STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365760	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Center of Boardman	830 Boardman Canfield Rd Boardman, OH 44512

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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 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 48565 Based on review of the resident funds accounts, review of the surety bond, interview, and review of the facility policy, the facility failed to provide a surety bond large enough to cover the total amount of money in all resident personal funds accounts. This had the potential to affect 20 residents identified as having resident fund accounts (Residents #3, # 4, #5, #7, #9, #10, #11, #12, #13, #20, #21, #23, #25, #26, #27, #31, #32, #33, #38, and #39). The facility census was 50. Findings include: A review of resident fund account for the facility dated 10/17/24 revealed a total amount of 98,931.82 dollars. A review of resident fund accounts revealed Resident #26 made a deposit of 101,801.07 dollars on 06/04/24. Resident #26 had a total of 91,442.68 dollars in the resident fund account on 10/17/24. A review of an email dated 09/26/24 from Business Office Manager (BOM) #533 revealed the active surety bond did not cover the amount in resident fund accounts. A review of the document by Merchants Bonding Company, bond number OH5329260, revealed an effective date of 08/01/24. The document also revealed the surety bond was for 20,000 dollars. A review of the document by Merchants Bonding Company, bond number 5329260 and dated 10/17/24 revealed a change to the surety bond amount to 120,000 dollars. The surety bond was back dated to 08/01/24. On 10/21/24 at 9:00 A.M. an interview with BOM #533 revealed the surety bond amount was for 20,000 dollars until the new bond came on 10/17/24. A review of the policy titled; Resident Personal Funds dated 09/2017 revealed the facility will maintain a surety bond to assure the security of all personal funds of residents deposited in the facility. The policy also stated the bond will be at least equal to the total amount of residents' funds as of the most recent quarter.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on record review, interview, and review of the facility policy, the facility failed to ensure Resident #31's advance directives in the medical record and physician orders matched. The facility also failed to ensure the nurse had knowledge of which code status to follow. This affected one resident (#31) out of four residents reviewed for advance directives and had the potential to affect all 50 residents residing in the facility. Findings include: Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including obstructive pulmonary disease with exacerbation, acute respiratory failure with hypoxia, seizure disorder, dementia, and schizophrenia. Review of the undated Do Not Resuscitate (DNR) Comfort Care form completed by Nurse Practitioner #701 revealed Resident #31 code status was DNR Comfort Care. This form was in the miscellaneous section of Resident #31's electronic medical record. Review of the nursing note dated [DATE] at 10:30 A.M. authored by Former Director of Nursing (DON) #700 revealed during a quarterly care plan meeting, Resident #31 stated he wanted his code status to be changed to a Full Code. Review of the care plan dated [DATE] revealed Resident #31 wanted his code status to be Full Code. Interventions included advance directives would be placed on the chart, call emergency rescue squad if needed, code status would be reviewed quarterly and as needed, staff to initiate cardiopulmonary resuscitation (CPR) until emergency services arrived, and staff would notify the physician of the residents' wishes. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had intact cognition. Review of the [DATE] physician's orders revealed Resident #31 had an order dated [DATE] to be a Full Code. Interview on [DATE] at 8:29 A.M. with Resident #31 revealed at first, he was not sure what a DNR was, but after the facility explained what it was, he stated he wanted to be resuscitated (Full Code). Interview on [DATE] at 8:41 A.M. with Licensed Practical Nurse (LPN) #535 was asked if she found a resident unresponsive, where she would go to find the resident's code status. She stated she would look in the physician's orders as everyone had an order regarding their code status or she would look in the miscellaneous section of the electronic medical record because DNR forms were located in this area. She was asked what she would do if the order in the physician's orders did not match what she found in the miscellaneous section, and she stated she would go by the state DNR form because that would be the most accurate. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 10:11 A.M. with the DON verified Resident #31's physician order dated [DATE] revealed Resident #31 was to be a Full Code and in the electronic record miscellaneous section, the form indicated he was to be a DNR-Comfort Care. The DON did not have an explanation why the code statuses did not match. Interview on [DATE] at 12:00 P.M. the DON provided a nursing note dated [DATE] at 10:28 A.M. that Resident #31 had a care plan meeting, and Resident #31 wanted to change his code status to Full Code. The DON was informed of an interview with LPN #535 who stated she would have checked the physician orders and the miscellaneous section of the electronic medical record, and if she found a DNR form, she would have gone by the state form, not the physician order. The DON revealed the DNR form remains in the miscellaneous section even if revoked. The DON the facility policy did not reflect what steps the nurse was to follow if they found a resident unresponsive, including where to check for the correct code status, and she had no documented evidence of staff training. She stated she would start training immediately as she verified this could lead to a nurse not following the correct code status chosen by the resident and/or the resident's family. Review of the undated facility policy labeled; Advance Directives revealed the facility would inform the residents about initiating an advance directive, and the facility would maintain written standards and practice guidelines regarding advance directives to assure that the residents' wishes were honored. The facility staff would explain to the residents their right to make health care decisions, including the right to make an advance directive. The facility would document in the clinical record whether the resident executed an advance directive. The facility staff would be provided with education at least annually. The policy revealed the physician would write an appropriate order for the resident related to the advanced directive, and all pertinent information related to advance directives would be documented in the clinical record. There was nothing in the policy regarding where a nurse should go to check if a resident was found unresponsive to find their code status: physician order or miscellaneous section of the electronic medical record and/or what code status to follow.

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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** 39973 Based on record review, interview, review of the Ohio Department of Health Gateway, and review of the facility abuse policy, the facility failed to report an allegation of resident-to-resident abuse within 24 hours to the state agency after Resident #38 threw a cup of hot coffee on Resident #144 . This affected one Resident (#144) out of one resident reviewed for abuse and had the potential to affect all 50 residents residing in the facility. Findings included: 1. Review of the medical record for Resident #38 revealed an admitted [DATE] and his diagnoses included psychosis, dementia, and malignant neoplasm of colon. Review of the care plan dated 07/26/24 revealed Resident #38 had a behavior problem related to verbal outbursts, exit seeking, and history of physical aggression. Resident #38's wife had an order of protection in place through the sheriff's office due to physical aggression. Interventions included administering medication per order, intervening and redirecting the resident as needed, monitoring and assessing behaviors, and referring to psychiatric services as needed. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 had impaired cognition. He had delusions for one to three days during the seven-day assessment reference period. He was independent with most of his activities of daily living (ADL) including transfers and ambulation. Review of the nursing note dated 10/16/24 at 7:35 A.M. authored by Licensed Practical Nurse (LPN) #535 revealed Resident #38 walked up to the nurse at the medication cart and stated, I threw hot coffee in his face. LPN #535 asked who and immediately checked Resident #144, who stated if Resident #38 continued to be his roommate he would kill him. 2. Review of the medical record for Resident #144 revealed an admitted [DATE] with diagnoses including schizoaffective disorder, depression, anxiety, and unspecified psychosis. Review of the GG Usual Performance Nursing Observations dated 10/08/24 and completed by Registered Nurse (RN) #554 revealed Resident #144 was dependent on staff for transfers and refused to ambulate. Review of the Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed Resident #144 had moderately impaired cognition. Review of the nursing note dated 10/16/24 at 7:51 A.M. with LPN #535 revealed Resident #144 was in bed, and Resident #38 threw coffee on him. Resident #144 was lying in bed unclothed and stated, his roommate threw coffee on him, he didn't know why. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the skin assessment dated [DATE] and completed by LPN #535 revealed at the time of the incident, Resident #144 felt burning as the liquid was hot on his skin. The assessment revealed no redness to his skin at that time. Interview on 10/17/24 at 8:22 A.M. with Resident #144 revealed he did not know why, but Resident #38, his roommate, just walked into the room when he was in bed and threw coffee on his left arm and hair. He stated, yes, it was hot it did not leave a mark, but it burned when Resident #38 first threw the coffee on him. He stated, out of the blue, his roommate threw coffee all over him and that it scared him as he was just lying in bed and cannot really go anywhere because he cannot get out of bed by himself. He was asked if he felt the incident was abusive in nature and he stated, well how would you feel, would you not feel it was abusive, I mean, how would you like a whole cup of coffee dumped on you for no reason. Resident #144 verified he felt the incident was abusive in nature. Interview on 10/17/24 at 11:11 A.M. with the Administrator revealed she was informed of the resident-to-resident incident between Resident #38 and Resident #144. She stated they were roommates and both in their room when Resident #38 spilled coffee on Resident #144 while he was in bed. She had not spoken to either resident and had not filed a self-reported incident (SRI) because she did not see the incident as abusive in nature. Interview on 10/17/24 at 11:21 A.M. with the Director of Nursing (DON) revealed she interviewed Resident #38 after the incident on 10/16/24, and he was ranting with a flight of thought. He used the word revenge but could not tell her why he threw the coffee on Resident #144. She verified Resident #38 admitted to throwing the coffee on his roommate, Resident #144. They increased monitoring and then sent him to a psychiatric hospital for evaluation. She had not interviewed Resident #144. Interview on 10/17/24 at 11:28 A.M. with Admission Director/Social Service Designee #541 revealed she talked to Resident #144 who had stated, his roommate spilled the coffee and that he did not remember the incident. He stated he felt startled by the incident. Review of the nursing note dated 10/17/24 at 11:35 A.M. authored by Admission Director/ Social Service Designee #541 revealed she followed up with Resident #144 regarding the incident and he had stated, I feel little abuse by roommate but not staff. The note revealed Resident #38 looked like he was going to take a sip of coffee and then threw it at him. Resident #144 refused any follow up counseling. Review of the Ohio Department of Health Gateway system for reporting facility SRIs on 10/17/24 at 11:00 A.M. revealed an SRI was not filed regarding the incident that occurred on 10/16/24 at 7:51 A.M. involving Resident #38 throwing hot coffee on Resident #144. The Administrator reported the incident on 10/17/24 at 11:35 A.M. after surveyor questioning (after 24 hours). Review of the facility policy labeled, Abuse, Neglect, and Exploitation of Residents and Misappropriation of Property dated September 2020 revealed residents would not be subjected to abuse, neglect, exploitation and/or mistreatment by anyone. Mistreatment was defined as the action of treating someone poorly. Abuse was defined as the willful infliction of injury. The policy revealed all alleged violations concerning abuse, neglect and misappropriation were reported immediately to the Administrator or designee. Allegations that involve abuse would be reported to the Ohio Department of Health and would not exceed 24 hours.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on record review, interview, and facility policy review the facility failed to ensure accurate care plans were in place for Residents #19 and #148. This affected two residents (#19 and #148) of four residents who were reviewed for care plans. This had the potential to affect all 50 residents residing in the facility. Findings include: 1. Review of the medical record for Resident #19 revealed an admitted [DATE] with diagnoses including dementia with behavioral disturbances, adult failure to thrive, and other signs and symptoms involving cognitive function. Significant orders included Depakote sprinkles oral capsule delayed releases (used to treat manic or mixed episodes associated with bipolar disorder) 125 milligrams (mg), 125 mg two times daily for behaviors and 250mg daily at bedtime for behaviors. There was also an order stating Do Not Resuscitate Comfort Care Arrest (DNRCCA) meaning life saving measures until the heart stops beating. Review of the care plan dated 09/01/24 revealed Resident #19 had a behavior problem related to profanity, refusals of care, and yelling out. Interventions included administering medication as ordered and monitoring for effectiveness of medication and potential side effects. Depakote and Depakote monitoring were not included in the care plan. In addition, the resident was cared planned as a Full Code status, not a DNRCCA. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had moderate cognitive deficit. The MDS also revealed verbal behaviors occurring one to three days of the seven-day assessment reference period. Review of laboratory results from 01/15/24 to 10/16/24 revealed no Depakote levels were drawn. On 10/16/24 at 1:30 P.M. an interview with Regional MDS Nurse/ Registered Nurse (RN) #567 verified Resident #19 did not have a care plan in place for the medication Depakote for behaviors. Regional MDS Nurse/RN #567 also verified Resident #19 was care planned as a Full Code, not DNRCCA as ordered. A review of the undated policy titled; Care Plan and Advanced Care Plan Process revealed advanced care planning may include but is not limited to discussion about a residents advanced directive, plan of care related to their wishes if a sudden life-threatening occurrence should happen. The policy also revealed the Interdisciplinary Team along with the resident will meet and review the care plan quarterly and annually. The plan of care identifies the date, problem and measurable and realistic goals, time frames for achievement and interventions specific to discipline. 39973 2. Review of the medical record for Resident #148 revealed an admitted [DATE] with diagnoses including hypertension, diabetes, acute myocardial infarction, and atrial fibrillation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the laboratory work revealed on 09/26/24 Resident #148's prothrombin time (PT) was 22 and his international normalized ratio (INR) was 2.1. Primary Care Physician (PCP) #702 reviewed and ordered no new orders. Resident #148 then refused his PT/ INR lab work on 10/03/24, 10/08/24, 10/10/24, 10/14/25, and 10/17/24 resulting in PCP #702 changing his anti-coagulant (medication that increase the time it takes for blood to clot) from coumadin to Eliquis. Review of the admission MDS assessment dated [DATE] revealed Resident #148 had impaired cognition. He was dependent on staff for most of his activities of daily living (ADL) including toileting, transfers, and showers. He was on an anti-coagulant medication. Review of the October 2024 physician orders revealed Resident #148 was on an anticoagulant since admission: Coumadin 5 mg one tablet every night due to atrial fibrillation which was discontinued on 10/18/24 and changed to Eliquis (anti-coagulant) 5 mg twice a day. He was to have a PT/ INR (lab) completed every Monday and Thursday. Interview on 10/17/24 at 3:17 P.M. with Regional MDS Nurse/RN #567 verified Resident #148 did not have an anti-coagulant therapy care plan in place including interventions to monitor any adverse side effects and/or medication management. She revealed the former MDS nurse, Licensed Practical Nurse (LPN)/ MDS #572 was no longer employed less than 24 hours ago and was unsure why there was no care plan but there should have been. Interview on 10/17/24 at 3:55 P.M. with the Director of Nursing (DON) verified Resident #148 did not have an anti-coagulant care plan, and he should have had one, especially since he had been refusing his lab work to monitor his PT/ INR levels and was at risk for adverse effects including bleeding. Review of the undated facility policy labeled, Care Plan and Advance Care Plan Process revealed the interdisciplinary team would coordinate with the resident and/or their responsible party to participate in an appropriate care plan for the residents needs or wishes specific to person centered care. The plan of care identifies the date, problem, measurable and realistic goals, time frames for achievement and specific interventions.

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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** 48565 Based on record review, interview, and review of the facility policy, the facility failed to ensure timely and accurate care plans for Residents #34 and #35. This affected two residents (#34 and #35) of four residents who were reviewed for care plans. This had the potential to affect all 50 residents residing in the facility. Findings include: 1. Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses including atrial fibrillation, multiple sclerosis (MS), diabetes mellitus type two, and morbid obesity. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 was cognitively intact. Review of the care conferences revealed Resident #34 had an admission care conference on 05/13/24. The next documented care conference was dated 06/03/24. At that meeting, Resident #34 had a change in discharge plans from short-term care to long-term care placement. Review of the care plan dated 08/11/24 revealed Resident #34 was to be discharged home. On 10/17/24 at 12:08 P.M. an interview with Social Service Designee/Admissions Director (SSD/AD) #541 revealed she does the short-term care resident care plan meetings. Once Resident #34 was converted to long-term care, the long-term care SSD was responsible for care plan meetings. SSD/AD #541 stated the long-term care SSD that would have conducted Resident #34's care plan was no longer with the company. SSSD/AD #541 stated there was no one doing long-term care plan meetings presently. On 10/17/24 at 12:12 P.M. an interview with the Director of Nursing (DON) revealed she was doing care plan meetings for long-term care residents. The DON also verified Resident #34 should have had a care plan meeting in September 2024 to review the resident's plan of care. 2. Review of the medical record for Resident #35 revealed an admitted [DATE] with diagnoses including sepsis, absence of the left foot, encounter for orthopedic aftercare following surgical amputation, and diabetes mellitus type two. Review of the quarterly MDS assessment dated [DATE] revealed Resident #35 was cognitively intact. Review of the care plan dated 08/26/24 revealed Resident #35 was to be discharged home. Review of the care plan conference dated 08/27/24 revealed Resident #35 was to be long-term care. The care plan conference dated 08/27/24 was the only documented care plan conference in Resident #35's medical record. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 1:00 P.M. an interview with Regional MDS Nurse/Registered Nurse (RN) #567 verified the care conference dated 08/27/24 was the only care plan conference noted in Resident #35's medical record. Regional MDS Nurse/ RN #567 also verified Resident #35 was long-term care, and the care plan dated 08/26/24 stated Resident #35 was to be discharged home. Review of the undated facility policy titled; Care Plan and Advanced Care Plan Process revealed the interdisciplinary team along with the resident will meet and review the care plan. Meetings take place upon admission with initial care conference, seven days after the closure date of the initial MDS assessment, every month for the first three months, quarterly, annually, and within 14 days after significant change status.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on record review, interview, and review of the facility policy, the facility failed to provide oral care for Resident #194, who had hemiplegia and hemiparesis affecting the right dominant side and required supervision or touching assistance for oral hygiene. This affected one resident (#194) of one resident reviewed for activities of daily living (ADL) care and had the potential to affect all residents except seven residents (#4, #10, #12, #23, #32, #33, and #36) identified by the facility as independent with oral care. The facility census was 50. Findings include: Review of the medical record for Resident #194 revealed an admitted [DATE] with diagnoses including cerebral infarction with hemiplegia and hemiparesis affecting the right dominant side, need for assistance with personal care, and ulcerative colitis. Resident #194 had a physician's order to provide oral care every shift. Review of the care plan dated 10/08/24 revealed Resident #194 required assistance with ADL care related to hemiplegia to the right side. Interventions included providing assistance as needed with daily hygiene. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #194 was cognitively intact and required supervision or touching assistance for oral hygiene. On 10/15/24 at 10:00 A.M. an observation of Resident #194 revealed teeth with a buildup of food and plaque. Resident #194 was also noted to have poor dentition with several missing teeth noted. On 10/16/24 at 12:00 P.M. an observation of Resident #194 again revealed teeth with food buildup and plaque. An interview with Resident #194 at the time of the observation revealed no one has brushed her teeth since admission. On 10/21/24 at 10:00 A.M. an observation of Resident #194 again revealed teeth with food buildup and plaque. An interview with Resident #194 and her mom at the time of the observation revealed no one has brushed her teeth since admission. Resident #194's mother searched the nightstand, and there were no supplies for oral care. An observation of the bathroom for Resident #194 revealed no supplies for oral care. Resident #194 and her mother verified the lack of supplies for oral care within Resident #194's room. On 10/21/24 at 10:30 A.M. the Director of Nursing (DON) was informed the Resident #194 stated she had not received oral care since admission on 10/08/24 of the lack of oral care supplies for Resident #194. The DON stated she would get her a toothbrush. Review of the undated policy titled; Personal Care/Bathing revealed residents will receive personal care in the facility according to the resident's plan of care to promote dignity, cleanliness, and general well-being. The policy also stated nailcare, oral care, and shaving are also offered during routine personal care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on observation, interview and review of facility documents and policy, the facility failed to provide therapeutic activities as scheduled and on weekends and evenings to meet the needs and preferences of the resident population. This had the potential to affect all 50 residents in the facility. The facility census was 50. Findings include: Review of the facility activity calendars dated October and September 2024 for the Secured Unit A revealed no activities were scheduled after 3:00 P.M. for the month of October. Review of the September 2024 Activity Calendar for Secure Unit A revealed no activities were scheduled past 4:00 P.M. Review of the October 2024 Unit B/C activity calendar revealed no activities were scheduled after 3:00 P.M. each day except for each Wednesday an activity was scheduled for 5:00 P.M. Review of the activity department staffing schedules for September 2024 and October 2024 which listed former Activities Director (AD) #801, former Activities Aid (AA) #800 and AA #536 as the staff for the department revealed no activity aid was scheduled in the building on Saturday 09/21/24, Thursday 09/26/24, Friday 09/27/24, Saturday 09/28/24, Sunday 09/29/24, Monday 09/30/24, Tuesday 10/01/24, Wednesday 10/02/24, Friday 10/04/24, Saturday 10/05/24, Sunday 10/06/24, Monday 10/07/24, Wednesday 10/08/24, Friday 10/11/24, Saturday 10/12/24, Sunday 10/13/24. Review of the facility job description for the Activity Director revealed they must be a qualified therapeutic recreation specialist or an activities professional who was licensed by this state and was eligible for certification as recreation specialist or as an activity professional. Review of the personnel file for the former AD #801 revealed a date of hire of 05/16/23 as the Activities Director and last day worked was 09/16/24. No certification from the Activity Directors Network was available in the file. Review of the personnel file for the former AA #800 revealed a hire date of 07/25/24 and last day worked was 09/25/24. Review of Behavioral Health Service Agreement dated September 19, 2024 revealed [NAME] Counseling and Recovery was to provide behavioral health and support services. [NAME] Health Services was to provide services Monday to Friday from 9:00 A.M. to 5:00 P.M. each day. There was no evidence in the agreement that BHS was responsible to ensure activities were provided to the residents in the facility. Interview on 10/15/24 at 9:36 A.M. with Resident #18 revealed she had not participated in activities because she felt there was no activities department. Resident #18 stated no activities came to visit her. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 10/16/24 at 2:31 P.M. with the Director of Nursing (DON) revealed there was no Activity Director for the past month. The facility was utilizing the [NAME] Counseling social worker and two counselors. The facility currently had one activity aid employee. The DON verified no activity department staff were scheduled on Saturday 09/21/24, Thursday 09/26/24, Friday 09/27/24, Saturday 09/28/24, Sunday 09/29/24, Monday 09/30/24, Tuesday 10/01/24, Wednesday 10/02/24, Friday 10/04/24, Saturday 10/05/24, Sunday 10/06/24, Monday 10/07/24, Wednesday 10/08/24, Friday 10/11/24, Saturday 10/12/24, Sunday 10/13/24. Interview on 10/16/24 at 3:19 P.M. with the Assistant Director of Nursing #501 verified no activities were planned after 3:00 P.M. for the Secure Unit A for the month of October 2024 and the facility did not assign a State tested Nurse Aid over the weekends when the facility Activities Aid was not in the building. Interview on 10/16/24 at 3:57 P.M. with [NAME] counseling Case Manager #566 revealed [NAME] Counseling was in the facility to do one on one counseling with Medicaid and Medicare residents only. No counselors were certified in Activities. No Case Manager from [NAME] Counseling came in on the weekend or worked past 4:00 P.M. Case Manager #566 also stated because the Activities Director and an Activities Aid quit this past month [NAME] Counseling had helped incorporate activities into counseling sessions, but [NAME] Counseling was not the activities department. Case Manager # 566 stated the [NAME] Counseling social worker made the October 2024 Activities Calendar. The facility had one activity aid who worked every other weekend and nursing staff was to provide activities on the weekends the activities aid was not on site. Interview on 10/16/24 at 4:00 P.M. with Resident #33 revealed there was not always activities on the weekends, so the residents have to entertain themselves. Resident #33 also stated it gets boring after 5:00 P. M. because there were no activities. Observation on 10/17/24 at 9:10 A,M. of the Secure Unit A activities room revealed Current Events was scheduled on the activities calendar at 9:00 A.M. on 10/17/24. No staff were in the Secure Unit A activities room and one resident was present but sleeping in the activities room. The Administrator verified at the time of the observation that no staff was engaged with residents at that time. Observation on 10/17/24 at 9:24 A.M. of the B/C Activities room revealed no staff was engaged with residents in the activities room. One resident was sitting in front of the television watching a sitcom. Review of the Activities Calendar for 10/17/24 at 9:00 A.M. an activity was planned for Current Events and coffee. No coffee was available in the activities room. The Administrator verified at the time of the observation that no coffee was in the activities room and no staff was engaged with residents for current events. Observation on 10/17/24 at 10:10 A.M. of the Secure Unit A activities room revealed staff were not engaged with residents during the planned game activity at 10:00 A.M. listed on the October 2024 activities calendar. Residents were scheduled to play a card game. STNA #507 verified there was one aid on the secure unit therefore the aid could not engage in activities at that time. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 10/17/24 at 10:10 A.M. with State tested Nurse Aid (STNA) #507 revealed STNAs can help with activities on the secure unit if two STNAs were scheduled. If one STNA was scheduled it was difficult to provide the planned activities so activities were not always provided to those residents. STNA #507 revealed the facility did not provide drums for the planned activity titled Drumming to Music for the Secure Unit A activity on 10/21/24 at 10:00 A.M. so the activity was unable to be implemented for the residents. STNA #507 also stated the secure unit did not have an activity aid since the aids stay on the B/C unit's activities room. Observation on 10/17/24 at 10:13 A.M. revealed the cativities room B/C had three residents watching television. All residents were poor historians. Review of the B/C activities calendar revealed relaxation exercises were planned on 10/17/24 at 10:00 A.M. There were no staff conducting relaxation exercises with any of the residents. STNA #507 verified the findings. Interview on 10/21/24 at 10:00 A.M. with [NAME] Counseling Licensed Social Worker (CLSW) #565 revealed [NAME] Counseling Services was not the activities department but were willing to provide activities to the residents. CLSW #565 verified they did not hold certification as a qualified Activity Director. Observation on 10/21/24 at 10:22 A.M. of the activity room for the Secure Unit A revealed four residents sitting in the activity room with the television on. One STNA was in the room playing music on her iPhone. Review of the activity calendar dated October 21, 2024 at 10:00 A.M. indicated an activity was scheduled titled Drumming to Music. Review of the facility policy titled Activity Programming, undated, revealed the Activities Director shall plan and organize a program of activities for residents on a group level and for individuals to meet the resident's interests and preferences. If a particular service or activity was canceled or changed it would be reported to the activity director to assure that proper notification or other personnel and department can be made. The resident should be notified of the change in the schedule and alternatives should be offered. Review of the facility policy titled Activity Programming Secure Unit , revised May 2022, revealed a therapeutic plan of care would be developed to meet the resident's needs and interests and provide social interaction and at the same time protect the resident from environmental over-stimulation. Participation in therapeutic activities would improve self-esteem, self confidence and quality of life.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on record review, interview and review of facility policy, the facility did not ensure a qualified activity director was overseeing the activity department to ensure therapeutic activities were being provided to the residents. This affected all 50 residents living in the facility. The facility census was 50. Findings include: Review of the facility job description for the Activity Director (AD) revealed they must be a qualified therapeutic recreation specialist or an activities professional who was licensed by the state and was eligible for certification as recreation specialist or as an activity professional. Review of the personnel file for the former AD #801 revealed a date of hire of 05/16/23 as the Activities Director and last day worked was 09/16/24. No certification from the Activity Directors Network was available in the file. Interview on 10/16/24 at 2:31 P.M. with the Director of Nursing (DON) revealed there was no Activity Director for the past month. The facility was utilizing the [NAME] Counseling social worker and two counselors to provide activities in the facility. The DON confirmed the facility currently had only one activity aid employed in the activity department. Review of the Behavioral Health Service (BHS) Agreement dated September 19, 2024, revealed [NAME] Counseling and Recovery was to provide behavioral health and support services Monday to Friday from 9:00 A.M. to 5:00 P.M. each day. There was no evidence in the agreement that BHS was responsible to ensure activities were provided to the residents in the facility. Interview on 10/16/24 at 3:57 P.M. with [NAME] counseling Case Manager #566 revealed [NAME] Counseling was in the facility to do one on one counseling with Medicaid and Medicare residents only. No counselors were certified in Activities. No case manager from [NAME] Counseling came in on the weekend or worked past 4:00 P.M. Case Manager #566 also stated because the Activities Director and an Activities Aid quit this past month [NAME] Counseling had helped incorporate activities into counseling sessions, but [NAME] Counseling was not the activities department. Case Manager # 566 stated the [NAME] Counseling social worker made the October 2024 Activities Calendar. The facility had one activity aid who worked every other weekend and nursing staff was to provide activities the weekend the activities aid was not on site. Interview on 10/21/24 at 10:00 A.M. with [NAME] Counseling Licensed Social Worker (CLSW) #565 revealed [NAME] Counseling Services was not the activities department but they were willing to do activities with the residents. CLSW #565 verified they did not hold certification as a qualified Activity Director. Review of facility policy titled Activity Programming, undated, revealed The Activities Director shall plan and organize a program of activities for residents on a group level and for individuals to meet the resident's interests and preferences.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, observation, record review and review of facility policy the facility did not ensure weights were timely completed or re-weights were conducted regarding possible inaccurate weights. This affected three Residents (#15, #31 and #195) out of four residents reviewed for nutrition. The facility census was 50. Findings included: 1. Review of the medical record for Resident #15 revealed an admitted [DATE] and diagnoses included Post Traumatic Stress Disorder (PTSD), bipolar disorder, major depression with severe psychotic symptoms and hypertension. Review of weight records revealed on 07/30/24 (admission) his weight was 160.2 pounds, on 08/15/24 his weight was 158.2 pounds, and on 10/08/24 his weight was 1722.0 pounds. There was no September 2024 weight. Review of theNutritional Evaluation dated 08/05/24 and completed by Dietary Tech #600 revealed Resident #15 was on a regular diet and his oral intakes were good as he averaged between 76 to 100 percent of his meals. The assessment revealed he was at risk of malnutrition due to chronic disease and will continue to monitor. Review of care plan dated 08/05/24 revealed Resident #15 had the potential for alteration in nutrition due to bipolar disorder, and dementia. Interventions included diet as ordered, weights as ordered, dietician referral as needed, and honor food preferences as able. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #15 had intact cognition. He ate independently and his weight was 161 pounds with no documented weight loss. Review of October 2024 physician orders revealed Resident #15 was on a regular diet. Interview on 10/15/24 at 9:12 A.M. with Resident #15 revealed if his tray was served last from the cart, his food was often cold which happened quite a bit. He revealed the food was just not very nourishing and he questioned, have you ever had to eat cold food? Resident #15 stated because the hot food was often served cold to him the food was not good. Observations on 10/16/24 at 8:28 A.M., 10/16/24 at 12:04 P.M., 10/16/24 2:42 P.M., and 10/17/24 at 8:31 A. M. revealed Resident #15 was observed pacing from one exit door to the other exit door back and forth walking at a brisk, fast pace. During the survey he received his diet as ordered and had no complaints. Interview on 10/16/24 at 9:40 A.M. with Former Dietician #562 revealed she was the dietician at the facility for the last four years until 08/31/24. She verified all residents were to be weighed monthly unless otherwise specified in the physician orders. She was not aware who oversaw the dietician services after her. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/16/24 at 10:40 A.M. with Dietician #563 revealed she began nutritional oversight at the facility on 09/23/24. She verified there was no documentation that a weight for Resident #15 was completed for September 2024. She verified his weight placed into the electronic medical record was recorded as 1722 for 10/08/24 and that the weight was inaccurate. She verified staff should have reweighed Resident #15 and at this time she did not have an accurate weight, so she was unsure if his weight was stable. She also verified all weights were to be completed at least monthly unless the physician order directed them to weigh more often. Interview on 10/16/24 at 12:56 P.M. with [NAME] President of Dietician Consulting Company #571 revealed the facility had a contract with them to provide dietician oversight. She revealed Former Dietician #562's last day at the facility was 08/31/24. She revealed from 08/31/24 until 09/23/24 Dietician #601 provided Dietician oversight remotely until Dietician #563 started at the facility on 09/23/24. Interview on 10/16/24 at 2:02 P.M. with the Director of Nursing verified Resident #15's weight was not completed in September 2024. She verified the last weight the facility had per the electronic medical record was on 10/08/24 and was recorded as 1722 pounds which was not accurate. She verified the last accurate weight they had completed was on 08/15/24 and his weight was 158.2 pounds. 2. Review of thr medical record for Resident #31 revealed an admitted [DATE] and diagnoses included obstructive pulmonary disease with exacerbation, acute respiratory failure with hypoxia, seizure disorder, dementia, and schizophrenia. Review of weight records revealed on admission Resident #31's weight on 10/16/23 (admission) was 221 pounds, on 06/03/24 his weight was 218 pounds, 08/15/24 his weight was 222 pounds, and on 10/08/24 his weight was 146.8 pounds indicating a 33.87 percent weight loss. There was no record of a weight being completed for the months of July 2024 and September 2024. Review of care plan dated 04/29/24 revealed Resident #31 had an alteration in nutrition and hydration due to dysphagia. The care plan indicated he had a significant weight loss during his stay at the facility. Interventions included diet as ordered, weights as ordered, dietician referral as needed, and honor food preferences as able. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #31 had intact cognition. He ate independently and had no weight loss. Review of the Nutritional Evaluation dated 07/31/24 completed by Former Dietician #562 revealed Resident #31 was on a double portion regular diet. She revealed his oral intakes were good as he averaged 76 percent to 100 percent of each meal. She had no new recommendations at the time of the assessment. Review of the October 2024 physician orders revealed Resident #31 had an order for a regular diet with double portions. He was to receive a house juice supplement every morning. Interview and observation on 10/15/24 at 9:33 A.M. with Resident #31 revealed he felt he had not had a weight loss. Observations on 10/16/24 at 8:29 A.M., 10/16/24 at 12:05 P.M., and 10/17/24 at 8:30 A.M. revealed he received his diet as ordered and had a good appetite. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/16/24 at 9:40 A.M. with Former Dietician #562 revealed she was the dietician at the facility for the last four years until 08/31/24. She verified all residents were to be weighed monthly unless otherwise specified in the physician orders. She was not aware who oversaw the dietician services after her. Interview on 10/16/24 at 10:40 A.M. with Dietician #563 revealed she began dietician oversight at the facility on 09/23/24. She verified per the medical record that Resident #31's weight was not completed for the months of July 2024 and September 2024. She verified on 08/15/22 Resident #31's weight was 222 and the last recorded weight was on 10/08/24 indicating his weight was 146.6 pounds (33.87 percent weight loss). She verified the weight completed on 10/08/24 was most likely inaccurate and staff should have reweighed Resident #31. She revealed at this time she did not have an accurate weight, so was unsure if his weight was stable. She also verified all weights were to be completed at least monthly unless the physician order directed them to weigh more often. Interview on 10/16/24 at 12:56 P.M. with [NAME] President of Dietician Consulting Company #571 revealed the facility had a contract with them to provide dietician oversight. She revealed Former Dietician #562's last day at the facility was 08/31/24. She revealed from 08/31/24 till 09/23/24 Dietician #601 provided Dietician oversight remotely until Dietician #563 started at the facility on 09/23/24. Interview on 10/16/24 at 2:02 P.M. with the Director of Nursing verified Resident #31's weight was not completed for July 2024 or September 2024. She verified on August 2024 Resident #31's weight was 222 and the last weight they had per his medical record was completed on 10/08/24 and was 146.6 pounds indicating a significant weight loss. She verified the staff should have had a re-weight completed. Review of undated facility policy labeled, Weight Policy and Procedure revealed weights would be obtained at least monthly to identify those residents who may be at nutritional risk and require further evaluation and monitoring. The policy revealed all monthly weights would be completed by the tenth of every month and any weight variance of three-pound increase or decrease in one month must be reweighed within 24 hours. The policy revealed all weights, and re-weights would be recorded. 48565 3. A review of medical records for Resident #195 revealed an admitted [DATE]. Significant diagnoses included mixed simple and mucopurulent chronic bronchitis and heart failure. Significant orders included bumex (a water pill for fluid retention) 0.5 milligrams, give one tablet by mouth in the morning for fluid retention for seven days dated 10/07/24 and weekly weights times four weeks then monthly. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #195 was cognitively intact. A review of weights revealed on 10/02/24 Resident #195 weighed 174.5 pounds. On 10/03/24 Resident #195 weighed 201.6 pounds. There was no reweigh noted. On 10/08/24 Resident #195 weighed 187.0 pounds. There was no reweigh noted. On 10/15/24 Resident #195 weighed 185 pounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the dietary assessment note dated10/07/24 revealed on 10/03/24 Resident #195 weighed 201.6 by standing scale. The assessment also revealed this was a gain of five percent or more in the last month without being on a weight gain regimen. There was a hospital weight of 145 pounds noted within the assessment. Resident #195 was noted to have three plus pitting edema (swelling) which may have contributed to the weight gain. The note stated there was a significant weight gain since admission. There was a request for additional weights for a baseline. Review of the physician note dated 10/08/24 revealed Resident #195 developed edema to the bilateral lower extremities related to receiving intravenous fluids in the hospital. Edema was noted to the bilateral lower extremities on examination. Review of the care plan dated 10/01/24 revealed Resident #195 was at risk for alterations in nutrition and to expect weight fluctuations related to edema. Additional weights requested on 10/07/24. Interventions included to obtain weights as ordered. On 10/15/24 at 9:52 A.M. an observation of Resident #195 revealed the resident to be sitting in a wheelchair with legs down and feet touching the floor. The bilateral lower extremities were noted to be swollen. An interview with Resident #195 at the time of the observation revealed her legs were painful due to swelling. On 10/16/24 at 2:00 P.M. an interview with the Director of Nursing (DON) revealed recommendations for weights were communicated in risk meetings weekly. A review of the policy titled; Weight Policy and Procedure that was undated revealed all new admissions will be weighed weekly for four weeks after admission. The policy also stated any weight variance (increase or decrease) of 3 pounds in one week or three pounds in one month must be re-weighed within 24 hours.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, interview, record review and review of facility policy, the facility failed to ensure Resident #15 received culturally competent trauma-informed care including the identification of triggers, and interventions to assist with the management to eliminate or mitigate re-traumatization of the resident. This affected one resident (#15) out of two residents reviewed for Post Traumatic Stress Disorder (PTSD). The facility census was 50. Findings include: Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including PTSD, bipolar disorder, major depression with severe psychotic symptoms, and hypertension. Review of Admission Packet- V12 dated 07/30/24 revealed under trauma, Resident #15 was asked if he experienced trauma in his life, and he answered yes. The assessment asked if he had any triggers that reminded him of the trauma, and he answered yes. In the additional comments section, it had listed PTSD/ Vietnam war. Review of the undated comprehensive care plan revealed Resident #15 did not have a care plan regarding PTSD including the identification of triggers and/or interventions to assist in the management of triggers. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had intact cognition. He displayed verbal behaviors one to three days during the seven-day assessment period. He also displayed rejection of care and wandering behaviors. Review of the Psychiatric Nurse Practitioner (NP) #573's progress note dated 08/06/24 revealed Resident #15 served in war (Vietnam) for 43 months and had been diagnosed with 100 percent disabled from PTSD. Resident #15 had a history of psychiatric hospital inpatient stays and one time when he was in the hospital, Resident #15 expressed that a family member overdosed. Resident #15 also described an incident at a campground where a group of people were playing loud music, and he confronted the group resulting in the police department being involved. Resident #15 expressed frustration and that he felt out of control. The progress note revealed Resident #15 exhibited rapid, tangential speech and frequently changed topics. He demonstrated frustration and difficulty maintaining focus on the conversation. He presented behaviors and speech patterns consistent with manic symptoms. The progress note included under PTSD to continue doxepin 25 milligram (mg) (antidepressant) at bedtime for sleep and anxiety and assess for potential trauma focused therapy options. Psychiatric NP #573 also recommended a stable environment, and manage stress which was crucial for Resident #15's mental health. He recommended engaging in activities that Resident #15 would find fulfilling and relaxing. Review of Psychiatric NP #573's progress note dated 09/16/24 revealed Resident #15 was very agitated, confused, difficult to redirect, and delusional. He had multiple psychiatric diagnoses including bipolar disorder, anxiety, and PTSD. Psychiatric NP #573 recommended continuing current medications, explained the risks and benefits of each treatment option. Resident #15 verbalized understanding of the treatment plan. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/15/24 at 9:12 A.M. with Resident #15 revealed he had mental issues as he was a veteran, and he had been at multiple psychiatric places all his life. He revealed he felt he had to provide several of the residents at the facility with their care as the staff just did not do their job. He revealed this morning, 10/15/24, they served syrup with the pancakes, so he had to assist a resident in cleaning the sticky syrup off his hands as staff just picked up his tray without cleaning his hands. Observation on 10/15/24 at 9:16 A.M. revealed Resident #15 came out of his room after the interview and began yelling at Resident #149 who was walking by his room for no apparent reason. Resident #15 stated in a very loud threatening tone he was going to knock Resident #149 out. Resident #15 then proceeded to walk away and start pacing in the hallway from one exit door to another. Observations on 10/16/24 at 8:28 A.M., 10/16/24 at 12:04 P.M., 10/16/24 2:42 P.M., 10/17/24 at 8:31 A.M. revealed Resident #15 was observed pacing from one exit door to the other exit door back and forth walking at a brisk fast pace. Interview on 10/16/24 at 11:53 A.M. with the Director of Nursing (DON) verified Resident #15 did not have a care plan that included the identification of his triggers and/or interventions to assist in the management of PTSD. She was not sure of Resident #15's triggers but revealed Resident#15's son stated at the campground a group of people were playing loud music and driving their car fast through the campground which resulted in an altercation and the police being called. Resident #15 was transported to a psychiatric hospital. If she had to guess through talking with Resident#15 and Resident #15's son, his triggers would include loud music, parties, and individuals that were rule breakers. She also verified the admission trauma assessment revealed Resident #15 experienced trauma in his life and continued to have triggers that reminded him of the trauma especially as he was in the Vietnam war. The DON verified she had no documented evidence that staff were educated on his PTSD, potential triggers, and how they should manage his PTSD through interventions. Interview on 10/16/24 at 12:36 P.M. with Registered Nurse (RN) Regional MDS #567 revealed the former MDS nurse, Licensed Practical Nurse (LPN)/MDS #572, was no longer employed as of 24 hours ago. She was unsure why Resident #15 did not have a care plan that identified his PTSD triggers and how to manage through interventions but verified that he should have had a care plan. Interview on 10/16/24 at 2:43 P.M. with State tested Nursing Assistant (STNA) #557 revealed she worked the secured unit She was not aware Resident #15 had PTSD and/or if he had any triggers, except that he was in the war from her conversations with him and was unsure if that played a role in some of his behaviors as at times. Resident #15 would get anxious and become verbal with staff and residents. She was asked if she knew where she could look up any information regarding Resident #15's PTSD and what triggers he may have, and she stated she was not aware of any information and that she had not received any training regarding PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy labeled; Trauma Informed Care dated October 2022 revealed the facility recognized that residents have had past experiences that have resulted in trauma. Veterans, victims of sexual physical and mental abuse, and crime survivors may be more likely to have trauma and need trauma informed care. The facilities goal was to provide services that were supportive of trauma related experiences to avoid reoccurrence of re-traumatization. Facility staff would be educated upon hire, annually and as needed regarding trauma informed care, precipitating triggers, and approaches to prevent re- traumatization. The facility would assess the resident for potential trauma upon admission quarterly and with significant change. The policy revealed any identified triggers would be documented and care planned. The facility would develop a care plan that addressed triggers and what interventions should be attempted. The policy revealed the facility staff would provide trauma informed care according to the established care plan and document behaviors accordingly.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 39973 Based on interview and record review the facility did not ensure each state tested nurse aide (STNA) received no less than twelve hours of annual in-service education. This had potential to affect all residents in the facility. The facility census was 50. Findings included: Review of personnel file for STNA #551 revealed her hire date was 02/02/22 and her training record in her file labeled, Course Status Report with Totals printed on 10/16/24 revealed STNA #551 had completed one training on 06/04/24 that was on corporate compliance. The training did not include how long the training was as at the bottom of the report it revealed STNA #551 had zero hours of training out of 20.83 assigned. The training record revealed she was assigned a variety of trainings including abuse, dementia care, infection control, fall management, fire safety, resident rights, and elopement prevention but these training were marked on the sheet as not attempted. Interview on 10/17/24 at 12:37 P.M. with Human Resource Manager #525 verified STNA #551 had not completed the required annual training and the corporate compliance training she believed was approximately one hour in length at the most. She verified there was only one hour of training that she had documentation for STNA #551 of completing. She stated, I assign the training, but I cannot make them do it as she pointed to the report sheet that had a variety of trainings assigned but STNA #551 had not completed. HR Manager #525 did not have a policy regarding in-service training for STNA's.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, record review and review of facility policy the facility did not ensure an Abnormal Involuntary Movement Scale (AIMS) test (a rating scale used by clinicians to assess the severity of abnormal movements in patients taking antipsychotic medications) was completed for Resident #15 and appropriate diagnosis and lab monitoring for Resident's #19's Depakote use. This affected two residents (15 and #19) out of five residents reviewed for unnecessary medications. The facility census was 50. Findings included: 1. Review of the medical record for Resident #15 revealed an admitted [DATE] and diagnoses included Post Traumatic Stress Disorder (PTSD), bipolar disorder, major depression with severe psychotic symptoms and hypertension. Review of medical record revealed no AIMS test was completed for Resident #15. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #15 had intact cognition. He displayed verbal behaviors one to three days during the assessment period. He also displayed rejection of care and wandering behaviors. He was on an anti-psychotic medication. Review of the care plan dated 08/13/24 revealed Resident #15 received anti-psychotic medications. Interventions included administering medications as ordered, monitor for potential side effects, obtain and monitor labs and diagnostics as ordered. Review of the care plan dated 08/13/24 revealed Resident #15 received psychoactive medications due to anxiety, depression, and persistent anger towards others. Interventions included AIMS test per policy, discuss feelings of anger and options of appropriate channeling of these feelings and offer suggestions for coping. Review of October 2024 physician orders revealed Resident #15 had an order dated from admission 7/30/24 for Olanzapine 2.5 milligram (mg) give one tablet by mouth two times a day related to severe psychotic symptoms and Resident #15 continued this medication. Interview on 10/16/24 at 11:53 A.M. with the Director of Nursing revealed Resident #15 received Olanzapine which was an anti-psychotic medication since admission 07/30/24. She verified an AIMS had not been completed to monitor for any adverse side effects of the medication. Review of undated facility policy labeled; Psychotropic Drug Use revealed qualified staff would monitor the resident for potential undesirable adverse effects that were associated with the use of psychotropic drugs. The policy revealed upon initiation of psychotropic medications and at minimum every six months utilizing the AIMS as well as monitoring for other adverse effects. Review of website labeled, Drugs.com last updated 01/30/24 revealed olanzapine had the potential for serious side effects including change in walking and balance, difficulty swallowing, muscle trembling, jerking or stiffness, shuffling walk, slowed movement and uncontrolled movements especially of the face, neck and back. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48565 2. A review of medical records for Resident #19 revealed an admitted [DATE] with diagnoses including dementia in other diseases classified elsewhere unspecified severity with other behavioral disturbances, adult failure to thrive and other signs and symptoms involving cognitive function. Physician orders included Depakote sprinkles oral capsule delayed releases 125 milligrams (mg), give 125 mg two times daily for behaviors and 250 mg daily at bedtime for behaviors. There were no orders for depakote levels to be drawn. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #19 had a moderate cognitive deficit. The MDS also revealed verbal behaviors occurring one to three days in the seven day look back period. Review of the care plan dated 09/01/24 revealed Resident #19 had a behavior problem related to profanity, refusals of care and yelling out. Interventions included administer medication as ordered and monitor for effectiveness of medication and potential side effects. The depakote and depakote monitoring was not care planned. A review of labs from 01/15/24 to current revealed no levels for Depakote were drawn. A review of a psychiatric note dated 05/16/23 revealed Resident #19 was being seen for a psychiatric evaluation and medication management. Resident #19 was to continue current medications, continue the current plan of care and medication reduction would worsen condition. Resident #19 was to have a follow up in one month. A review of the consultant pharmacist medication regimen review dated 08/23/24 revealed Resident #19 has had an order for depakote sprinkles 125 mg two times daily and 250 mg at bedtime. The consultant pharmacist stated to continue the current dose. On 10/16/24 at 5:06 P.M. an interview with the Director of Nursing (DON) revealed no depakote levels have been drawn for Resident #19. The DON also verified the psychiatric note dated 05/16/23 was the last psychiatric note for Resident #19. A review of the policy titled; Psychtropic Drug Use ,undated, revealed under the section unnecessary drugs that each resident must have a drug regimen free of unnecessary drugs/medications. By definition, an unnecessary drug is any medication that is used in excessive doses or duplicate therapy, for excessive duration, without proper monitoring, without indications for use, in the presence of potential adverse consequences that may indicate that the medication should be discontinued, or the dose should be decreased, or any combination of the listed reasons.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 47570 Based on record review and interview the facility did not ensure the dietary manager was qualified to oversee dietary service operations. This had the potential to affect all 50 residents receiving meals from the kitchen, as the facility did not identify any residents who did not eat by mouth (NPO). The facility census was 50. Findings include: Review of Dietary Manager (DM) #511's employee file revealed no formal certified dietary manager training nor certificate of completion for the SERV Safe course. Interview on 10/16/24 at 11:32 A.M. with DM #511 revealed there was not a full-time dietitian in the facility. A company called Dietary Solution provided the menu but no kitchen oversight. DM #511 stated she had not passed the SERV Safe exam and was not certified as a dietary manager. DM #511 stated she was a cook for the facility starting January 2024 then was promoted in May 2024 to the DM position and had no additional formal training to qualify as the DM. Interview on 10/21/24 at 8:42 A.M. with Dietary Solution [NAME] President of Operations #571 confirmed a registered dietitian was not on site full-time. A dietitian was scheduled to be on site in the facility one day a week for six hours and two hours remote access during which time they were working clinically and not overseeing the kitchen. Interview on 10/21/24 at 2:01 P.M. with the Administrator confirmed DM #511 did not meet the required qualifications for the position of DM,was not a certified dietary manager but was working on it.

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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. 47570 Based on observation, interview and policy review, the facility failed to ensure palatable food was served to the residents. This had the potential to effect 50 residents who received a meals from the facility kitchen. The facility identified there were no residents who did not eat by mouth (NPO). The facility census was 50. Findings include: Interview on 10/15/24 at 9:12 A.M. with Resident #15 revealed if his tray was served last from the cart, his food was often cold which happened quite a bit. He revealed the food was just not very nourishing and he questioned, have you ever had to eat cold food? Resident #15 stated because the hot food was often served cold to him the food was not good. Interview on 10/15/24 at 11:43 A.M. Resident #196 stated the food did not taste good and the food was cold. Resident #196 had his family bring in outside food because he did not like the quality of the facility food. An observation was conducted on 10/16/24 from 11:43 A.M. to 12:51 P.M. with Dietary Manager (DM) #511 of the lunch tray line and a test tray. The lunch menu consisted of sauce with meatballs, rigatoni pasta, Italian blend vegetables, wheat bread, cake, coffee or tea. A test tray was requested, and tray line started at 11:30 A.M. The starting food temperatures consisted of 182 degrees Fahrenheit (F) for the meatballs with sauce, 177 degrees F for the Italian vegetables, 186 degrees F for the rigatoni pasta, 34 degrees F for the milk, 186 degrees F for the carrots and 198 degrees F for the coffee. At 12:30 P.M. the test tray was placed on the 200-wing cart to be transported out of the kitchen to the 200 hall. At 12:35 P.M. the test tray reached the 200 hall for staff to pass trays. At 12:51 P.M. all trays were passed, and test tray temperatures were obtained by DM #511 using the facility calibrated thermometer and consisted of carrots 114 degrees F, meatballs in sauce was 121 degrees F, rigatoni noodles were 112 degrees F, coffee was 144 degrees F and milk was 40 degrees F. The food was tasted, and the meatballs with rigatoni were lukewarm and the cooked carrots were hard. DM #511 verified the temperatures of the the carrots, meatballs and noodles were not hot or palatable at those temperatures. Interview on 10/21/24 at 8:39 A.M. Resident #26 stated the food was not good and hot foods were served cold. Interview on 10/21/24 at 8:39 A.M. with Registered Nurse #554 revealed the residents tended to complain about hot foods being served cold to them. Review of facility document titled Temperatures for food safety dated 2013 Federal Food Code, revealed food danger zone temperature to promote rapid bacteria growth zone was 41 Degrees Fahrenheit to 135 Degrees Fahrenheit. The facility did not provide a policy related to palatability of food.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48565 Based on observation, interview and policy review, the facility did not ensure food was stored in a manner to prevent contamination and/or food borne illness. The facility also did not ensure the kitchen was maintained in a sanitary manner. This had the potential to affect 50 residents. There were no residents identified by the facility as eating nothing by mouth (NPO). The facility census was 50. Findings include: On 10/15/24 at 8:32 A.M. an initial tour of the kitchen revealed dried noodles and chicken sitting the empty wash bay of the three bay sink. Dietary manager (DM) #511 verified the dried noodles and chicken in this sink at the time of the observation. DM #511 stated the sink was to be cleaned every night and as needed. The initial tour also revealed noodles and white beans in the drain of the dishwasher. DM #511 verified the noodles and white beans in the dishwasher drain. Observation of the dry storage area revealed a dented 113 ounce can of Fancy Midwest Chili Sauce and a dented six-pound 11 ounce can of Manwich. There was a 10-pound bag of pancake mix opened and undated. There was a case of bananas sitting directly on the floor. There was a small plastic three drawer bin located below the preparation counter that contained one pie server, three spatulas and one icing knife in the top drawer. The top drawer had visible dirt in it. The walk-in refrigerator contained a piece of cake on the top shelf that was unwrapped. The walk-in freezer had buildup ice on the floor and icicles hanging from the fan. There was a small white plastic container located under the preparation counter that contained flour. There was a scoop noted in the flour bin. DM #511 verified the findings at the time of the observations. DM #511 was asked to wipe the ice machine where ice was distributed from. A black substance was noted on the paper towel after the ice distribution area was wiped by DM #511. This occurred after wiping the ice distribution area two times. DM #511 verified the black substance on the paper towels. On 10/16/24 at 11:30 A.M. a return observation of the kitchen revealed the freezer contained garlic bread slices and a bag of mini meatballs that were opened, undated and unlabeled. DM #511 verified the garlic bread and the mini meatballs as being opened and unlabeled at the time of the observation. The dry storage area contained a 50-pound bag of rice. The bag of rice was opened and unlabeled. DM #511 verified the rice was opened and unlabeled. A review of the policy titled; Food Storage dated 2023 revealed in point nine, scoops must be provided for bulk foods such as sugar, flour and spices. Scoops should be kept covered in a protected area near the containers rather than in the containers. Point 10 revealed food should be stored a minimum of six inches above the floor. Point 12 revealed leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the policy titled; Food Safety and Sanitation' dated 2023 revealed the purpose was to assure a safe and sanitary food and nutrition service department. In section three subpoint e the policy stated, bulging or leaking cans and cans with severe dents should not be used. In section four, bullet point four the policy stated, All time and temperature control for safety foods including leftovers should be labeled, covered and dated when stored. In section four bullet point 8 the policy stated, Food stored in dry storage will be placed on clean racks at least six inches above the floor. In point four, bullet point nine the policy revealed when a food package is opened the food item should be marked to indicate the open date.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on record review, review of the administrator job description and interview the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident which included failure to ensure the Quality Assurance Performance Improvement (QAPI) committee meetings were held to include the medical director or designee and evidence of meetings as required were maintained, failure to ensure a qualified director of activities was employed in the facility and failure to ensure a therapeutic activities program was being developed and implemented for the residents. This had the potential to affect all 50 residents residing in the facility. Findings include: Review of the job description for the facility Administrator, signed on 04/01/24 by the Administrator, revealed the primary purpose of the Administrator was to direct the day-to-day functions of the facility in accordance with state, federal and local standards, guidelines and regulations that govern nursing facilities to ensure the highest degree of quality of care to the residents at all times. The essential duties and responsibilities included plan, develop, implement, evaluate and direct the facilities programs and activities in accordance with guidelines issued by the governing board, develop and maintain written policies and procedures and professional standards of practice that govern the operations in the facility. Interview with the Administrator was conducted on 10/21/24 at 1:57 P.M. and revealed the Administrator had assumed the position of Administrator in April 2024. During the onsite investigation, the following concerns were identified related to a lack of comprehensive and effective administrative oversight: 1.Review of the attendance signature sheets for the QAPI members revealed Medical Director #702 was not listed as present during the meetings on 04/30/24, 05/21/24, 06/03/24, 07/17/24, 08/21/24, and 09/20/24. There was also no evidence QAPI meetings were held prior to April 2024. Interview on 10/21/24 at 1:57 P.M. with the Administrator confirmed there was no evidence of the medical director's or designee's attendance at the QAPI meetings as required, and the Administrator stated she could not provide any evidence of QAPI meetings prior to April 2024 when she took over as Administrator at the facility. 2. Review of the facility job description for the Activity Director (AD) revealed they must be a qualified therapeutic recreation specialist or an activities professional who was licensed by the state and was eligible for certification as recreation specialist or as an activity professional. Review of the personnel file for the former AD #801 revealed a date of hire of 05/16/23 as the Activities Director and last day worked was 09/16/24. No certification from the Activity Directors Network was available in the file. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 10/16/24 at 2:31 P.M. with the Director of Nursing (DON) revealed there was no Activity Director for the past month. The facility was utilizing the [NAME] Counseling social worker and two counselors to provide activities in the facility. The DON confirmed the facility currently had only one activity aid employed in the activity department. Interview on 10/16/24 at 3:57 P.M. with [NAME] counseling Case Manager #566 revealed [NAME] Counseling was in the facility to do one on one counseling with Medicaid and Medicare residents only. No counselors were certified in Activities. No case manager from [NAME] Counseling came in on the weekend or worked past 4:00 P.M. Case Manager #566 also stated because the Activities Director and an Activities Aid quit this past month [NAME] Counseling had helped incorporate activities into counseling sessions, but [NAME] Counseling was not the activities department. Case Manager # 566 stated the [NAME] Counseling social worker made the October 2024 Activities Calendar. The facility had one activity aid who worked every other weekend and nursing staff was to provide activities the weekend the activities aid was not on site. Interview on 10/21/24 at 10:00 A.M. with [NAME] Counseling Licensed Social Worker (CLSW) #565 revealed [NAME] Counseling Services was not the activities department but they were willing to do activities with the residents. CLSW #565 verified they did not hold certification as a qualified Activity Director. 3. Review of the facility activity calendars dated October and September 2024 for the Secured Unit A revealed no activities were scheduled after 3:00 P.M. for the month of October. Review of the September 2024 Activity Calendar for Secure Unit A revealed no activities were scheduled past 4:00 P.M. Review of the October 2024 Unit B/C activity calendar revealed no activities were scheduled after 3:00 P.M. each day except for each Wednesday an activity was scheduled for 5:00 P.M. Review of the activity department staffing schedules for September 2024 and October 2024 which listed former Activities Director (AD) #801, former Activities Aid (AA) #800 and AA #536 as the staff for the department revealed no activity aid was scheduled in the building on Saturday 09/21/24, Thursday 09/26/24, Friday 09/27/24, Saturday 09/28/24, Sunday 09/29/24, Monday 09/30/24, Tuesday 10/01/24, Wednesday 10/02/24, Friday 10/04/24, Saturday 10/05/24, Sunday 10/06/24, Monday 10/07/24, Wednesday 10/08/24, Friday 10/11/24, Saturday 10/12/24, Sunday 10/13/24. Interview on 10/15/24 at 9:36 A.M. with Resident #18 revealed she had not participated in activities because she felt there was no activities department. Resident #18 stated no activities came to visit her. Interview on 10/16/24 at 2:31 P.M. with the Director of Nursing (DON) revealed there was no Activity Director for the past month. The facility was utilizing the [NAME] Counseling social worker and two counselors. The facility currently had one activity aid employee. The DON verified no activity department staff were scheduled on Saturday 09/21/24, Thursday 09/26/24, Friday 09/27/24, Saturday 09/28/24, Sunday 09/29/24, Monday 09/30/24, Tuesday 10/01/24, Wednesday 10/02/24, Friday 10/04/24, Saturday 10/05/24, Sunday 10/06/24, Monday 10/07/24, Wednesday 10/08/24, Friday 10/11/24, Saturday 10/12/24, Sunday 10/13/24. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 10/16/24 at 3:19 P.M. with the Assistant Director of Nursing #501 verified no activities were planned after 3:00 P.M. for the Secure Unit A for the month of October 2024 and the facility did not assign a State tested Nurse Aid over the weekends when the facility Activities Aid was not in the building. Interview on 10/16/24 at 3:57 P.M. with [NAME] counseling Case Manager #566 revealed [NAME] Counseling was in the facility to do one on one counseling with Medicaid and Medicare residents only. No counselors were certified in Activities. No Case Manager from [NAME] Counseling came in on the weekend or worked past 4:00 P.M. Case Manager #566 also stated because the Activities Director and an Activities Aid quit this past month [NAME] Counseling had helped incorporate activities into counseling sessions, but [NAME] Counseling was not the activities department. Case Manager # 566 stated the [NAME] Counseling social worker made the October 2024 Activities Calendar. The facility had one activity aid who worked every other weekend and nursing staff was to provide activities on the weekends the activities aid was not on site. Interview on 10/16/24 at 4:00 P.M. with Resident #33 revealed there was not always activities on the weekends, so the residents have to entertain themselves. Resident #33 also stated it gets boring after 5:00 P. M. because there were no activities. Observation on 10/17/24 at 9:10 A,M. of the Secure Unit A activities room revealed Current Events was scheduled on the activities calendar at 9:00 A.M. on 10/17/24. No staff were in the Secure Unit A activities room and one resident was present but sleeping in the activities room. The Administrator verified at the time of the observation that no staff was engaged with residents at that time. Observation on 10/17/24 at 9:24 A.M. of the B/C Activities room revealed no staff was engaged with residents in the activities room. One resident was sitting in front of the television watching a sitcom. Review of the Activities Calendar for 10/17/24 at 9:00 A.M. an activity was planned for Current Events and coffee. No coffee was available in the activities room. The Administrator verified at the time of the observation that no coffee was in the activities room and no staff was engaged with residents for current events. Observation on 10/17/24 at 10:10 A.M. of the Secure Unit A activities room revealed staff were not engaged with residents during the planned game activity at 10:00 A.M. listed on the October 2024 activities calendar. Residents were scheduled to play a card game. STNA #507 verified there was one aid on the secure unit therefore the aid could not engage in activities at that time. Interview on 10/17/24 at 10:10 A.M. with State tested Nurse Aid (STNA) #507 revealed STNAs can help with activities on the secure unit if two STNAs were scheduled. If one STNA was scheduled it was difficult to provide the planned activities so activities were not always provided to those residents. STNA #507 revealed the facility did not provide drums for the planned activity titled Drumming to Music for the Secure Unit A activity on 10/21/24 at 10:00 A.M. so the activity was unable to be implemented for the residents. STNA #507 also stated the secure unit did not have an activity aid since the aids stay on the B/C unit's activities room. Observation on 10/17/24 at 10:13 A.M. revealed the activities room B/C had three residents watching television. All residents were poor historians. Review of the B/C activities calendar revealed relaxation exercises were planned on 10/17/24 at 10:00 A.M. There were no staff conducting relaxation exercises with any of the residents. STNA #507 verified the findings. (continued on next page)

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	365760	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 10/21/24 at 10:00 A.M. with [NAME] Counseling Licensed Social Worker (CLSW) #565 revealed [NAME] Counseling Services was not the activities department but were willing to provide activities to the residents. CLSW #565 verified they did not hold certification as a qualified Activity Director. Observation on 10/21/24 at 10:22 A.M. of the activity room for the Secure Unit A revealed four residents sitting in the activity room with the television on. One STNA was in the room playing music on her iPhone. Review of the activity calendar dated October 21, 2024 at 10:00 A.M. indicated an activity was scheduled titled Drumming to Music.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 47570 Based on record review and interview the facility failed to ensure quarterly Quality Assurance Performance Improvement (QAPI)meetings were conducted and failed to have the designated medical director participate in the QAPI meetings. This had the potential to affect all residents. The facility census was 50. Findings include: Review of the attendance signature sheets for the QAPI members revealed Medical Director #702 was not listed as present during the meetings on 04/30/24, 05/21/24, 06/03/24, 07/17/24, 08/21/24, and 09/20/24. There was also no evidence QAPI meetings were held prior to April 2024. Interview on 10/21/24 at 1:57 P.M. with the Administrator confirmed there was no evidence of the medical director's or designee's attendance at the QAPI meetings as required, and the Administrator stated she could not provide any evidence of QAPI meetings prior to April 2024 when she took over as Administrator at the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on record review, observation, review of Centers for Medicare and Medicaid (CMS) Quality, Safety, and Oversight (QSO) Memo 24-08-NH, staff interview, and policy review , the facility failed to ensure enhanced barriers precautions (EBP) were followed for one resident (Resident #194) of nine residents who were identified by the facility as being on EBP (Residents #6, #12, #21, #26, #34, #35, #193, #194, and #196). The facility also failed to ensure annual tuberculosis (TB) signs and symptoms for employes were completed per the TB risk assessment and policy. This had the potential to affect all 50 residents in the facility. The facility census was 50. Findings include: 1. A review of medical records for Resident #194 revealed an admitted [DATE] with diagnoses included cerebral infarction with hemiplegia and hemiparesis affecting the right dominant side, need for assistance with personal care, and ulcerative colitis. Review of physician orders for October 2024 included check placement of gastric tube every shift, cleanse gastric tube daily and as needed, change end cap to midline daily and as needed and total parenteral nutrition (TPN) to run over 16 hours from 8:00 P.M. until 12:00 P.M. daily. Review of an admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively intact. Review of a nurse practitioner note dated 10/15/24 revealed the gastric tube was intact and clamped a central line with TPN running to the upper left chest. Review of the care plan dated 10/08/24 revealed Resident #194 was at risk for infection related to the gastric tube and TPN. Interventions included to maintain EBP. On 10/16/24 at 11:15 A.M. observation of the room for Resident #194 revealed signage for EBP to be maintained. There was a well-stocked cart with proper personal protective equipment (PPE). On 10/16/24 at 11:20 A.M. observation of incontinence care for Resident #194 revealed Certified Nurse Assistant (CNA) #531 rendered care without donning a gown. On 10/16/24 at 11:30 A.M. an interview with CNA #531 verified a gown was not donned while incontinence care was rendered to Resident #194. An interview with License Practical Nurse (LPN) #501 who was the infection control nurse, verified Resident #194 was on EBP and a gown should have been worn to render incontinence care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the policy titled; Enhanced Barrier Precautions dated 03/2024 revealed residents with the following triggers will receive EBP and it should be followed for any resident in the facility with wounds and/or an indwelling medical device. Indwelling medical devices may include central lines, urinary catheters, feeding tubes and tracheostomies. The policy further stated EBP was to be used in conjunction with standard precautions and requires use of gown and gloves during high-contact resident care activities. Examples of high contact resident care activities requiring a gown and glove use include changing briefs or assisting with toileting. Review of CMS's QSO-24-08-NH dated 03/20/24 pertaining to Enhanced Barrier Precautions in Nursing Homes revealed CMS was issuing new guidance for [NAME] survey agencies and long-term care facilities on the use of enhanced barrier precautions (EBP) to align with nationally accepted standards. EBP recommendations now included use of EBP's for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multi-drug-resistant organism status. The new guidance related to EBP's was being incorporated into F880 Infection Prevention and Control. Guidance under F880 indicated EBP's referred to an infection control intervention designed to reduce transmission of multi-drug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. EBP's were to be used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. 39973 2. Review of the personnel file for State tested Nursing Assistant (STNA) #516 revealed her hire date as 03/10/21 and she received a two-step Mantoux (skin test used to screen for TB) upon hire. There was no annual sign and symptom sheet completed within the last year. Interview on 10/17/24 at 12:51 P.M. with Human Resource (HR) Manager #525 verified there was no annual TB sign and symptom completed as she revealed there should have been one completed March 2023 and March 2024. 3. Review of the personnel file for STNA #551 revealed her hire date as 02/02/22 and she received a two-step Mantoux upon hire. There was no annual sign and symptom sheet completed within the last year. Interview on 10/17/24 at 12:37 P.M. with HR Manager #525 verified there was no annual TB sign and symptom sheet completed as she revealed there should have been one completed February 2023 and February 2024. 4. Review of the personnel file for Licensed Practical Nurse (LPN) #522 revealed her hire date as 10/13/22 and she had received a two-step Mantoux upon hire. There was no annual sign and symptom sheet completed within the last year. Interview on 10/17/24 at 12:43 P.M. with HR Manager #525 verified there was no annual TB sign and symptom sheet as she revealed there should have been one completed October 2023. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 10/17/24 at 12:50 P.M. with HR Manager #525 verified the facility policy stated employees would receive TB screening for symptoms of TB annually and as needed. She revealed she did not track or complete these screenings and was unsure who did. Interview on 10/17/24 at 3:04 P.M. and on 10/21/24 at 11:00 A.M. with the Director of Nursing verified the TB policy stated the facility would annually screen each employee for signs and symptoms of TB. She verified the TB risk assessment revealed the facility would test employees annually and stated the facility was to complete annual TB screenings per a sign and symptom sheet for each employee. She verified nursing does not complete these screenings and revealed she assumed HR was doing the annual screenings. Review of Tuberculosis (TB) Risk Assessment Worksheet dated 02/26/24 revealed the facility was at low risk for TB. The facility assessment revealed they would complete baseline skin testing with a two-step Mantoux for healthcare workers and then test on an annual basis. Review of undated facility policy labeled, Tuberculosis Testing and Monitoring revealed resident and staff would be tested and monitored for TB routinely. The policy revealed that after baseline negative testing for TB, employees would receive TB screening for symptoms of TB annually and as needed. If the results of the symptom review indicated the employee had signs and symptoms of TB a single Mantoux would be administered.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 47570 Based on observation, interview and review of facility policy the facility did not ensure a safe, functional and comfortable environment for all residents. This had the potential to affect all 50 residents residing in the facility. Findings include: Observation on 10/21/24 from 11:15 A.M. to 11:27 A.M. with Maintenance Director(MD) #526 revealed the following which were verified by MD #526 at the time of the observation: Resident #148's side rail was breaking off the bed and able to be pulled off the side of the bed. A corroded hole in the ceiling leading into the 100 hall was found to be open. MD #526 indicated that the hole was caused by water leaking from the roof and reported that he did not have the necessary materials to repair it. The hole was large enough to allow potential pests such as insects or rodents to enter the hallway in resident occupied areas. The 100 hall contained a hole measuring 4.5 inches across and 2.5 inches wide with sharp edges exposed. The hole was at the level where a resident passing by could make bodily contact with the sharp edges. MD #526 indicated the hole resulted from heavy items bumping into the railing and suggested that pushing in the sharp edges would better protect the residents from scrapping their skin. The corner of C hall transition to the B hall revealed a ripped corner molding had caused a sharp piece of the wall to be exposed and stick out. The sharp piece of wall was at the level where a resident passing by, if they bumped into it, could make bodily contact with the sharp piece. The floor strip leading into Resident #148's room was not glued to the floor causing a tripping hazard. Review of facility policy titled Housekeeping Procedure, dated 12/28/13, revealed the facility would be maintained to meet a home like environment for residents