STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365577	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Gardens Rehabilitation and Nursing Center	755 South Plum Street Marysville, OH 43040

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observation, staff interviews and review of facility policy, the facility failed to provide dignity during dining when staff was standing over a resident while assisting with feeding. This affected one resident (Resident #16) out of six residents (#7, #12, #14, #15, #16, #36) reviewed for dignity. The census was 56 residents. Findings include: Review of Resident #16's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses that included hypertension, osteoarthritis, major depressive disorder, and generalized anxiety disorder. Review of Resident #16's quarterly Minimal Data Set (MDS) assessment dated [DATE] revealed she had a Brief Interview for Mental Status score of 11, indicative of mildly impaired cognition. MDS assessment further revealed Resident #16 was independent for eating. Review of Resident #16's self care deficit care plan dated 06/22/22 revealed she was at risk for self care deficit related to an increased need for assistance with her activities of daily living depending on her mood, energy level and pain. The care plan indicated one of her interventions was to provide supervision with one person assistance. Observation on 05/05/25 from 4:32 P.M. to 4:37 P.M. revealed Certified Nursing Aide (CNA) #32 was standing over Resident #16 while assisting with feeding her. Interview with Licensed Practical Nurse (LPN) #94 on 05/05/25 at 4:37 P.M. confirmed CNA #32 was standing over Resident #16 while feeding her. Interview with CNA #53 on 05/05/25 at 4:57 P.M. confirmed the CNAs frequently stand while assisting with feeding residents. Review of a facility policy titled Assistance with Meals dated July 2017 revealed that the facility staff will serve resident trays and will help residents who require assistance with eating. Residents will be fed with attention to dignity, for example, not standing over residents while assisting them with meals.

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review, observations and resident interviews, the facility failed to ensure resident concerns were addressed timely and appropriately during resident council meetings. This affected six Residents (#5, #15, #17, #27, #35 and #44) that regularly attend resident council meetings. The facility census was 56. Findings include: Interview on 05/06/25 at 10:01 A.M. with Resident #30 revealed the facility staff do not respond to call lights timely. Interview on 05/06/25 at 11:10 A.M. with Resident #13 reported the facility had issues with smoke breaks including missing them, being late, and not allowing them to be long enough. He revealed the facility did not address concerns in a timely manner. Interview on 05/08/25 at 11:03 A.M. with Activity Director #16 confirmed resident have the same concerns brought up each resident council meeting including call light response times and issues with the smoke break. She revealed after the council meeting she completes the top part portion of a resident concern form and provides the form to the Administrator who passes them out to various department heads. She acknowledged issues with activities was brought up a few times and revealed they are trying to add new activities to the calendar, however a lot of resident want to keep the activities the same and not change the activities. She acknowledged a concern with having the same topic brought up every month or consistently brought up showing the facility had not addressed the issue to the residents satisfaction. Review of resident council meeting dated 06/05/24 revealed concern related to having trouble finding an aide in the dining room, showered not being timely, residents not being changed timely (incontinence care), wanting more activities, and aides on all shifts not answering call lights. Review of concern form dated 06/05/24 revealed the Assistant Director of Nursing completed an audit and check and changes were completed every two hours. Facility was unable to provide any evidence of an audit being completed. Review of concern form dated 06/05/24 revealed Activities needed to change it up and resident wanted to go on outings. The response included scheduled more outings and changed things slowly as residents do not like change. Review of concern form dated 06/06/24 revealed two resident had identified concerns regarding not receiving showers and the response was both residents had history of frequent refusals. It was not mentioned if they were offered a shower or asked about changing schedules or to trouble shoot why they had a history of refusals. It also stated staff to continue to encourage residents. Review of concern form dated 06/09/24 revealed aides on all shifts were not answering call light timely. Facility completed an audit from 7:00 P.M. to 7:00 A.M. and 7:00 P.M. to 11:00 P.M. and all were answered within 20 minutes with most answered in less than 5 minutes. It also mentioned education was provided but did not state to whom or what the education included. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident council meeting dated 07/03/24 revealed concern related to an specific aide not doing her job, being rude and neglecting her duties. Review of the concern form dated 07/08/24 revealed the staff member was educated. Facility had no statements from staff, audits or observations of staff behavior documented after allegation. Review of resident council meeting dated 09/13/24 revealed concern related to activities and resident wanting more outdoor trips traveling with facility van. Facility had no evidence of any concern form from this resident council meeting. Review of resident council meeting dated 10/02/24 and 10/03/24 revealed staff on third shift shut off call lights without completing request, more outdoor activities, and issues with the 9:00 P.M. smoke break Facility had no evidence of any concern form from this resident council meeting. Review of resident council meeting dated 11/20/24 revealed concern related to call lights being shut off and not answered in a timely manner Review of the concern form dated 11/27/24 revealed interviews were completed and no concerns identified. It did not state who was interviewed. Call light audits were not completed and call light responses were not monitored. Review of the resident council meeting dated 12/2024 revealed no meeting was held this months due to holidays and illness. Review of resident council meeting dated 01/09/25 revealed concern related to nurses not passing pain medication timely. Review of the concern form dated 01/13/25 revealed more information, will discuss with a (named individual). It was unknown if this was a resident or staff. The form did not provide any added resolution of what was done or how concern was monitored for compliance. Review of resident council meeting dated 02/05/25 revealed concern related to call lights not being answered timely and being shut off without completing requests and more choices for food. Review of the concern form dated 02/10/25 revealed a call response delay was identified with plan to monitor call light. It included no call light audits or plan for how call light responses would be monitored. Facility had no evidence of any concern form from this resident council meeting related to food choices. Review of resident council meeting dated 03/07/25 revealed concern related to the 9:00 P.M. smoke break and no staff available to take residents out. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the concern form dated 03/10/25 the smoke break process was discussed at morning meeting and plan for camera support for write ups if staff are not taking residents out for the 9:00 P.M. smoke break. Review of resident council meeting dated 04/02/25 revealed concern related to call lights not being answered timely, wanting more activity outings, and laundry not being delivered timely. Review of the concern form dated 04/02/25 for the laundry concern stated, needs more detail. Review of the concern form dated 04/12/25 for the call lights revealed DON said he could do an audit and stated, needs more information. Review of the concern form dated 04/12/25 for the 9:00 P.M. smoke break stated the cameras were reviewed and smoke break was late and staff should be more cognizant of the smoke time but provided no plan or follow up for how facility would ensure smoke times were honored. Interview on 05/08/25 at 12:00 P.M. with Administrator confirmed the same topics had been brought up several times in the past 10 months at resident council meetings. He acknowledged the facility should address concerns that residents bring up during the resident council meetings and had no explanation for missing concern forms, and forms completed which provided little details on a plan to be in compliance. He also acknowledged putting needs more information on a concern form did not show the facility made any corrections.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to ensure residents had access to their personal care needs account on an ongoing basis. This had the potential to affect all 24 (#01, #04, #05, #06, #07, #08, #10, #13, #14, #16, #19, #21, #22, #23, #25, #26, #28, #35, #36, #38 , #39, #42, #44, and #162) residents who have authorized the facility to [NAME] their personal financial accounts. The census was 56. Findings Include: An interview on 05/08/25 at 9:15 A.M. with the Business Office Manager #20 (BOM) confirmed the banking hours for residents to receive funds from their personal care needs account are 10:00 A.M. to 3:00 P.M. Monday through Friday. She denied knowing if residents could get money out of their accounts on weekends or after 3:00 P.M. during the weekdays. An interview on 05/08/25 at 10:00 A.M. with the Administrator confirmed banking hours for residents to withdraw money from their personal care accounts is Monday through Sunday 10:00 A.M. to 3:00 P.M. He denied anyone being able to get their money after these hours. A supervisor is on staff during all shifts, however, they do not have access to petty cash; to accommodate residents should they need money after 3:00 P.M. He revealed he could not trust a nurse to handle a petty cash box. Observation upon entry into the building at the receptionist area on a side table revealed a sign stating, Banking Hours Monday-Friday 10 AM to 3PM Sat. -Sun please report to the Manager on duty/Receptionist to get funds. Review of facility policy titled, Deposit of Resident Funds, dated 04/2017, revealed provide the resident's access to funds of fifty (50) dollars within a reasonable period, and access to funds more than fifty (50) dollars within three banking days.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, staff interviews and review of facility policy, the facility failed to provide a homelike dining environment in the main dining room, this affected eight residents that were identified as eating lunch in the dining room (Resident #5, #6, #7, #21, #28, #35, #36, and #41). The facility also failed to ensure clean linens were provided to one (Resident #309) of nine (Resident #4, #10, #14, #18, #19, #36, #50, and #51) residents reviewed for environment. The facility census was 56 residents. Findings include: 1. Observation on 05/05/25 at 11:41 A.M. of the dining room during lunch time revealed an unclean un-homelike environment when the following was observed: a full-size refrigerator with a padlock locking mechanism on the outside of it. On the refrigerator there was dry food and dust . A counter housing a sink revealed four dishes dirty with dry food , silverware, and cups from the breakfast service were present. In the far-right corner of the dining room closest to the entry to the kitchen revealed a mop bucket with a dirty mop and dirty water in it. Beside the bucket a sheet pan rack with two bins at the bottom with dirty dishes, on the top of the rack three rows down were two trays with breakfast remains on the trays. Interview with Regional Dietary Services Director #150 on 05/05/25 at 11:45 A.M. confirmed the presence of the above description of the dining room during lunch service. 2. Review of the medical record for Resident #309 revealed an admission date of 04/16/25. Diagnoses included urinary tract infection, metabolic encephalopathy, and neurocognitive disorder. Observation 05/05/25 at 10:32 A.M. revealed Resident #309 had a cut on her elbow. Resident had a pillow without a pillow case that had several dried blood stains on it. On the sheet were observed with several spots of dried blood on both the top and side of the sheet. Observation on 05/05/25 at 5:10 P.M. with Licensed Practical Nurse #97 confirmed resident had linens with dried blood. Review of facility policy titled, Quality of Life - Homelike Environment dated 05/2017 revealed residents shall be provided with a clean and homelike environment including clean bed and bath linens in good condition.

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F 0600 Level of Harm - Minimal harm or potential for actual harm 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** Based on medical record review, resident interviews, staff interviews, and review of facility policy, the facility failed to protect a resident (Resident #14) after an allegation of verbal abuse by a staff member and continued to let the staff member work at the facility. This affected one resident, Resident #14, out of three residents (#15, and #16) reviewed for abuse. The facility census was 56. Findings include: Review of the medical record for Resident #14 revealed an admission date of 01/16/23. Diagnoses included carcinoma in situ of esophagus, severe protein calorie malnutrition, hypertension, depression, hyperlipidemia, chronic kidney disease stage III, vascular dementia, alcohol abuse, muscle weakness, cognitive communication deficit, metabolic encephalopathy, and acquired AKA (above the knee amputation). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 is cognitively intact with a BIMS (Brief Interview for Mental Status) score of 13 and required one person assist with activities of daily living and had no history of behaviors. Review of facility self reported incidents (SRI)s revealed no submission related to verbal abuse allegation involving Resident #14. Interview with Regional Operations Director #154 on 05/06/25 at 9:29 A.M. revealed no reports of abuse in the last month. Telephone interview on 05/06/25 at 9:43 A.M. with Certified Nursing Assistant (CNA) #51 revealed she witnessed very concerning behavior from CNA #22 a little less than one month ago. CNA #51 stated that she overheard CNA #22 get into a verbal disagreement with Resident #14 and Resident #27 in the TV room/hallway and it escalated when that aide got into Resident #14's face yelling shut up and pointing finger at him. CNA #51 described it as a full-on fight and advised CNA #22 to walk away and ignore Resident #14. Furthermore, CNA #22 was saying offensive things to other residents and making side comments. CNA #51 attested this was full on verbal abuse because CNA #22 was threatening, getting too aggressive, and she believed it was going to turn into something more. CNA #51 reported to Unit Manager Nurse (UMN) #127 by phone 30 minutes after the incident occurred. CNA #51 confirmed she filled out a paper report and slid it under a staff's door. Interview with UMN #127 on 05/06/25 at 9:52 A.M. confirmed CNA #51 notified her by telephone of the incident and reported residents were getting loud with staff and that residents were yelling at CNA #22. She stated she was unsure what they were yelling about. UMN #127 confirmed CNA #22 was working the evening of the alleged incident and CNA #51 intervened. UMN #127 stated followed up was completed with Resident #14 and Resident #127 and reported there were no issues, however UMN #127 could not recall when the follow up occurred. UMN #127 stated they spoke with CNA #22 who reported residents did get loud on the evening of the incident and there was an argument. UMN #27 confirmed the interviews reveled no indications there was a problem during that night shift. UMN #127 confirmed she did not report the alleged incident of verbal abuse to the Director of Nursing and/or Administrator. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #14 on 05/06/25 at 9:59 A.M. confirmed CNA #22 initially yelled at Resident #27, so Resident #14 stood up for him and that is when CNA #22 got in his face and was screaming and hollering at him. He could not recall exact words. Staff intervened and the incident was over. Resident #14 confirmed he felt threatened and reported it was verbal abuse. Interview with Resident #27 on 05/06/25 at 10:04 A.M. revealed that he didn't remember the incident and did not elaborate. Interview with UMN #127 on 05/06/25 at 4:43 P.M. confirmed no paper report from CNA #51 could be located as she claimed she checked multiple places and mailboxes including the Director of Nursing (DON)'s office and her office. Interview with DON on 05/07/25 at 8.56 A.M. confirmed he had not received a report of abuse involving Resident #14 and this was the first time he heard about it. Interview with Administrator on 05/07/25 at 9:00 A.M. confirmed he was not aware of a report of abuse between CNA #22 and Resident #14. He denied having a report from CNA #51. With surveyor intervention a State Reported Incident (SRI) has been filled with the State Agency. Review of facility staff assignments, including all shifts, from beginning of April 2025 until current day were provided. CNA #22 was on schedule for various night shifts. DON confirmed that CNA #22 worked shifts through April 2025 and May of 2025 even after UMN #127 received a report of resident abuse by CNA #51 to UMN#127. Review of facility policy titled 'Abuse, Neglect, Exploitation, & Misappropriation of Resident Property,' states If a staff member is accused or suspected of Abuse, Neglect, Exploitation, Mistreatment of a resident, or Misappropriation of Resident Property, the facility should immediately remove that staff member from the facility and the schedule pending the outcome of the investigation.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review, interviews and facility policy and procedures review, the facility failed to ensure the physician and or prescribing practitioner documented a rationale in the resident's medical record for the use of a psychotropic drug for 180 days. This had the potential to affect one (Resident #4) out of five residents reviewed for unnecessary medications. The census was 56. Findings include: Review of the medical record for Resident #4 revealed an admission date of 11/04/22 with mild cognitive deficits. Diagnoses included traumatic hemorrhage of the cerebrum, hemiplegia and hemiplegia, acute chronic respiratory and obstructive pulmonary disease. A care plan relative to her physical and psychological needs revealed individualized interventions with measurable goals. Review of the Consultant Pharmacist Recommendation to Physician dated 7/16/24 and 2/11/25. The pharmacist requested a recommended reorder for specific number of days for the as needed (PRN) order of Lorazepam (antianxiety) 1 milligram (mg) for Resident #4 or to discontinue the medication per federal guideline. Response continue PRN use of Lorazepam for 180 days, as the benefit outweighs the risk. The physician agreed; however, did not indicate the rationale in the medical record or on the recommendation form. Review of Resident #4's Physician Order Summary Report revealed an order for Ativan (Lorazepam) Oral Tablet 1 mg give 1 mg by mouth every 12 hours as needed for 180 days. Review of Resident #4's Physician Progress Notes from 07/16/24 to 02/11/25 revealed no rationale for the use of Lorazepam as needed every 12 hours for 180 days. Review of Resident #4's Psychiatric visit notes dated 07/23/24, 03/12/25 and 04/10/25 revealed Resident #04 was not taking Lorazepam. The interview with the Director of Nursing on 05/07/25 at 1:30 P. M. revealed because the physician agreed with the pharmacist and checked the box to continue the PRN use of the Lorazepam for 180 days, as the benefit outweighs the risk, was the reason to continue the medication. An Interview by telephone on 05/07/25 at 3:24 P. M. with the Pharmacist confirmed the physician did agree to continue the medication for 180 days, but by checking the box to continue PRN use of Lorazepam for 180 days, as the benefit outweighs the risk is not enough. The physician must give a rationale to continue the psychotropic medication for 180 days in the resident's medical record. An Interview on 05/07/25, at 4:00 P. M. with the Regional Clinical Registered Nurse #152 confirmed Resident #4 sees psychiatric nurse practitioner and she should provide the rationale for the Lorazepam to be extended for 180 days. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 05/07/25, at 4:50 P. M. with Regional Clinical Registered Nurse #152 confirmed Resident #4's physician did not put a rational on the pharmacy recommendations dated 7/16/24 and 2/11/25 or have a rationale in his visit notes and progress notes. The psychiatric nurse dated practitioner visits notes dated 07/23/24, 03/12/25 and 04/10/25 did not include Lorazepam as a medication Resident #4 was prescribed. Review of the Facility's Medication Regimen Reviews Policy, dated 04/2007 The Consultant Pharmacist will document his/her findings and recommendations on the monthly drug/medication review report and provide a written report for each resident with an identified irregularity to the ordering physician. If the Physician does not provide a pertinent response, or the Consultant Pharmacist identifies that no action has been taken, he or she will contact the Medical Director, or -if the Medical Director is the Physician of Record-the Administrator.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of the medical record for Resident #14 revealed an admission date of 01/16/23. Diagnoses included carcinoma in situ of esophagus, severe protein calorie malnutrition, hypertension, depression, hyperlipidemia, chronic kidney disease stage III, vascular dementia, alcohol abuse, muscle weakness, cognitive communication deficit, metabolic encephalopathy, and acquired AKA (above the knee amputation). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 is cognitively intact with a BIMS (Brief Interview for Mental Status) score of 13 and required one person assist with activities of daily living and had no history of behaviors. Review of facility self reported incidents (SRI)s revealed no submission related to verbal abuse allegation involving Resident #14. Telephone interview on 05/06/25 at 9:43 A.M. with Certified Nursing Assistant (CNA) #51 revealed she witnessed very concerning behavior from CNA #22 a little less than one month ago. CNA #51 stated that she overheard CNA #22 get into a verbal disagreement with Resident #14 and Resident #27 in the TV room/hallway and it escalated when that aide got into Resident #14's face yelling shut up and pointing finger at him. CNA #51 described it as a full-on fight and advised CNA #22 to walk away and ignore Resident #14. Furthermore, CNA #22 was saying offensive things to other residents and making side comments. CNA #51 attested this was full on verbal abuse because CNA #22 was threatening, getting too aggressive, and she believed it was going to turn into something more. CNA #51 reported to Unit Manager Nurse (UMN) #127 by phone 30 minutes after the incident occurred. CNA #51 confirmed she filled out a paper report and slid it under a staff's door. Interview with UMN #127 on 05/06/25 at 9:52 A.M. confirmed CNA #51 notified her by telephone of the incident and reported residents were getting loud with staff and that residents were yelling at CNA #22. She stated she was unsure what they were yelling about. UMN #127 confirmed CNA #22 was working the evening of the alleged incident and CNA #51 intervened. UMN #127 stated followed up was completed with Resident #14 and Resident #127 and reported there were no issues, however UMN #127 could not recall when the follow up occurred. UMN #127 stated they spoke with CNA #22 who reported residents did get loud on the evening of the incident and there was an argument. UMN #27 confirmed the interviews reveled no indications there was a problem during that night shift. UMN #127 confirmed she did not report the alleged incident of verbal abuse to the Director of Nursing and/or Administrator. Interview with Resident #14 on 05/06/25 at 9:59 A.M. confirmed CNA #22 initially yelled at Resident #27, so Resident #14 stood up for him and that is when CNA #22 got in his face and was screaming and hollering at him. He could not recall exact words. Staff intervened and the incident was over. Resident #14 confirmed he felt threatened and reported it was verbal abuse. Interview with Resident #27 on 05/06/25 at 10:04 A.M. revealed that he didn't remember the incident and did not elaborate. Interview with UMN #127 on 05/06/25 at 4:43 P.M. confirmed no paper report from CNA #51 could be located as she claimed she checked multiple places and mailboxes including the Director of Nursing (DON)'s office and her office. (continued on next page)

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	365577	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Gardens Rehabilitation and Nursing Center	755 South Plum Street Marysville, OH 43040

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DON on 05/07/25 at 8.56 A.M. confirmed he had not received a report of abuse involving Resident #14 and this was the first time he heard about it. Interview with Administrator on 05/07/25 at 9:00 A.M. confirmed he was not aware of a report of abuse between CNA #22 and Resident #14. He denied having a report from CNA #51. With surveyor intervention a State Reported Incident (SRI) has been filled with the State Agency. Review of facility staff assignments, including all shifts, from beginning of April 2025 until current day were provided. CNA #22 was on schedule for various night shifts. DON confirmed that CNA #22 worked shifts through April 2025 and May of 2025 even after UMN #127 received a report of resident abuse by CNA #51 to UMN #127. Review of facility policy titled 'Abuse, Neglect, Exploitation, & Misappropriation of Resident Property,' states If a staff member is accused or suspected of Abuse, Neglect, Exploitation, Mistreatment of a resident, or Misappropriation of Resident Property, the facility should immediately remove that staff member from the facility and the schedule pending the outcome of the investigation. Based on observation, medical record review, staff and resident interview and policy review the facility failed to ensure the abuse policy was followed for an injury of unknown origin for Resident #159 and an allegation of verbal abuse for Resident #14. This affected two (#159 and #14) of three residents reviewed for following the abuse policy. The census was 56. Findings included: 1. Medical record review for Resident #159 revealed an admission date of 01/15/25. Medical diagnoses included heart failure, renal insufficiency, diabetes, depression and chronic obstructive pulmonary disease (COPD). Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #159 was cognitively intact. Functional status was setup or clean up for eating, she was dependent for toileting and transfers. She was substantial/maximal assistance for bed mobility. She was frequently incontinent for bowel and bladder. Review of a progress note dated 04/16/25 at 6:00 P.M. for Resident #159 revealed the hospital had called the facility and reported the resident was being admitted due to a fall. She was out of the facility for a follow-up doctor's appointment and during transport, with a company that was an outside service, the resident fell out of her wheelchair and broke her left lower extremity and will be needing surgery. Review of the hospital paperwork dated 04/16/25 revealed Resident #159 presented to the emergency room after a motor vehicle accident with complaints of left leg pain. An X-ray revealed a displaced left tibia and fibula fractures with associated proximal fibula fracture. Review of the investigation for Resident #159 dated 04/17/25 revealed there was a timeline of events, resident interview, and hospital paperwork. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #159 on 05/05/25 at 10:52 A.M. revealed she went out to an appointment on 04/16/25 to see her vascular surgeon. On the way back to the facility, she reported the driver was going the wrong way and she told him he took the wrong exit and he slammed on the brakes and she became unbuckled from her wheelchair and dropped onto the floor and slid on the floor and her left leg jammed underneath the drivers seat in front of her. She revealed she was sent to the hospital and had surgery to repair her leg. Interview with the Director of Nursing (DON) on 05/05/25 at 1:04 P.M. revealed the hospital called and said the resident had been in a motor vehicle accident. He reported the facility received the hospital records and they said Resident #159 had been in a motor vehicle accident. He reported he didn't called the police department to get the details of the accident or get a police report. He confirmed he didn't investigate thoroughly, didn't report the alleged abuse, or follow the policy. Review of the policy entitled Abuse, Neglect, Exploitation, and Misappropriation of Resident's Property dated 11/01/19 revealed all incident and allegations of Abuse, Neglect, Exploitation, Mistreatment of a resident, or Misappropriation of Resident Property and all Injuries of Unknown Source must be reported immediately to the State Agency. Once the Administrator and the state agency were notified, an investigation of the allegation violation will be conducted. an investigation of the allegation violation will be conducted. 1. Time frame for investigation The investigation must be completed within five (5) working days, unless there are special circumstances causing the investigation to continue beyond 5 working days 2. Investigation protocol The person investigating the incident should generally take the following actions: Interview the resident, the accused, and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident; came in close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident. 3. If there are no direct witnesses, then the interviews may be expanded. For example, to cover all employees on the unit, or, as appropriate, the shift. For Injuries of Unknown Source, the investigation may generally involve talking with both the shift on duty when the injury was discovered and prior shifts as well.

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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** 2. Review of the medical record for Resident #14 revealed an admission date of 01/16/23. Diagnoses included carcinoma in situ of esophagus, severe protein calorie malnutrition, hypertension, depression, hyperlipidemia, chronic kidney disease stage III, vascular dementia, alcohol abuse, muscle weakness, cognitive communication deficit, metabolic encephalopathy, and acquired AKA (above the knee amputation). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 is cognitively intact with a BIMS (Brief Interview for Mental Status) score of 13 and required one person assist with activities of daily living and had no history of behaviors. Interview with Regional Operations Director #154 on 05/06/25 at 09:29 A.M. revealed no reports of abuse in the last month. Review of the facility's Self Reported Incidents (SRI)s revealed there was no report completed regarding Resident #14 in regards to verbal abuse. Telephone interview on 05/06/25 at 09:43 A.M. with Certified Nursing Assistant (CNA) #51 revealed she witnessed very concerning behavior from CNA #22 a little less than one month ago. CNA #51 stated that she overheard CNA #22 get into a verbal disagreement with Resident #14 and Resident #27 in the TV room/hallway and it escalated when that aide got into Resident #14's face yelling shut up and pointing finger at him. CNA #51 described it as a full-on fight and advised CNA #22 to walk away and ignore Resident #14. Furthermore, CNA #22 was saying offensive things to other residents and making side comments. CNA #51 attested this was full on verbal abuse because CNA #22 was threatening, getting too aggressive, and she believed it was going to turn into something more. CNA #51 stated the incident was reported to Unit Manager Nurse (UMN) #127 by telephone 30 minutes after the incident occurred. CNA #51 confirmed she filled out a paper report and slid it under a staff's door. Interview with UMN #127 on 05/06/25 at 9:52 A.M. confirmed CNA #51 notified her by telephone of the incident and reported residents were getting loud with staff and that residents were yelling at CNA #22. She stated she was unsure what they were yelling about. UMN #127 confirmed CNA #22 was working the evening of the alleged incident and CNA #51 intervened. UMN #127 stated followed up was completed with Resident #14 and Resident #127 and reported there were no issues, however UMN #127 could not recall when the follow up occurred. UMN #127 stated they spoke with CNA #22 who reported residents did get loud on the evening of the incident and there was an argument. UMN #27 confirmed the interviews reveled no indications there was a problem during that night shift. UMN #127 confirmed she did not report the alleged incident of verbal abuse to the Director of Nursing and/or Administrator. Interview with Resident #14 on 05/06/25 at 09:59 A.M. confirmed CNA #22 initially yelled at Resident #27, so Resident #14 stood up for him and that is when CNA #22 got in his face and was screaming and hollering at him. He could not recall exact words. Staff intervened and the incident was over. Resident #14 confirmed he felt threatened and reported it was verbal abuse. Interview with DON on 05/07/25 at 08.56 A.M. confirmed he had not received a report of abuse involving Resident #14 and this was the first time he heard about it. (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	Interview with Administrator on 05/07/25 at 09:00 A.M. confirmed he was not aware of a report of abuse between CNA #22 and Resident #14. He denied having a report from CNA #51, and no SRI had been filed with the State Agency. Review of the policy entitled Abuse, Neglect, Exploitation, and Misappropriation of Resident's Property dated 11/01/19 revealed all incident and allegations of Abuse, Neglect, Exploitation, Mistreatment of a resident, or Misappropriation of Resident Property and all Injuries of Unknown Source must be reported immediately to the State Agency. Based on observation, medical record review, staff and resident interview and policy review the facility failed to ensure an injury of unknown origin for Resident #159 and an allegation of verbal abuse for Resident #14 were reported to the state agency. This affected two (#159 and #14) of three residents reviewed for reporting abuse. The census was 56. Findings included: Medical record review for Resident #159 revealed an admission date of 01/15/25. Medical diagnoses included heart failure, renal insufficiency, diabetes, depression and chronic obstructive pulmonary disease (COPD). Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #159 was cognitively intact. Functional status was setup or clean up for eating, she was dependent for toileting and transfers. She was substantial/maximal assistance for bed mobility. She was frequently incontinent for bowel and bladder. Review of a progress note dated 04/16/25 at 6:00 P.M. for Resident #159 revealed the hospital had called the facility and reported the resident was being admitted due to a fall. She was out of the facility for a follow-up doctor's appointment and during transport, with a company that was an outside service, the resident fell out of her wheelchair and broke her left lower extremity and will be needing surgery. Review of the hospital paperwork dated 04/16/25 revealed Resident #159 presented to the emergency room after a motor vehicle accident with complaints of left leg pain. An X-ray revealed a displaced left tibia and fibula fractures with associated proximal fibula fracture. Interview with Resident #159 on 05/05/25 at 10:52 A.M. revealed she went out to an appointment on 04/16/25 to see her vascular surgeon. On the way back to the facility, she reported the driver was going the wrong way and she told him he took the wrong exit and he slammed on the brakes and she was unbuckled from of her wheelchair and slid onto the floor and slid on the floor and her left leg got jammed underneath the seat of the driver's. She revealed she was sent to the hospital and had surgery to repair her leg. Interview with the Director of Nursing (DON) on 05/05/25 at 1:04 P.M. revealed the hospital called and said the resident had been in a motor vehicle accident. He reported the facility received the hospital records and they said Resident #159 had been in a motor vehicle accident. He confirmed he didn't report to the state since he took what the hospital paperwork said and the call from the hospital as to what happened on the transport van to Resident #159.

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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** 2. Review of the medical record for Resident #14 revealed an admission date of 01/16/23. Diagnoses included carcinoma in situ of esophagus, severe protein calorie malnutrition, hypertension, depression, hyperlipidemia, chronic kidney disease stage III, vascular dementia, alcohol abuse, muscle weakness, cognitive communication deficit, metabolic encephalopathy, and acquired AKA (above the knee amputation). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 was cognitively intact with a BIMS (Brief Interview for Mental Status) score of 13 and required one person assist with activities of daily living and had no history of behaviors. Telephone interview on 05/06/25 at 09:43 A.M. with Certified Nursing Assistant (CNA) #51 revealed she witnessed very concerning behavior from CNA #22 a little less than one month ago. CNA #51 stated that she overheard CNA #22 get into a verbal disagreement with Resident #14 and Resident #27 in the TV room/hallway and it escalated when that aide got into Resident #14's face yelling shut up and pointing finger at him. CNA #51 described it as a full-on fight and advised CNA #22 to walk away and ignore Resident #14. Furthermore, CNA #22 was saying offensive things to other residents and making side comments. CNA #51 attested this was full on verbal abuse because CNA #22 was threatening, getting too aggressive, and she believed it was going to turn into something more. CNA #51 reported the incident to Unit Manager Nurse (UMN) #127 by telephone 30 minutes after the incident occurred. CNA #51 confirmed she filled out a paper report and slid it under a staff's door. Interview with UMN #127 on 05/06/25 at 9:52 A.M. confirmed CNA #51 notified her by telephone of the incident and reported residents were getting loud with staff and that residents were yelling at CNA #22. She stated she was unsure what they were yelling about. UMN #127 confirmed CNA #22 was working the evening of the alleged incident and CNA #51 intervened. UMN #127 stated followed up was completed with Resident #14 and Resident #127 and reported there were no issues, however UMN #127 could not recall when the follow up occurred. UMN #127 stated they spoke with CNA #22 who reported residents did get loud on the evening of the incident and there was an argument. UMN #27 confirmed the interviews reveled no indications there was a problem during that night shift. UMN #127 confirmed she did not report the alleged incident of verbal abuse to the Director of Nursing and/or Administrator. Interview with Resident #14 on 05/06/25 at 9:59 A.M. confirmed CNA #22 initially yelled at Resident #27, so Resident #14 stood up for him and that is when CNA #22 got in his face and was screaming and hollering at him. He could not recall exact words. Staff intervened and the incident was over. Resident #14 confirmed he felt threatened and reported it was verbal abuse. Interview with UMN #127 on 05/06/25 at 4:43 P.M. confirmed no paper report from CNA #51 could be located as she claimed she checked multiple places and mailboxes including the Director of Nursing (DON)'s office and her office. Interview with DON on 05/07/25 at 8.56 A.M. confirmed he had not received a report of abuse involving Resident #14 and this was the first time he heard about the alleged abuse. Interview with Administrator on 05/07/25 at 9:00 A.M. confirmed he was not aware of a report of abuse between CNA #22 and Resident #14. He denied having a report from CNA #51. (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	Based on observation, medical record review, staff and resident interview and policy review the facility failed to ensure an injury of unknown origin for Resident #159 and an allegation of verbal abuse for Resident #14 were investigated thoroughly. This affected two (#159 and #14) of three residents reviewed for reporting abuse. The census was 56. Findings included: 1. Medical record review for Resident #159 revealed an admission date of 01/15/25. Medical diagnoses included heart failure, renal insufficiency, diabetes, depression and chronic obstructive pulmonary disease (COPD). Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #159 was cognitively intact. Functional status was setup or clean up for eating, she was dependent for toileting and transfers. She was substantial/maximal assistance for bed mobility. She was frequently incontinent for bowel and bladder. Review of a progress note dated 04/16/25 at 6:00 P.M. for Resident #159 revealed the hospital had called the facility and reported the resident was being admitted due to a fall. She was out of the facility for a follow-up doctor's appointment and during transport, with a company that was an outside service, the resident fell out of her wheelchair and broke her left lower extremity and will be needing surgery. Review of the hospital paperwork dated 04/16/25 revealed Resident #159 presented to the emergency room after a motor vehicle accident with complaints of left leg pain. An X-ray revealed a displaced left tibia and fibula fractures with associated proximal fibula fracture. Review of the investigation for Resident #159 dated 04/17/25 revealed there was a timeline of events, resident interview, and hospital paperwork. Interview with Resident #159 on 05/05/25 at 10:52 A.M. revealed she went out to an appointment on 04/16/25 to see her vascular surgeon. On the way back to the facility, she reported the driver was going the wrong way and she told him he took the wrong exit and he slammed on the brakes and she became unbuckled from her wheelchair and dropped onto the floor and slid on the floor and her left leg jammed underneath the drivers seat in front of her. She revealed she was sent to the hospital and had surgery to repair her leg. Interview with the Director of Nursing (DON) on 05/05/25 at 1:04 P.M. revealed the hospital called and said the resident had been in a motor vehicle accident. He reported the facility received the hospital records and they said Resident #159 had been in a motor vehicle accident. He reported he didn't called the police department to get the details of the accident or get a police report. He confirmed he didn't investigate thoroughly. He reported he didn't try to get a police report to see if another car was involved in the accident he took the word of the hospital paperwork. Review of the policy entitled Abuse, Neglect, Exploitation, and Misappropriation of Resident's Property dated 11/01/19 revealed once the Administrator and the state agency were notified, an investigation of the allegation violation will be conducted. 1. Time frame for investigation The investigation must be completed within five (5) working days, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unless there are special circumstances causing the investigation to continue beyond 5 working days 2. Investigation protocol The person investigating the incident should generally take the following actions: Interview the resident, the accused, and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident; came in close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident. 3. If there are no direct witnesses, then the interviews may be expanded. For example, to cover all employees on the unit, or, as appropriate, the shift. For Injuries of Unknown Source, the investigation may generally involve talking with both the shift on duty when the injury was discovered and prior shifts as well.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure the appropriate and pertinent information was communicated to the receiving health care institution during a resident transfer. This had the potential to affect one (#57) of five residents reviewed for transfer and discharge. The facility census was 56. Finding Include: Review of the medical record for Resident #57 revealed an admission date of 01/30/24. Diagnoses included arthritis due to other bacteria of the right knee, chronic pain, acute kidney failure, unspecified low back pain, hypo-osmolality and hyponatremia, multiple myeloma, hypertension, pneumonia, ileus, unspecified muscle weakness. Review of physician orders dated 02/04/25 revealed routine laboratory values were ordered to assess Resident #57's hemoglobin (an iron-containing protein found in red blood cells that is responsible for transporting oxygen throughout the body) levels. Review of additional orders on 02/07/25 revealed Resident #57 was to be transferred to the hospital due to low hemoglobin. Review of progress notes dated 02/04/25 revealed Resident #57's hemoglobin was 7.6 grams per deciliter (g/dL) on 01/30/25, and laboratory values were ordered to assess Resident #57 hemoglobin. Review of progress notes dated 02/07/25 showed the provider was notified by the facility of the laboratory results results from 02/04/25 and Resident #57 hemoglobin was 6.5 g/dL. Interview with the Director of Nursing (DON) on 05/06/25 at 3:27 P.M. confirmed that laboratory values were obtained on 02/05/25 and Resident #57 was transferred to the hospital on [DATE]. The DON confirmed the facility failed to document Resident #57 was transported to the hospital with the appropriate information provided to the receiving facility. Review of facility policy titled, Transfer, Reducing Acute Care or Discharge Notice Policy, dated 04/2016, revealed the facility will use a standard tool for early recognition and management of acute changes of condition which include situation, background, and assessment or appearance.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to complete and provide a bed hold notice and reason for transfer to residents and resident representative and failed to notify the long-term care ombudsman of a resident transfer as required. This affected three (#57, #56, and #12) of five residents reviewed for transfer and discharge. The facility census was 56. Finding include: 1. Review of the medical record for Resident #57 revealed an admission date of 01/30/24. Diagnoses included arthritis due to other bacteria of the right knee, chronic pain, acute kidney failure, unspecified low back pain, hypo-osmolality and hyponatremia, multiple myeloma, hypertension, pneumonia, ileus, and unspecified muscle weakness. Review progress notes dated 02/04/25 revealed Resident #57's hemoglobin (an iron-containing protein found in red blood cells that is responsible for transporting oxygen throughout the body) was 7.6 grams per deciliter (g/dL) on 01/30/25 and laboratory values were ordered to assess the resident's hemoglobin. Review of progress notes dated 02/07/25 show the provider was notified by the facility of the laboratory value results from 02/04/25 and Resident #57's hemoglobin was 6.5 g/dL. Review of physician orders dated 02/04/25 revealed routine laboratory values were ordered to assess Resident #57's hemoglobin level. Review of additional orders on 02/07/25 revealed Resident #57 was to be transferred to the hospital due to low hemoglobin. There was no evidence in the medical record of the ombudsman being notified of Resident #57's transfer to the hospital nor a bed hold notice or notice of transfer being given to the resident or representative. Interview with the facility Administrator on 05/07/25 at 9:51 A.M. confirmed facility failed to provide the ombudsman with a notification of transfer for Resident #57. Interview with the Director of Nursing (DON) on 05/07/25 at 3:25 P.M. confirmed the facility failed to complete and provide a reason for transfer notice to Residents #57 or the resident's representative. Interview with Regional Director of Operations #157 on 05/07/25 at 4:25 P.M. confirmed the facility failed to offer a bed hold to Resident #57 or the resident's representative. 3. Review of Resident #12's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, chronic obstructive pulmonary disease, multiple sclerosis, major depressive disorder, generalized anxiety disorder, and schizoaffective disorder. Review of Resident #12's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had a Brief Interview for Mental Status score of 14, indicative of an intact cognitive status. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #12's nursing progress notes revealed on 01/18/25 Resident #12 was discharged to the hospital related to uncontrolled pain. Review of Resident #12's electronic medical record revealed there was no evidence of a notification to the ombudsman when Resident #12 was discharged to the hospital on [DATE]. Interview with the Administrator on 05/07/25 at 9:51 A.M. revealed he could not produce any evidence the Long Term Care Ombudsman was notified of Resident #12's discharge to the hospital. Review of a facility policy titled, Transfer or Discharge Notice, dated December 2016, revealed when a resident is discharged from the facility, the resident or resident representative will be notified in writing about the reason for the transfer or discharge, the effective date of the transfer or discharge, the bed hold policy, the location to which the resident is being transferred or discharged , the name, address and telephone number of the Office of the State Long term care Ombudsman. A copy of this notice will be sent to the Office of the State Long Term Care Ombudsman. 2. Review of the medical record for Resident #56 revealed an admission date of 02/12/25 and discharge on [DATE]. Diagnoses included chronic obstructive pulmonary disease, pulmonary hypertension, heart disease and muscle weakness. Review of the progress notes dated 02/24/24 to 03/01/24 revealed Resident #56 left the facility and failed to return. Resident #56 was educated on the recommendation to return for care and declined the need for any services such as home health care. Review of Resident #56's medical record found no evidence the notice for reason of transfer was sent to the ombudsman. Interview on 05/07/25 at 2:30 P.M. with the Administrator revealed facility had no evidence the ombudsman notification was completed for Resident #56.

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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. Based on medical record review and staff interview, facility failed to ensure Pre-admission Screening and Resident Review (PASARR) documents were accurately completed for two (#23 and #27) of five residents reviewed for PASARR. The facility census was 56. Findings include 1. Review of the medical record for Resident #23 revealed an admission date of 03/21/23. Diagnoses included schizoaffective disorder (added 03/21/23), insomnia, diabetes, cognitive communication deficit, and encephalopathy. Review of Resident #23's PASARR dated 03/17/23 revealed the only diagnosis marked was mood disorder. Interview on 05/05/25 at 5:15 P.M. with Admissions #18 and Social Service Designee (SSD) #126 confirmed PASARR should be reviewed for accuracy at admission and updated for any changes in diagnosis during the admission. Both staff members confirmed Resident #23 PASARR document was not accurate. 2. Review of the medical record for Resident #27 revealed an admission date of 09/21/18. Diagnoses included cerebral palsy, depression, cognitive communication deficit, schizophrenia (added 11/22/23), and unspecified psychosis (added 03/05/19). Review of Resident #27's PASARR dated 09/25/18 revealed the only diagnoses marked were mood disorder, anxiety, and conversion disorder. Interview on 05/05/25 at 5:15 P.M. with Admissions #18 and SSD #126 confirmed PASARRs should be reviewed for accuracy at admission and updated for any changes in diagnosis during the admission. SSD #126 confirmed facility staff had not informed him of a change in Resident #27's diagnoses. Both staff members confirmed Resident #27's PASARR was not accurate. Review of facility policy titled, Resident Assessment Coordination with PASARR Program, dated 2024, revealed all residents shall be screened for serious mental disorders. A record of prescreening shall be maintained in the resident medical records and social service director was responsible for keeping track of each resident PASARR status.

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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** 2. Review of the medical record for Resident #23 revealed an admission date of 03/21/23. Diagnoses included schizophrenia, diabetes, cognitive communication deficit, encephalopathy and insomnia. Review of Resident #23's plan of care dated 03/22/23 revealed the nutritional care plan had no intervention changes or updates in over two years in which time resident had significant weight loss of over 20 pounds, or 12.22 percent (%) weight loss, in six months. The interventions in the current care plan included monitoring for weight loss and to make diet recommendations as needed. Review Resident #23's progress notes revealed no notes regarding nutrition from 03/27/24 to 03/05/25. Review of a note dated 03/05/25 revealed the resident had excessive weight loss and a second weight was requested to confirm weight loss. Review of a note dated 03/12/25 revealed weight loss was acceptable and the resident went from an overweight body max index (BMI) to a healthy BMI. The note continued to begin weekly weights and monitor for continued weight loss. Review of a note dated 04/15/25 revealed the resident's intake was within estimated nutritional needs. Review of a note dated 05/07/25 revealed the resident's intake was within normal limits and no new nutrition recommendations. Review of Resident #23's weight revealed the resident had a steady weight loss from 11/06/24 when the resident's weight was 180.2 pounds to 05/06/25 when the resident's weight was 158.2 pounds. Interview on 05/07/25 at 2:43 P.M. with the Dietician revealed Resident #23 had a weight loss and confirmed she was not concerned about the weight loss as the resident had gained weight the prior year and was now at a health BMI. The Dietician confirmed Resident #23's care plan identified the resident was at risk of weight loss and had interventions to prevent weight loss. She also confirmed no interventions had been changed, added, or adjusted after Resident #23's significant weight loss of 20 pounds in six months to include the resident was to maintain at a health weight around 155 pounds to 170 pounds. Based on medical record review, staff interview, and resident interview, the facility failed to ensure care conferences were held timely and with appropriate parties invited and/or in attendance and failed to ensure care plan interventions were updated with a significant change in a resident's nutritional status. This affected two (#51 and #23) of three residents reviewed for care planning. The census was 56. Findings included: 1. Medical record review for Resident #51 revealed an admission date of 12/18/24. Diagnoses included heart failure, peripheral vascular disease (PVD), renal insufficiency, and diabetes. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 was cognitively intact. (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 Resident #51's care conferences dated 01/08/25 revealed the only person in the care conference was Social Worker Assistant (SWA) #126. Further review of paperwork given to the surveyor dated 04/01/25 revealed an assessment for a Brief Interview for Mental Status (BIMS) was completed with a note the resident refused the care conference. Interview with Resident #51 on 05/05/25 at 3:19 P.M. revealed she had not received a care conference on admission or quarterly. Interview with SWA #126 on 05/07/25 at 12:33 P.M. revealed he was supposed to conduct care conferences within 72-hours of admission and confirmed the 01/08/25 care conference was late. He revealed a night nurse completed the BIMS on Resident #51 on 04/01/25, but said the resident refused a care conference and he had no documentation the care conference was conducted without the resident. SWA #126 reported he checked with residents before a care conference to see if they wanted anyone from the interdisciplinary team (IDT) and, if they did not, he would not invite anyone to the care conference.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, and medical record review, the facility failed to ensure staff followed physician orders for use of and documented use of specialized devices to aid in turning and repositioning as a pressure ulcer prevention intervention. This had the potential to affect one (#30) of three residents reviewed for pressure ulcers. The facility census was 56. Finding Include: Review of the medical record for Resident #30 revealed an admission date of 02/22/25. Diagnoses included hypo-osmolality and hyponatremia, malignant neoplasm of bilateral ovaries, hypothyroidism, Crohn's disease, morbid obesity, difficulty walking, need for assistance with personal care, major depressive disorder, pressure ulcer of the right buttocks, chronic kidney disease, and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 was cognitively intact, required extensive assistance of two staff members for bed mobility, and total dependence of staff for personal hygiene, toileting, and rolling left and right. Review of the plan of care dated 02/23/25 revealed Resident #30 was at risk for skin breakdown related to anemia and increased need for assistance with a self-care deficit related to morbid obesity, increased need for assistance with bed mobility and transfers. Review of physician orders dated 03/14/25 for Resident #30 revealed for staff to turn and reposition the resident using a wedge every two hours as tolerated. Review of wound care notes dated 05/07/25 revealed Resident #30 had a stage II pressure ulcer (partial-thickness skin loss with exposed dermis) on her right buttocks measuring 1.9 centimeters (cm) long by 0.6 cm wide by 0.1 cm deep. Interview on 05/07/25 at 12:44 P.M. with Resident #30 confirmed the facility ordered a wedge to help with turning and repositioning and the wedge had been missing for multiple days. Interview on 05/07/25 at 12:52 P.M. with Licensed Practical Nurse (LPN) #92 confirmed there was no wedge in Resident #30's room. LPN #92 confirmed she has not worked since last week and last saw the wedge then. Record review of treatment orders dated 05/07/25 at 1:01 P.M. showed LPN #92 signed off that Resident #30 was to be turned and repositioned using a wedge every two hours. Interview on 05/07/25 at 1:22 P.M. with LPN #92 confirmed the nurse signed off the treatment record to turn and reposition Resident #30 using a wedge every two hours. LPN #92 confirmed she used a pillow when she could not find a wedge. Interview on 05/08/25 at 11: 55 A.M with Regional Clinical Director #152 and Regional Operations Manager #154 confirmed that orders are to be followed as written and staff should visualize the ordered equipment prior to signing off the treatment order. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was unable to provide a policy for following physician orders.

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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** Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure residents were provided with adequate peri-care. This affected one (#161) of one residents reviewed for peri-care. The census was 56. Findings included: Medical record review for Resident #161 revealed an admission date of 04/24/25. Medical diagnoses included pneumonia, hypertension, and diabetes. Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #161 was cognitively intact and was assessed as continent for bowel and bladder. Observation of peri-care on 05/08/25 at 5:39 A.M. revealed Resident #161 was on the bedpan. Certified Nurse Aide (CNA) #500 revealed he placed on gloves and had cleansing wipes for the care. While the resident was still on the bed pan, CNA #500 wiped down each side of the resident's inner thigh area and did not touch either side of the resident's labia. He removed the bed pan and rolled the resident to the left side and provided care to the resident's bottom in an upward motion. Interview with the CNA #500 on 05/08/25 at 5:45 A.M. confirmed he did not clean Resident #161's labia area. He reported he was nervous, that was not his standard practice, and normally would have washed down each side of the labia area. Review of the policy titled, Perineal Care, dated 10/01/10, revealed the purposes of the procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. For a female resident staff are to wet a washcloth and apply soap or skin cleansing agent and wash the perineal area, wiping from front to back. The policy continued when cleaning a female's perineal area, staff are to separate the labia and wash the area downward from front to back and gently rinse and dry the area, continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. Do not reuse the same washcloth or water to clean the urethra or labia. Rinse the perineum thoroughly in same direction, using fresh water and a clean washcloth. (Note: If the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter.) Next, gently dry the perineum, instruct or assist the resident to turn on her side with her top leg slightly bent, if able, rinse the wash cloth and apply soap or skin cleansing agent. Then wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not reuse the same washcloth or water to clean the labia. Rinse thoroughly using the same technique as described above and dry the area thoroughly.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident and staff interviews, and review of a facility policy, the facility failed to ensure pain was adequately addressed and managed for a resident with complaints of pain. This resulted in actual harm when Resident #159 experienced severe breakthrough pain from a fractured tibia and fibula and was not assessed for pain or offered pain relieving interventions, including medications, to treat the resident's pain. The resident was observed multiple times displaying outward expressions of pain including moaning, tearfulness, and fist-clinching, during general observations and during direct care. This affected one (#159) of two residents reviewed for pain. The census was 56. Findings include: Medical record review for Resident #159 revealed an admission date of 01/15/25. Diagnoses included heart failure, renal insufficiency, diabetes, depression, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #159 was cognitively intact and required setup or clean-up assistance for eating, was dependent for toileting and transfers, required substantial/maximal assistance for bed mobility and was frequently incontinent bowel and bladder. Review of the physician orders dated 03/11/25 revealed Resident #159 was to receive the narcotic pain medication Norco 7.5-325 milligrams (mg) with instructions to give one tablet every six hours as needed for pain. Further review revealed the resident was ordered the pain medication Tylenol 650 mg with instructions to give one tablet every six hours as needed for pain. Review of the care plan for Resident #159 dated 03/11/25 revealed the resident was on pain medication therapy related to generalized complaints of pain, surgical wounds, with an updated notation on 04/24/25, indicating the resident experienced pain from fracture. Interventions were to administer analgesic medications as order by the physician, monitor and document side effects and effectiveness every shift, attempt non-pharmacological interventions prior to as needed medication, monitor for increase of falls, anticipate the resident's need for pain, and respond immediately to any complaint of pain. Review of a pain assessment dated [DATE] revealed Resident #159 had frequent pain in the last five (5) days that made it hard to sleep at night and limited her day-to-day activities because of the pain. The resident's pain was rated at a seven on a 10-point scale with a goal of a pain score of one (1) and there were not any verbal descriptors documented. Review of Resident #159's May 2025 medication administration record (MAR) revealed there was not any Tylenol or Norco administered to the resident between 05/02/25 at 2:16 P.M. to 05/04/25 at 7:39 P.M. There were no pain medications administered on 05/03/25 and no documented evidence of the resident refusing Norco or Tylenol in May 2025. Further review revealed there was no documentation of non-pharmacological interventions for pain attempted between 05/02/25 at 2:16 P.M. to 05/04/25 at 7:39 A.M. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the progress notes dated 05/03/25 revealed there was no documentation regarding Resident #159's pain or interventions to manage pain. Observation and interview with Resident #159 on 05/05/25 at 10:47 A.M. revealed she was lying in bed tearful and moaning, and stated her pain was in her left tibia and fibula due to a fracture. The resident reported she had to wait another two hours until her pain medication was due, and she rated her pain as an eight (8) on a 10-point scale. She stated she was used to waiting until her pain medication came due. A follow-up interview with Resident #159 at 11:22 A.M. revealed on 05/03/25 she did not receive any medications for pain and usually when she was in pain the nurse would call the physician and get her more medication to help with her pain. She reported this was not done on the 05/03/25. Observation and interview with Certified Nurse Aide (CNA) #53 on 05/05/25 at 11:18 A.M. revealed, while repositioning Resident #159 the resident moaned, and CNA #53 stated the resident was in more pain than normal and could not have her pain medication until 12:00 P.M. CNA #53 stated the resident was also in pain on 05/03/25 and CNA #53 reported it to Licensed Practical Nurse (LPN) #98. Interview with LPN #98 on 05/05/25 at 1:38 P.M. revealed CNA #53 told him Resident #159 was in pain on 05/03/25. He confirmed he would usually go to the resident's room and assess the resident for pain and medicate them. LPN #98 confirmed he did not give Resident #159 anything for pain on 05/03/25 and could not remember why he did not. Interview with Registered Nurse (RN) #118 on 05/05/25 at 11:53 A.M. revealed Resident #159 reported to her at about 10:02 A.M., she was in pain that was aching since she fractured her tibia and fibula, and the resident refused the Tylenol the nurse offered. RN #118 also stated she told Resident #159 her Norco was not due yet. She stated she reported Resident #159's pain to Nurse Practitioner (NP) #502 and the NP was not going to change the order at that time. Interview with NP #502 on 05/05/25 at 11:58 A.M. denied she was called or informed when she made rounds on that day by RN #118 concerning Resident #159's pain. A subsequent interview on 05/07/25 at 10:44 A.M. with NP #502 revealed she did not work on weekends and the service was not notified of any pain issues for Resident #159 on 05/03/25. Observation and interview on 05/06/25 at 7:42 A.M. of Resident #159 revealed she was lying in bed tearful and moaning and said she was in pain with a pain level of 8. She reported she received her pain medication at 7:00 A.M. Observation and interview on 05/06/25 at 7:50 A.M. during incontinence care, placing Resident #159 in the mechanical (Hoyer) lift, and transferring her to the dialysis chair revealed, during incontinence care, Resident #159 stated every time the nurse aides turned her, she yelled out in pain, but they continue with the care. Observation revealed when the staff members placed Resident #159 in the Hoyer lift, she was tearful, moaning, and clenching her fists. CNA #45 asked the resident how her leg was doing and the resident said she was in pain and had her pain medication at 7:00 A.M. Continued observation revealed the resident moaned in pain again when the nurse aides placed her in the dialysis chair. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of policy titled, Pain Protocol, dated 06/01/13 revealed the physician and staff will identify individuals who have pain or who are at risk for having pain. This includes a review of each person's known diagnoses and conditions that commonly cause or predispose to pain; for example, degenerative joint disease, rheumatoid arthritis, osteoporosis (with or without vertebral compression fractures), diabetic neuropathy, oral or dental pathology, and post stroke syndromes. It also includes a review for any treatments that the resident currently is receiving for pain, including complementary (non-pharmacological) treatments. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly re view, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. The staff and physician will identify the nature (characteristics such as location, intensity, frequency, pattern, etc.) and severity of pain. Staff will assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. The staff will observe the resident (during rest and movement) for evidence of pain; for example, grimacing while being repositioned or having a wound dressing changed. The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated; for example, wound care, ambulation, or repositioning. The staff and physician will also evaluate how pain is affecting mood, activities of daily living, sleep, and the resident's quality of life, including complications such as gait disturbances, social isolation, and falls.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, resident interview, staff interview, and review of facility policy, the facility failed to provide palatable meals to the residents. This had the potential to affect all 56 residents living in the facility whom all ate meals from the kitchen. The facility census was 56. Findings include: Observation of a lunch test tray meal on 05/07/25 at 11:52 A.M. revealed the meatloaf served was dark, crunchy, and dry. Interview with Regional Director of Dining Services #150 on 05/07/25 at 11:58 A.M. confirmed the meatloaf was dry. He stated it stayed in the oven too long. Interview with three (#46, 51, and 53) residents on 05/07/25 from 12:00 P.M. to 12:06 P.M. confirmed the meatloaf served to them was dry, crunchy, and cut too thin. Review of an undated facility policy titled, Food Presentation, revealed meals will be served in a manner that enhances the appetite through eye appeal. Foods are prepared to prevent overcooking of foods. Each item is checked for proper temperature, taste and consistency prior to serving time.

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	365577	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** Based on observation, medical record review, and staff interview, the facility failed to provide complete information requested. This affected one (#159) of one residents reviewed for medical record documentation. The census was 56. Findings included: Medical record review for Resident #159 revealed an admission date of 01/15/25. Medical diagnoses included heart failure, renal insufficiency, diabetes, depression, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #159 was cognitively intact. The resident's functional status was assessed as setup or clean up assistance for eating, dependent for toileting and transfers, and substantial/maximal assistance for bed mobility. Resident #159 was frequently incontinent of bowel and bladder. During an interview and observation on 05/05/25 at 12:16 P.M. revealed Receptionist #116, who also was the appointment scheduler, pulled out the appointment book and showed the surveyor a date on a paper with significant handwriting on it and highlighted in places which Resident #159 went out to an appointment on 04/16/25. A copy of the appointment was requested from Receptionist #116 whom went down the hall to a copy room. A few minutes went by and Clinical Regional Registered Nurse (CRRN) #152 came down the hall and informed the surveyor Receptionist #116 had menus that were printing and it was taking her a bit longer to run a copy of the appointment document. A few more minutes went by, and the surveyor walked into the copy room and there were no menus printing out in the copier, but Receptionist #116 was writing on a new appointment form to give to the surveyor. Interview with Receptionist #116 and CRRN #152 on 05/05/25 at 12:45 P.M. revealed the printer had been stopped and they both said she was changing the document to reflect the date of the appointment and was going to give a copy of that to the surveyor even though the surveyor requested the entire copy from the Receptionist #116 and not just the date of the appointment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, staff interview, and policy review, the facility failed to maintain proper infection control practices in handling soiled linens, sanitizing glucometers, and providing care of a gastrostomy tube. This deficient practice had the potential to affect all 56 residents residing in the facility. The census was 56. Findings included: 1. Observation on 05/08/25 at 5:10 A.M. revealed Certified Nurse Aide (CNA) #26 was walking in the 400 hall while carrying unbagged linens. Interview on 05/08/25 at 5:11 A.M. with CNA #26 confirmed he was carrying unbagged linens and recently walked out of a resident's room. CNA #26 confirmed dirty linens were to be placed in a bag prior to leaving a resident's room. Review of facility policy for soiled laundry and bedding, dated July 2009, revealed contaminated or potentially contaminated laundry is to be placed in a bag or container a the location were it is used and transport contaminated laundry in bags or containers. 2. During an observation of medication administration for Resident #32 on 05/08/25 at 6:15 A.M. revealed Licensed Practical Nurse (LPN) #90 took gentamicin cream into the room, washed her hands, and placed gloves on her hands. LPN #90 then proceeded to remove the bandage with yellow drainage on it from around the resident's gastrostomy tube (g-tube). The LPN continued the procedure wearing the same gloves, took a cotton swab, and ran it around the g-tube site, then took a new cotton swab, placed the gentamicin ointment on it, and placed ointment around the resident's g-tube site. LPN #90 proceeded to place a new dressing around the g-tube site at that time. Interview with LPN #90 on 05/08/25 at 6:29 A.M. revealed she did not wash around Resident #90's g-tube site because the medication was oil-based and she confirmed she did not change her gloves in between removing the old bandage and applying a clean treatment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the policy titled, Dressing Dry/Clean, dated 09/01/13, revealed the procedure instructed staff to clean the bedside stand and establish a clean field. Next, place the clean equipment on the clean field and arrange the supplies so they can be easily reached. Tape a biohazard or plastic bag on the bedside stand or use a waste basket below clean field. Position resident and adjust clothing to provide access to affected area. Wash and dry your hands thoroughly then put on clean gloves and loosen tape and remove soiled dressing. Next, pull gloves over dressing and discard into plastic or biohazard bag, and wash and dry your hands thoroughly. Then, open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface. Label tape or dressing with date, time and initials and place on clean field. Using clean technique, open other products (i.e., prescribed dressing; dry, clean gauze), wash and dry your hands thoroughly, and put on clean gloves. Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress. Cleanse the wound with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward). Use dry gauze to pat the wound dry. Apply the ordered dressing and secure with tape or bordered dressing per order, and label with date and initials to top of dressing. Staff then should discard disposable items into the designated container, remove disposable gloves and discard into designated container, wash and dry your hands thoroughly, then reposition the bed covers to make the resident comfortable. 3. During an observation of a blood glucose test on 05/08/25 at 6:35 A.M., LPN #90 took a glucometer out of the medication cart and cleaned it with an alcohol swab. Interview with the LPN #90 on 05/08/25 at 6:39 A.M. revealed she cleaned the glucometer with an alcohol swab because that was what she was supposed to cleanse it with. Review of policy titled, Cleansing and Disinfecting Blood Glucose Monitoring System, dated 06/01/15, revealed to use Clorox Germicidal Wipes or Super Sani-Cloth Germicidal Disposable Wipes for cleaning the glucometer.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of infection control logs, and staff interview, the facility failed to ensure an adequate and complete antibiotic stewardship program was implemented to monitor for possible infections within the facility and determine appropriateness of antibiotic use. This had the potential to affect all 56 residents residing in the facility. The facility census was 56. Findings include: 1. Review of the facility infection logs dated between November 2024 and April 2025 revealed the facility did not include any other possible infectious findings or residents with possible symptoms of an infection that were not started on antibiotics. The facility only included those residents who were started on an antibiotic medication on their infection control tracking logs. Further review revealed the facility also did not include the start date of any symptoms of possible infections what the symptoms were, and the logs did not include whether a chest x-ray or laboratory values were ordered and/or completed. Interview on 05/08/25 at 5:50 P.M. with Regional Clinical (RC) #152 confirmed she would expect the facility to maintain a thorough infection control log of infections including information of symptom onset and what the symptoms were, if scans or laboratory values were taken and what the results were, and if the totality of the information met criteria for antibiotic usage using McGeer's criteria (a set of standardized definitions used in long-term care facilities (LTCFs) to identify and track healthcare-associated infections (HAIs). RC #152 confirmed the infection control logs from November 2024 through April 2025 were missing this information. 2. Review of the medical record for Resident #22 revealed an admission date of 06/09/21. The resident had a diagnosis of a stage four pressure wound (full-thickness skin and tissue loss). Review of a McGeer's assessment dated [DATE] revealed Resident #22 had a wound infection with symptoms including heat, redness, swelling, tenderness, and drainage at the site. Resident #22 met criteria for antibiotics. Review of Resident #22's physician orders dated 04/09/25 revealed an order for the antibiotic medication metronidazole oral tab 500 milligrams (mg) with instructions to apply cream to the sacral wound every shift and as needed. Review of the wound assessment dated [DATE] revealed Resident #22 had a stage four sacral pressure wound with drainage that was foul smelling, suggesting possible bacterial burden. The orders included instructions to fill the wound cavity with gauze puffs. Interview on 05/08/25 from 4:00 P.M. to 5:34 P.M. with RC #152 reported Resident #22's wound did not have anything to be cultured and hospice ordered the antibiotic. RC #152 stated the facility had no evidence to provide as to why a culture was not completed on the wound drainage or that the wound bed was not swabbed for possibly infectious matter. RC #152 also stated there was no evidence to provide for any additional evidence of an infection in March 2025 as the McGeer's assessment would suggest and confirmed it was on the infection log for April 2025. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Review of the medical record for Resident #162 revealed an admission date of 06/08/21. The resident had a diagnosis of a urinary tract infection (UTI). Review of Resident #162's urine sensitivity laboratory values revealed the resident's urine was cultured on 04/03/25 and results mentioned the culture was 75,000 colony forming units per milliliter (CFU/mL) to 100, 000 CFU/mL (not over). The facility was unable to produce evidence the culture that was completed to determine organism. Review of Resident #162's McGeer's assessment dated [DATE] revealed the resident met criteria including acute dysuria or pain or swelling and over 100,000 CFU/mL of no more than two species of organisms. Review of Resident #162's physician orders from 04/07/25 to 04/09/25, and again from 04/09/25 to 04/12/25, revealed the resident was ordered the antibiotic Macrobid oral capsule 100 mg. Interview on 05/08/25 between 4:00 P.M. and 5:34 P.M. with RC #152 confirmed the facility did not have any records onsite and had to gather them from outside agencies. RC #152 stated the facility did not have a copy of Resident #162's urine culture for use of Macrobid. 4. Review of the medical record for Resident #309 revealed an admission date of 04/16/25. The resident had a diagnosis of a UTI. Review of Resident #309's urinary culture dated 04/14/25 revealed multiple organisms greater than 100,000 CFU/mL with a notation that results suggest improper specimen collection or delay in delivery. Review of Resident #309's physician orders for 04/16/25 to 04/17/25 revealed an order for the antibiotic cephalexin 500 mg oral tab with the order rewritten from 04/17/25 to 04/20/25. Review of infection control documentation provided revealed facility had no evidence of a McGeer's assessment being completed for Resident #309's UTI to determine if use of the antibiotic was appropriate. Interview on 05/08/25 between 4:00 P.M. to 5:34 P.M. with RC #152 confirmed the facility did not complete McGeer's assessments for hospital admissions and revealed Resident #309 was started on the antibiotic in the hospital and the facility does not review those to ensure they meet criteria for antibiotic use when a resident is admitted to the facility. Review of the facility policy titled, Antibiotic Stewardship, dated 12/2016, revealed antibiotics shall be prescribed under the guidance of the antibiotic stewardship program. The policy did not describe how facility shall ensure appropriateness before starting an antibiotic and did not discuss logging information related to infections.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of employee files, resident interviews and staff interviews, the facility failed to ensure a certified nurse aide (CNA) completed no less than twelve (12) hours of required in-servicing education each year. This had the potential to affect all 56 residents in the facility. The census was 56. Findings include: Review Resident #15's medical record revealed an admission date of 06/25/21. The resident was admitted with a diagnosis of major depressive disorder. Review of Resident #15's Minimum Data Set (MDS) assessment dated [DATE] revealed she had a Brief Interview Mental Status (BIMS) score of 13, indicative of intact cognition. Interview with Resident #15 on 05/06/25 at 10:25 A.M. revealed she had experienced CNA #22 treating her in a disrespectful manner in the recent past. Resident #15 indicated she did not feel threatened. Review of the medical record for Resident #12 revealed an admission date of 05/01/23 with diagnoses including major depressive disorder and generalized anxiety disorder. Review of Resident #12's quarterly MDS assessment dated [DATE] revealed she had a BIMS score of 14, indicative of intact cognition. Interview with Resident #12 on 05/08/25 at 3:05 P.M. revealed she had witnessed CNA #22 treating Resident #15 in an undignified and disrespectful manner. Resident #12 communicated she did not classify CNA #22's behavior as abusive, but she felt that it was disrespectful. Review of CNA #22's employee file revealed he was hired on 08/02/23. Review of CNA #22's attended in-service educations revealed he attended three (3) out of twelve in-service educations in the previous 12 months for a total of 3 hours. Review of the twelve offered in-service educations from the previous twelve months revealed he missed the in-service educations for resident rights, infection control, code of conduct compliance and ethics, emergency preparedness, elopement, customer service with a person-centered approach, first aid basics, behavior management, communication and conflict resolution, and abuse and neglect. Interview with Business Office Manager #20 on 05/08/25 at 4:14 P.M. confirmed CNA #22 only completed 3 out of 12 required in-services, for a total of 3 hours of education in the previous 12 months, and also confirmed CNA #22 did not complete the in-service educations on customer service, communication and conflict resolution, and abuse and neglect.