to responsible party. 28923 2. Review of Resident #1's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included paraplegia, neurogenic bowel, colostomy status, neuromuscular dysfunction of the bladder, supra-pubic catheter status, peripheral vascular disease, chronic pain syndrome, muscle weakness, and a stage IV pressure ulcer (full-thickness skin and tissue loss with exposed fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer) on her buttocks. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. She was known to display verbal behaviors directed at others during the seven day assessment period, but was not known to reject care. She had a functional limitation in her range of motion of her bilateral lower extremities. She was dependent on staff for bed mobility and transfers and used a motorized wheelchair for mobility. She was identified as being at risk for pressure ulcers and had two unhealed pressure ulcers that were stage IV pressure ulcers that were present upon admission. Pressure reduction for her bed and chair, turning and repositioning, pressure ulcer care, application of medications/ ointments/ and dressings were all indicated to have been used for skin/ ulcer treatment. Review of Resident #1's active care plans revealed she had a care plan in place for having pressure ulcers on her her buttocks. The care plan was initiated on 02/24/23. The goal was for the resident's pressure ulcers to heal without complications. The interventions included the use of a pressure reducing mattress and to provide treatment per the physician's orders. Further review of Resident #1's active care plans revealed she also had a care plan in place for being at risk for skin breakdown related to paraplegia, existing pressure ulcers, bowel incontinence, and decreased mobility. That care plan was initiated on 02/24/23. The goal was for the resident's skin to remain intact. Interventions included avoiding shearing of the skin during positioning/ turning/ transferring, encourage and assist the resident with turning and repositioning for comfort and as needed, float heels as needed, and pressure reducing mattress to bed. Review of Resident #1's physician's orders revealed she had a treatment in place to cleanse her wounds daily with normal saline, pat dry, lightly pack the wound with 1/4 inch Iodoform packing gauze, cover with a Mepilex border dressing or an equivalent, and they could continue to use an ABD pad and tape to cover. The physician's orders also included the use of an low air loss alternating mattress with directions to check the function every shift, encourage the resident to float heels when in bed, and a trapeze bar to her bed to assist the resident with bed mobility. On 01/14/25 at 10:30 A.M., an observation of Resident #1 noted her to be lying in bed in a supine position. The low air loss (LAL) alternating mattress on her bed was under-inflated as the resident was sunk down into the mattress. The settings on the pump that was attached to the foot of her bed revealed it was set on the softest setting with only the first green light of eight illuminated. The more lights illuminated the firmer the mattress was. There were setting guidelines on a label stuck to the top of the pump that indicated what the bed setting should be set on based on the resident's weight. The resident reported she was around 150 pounds (163 pounds was her actual weight recorded in her EMR when last weighed in January 2025), which both weights indicated the softness/ firmness setting of her mattress should have been set between two and four. The resident was asked at the time of the observation who adjusted the settings on her LAL mattress. The resident reported the maintenance employee had changed the settings on her bed when she last complained that the bed was not comfortable. The maintenance employee stated he wanted to try that softer setting before he proceeded with having to replace her mattress. She was not observed to have a trapeze bar in place over her bed as ordered to assist her with bed mobility. The resident was asked if staff were providing her encouragement or assistance with turning and repositioning. She denied that they were regularly coming in to encourage or assist her with turning and repositioning, as per her orders and plan of care. She reported there had been times she had been asleep in her bed and she would wake up four or five hours later in the same position. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 01/14/25 at 2:20 P.M., an interview with Certified Nursing Assistant (CNA) #199 revealed Resident #1 was known to have two wounds to her buttocks area that had dressings on them. She reported the wounds had been there since her admission and the nurses took care of the wounds. They tried to keep the resident on her side. She liked to be on her side, unless she was eating or up in her wheelchair. She claimed the resident would let them know when she wanted to be turned. It was typically maybe twice a shift (eight hour shifts) that the resident would ask to be turned and repositioned. She denied that they offloaded the resident's heels when she was in bed. The resident had the use of an air mattress and she had heard the resident complain there were areas on her bed that were hard on her back. She denied that the aides messed with the settings on the resident's mattress. If the bed beeped, they called the bed company to come in and fix it. She denied the resident had a trapeze over her bed to assist with bed mobility. On 01/14/25 at 2:30 P.M., an interview with RN #162 revealed Resident #1 had pressure ulcers on her bilateral buttocks that had tunneling. She was aware they were pressure ulcers but was not sure what stages they were classified as. The resident was being followed by the local hospital's wound clinic and the facility's visiting nurse practitioner. She confirmed the pressure ulcers were present upon the resident's admission. Tunneling had decreased according to the report the resident gave them following her last wound clinic appointment. She verified the resident had the use of a LAL mattress. She claimed the resident was able to turn and reposition herself, but the aides would assist as needed. She denied the resident had the use of a trapeze to assist with bed mobility that she was aware of. On 01/14/25 at 3:10 P.M., observations made during a treatment observation of Resident #1's pressure ulcers revealed her LAL mattress remained on the softest setting and not according to her known weight. She also did not have a trapeze bar over her bed as ordered and per her plan of care. After the completion of her wound treatments, Resident #1 informed RN #162 that the surveyor had concerns with her LAL mattress not being properly inflated based on her known weight and what the settings called for based on that weight. LPN #165, who was in the room assisting RN #162 with the treatment, verified the resident's LAL mattress was set on the first setting (softest) and should have been set between two and four based on the resident's weight. She was observed to raise the setting to three and informed the resident that they would try that setting since it was in the middle of what was called for based on her weight. They would then adjust it between two and four as needed until the desired comfort was achieved. On 01/14/25 at 3:30 P.M., a follow up interview with RN #162, after she left Resident #1's room following the completion of her dressing changes. She acknowledged skin prevention interventions were not being followed for the resident as per her plan of care as a trapeze bar was not in place over the resident's bed to assist her with bed mobility and her heels were not being offloaded as ordered. She further acknowledged the LAL mattress should have been inflated to the proper setting based on the resident's known weight. She further acknowledged inconsistencies in the information provided by the nursing staff and the resident on how often the resident was to be encouraged and assisted with turning and repositioning. The aides reported they turned and repositioned the resident twice a shift and not every two hours as per her plan of care and the nurse had indicated the resident was able to turn and reposition herself when the resident denied being able to do so.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on observation, record review and interview, the facility failed to develop and implement comprehensive, individualized and effective interventions to prevent a fall and wandering behavior resulting in Resident #71 exiting the facility. Actual harm occurred on 07/31/24 when the facility failed to prevent Resident #71 from exiting the building to the patio after the resident reported he was aware he could exit after pushing on the door for 15 seconds to get out. Following this incident on this date, the facility failed to implement additional/new interventions for Resident #71's safety and five hours later, Resident #71 exited the building again, and sustained a fall. The resident complained of pain and was transported to the emergency department where he was diagnosed with a fracture of the shaft of the left femur. In addition, a concern not rising to the level of actual harm, was identified when the facility failed to ensure medications were stored properly on the memory care unit. This affected one resident (#71) of three residents reviewed for falls and had the potential to affect 18 residents (#5, #17, #21, #24, #27, #34, #37, #39, #58, #59, #62, #66 #71, #72, #76, #79, #83, and #85) of 85 resident's residing in the facility. Findings include: 1. Record review revealed Resident #71 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation, dementia, memory deficit following cerebral infarction, and history of a transient ischemic attack. Review of the Minimum Data Set (MDS) assessment completed 06/27/24 revealed Resident #71 had moderately impaired cognition and wandered daily. Review of a nursing note dated 07/31/24 at 3:31 A.M. revealed Resident #71 was awake all night, asking repetitive questions of where the bathroom was and where to go. He had verbal agitation with redirection. Review of a nursing note dated 07/31/24 at 10:04 A.M. revealed Resident #71 got out of the facility into the courtyard area and stated he knew if he pushed on the door long enough it would open. Staff accompanied Resident #71 until he wanted to go back into the facility. No additional interventions were implemented to keep Resident #71 from exiting the building following this incident. Review of a nursing note dated 07/31/24 at 3:10 P.M. revealed Resident #71 went out the locked door, started to run, slipped on the sidewalk and hit his head on the white plastic fence and then hit the ground with his left hip. Resident #71 had a laceration to the left side of his head; he was complaining of hip pain in his right leg area. An emergency squad was called, and the resident left the facility at 3:56 P.M. (to go to the hospital). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a nursing note dated 07/31/24 at 5:24 P.M. recorded as a late entry for 3:25 P.M. revealed staff stated Resident #71 was pushing on the exit door and when staff tried to redirect him, he raised his fists to her so she stepped back, and the resident forced the door open falling forward to the pavement. Outward rotation of the left lower extremity was noted and Resident #71 complained of pain and was sent to the emergency department. Review of the fall investigation revealed no evidence of statements from staff were obtained as part of the investigation. Review of a care plan initiated on 08/14/24 revealed Resident #71 wanders without purpose. Interventions included assessing cognition quarterly; encourage resident to participate in brief periods of structured activity; encourage resident's family to visit on a schedule that meets the needs of the resident as appropriate; maintain routine in the resident's day including meal time, activity, family visits, etcetera; monitor cognitive function for significant fluctuations and refer to physician as needed; observed wandering patterns and escort away from other residents or other resident rooms as needed; and provide meaningful leisure activity as appropriate. Review of a care plan initiated on 08/14/24 revealed Resident #71 was at risk for falls related to dementia, impaired gait, and medication side effects. Interventions included to assure the floor is free of liquids and foreign objects; encourage and assist resident to assume a standing position slowly; keep call light in reach; keep personal items and frequently used items in reach; provide non-skid footwear; therapy evaluation and treatment as needed; and increase frequency of visual reminders. Interview on 01/15/25 with CNA #202 revealed she was not present when Resident #71 broke his hip. Interview on 01/15/25 at 2:30 P.M. with the Director of Nursing (DON) revealed Resident #71 had been exit seeking prior to his fall with fracture, but she was not aware of any additional interventions to stop him from continued exit seeking. The DON also confirmed two separate nursing notes had different descriptions of the event. Interview on 01/21/25 at 8:04 A.M. with the DON revealed a hand-written statement was completed the same day with a staff member who worked the day of Resident #71's fall. The DON stated a statement had been written at the time of the incident, but it could not be located. The DON stated the facility does utilize a 15-minute check form, but there was no evidence it was completed for the resident at the time of this incident. The DON stated she just found out today it was standard for the unit to use heightened checks but they do not enter orders for it. The DON stated the second note entered was the correct version of the incident. The DON stated in her mind, heightened checks means the resident is in line of sight, but not one-on-one. Review of a statement received at the time of the survey on 01/21/25 by Certified Nursing Assistant (CNA) #202 revealed Resident #71 was having increased behaviors and exit seeking. Heightened checks and frequent re-direction were initiated. 2. Observation on 01/13/25 at 8:55 A.M. on the memory care unit in the living room revealed two residents seated in the living room area with no staff supervision. A closet was unlocked and revealed multiple medications, a credit card, and a dull knife. The medications included: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- a full bottle of probenecid - a full bottle of sodium bicarbonate, opened and unlabeled - a bottle of vitamin D - an open bottle of aspirin 325 milligrams (mg), unlabeled - two boxes of fluticasone propionate and salmeterol powder 250 micrograms (mcg)/50 mcg - a bottle of multi-vitamins opened on 12/12/24 - unopened box of anti-diarrheal 24 2 mg capsules - a pill organizer for Sunday-Saturday morning and evening medications; morning pills were in container for Wednesday through Saturday and Sunday through Saturday for evening medications. The organizer was not labeled with the medication information or who they belonged to. - ondansetron four 4 mg tablets - one 21 mg nicotine patch - half a bottle vitamin B6 50 mg opened on 03/17/24 - a bottle opened on 12/31/22 with an expiration date of 04/2024 of geri-kot 8.6 mg - megesterol - cyclosprorine 0.05% eye drops - albuterol sulfate one inhaler with the label ripped off - finestreride 5 mg tablets - escitalopram 20 mg tablets - memantine 10 mg 136 tablets - two bottles of calcium 250 mg - carboxymethylcellulose gel - mucus-ER 40 tablets unopened - sodium chloride half bottle - unopened, unlabeled box of Tagamet 200 mg 30 tablets (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- estradiol 0.1 mg vaginal cream - nyastatin 100,000 units/gram powder - tacrolimus ointment 0.1% - clobetasol 0.05% cream - silver sulfadiazine 1% cream - megestrol acetate 40 mg half a bottle Interview on 01/13/25 at 9:25 A.M. with Licensed Practical Nurse (LPN) #165 confirmed the medication findings and the door being unlocked. LPN #165 stated she noticed over the weekend the door would be locked but wasn't latching. LPN #165 confirmed the door handle was not locked at the time of the observation. A list provided by the Director of Nursing (DON) on 01/13/25 at approximately 10:45 A.M. revealed the memory care unit residents were all confused and 18 residents (#5, #17, #21, #24, #27, #34, #37, #39, #58, #59, #62, #66 #71, #72, #76, #79, #83, and #85) residing on the memory care unit wandered throughout the memory care unit independently.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review, interviews and facility policy review, the facility failed to treat one resident (#11) for a urinary tract infection (UTI) in a timely manner. Additionally, the facility also failed to provide one resident (#1) with routine indwelling urinary catheter care. This affected two residents (#11, #1) of three residents reviewed for catheter or UTI. The facility census was 85. Findings Include: 1. Review of the medical record for Resident #11 revealed an initial admitted [DATE] with the latest readmission of 07/05/22 with the diagnoses including but not limited to osteoarthritis, major depressive disorder, mood disorder, constipation, Major depressive disorder, irritable bowel syndrome, hypertension, dysphagia, acute failure to thrive, insomnia, anxiety and palliative care. Review of Resident #11's progress notes dated 10/01/24 at 10:53 A.M. revealed the resident believed she had a urine infection. The hospice nurse visited and was aware. The entry indicated a urine was sent on 09/30/24 and results were pending. Review of the urinalysis and culture and sensitive (UA/C&S) results dated 10/03/24 from the urine collected on 09/30/24 revealed the resident had greater than 100,000 of the two bacteria aerococcus urinae and enterococcus faecalis and the bacteria was sensitive to the antibiotic Macrobid (a medication used to treat an infection). Review of the progress note dated 10/05/24 at 3:24 P.M. revealed the nurse called the facility contracted lab for the urine results completed on 09/30/24. Review of the progress note dated 10/06/24 at 3:34 P.M. revealed the nurse again phone the facility contracted lab for the 09/30/24 urine results. The entry documented the facility was awaiting results. Review of the progress note dated 10/06/24 at 5:02 P.M. revealed the facility received the culture and sensitivity (C&S) results. The hospice nurse practitioner was notified and a new order was received for Macrobid 100 milligrams (mg) by mouth twice daily for seven days. The entry indicated the resident's hospice services wound deliver the medication to the facility on [DATE]. Review of the resident's progress note dated 10/07/24 at 1:21 P.M. revealed the resident's hospice service had not delivered the resident's medication to the facility. The nurse pulled the first dose of the medication from the facility's Omnicell (emergency drug system). Review of the resident's October 2024 Medication Administration Record (MAR) revealed the first dose of Macrobid 100 mg was not administered until 10/07/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident was always incontinent of both bowel and bladder. The assessment indicated the resident had not been treated for an infection in the past 30 days. On 01/22/25 at 12:50 P.M., interview with the Director of Nursing (DON) verified the UA/C&S results were available on 10/03/24 and the treatment for the resident's UTI was not started until 10/07/24. 28923 2. Review of Resident #1's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included paraplegia, Stage IV pressure ulcer (full-thickness skin and tissue loss with exposed fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer) of the buttocks, neuromuscular dysfunction of the bladder, supra-pubic catheter status, and muscle weakness. Review of Resident #1's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. She was known to display verbal behaviors directed at others, but was not known to reject care during the seven days of the assessment period. She had a functional limitation in her range of motion of her bilateral lower extremities. She was dependent on staff for bed mobility and transfers. She required supervision or touching assistance for toileting hygiene. She was coded as having the use of an indwelling urinary catheter. Review of Resident #1's active care plans revealed the resident had a care plan in place for the use of an indwelling urinary catheter related to a neurogenic bladder. The care plan was initiated on 02/09/23. The goal was for the resident to be free of any signs of complication such as a urinary tract infection. The interventions included the need to provide assistance with catheter care per the physician's orders. Review of Resident #1's physician's orders revealed the resident had an order in place to provide supra-pubic catheter care every shift (twice a day). The order had been in place since 03/10/23. On 01/13/25 at 11:02 A.M., an interview with Resident #1 revealed she was not receiving routine supra-pubic catheter care. She denied the staff were completing catheter care every shift (twice a day) as ordered. On 01/14/25 at 2:20 P.M., an interview with State tested Nursing Assistant (STNA) #199 revealed the aides were responsible for doing catheter care and it was done at least once a day. She was not aware Resident #1's physician's orders was for it to be done every shift (twice a day). She could not say if the resident's catheter care was being done on day shift or the afternoon shift when she thought it was only to be done once a day. She indicated all she knew was that it (catheter care) would be done at some point before the resident went to bed for the night. She recalled she had performed catheter care for the resident in the past and the resident was compliant with her catheter care. On 01/14/25 at 2:30 P.M., an interview with RN #162 revealed Resident #1 had the use of a supra-pubic catheter. She claimed catheter care was being performed by the resident and was not completed by the staff, unless it was needed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/14/24 at 3:00 P.M., a follow up interview with Resident #1 revealed she was not performing her own catheter care, as was indicated by RN #162. She asked how she could be performing her own catheter care if the staff were not sitting her up with any supplies to do so. She indicated on occasion she would ask for supplies to do it when she noted a spot of blood on her bed sheets or if she noted her catheter site to appear irritated. On 01/14/25 at 3:30 P.M., a follow up interview with RN #162 was conducted to inform her Resident #1 denied she was doing her own catheter care as the nurse believed. She was also informed the aide interviewed believed catheter care was only needed to be completed once a day instead of every shift (twice a day) as ordered. Review of the facility's policy on Urinary Catheter Care (revised September 2014) revealed the purpose of the procedure was to prevent catheter associated urinary tract infections. They were to review the resident's plan of care for any special needs of the resident. The policy was vague and was not specific as to how often catheter care was to be provided.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review, Registered Dietician (RD) recommendation review, interview and facility policy review, the facility failed to implement dietary recommendations and obtain physician ordered daily weights for one resident (#30). This affected one resident (#30) of two residents reviewed for nutrition. The facility census was 85. Findings Include: Review of the medical record for Resident #30 revealed an initial admitted [DATE] with the latest readmission of 12/10/24 with the diagnoses including but not limited to partial traumatic amputation of left foot, osteomyelitis, sepsis, diabetes mellitus with neuropathy, hypertension, hyperlipidemia, osteoarthritis, gastro-esophageal reflux disease, constipation, edema, nausea and vomiting and anemia. Review of the plan of care dated 09/05/23 revealed the resident required increased caloric, protein, and/or nutrient needs, protein intake encourage, food related diet noncompliance with therapeutic diet restriction, end stage renal disease (ESRD), weight loss desired, diet noncompliance increased protein needs albumin within normal limits and target weight fluctuations. Interventions included communicate with dialysis as needed, nutrition education, dietitian to re-evaluate as indicated, encourage fluids, labs as ordered by physician, obtain weights as ordered an as needed, provide diet as ordered, provide supplements and vitamins and/or minerals as ordered. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was not assessed. The assessment indicated the resident had a known weight loss and was on a physician prescribed weight loss regimen and received a therapeutic diet. Review of the resident's monthly physician orders for January 2025 identified and order dated 10/29/24 for daily weight. Review of the resident's daily weights from 10/29/24 revealed the resident's daily weight was not obtained on 11/18/24, 12/14/24, 12/20/24, 12/23/24, 12/28/24, 12/30/24, 01/02/25, 01/03/25 and 01/16/24. Review of the resident's nutritional observation dated 12/14/24 revealed the RD recommended to add a renal diet and double protein portion to the resident's diet. Review of the diet recommendation dated 12/15/24 revealed the RD recommended to add renal diet and double protein portions for all meals to the resident's diet. Review of the medical record revealed no evidence the RD recommendations were implemented. On 01/15/25 at 3:52 P.M., interview with the Director of Nursing (DON) verified the resident's daily weights were not obtained as physician ordered. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/21/25 at 11:49 A.M., interview with RD #350 revealed she spoke with dialysis on 01/20/25 and no longer recommended adding the renal diet. RD #350 verified the double protein portion for all meals was recommended. RD #350 verified the recommendation had not been implemented. Review of the facility policy titled, Weight Policy, (dated 11/18) revealed it was the policy of the facility to attain/maintain a resident's weight within the recommended range as appropriate in relation to their medical and physical status. Weights will be obtained in a timely and accurate manner, documented and responded to appropriately. The resident will be weighted every week for three weeks for the following three weeks then monthly unless otherwise by the physician/Nurse Practitioner (NP) or dietician.

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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** 32801 Based on medical record review, review of hospital records, observation, interview, and policy review the facility failed to ensure residents had oxygen orders, respiratory medications were administered as ordered, respiratory supplies were stored properly, and emergency tracheostomy supplies were readily available. This affected three residents (#57, #67, #191) of three residents reviewed for respiratory care and medication observation. Findings included: 1. Record review revealed Resident #191 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, sepsis, tracheostomy, gastrostomy, hypertension, atrial fibrillation, acute kidney failure, protein-calorie malnutrition, anxiety, hyperlipidemia, and tobacco use. A. Review of Resident #191's current order revealed no evidence of oxygen orders. Observation on 01/13/25 at 10:24 A.M., revealed there was a used tracheostomy mask lying on the resident's bedside table she was using, and her nebulizer was in a chair and her mouthpiece was lying directly on the chair seat without any barrier or bag. There were no emergency trach supplies (cannula, ambu bag, tracheostomy kit, etc.) readily available. The resident reported she had an ambu bag the hospital gave her that was under a pile of clothing that she had piled in the corner of the room near her chair. The resident trach mask was attached to an oxygen concentrator. Interview on 01/13/25 at 10:35 A.M., with Licensed Practical Nurse (LPN) #177 and Registered Nurse (RN) #162 confirmed the resident's emergency tracheostomy supplies and ambu bag should have been in a bag near the head of the resident's bed in case of an emergency. The staff were not sure of the size of cannula the resident currently had in-place. The staff searched the resident room and found size 6.5 and 7.0 cannulas box in the resident's closet. The nurses reported they were not sure what the facility's policy was on tracheostomy care. The staff members confirmed the resident's nebulizer mouthpiece was lying on the chair without a barrier and the used tracheostomy mask should have been discarded after used. B. Observation on 01/15/25 at 10:16 A.M. revealed Resident #191's nebulizer mouthpiece was lying directly on the chair without a bag or barrier. The resident reported she was never provided with a bag to place the mouthpiece in. The resident was receiving oxygen via trach. Interview on 01/15/25 at 10:16 A.M., with RN #212 confirmed the nebulizer mouthpiece was lying directly on the chair without a barrier or in a bag. The RN reported the resident must have thrown the bag away. An interview on 01/15/25 at 1:52 P.M., with the Director of Nursing (DON) revealed the facility doesn't have a policy for nebulizer storage/care and was told to give the surveyor the cleaning and disinfection of resident-care items and equipment, which did not include nebulizers storage/care. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/16/25 at 9:20 A.M. with the Resident#191 verified she was receiving oxygen via trach. Interview on 01/16/25 at 10:56 A.M., with Nurse Practitioner (NP) 315 confirmed the resident did not have oxygen orders and she had just added them to the resident's orders. Interview on 01/16/25 at 11:06 A.M., with LPN #177 confirmed the resident was on oxygen via trach and the resident did not have orders or oxygen. Review of the facility policy titled Tracheostomy Care (dated 04/2021) revealed a replacement tracheostomy tube must always be available at the bedside. A suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must always be available at the beside. Review of the policy titled Cleaning and Disinfection of Resident-Care items and Equipment (dated 2001) revealed no procedures for storing nebulizers or caring for nebulizer equipment. C. Review of Resident #191's discharge hospital orders dated 01/06/25 and the Physician History and Physical dated 01/08/25 revealed the resident was ordered DuoNeb (Albuterol and Atrovent) inhalation treatments via nebulizer four times daily and Albuterol inhalation treatments as needed for six hours for wheezing and shortness of breath. Review of Resident #191's Medication Administration Records (MAR) and orders dated 01/2025 revealed no evidence the DuoNeb was ordered or administered. Further review revealed the albuterol was ordered four times daily. The interview on 01/16/25 at 9:20 A.M., with Resident #191 revealed staff were administering the inhalation treatments (nebulizer) treatments mostly orally and no using the tracheostomy. Interview on 01/16/25 at 10:56 A.M., with Nurse Practitioner (NP) 315 confirmed staff did not enter the correct orders on admission. The residents should have been receiving the DuoNeb four times a day and the Albuterol only as needed via trach and not by mouth. Interview on 01/16/25 at 11:06 A.M., with LPN #177 verified she had spoken to NP #315 to reconcile admission orders and the current orders. The LPN confirmed the DuoNeb was never ordered, and the Albuterol should have been as needed and not scheduled four times a day. LPN #177 confirmed staff should have been administering the inhalation/nebulizer treatment via trach mask and not by mouth. 2. Medical record review revealed Resident #67 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease with (acute) exacerbation, acute and chronic respiratory failure with hypoxia, toxic effect of tobacco cigarettes, intentional self-harm, sequela, respiratory conditions due to other specified external agents, dependence on supplemental oxygen, chronic kidney disease. Review of Resident #67's current orders dated 01/2025 revealed Norvasc (calcium channel blocker) 5 milligrams (MG) administer two tablets once daily and Breztri (bronchodilator) Aerosphere 160-9-4.8 micrograms (mcg) aerosol two puffs twice daily and to rinse mouth with water after using. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Medscape revealed Breztri was an orally inhaled corticosteroid that could cause oropharyngeal candidiasis (yeast infection), and patients were advised to rinse mouth out with water and without swallowing after use. Observation on 01/15/25 at 7:51 A.M., of Resident #67's medication administration with Registered Nurse (RN) #110 revealed RN #110 only administered one 5 mg tablet of Norvasc (order was for two tablets) and did not have Resident #67 rinse with water after the administration of Breztri per order. Findings were confirmed with RN #110 after observation. Review of the facility's policy titled Medication Administration-General Guidelines (dated 11/2018) revealed medication are administered as prescribed in accordance with good nursing principles and practices and only by person legally authorized to do so. The person administering medication adheres to good hand hygiene. Follow the five rights (right resident, right drug, right dose, right route, and right time) are applied for each medication being administered. The medication administration record (MAR) is always employed during medication administration. Medication are administered in accordance with written orders of the prescriber. 2. Medical record review revealed Resident #67 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease with (acute) exacerbation, acute and chronic respiratory failure with hypoxia, toxic effect of tobacco cigarettes, intentional self-harm, sequela, respiratory conditions due to other specified external agents, dependence on supplemental oxygen, chronic kidney disease. Review of Resident #67's current orders dated 01/2025 revealed Norvasc (calcium channel blocker) 5 milligrams (MG) administer two tablets once daily and Breztri (bronchodilator) Aerosphere 160-9-4.8 micrograms (mcg) aerosol two puffs twice daily and to rinse mouth with water after using. Review of Medscape revealed Breztri was an orally inhaled corticosteroid that could cause oropharyngeal candidiasis (yeast infection), and patients were advised to rinse mouth out with water and without swallowing after use. Observation on 01/15/25 at 7:51 A.M., of Resident #67's medication administration with Registered Nurse (RN) #110 revealed RN #110 only administered one 5 mg tablet of Norvasc (order was for two tablets) and did not have Resident #67 rinse with water after the administration of Breztri per order. Findings were confirmed with RN #110 after observation. Review of the facility's policy titled Medication Administration-General Guidelines (dated 11/2018) revealed medication are administered as prescribed in accordance with good nursing principles and practices and only by person legally authorized to do so. The person administering medication adheres to good hand hygiene. Follow the five rights (right resident, right drug, right dose, right route, and right time) are applied for each medication being administered. The medication administration record (MAR) is always employed during medication administration. Medication are administered in accordance with written orders of the prescriber. 32654 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #57 revealed an initial admitted [DATE] with the diagnoses including but not limited to Alzheimer's disease, dementia, chronic kidney disease, hypertension, vitamin D deficiency and dysphagia. Review of the resident's plan of care revealed no care plan addressing the resident's oxygen use. Review of the resident's comprehensive Minimum Data Set (MDS) dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident had not utilized oxygen therapy. Review of the resident's monthly physician orders identified no orders for oxygen use. Review of the resident's progress note dated 01/13/25 at 4:44 P.M. revealed the resident had reported new onset of wheezing and shortness of breath. The Nurse Practitioner (NP) was notified while in house on rounds. New orders received for chest x-ray and start DuoNebs four times daily for five days. Further review of the resident's progress notes revealed no documented evidence of when and why the resident was started on oxygen therapy on the night shift on 01/13/25. On 01/13/25 at 10:55 A.M., observation of Resident #57 revealed he was sitting in his chair with oxygen on via nasal cannula at three liters. Further observation revealed the oxygen had no humidification. On 01/13/25 at 12:05 P.M., observation of Certified Nursing Assistant (CNA) #183 revealed the CNA assisted the resident into his bedside chair. The resident's oxygen tubing was noted to be laying on the floor. The CNA picked the tubing up and placed in the crease of the resident's chair. On 01/13/25 at 2:16 P.M., observation of the resident revealed he had oxygen on via nasal cannula at three liters. Further observation revealed the nasal cannula was the same nasal cannula as laying on the floor. On 01/13/25 at 2:23 P.M., interview with Licensed Practical Nurse (LPN) #211 verified the resident had the same oxygen tubing dated 01/12/25 that was on the floor. The LPN also verified the resident had no physician orders for the oxygen. She stated the night shift nurse reported the resident's oxygen saturation had dropped so she put him on oxygen. Review of the facility policy titled, Oxygen Administration, (last revised 10/10) revealed the purpose of the procedure was to provide guidelines for safe oxygen administration. Preparation included verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Check the humidifying jar to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. After completing the oxygen setup or adjustment, the following should be recorded in the resident's medical record, the date and time the procedure was preformed, the name and title of the individual who performed the procedure, the rate of oxygen flow, route and rationale, the frequency and duration of the treatment, the reason for as needed administration, all assessment data obtained before, during and after the procedure, how the resident tolerated the procedure, if the resident refused the procedure and the signature and title of the person recording the data.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review, observation, interviews and facility policy review, the facility failed to ensure a resident who required dialysis services received ordered care. This affected one resident (#30) of one resident reviewed for dialysis. The facility census was 85. Findings include Review of the medical record for Resident #30 revealed an initial admitted [DATE] with the latest readmission of 12/10/24 with the diagnoses including but not limited to partial traumatic amputation of left foot, osteomyelitis, sepsis, diabetes mellitus with neuropathy, hypertension, hyperlipidemia, osteoarthritis, gastro-esophageal reflux disease, constipation, edema, nausea and vomiting and anemia. Review of the resident's plan of care revealed no care plan addressing the resident's dialysis or potential for infection related to the central line. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was not assessed. The assessment indicated the resident had a known weight loss and was on a physician prescribed weight loss regimen and received a therapeutic diet. The assessment indicated the resident had not received dialysis services. Review of the resident's monthly physician orders for January 2025 revealed no physician orders for the name, location and phone number of the offsite dialysis, days of the week dialysis would occur and chair time. Review of the medical record revealed no evidence of dialysis communications forms, labs or communication between the dietician and the dialysis center. On 01/14/25 at 9:40 A.M., interview with the resident revealed she receives dialysis every Tuesday, Thursday and Saturday. She revealed she leaves for dialysis at 10:00 A.M. and does not take a communication form to dialysis with her for the dialysis center. She then revealed when she brings papers back from dialysis she tries to give them to the nurse, however they tell her the papers are for her. On 01/14/25 at 2:07 P.M., interview with Registered Nurse (RN) #162 confirmed the facility does not send a dialysis communication form with the resident. On 01/15/25 at 3:52 P.M., interview with the Director of Nursing (DON) verified a dialysis communication form was to be sent with the resident with each dialysis day. She revealed she was unaware the staff nurses was not providing the form. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/16/25 at 9:33 A.M., interview with Dialysis Registered Dietician (DRD) #355 revealed the facility does not communicate with the dialysis center. She stated the facility was unreliable so the resident is weighed prior to being placed on dialysis and after dialysis. She revealed she was unsure who the facility RD was and had not communicated with her. She revealed she faxes treatment sheets weekly and laboratory results monthly. Review of the facility policy titled, Dialysis Care, (last reviewed 06/22) revealed it was the policy of this facility to ensure resident that receive dialysis treatment are safe, well assessed and that the facility collaborates care with the dialysis center. Dialysis requires a physician's order that is specific to the individual resident's needs. The order should include which dialysis center, dialysis schedule of days/times ad the phone number of the dialysis center. The facility shall use a form to communicate between the dialysis center with each visit. The nurse will complete and assessment of the resident prior to leaving facility and upon return to facility for each dialysis visit. Upon return from dialysis the nurse will review the communication form sent to dialysis center. The care plan for the resident who receives dialysis care should include but not limited to name of dialysis center, treatment days/times and phone number, if/when a meal is needed to be sent with resident to dialysis, method of transportation to/from dialysis care, emergency contact name and phone number for dialysis center, emergency contact name and phone number for resident, port/shunt/fistula site location, bruit and thrill of the fistula to be assessed every shift, directions related to care of the port/shunt/fistula site, observe port/shunt/fistula site for signs/symptoms of infection every shift, observe port/shunt/fistula site for signs/symptoms of bleeding every shift, observation of mental status, activity to be tolerated, encourage use of arm with port/shunt/fistula, dietary recommendations, fluid restrictions recommendations, weekly weights as ordered and observation for shortness of breath and increase of congestion.

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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** 32654 Based on record review, staff interview and facility policy review, the facility failed to assess, implement and monitor one resident (#38) with known post traumatic stress disorder (PTSD) for triggers and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. This affected one resident (#38) of five residents reviewed for behavioral-emotional needs. The facility census was 85. Findings Include: Review of the medical record for Resident #38 revealed an initial admitted [DATE] with the latest readmission of 06/02/23 with the diagnoses including but not limited to metabolic encephalopathy, sepsis, acidosis, epilepsy, solitary pulmonary nodule right upper lobe, dementia with behavioral disturbances, esophageal thickening, diabetes mellitus, hypertension, anxiety disorder, mood disorder, insomnia, dental caries and added on 09/20/24 schizophrenia. Review of the plan of care dated 02/02/23 revealed the resident presents with diagnoses of post traumatic stress disorder (PTSD). Interventions included assist the resident to identify and avoid triggers from the traumatic experience which may include arguing and raised voice, encourage family support system as appropriate, medications as orders, observe for changes in behaviors and altered mood and refer to physician as needed, provide supportive counseling contracts as needed and psych services referral as needed. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated dementia, anxiety and schizophrenia was a current diagnoses, however PTSD was not coded as a current diagnoses. Review of the medical record revealed no evidence a trauma assessment was completed to identify the resident's cause of PTSD, triggers and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. On 01/14/25 at 1:35 P.M., interview with Social Service Director (SSD) #190 verified a trauma assessment was completed to identify the resident's cause of PTSD, triggers and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. Review of the facility policy titled, Trauma Informed Care, (dated 03/19) revealed the purpose of the policy was to guide the staff in appropriate and compassionate care specific to individuals who have experienced trauma. Nursing staff are trained on screening tools, trauma assessments and how to identify triggers associated with re-traumatization.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 32654 Based on employee record review and staff interview, the facility failed to ensure Certified Nursing Assistants (CNA) performance reviews were completed as required at least every 12 months. This had the potential to affect all 85 residents residing in the facility. The facility census was 85. Findings Include: 1. Review of the employee file for CNA #106 revealed a hire date of 06/10/22. Further review of the employee file revealed no annual performance review for 2024. On 01/22/25 at 5:45 P.M., interview with Human Resource (HR) #187 and the Director of Nursing (DON) verified the employee performance review was not completed as required. 47985 2. Review of the employee file for CNA #182 revealed no evidence of annual training for the memory care unit and 12 hours of annual in-services. Interview on 01/22/25 at 5:42 P.M. with the DON confirmed she was not able to provide evidence of CNA #182's annual training for the memory care unit or 12 hours of annual in-services.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review and interviews, the facility failed to ensure a resident received referrals for psychiatric services and failed to ensure a resident had interventions in place to address aggressive behaviors. This affected one resident (#71) of one reviewed for choices and one resident (#85) two reviewed for dementia care. Findings included: 1. Medical record review revealed Resident #85 was admitted to the facility on [DATE] with diagnoses including dementia, post-traumatic stress disorder, insomnia, generalized anxiety, and wandering. Review of Resident #85's current orders dated 01/2025 revealed the resident was ordered clonazepam 0.25 milligrams (mg) 0.25 mg in the morning 0.5 mg in the evening and every eight hours needed for agitation and anxiety. The resident was also ordered Zyprexa (antipsychotic) 2.5 mg in the morning and 5 mg at 4:00 P.M. There was no indication for use. Review of Resident #85's hospital notes dated 11/22/4 indicated the resident was on Zyprexa for anxiety and agitation. Review of Resident #85's history and physical dated 11/27/24 revealed the resident was on Zyprexa for chronic stress disorder and psych (services) was to follow. Review of Resident #85's physician note dated 12/25/24 revealed the resident to follow up with psych (services). Review of Resident #85's medical record revealed no evidence the resident had been seen or referred to psych services. Interview on 01/22/25 at 2:37 P.M. and 3:08 P.M., with Licensed Practical Nurse (LPN) #177 confirmed the physician had indicated the resident was to be followed by psych services for the chronic stress disorder, however the referral was never made. The LPN #177 called psych services and they would see the resident tomorrow. 47985 2. Record review revealed Resident #71 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation, dementia, anxiety disorder, and mild cognitive impairment. Review of an MDS assessment completed on 09/30/24 revealed Resident #71 had severe cognitive impairment and behaviors including delusions and wandering daily. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nursing note dated 10/31/24 at 7:58 P.M. by RN #188 revealed Resident #71 had his hands wrapped around a Certified Nursing Assistant (CNA)'s neck, and the CNA was red and sweating. Resident #71 was redirected and was sent to the emergency department for evaluation. Review of a nursing note dated 10/31/24 at 8:44 P.M. by RN #162 revealed Resident #71 returned to the facility with no new orders. Review of a social services note dated 11/01/24 at 11:31 A.M. by Social Services Director (SSD) #190 revealed she left a message with the facility's consulting psychiatrist to discuss the incident and best next steps for Resident #71. Review of a nursing note dated 11/08/24 at 5:49 A.M. by Licensed Practical Nurse (LPN) #177 revealed Resident #71 was restless throughout the night, urinated on the floor, was verbally aggressive, and difficult to redirect. Review of a care plan last reviewed on 11/13/24 revealed no care plan to address Resident #71's aggressive behaviors. Interview on 01/14/25 at 10:28 A.M. with SSD #190 revealed Resident #71 had abnormally aggressive behaviors after having a surgery, but he has gotten better. SSD #190 stated she was aware of the incident where Resident #71 grabbed an STNA by the neck and after the incident, she allowed nursing staff to apply their own interventions and nursing staff complete the care plan. SSD #190 stated nursing staff reported Resident #71 is only aggressive to staff and not residents. Review of the medical record revealed no evidence Resident #71 was seen by psychiatric services to address the increase in behaviors. An additional interview with SSD #190 on 01/14/25 at 3:07 P.M. confirmed Resident #71 had not been seen by the psychiatrist yet after the outburst of aggression in October. SSD #190 stated a follow up evaluation will be completed during the psychiatrist's next visit on 01/16/25. Interview on 01/15/25 at 8:37 A.M. with CNA #153 revealed she had seen Resident #71 have aggressive behaviors and at one point, Resident #71 got out the doors of the facility and when she went to redirect, Resident #71 pinned her against the fence and was yelling in her face. CNA #153 stated over the last couple days, Resident #71 had been more aggressive and she had seen him be irritated with other residents. Interview on 01/15/25 at 8:44 A.M. with CNA #202 revealed she has seen Resident #71 have behaviors including threatening to hit, choke, or throw things at people, usually staff. Interview on 01/22/25 at 1:37 P.M. with SSD #190 confirmed despite requesting the psychiatrist follow up with Resident #71, she did not request he be seen again until the survey took place and brought the lack of follow up to her attention.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of facility contracts, interviews, and policy review the facility failed to ensure medications were available for administration as ordered. This affected four residents (#1, #31, #85, and #191) of seven residents reviewed for medication review. Findings included: 1. Medical record review revealed Resident #31 was admitted to the facility on [DATE] at 5:05 P.M., with diagnoses including diffuse traumatic brain injury with loss of consciousness, hemiplegia, depression, gastro-esophageal reflux, insomnia, chronic kidney disease, deformity of the head, atrial fibrillation, chronic pain, and iron deficiency anemia. Review of Resident #31's current orders dated 01/2025 revealed meropenem two grams intravenous every eight hours (6:00 A.M., 2:00 P.M., and 10:00 P.M.) and vancomycin 750 mg intravenous every 12 hours (goal trough range 15-20 mcg/ml) at 8:00 A.M. and 8:00 P.M. Review of Resident #31's Medication Administration Record (MAR) dated 12/16/24 to 01/15/25 revealed the resident didn't receive meropenem (antibiotic) on 12/18/24 10:00 P.M., 12/19/24 at 6:00 A.M.,12/29/24 at 2:00 P.M. due to the medication was not available. Further review revealed the resident was not administered Vancomycin on 12/18/24 8:00 P.M., 12/19/24 at 8:00 A.M., 12/23/24 at 8:00 A.M., 12/29/24 at 8:00 P.M., 12/30/24 at 8:00 A.M. and 8:00 P.M. and 12/31/24 at 8:00 A.M., due to the medication was not available. The physician was not notified until 12/31/24 the medication was not available. Interview on 01/21/24 at 12:56 P.M. and 1:38 P.M., with Licensed Practical Nurse (LPN) #177 confirmed Resident #31 did not receive meropenem on 12/18/24 10:00 P.M., 12/19/24 at 6:00 A.M.,12/29/24 at 2:00 P. M. and vancomycin on 12/18/24 8:00 P.M., 12/19/24 at 8:00 A.M., 12/23/24 at 8:00 A.M., 12/29/24 at 8:00 P. M., 12/30/24 at 8:00 A.M. and 8:00 P.M. and 12/31/24 at 8:00 A.M., due to the medications were not available to administer. LPN #177 confirmed the facility has had issues getting medication timely from the pharmacy. The pharmacy was four hours away from the facility and was not local. 2. Medical record review revealed Resident #85 was admitted to the facility on [DATE] with diagnoses including dementia, post-traumatic stress disorder, gout, insomnia, generalized anxiety, hypertension, hyperlipemia, and wandering. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #85's MAR and orders dated 12/16/24 to 01/15/25 revealed on 01/07/25 the resident was not administered Vitamin C (supplement) two tablets once daily and Calcium 500 (supplement) milligrams (mg) due to the medications were not available. The resident did not receive carvedilol (beta-blocker) 25 mg A.M. and P.M. dose on 01/01/25, the P.M. dose on 01/02/25 and 01/03/25, 01/06/25, 01/07/25, 01/08/25, and 01/10/25 due to the medication was not available. On 01/01/25 the resident was not administered the 0.25 mg and the 0.5 mg dose of clonazepam (antianxiety) due to not being available. On 01/02/25 the resident did not receive four doses of polymyxin (antibiotic) due to the medication was not available. On 01/20/25 the pravastatin (cholesterol medication) was not administered due to it was not available. Interview on 01/22/25 at 2:37 P.M., with LPN #177 confirmed Resident #85 did not receive the above medications because they were not available from the pharmacy to administer. 3. Medical record review revealed Resident #191 was admitted to the facility on [DATE] at 7:00 P.M. with diagnoses including chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, sepsis, tracheostomy, gastrostomy, hypertension, atrial fibrillation, acute kidney failure, protein-calorie malnutrition, anxiety, hyperlipidemia, and tobacco use. Review of Resident #191's MAR and orders dated 01/06/25 to 01/15/25 revealed the resident did not receive amiodarone (antiarrhythmic), budesonide (steroid), prempro (estrogen), Xarelto (anticoagulant), Flonase nasal spray, Lipitor (cholesterol), and Zoloft (depression) on 01/07/25 or 01/08/25, due to the medications were not available. The resident did not receive Prevacid (proton pump inhibitor) on 01/07/25, 01/08/25, 01/11/25, 01/13/25, 01/14/25, due to the medication was not available. The midodrine (alpha 1 agonists) was not administered three doses on 01/07/25, and two doses on 01/08/25 due to the medication was not available. Interview on 01/16/25 at 9:20 A.M., with Resident #191 confirmed she did not receive most of her medication for two or three days after she was admitted . Interview on 01/16/25 at 11:06 A.M., with LPN #177 confirmed Resident #191 was admitted on [DATE] and did not receive the above medication due to they were not available from the pharmacy. The LPN reported it has been an issue with pharmacy not delivering medication timely. The facility has an emergency stock of medication, however most of Resident #191's medications were not available in the emergency stock nor did staff remove the two (Lipitor and Xarelto) that were available to administer. Review of the pharmacy agreement (dated 10/01/22) revealed the pharmacy shall deliver medications and provide services to the facility seven days a week, three-hundred sixty-five days a year, with modified schedules for national holidays based on a daily delivery schedule mutually determined by the facility and pharmacy. Emergency delivery of medications shall be done by the Pharmacy during normal business hours, except for circumstances beyond reasonable control, and emergency services shall be available after hours through an answering service with a pharmacist on-call. The Pharmacy shall establish an emergency system for backup and/or interim order dispensing. Any emergency drug supply provided under Section shall be property of the Pharmacy as prescribed by applicable laws. During the course of the survey, the surveyor requested information regarding the pharmacy emergency system from the Administrator, however no information was received. 28923 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included paraplegia, neurogenic bowel, colostomy status, neuromuscular dysfunction of the bladder, supra-pubic catheter status, stage IV pressure ulcer on her buttock, chronic pain syndrome, chronic obstructive pulmonary disease (COPD), major depressive disorder, attention deficit/ hyperactive disorder, bipolar disorder, anxiety disorder, nicotine dependence, neuralgia, and neuritis. Review of Resident #1's physician's orders revealed she had an order in place to receive Dayvigo 5 milligrams (mg) by mouth every night at bedtime for insomnia. The order had been in place since 11/22/24. Review of Resident #1's medication administration records (MAR's) for December 2024 and January 2025 revealed the resident was not receiving Dayvigo 5 mg by mouth every night at bedtime as was ordered for insomnia. The MAR for December 2024 showed the Dayvigo was not administered on 12/07/24, 12/15/24, 12/16/24, or on 12/17/24 due to the medication being unavailable. The MAR's for January 2025 revealed the resident was not given Dayvigo on 01/01/25 and then again between 01/06/25 through 01/12/25. The reason specified on the MAR as to why the Dayvigo was not given as ordered was again due to the medication being unavailable. Review of pharmacy delivery manifests revealed the facility's contracted pharmacy was sending Dayvigo for Resident #1's use in the quantity of three tablets with each delivery. Three tablets of Dayvigo was indicated to have been delivered on 11/22/24, 11/27/24, 12/01/24, 12/11/24, 12/25/24, and again on 12/31/24. Five tablets of Dayvigo was delivered on 12/18/24. The doses provided as indicated on the delivery manifest did not allow the resident to receive the Dayvigo on a nightly basis as ordered for insomnia. On 01/16/25 at 10:20 A.M., an interview with LPN #125 revealed the facility was having issues with receiving medications from their contracted pharmacy when needed. She stated it was just not for Resident #1, but for other residents too. She indicated refills could be ordered ahead of time using the computer, but there were times they would be told it was too soon to order a refill. She acknowledged there were four days in December and nine days in January 2025 in which Resident #1's MAR's indicated the resident had not received her Dayvigo as ordered due to the medication not being available for administration. She was not sure if there was some insurance issue going on and the medication needed pre-authorization. She acknowledged Dayvigo was a scheduled medication the resident had ordered and had been receiving since 11/22/24. She agreed it should be made available to them by the pharmacy for administration to the resident since it was a scheduled medication. She reported she would contact the pharmacy to get clarification as to why there had been issues having the medication on hand to administer. On 01/16/25 at 12:25 P.M., a follow up interview with LPN #125 revealed she had spoken to the pharmacist regarding Resident #1's Dayvigo. She was told the resident's insurance was not covering the medication. She was not able to state if or when the pharmacist had been in contact with the facility to let them know what the issue was with delivering the Dayvigo so it was available for administration as ordered. She had reached out to the psychiatrist and they were going to restart the resident on Belsomra for her insomnia that had been used in the past.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, staff interview, and policy review, the facility failed to ensure pharmacy recommendations that were the result of monthly medication regimen reviews were responded to timely or at all by the physician. This affected two residents (#1 and #19) of five residents reviewed for unnecessary medications. Findings include: 1. Review of Resident #1's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included bipolar disorder, attention deficit/ hyperactive disorder, major depressive disorder, anxiety disorder, and insomnia. Review of the facility's pharmacy reports for monthly medication regimen reviews revealed Resident #1's medications were reviewed monthly over the past 12 months by the contracted pharmacist to note any irregularities in the resident's medications that needed to be addressed by the physician. The pharmacy provided two separate reports showing those residents who had been seen for a monthly medication regimen review and those seen that did not have any irregularities noted during that monthly review. Out of the 12 monthly medication regimen reviews that had been completed for the resident, pharmacy recommendations made on 03/07/24, 05/07/24, 08/07/24, 09/04/24, and 10/07/24, as a result of those reviews. Review of Resident #1's pharmacy recommendation dated 03/07/24 revealed the pharmacist recommended the physician evaluate the resident for the continued use of Aripiprazole (an anti-psychotic) 2 milligrams (mg) that was being used daily. The resident had been on Aripiprazole 2 mg daily since 12/27/23. There was no documented evidence of the physician responding to that recommendation timely, as the facility was unable to provide a copy of the pharmacy recommendation with the physician's response, and the resident continued to receive that medication at the same ordered dose until 08/30/24. Review of Resident #1's pharmacy recommendation dated 05/07/24 revealed the pharmacist recommended the physician evaluate the resident for the continued use of Bupropion ER 450 mg daily. The resident had been on Bupropion ER 450 mg daily since 12/19/23. There was no documented evidence of the physician responding to that recommendation, as the facility was unable to provide a copy of the pharmacy recommendation with the physician's response, and the resident continued to receive that medication at the same ordered dose since 12/19/23. Review of Resident #1's pharmacy recommendation dated 08/07/24 revealed the pharmacist recommended the physician evaluate the resident for the use of Belsomra 10 mg every night at bedtime. The resident was started on that medication on 07/25/24 and, according to the manufacturer, it should not be used more than seven to 10 days. There was no documented evidence of the physician responding to that recommendation timely, as the facility was unable to provide a copy of the pharmacy recommendation with the physician's response, and the resident continued to receive that medication at the same ordered dose until 10/03/24 (when the medication was discontinued). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's pharmacy recommendation dated 09/04/24 revealed the pharmacist recommended the physician evaluate the resident for the continued use of Fluoxetine 40 mg daily. The resident had been on Fluoxetine 40 mg daily since 04/25/24. There was no documented evidence of the physician responding to that recommendation, as the facility was unable to provide a copy of the pharmacy recommendation with the physician's response, and the resident continued to receive that medication at the same ordered dose since 04/25/24. Review of Resident #1's pharmacy recommendation dated 10/07/24 revealed the pharmacist recommended the physician evaluate the resident for the use of Rozerem. The resident was started on that medication on 10/03/24 and, according to the manufacturer, that medication should not be used for more than seven to 10 days. There was no documented evidence of the physician responding to that recommendation timely, as the facility was unable to provide a copy of the pharmacy recommendation with the physician's response, and the resident continued to receive that medication at the same ordered dose of 8 mg every night at bedtime from 10/03/24 until 11/21/24, when the medication was discontinued. Review of the facility's policy on Medication Regimen Reviews (revised May 2019) revealed the consulting pharmacist would review the medication regimen of each resident at least monthly. The goal of the medication regimen review (MRR) was to promote positive outcomes while minimizing adverse consequences and potential risks associated with medications. Within 24 hours of the MRR, the consulting pharmacist provided a written report to the attending physicians for each resident identified as having a non-life threatening medication irregularity. The attending physician was to document in the medical record that the irregularity had been reviewed and what (if any) action was taken to address it. If the physician did not provide a timely or adequate response, or the consulting pharmacist identified that no action had been taken, he/ she was to contact the medical director or (if the medical director was the physician of record) the Administrator. Copies of the medication regimen review reports, including the physician's responses, were to be maintained as part of the permanent medical record. 32654 2. Review of the medical record for Resident #19 revealed an initial admitted secondary Parkinsonism, diabetes mellitus, aphasia, hyperlipidemia, bipolar disorder, depressive episodes, schizoaffective disorder, bipolar type, anxiety disorder, schizophreniform and dementia. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors. The assessment indicated dementia, anxiety disorder, depression, bipolar disorder and schizophrenia were active diagnoses. The resident received antipsychotic, antianxiety, antidepressant and hypoglycemic medications. Review of the pharmacy recommendation dated 04/08/24 revealed the pharmacist recommended the following labs, basic metabolic panel (BMP), hemoglobin A1c (Hgb A1c), liver function test (LFT) and complete blood count (CBC) every six months. The physician addressed the recommendation on 04/15/24 and agreed with the recommendation. Review of the resident's monthly physician orders revealed no orders for the laboratory tests BMP, HgbA1c, LFT and CBC every six months. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/15/25 at 11:58 A.M., interview with the Director of Nursing (DON) verified the pharmacy recommendation with the ordered laboratory tests were not implemented. Review of the facility policy titled, Lab Results, (not dated) revealed the physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The laboratory, diagnostic, radiology provider or other testing source will report test results to the facility.

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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** 32801 Based on medical record review, interview, and policy review the facility failed to ensure residents were free from unnecessary medications when pain medication failed to have parameters and failed to ensure sliding scale insulin was followed per orders. This affected three residents (#74, #85, and #191) of six reviewed for unnecessary medication review. The facility census was 85. Findings included: 1. Medical record review revealed Resident #85 was admitted to the facility on [DATE] with diagnoses including dementia, post-traumatic stress disorder, gout, insomnia, generalized anxiety, hypertension, hyperlipemia, and wandering. A. Review of Resident #85's orders and medication administration record dated 12/22/24 to 01/21/25 revealed the resident was ordered lidocaine patch 5% apply one patch on in the morning and remove at night. Do not wear it for more than 12 hours in a 24-hour period. The resident refused to apply the patch 11 times and refused to have the patch removed 10 times. Interview on 01/22/25 at 2:37 P.M. and 3:08 P.M., with Licensed Practical Nurse (LPN) 177 confirmed resident had refused his Lidocaine Patch applied 11 times and removed 10 times and there was no evidence the provider was notified of the refusals. The LPN reported she contacted the Nurse Practitioner (NP) after reviewing with the surveyor and the NP gave new orders to discontinue the Lidocaine patch. B. Review of Resident #85's progress note dated 01/01/25 revealed the nurse was notified the resident's right eye was red in color. The nurse called the on call provider and received new orders for polymyxin (antibiotic) one drop every four hours for seven days. Review of Resident #85's orders dated 01/2025 revealed polymyxin one drop four times daily was ordered on 01/01/25 to start on 01/02/25. There was no evidence of which eye to administer the eye drop. Review of Resident #85's medication administration record (MAR) dated 01/2025 revealed polymyxin one drop four times a day. There was no evidence of which eye to administer the medication. The residents did not receive any doses on 01/02/24 of the polymyxin and the medication was discontinued on 01/08/25 (six days). Interview on 01/22/25 at 3:43 P.M., with the Director of Nursing (DON) confirmed the resident was ordered polymyxin for seven days, however only received six days due the medication was not available for all four doses on 01/02/25. 2. Medical record review revealed Resident #191 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, sepsis, tracheostomy, gastrostomy, hypertension, atrial fibrillation, acute kidney failure, protein-calorie malnutrition, anxiety, hyperlipidemia, and tobacco use. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #191's hospital discharge orders dated 01/06/25 revealed to administer oxycodone 2.5 to 5 milligrams (mg) give 2.5 milligrams for pain 5-7 and 5 mg for pain 8-10 every six hours as needed. Review of Resident #191's history and physical data dated 01/08/25 revealed to administer oxycodone 2.5 to 5 milligrams (mg) give 2.5 milligrams for pain 5-7 and 5 mg for pain 8-10 every six hours as needed. Review of Resident #191's orders and medication administration record (MAR) dated 01/06/25 to 01/15/25 revealed oxycodone 5 mg give 0.5 to one tablet every six hours as needed. There was no evidence of parameters when to administer 0.5 or one tablet. The resident had received eight doses from 01/11/25 to 01/15/25 without evidence if 0.5 or one tablet was administered or rate of pain. Interview on 01/16/25 at 10:56 A.M., with the Nurse Practitioner (NP) 315 revealed the unit manager had shared the surveyor's concerns today with her. The NP reported the facility had contacted her upon admission and they were to follow the hospital discharge orders administer oxycodone 2.5 to 5 milligrams (mg) give 2.5 milligrams for pain 5-7 and 5 mg for pain 8-10 every six hours as needed. The NP changed the order today to administer one tablet every six hours as needed for pain. Interview on 01/16/25 at 11:06 A.M., with Licensed Practical Nurse (LPN)/Unit Manger #177 confirmed the order was entered incorrectly and order didn't indicate when to administer 0.5 or one tablet was administered and staff were not documenting the resident pain rating prior to or after administering the oxycodone. 28923 3. Review of Resident #74's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included adult onset diabetes mellitus. Review of Resident #74's physician's orders revealed the resident had an order for Basaglar (Insulin Glargine) KwikPen (long acting insulin) 100 units/ milliliter (ml) 35 units subcutaneously (SQ) twice a day (BID), Insulin Aspart (rapid acting insulin) 100 units/ ml 14 units SQ before meals (ac), Insulin Aspart 100 units/ ml before meals as per sliding scale. The sliding scale was for the resident to receive additional Insulin Aspart before meals based on the resident's blood glucose level. He was to receive two additional units if his blood sugar was 151 milligrams (mg)/ deciliter (dl) to 200 mg/dl, four additional units if his blood sugar was 201-250 mg/dl, six additional units if his blood sugar was between 251- 300 mg/dl, eight additional units if his blood sugar was between 301-350 mg/ dl, and 10 additional units if his blood sugar was between 351- 400 mg/ dl. The order also included parameters in which to notify the physician. They were directed to notify the physician if the resident's blood sugar was less than 60 mg/ dl or above 400 mg/ dl. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #74's medication administration records (MAR's) for January 2025 revealed there were two separate occasions in which the resident's blood sugars were found to be outside the parameters that required physician notification. The resident's blood sugar was recorded as being low at 57 mg/ dl (normal ranges 80- 130 mg/dl) on 01/17/25 between the hours of 4:00 A.M. and 6:00 A.M. and was then high at 473 mg/ dl on 01/18/25 between the hours of 10:00 A.M. and 12:00 P.M. without documented evidence on the MAR of the physician being notified as ordered. In addition, on 01/17/25 between the hours of 4:00 P.M. and 6:00 P.M., the resident's blood sugar was recorded as being 487 mg/ dl. The physician was notified of that elevated blood sugar and gave instructions to the nurse to administer the highest amount of Insulin Aspart the resident could receive based on his current sliding scale orders. The MAR did not provide any evidence of the resident being given any additional Insulin Aspart allowable by his sliding scale as was ordered by the physician when the resident's blood sugar was 487 mg/ dl. The nurse was further instructed to recheck the resident's blood sugar in two hours and to provide additional insulin coverage based on the sliding scale, if needed. The resident's blood sugar was rechecked on 01/18/25 at 7:30 P.M. and found to remain high at 394 mg/ dl. There was no documented evidence of any additional insulin coverage being given to the resident when his blood sugar remained high, as was ordered by the physician. Review of Resident #74's progress notes revealed there was no documented evidence to show the physician was notified of the resident's low blood sugar of 57 mg/ dl on 01/17/25 between the hours of 4:00 A.M. and 6:00 A.M. as was set forth in the parameters given as part of the resident's sliding scale insulin coverage. There was also no documented evidence to show the physician was notified of the resident's elevated blood sugar of 473 mg/ dl on 01/18/25, when checked between 10:00 A.M. and 12:00 P.M., as was indicated in the parameters set forth in the physician's orders. The progress notes also did not provide any documented evidence of the nurse administering any additional insulin coverage to the resident based on his sliding scale when the resident's blood sugar was initially high on 01/17/25 between 4:00 P.M. and 6:00 P.M. or when rechecked on 01/17/25 at 7:30 P.M. as ordered by the physician. Findings were verified by the Director of Nursing (DON). On 01/21/25 at 4:30 P.M., an interview with the DON confirmed Resident #74 had parameters in place to notify the physician, if the resident's blood sugar was less than 60 or greater than 400 mg/ dl. She acknowledged the MAR and the progress notes did not provide any evidence the physician was notified when the resident's blood sugar was found to be low at 57 mg/ dl on 01/17/25 between 4:00 A.M. and 6:00 A. M. or when it was high at 473 mg/ dl on 01/18/25 between 10:00 A.M. and 12:00 P.M. She further acknowledged there was no documented evidence of the resident being given the highest dose of Insulin Aspart, as allowed per his sliding scale, when his blood sugar was 487 mg/ dl on 01/17/25 between 4:00 P. M. and 6:00 P.M. as was instructed to do so by the physician according to the progress notes on 01/17/25 at 4:45 P.M. She also confirmed that on 01/17/25 at 7:30 P.M., when the resident's blood sugar was rechecked and found to remain high at 394 mg/ dl, there was no evidence of any additional insulin being given, as per the resident's sliding scale, and as was directed to do so by the physician.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of hospital records, interviews, and policy review the facility failed to ensure psychotropic drugs were administered as ordered, properly assessed, and had appropriate diagnoses. This affected three residents (#19, #85, and #191) of six reviewed of unnecessary medication review. Findings included: 1. Medical record review revealed Resident #85 was admitted to the facility on [DATE] with diagnoses including dementia, post-traumatic stress disorder, insomnia, generalized anxiety, and wandering. Review of Resident #85's current orders dated 01/2025 revealed the resident was ordered clonazepam 0.25 milligrams (mg) 0.25 mg in the morning 0.5 mg in the evening and every eight hours as needed for agitation and anxiety. There was no evidence of a stop date for the as needed clonazepam order. The resident also ordered Zyprexa (antipsychotic) 2.5 mg in the morning and 5 mg at 4:00 P.M. There was no indication for use. Review of Resident #85's hospital notes dated 11/22/24 indicated the resident was on Zyprexa for anxiety and agitation. Review of Resident #85's history and physical dated 11/27/24 revealed the resident was on Zyprexa for chronic stress disorder and psych (services) was to follow. Review of Resident #85's physician note dated 12/25/24 revealed the resident to follow up with psych (services). Review of Resident #85's medical record revealed no evidence the resident had been seen or referred to psych services. Review of Resident #85's assessment/observation revealed no evidence the resident had an abnormal involuntary movement scale (AIMS) test performed (test to measure the severity of orofacial and extremity movement in adults taking antipsychotic medications). Interview on 01/22/25 at 2:37 P.M. and 3:08 P.M., with Licensed Practical Nurse (LPN) #177 confirmed the physician had indicated the resident was to be followed by psych services for the chronic stress disorder, however the referral was never made. LPN #177 also confirmed the resident did not have an appropriate diagnosis for the use of Zyprexa and the as needed clonazepam order did not have a stop date. She had reached out the Nurse Practitioner and she wanted the resident seen by psych services for an appropriate diagnosis, however she ordered the clonazepam to be stopped in 14 days. Interview on 01/22/25 at 4:47 P.M., with LPN #165 confirmed Resident #85 did not have an AIMS test performed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review revealed Resident #191 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, sepsis, tracheostomy, gastrostomy, hypertension, atrial fibrillation, acute kidney failure, protein-calorie malnutrition, anxiety, hyperlipidemia, and tobacco use. Review of Resident #191's hospital discharge orders dated 01/06/25 revealed Xanax 0.25 milligrams (mg) three times daily as needed for anxiety and panic disorder. Review of Resident #191's orders dated 01/06/25 revealed Xanax 0.25 mg three times daily. Review of Resident #191's history and physical dated 01/08/25 revealed Xanax 0.25 milligrams (mg) three times daily as needed for anxiety and panic disorder. Review of Resident #191's progress note dated 01/11/2025 revealed the resident requested this nurse come into her room and discuss her medication. The resident states that she no longer wishes to receive Xanax unless it is extremely necessary, states she does not like the way it makes her feel. The writer informed the resident that she was free to refuse any medication and this nurse would not administer it unless she has requested. Review of Resident #191's Medication Administration Record (MAR) dated 01/06/25 to 01/15/25 revealed Xanax 0.25 mg three times daily. The Xanax was not administered on 01/07/25 and two doses on 01/08/25 due to it not being available. The resident refused two doses on 01/11/25, 01/12/25, one dose on 01/13/24 and 01/14/25, and two doses on 01/15/25. An interview on 01/16/25 at 10:56 A.M., with the Nurse Practitioner #315 revealed the unit manager had shared the surveyors concerns today with her. The NP reported the facility had contacted her upon admission and they were to follow the hospital discharge orders for the Xanax 0.25 mg to be as needed not scheduled three times daily. Interview on 01/16/25 at 11:06 A.M., with Licensed Practical Nurse (LPN)/Unit Manger #177 confirmed the Xanax order was entered into the medical record incorrectly. The Xanax was ordered as needed three times a day and staff had entered it was scheduled three times a day. The facility will complete a medication error form for Xanax. Review of the facility's policy titled Antipsychotic Medication Use (dated 12/2016) revealed antipsychotic medication may be considered for a resident with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social, and environmental causes of behavioral symptoms have been identified and addressed. Antipsychotic medication would be prescribed at the lowest possible dose for the shortest period of time. Residents would only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. New admission would be evaluated for appropriateness and indication for use. As needed orders will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication. 32654 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #19 revealed an initial admitted secondary Parkinsonism, diabetes mellitus, aphasia, hyperlipidemia, bipolar disorder, depressive episodes, schizoaffective disorder, bipolar type, anxiety disorder, schizophreniform and dementia. Review of the plan of care dated 08/07/24 revealed the resident was at risk for adverse consequences related to receiving antianxiety medication for anxiety. Interventions included administer medication per physician orders, attempt gradual does reduction (GDR) in two separate quarters (with at least one month between the attempts) during the first year the resident receives an anxiolytic medication, then yearly, unless clinically contraindicated, attempt non-pharmacological interventions prior to administering as needed anxiolytic, observe for drug use effectiveness and adverse consequences, notify physician of adverse effects, pharmacy consultant as needed and provide the lowest effective dose possible. Review of the psych consult dated 10/29/24 revealed the medication Buspar 7.5 milligrams (mg) twice daily was to be discontinued due to no longer needed and the amount of serotonergic agents the resident was on. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors. The assessment indicated dementia, anxiety disorder, depression, bipolar disorder and schizophrenia were active diagnoses. The resident received antipsychotic, antianxiety, antidepressant and hypoglycemic medications. Review of the monthly physician orders for January 2025 identified an order for Buspar 7.5 mg by mouth twice daily. Review of the resident's October, November and December 2024 and January 2025 Medication Administration Records (MAR) revealed the resident was administered Buspar 7.5 mg by mouth twice daily. On 01/15/25 at 9:25 A.M., interview with the Director of Nursing (DON) verified the Buspar 7.5 mg was not discontinued on 10/29/24 as indicated by the psychiatrist.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32801 Based on medical record review, observation, interview and policy review the facility failed to ensure medications were properly stored, medication carts were locked when unsupervised, and insulin medications were dated when opened. This had the potential to affect all 22 of 22 residents on 200 hall, all 14 of 14 residents on 300 hall, and all 22 of 22 residents on 400 hall. Findings included: 1. Observation of medication administration on 01/15/25 at 7:51 A.M., with Registered Nurse (RN) #110 revealed the RN left the medication cart unlocked with the keys in the lock and walked into Resident #67's room to administer medications. The medication cart was not in RN #110's view. Interview on 01/15/24 at 8:33 A.M., with RN #110 confirmed he left the 400-medication unlocked and left the keys in the lock and the medication cart was not in his view. 2. Observation on 01/16/25 at 10:16 A.M. of the 400 hall medication cart revealed the medication cart was left unlocked and unattended. No staff were observed on the 400 hall. The surveyor waited a few minutes and then walked down to 300 hall to get the nurse (RN #110). Interview on 01/16/25 at 10:19 A.M. RN #110 confirmed he was responsible for 300 and 400 medication carts today and he had left the 400-medication cart unlocked and unattended. 3. Observation on 01/22/25 at 1:45 P.M., the 400 hall cart was left unlocked and unattended. Interview on 01/22/25 at 1:48 P.M. RN #162 confirmed she left the medication cart unlocked and unattended. Review of the facility's policy titled Medication Administration-General Guidelines (dated 11/2018) revealed medication are administered as prescribed in accordance with good nursing principles and practices and only by person legally authorized to do so. During administration of medications, the medication cart was kept closed and locked when out of sight of the facility medication administration personnel. 28923 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 01/22/25 at 9:35 A.M., an observation of the 300 hall medication administration cart revealed there were two insulin flexpens found in the top drawer of the medication cart that were not dated when first used. There was a Lantus (slow acting insulin) flexpen that belonged to Resident #9 that was stored in a plastic bag. The plastic bag had a label that identified what the medication was and who it belonged to. There was not a date written on the plastic bag or the flexpen itself that showed when the Lantus flexpen was first used. A second insulin flexpen was also found in the top drawer of the medication administration cart for Resident #54. The flexpen was Insulin Lispro 100 units/ ml Kwikpen and had a label that indicated it was pulled out of the facility's Omnicell medication dispensing system. The resident's name was written on the bag, but there was no date that indicated when the flexpen was first used. Due to the insulin flexpens not being dated when first put in use, it could not be known when the insulin flexpens should be disposed of. Findings were verified by RN #162. On 01/22/25 at 9:37 A.M., an interview with RN #162 confirmed the two insulin flexpens found in the top drawer of the 300 hall medication administration cart did not include a date to show when it was first used. She acknowledged a date should have been added on the plastic bag the insulin flexpens were being stored in or on the flexpens themselves so the nurses would know what their expiration dates were. She knew the flexpens were only good for a certain number of days, after they had been removed from the refrigerator and put in use. On 01/22/25 at 9:40 A.M., an interview with the Director of Nursing (DON) revealed she and the unit manager had just went through the medication administration carts last evening to check and ensure all items were properly labeled and dated. She acknowledged two flexpens were found in the 300 hall medication administration cart that had not been dated when first used. She confirmed insulin flexpens should be dated when first used, so they knew when to discard them. Review of the facility's Insulin Reference Guide (updated February 2024) revealed Lantus (Insulin Glargine) should be refrigerated until it's expiration date or could be stored at room temperature for up to 28 days. In-use storage indicated it should be stored at room temperature for up to 28 days. They were not to refrigerate it, after being put in use. Insulin Lispro was also only to be stored at room temperature for up to 28 days.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review, staff interview and facility policy review, the facility failed to ensure physician ordered laboratory tests were obtained as ordered. This affected two residents (#19, #38) of five residents reviewed for unnecessary medications. The facility census was 85. Findings Include: 1. Review of the medical record for Resident #19 revealed an initial admitted secondary Parkinsonism, diabetes mellitus, aphasia, hyperlipidemia, bipolar disorder, depressive episodes, schizoaffective disorder, bipolar type, anxiety disorder, schizophreniform and dementia. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the resident's monthly physician orders identified an order dated 06/08/19 for the laboratory tests complete blood count (CBC), thyroid stimulating hormone (TSH), hemoglobin A1c (HgbA1c), vitamin D level, vitamin B 12 level and lipid panel annually in July. Review of the medical record revealed no evidence the physician ordered CBC, TSH, HgbA1c, vitamin D level, vitamin B 12 leve and lipid panel was obtained annually in July 2024. Review of the medical record revealed no documented evidence the resident refused the laboratory tests in July 2024. On 01/16/25 at 10:39 A.M., interview with the Director of Nursing (DON) revealed the resident refuses labs. The DON revealed she called the facility contracted lab for the test results, however the laboratory tests had not been drawn. Review of the facility policy titled, Lab Results, (not dated) revealed the physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The laboratory, diagnostic, radiology provider or other testing source will report test results to the facility. 2. Review of the medical record for Resident #38 revealed an initial admitted [DATE] with the latest readmission of 06/02/23 with the diagnoses including but not limited to metabolic encephalopathy, sepsis, acidosis, epilepsy, solitary pulmonary nodule right upper lobe, dementia with behavioral disturbances, esophageal thickening, diabetes mellitus, hypertension, anxiety disorder, mood disorder, insomnia, dental caries and added on 09/20/24 schizophrenia. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the resident's monthly physician orders for January 2025 identified an order dated 05/30/24 hemoglobin A1c (HgbA1c) every six months. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed no evidence the HgbA1c were drawn ever six months as physician ordered. On 01/14/25 at 12:14 PM interview with the Director of Nursing (DON) confirmed the physician ordered HgbA1c every six months was not drawn as physician ordered. Review of the facility policy titled, Lab Results, (not dated) revealed the physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The laboratory, diagnostic, radiology provider or other testing source will report test results to the facility.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, interviews and facility policy review, the facility failed to ensure one resident (#38) received routine dental care. This affected one resident (#38) of one resident reviewed for dental services. The facility census was 85. Findings Include: Review of the medical record for Resident #38 revealed an initial admitted [DATE] with the latest readmission of 06/02/23 with the diagnoses including but not limited to metabolic encephalopathy, sepsis, acidosis, epilepsy, solitary pulmonary nodule right upper lobe, dementia with behavioral disturbances, esophageal thickening, diabetes mellitus, hypertension, anxiety disorder, mood disorder, insomnia, dental caries and added on 09/20/24 schizophrenia. Review of the resident's admission observation and data collection dated 02/02/23 revealed the resident had her own natural teeth. The assessment indicated the resident's teeth had no cavities or broken teeth. Review of the plan of care dated 02/16/23 revealed the resident had potential for mouth pain related to problems developing with natural teeth. Interventions included assess condition of oral cavity, teeth, tongue and lips as needed, assess location of pain, quality and characteristic of pain, duration, intensity and severity of pain, aggravating and alleviating factors as needed, check dentures for a proper/comfortable fit, dental evaluation and intervention as needed, encourage fluids to keep oral cavity moist, medications as ordered, observe and report difficulties, observe and report difficulties chewing/swallowing, observe for need for change diet consistency to increase ease of eating, obtain a dietary consult as needed, follow recommendations as required and offer and provide mouth care as needed. Review of the resident's quarterly observation and data collection dated 11/01/24 revealed the resident's natural teeth had no cavities or were not broken. The assessment indicated the resident had no ulcers, lesions, halitosis, dry membranes or bleeding gums. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had no obvious or likely cavity or broken natural teeth. not coded as a current diagnoses. Review of the resident's monthly physician orders for January 2025 identified and order dated 02/02/23 may see as needed audiologist, dentist, podiatrist, psychologies and optometrist. Review of the resident's medical record revealed the resident had not been seen by a dentist since 08/17/23. On 01/13/25 at 9:19 A.M., observation of the resident revealed she had multiple black broken teeth with obvious caries. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/14/25 at 12:14 P.M., interview with the Director of Nursing (DON) verified the resident had not seen a dentist since 08/17/23. Review of the facility policy titled, Dental Services, (dated 12/16) revealed routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Routine and 24-hour emergency care dental services are provided to residents through a contract agreement with a licensed dentist that comes ot the facility monthly, referral to the resident's personal dentist, referral to community dentist or referral to other health care organizations that provide dental care. Social services representatives will assist residents with appointments, transportation, arrangements, and for reimbursement of dental services under the state plan, if eligible.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, medical record review, and interview, the facility failed to ensure a complete and accurate record. This affected three residents (#57, #11, #85) of 20 sampled residents. The census was 85. Findings Include: 1. Review of the medical record for Resident #57 revealed an initial admitted [DATE] with the diagnoses including but not limited to Alzheimer's disease, dementia, chronic kidney disease, hypertension, vitamin D deficiency and dysphagia. Review of the resident's plan of care revealed no care plan addressing the resident's oxygen use. Review of the resident's comprehensive Minimum Data Set (MDS) dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident had not utilized oxygen therapy. Review of the resident's monthly physician orders identified no orders for oxygen use. Review of the resident's progress note dated 01/13/25 at 4:44 P.M. revealed the resident had reported new onset of wheezing and shortness of breath. The Nurse Practitioner (NP) was notified while in house on rounds. New orders received for chest x-ray and start DuoNebs four times daily for five days. Further review of the resident's progress notes revealed no documented evidence of when and why the resident was started on oxygen therapy on the night shift on 01/13/25. On 01/13/25 at 2:23 P.M., interview with Licensed Practical Nurse (LPN) #211 verified the resident had no physician orders for the oxygen or why the oxygen was initiated. 2. Review of the closed medical record for Resident #11 revealed an initial admitted [DATE] with the latest readmission of 05/07/22 with the admitting diagnoses including but not limited to osteoarthritis, major depressive disorder, mood disorder, constipation, irritable bowel syndrome, hypertension, malignant neoplasm of female genital organ, dysphagia, tract infection, insomnia, unspecified, palliative care, and anxiety disorder. Review of the resident's discontinued physician orders revealed an order dated 10/22/24 for Cipro 500 milligrams (mg) by mouth twice daily until 10/29/24 for a urinary tract infection. Review of the medical record revealed no laboratory results or documentation related to the order for the Cipro 500 mg. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident was always incontinent of both bowel and bladder. The assessment indicated the resident had not been treated for an infection in the past 30 days. On 01/22/25 at 12:50 P.M., interview with the Director of Nursing (DON) confirmed the lack laboratory results or documentation related to the use of the medication Cipro 500 mg. 32801 3. Medical record review revealed Resident #85 was admitted to the facility on [DATE] with diagnoses including dementia, post-traumatic stress disorder, insomnia, generalized anxiety, and wandering. Review of Resident #85's orders dated 01/02/25 revealed orders for basic metabolic profile, completed blood count, sed rate, uric acid, and c-reactive protein. Review of Resident #85's medical record revealed no evidence of the basic metabolic profile, completed blood count, sed rate, uric acid, and a c-reactive protein was completed. Interview on 01/22/25 with Licensed Practical Nurse (LPN) 177 revealed the basic metabolic profile, completed blood count, sed rate, uric acid, and a c-reactive protein was completed, however it was never scanned into the resident's medical record. LPN #177 reported she could not print off the resident results, but she had it pulled up in the laboratory portal to provide evidence the testing was completed to the surveyor.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, interviews and facility policy review, the facility failed to maintain appropriate infection control practices to prevent the potential spread of infection in the area of tracheostomy care, dressing change, medication administration and enhanced barrier precautions (EBP). This affected ten residents (Residents #1, #9, #22, #30, #31, #54, #61, #74, #191, #240) of 85 residents who require enhanced barrier precautions and four residents (#1, #10, #67, and #191) of 20 residents reviewed for infection control practices. Additionally, the facility failed to ensure the infection control log was accurate and tracked bacteria from nosocomial infections and infection control polices were reviewed annually. This had the potential to affect all 85 residents residing in the facility. Findings Included: 1. Observation on 01/13/25 during the initial tour of the facility revealed no evidence of the facility implementing EBP for those residents observed having tracheostomy, enteral tubes, indwelling urinary catheter and dialysis port. Review of the facility provided list revealed Resident #1, #9, #22, #30, #31, #54, #61, #74, #191, #240 required EBP and was not implemented. On 01/15/25 at 11:30 A.M., interview with the Director of Nursing (DON) confirmed the lack of EBP being implemented for those residents with wounds and/or an indwelling medical device. Review of the facility policy titled, Enhanced Barrier Precautions, (dated 04/01/24) revealed it was the policy of the facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multi-drug-resistant organisms (MDRO). EBP refer to an infection control intervention designed yo reduced transmission of MDRO that employs targeted gown and gloves use during high contact resident care activities. A physician's order will be obtained for EBP for residents with any of the following , wounds (pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and chronic venous stasis ulcer) and indwelling medical device (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes), even if the resident is not known to be infection or colonized with a MDRO. Implementation of EBP include make gowns and gloves available immediately near or outside of the resident's room. The Infection Preventionist will incorporate monitoring and assessment of adherence to determine the need for additional training and education. High contact resident care activities included, dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use and wound care. EBP should be used for for the duration of the affected resident's stay in the facility or until the resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. 2. Review of the August, September, October, November and December 2024 infection control log revealed the facility was not tracking all bacteria, including nosocomial bacteria. On 01/22/25 at 12:50 P.M. interview with the Director of Nursing (DON) verified the lack of infection control monitoring, infection control log not being correct. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the facility policy titled, Infection Control and Prevention Policy and Guidelines, (last revised 08/19) revealed no documented evidence the policy is reviewed annually. On 01/22/25 at 3:21 P.M., interview with the DON verified the infection control policy is not reviewed yearly and policies are being sent to her by the facility's consultant. 32801 4. Observation of medication administration pass on 01/15/25 from 7:35 A.M. to 7:51 A.M., with Registered Nurse (RN) 110 removed a Potassium (supplement) 20 milliequivalent (meq) tablet from a blister packet into his ungloved hand and then broke it in half and placed the two halves into a medication cup. Next, RN #110 moved another blister packet from the mediation cart of Bumetanide (diuretic) 2 milligrams (mg) and popped one pill into his ungloved and un-sanitized hand and placed it in the medication cup with Potassium. The RN took the medication cup to room [ROOM NUMBER] (Resident #10) and gave the medication to the resident to take. The resident consumed the medication the nurse had touched with his bare and un-sanitized hands. RN #110 returned to the medication cart and performed hand hygiene with hand sanitizer and then took his keys out of his pocket to open the medication cart to administer the next residents' medications. RN #110 removed 10 pills from blister packets/pill bottles using the same technic by popping the pills into his bare un-sanitized/ungloved hands or pouring into his hands and then placed the pills into a medication cup. The RN took the pills to room [ROOM NUMBER] and administered the medication to Resident #67. Resident #67 had consumed the medications. Interview on 01/15/25 at 8:33 A.M., with RN #110 verified he pops medication from the blister packages/bottles into his bare hands first and then place the pills into the medication cups instead of popping/pouring them directly into the medication cup preventing contamination. The RN also confirmed he broke the Potassium pill with his bare hands and then placed it into the medication cup instead of using gloves. Review of the facility's policy titled Medication Administration-General Guidelines (dated 11/2018) revealed medication are administered as prescribed in accordance with good nursing principles and practices and only by legally authorized person to do so. The person administering medication adheres to good hand hygiene. If breaking a tablet performs appropriate hand hygiene prior to handling tablets and examination gloves must be worn to prevent touching the tablet during the process. 5. Record review revealed Resident #191 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, sepsis, tracheostomy, gastrostomy, hypertension, atrial fibrillation, acute kidney failure, protein-calorie malnutrition, anxiety, hyperlipidemia, and tobacco use. A. Observation on 01/13/25 at 10:24 A.M., and 01/15/25 at 10:16 A.M. of Resident #191's room, revealed no evidence the resident was in enhanced barrier precautions (EBP). Review of Resident #191's current orders dated 01/2025 revealed no evidence of orders for EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/15/25 at 10:30 A.M., with Licensed Practical Nurse (LPN) 177 and Registered Nurse (RN) #212 reported they have never heard of enhanced barrier precautions (EBP) and were not aware residents that had a foley catheter, chronic wound, or indwelling mech device required to follow EBP. The LPN and RN confirmed the resident was not on any type of precautions and had a tracheostomy and gastrostomy tube. B. Observation of Resident #191's tracheostomy care on 01/15/25 at 10:16 AM with RN #212 performing the procedure and LPN #177 assisting revealed neither staff had applied a gown or mask. RN #212 had set up a sterile field to perform tracheostomy care. During the procedure the RN cleaned the cannula with a brush and then placed the contained brush back in the middle of the sterile field. The pipe cleaners, four by fours, and split drain sponge were still on the sterile field. After the RN cleaned the cannula, she placed the clean cannula into the stoma and did not change her gloves and wash her hands. The RN wore the same gloves throughout the entire procedure. Interview on 01/15/25 at 10:30 A.M., with LPN #177 and RN #212 confirmed they did not wear a gown or mask during tracheostomy care. RN #212 confirmed she had placed the contaminated brush on the sterile field instead of throwing the brush in the trash that was next to her, and she didn't wash her hands after cleaning the cannula and replacing the cannula back into the stoma per the facility's policy to prevent the spread of infections. Review of the facility's policy titled Enhanced Barrier Precaution (dated 04/01/24) revealed the facility responsibility to implement enhanced barrier precautions for the prevention of transmission of multi-drug-resistant organisms. EBP refers to an infection control intervention designed to reduce transmission of multi-drug-resistant organism that employs targeted gown, and gloves used during high contact resident care activities. All staff received training on EBP upon hire and at least annually and are expected to comply with all designated precautions. An order for EBP would be obtained for residents with an of the following: wound, and/or indwelling, medical devices (tracheostomy) even if the resident was not known to be infected or colonized with a MDRO. EBP include make gowns and gloves available immediately near or outside of the resident's room. Faced protection may also be needed if performing activity with risk of splash or spray example tracheostomy care. High-contact resident care activity dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, devices care use, tracheostomy and wound care. Review of the facility policy titled Tracheostomy Care (dated 04/2021) revealed when providing cannula care a sterile field must be maintained. Soak the cannula in hydrogen peroxide/saline solution mixture, clean with a brush, rinse with saline and dry with pipe cleaners. Remove and discard gloves into appropriate receptacles. Wash hands and put on fresh gloves and replace the cannula carefully and lock in place. 28923 6. Review of Resident #1's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included paraplegia, neurogenic bowel, colostomy status, neuromuscular dysfunction of the bladder, supra-pubic catheter status, peripheral vascular disease, chronic pain syndrome, muscle weakness, and a stage IV pressure ulcer (full-thickness skin and tissue loss with exposed fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer) on her buttocks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's physician's orders revealed the resident had an order in place to cleanse her wounds with normal saline, pat dry, lightly pack her wounds with 1/4 inch Iodoform packing gauze, cover with Mepilex border dressing or equivalent, may use ABD pad and tape to cover. The order had been in place since 11/08/24. Review of Resident #1's active care plans revealed she had a care plan in place for having pressure ulcers on her buttocks. The care plan originated on 02/24/23. The goal was for the resident's pressure ulcers to heal without complications. Interventions included providing treatment as per the physician's orders. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/14/25 at 3:10 P.M., a treatment observation was made of the treatment to Resident #1's pressure ulcers. The treatment was provided by RN #162 and she was assisted by LPN #165. The resident was not noted to be in enhanced barrier precautions despite being known to have chronic wounds and medically invasive devices, which included a colostomy and a supra-pubic catheter. The nurses did not don a gown while preparing to do her treatments. Treatments were observed for the resident's stage IV pressure ulcers to her left buttocks and her right hip. LPN #162 performed the treatments to both the resident's pressure ulcers at the same time and did not treat each wound separately to prevent any potential cross-contamination between the two wounds. She was observed to don disposable gloves, after washing her hands, and removed the old dressings covering the pressure ulcer to the right hip followed by the left buttocks. The old dressing over the right hip ulcer had a moderate amount of serosanguineous drainage on it. The old dressing covering the left buttock ulcer had a small amount of serosanguineous drainage. Both dressings were disposed of in a plastic bag sitting at the foot of the bed. The nurse removed her disposable gloves and donned new disposable gloves without performing any hand hygiene between glove changes. She cleansed the right hip wound first using a 4x4 gauze that she moistened with wound cleanser. She wiped around the wound and then the center of the wound, without using separate areas of the moistened gauze. She was not noted to pat the wound to the right hip with a dry 4x4 gauze, after it was cleansed. She then proceeded to clean the wound on the left buttock in the same fashion she did the right hip wound. She did not change gloves or perform any hand hygiene between cleansing the two wounds. After cleansing the left buttock wound, she removed her disposable gloves and donned new gloves, again without performing hand hygiene. She did not bring in a pair of scissors with her to use during the treatment. The resident informed the nurse that she had a pair of surgical scissors she got when out to the wound clinic and gave them to the nurse to use. The resident's scissors were stored in a fanny pack pouch. The nurse was not observed to disinfect the scissors before she was noted to use them to cut off the amount of Iodoform packing gauze she needed to pack the right hip wound. A cotton tip applicator was then used to pack the wound on the right hip. The right hip had a circular red area around the opening of the ulcer that was larger than the size of a golf ball. The nurse then obtained another piece of the Iodoform packing gauze from it's bottle cutting a piece off using the same scissors she had that had not been properly disinfected. She did not dispose of her gloves, perform hand hygiene, and don new gloves before she proceeded to pack the resident's left buttock pressure ulcer. The left buttock wound was packed using less Iodoform packing gauze than what was used to pack the right hip pressure ulcer. She laid an ABD pad on the resident's right hip area above the wound opening with the surface of the ABD pad that was going to be placed over the right hip wound in direct contact with the resident's skin. While the ABD pad was resting on the resident's skin above the right hip area, she applied tape along the four edges of the ABD pad. After securing the tape, she then placed the same side of the ABD pad that had been in contact with the resident's skin over the right hip wound before securing it in place by pressing down on the taped edges. She was then observed to use the scissors that had not been properly disinfected to cut a second ABD pad in half. The half of the ABD pad she intended to use was laid on top of a paper towel that she had previously placed on the bedside table to use as a barrier. She did not lay the ABD pad on the inside of the dressing package that it came in. The surface side that was going to be applied over the resident's left buttock pressure ulcer was laid directly on the paper towel. She then placed tape around the border of the ABD pad that had been cut in half. She placed the side of the ABD pad that had been in direct contact with the paper towel directly over the resident's wound on her left buttock. She then secured the dressing by pressing over the taped edges of the ABD pad. She dated the dressings and gathered her supplies putting all used supplies in her plastic bag. The nurse left the resident's room taking her used treatment supplies that were put in a plastic bag to the nurses's station without performing any hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/14/25 at 3:30 P.M., an interview with RN #162 confirmed she completed the treatments to Resident #1's two pressure ulcers at the same time instead of doing each treatment separately. She acknowledged by doing them at the same time she increased the risk of cross-contamination if one of the two wounds would have been infected. She further acknowledged that she did not perform proper glove changes and hand hygiene at appropriate times during the course of the treatments, as she should have. She was informed changing disposable gloves did not negate the need to perform hand hygiene between glove changes. She confirmed she did not bring in a pair of scissors to use during the dressing changes and used a pair that the resident had in her fanny pack. She denied she disinfected the scissors before she used them to cut the Iodoform packing gauze or the ABD pad, which could have contaminated the dressing supplies that she placed in and over the resident's wounds. She also confirmed she had placed the sides of the ABD pads that she used to cover the resident's open wounds on surfaces that were not clean, while placing the tape around the ABD pads' edges. She agreed it would have been easier to cut the tape to the lengths she needed prior to getting the ABD pads out of their packaging so she could have placed the ABD pads directly over the wounds with clean surfaces and then tape the edges of the ABD pads to the resident's skin. She acknowledged the practice she followed did not follow proper infection control practices, as it was possible the resident had bacterial organisms on her skin and she was more likely to introduce bacterial organisms into the wounds causing infections by doing what she did. She then confirmed she had removed her gloves and gathered the trash bag containing the used supplies and left the resident's room without performing any hand hygiene. Review of the facility's policy on Dry/ Clean Dressings (revised September 2013) revealed the purpose of the procedure was to provide guidelines for the application of dry, clean dressings. Steps in the procedure included the need to remove gloves after removing the old dressing and discard both the gloves and the dressing into a plastic or biohazard bag. The nurse was then directed to wash and dry their hands thoroughly. The nurse was then directed to remove her disposable gloves and discard into a designated container and to wash and dry hands thoroughly upon leaving the resident's room.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review, interview and facility policy review, the facility failed to ensure an appropriate reason for the use of an antibiotic for one resident (#11). This affected one resident (#11) of three residents reviewed for antibiotic use. The facility census was 85. Findings Include: Review of the closed medical record for Resident #11 revealed an initial admitted [DATE] with the latest readmission of 05/07/22 with the admitting diagnoses including but not limited to osteoarthritis, major depressive disorder, mood disorder, constipation, irritable bowel syndrome, hypertension, malignant neoplasm of female genital organ, dysphagia, tract infection, insomnia, unspecified, palliative care, and anxiety disorder. Review of the resident's discontinued physician orders revealed an order dated 10/22/24 for Cipro 500 milligrams (mg) by mouth twice daily until 10/29/24 for a urinary tract infection. Review of the medical record revealed no laboratory results or documentation related to the order for the Cipro 500 mg. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident was always incontinent of both bowel and bladder. The assessment indicated the resident had not been treated for an infection in the past 30 days. On 01/22/25 at 12:50 P.M., interview with the Director of Nursing (DON) confirmed the lack supporting laboratory results or documentation related to the use of the medication Cipro 500 mg. Review of the facility policy titled, Antibiotic Stewardship, (not dated) revealed it was the policy of the facility to maintain an antibiotic stewardship program with the mission of promoting the appropriate use of antibiotics to treat infection and reduce possible adverse events associated with antibiotic use. Providers will utilize the MGreers criteria when considering initiation of antibiotics. When an infection is suspected review with physician the criteria was met for use of antibiotics.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review, interview and facility policy review, the facility failed to ensure two residents (#30, #40) received vaccinations as requested. This affected two residents (#30, #40) of five residents reviewed for immunizations. Findings Include: 1. Review of the medical record for Resident #40 revealed an initial admitted [DATE] with the diagnoses including but not limited to dementia, urinary tract infection (UTI), chronic obstructive pulmonary disease, convulsions, Rheumatoid arthritis, malignant neoplasm of prostate, benign neoplasm of prostate, diabetes mellitus and hyperlipidemia. Review of the resident's admission immunization consent packet dated 10/08/24 revealed the resident consented to have the influenza vaccine, pneumonia vaccine and COVID-19 vaccine. Review of the resident's November 2024 Medication Administration Record (MAR) revealed the resident received the influenza vaccination on 11/06/24. Review of the resident's medical record revealed no documented evidence the resident received the requested pneumonia vaccination as requested. On 01/22/25 at 2:20 P.M., interview with the Director of Nursing (DON) verified the resident had in fact requested the pneumonia vaccinations also and was not provided as requested. 2. Review of the medical record for Resident #30 revealed an initial admitted [DATE] with the latest readmission of 12/10/24 with the diagnoses including but not limited to partial traumatic amputation of left foot, osteomyelitis, sepsis, diabetes mellitus with neuropathy, hypertension, hyperlipidemia, osteoarthritis, gastro-esophageal reflux disease, constipation, edema, nausea and vomiting and anemia. Review of the medical record revealed no immunization consent packet for the immunization consent for the 2024-2025 season. Review of the medical record revealed a family member was her financial POA and not her healthcare POA. On 01/22/25 at 2:20 P.M., interview with the DON she was trying to get contact the resident's power of attorney (POA). The DON verified the resident was her own person and the resident had not received the flu and pneumonia vaccinations as requested. Review of the facility policy titled, Pneumococcal Vaccine, (not dated) revealed all residents will be offered Pneumococcal vaccines to aid in preventing pneumonia/Pneumococcal infections. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Influenza Vaccine, (not dated) revealed all residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review and interview, the facility failed to ensure two residents (#30, #40) received vaccinations as requested. This affected two residents (#30, #40) of five residents reviewed for immunizations. Findings Include: 1. Review of the medical record for Resident #40 revealed an initial admitted [DATE] with the diagnoses including but not limited to dementia, urinary tract infection (UTI), chronic obstructive pulmonary disease, convulsions, Rheumatoid arthritis, malignant neoplasm of prostate, benign neoplasm of prostate, diabetes mellitus and hyperlipidemia. Review of the resident's admission immunization consent packet dated 10/08/24 revealed the resident consented to have the COVID-19 vaccine. Review of the resident's medical record revealed no documented evidence the resident received the requested COVID-19 vaccination as requested. On 01/22/25 at 2:20 P.M., interview with the Director of Nursing (DON) verified the resident had in fact requested the COVID-19 vaccination and was not provided as requested. 2. Review of the medical record for Resident #30 revealed an initial admitted [DATE] with the latest readmission of 12/10/24 with the diagnoses including but not limited to partial traumatic amputation of left foot, osteomyelitis, sepsis, diabetes mellitus with neuropathy, hypertension, hyperlipidemia, osteoarthritis, gastro-esophageal reflux disease, constipation, edema, nausea and vomiting and anemia. Review of the medical record revealed no immunization consent packet for the immunization consent for the 2024-2025 season. Review of the medical record revealed a family member was her financial POA and not her healthcare POA. On 01/22/25 at 2:20 P.M., interview with the DON she was trying to get contact the resident's power of attorney (POA). The DON verified the resident was her own person and the resident had not received the COVID-19 vaccination as requested.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 32801 Based on observation and interview the facility failed to ensure the oven was in safe operational condition and failed to ensure the facility had adequate supply of plates and cups. This had the potential to affect all 85 residents residing in the facility. Findings included: 1. Observation of 400 hall lunch dining on 01/13/25 12:03 P.M., revealed disposable plates were used for the grilled cheese and desserts. Interview on 01/13/25 at 12:03 A.M. with Certified Nurse's Aide (CNA) #183 confirmed some lunch items were served on disposable plates. The CNA was unsure why the kitchen was using them unless the dishwasher was down. Interview on 01/14/25 at 10:27 A.M., with [NAME] #144 and the Dietary Manger (DM) #128 confirmed the facility had to use disposable plates yesterday for lunch due to the kitchen was short about 80 small plates. The DM reported he had put several requests in for more small plates but was denied. 2. Observation of lunch tray line on 01/14/25 at 11:15 A.M., revealed the mashed potatoes temperature measured 109 degrees Fahrenheit (F) when removed from the oven. [NAME] #144 placed the mashed potatoes back in the oven. At 11:22 A.M. [NAME] #144 removed the mashed potatoes to check the temperature and the potatoes remained at 109 degrees Fahrenheit. The [NAME] reported the oven was newer however there has been issues with the pilot light not staying lit. The [NAME] reported she must frequently remove the front panel and relight the pilot light with a lighter. The [NAME] reported you never know when the pilot light is going to go out. There was no warning. Last week she was cooking bacon, and the bacon was not getting done and she kept adding time and after 10 minutes she realized the pilot light had went out. The facility has not called anyone to come and look at the oven. Interview on 01/14/25 at 11:22 A.M., with the DM #128 confirmed he was aware of the issues with the pilot light; however, the facility had switched contract company, and he didn't have a number to contact the new contractor. 3. Observation on 01/14/25 at 12:11 P.M., of 500 lunch dining revealed the staff ran out plastic cups for drinks. Certified Nursing Assistants (CNA) #160 and #169 confirmed they had to stop serving lunch trays while another staff member went to find cups. The CNA's reported they frequently run out of plastic cups and coffee cups during dining. Interview on 01/14/25 at 12:46 P.M. with [NAME] #144 and Dietary Assistants #121 and #181 confirmed the kitchen was short on coffee cups and plastic drinking cups. The Dietary Aides reported they can usually get coffee cups back out quickly; however, the plastic cups have been an issue, and they have been replacing them with disposable cups. Interview on 01/14/25 at 12:40 P.M., with DM #128 revealed he had just ordered plates and had the maintenance director reach out to the contracting company to service the oven. He would have to order cups and he would do that now.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 32654 Based on employee record review and staff interview, the facility failed to ensure Certified Nursing Assistants (CNA) were provided 12 hours of continuing education per year. This had the potential to affect all 85 residents residing in the facility. Findings Include: 1. Review of the employee file for CNA #106 revealed a hire date of 06/10/22. Further review of the employee file revealed no evidence of 12 hours of continuing education per year. 2. Review of the employee file for CNA #119 revealed a hire date of 08/28/19. Further review of the employee file revealed no evidence of 12 hours of continuing education per year. 3. Review of the employee file for CNA #208 revealed a hire date of 02/08/21. Further review of the employee file revealed no evidence of 12 hours of continuing education per year. On 01/22/25 at 5:45 P.M., interview with Human Resource (HR) #187 and the Director of Nursing (DON) verified the employees had not completed the 12 hours of continuing education per year.