STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366001	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmar Place Rehab & Extended Care	401 Harmar Street Marietta, OH 45750

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review and staff interview, the facility failed to ensure the physician was notified when a resident's blood sugar level was above the parameters in which the physician wanted notified. They also failed to ensure the physician was notified of another resident's weight gain of more than three pounds in a day and/ or more than five pounds in a week who was having daily weights obtained for monitoring of congestive heart failure (CHF). This affected one resident (#5) of five residents reviewed for unnecessary medications and one resident (#28) of one residents reviewed for edema. Findings include: 1. Review of Resident #5's medical record revealed she was admitted to the facility on [DATE] with a readmitted [DATE]. Her diagnoses included adult onset (Type II) diabetes mellitus (DM), Alzheimer's disease, and dementia. Review of Resident #5's physician's orders revealed she had an order in place to receive Lantus (slow acting insulin used to lower blood sugars) 100 units/ milliliter with instructions to inject 28 units subcutaneously (SQ) every night at bedtime for Type II DM. She also had an order in place to administer Insulin Lispro (fast acting insulin) 100 units/ ml with instructions to inject twice daily per sliding scale. The order included parameters to notify the physician if the resident's blood sugar was less than 60 or greater than 400. Review of Resident #5's medication administration record (MAR) for January 2025 revealed the resident's blood sugar was checked via a fingerstick using a blood glucose monitor on 01/04/25 at 4:00 P.M. and found to be 436 milligrams (mg)/ deciliter. The sliding scale coverage directed the resident to be given 6 units of Insulin Lispro SQ and to notify the physician. There was no documentation on the MAR to show the physician had been notified as ordered. Review of Resident #5's nurses' progress notes revealed it too was absent for any documented evidence of the physician being notified on 01/04/25 at 4:00 P.M., when the resident's blood sugar was recorded as being 436 mg/dl. Findings were verified by the facility's Director of Nursing (DON). (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/25/25 at 11:15 A.M., an interview with the DON confirmed Resident #5's physician's order for the resident's sliding scale coverage included parameters in which the physician was to be notified of blood sugar levels less than 60 mg/dl or greater than 400 mg/dl. She denied she was able to provide any documented evidence of the resident's physician being notified of the elevated blood sugar of 436 mg/dl that was noted on 01/04/25 at 4:00 P.M. 2. Review of Resident #28's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included congestive heart failure (CHF), pulmonary hypertension, chronic kidney disease, rheumatic mitral stenosis, hypertension, and a history of a myocardial infarction (heart attack). Review of Resident #28's physician's orders revealed she was receiving Aldactone (a diuretic) 25 milligrams (mg) by mouth (po) every night at bedtime and Bumex (a diuretic) 1 mg po every day for CHF. Her physician's orders also included the need to obtain daily weights and, if she had a gain of more than three pounds a day or more than five pounds a week, they were to notify the physician. That order originated on 01/23/25. Review of Resident #28's treatment administration record (TAR's) for February 2025 revealed the resident's weight was 94.8 pounds on 02/13/25 and on 02/20/25 it was 101.8 pounds, which reflected a weight gain of seven pounds in a week. The resident also weighed 99 pounds on 02/16/25 and was 102.2 pounds on 02/17/25, which was a 3.2 pound weight gain in a day. There was no indication on the TAR of the resident's physician having been notified of the resident's weight gain of more than three pounds in a day between 02/16/25 and 02/17/25, or more than five pounds in a week between 02/13/25 and 02/20/25. Review of Resident #28's progress notes revealed there was no documented evidence of the resident's physician being notified when the resident gained more than three pounds between 02/16/25 and 02/17/25, as ordered by the physician. There was also no documented evidence of the resident's physician being notified of the resident's weight gain of more than five pounds between 02/13/25 and 02/20/25. On 02/24/25 at 1:50 P.M., an interview with the facility's Director of Nursing (DON) confirmed Resident #28 was known to have a weight gain of greater than 5 pounds in a week from 02/13/25 and 02/20/25. She further confirmed the resident had a weight gain greater than three pounds in one day between 02/16/25 and 02/17/25. She stated she could not find any evidence in the progress notes of the physician being notified when the resident experienced weight gains outside the parameters set in the physician's orders.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on record review, staff interview, resident interview, policy review, and review of a facility investigation, the facility failed to ensure residents were free from misappropriation of medications. This affected four residents (#40, #78, #184 and #187) of four residents reviewed for misappropriation of narcotic pain medications. The facility census was 75. Findings include: Review of the medical record for Resident #187 revealed an admitted [DATE]. A BIMS score of 15 (intact cognition) was noted on a BIMS evaluation completed 02/17/25. He had a physician's order for Norco 5-325 milligrams every eight hours as needed for pain on 02/12/25. Review of the medication administration record (MAR) revealed Registered Nurse (RN) #481 administered the Norco six times between 02/13/25 and 02/17/25 for a beginning pain level of either 1 or 2 (pain scale 1-10). However, review of the controlled substance record revealed RN #481 signed out seven doses of Norco pain medication for Resident #187. One dose had not been documented on the MAR. She was the only nurse that administered the Norco up until one dose was requested on 02/17/25 for a pain level of 8. The doses given included Norco 5-325 milligrams at 8:37 P.M. on 02/16/25 and 4:30 A.M. on 02/17/25 by RN #481. Review of the medical record for Resident #78 revealed an admitted [DATE]. A BIMS score of 15 was noted on a minimum data set (MDS) completed 02/04/25. She had a physician's order for Oxycodone 5 milligrams every six hours as needed for moderate pain. The Medication Administration Record (MAR) documented receiving Oxycodone 5 milligrams on 02/16/25 at 7:48 P.M. and at 2:41 A.M. on 02/17/25 by RN #481 for a beginning pain level of 2. Review of the medical record for Resident #184 revealed an admitted [DATE]. A MDS assessment in progress documented a BIMS score of 15. The MAR documented receiving Oxycodone 5 milligrams on 02/16/25 at 7:03 P.M. (pain level of 2) and at 12:18 A.M. (pain level 4) and 4:36 A.M. on 02/17/25 (pain level 3) by RN #481. Review of the medical record for Resident #40 revealed an admitted [DATE]. A MDS assessment 02/06/25 documented a BIMS score of 14. The resident had a physician's order for Hydrocodone-Acetaminophen 5-325 milligrams one tablet every four hours as needed for pain. The MAR documented the resident receiving Hydrocodone-Acetaminophen 5-325 milligrams at 7:20 P.M. on 02/16/25 for a pain level of 2, at 12:21 A.M. on 02/17/25 for a pain level of 2, and at 4:38 A.M. on 02/17/25 for a pain level of 2. All were given by RN #481. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/18/25 the facility submitted a self reported incident form to the State Survey Agency. It stated that on 02/17/25 residents had alleged that pain medications were not administered even though documented that they were. The category of allegation was listed as neglect. The alleged perpetrator was noted to be a facility nurse (Registered Nurse (RN) #481). Involved residents were noted to be Residents #40, #78, #184, and #187. The report stated that Resident #40 had a brief interview for mental status (BIMS) score of 14 (intact cognition) and had stated she was hurting and had not taken any pain medications through the night. (The controlled substance record documented receiving Hydrocodone-Acetaminophen 5-325 milligrams on 02/16/25 at 7:23 P.M. and at 12:10 A.M. and 4:39 A.M. on 02/17/25 by RN #481). Resident #78 had a BIMS score of 15 (intact cognition) and had stated she was asleep and did not receive pain meds through the night. (The Medication Administration Record (MAR) documented receiving Oxycodone 5 milligrams on 02/16/25 at 7:48 P.M. and at 2:41 A.M. on 02/17/25 by RN #481). Resident #184 (BIMS score of 15 documented on assessment in progress on 02/23/25) when asked by day nurse if the pain pills had helped her through the night and resident stated she had not taken any pain medication all night. (The MAR documented receiving Oxycodone 5 milligrams on 02/16/25 at 7:03 P.M. and at 12:18 A.M. and 4:36 A.M. on 02/17/25 by RN #481). Resident #187 had a BIMS score of 15 and stated he had not taken any pain medication through the night when asked by the day nurse. (The MAR documented receiving Norco 5-325 milligrams at 8:37 P.M. on 02/16/25 and 4:30 A.M. on 02/17/25 by RN #481). The self reported incident form stated the nurse in question had been suspended 02/17/25. (The nurse in question routinely worked from 6:00 P.M. to 6:30 A.M.). It stated, as a result of the allegations, residents were being interviewed on the unit, pain being assessed, record reviews being conducted, and staff interviews occurring. Review of a written statement by Licensed Practical Nurse (LPN) #404 dated 02/17/25 revealed that during her morning medication pass that morning on the East unit she had a few residents who complained of pain during her initial assessment. Resident #40 complained of pain and not being able to sleep all night. Upon checking the narcotic book for last dose, it was noted she had been medicated at 4:39 A.M. At that time, she let the resident know that it was too early for another pain medication. The resident became tearful and stated that she did not take anything for pain all night. Resident is alert and oriented. Medicated as soon as able. Resident #184 said that she had not had any pain medication all night but would let her know if she needed any before therapy. The narcotic book had medications signed out for Resident #184 at 12:00 A.M. and 4:00 A.M. (2 pills each time). She asked the resident if the two pills were helping or if it was too strong because the order said one or two pills depending on pain level. Again the resident stated she did not take any pain medication. She is alert and oriented. Upon assessment with Resident #78, she asked when she had her pain pill last night. Looked at narcotic book which stated medication given at 2:00 A.M. Resident stated she was asleep then and did not receive pain medications. Resident #187 asked to not have pain medications as much as possible because he is trying not to take them as much. When his pain was assessed this morning, he has an intact pain patch on his right hip/groin area. The MAR stated the resident was given Norco 5/325 milligrams at 4:30 A.M. Resident denies taking the medication. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility concluded their investigation on 02/24/25. The investigation report stated that on 02/17/25 a nurse reported that four short term residents had not received their pain medications during the night shift. Upon further review, it was noted that this involved one specific night nurse (RN #481). On 02/17/25 RN #481 was suspended pending an investigation into pain medications. Residents involved included Residents #40, #78, #184, and #187. It noted that Resident #40 was discharged on [DATE], prior to the conclusion of the investigation. Investigation included obtaining further statements from the noted residents. Resident #78 was interviewed on 02/18/25 and when asked if she had taken pain medication she replied yes and when asked if it had been administered at night when she asked for it she replied yes, except two times. When asked when it was not administered she replied two and a half weeks after being admitted . Resident #40 was interviewed on 02/18/25 and replied yes when asked if she had taken pain medication. When asked if it had been administered at night when she asked for it she replied I do, but one nurse won't give it. She did not remember when it was. Resident #184 was interviewed on 02/18/25 and when asked if she had taken pain medication she replied yes. When asked if it had been administered at night when she asked for it she replied yes. Resident #187 was interviewed on 02/18/25. When asked if he had taken pain medication he replied yes, one yesterday. When asked if it had been administered at night when he asked for it, he replied didn't ask. The facility investigation included interviews with staff, including 23 nursing assistants and eight nurses. Of the eight nurses interviewed, four noted there were concerns of pain medications taking time to be administered and three of the four nurses stated they had been told it was RN #481. Of the 23 nursing assistant interviews, 12 noted concerns regarding pain medication administration and resident waiting times. Four of the nursing assistants referenced RN #481 and two referenced a newer night nurse (RN #481 had been employed since 01/15/25 and worked night shift). The facility investigation revealed an interview was conducted with RN #481 on 02/18/25. She stated that medication was given to the four residents who had initial concerns voiced. She stated medications were given in a timely manner. As the investigation progressed, it was noted that Resident #187, per a third interview, still said he had not requested pain medication at night. He also denied taking the medication at specific times when re-interviewed. Per review of the MAR, RN #481 was the nurse noted to have signed these medications off as being administered. Upon further review it was also noted that a medication was signed off on the narcotic sheet and was not noted on the MAR for Resident #187. Upon further facility interview with RN #481 on 02/24/25, she stated she would try intervention prior to administering a Norco for a pain level of 1 or 2 (RN #481 had administered six doses of Norco to Resident #187 for a pain level of 1 or 2). The investigation report stated that the investigation became more of a drug diversion allegation and was reported to the City Police Department on 02/24/25. Resident #187 was interviewed by the police. RN #481 agreed to be drug tested on [DATE] (7 days after the allegations were made). (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The report stated the facility would not substantiate an allegation of neglect based on inconsistencies in second interviews with some residents in question. The facility would however substantiate that misappropriation did occur as noted during the investigation. The facility noted medications in question were replaced to the resident and billed to the facility. (Review of an email sent to the pharmacy by the Director of Nursing revealed Resident #187 had a medication card sent for seven narcotics. We are suspecting misappropriation may have occurred with these pills. Could you please replace them and bill the facility for this as soon as possible). The nurse in question has now been terminated from employment. (However, review of a corrective action form revealed RN #481 was terminated 02/24/25 for failure to provide complete and accurate information on all work records including but not limited to time records, incident/accident and exposure reports, applications for employment and benefits and resident care records). The nurse in question (RN #481) would also be reported to the Ohio Board of Nursing. Abuse education was provided to staff. The report was signed by the Director of Nursing. Interview with Resident #78 on 02/18/25 at 11:01 A.M. revealed she feels like staff are documenting that they are giving her pain medications and keeping them for themselves. She stated a nurse told her that other residents had complained of not getting pain medications when they needed them and they are looking into it. She was unable to identify any nurse she felt may not give her pain medications as needed. Interview with Nursing Assistant #443 on 02/20/25 at 8:00 A.M. revealed a nurse on night shift that has only worked there a few weeks, said that if a resident didn't need pain medication during the day then they didn't need it at night. She stated residents asked for pain medications during the night and the nurse did not provide them. She stated this affected Residents #78, #40, and #184 on 02/03/25. (Review of the schedule revealed RN #481 worked on that unit on night shift on 02/03/25). Interview with LPN #404 on 02/20/25 at 1:40 P.M. revealed that during her morning medication pass on 02/17/25 she was assessing each resident for pain (working on East 300 hall). She stated she looks at the MAR to see if resident's took pain medications during the night and to see how they are feeling. She stated most residents on that unit are alert and oriented. She stated that she noted that residents were documented as receiving pain medications during the night (prior to her shift) and the resident's were telling her they did not get any medications during the night. This included Residents #187, #78, #40, and #184. Interview with LPN #404 on 02/24/25 at 7:30 A.M. revealed she would never give a narcotic pain medication to a resident who only had a pain level of 1 or 2. On 02/24/25 at 1:50 P.M. LPN #404 stated she reported the issues identified with resident pain medications before 8:00 A.M. on 02/17/25 to the Assistant Director of Nursing. Interview with Resident #187 on 02/20/25 at 3:00 P.M. revealed he does not have a lot of pain. He stated he wears a pain patch that stays on for a week. He stated that he does not take any pain pills at night. He stated he sleeps good at night and would never take a pain pill for a pain level of 1 or 2. He stated he would be asleep at 4:30 to 5:00 A.M. in the morning. He stated his pain level would have to be 8, 9, or 10 before he would take a pain pill. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing (DON) on 02/25/25 at 7:30 A.M. revealed the facility substantiated misappropriation of narcotics for Resident #187. The DON stated Resident #187's statement did not change during the investigation. The DON stated the facility could not substantiate misappropriation for the other three residents in the investigation. She stated their statements changed upon a second interview. She stated the facility would replace the seven narcotic pills documented as given to Resident #187 by RN #481. She confirmed RN #481 was terminated on 02/24/25. She confirmed the police and the Board of Nursing were notified 02/24/25. Interview with Resident #184 on 02/25/25 at 1:30 P.M. revealed she does not remember at this point if she got any pain medications during the night on 02/16/25 into 02/17/25. She stated she would have been able to answer better right after it happened. She stated she did not think that she received any pain medication as documented on 02/16/25 into 02/17/25 (night shift). Review of the personnel file for Registered Nurse (RN) #481 revealed she was hired on 01/15/25 to work as an RN. Interview with RN #481 on 02/25/25 at 9:30 A.M. revealed she had only worked at the facility for about a month. When asked about her work history, she stated she had worked at the facility listed on her application for [AGE] years (as the Director of Nursing) but had left there 5 years ago. (However, this did not match dates on the application). When questioned why the dates on her application did not align with what she had just said, she stated it must have been an old application. She stated that she had worked at another nursing home in 2020 and the last place she worked prior to employment at this facility was another nursing home. She did not mention working for a staffing agency. She stated she left her most recent employment at another nursing home because she and her girlfriend (LPN #446) wanted to work together again. (The last place listed as employment by LPN #446 was the same place RN #481 just said she left employment from). During the interview, RN #481 confirmed she had been suspended on 02/17/25 because there were allegations that residents did not get their pain medications while she was working. RN #481 revealed she gave everyone their pain medications in a timely manner. During the interview, the RN denied she had ever had allegations of misappropriation against her prior to working at this facility and had never been asked to take a drug test prior to working at this facility. However, review of a nursing home facility Self Reported Incident (SRI) (tracking number 248027) submitted by the facility that RN #481 told the surveyor she was last employed by revealed allegations of misappropriation against RN #481. On 05/27/24 at 7:34 P.M. the facility noted during shift change that one card of 30 Ativan 1 milligram tablets were missing from the 300 hall cart. RN #481 was the nurse on duty and did not know what happened to the medication. She stated she did not give the keys to anyone else during the shift. A search was unable to locate the medication. RN #481 was suspended. RN #481 completed a drug test on 05/28/24. An investigation was completed and RN #481 returned to work. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a second Self Reported Incident (tracking number 250227) also submitted by the facility that RN #481 told the surveyor she was last employed by revealed an allegation of emotional/verbal abuse and misappropriation against RN #481. On 07/30/24 it was reported that RN #481 was verbally aggressive towards residents. Additionally, resident interview indicated she does not always receive her medications and at times not timely from RN #481. RN #481 was suspended on 07/30/24. The facility initiated an investigation. During the investigation a resident reported concerns with both medication administration and interactions with RN #481. She stated RN #481 does not always give her all of her pills and pretends to give her insulin. She stated RN #481 will say I am the nurse and you know nothing. An investigation was completed; RN #481 was terminated for violation of company policy unrelated to verbal abuse and medication administration. When asked about these two Self Reported Incidents from the facility she last worked at (allegations of misappropriation and drug testing), on 02/25/25 at 9:30 A.M. RN #481 stated she had forgotten about that. Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property (dated 03/30/12 and last revised 10/10/24) revealed residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. Misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. This deficiency represents non-compliance investigated under Complaint Number OH00163071.

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on staff interview, policy review, review of employee personnel files, and review of facility investigation reports, the facility failed to implement their abuse/misappropriation policy related to screening by failing to attempt to obtain information from current or previous employers regarding work history prior to hiring employees to provide services in the facility. This had the potential to affect all 75 of 75 residents residing in the facility. Findings include: Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property (dated 03/30/12 and revised last on 10/10/24) revealed residents have the right to be free from abuse, exploitation and misappropriation of resident property. Misappropriation was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. The policy included screening procedures for prospective employees. It stated the facility would attempt to obtain information from previous or current employers prior to hiring a new employee. a. Review of the personnel file for Registered Nurse (RN) #481 revealed she was hired on 01/15/25 to work as an RN. Review of her application for employment revealed she listed only one place of employment in the job history section. The application indicated she had worked at that place from 02/01/17 to January 2025 (8 years). Review of reference checks revealed two were completed. Both were completed 01/17/25 by Human Resource Manager #423. Both reference sheets had individual names on them and not a facility. The reference sheets included dates employed in position. One stated 2015-2025 and the other stated 2020-2025. Both reference sheets stated the applicant was eligible for rehire with their company. Interview with Human Resource Manager (HRM) #423 on 02/24/25 at 3:00 P.M. revealed the facility listed on RN #481's application was a nursing home in [NAME] Virginia. She stated she did not attempt to contact them to verify work history (employment dates, eligible for rehire, etc). She stated that during RN #481's interview, she stated that she currently worked for a staffing agency. HRM #423 stated she did not ask which one and did not attempt to contact them to verify work history. HRM #423 stated that the two reference checks she did were with individual nurses that RN #481 had provided for reference checks. One was Licensed Practical Nurse (LPN) #446, who had also just been hired by the facility as a nurse. HRM #423 stated that RN #481 had told her that she and LPN #446 had worked everywhere together, including the staffing agency. The other was a nurse that HRM #423 did not know and did not know how she knew RN #481. HRM #423 confirmed the reference check forms made it look like she was contacting a company since it said the applicant was eligible for rehire with your company. HRM #423 stated she marked both yes because the nurses told her they thought RN #481 would be eligible for rehire where she had worked. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Interview with RN #481 on 02/25/25 at 9:30 A.M. revealed she had only worked at the facility for about a month. When asked about her work history, she stated she had worked at the facility listed on her application for [AGE] years (as the Director of Nursing) but had left there 5 years ago. (This did not match dates on application). When questioned why the dates on her application did not align with what she had just said, she said it must have been an old application. She stated that she had worked at another nursing home in 2020 and the last place she worked prior to employment at this facility was another nursing home. She did not mention working for a staffing agency. She stated she left her most recent employment at another nursing home because she and her girlfriend (LPN #446) wanted to work together again. (The last place listed as employment by LPN #446 was the same place RN #481 just said she left employment from). b. Review of the personnel file for LPN #446 revealed she was hired by the facility as a nurse on 01/16/25. Her Ohio Board of Nursing License Look Up form indicated board action. However, further investigation revealed she was eligible to work as a nurse. She listed nine places of employment since 1999 but did not include a staffing agency. Her last listed employment was a nursing home (March 2024 to present). Review of reference checks revealed two were completed. Both were completed 01/17/25 by Human Resource Manager #423. Both reference sheets had individual names on them and not a facility. The reference sheets included dates employed in position. One stated 2021-2025 and the other stated 2020-2025. Both reference sheets stated the applicant was eligible for rehire with their company. Interview with HRM #423 on 02/25/25 at 10:40 A.M. revealed she did not attempt to contact any of LPN #446's previous employers to verify work history. She stated that the two reference checks she did were with individual nurses that LPN #446 had provided for reference checks. One was RN #481, who had also just been hired by the facility as a nurse and had indicated her and LPN #446 worked together at a staffing agency. The other was a nurse that HRM #423 did not know and did not know how she knew LPN #446. It was the same second reference name provided by RN #481. She confirmed that the reference check forms made it look like she was contacting a company since it said the applicant was eligible for rehire with your company. She said she marked both yes because the nurses told her they thought LPN #446 would be eligible for rehire where she had worked. c. Review of the personnel file for two additional nurses, LPN #442 hired 09/25/24 and LPN #493 hired 01/28/25 revealed no evidence that attempts were made to contact previous employers or college instructors (LPN #442 stated no work history and had just finished nursing school) to verify employment history. Interview with HRM #423 on 02/25/25 at 10:40 A.M. confirmed no attempts to contact previous employers for LPN #493 or LPN #442. Interview with the Assistant Director of Nursing on 02/25/25 at 11:32 A.M. revealed nurses could be scheduled to work anywhere in the building with any of the 75 residents. Interview with the Administrator on 02/25/25 at 8:00 A.M. confirmed the abuse/misappropriation policy had not been implemented as the screening procedures for new employees as it pertained to obtaining information from current or previous employers regarding work history prior to hiring employees to provide services in the facility had not been completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on record review, staff interview, resident interview, policy review, and review of a facility investigation, the facility failed to thoroughly investigate allegations of misappropriation of medications. This affected six residents (#187, #78, #184, #40, #6, and #26) of six residents reviewed for misappropriation of narcotic pain medications or secured antianxiety medications and had the potential to affect two additional residents (#6 and #26) identified with orders and administration of controlled substances. The facility census was 75. Findings include: On 02/18/25 the facility submitted a self reported incident (SRI) #257304 form to the State Survey Agency. It indicated on 02/17/25 residents had alleged that pain medications were not administered even though documented that they were. The category of allegation was listed as neglect. The alleged perpetrator was noted to be a facility nurse (Registered Nurse (RN) #481). Involved residents were noted to be Residents #40, #78, #184, and #187. The report revealed Resident #40 had a brief interview for mental status (BIMS) score of 14 (intact cognition) and had stated she was hurting and had not taken any pain medications through the night. (The controlled substance record documented receiving Hydrocodone-Acetaminophen 5-325 milligrams on 02/16/25 at 7:23 P.M. and at 12:10 A.M. and 4:39 A.M. on 02/17/25 by RN #481). Resident #78 had a BIMS score of 15 (intact cognition) and had stated she was asleep and did not receive pain meds through the night. (The Medication Administration Record (MAR) documented receiving Oxycodone 5 milligrams on 02/16/25 at 7:48 P.M. and at 2:41 A.M. on 02/17/25 by RN #481). Resident #184 (BIMS score of 15 documented on assessment in progress on 02/23/25) when asked by day nurse if the pain pills had helped her through the night and resident stated she had not taken any pain medication all night. (The MAR documented receiving Oxycodone 5 milligrams on 02/16/25 at 7:03 P.M. and at 12:18 A.M. and 4:36 A.M. on 02/17/25 by RN #481). Resident #187 had a BIMS score of 15 and stated he had not taken any pain medication through the night when asked by the day nurse. (The MAR documented receiving Norco 5-325 milligrams at 8:37 P.M. on 02/16/25 and 4:30 A.M. on 02/17/25 by RN #481). The self reported incident form revealed the nurse in question (RN #481) had been suspended 02/17/25. (The nurse routinely worked from 6:00 P.M. to 6:30 A.M.). It revealed, as a result of the allegations, residents were being interviewed on the unit, pain being assessed, record reviews being conducted, and staff interviews occurring. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a written statement by Licensed Practical Nurse (LPN) #404 dated 02/17/25 revealed that during her morning medication pass that morning on the East unit she had a few residents who complained of pain during her initial assessment. Resident #40 complained of pain and not being able to sleep all night. Upon checking the narcotic book for last dose, it was noted she had been medicated at 4:39 A.M. At that time, she let the resident know that it was too early for another pain medication. The resident became tearful and stated that she did not take anything for pain all night. Resident is alert and oriented. Medicated as soon as able. Resident #184 said that she had not had any pain medication all night but would let her know if she needed any before therapy. The narcotic book had medications signed out for Resident #184 at 12:00 A.M. and 4:00 A.M. (2 pills each time). She asked the resident if the two pills were helping or if it was too strong because the order said one or two pills depending on pain level. Again the resident stated she did not take any pain medication. She is alert and oriented. Upon assessment with Resident #78, she asked when she had her pain pill last night. Looked at narcotic book which stated medication given at 2:00 A.M. Resident stated she was asleep then and did not receive pain medications. Resident #187 asked to not have pain medications as much as possible because he is trying not to take them as much. When his pain was assessed this morning, he has an intact pain patch on his right hip/groin area. The MAR stated the resident was given Norco 5/325 milligrams at 4:30 A.M. Resident denies taking the medication. The facility concluded their investigation on 02/24/25. The investigation report revealed on 02/17/25 a nurse reported that four short term residents had not received their pain medications during the night shift. Upon further review, it was noted that this involved one specific night nurse. On 02/17/25 RN #481 was suspended pending an investigation into pain medications. Residents involved included Residents #40, #78, #184, and #187. It noted that Resident #40 was discharged on [DATE], prior to the conclusion of the investigation. Investigation included obtaining further statements from the noted residents. Resident #78 was interviewed on 02/18/25 and when asked if she had taken pain medication she replied yes and when asked if it had been administered at night when she asked for it she replied yes, except two times. When asked when it was not administered she replied two and a half weeks after being admitted . Resident #40 was interviewed on 02/18/25 and replied yes when asked if she had taken pain medication. When asked if it had been administered at night when she asked for it she replied I do, but one nurse won't give it. She did not remember when it was. Resident #184 was interviewed on 02/18/25 and when asked if she had taken pain medication she replied yes. When asked if it had been administered at night when she asked for it she replied yes. Resident #187 was interviewed on 02/18/25. When asked if he had taken pain medication he replied yes, one yesterday. When asked if it had been administered at night when he asked for it, he replied didn't ask. The investigation report stated that ten additional resident interviews were conducted with like residents on the East unit on 02/18/25. No further issues were noted from these interviews. Interviews were completed with staff that included 23 nursing assistants and eight nurses. Of the eight nurses interviewed, four noted there were concerns of pain medications taking time to be administered and three of the four nurses stated they had been told it was RN #481. Of the 23 nursing assistant interviews, 12 noted concerns regarding pain medication administration and resident waiting times. Four of the nursing assistants referenced RN #481 and two referenced a newer night nurse (RN #481 had been employed since 01/15/25 and worked night shift). An interview was conducted with RN #481 on 02/18/25. She stated that medication was given to the four residents who had initial concerns voiced. She stated medications were given in a timely manner. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	As the investigation progressed, it was noted that Resident #187, per his third interview, still said he had not requested pain medication at night. He also denied taking the medication at specific times when re-interviewed. Per review of the MAR, RN #481 was the nurse noted to have signed these medications off as being administered. Upon further review it was also noted that a medication was signed off on the narcotic sheet and was not noted on the MAR for Resident #187. Upon further facility interview with RN #481 on 02/24/25, she stated she would try intervention prior to administering a Norco for a pain level of 1 or 2 (RN #481 had administered six doses of Norco to Resident #187 for a pain level of 1 or 2). The investigation report stated that the investigation became more of a drug diversion allegation and was reported to the City Police Department on 02/24/25. Resident #187 was interviewed by the police. RN #481 agreed to be drug tested on [DATE] (7 days after the allegations made). The facility investigation revealed the facility would not substantiate the allegation of neglect based on inconsistencies in second interviews with some residents in question. The facility would substantiate that misappropriation did occur as noted during this investigation. The facility noted medications in question were to be replaced to the resident and billed to the facility. (Review of an email sent to the pharmacy by the Director of Nursing revealed Resident #187 had a medication card sent for seven narcotics. We are suspecting misappropriation may have occurred with these pills. Could you please replace them and bill the facility for this as soon as possible). The nurse in question has now been terminated from employment. (However, review of a corrective action form revealed RN #481 was terminated 02/24/25 for failure to provide complete and accurate information on all work records including but not to time records, incident/accident and exposure reports, applications for employment and benefits and resident care records). The nurse in question would also be reported to the Ohio Board of Nursing. Abuse education was provided to staff. The report was signed by the Director of Nursing. Interview with the Director of Nursing on 02/25/25 at 7:30 A.M. revealed the facility substantiated misappropriation of narcotics for Resident #187. She stated his statement did not change during the investigation. She stated the facility could not substantiate misappropriation for the other three residents in the investigation because their statements changed upon a second interview. She stated the facility would replace the seven narcotic pills documented as given to Resident #187 by RN #481. She confirmed RN #481 was terminated on 02/24/25. She confirmed the police and the Board of Nursing were notified 02/24/25. However, review of the interview documents with Residents #187, #78, #184, and #40 on 02/18/25 revealed the residents were only asked: Have you taken pain medication? Have you had it administered when asked for at night? If not, when? There was no evidence the residents were asked specifically about the medications that were documented as given on 02/16/25 and 02/17/25 (during the shift RN #481 worked) and if they had received the pain medications at those specific times. The interviews were conducted by RN #540. An additional interview was conducted with Resident #187 on 02/24/25. This interview included asking the resident if he had received Norco at specific times (the seven specific times it was documented as given by RN #481). The resident responded not sure, doubt it, don't think so, or possible. This interview was conducted seven days after the initial allegations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with RN #540 on 02/25/25 at 10:00 A.M. confirmed she conducted the interviews with Residents #187, #78, #184, and #40 on 02/18/25 (after the initial allegations were made on 02/17/25). She confirmed she did not specifically ask the residents if they had received the pain medications that were documented as given on 02/16/25 and 02/17/25 (during the shift RN #481 worked). She stated the questions asked were general questions and she only asked what was typed on the interview forms to ask. She confirmed there were no other interviews conducted with these residents, except for the interview with Resident #187 on 02/24/25. Interview with LPN #404 on 02/20/25 at 1:40 P.M. revealed that during her morning medication pass on 02/17/25 she was assessing each resident for pain (working on East 300 hall). She stated she looks at the MAR to see if resident's took pain medications during the night and to see how they are feeling. She stated most residents on that unit are alert and oriented. She stated that she noted that residents were documented as receiving pain medications during the night (prior to her shift) and the resident's were telling her they did not get any medications during the night. This included Residents #187, #78, #40, and #184. Interview with LPN #404 on 02/24/25 at 7:30 A.M. revealed she would never give a narcotic pain medication to a resident who only had a pain level of 1 or 2. On 02/24/25 at 1:50 P.M. LPN #404 stated she reported the issues identified with resident pain medications before 8:00 A.M. on 02/17/25 to the Assistant Director of Nursing. Review of the medical record for Resident #187 revealed an admitted [DATE]. A BIMS score of 15 (intact cognition) was noted on a BIMS evaluation completed 02/17/25. He had a physician's order for Norco 5-325 milligrams every eight hours as needed for pain on 02/12/25. Review of the MAR revealed RN #481 administered the Norco six times between 02/13/25 and 02/17/25 for a beginning pain level of either 1 or 2. However, review of the controlled substance record revealed RN #481 signed out seven doses of Norco pain medication for Resident #187. One dose had not been documented on the MAR. She was the only nurse that administered the Norco up until one dose was requested on 02/17/25 for a pain level of 8. The doses given included Norco 5-325 milligrams at 8:37 P.M. on 02/16/25 and 4:30 A.M. on 02/17/25 by RN #481. Review of the medical record for Resident #78 revealed an admitted [DATE]. A BIMS score of 15 was noted on an MDS completed 02/04/25. She had a physician's order for Oxycodone 5 milligrams every six hours as needed for moderate pain. The Medication Administration Record (MAR) documented receiving Oxycodone 5 milligrams on 02/16/25 at 7:48 P.M. and at 2:41 A.M. on 02/17/25 by RN #481 for a beginning pain level of 2. Review of the medical record for Resident #184 revealed an admitted [DATE]. A MDS assessment in progress documented a BIMS score of 15. The MAR documented receiving Oxycodone 5 milligrams on 02/16/25 at 7:03 P.M. (pain level of 2) and at 12:18 A.M. (pain level 4) and 4:36 A.M. on 02/17/25 (pain level 3) by RN #481. Review of the medical record for Resident #40 revealed an admitted [DATE]. A MDS assessment 02/06/25 documented a BIMS score of 14. The resident had a physician's order for Hydrocodone-Acetaminophen 5-325 milligrams one tablet every four hours as needed for pain. The MAR documented the resident receiving Hydrocodone-Acetaminophen 5-325 milligrams at 7:20 P.M. on 02/16/25 for a pain level of 2, at 12:21 A.M. on 02/17/25 for a pain level of 2, and at 4:38 A.M. on 02/17/25 for a pain level of 2. All were given by RN #481. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #187 on 02/20/25 at 3:00 P.M. revealed he does not have a lot of pain. He stated he wears a pain patch that stays on for a week. He stated that he does not take any pain pills at night. He stated he sleeps good at night and would never take a pain pill for a pain level of 1 or 2. He stated he would be asleep at 4:30 to 5:00 A.M. in the morning. He stated his pain level would have to be 8, 9, or 10 before he would take a pain pill. Interview with Resident #184 on 02/25/25 at 1:30 P.M. revealed she does not remember at this point if she got any pain medications during the night on 02/16/25 into 02/17/25. She stated she would have been able to answer better right after it happened. She stated she did not think that she received any as documented on 02/16/25 into 02/17/25 (night shift). Interview with Resident #78 on 02/18/25 at 11:01 A.M. revealed she feels like staff were documenting that they were giving her pain medications and keeping them for themselves. She stated a nurse told her that other residents had complained of not getting pain medications when they needed them and they are looking into it. She was unable to identify any nurse she felt may not give her pain medications as needed. Interview with Nursing Assistant #443 on 02/20/25 at 8:00 A.M. revealed a nurse on night shift that has only worked there a few weeks, said that if a resident didn't need pain medication during the day then they didn't need it at night. She stated residents asked for pain medications during the night and the nurse did not provide them. She stated this affected Residents #78, #40, and #184 on 02/03/25. (Review of the schedule revealed RN #481 worked on that unit on night shift on 02/03/25). Interview with the Director of Nursing on 02/20/25 at 7:10 A.M. revealed a drug test was not done for RN #481 after the allegation of possible misappropriation of narcotics for four residents on 02/17/25. She stated the facility policy was to do a drug test if the employee showed signs of impairment, and RN #481 did not. Review of the facility policy titled Drug Free Workplace (dated 04/01/01 and last revised 03/15/24) revealed drug or alcohol tests would be conducted for reasonable suspicion/for cause based on four listed criteria which included: evidence that a resident's prescribed medication(s) is missing to which access and timing is pinpointed to a specific staff member or group of staff members; Information provided to the facility by a customer or other reliable and credible source reporting any of the above behaviors or reporting suspected drug or alcohol use. Review of the facility investigation report revealed RN #481 agreed to be drug tested on [DATE] (7 days after the initial allegations of misappropriation by LPN #404) despite showing no noted signs of impairment but do to the diversion suspicion. The results were expected in 3-5 days. Interview with Human Resource Manager #423 on 02/24/25 at 3:00 P.M. revealed she felt being able to conduct an employee drug test for reasonable suspicion would include if a staff member was alleged to have taken resident narcotics. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing on 02/25/25 at 7:30 A.M. (after investigation completed) revealed the facility did not evaluate the narcotic documentation records for any other resident on the East unit (where RN #481 worked). She stated they only looked at the documentation for the four residents initially with concerns. (There were 15 residents residing on the East unit on 02/18/25 at the start of the survey). She confirmed the facility pharmacy had not been involved in the investigation and had not completed an audit of narcotic records to look for irregularities related to narcotic/double secured medications. Review of the medical record for Resident #26 revealed an admitted [DATE]. A MDS assessment 01/21/25 documented a BIMS score of 11 (moderately impaired cognition). The resident had a physician's order for Hydrocodone-Acetaminophen 5-325 milligrams one tablet every four hours as needed for pain beginning 01/15/25. The resident did not receive any of the pain medication between 01/15/25 and 01/18/25 per the medication administration record (MAR). Review of nursing schedules revealed RN #481's first day of work on the East unit was 01/19/25. Between 01/19/25 and 02/12/25, RN #481 documented on the MAR that she administered the Hydrocodone to Resident #26 25 times for pain levels of 1-2 (one pain level of 3). No other nurse documented on the MAR that the Hydrocodone was given during that time period. Interview with the Director of Nursing on 02/25/25 at 10:15 A.M. confirmed Resident #26's narcotic use had not been evaluated as a result of the allegation of misappropriation of narcotics. She confirmed the fact that RN #481 had documented that she had given the resident the narcotic pain medication that many times for a pain level of 1-3 and no other nurse was giving it was suspicious. Review of the medical record for Resident #6 revealed an admitted [DATE]. A MDS assessment 01/29/25 documented a BIMS score of 12 (moderately impaired cognition). The resident had a physician's order for Ativan 0.5 milligrams every eight hours as need for anxiety for 14 days beginning 01/31/25 and ending 02/12/25. During the 14 day period, the controlled substance record documented the Ativan was administered ten times between 02/01/25 and 02/12/25. Nine of those were administered by RN #481 during the six shifts she worked during that time period. Interview with the Director of Nursing on 02/25/25 at 10:15 A.M. confirmed Resident #6's secured medication use had not been evaluated as a result of the allegation of misappropriation of narcotics. She confirmed the fact that RN #481 had documented that she had given the resident the Ativan that many times and only one other nurse had given it once was suspicious. Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property (dated 03/30/12 and last revised 10/10/24) revealed residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. Misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. It further stated investigation protocol included reviewing all relevant medical reports/records, as applicable.

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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** 28923 Based on record review, resident interview, staff interview, and policy review, the facility failed to ensure a resident was included in their quarterly care conference to help develop an individualized plan of care for the resident as they desired. This affected one resident (#11) of one residents reviewed for care planning conferences. Findings include: Review of Resident #11's medical record revealed the resident was admitted to the facility on [DATE] with a readmission to the facility on [DATE]. Her diagnoses included senile degeneration of the brain, unspecified dementia, schizo-affective disorder, bipolar disorder, heart failure, and palliative care. Review of Resident #11's most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had clear speech and adequate hearing. She was usually able to make herself understood and was able to understand others. She was assessed as being cognitively intact and was not known to display any behaviors or reject care. Review of Resident #11's progress notes revealed a social service note dated 01/21/25 at 1:45 P.M. that indicated a care conference was held on that date with resident's son over the phone. Hospice, nursing, and social services were indicated to have been in attendance. There was no indication of the resident having been part of that meeting. The resident's care plan was reviewed and updated, and medications, code status, orders, and immunizations were reviewed as well. They addressed any questions or concerns that were raised. On 02/18/25 at 11:44 A.M., an interview with Resident #11 revealed she did not recall ever being invited to attend any of her care planning conferences. Her family may have been invited, but she never was. She verbalized attending her care planning conferences was something she would be interested in doing. On 02/24/25 at 10:10 A.M., an interview with Admissions Coordinator #457 revealed the facility's social worker usually handled the care planning conferences, but was off work due to an illness. She was informed Resident #11 was reporting she was not included in her care planning conferences and had not been asked to attend. She was asked to provide any documented evidence to show the resident did participate in the care planning conference or that she was offered and declined. On 02/24/24 at 10:10 A.M., a follow up interview with Admissions Coordinator #457 revealed she was only able to find a social service note dated 01/21/25 that revealed a care planning conference had been held on that date and the resident's son participated over the phone. She was not able to provide any documented evidence of the resident's participation or evidence she was invited and opted not to be a participant. She acknowledged the resident should be included as part of that meeting, if they so chose to, since the meetings' intent was to develop the plan of care for the resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy on Interdisciplinary Care Conferences (revised 01/19/07) revealed each resident would have an individualized plan of care based on the comprehensive assessment and developed by the interdisciplinary team (IDT) during care conferences. The care conference would be held no less than quarterly or at any completion of the MDS assessment. The IDT may include but was not limited to the medical director, the DON, the unit nurse, a certified nursing assistant, the resident, the resident's family, social services, dietician/ dietary tech, activities, restorative nursing, and the MDS coordinator. The care conference structure guidelines in the policy indicated they were to be sure to invite the residents and families. They were then to document they invited them and whether they attended.

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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** 32801 Based on medical record review, observation, interview, and policy review the facility failed to ensure residents dependent on staff for personal care received nail care timely. This affected two residents (#61 and #73) of four reviewed for activity of daily living (ADL). Findings include: 1. Medical record review revealed Resident #61 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of muscle, protein-calorie malnutrition, vascular disease, diabetes, kidney disease, anemia, and cervical disc disorder. Review of Resident #61's annual Minimal Data Set (MDS) assessment dated [DATE] revealed the resident required partial to moderate assistance with personal hygiene. Review of Resident #61's nursing note dated 02/11/25 revealed the resident required one on one assisting during activities of daily (ADL) care including bathing, dressing, and toileting. Review of Resident #61's ADL plan of care dated 06/12/24 revealed the resident had an ADL self-care performance deficit related to generalized weakness/deconditioning. Resident #61 required extensive assistance of one staff member for bathing and limited assistance of one staff for hygiene care. Review of Resident #61's task dated 01/26/25 to 02/23/25 revealed the resident was independent to dependent on staff for personal hygiene. There was document evidence that the resident had received nail care. Review of Resident #61's medical record revealed no documented evidence the resident had received nail care. Observation and interview on 02/18/25 at 10:18 A.M., of Resident #61 revealed the resident's fingernails were long and had a dark yellow/brown substance under them. Resident #61 reported that staff were usually pretty good about providing nail care, however they had been short staffed due to the weather conditions. Observation and interview on 02/19/25 at 11:06 A.M., with Resident #61 and Licensed Practical Nurse (LPN) #407 confirmed the resident's nails were long, some were jagged, and some had a brown/yellow substance under them. The resident confirmed it had been some time since staff had trimmed his nails and he required staff to perform his nail care. Licensed Practical Nurse (LPN) #407 confirmed findings during the observation and reported she was not sure of the schedule or policy for nail care and would have to look into it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/24/25 at 8:01 A.M., with the Director for Nursing (DON) revealed she was notified by staff regarding the surveyor's concerns regarding nail care not being performed timely for Resident #61. The DON confirmed nail care should be part of ADL care. The DON confirmed there was no documented evidence Resident #61 had received nail care and she was going to add nail care to the task tab for staff to document when nail care was provided to residents. Review of the facility's policy titled Nail Care (dated 11/01/16) revealed the facility was to provide resident safe, hygienic and thorough nail care assistance. Direct care staff would consult with a Registered Nurse (RN) for any special direction as they may apply to diabetic residents. Document any nail care provided. 07316 2. Review of the medical record for Resident #73 revealed an admitted [DATE] and diagnoses of hypertension, anxiety disorder, and morbid obesity. Review of a Minimum Data Set assessment completed 01/17/25 revealed a brief interview for mental status score of 9, indicating moderate cognitive impairment. It stated he required substantial/maximal assistance from staff with personal hygiene. Rejection of care was not indicated on the assessment. Observations on 02/18/25 at 2:30 P.M., 02/19/25 at 10:43 A.M. and 1:58 P.M. and 02/20/25 at 9:38 A.M. revealed Resident #73 to have a dark brown substance under his fingernails on both hands. (Resident #73 fed himself meals). Interview with Licensed Practical Nurse (LPN) #411 on 02/20/25 at 9:38 A.M. confirmed Resident #73 had a dark brown substance under his fingernails. She stated he digs near his prostate and it was probably bowel movement under his nails. She stated the staff should clean his hands. She stated if you talk nicely to him, he will let you provide hygiene care. She stated he was sometimes combative but if he refuses it should be documented. Review of the plan of care dated 11/18/24 revealed the resident had a self-care performance deficit. It stated he required 1-2 staff assistance with hygiene. The plan of care did not indicate a refusal of personal care. Review of nurses progress notes since admission did not reveal any refusal of care except for one time on 02/14/25 at 8:19 P.M. when he was refusing to go to bed for incontinence care. Interview with Registered Nurse (Unit Manager) #517 on 02/24/25 at 8:30 A.M. confirmed there was no evidence of any refusal of personal care in the past few days. She confirmed Resident #73 does have a tendency to dig at his private area. She confirmed the nursing assistants should check his nails daily and provide nail care when needed.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on closed medical record review, review of emergency responder record, hospital record review, facility policy and procedure review and interview, the facility failed to provide timely, necessary and adequate care and services following an acute change in condition involving Resident #26. The facility failed to ensure changes in the resident's medical condition were timely identified and comprehensive and individualized interventions were implemented for Resident #26 when the resident was assessed to have a decline in health including tachycardia, shortness of breath, fatigue, and weakness. This resulted in Immediate Jeopardy and Actual Harm with subsequent death beginning on [DATE] when Resident #26 had increased weakness and need for assistance with activities of daily living (ADLs) during therapy treatment. On [DATE] and [DATE], Resident #26 continued to have shortness of breath and tachycardia during therapy treatments. Nurse Practitioner (NP) #337 saw Resident #26 on [DATE] after staff had concerns with tachycardia but failed to address the resident's decline in condition (shortness of breath, fatigue and increased weakness). Resident #26 continued to have symptoms and decline in her condition through [DATE] when staff transferred the resident to the hospital. Resident #26 was admitted to the hospital with diagnoses including metabolic encephalopathy, pneumonia, urinary tract infection (UTI), sepsis, and altered mental status and expired at the hospital on [DATE] at 11:52 A.M. On [DATE] at 12:00 P.M. the Administrator, Senior Administrator, and Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] when staff identified Resident #26 exhibited a change in condition which included shortness of breath, tachycardia, and increased weakness, within 30 days of admission, without evidence of timely or adequate interventions/medical treatment being provided. Resident #26 continued to display a deterioration in condition between [DATE] and [DATE] that was not comprehensively addressed. On [DATE] at approximately 7:02 A.M. Resident #26 was transferred to the hospital where she was admitted with diagnoses of pneumonia, UTI, altered mental statis, and sepsis. Resident #26 expired at the hospital on [DATE] at 11:52 A.M. In addition, a concern that did not rise to the level of Immediate Jeopardy was identified when the facility staff failed to monitor a change in Resident #12's bowel movements to ensure necessary and appropriate treatment was provided. This affected two residents (#26 and #12) of three residents reviewed for change in condition. The facility census was 75. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following actions: On [DATE] at 7:02 A.M. Resident #26 was sent to the hospital. The resident did not return to the facility and passed away in the hospital on [DATE]. On [DATE] the Director of Nursing/Designee completed a whole house audit of resident's charts for the past 48 hours to review for documentation of a change in condition and to ensure timely notification of physician and family if a change in condition was identified. On [DATE] the Director of Nursing/Designee completed resident interviews on residents residing on East unit to investigate if a delay in care was noted in the past 48 hours. Any variances were addressed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] the Director of Nursing/Designee completed a review of residents hospitalized and/or expired spanning the past 2 weeks ([DATE]-[DATE]) to determine if a delay in care was documented. On [DATE] licensed nursing staff including six Registered Nurses (RNs), 21 Licensed Practical Nurses (LPNs) and 40 Certified Nursing Assistants (CNAs) were educated by the Director of Nursing/Designee to ensure residents who exhibit a change in condition are assessed timely with interventions in place, report to another nurse or up the chain if you feel a change in condition is not being addressed, and to notify the physician and family of the change in condition. Staff were educated that a change in condition relates to a significant change in the residents physical, mental, or psychosocial status in either life-threatening conditions or clinical complications. Licensed nursing staff must document that the change in condition was assessed, documentation of the assessment and follow-up. Remaining licensed nursing staff not educated on [DATE] includes one LPN and three CNAs. These individuals would not be permitted to work until educated, which would be completed by Director of Nursing/Designee prior to their shift. On [DATE] licensed nursing staff including six RNs and 21 LPNs were educated by the Director of Nursing/Designee to ensure resident after visit summaries were reviewed to identify any signs and symptoms of complications. Remaining licensed nursing staff not educated on [DATE] includes one LPN. This individual would not be permitted to work until educated, which would be completed by Director of Nursing/Designee prior to their shift. On [DATE], an ad hoc Quality Assessment and Performance Improvement (QAPI) meeting was held at approximately 4:15 p.m. with the Administrator, Director of Nursing/Designee, Assistant Director of Nursing, Unit Managers, Director of Therapy and the Medical Director to review Resident #26's change of condition, and to discuss the above interventions and removal plan. The Change in Condition Policy was reviewed with no changes to the policy. The facility implemented a plan for the Director of Nursing/Designee to audit five residents a week for four weeks to ensure residents with a change in condition were assessed, interventions were in place, the physician and responsible party were notified of the change in condition. Results of the audits would be reviewed in the QAPI Committee meeting for one month with revisions to the plan / change in monitoring as deemed by the QAPI Committee. Although the Immediate Jeopardy was removed on [DATE] the deficiency remains at a Severity Level II (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: 1.Review of Resident #26's closed medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including encounter for surgical aftercare following surgery on the circulatory system, pulmonary hypertension, acute systolic congestive heart failure, and presence of prosthetic heart valve. The resident was discharged from the facility on [DATE] and passed away in the hospital on [DATE]. Review of the resident's advance directives revealed the resident was a full code. Review of an order dated [DATE] revealed Resident #26 was admitted to the facility for skilled level of care with therapy and/or nursing services. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a hospital after visit summary dated [DATE] revealed Resident #26 should call her doctor right away if she had shortness of breath, an abnormal heart rate- fast or slow- if new to the resident and worsening or severe fatigue. Resident #26's discharge disposition from the hospital was to a skilled nursing unit. Review of a care plan dated [DATE] revealed Resident #26 was new to the facility and planned to return to her home following her recovery. Goals included achieving and maintaining highest function in her preferred environment, and returning home after her recovery. Interventions included scheduling discharge planning meetings as needed, initiating services needed to return home, making referrals needed to return home, and ordering medical equipment at home if needed. Review of the resident's physician orders dated [DATE] revealed Resident #26 had a full code status in place, would receive occupational therapy services five times a week for four weeks with treatment including therapeutic exercises, activities, activity of daily living (ADL) training, and group therapy. Additionally, there was an order for the resident to receive physical therapy five times a week for four weeks for therapy exercise, activities, neurological re-education, gait training and group therapy. Review of a care plan dated [DATE] revealed Resident #26 had an altered cardiovascular status related to congestive heart failure (CHF), hypertension, myocardial infarction, aortic valve stenosis, atherosclerotic heart disease, tricuspid valve insufficiency, atrial fibrillation, status post transcatheter aortic valve replacement (TAVR), and pulmonary hypertension. The goal was for Resident #26 to be free of complications of cardiac problems through the review date of [DATE]. Interventions included to assess for chest pain, shortness of breath and cyanosis; dietary consult as needed; monitor vital signs and notify provider of abnormalities; monitor/document/report as needed any changes in lung sounds on auscultation, edema and changes in weight; monitor/document/report as needed any signs or symptoms of coronary artery disease (CAD) including chest pain or pressure especially with activity, heartburn, nausea and vomiting, shortness of breath, excessive sweating, dependent edema, changes in capillary refill, color/warmth of extremities; and O2 settings per provider orders (dated [DATE]). Review of an Occupational Therapy plan of treatment dated [DATE] revealed Resident #26's goals included increasing bilateral upper extremity strength in order to increase independence with ADLs; increase static and dynamic standing balance to fair spontaneously righting self when needed in order to improve ability to perform ADLs; improve ability to safely and efficiently maintain perineal hygiene, adjust clothes before/after voiding or having a bowel movement with supervision or touching assistance; improve ability to safely and efficiently bathe self, including washing, rinsing, and drying self with supervision or touching assistance in order to return to prior level of skill performance; improve ability to safely and efficiently perform lower body dressing with supervision or touching assistance in order to return to prior level of skill performance; improve ability to safely transfer to a standing position from sitting in a chair, wheelchair or on the side of the bed and chair/toilet transfers with independence in order to return to prior level of functional abilities; improve ability to safely and efficiently maintain perineal hygiene, adjust clothes before/after voiding or having a bowel movement with independence; improve ability to bathe self, including washing, rinsing, and drying self with independence in order to return to prior level of skill or function; and improve ability to safely and efficiently perform lower body dressing and footwear with independence in order to return to prior level of skill. Resident #26's potential to reach her goals was noted to be good. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a Physical Therapy plan of treatment dated [DATE] revealed Resident #26's goals included increasing bilateral hip strength to ,d+[DATE] in order to improve ability to transfer to standing; increase bilateral knee strength in order to improve stability in standing and reduce knee buckling when ambulating; tolerate static standing with one upper extremity task for three minutes in order to improve ambulation tolerance; increase dynamic standing balance to fair- spontaneously righting self when needed without kiss of balance in order to prepare to gait activities; transfer from one surface to another using a rolling walker with contact guard assistance and demonstrating good safety with minimum verbal cues to decrease fall risk; would ambulate 20 feet with a rolling walker at contact guard assist without knee bucking in order to safely ambulate to the restroom with caregiver assistance; ambulate 60 feet using a rolling walker with stand by assist and SpO2 greater than 90% to safely ambulate at home; and improve ability to safely transfer to a standing position from sitting in a chair, wheelchair, or on the side of the bed with supervision or touching assistance in order to decrease level of assistance from caregivers. The plan of treatment reflected the resident's potential for achieving goals was fair. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had mildly impaired cognition, no behaviors and no pain. The assessment revealed the resident required (staff) set-up assistance for eating and oral hygiene, maximal (staff) assistance for toileting and bathing, was dependent on staff for dressing and personal hygiene and required maximal (staff) assistance for bed mobility and transfers. The assessment revealed the resident could walk 10 feet with a walker with moderate assistance. Additionally, the assessment revealed Resident #26's plan was to discharge to her home. Review of a physician order dated [DATE] revealed an order for Resident #26 to have as needed oxygen in place at two liters per minute via nasal cannula for shortness of breath. Review of a nursing note dated [DATE] at 10:59 A.M. revealed Nurse Practitioner (NP) #337 saw Resident #26 and ordered a stat chest x-ray and labs for dyspnea. Vitals signs at the time were ,d+[DATE], 84 pulse, temperature was 97, respirations were 18, and O2 was 96% on 2 liters per minutes via nasal cannula. Review of a nursing note dated [DATE] at 1:56 P.M. revealed Resident #26's chest x-ray was negative for concerns and all parties were aware. Blood draw would not be completed until the following Monday ([DATE]). Review of a nursing note dated [DATE] at 5:30 P.M. revealed lab results were received and reviewed by NP #337 with no new orders. Review of a skilled nursing note dated [DATE] at 10:12 A.M. revealed Resident #26's vitals were within normal limits, her mental status was alert and oriented to person, place, and time with some forgetfulness, no signs of difficulty breathing or shortness of breath noted. Review of an occupational therapy (OT) note dated [DATE] at 1:14 P.M. by OT Assistant (OTA) #305 revealed treatment had to be completed with a physical therapy assistant (PTA) due to the resident's decreased activity tolerance. (Resident 26's baseline in therapy was noted to be moderate assistance for a sit-to-stand, chair to chair transfer, toilet transfer, lower body dressing, bathing, or walking 10 feet; independent for eating and oral hygiene; and supervision for personal hygiene, toileting hygiene, and upper body dressing.) (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a nursing note dated [DATE] at 3:46 P.M. by Licensed Practical Nurse (LPN) #341 revealed therapy reported Resident #26 had increased weakness and need for assistance with ADLs and mobility during this dates treatment. Nursing interventions were in place to monitor for further changes in status. There was no evidence of notification to the physician or responsible party regarding the resident's change/decline in condition that had been reported by therapy. In addition, there was no evidence of a physical/comprehensive assessment of Resident #26 being completed by nursing staff at this time (including vital sign monitoring). Review of a physical therapy note dated [DATE] at 4:35 P.M. by PTA #303 revealed Resident #26's treatment was completed (on this date) with OT due to decreased activity tolerance. Resident #26 experienced shortness of breath due to fatigue from standing statically. Resident #26 walked with decreased stability and reported her left knee was weak and felt like it was going to give out. Review of a physician's order dated [DATE] revealed Resident #26 had an order for a 4 Plex swab (test for Flu and COVID), oxygen at two liters per minute via nasal cannula for SpO2 less than 90% as needed, to check SpO2 every shift, and place the resident on droplet precautions. The resident's 4 Plex swab was noted to be negative. Review of a nursing note dated [DATE] at 11:12 A.M. by LPN #493 revealed droplet precautions were discontinued in accordance to facility guidelines (the resident's Plex swab was negative), provider and family aware and Resident #26 verbalized understanding. Record review revealed no additional comprehensive assessment of Resident #26's condition was completed at this time. Review of an occupational therapy note dated [DATE] at 2:19 P.M. by OTA #305 revealed Resident #26 required monitored seated recovery breaks secondary to shortness of breath and fatigue. Resident #26's SpO2 was ,d+[DATE]% on room air, and her heart rate was ,d+[DATE] beats per minute (bpm). Treatment was completed with a PTA due to the resident's decreased activity tolerance. The note revealed nursing was notified. Review of a physical therapy note dated [DATE] at 2:50 P.M. by PTA #303 revealed therapy was completed with OT due to decreased activity tolerance. Resident #26 had fatigue and required several rest breaks with statis standing. Resident #26 had ,d+[DATE]% O2 saturation and a heart rate of ,d+[DATE] bpm. However, review of the resident's medical record revealed there was no nursing note to address the concerns identified by OT/PT staff. Review of a nurse practitioner (NP) note dated [DATE] at 12:52 P.M. and authored by NP #337 revealed Resident #26 was seen for episodes of tachycardia intermittently with heart rates between 120s to 140s which then returned to 70s and 80s. The episodes were more frequent over the last day or two. During the visit, Resident #26 did not complain of chest pain, fever or chills, or shortness of breath. The note included the resident's vital signs were blood pressure ,d+[DATE], pulse 73 beats per minute and SpO2 was 96%. The resident's diagnoses reviewed during visit were atrial fibrillation and tachycardia. The plan was to continue apixaban (blood thinner) for anticoagulation and increase metoprolol succinate to 75 milligrams (mg) by mouth daily and reduce losartan to 25 mg daily and continue to monitor. No further orders were noted. There was no indication Resident #26 was evaluated related to the shortness of breath or increased weakness and fatigue during exertion that had been identified by therapy staff. There were no additional NP (or physician) provider visit notes for Resident #26 after [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of an occupational therapy note dated [DATE] at 1:40 P.M. by OTA #305 revealed Resident #26 completed upper body dressing while seated for safety with moderate assistance and increased time. Lower body dressing was completed with moderate assistance and increased time as well as verbal cues for sequencing of task. Resident #26 had increased shortness of breath for ADL tasks with SpO2 at 83% on room air and her heart rate was ,d+[DATE] beats per minute. Nursing was notified and Resident #26 was placed on O2 via nasal cannula at two liters per minute. Resident #26 then required monitored recovery breaks with her SpO2 at ,d+[DATE]% on two liter per minute and heart rate of ,d+[DATE] beats per minute. There was no documented evidence that nursing staff completed an assessment of Resident #26's condition after being notified by OTA #305 of the resident's condition during therapy. Review of a Utilization Review note dated [DATE] at 2:35 P.M. revealed therapy staff were concerned about Resident #26's plans to discharge to her home due to the amount of care she was needing. However, there was no additional interdisciplinary note (comprehensive evaluation or assessment) to determine why the resident's care needs had increased following her admission, or evidence the resident's discharge plan needs were addressed at this time as it related to her current condition as of this date. Review of a physical therapy note dated [DATE] at 3:31 P.M. by PTA #303 revealed Resident #26's activities were completed sitting at the edge of a chair with various reaching activities for about 14 minutes with rest breaks due to O2 dropping to ,d+[DATE]% and O2 had to be applied. Review of an occupational therapy note dated [DATE] at 3:39 P.M. by OT #307 revealed Resident #26's O2 desaturated to 85% during functional mobility but recovered quickly with the use of O2. Resident #26 was educated to have O2 on with activity and verbalized understanding. Review of a physical therapy note dated [DATE] at 4:18 P.M. by PTA #303 revealed Resident #26's heart rate was ,d+[DATE] bpm and her O2 saturation was ,d+[DATE]%. The resident's OT and PT sessions were completed as cotreatments on this date as the resident exhibited decreased tolerance with physical activity during the treatments. There was no evidence of a comprehensive nursing assessment of Resident #26's condition on [DATE] related to the decreased tolerance, oxygen saturation and elevated heart rate that was identified by therapy staff. Review of a physical therapy note dated [DATE] at 12:24 P.M. by PT #311 revealed Resident #26 had rest breaks to recover from shortness of breath during treatment and patient was being impulsive to sit during treatment. Resident #26 required maximum verbal cues to slow pace and complete turn before sitting. Review of a skilled nursing note dated [DATE] at 12:26 P.M. by LPN #404 revealed Resident #26 had difficulty breathing, nurse reported labored breathing and shortness of breath. The note indicated Resident #26's oxygen saturation was noted to be 99% with O2 in place via nasal cannula. All vitals were checked and an assessment was completed. However, there was no documented evidence that the medical provider (NP or physician) or responsible party were notified of the resident's difficulty in breathing labored breathing/shortness of breath. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a change in condition note dated [DATE] at 6:15 A.M. by LPN #411 revealed Resident #26 had altered mental status, a resting pulse of 122, difficulty swallowing, decreased mobility, more assistance with ADLs, was not able to follow commands, was not able to walk or sit up, and was trying to get out of bed and chair when she normally does not try to. An order was received to send Resident #26 to the emergency department. Review of a vital sign record dated [DATE] at 6:28 A.M. by LPN #411 revealed Resident #26's heart rate was 122 bpm, her blood pressure was ,d+[DATE], and her O2 saturation was 91% on room air. Review of a nursing note dated [DATE] at 7:03 A.M. by LPN #411 revealed Resident #26 was transferred to the hospital by squad due to a change in mental status. Resident #26 had increased confusion, was not able to follow commands, was not walking with her walker with assistance like she normally could and was trying to get out of bed and chair when she normally would not. Review of the report from the responding fire department revealed they received a call on [DATE] at 6:46 A. M. for a confused female patient. Crews arrived and found Resident #26 in bed with oxygen in place at three liters per nasal cannula. The report included staff reported the resident being confused and weak the past two days and that family and the physician wished to have the resident transported to the hospital. The fire department left the facility with the resident at 7:07 A.M. Review of an initial hospital note dated [DATE] revealed Resident #26 presented to the hospital with altered mental status and a positive urine analysis concerning for UTI. A chest x-ray was completed with possible infiltrates versus atelectasis for possible pneumonia. Resident #26's heart rate was 108. The note revealed Resident #26 had severe sepsis due to UTI and possible pneumonia. Intravenous (IV) antibiotics of azithromycin and Rocephin were started but the resident was unable to receive a sepsis fluid bolus due to her cardiac history. The hospital record included Resident #26 had metabolic encephalopathy likely due to infection. Review of a Pulmonary Critical Care note dated [DATE] revealed Resident #26 had cardiac arrest in the emergency room with successful resuscitation at 2:00 P.M., biventricular failure on echocardiogram, possible aspiration pneumonia, pulmonary edema. Resident #26 received chest compressions three times after losing her pulse. Resident #26 received an epinephrine drip, and her airway was secured. Resident #26 was placed on a ventilator and was desaturating in the low 80s on mechanical ventilation. Resident #26's prognosis was poor. Review of a facility nursing note dated [DATE] at 11:56 A.M. by LPN #411 revealed Resident #26 was admitted to the hospital with diagnoses of altered mental status, a UTI, and pneumonia. Review of a social services note dated [DATE] at 12:01 P.M. by Social Services Designee (SSD) #439 revealed SSD contacted Resident #26's daughter regarding missing bottom dentures and was informed Resident #26 had expired at the hospital. Review of a discharge summary from the hospital dated [DATE] at 12:17 P.M. revealed Resident #26 expired related to acute hypoxemic respiratory failure at 11:52 A.M. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on [DATE] at 10:19 A.M. with OTA #305 revealed Resident #26 had a decline over the last week she was at the facility. The resident kept getting weaker, had shortness of breath and she was not feeling well. OTA #305 stated therapy staff noticed the change and Resident #26 would be tachycardic and they let nursing staff know. OTA #305 stated Resident #26's condition did not get any better as time went on. Resident #26 was weak and having trouble doing things she was normally able to do. OTA #305 stated part of Resident #26's therapy was assistance with toileting, and she always had to use the bathroom a lot. The OTA revealed Resident #26 was not feeling well on [DATE] but she did try to participate the best she could (in therapy). OTA #305 stated she knew Resident #26 was not feeling well because instead of doing therapy exercises while standing up, she just wanted to sit. Resident #26 was short of breath and tired and OTA #305 reported to nursing staff on [DATE] her concerns to the dayshift nurse. Interview on [DATE] at 11:21 A.M. with Registered Nurse (RN) #431 revealed she worked with Resident #26 on [DATE] and noted the resident was tired and it was reported she was not at her baseline. RN #431 stated Resident #26's O2 saturation would dip for no reason, and they did not know why. RN #431 could not recall any specifics on who reported Resident #26 was not at her baseline or any additional details during the interview. Interview on [DATE] at 11:31 A.M. with LPN #404 revealed Resident #26 was placed on O2 because of shortness of breath which would increase while working with therapy. LPN #404 stated when previously working with Resident #26 (prior to [DATE]), she would be able to get up with her walker but the last two times she worked with her, including on [DATE], Resident #26 was having a hard time getting up from her chair and required assistance with a gait belt to physically help her stand up due to weakness. LPN #404 stated she thought she reported concerns to NP #337, but stated she was unsure of when she had notified her; however, she knew it was not on [DATE]. Interview on [DATE] at 11:43 A.M. with LPN #411 revealed she worked with Resident #26 on [DATE] and [DATE]. LPN #411 indicated on [DATE], Resident #26 was a little confused about what would happen sometimes. LPN #411 stated she instructed the night shift nurse to keep an eye on Resident #26 because she thought the resident may have a UTI. The LPN stated Resident #26 was not terribly confused and was able to answer questions and talk. When LPN #411 returned on [DATE], Resident #26 was totally different. Resident #26 was really out of it, confused and trying to get out of bed. The LPN revealed the resident was usually able to walk to the bathroom, but she was not even able to stand. LPN #411 reported she asked the night shift nurse why Resident #26 was not sent to the hospital, and the night shift nurse (RN #481) stated Resident #26 was at her baseline. LPN #411 stated Resident #26 was not at her baseline, called the provider, and had the resident transferred to the hospital. LPN #411 reported when she first arrived for her shift, the night shift aide approached her and asked her to assess Resident #26 and when she made the decision to send Resident #26 to the emergency department, RN #481 stated she would not send her out. The night shift aide (Certified Nursing Assistant (CNA) #470) reported Resident #26 had declined in the night but did not specify when. Interview on [DATE] at 3:55 P.M. with the Director of Nursing (DON) revealed she had been unaware of what happened with Resident #26 until she read the NP note dated [DATE] on this date. The DON confirmed the resident's nursing notes, therapy notes, orders, and the NP note that identified the resident was first noted with a change in condition on [DATE] but not transferred to the hospital until [DATE]. During the interview, the DON revealed the symptoms exhibited by Resident #26 could be a sign of infection. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on [DATE] at 4:16 P.M. with NP #337 revealed she adjusted Resident #26's blood pressure medications (on [DATE]) to help lower Resident #26's heart rate so her body was not working so hard, but also so her blood pressure would not drop too low. NP #337 stated she knew about Resident #26 having tachycardia but could not recall being informed of the resident's O2 desaturation. NP #337 stated tachycardia and shortness of breath could be signs of an infection even if other vitals were within normal limits. The NP revealed this could be an indicator of pneumonia specifically. NP #337 stated if she was made aware problems persisted, she would have ordered a chest x-ray to rule out pneumonia. NP #337 stated she was not aware of the resident's hospital admission, diagnoses, or Resident #26 expiring. Interview on [DATE] at 5:24 P.M. with CNA #470 revealed she worked night shift and had been working from the night of [DATE] through the morning of [DATE]. CNA #470 stated on [DATE] at about 2 A.M., Resident #26 was not acting right, was restless and trying to climb out of bed, had a lot of confusion and was very weak. CNA #470 stated RN #481 did not evaluate Resident #26 and had made a comment, I have given her everything I can give her, and I can't do anything else. CNA #470 stated she asked RN #481 about calling the provider or sending Resident #26 to the hospital and RN #481's response was Resident #26 would be fine. CNA #470 stated when LPN #411 came in for dayshift, she expressed concerns to her and LPN #411 immediately assessed Resident #26 and prepared to send her to the hospital. CNA #470 stated RN #481 stated, if you send her to the hospital, they will just send her back and we will get 'dinged.' CNA #470 stated she was in the room while LPN #411 was assessing Resident #26 and noticed her face was gray and her ears were turning purple. CNA #470 stated she initially noticed Resident #26 looked gray at about 2:00 A.M. CNA #470 stated RN #481 was aware of Resident #26's change in skin tone but still declined to send her to the hospital despite her being a full code. CNA #470 stated she was just an aide, but usually if she had concerns resident needs were not being addressed, she would get a nurse from another hall, however RN #481 was an RN and seemed like she knew what she was doing. Interview on [DATE] at 9:21 A.M. with RN #481 revealed she had worked night shift on [DATE] into the morning of [DATE] and was Resident #26's nurse. RN #481 stated Resident #26 was agitated and her daughter came in to help calm her down. RN #481 stated it was her belief that Resident #26 did not have a change in condition. When the day shift nurse came in, she stated something was wrong with Resident #26, but RN #481 stated she had checked the resident's vitals and lung sounds with no concerns. RN #481 confirmed CNA #470 expressed concerns to her multiple times due to Resident #26 being Resident #26. RN #481 stated Resident #26 was hollering and agitated but had no changes in appearance. RN #481 stated she was alarmed to know Resident #26 was admitted to the hospital and expired. Interview on [DATE] at 10:19 A.M. wi [TRUNCATED]

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, record review, staff interview, and resident interview, the facility failed to ensure a resident with a pressure ulcer received the necessary treatment and services to promote healing and prevent new ulcers from developing. This affected one resident (#66) of three residents reviewed for pressure ulcers. The facility census was 75. Findings include: Review of the medical record for Resident #66 revealed an admitted [DATE] and diagnoses including acute kidney failure, hypertension, and stage four pressure ulcer. A Minimum Data Set assessment completed 12/28/24 documented a brief interview for mental status (BIMS) score of 11 (moderately impaired cognition). The resident was dependent upon staff for lower body dressing, required substantial/maximal assistance from staff with bed to chair transfers, and required partial/moderate assistance from staff with rolling in bed. The resident was unable to walk. The resident was noted to have a Stage 4 pressure ulcer present upon admission (Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur). A pressure ulcer risk evaluation completed on 01/11/25 resulted in a score of 11. A total score of 12 or less represents a high risk for developing pressure ulcers. Upon admission, the Stage 4 pressure ulcer on the sacrum measured 13 by 10 by 1.8 centimeters deep. The most recent skin assessment on 02/19/25 revealed the sacrum measured 2 by 1 by 0.1 centimeters deep. The resident had physician's orders dated 02/08/25 to cleanse sacrum with wound cleanser, pat dry, apply calcium alginate with silver to wound bed, cover with telfa, then secure with hypafix every day shift. The resident had physician's orders dated 11/25/24 to cleanse right heel with wound cleaner, pat dry, and apply skin prep topically daily as preventative and 10/30/24 same treatment for left heel. On 08/06/24 heel protectors were ordered for bilateral lower extremities in bed as tolerated. Observations on 02/19/25 at 10:41 A.M. revealed Resident #66 to be in bed without heel protectors on. The resident stated he had not had his dressing to sacrum changed yet that day. Review of the treatment administration record on 02/19/25 at 10:55 A.M. revealed the treatment to the sacrum was signed off as completed and the heel protectors were signed off as in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/19/25 at 11:00 A.M. Resident #66's nurse (Licensed Practical Nurse #493) stated that it was reported by the aides that the resident's dressing to his sacrum had come off. The surveyor and LPN #493 went to the resident's room to check. The resident had a dressing covering the sacrum. However, it was not dated to indicate when it had been changed. LPN #493 stated that he had not yet changed the dressing. When the surveyor asked LPN #493 why he had signed the treatment off as completed on the treatment administration record, he then said he had already changed the dressing that morning, but did not remember when. (He came on duty at 6:00 A.M.). He stated that he had put a date on the dressing but it had already smudged off. Review of the time stamp on the treatment administration record revealed LPN #493 signed the treatment of the sacrum completed on 02/19/25 at 10:32 A.M. (approximately 30 minutes before going in the room and saying he had not changed it that day). In addition, on 02/19/25 at 11:00 A.M. Resident #66 was noted in bed with no heel protectors on. LPN #493 confirmed the resident did not have heel protectors on, even though he had signed off on the treatment administration record that they were in place. He stated the resident took them off. When asked where the heel protectors were, LPN #493 stated how am I supposed to know. Interview with the two nursing assistants working on Resident #66's hallway on 02/19/25 at 11:14 A.M. (Nursing Assistants #471 and #491) confirmed the resident had not had heel protectors on that day. Nursing Assistant #471 stated she worked on that hall often and had never seen him have heel protectors on. Interview with Assistant Director of Nursing #417 on 02/19/25 at 11:30 A.M. confirmed Resident #66 did not have heel protectors on. She stated the resident required a hoyer lift for transfers and if he had taken heel protectors off by himself they could not be very far away. She checked the room and could not find any heel protectors. She confirmed Resident #66's left heel was resting on the mattress. Observations on 02/20/25 at 1:00 P.M. of the treatment to Resident #66's sacrum revealed a 2 by 1.5 centimeter area of raised, thick, pink tissue. There were no open areas. His heels did not have signs of pressure ulcers. Interview with LPN #404 on 02/20/25 at 1:00 P.M. revealed dressings are to be dated to determine when they were changed last and Resident #66 should have heel protectors on in bed.

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F 0692 Level of Harm - 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** 32801 Based on observation, record review, policy review and interview the facility failed to ensure residents were properly assessed, monitored, and provided adequate nutrition to prevent weight loss. This affected three residents (#5, #7, and #69) of five residents reviewed for nutrition. Actual harm occurred on 01/29/25 when Resident #5, who required staff set-up assistance with meals was assessed to sustain a 12.1 pound severe weight loss (in approximately 30 days) as a result of the facility's failure to revise and/or implement comprehensive and individualized care plan interventions to address changes in the resident's nutritional status (decrease in oral intake) and impaired wound healing (of a Stage III pressure ulcer). On 12/26/24 Resident #5 weighed 157.4 pounds and on 01/29/25 the resident weighed 145.3 pounds without evidence the facility accurately assessed, monitored, and provided adequate nutrition/interventions timely to prevent the weight loss and support healing of the resident's pressure ulcer. The resident's decline in weight continued and on 02/25/25 the resident was assessed to sustain an additional weight loss of 10.4 pounds with a recorded weight of 134.9 pounds. Findings include: 1. Medical record review revealed Resident #5 was admitted [DATE] with diagnoses including Alzheimer's disease, dementia, diabetes, chronic obstructive pulmonary disease, heart failure, chronic kidney disease, rheumatoid arthritis, osteoarthritis, hypothyroidism, and anemia. The resident had a history of pressure ulcers. Review of Resident #5's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a five percent weight loss noted and required set up assistance with eating. Review of Resident #5's nutritional plan of care dated 06/05/24 and revised 01/07/25 revealed the resident had nutritional problems or potential nutritional problems related to advanced age, chronic disease, altered diet, variable meal acceptance, increased metabolic demand related to skin alteration, elevated body mass index, history of abnormal lab values, diuretic use, and malnutrition risk. Interventions included consistent carb diet, regular texture, thin liquids, gravy in bowl on side for moisture as well as appropriate condiments. Fluids intake and toss cup, document/monitor/report signs and symptoms of dysphagia, refusing to eat, and appears concerned during meals. Monitor/record/report to physician any signs and malnutrition including significant weight loss of three pounds in one week, greater than 5% in one month, greater than 7.5% in three months, and greater than 10% in six months. Occupational Therapy (OT) to screen and provide adaptive equipment for feeding as needed. Provide and serve supplements as ordered. Provide, serve diet as ordered. Monitor intakes and record every meal. RD to evaluate and make diet changes recommendation as needed. Take and toss cup (toddler sippy cup) and weights as ordered. Review of Resident #5's current orders dated 02/2025 revealed the resident was receiving Toresmide (diuretic) 20 milligrams daily for edema. Review of Resident #5's physician notes dated 12/17/24, 01/10/25, 01/16/25, and 02/08/25 revealed no evidence the resident had edema. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #5's nursing notes dated 11/24/24 to 02/25/25 revealed no evidence the resident had edema. Review of Resident #5's weekly skin assessments dated 12/2024 to 02/25/25 revealed no evidence the resident had edema noted. Review of Resident #5's current orders dated 02/2025 revealed to weigh monthly, Ensure Clear two times a day (active 02/11/25), nutritional treat with lunch and dinner for decreased intake (active 09/30/24), consistent carb diet, regular texture, thin consistency (referring to liquids) (active 09/27/24). Review of the aide assignment sheet (undated) revealed Resident #5 was to receive an Ensure Clear at breakfast and dinner. There was no evidence of the nutritional treat on the assignment sheet. a. Observation on 02/19/25 at 12:32 P.M., revealed Resident #5's lunch tray had been picked up and was sitting in the hallway on a cart. The lunch tray contained lima beans, chicken, dessert, and coffee had not been touched. There was no evidence of nutritional treat. Observation on 02/20/25 at 8:55 A.M., of Resident #5 revealed the resident was in bed and her breakfast tray had not been touched. The tray had ham, eggs, and a bowl of cereal on it. There was no evidence of Ensure Clear supplement or staff assisting the resident with the meal. Observation on 02/24/25 at 9:20 A.M., revealed Resident #5 was in bed and her breakfast tray had not been touched. The resident's lips were dry and flaky. Resident #5 had dried blood on her top lip and in her bilateral nasal passages. There was no evidence of Ensure Clear supplement. There was no evidence of staff assisting the resident with her meal. There was a sign above the resident's bed dated 10/18/24 that indicated the resident's diet was regular. Liquids were thin and liquids were to be in take-n-toss cups. Swallowing Guidelines included small bites/sips, upright at 90 degrees for all intakes, and liquids removed from reach when head of bed was not all the way up. The sign was signed by OT staff. Observation and interview on 02/24/25 at 9:40 A.M., with Certified Nursing Assistant (CNA) #606 revealed she was the aide that set up Resident #5's breakfast tray, however, she did not provide the drinks to the resident. The CNA reported the resident was not receiving a supplement and believed the drinks on her tray were water and cranberry juice. The CNA reported she was told the resident didn't require assistance with meals. The CNA confirmed the resident had not touched her breakfast tray and had sipped her cranberry juice on her meal tray. Observation and interview on 02/24/25 at 9:56 A.M., of Resident #5 with Nurse Practitioner (NP) #337 confirmed the resident's lips and nasal passages were dry. The NP confirmed she was not aware the resident was not eating. The NP confirmed there was a sign hung near the resident's bed that indicated small bites and sips, however the resident's banana and toast, were not cut up in small bites. The NP confirmed the resident had not touched her cereal, banana, toast or eggs. The NP started assisting the resident with breakfast. The resident accepted the NP's assistance and began to eat. Interviews were attempted on 02/19/25 at 12:32 P.M., 02/20/25 at 8:55 A.M., 02/24/25 at 9:20 A.M., 02/24/24 at 9:56 A.M., and 02/25/25 at 11:09 A.M., with Resident #5 revealed the resident was not able to provide reliable information. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview on 02/24/25 at 10:12 A.M. and 1:09 P.M. with Licensed Practical Nurse (LPN) #487 reported a nutritional treat would be ice cream, magic cup, and the aides administer the supplement according to aide assignment sheet. The LPN confirmed nutritional treat was not on the aide's sheet. LPN #487 confirmed the nurses document the nutritional treat and supplement intakes on the resident treatment administration records (TAR), however the aides were the ones administering the treat and supplement. The LPN confirmed the facility has not had Ensure Clear for months and staff were giving Resident #5 a Boost Breeze which looks like cranberry juice, however, the order was for Ensure Clear. The LPN confirmed staff were signing off they were administering Ensure Clear even though it was not available. LPN #487 confirmed she had signed off the amount given this morning before the resident had consumed the supplement. The LPN measured the remainder of the supplement at 1:09 P.M. and the amount remaining from the breakfast supplement was 100 ml and it was unclear of how much was spilled on her breakfast tray this morning. The LPN reported she documented 120 ml because that was the amount the resident had taken when she observed the resident this morning during her medication pass. On 02/25/25 at 7:39 A.M. interview with Speech Therapist #309 revealed she had not seen Resident #5 since October 2024. She had placed a sign in the room for small bites and sips, however it was more for the liquids due to resident was coughing when she was taking fluids. Speech Therapist #309 also recommended sippy cups. The resident used to feed herself. Speech Therapist #309 was unaware the resident had declined. b. Review of Resident #5's weights dated 10/23/24 to 02/05/25 revealed the following weights: 10/23/24 160.3 pounds 10/30/24 158.2 pounds 11/01/24 158.2 pounds 11/06/24 159.1 pounds 12/26/24 157.4 pounds 01/02/25 153.2 pounds 01/15/25 153.2 pounds 01/22/25 153.2 pounds 01/29/25 145.3 pounds 02/05/25 145.3 pounds. There was no documented evidence that the resident was weighed after 02/05/25. Observation on 02/25/25 at 11:09 A.M., of Resident #5 weight with LPN #487 and CNA #421 per the surveyor's request revealed the resident weighed 134.9 pounds via mechanical lift. The resident had lost an additional 10.4 pounds since 02/05/25. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	c. Review of Resident #5's current dietary ticket for breakfast, lunch, and dinner revealed the resident was ordered a regular, consistent carb, thin liquid diet. The resident was on 1500 milliliter (ml) fluid restriction and gravy with meals. There was no evidence of Ensure Clear supplement or nutritional treat. Review of Resident #5's current orders revealed no evidence of an order for 1500 ml fluid restriction or gravy with meals. Review of the supplement list dated 02/24/25 revealed Resident #5 was to receive an Ensure Clear two times a day for weight loss. There was no evidence Resident #5 was to receive a nutritional treat. Interview on 02/24/25 at 10:28 A.M., and 11:23 A.M., with Dietary Manger (DM) #429 confirmed Resident #5's the meal tickets were inaccurate and had not been updated. The resident had not been on a fluid restriction since 09/2024. A nutritional treat would be something the floor staff would provide to the resident such as a yogurt per the Director of Nursing (DON). The DM reported the floor staff were also responsible for administering supplements and he didn't know what the difference between the Boost Breeze and Ensure Clear and he does not order the supplements. d. Review of Resident #5's meal intakes dated 01/26/25 to 02/23/25 revealed on 02/16/25 and 02/17/25, only one of the three meals were documented and 02/19/25 and 02/20/25 only two of the three meals were documented. The resident had refused 20 meals, 42 meals she ate at less than 50%, and 21 meals she ate greater than 50%. The resident was noted to range in ability from independent to dependent at times with meals. Interview on 02/24/25 at 3:12 P.M., with the Administrator revealed staff were not documenting all meal intakes on 02/16/25, 02/17/25, 02/19/25, and 02/20/25. e. Review of Resident #5's skin/wound note dated 06/05/24 revealed the nurse was notified the resident had an open area noted to her coccyx. This nurse and the unit manager Registered Nurse (RN) assessed the resident's coccyx area and a Stage III (full thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present pressure area) was noted to the site that resident had previously had a pressure injury where a divot remained. The wound measured 1.0 cm by 0.5 cm by 0.2 cm with 100% granulated tissue noted, scant amount of sanguineous drainage (red) noted. The peri wound was red, blanchable, and intact. Resident reported the area was tender to touch. The Nurse Practitioner was notified and new orders received for treatments, supplements, and a wound consult. Review of Resident #5's telemedication wound visit notes dated 01/08/25 to 02/19/25 revealed the physician had documented the resident's appetite was fair and indicated a protein supplement. Review of Resident #5's current orders revealed no evidence of a protein supplement order. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #5's telemedicine wound care note dated 02/19/25 revealed the resident had a Stage III pressure ulcer on the coccyx measuring 1.0 centimeters (cm) by 1.0 cm by 0.1 cm with moderate serous drainage. The wound bed was 80 percent granulation and 20% other viable tissue. The wound has exacerbated due to generalized decline of resident, non-compliance with wound care, and nutritional compromise. (The resident's medical record revealed the resident would at times refuse medications and would refuse an occasional pressure ulcer dressing change). Interview on 02/24/25 at 3:51 P.M., with the Assistant Director of Nursing (ADON), Infection Preventionist (IP), and Wound Nurse (WN) #417 (one staff member with three facility job titles) confirmed Resident #5 had a Stage III pressure ulcer on her coccyx and a diabetic wound on her right foot. The ADON/IP/WN #417 confirmed she had to call the wound physician to get his assessment notes due to the facility did not have them. The wound physician does telemedication visits with her weekly. The ADON/IP/WN #417 confirmed the wound notes indicated the resident needed a protein supplement, however the facility's physician had discontinued Prosource in December 2024 due to the resident had refused four doses. The nurse reported she would call the wound physician today to see what recommendation he had for a protein supplement for Resident #5. f. Review of Resident #5's medication administration record (MAR) and treatment administration record (TAR) dated 01/2025 and 02/2025 revealed the resident was ordered Ensure Clear once daily, however there was no documented evidence of the percent of the intake. The resident consumed 25-50% of the nutritional treat for lunch and dinner. g. Review of Resident #5's dietary note dated 11/26/24 revealed the resident estimate calorie needs were 2250-2620 k/calories and 90-112 grams (gm) of protein. The resident's ideal body weight was 125 pound plus/minus 10%. The resident was on a diuretic for congestive heart failure and weight loss was desired and expected. Review of Resident #5's dietary note dated 12/27/24 revealed the resident's weight was 153.2 pounds which was 10.5% weight loss in 180 days. The resident's diet was consistent carb diet, regular texture, thin liquids, no added salt, 1500 ml fluid restriction, gravy in bowl on side for moisture as well as appropriate condiments. Ensure Clear daily. The resident was able to assist with meals and makes preferences known. No chewing or swallowing difficulties noted at this time. Meal intakes vary. Weight loss desired and expected. Continues to meet Aspen criteria (a table that provides clinical characteristics to support a diagnosis of malnutrition in adults based on consensus statement from the Academy of Nutrition) for malnutrition risk due to chronic disease, weight changes, and decreased po (oral) intakes. Weights as per order. Encourage and assist with meals as needed. Review of Resident #5's dietary note dated 12/31/24 revealed Registered Dietician (RD) reviewed related to pressure injury. Resident noted with increased metabolic needs related to skin integrity as evidenced by pressure injury. The resident ordered consistent carb diet/no added salt diet, 1500 ml fluid restriction, regular texture with thin liquids. Additional support of ProSource twice daily and Ensure Clear daily. Intakes of meals are 25-100%. Current nutritional interventions remain appropriate, no new recommendations. Will continue to monitor. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #5's dietary note dated 01/07/25 revealed the resident's weight was 153.2 pounds which was 10.5% weight loss in 180 days. The resident's diet was consistent carb diet, regular texture, thin liquids, no added salt, 1500 ml fluid restriction, gravy in bowl on side for moisture as well as appropriate condiments. Ensure Clear daily. The resident was able to assist self with meals and makes preferences known. No chewing or swallowing difficulties noted at this time. Meal intakes vary. Weight loss desired and expected. Continues to meet Aspen criteria for malnutrition risk due to chronic disease, weight changes, and decreased po intakes. Weights as per order. Encourage and assist with meals as needed. Review of Resident #5's dietary note dated 01/31/25 revealed a weight warning. The resident's weight was 145.3 pounds, which was 5.2% weight loss over 30 days and 13.2% weight loss over 180 days. Requested reweigh for accuracy. Increased metabolic needs relate to skin integrity as evidence by pressure injury. Current nutritional intervention remains appropriate with additional nutritional support in place. Intakes were appropriate. Current body weight indicates a previously identified significant weight loss, Registered Dietician reviewed weight change noted on 01/07/25. No new recommendation and will follow as needed. Review of Resident #5's dietary notes dated 02/06/25 there was a weight change warning indicating the resident weighed 145.3 pounds which was 5.2 % weight loss over 30 days and 14.2% weight loss over 180 days. New recommendation to increase Ensure Clear to twice daily. The resident remains on a consistent carb diet regular texture, thin liquids, no added salt, 1500 ml fluid restriction, gravy in bowl on side for moisture as well as appropriate condiments. The resident was able to assist self with meals and makes preferences known. No chewing or swallowing difficulties noted at this time. The meal intakes vary. The resident meets Aspen criteria for malnutrition as evidenced by chronic disease, weight changes, and decreased by mouth (po) intakes. Weights as per order, encourage and assist with meals as needed. There was documentation regarding the resident's nutritional needs for wound healing. On 02/24/25 at 11:56 A.M., phone interview with Registered Dietitian (RD)#900 revealed she could write down the surveyor's concerns regarding Resident #5's nutrition and weight and follow up with the Dietician Tech due to RD #900 had not been involved with the resident's care recently. Per RD #900, the RDs take turns rotating in the buildings. The Dietician Tech was the one following up with most of Resident #5's care. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview on 02/24/25 at 2:07 P.M. and 02/25/25 at 10:18 A.M., with Dietary Tech (DT) #339 confirmed her assessments were inaccurate due to the resident was not on a fluid restriction or required gravy with meals. The DT confirmed she had not observed the resident eat and she obtained most of her information from the medical record. The DT reported she looks at the meal intake percentages, however she doesn't look to see if staff were documenting meal intakes for all three meals. The DT confirmed staff were not recording intakes of supplement prior to 02/11/25 and she could not verify the resident intakes an acceptance, however she had increased the supplements on 02/11/25 due to the resident having weight loss. The DT confirmed the supplements should not be given with meals and the nutritional treats should not be given with meals as well due to it may prevent the resident from eating her meals. DT #339 reported she was unaware the facility didn't have Ensure Clear available. The DT confirmed she was not aware the resident was not receiving Ensure Clear and there was a slight difference in the Ensure Clear and Boost Breeze and the facility needed to get a clarification order. The DT reported she had questioned the facility about the nutritional treats and was told it was just a snack. The DT confirmed her assessments didn't include nutritional needs for pressure ulcers and skin alteration and those recommendations usually come from the Registered Dietician. The DT reported if the wound physician recommended a protein supplement, she would probably recommend fortified foods due to the resident's meal intakes being poor and if she refused Prosource (in the past). The DT confirmed the Dietary Note dated 12/31/24 indicated the resident was on Prosource, however the resident was not receiving ProSource due to it had been discontinued on 12/24/24. The DT reported the resident should have been on weekly weights due to the continued weight loss. DT #339 revealed she didn't realize the resident's order was for monthly weights. The DT confirmed there had been some issues with weights not being obtained timely. Review of Resident #5's progress notes dated 02/25/25 revealed Remeron (medication used to treat clinical depression and insomnia) was ordered for weight loss, supplement changed to Boost Breeze, and Prosource 30 ml twice a day was added for supplement and wound healing. Review of Resident #5 dietary note dated 02/25/25 revealed the resident had significant weight loss and skin alteration noted. The resident's diet was consistent carb diet, regular texture, regular thin consistency. Meal intakes were variable with reduced overall average with four noted refusals over the last seven days. ProSource 30 ml started yesterday with acceptance thus far. Boost Breeze twice a day was ordered 02/24/25. The resident's current body weight was 134.9 pounds which was 36.3-pound weight loss from 09/02/24 and 22.5-pound weight loss from 12/26/24. Weight loss was previously identified but the resident continues to lose weight. Remeron ordered on 02/24/25 to aid in appetite. Occupational and Speech therapy screening pending. New intervention started this week and current intervention for wound healing and weight management deemed appropriate at adequate, however recommend changing diet to liberalization to help encourage intakes. Review of the facility policy titled Dietary Supplements (undated) revealed dietary supplements would be given to residents when recommended by the dietician and ordered by the physician. Residents should not be given dietary supplements at mealtimes unless ordered by the physician because the resident's appetite may be sated from the supplement, and this may cause the resident to eat less. The nurse would chart the supplement intakes. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy titled Weight Change (dated 04/2007 and revised 03/2018) revealed to ensure consistent monitoring and documentation of resident weights and implementation of dietary plan of care with significant changes. The dietitian or the registered dietetic technician would review the weight changes and make recommendations to the neighborhood nurse for follow-up with the physician as needed. The neighborhood nurse would notify the physician, family, and document in the nurse's notes in PCC. 28923 2. Review of Resident #7's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, vascular dementia, cognitive communication deficit, delusional disorder, depression, and a malignant neoplasm of the right breast. Review of Resident #7's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and her cognition was severely impaired. She was known to have other behaviors not directed at others, but was not known to reject care. She was independent with eating. Her height was 60 inches and her weight was 111 pounds. She was not indicated to have had a significant weight loss during that time. Review of Resident #7's care plans revealed the resident had a care plan in place for having a nutritional problem or the potential for nutrition problems related to her advanced age, chronic disease, variable meal acceptance, and psychoactive medication use that may alter her appetite and weight. The care plan was updated on 02/13/25 to reflect a significant weight loss at 30, 90, and 180 days. The goal was for the resident to maintain adequate nutritional status as evidenced by maintaining weight with no significant weight changes. The interventions included providing her diet as ordered, monitor intake and record every meal, and provide and serve supplements as ordered. Review of Resident #7's physician's orders revealed the resident was to receive a regular diet. She was ordered to receive Boost (a nutritional supplement) twice a day as a supplement. The Boost order had been in place since 01/18/25. She was to be weighed weekly. Review of Resident #7's weekly weights revealed the resident's weights were trending down. She weighed 111.8 pounds on 01/28/25. Her weight on 02/12/25 was 105.4 pounds, which reflected a weight loss of 5.7%. Her last recorded weight on 02/19/25 was 103.8 pounds. Review of Resident #7's meal intakes for the past 30 days (01/27/25- 02/24/25) revealed the resident's meal intake was not being consistently recorded, as not all three meals each day were being documented to reflect the percentage of the meal the resident consumed. Seven of the 30 days reviewed only had two of the three meals recorded on those days. Missing meal consumptions were noted for 01/30/25, 02/01/25, 02/06/25, 02/07/25, 02/13/25, 02/20/25, and 02/21/25. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #7's medication administration record (MAR's) for February 2025 revealed the nurses were recording the resident's consumption of her Boost supplement that was ordered twice a day. The times for the administration of Boost was set up for the morning and again in the evening (7:00 P.M.). The nurses were inconsistent in the way they documented the amount of the supplement the resident consumed. The nurses were supposed to document the amount consumed in milliliters (ml). Some were documenting 237, which was the total amount of ml that the Boost bottle contained. Others were documenting 100% or 100. It was not clear if the 100 meant the resident consumed 100% of the supplement or only 100 ml. On 02/25/25 at 10:00 A.M., an interview with RN #417 confirmed Resident #7's meal intakes were not being consistently recorded to reflect the amount she consumed for all three meals per day. She acknowledged that failing to record all three meals a day showed her nutritional intake was being inadequately monitored. She further acknowledged the staff were not consistent in how they were recording the resident's supplement intake, as some would record 237 while others were writing either 100 or 100%. She confirmed it could not be determined if those documenting 100 meant 100% or if they were recording it in ml's. She reported the resident's acceptance of the Boost supplement was to be documented in ml's not a percentage as was recorded for some of the entries. She agreed, with the inconsistencies on how the supplement acceptance was being recorded, it made it difficult to determine what the resident's acceptance was and if it was an effective nutritional intervention. 3. Review of Resident #69's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including protein-calorie malnutrition, chronic kidney disease, and adult onset diabetes mellitus. Review of Resident #69's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. She was not known to display any behaviors and was not known to reject care. Her height was 66 inches and her weight was 174 pounds. She was not indicated to have had any significant weight loss. Review of Resident #69's care plans revealed the resident had a care plan in place for having a nutritional problem or potential nutritional problem related to a decreased intake, therapeutic diet, history of weight changes, diuretic use, and a history of significant weight loss at 30 days, 90 days, and 180 days on 02/04/25. The goal was for the resident to have optimal nutrition within constraints of her disease process as evidenced by accepting a well balanced diet. The interventions included providing her diet as ordered, providing supplements as ordered, and monitor her intake and record every meal. Review of Resident #69's physician's orders revealed the resident was on a consistent carbohydrate diet. She was also supposed to receive Boost three times a day between meals. The Boost was ordered on 02/05/25. The resident also had an order to be weighed weekly. Review of Resident #69's weights revealed the resident weighed 162.4 pounds on 01/15/25. Her weight on 02/12/25 was 153.4 pounds reflecting a 5.5% loss in the past 30 days. Her most recent weight on 02/19/25 revealed a weight of 157 pounds showing her weight was starting to trend back up. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #69's meal intakes for the past 30 days (01/22/25- 02/20/25) revealed the resident had an overall poor appetite. She ate less than 50% 39 times and ate more than 50% 28 times. She was known to refuse meals 16 times. Out of the 30 days recorded, the resident did not have all three meals recorded 27 of those 30 days. On 02/16/25 and on 02/17/25, only one of the three meals the resident was provided was recorded on the meal intake record. On 02/19/25, only two of her three meals got recorded that she received that day. Review of Resident #69's MAR for February 2025 revealed the resident was supposed to receive Boost three times a day and they were scheduled for 10:00 A.M., 2:00 P.M., and 7:00 P.M. The nurses were documenting the resident was receiving her supplement three times a day as ordered. On 02/20/25 at 12:23 P.M., an interview and observation with Resident #69 revealed she had not been getting her Boost supplement three times a day between meals as ordered. She reported she had not been given the Boost supplement that should have been given to her at 10:00 A.M. that morning. She was noted to have her lunch tray sitting on the bedside table in front of her while she was sitting up in her recliner at bedside. She was not noted to have ate any of the meal that was sitting in front of her and reported she had no intent on eating it. LPN # 404 was in her room preparing to perform her treatment to the pressure ulcer on her left great toe. The resident asked her to take her tray away. LPN #404 was asked at the time of the observation who was responsible for providing the resident her Boost supplement. She reported the aides provided the Boost supplements to the residents, if ordered, when bringing them their meal trays. She was asked if the resident had received her Boost for that morning. The resident spoke up and told LPN #404 that she had not been given a Boost that day. The nurse asked the resident what flavor she wanted and the resident reported she wanted chocolate. The nurse left the room with the resident's tray to get the resident her Boost that was scheduled to be given at 10:00 A.M. On 02/20/25 at 12:24 P.M., further interview with Resident #69 revealed she was not consistently receiving her Boost as ordered. She reported she would get it on occasion, but denied she was receiving it three times a day and between meals as ordered. She again denied she had been given one that morning. Her roommate was noted to have a Boost sitting on her bedside table, but Resident #69 did not have one in her room or in her trash can. On 02/20/25 at 1:25 P.M., an interview with Certified Nursing Assistant (CNA) #486 revealed Resident #69 was supposed to get Boost at 10:00 A.M. and 2:00 P.M. He was asked why the resident was not given a Boost at 10:00 A.M. that morning as ordered. He stated they were busy at 10:00 A.M. and it must have just slipped his minds. He then reported that he had just been told by LPN #404 that Resident #69 was to receive a Boost supplement at 10:00 A.M. and 2:00 P.M. He was not previously aware of the resident was supposed to get a Boost at 10:00 A.M. until he was told by the nurse. He confirmed the aides were supposed to provide the Boost supplements to the residents. They kept them in the refrigerator located in the dining room just off the unit. He was not sure where it was listed to show what residents were to receive supplements or when. LPN #404 was in the general area and informed CNA #486 that information was on the clipboard that had their assignment sheet on it. He reviewed the assignment sheet and noted Resident #69's name was not on it to show she was supposed to be receiving a supplement. There [TRUNCATED]

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review, resident interviews, staff interviews, and review of written staff statements from facility investigation, the facility failed to timely address pain. This affected three residents (#36, #78, #185) of three residents reviewed pain. The facility census was 75. Findings include: 1. Record review revealed Resident #36 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation, dementia, and atherosclerotic heart disease. Review of physician orders revealed Resident #36 had an order in place dated 09/24/23 for Tylenol oral tablet 325 milligrams (mg) give two tablets by mouth every four hours as needed for pain not to exceed 3000 mg per day. Review of a care plan dated 06/10/24 revealed Resident #36 had pain related to an old left arm fracture which left her with limited range of motion and chronic pain. Her goal was to verbalize satisfaction with her pain control regimen through the review date of 02/24/25. Interventions included assessing for cause of pain, monitoring pain levels, position for comfort, and therapy referrals. Review of a minimum data set (MDS) assessment dated [DATE] revealed Resident #36 had moderate cognitive impairment, no behaviors, and no pain. Review of a nursing note dated 01/16/25 at 4:00 P.M. by Licensed Practical Nurse (LPN) #442 revealed Resident #36 had an unwitnessed fall in her bathroom while attempting to toilet self. Resident #36 was found lying on her right side on the floor, hit the back of her head and her right hip. Resident #36 was sent to the hospital for evaluation. The physician and responsible party were aware. Review of a nursing note dated 01/16/25 at 9:37 P.M. revealed Resident #36 returned to the facility with her daughter with no new orders. Review of nursing notes on 01/17/25 from 12:06 P.M. to 10:50 P.M. revealed no evidence Resident #36 was in pain. Review of the Medication Administration Record (MAR) for January 2025 revealed on 01/17/25, Resident #36 had a pain level of 5 (pain scale 1-10) during day shift and a pain level of 2 for night shift. There was no evidence as needed medications were administered or interventions were attempted to address Resident #36's pain. Review of the MAR for 01/18/25 revealed Resident #36 had a pain level of 6 at 5:50 A.M. and received a dose of Tylenol. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/20/25 at 12:18 P.M. with Certified Nursing Assistant (CNA) #511 revealed she worked with Resident #36 on 01/17/25 and could recall the resident having behaviors, she kept hollering for help, was very restless, and fidgeting. CNA #511 revealed Resident #36 was saying strange things about someone coming to get her which was abnormal. Resident #36 was groaning during repositioning, and the pain was reported to the nurse. CNA #511 stated repositioning Resident #36 would help some but within an hour, the resident would show signs of pain again. Interview on 02/20/25 at 12:26 P.M. with CNA #489 revealed she worked with Resident #36 the night of 01/17/25. Resident #36 had attempted to get out of bed to use the restroom but was agreeable to using the bed pan when reminded of her previous fall. While placing Resident #36 on the bed pan, she started to smack CNA #489 which was unusual for her. CNA #489 stated nonverbal signs of pain can include aggression, change in mental status, facial expressions an grimacing. CNA #489 stated this incident occurred at either 2:00 A.M. or 4:00 A.M. Interview on 02/20/25 at 1:10 P.M. with Licensed Practical Nurse (LPN) #602 revealed she worked on 01/17/25 with Resident #36. LPN #602 does not recall Resident #36 having pain anywhere. LPN #602 stated she has worked at the facility a couple times. When asked about her signing off on the MAR for 01/17/25 that Resident #36 had a pain level of 5, she confirmed her initials were used to sign off Resident #36's pain level and if she signed it, then the resident had pain. She was unable to recall administering medications but stated she recalled repositioning Resident #36 to manage her pain. Interview on 02/20/25 at 3:08 P.M. with Director of Nursing confirmed the MAR for 01/17/25 indicated Resident #36 was in pain but did not receive pain interventions per the plan of care. 07316 2. Review of the medical record for Resident #78 revealed an admitted [DATE] and diagnoses including depression, bipolar disorder, PTSD, and anxiety disorder. A physician progress note on 01/31/25 stated the resident was admitted after a recent craniotomy for meningioma (a tumor of the membranes surrounding the brain). A Minimum Data Set (MDS) assessment completed 02/04/25 documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident had a physician's order for Oxycodone 5 milligrams every six hours as needed for moderate pain on 01/31/25. Pain assessments were completed each shift from 02/01/25 to 02/19/25 with pain levels ranging from 0-7 (pain scale 1-10). Review of the plan of care dated 02/03/25 revealed the resident had potential for pain related to osteomyelitis and recent cranial surgery. The goal was for the resident to verbalize satisfaction with her pain control regimen. Interventions included administer medications as ordered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #78 on 02/18/25 at 11:01 A.M. revealed she has to wait a long time to get pain medication. She stated she has pain in her head from recent brain surgery. She stated she had waited 3-4 hours for pain medication. She stated it was on night shift. She stated she feels like they are documenting that they are giving her pain medications and keeping it for themselves. A nurse told her that other residents had complained of not getting their pain medications when they needed them and they are looking into it. She did not know the names of any nurse that she felt took too long to provide her pain medication. Interview with Nursing Assistant #428 on 02/19/25 at 2:35 P.M. revealed most nurses provide pain medications timely after she reports pain by the resident. She stated there was one nurse on nights (Registered Nurse (RN) #481) who will wait two hours to give resident's their pain medication after they ask for it. She stated residents, including Resident #78, have complained repeatedly about having to wait on this nurse to give their pain medications. Nursing Assistant #428 stated she had just come back to work at the facility a couple of weeks ago. She stated this issue had been going on since she came back to work. Interview with Nursing Assistant #443 on 02/20/25 at 8:00 A.M. revealed she worked a night shift on 02/03/25. She stated a couple of residents were asking for pain medications. She stated the nurse said if the resident did not need pain medication during the day, then they did not need it at night. (Review of the schedule revealed the nurse was RN #481). 3. Review of the medical record for Resident #185 revealed an admitted [DATE] and diagnoses including diabetes, peripheral vascular disease, and chronic ulcer of the left lower leg. A MDS assessment 02/07/25 documented a BIMS score of 15, indicating intact cognition. The resident had a physician's order for Tramadol 50 milligrams every six hours as needed for pain on 02/02/25. The resident had a pain assessment completed every shift from 02/02/25 through 02/29/25 with pain levels ranging from 0-8 (pain scale 1-10). Review of the plan of care dated 02/05/25 revealed a potential for pain related to peripheral vascular disease, diabetes, low back pain, gastrointestinal reflux disease, and atrial fibrillation. The goal was for the resident to verbalize satisfaction with her pain control regimen. Interventions included administer medications as ordered. Interview with Resident #185 on 02/19/25 at 8:42 A.M. revealed she has pain in her left leg. She stated she has to wait a long time for pain medication. She stated she has to wait sometimes up to one and a half hours to get the pain medication. She stated she usually has a pain level of at least six when she requests the medication. Interview with Nursing Assistant #428 on 02/19/25 at 2:35 P.M. revealed most nurses provide pain medications timely after she reports pain by the resident. She stated there was one nurse on nights (Registered Nurse RN #481) who will wait two hours to give resident's their pain medication after they ask for it. She stated residents, including Resident #185, have complained repeatedly about having to wait on this nurse to give their pain medications. She stated she had just come back to work at the facility a couple of weeks ago. She stated this issue had been going on since she came back to work. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Nursing Assistant #443 on 02/20/25 at 8:00 A.M. revealed she worked a night shift on 02/03/25. She stated a couple of residents were asking for pain medications. She stated the nurse said if the resident did not need pain medication during the day, then they did not need it at night. (Review of the schedule revealed the nurse was RN #481). Written statements taken from staff by the facility during an investigation into misappropriation (self-reported incident #257304) revealed the following: a. LPN #411 wrote on 02/21/25 the she had residents saying they were getting their medications late at night. Residents stated it was RN #481. b. Nursing Assistant #470 wrote (undated) that she had witnessed residents waiting longer than 15 minutes for pain medication. After resident's asked her, the nurse was off the floor smoking. Nurse was RN #481. c. Nursing Assistant #415 wrote on 02/24/25 that residents had to wait for pain medications from RN #481 because the residents asked for pain meds more than once. She stated RN #481 went out for smoke breaks frequently for 10-20 minutes per break. Had to ask nurse multiple times. d. Nursing Assistant #409 wrote on 02/24/25 that she had witnessed residents waiting longer than 15 minutes for pain medications. The nurse was RN #481. She stated she was outside for long periods of time. Sometimes 30 minutes to an hour. e. Nursing Assistant #503 wrote on 02/22/25 that she had several residents complain that they did not receive their medication on night shift. f. Email statement without indicating who wrote it: The last weekend I worked, I did have nursing assistant #470 come to me multiple times to ask where her nurse was as residents were asking for pain medications. The nurse was RN #481, who has been known to disappear from her floor frequently even during times the aide is off the floor for lunch or getting ice or stock. The residents were made to wait longer that 15 minutes as staff would have to hunt down the nurse. Nurse was sneaking out the dining room on east to smoke. I know of one incident in which the aide had me assist in looking for her nurse for over 20 minutes. g. Staff written statement on 02/22/25 (name not legible) revealed heard from residents about nurse not giving them medications for over an hour. Resident indicated it was RN #481. Review of the facility policy titled Pain Management (dated 9/2002 and reviewed 03/03/17) revealed it is the policy of the facility to assist each resident with pain management to maintain or achieve the highest practicable level of well-being and functioning. The resident's pain is managed through individualized assessment and care planning. Pain is recognized, assessed, treated, and monitored through pain management. Pain management is tailored to each resident's needs and circumstances through the interdisciplinary team approach.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on record review, staff interview, and resident interview, the facility failed to ensure a resident received the appropriate treatment and services for depression. This affected one resident (#78) of two residents reviewed for behavioral care in a sample of 24. The facility census was 75. Findings include: Review of the medical record for Resident #78 revealed an admitted [DATE] and diagnoses including depression, bipolar disorder, post traumatic stress disorder (PTSD), and anxiety disorder. A physician progress note on 01/31/25 stated the resident was admitted after a recent craniotomy for meningioma (a tumor of the membranes surrounding the brain). The resident had physician's orders for an antidepressant medication daily (started 02/01/25) and an antianxiety medication three times daily (started 01/31/25). A Minimum Data Set assessment completed 02/04/25 documented a brief interview for mental status score of 15 (intact cognition). It also documented a mood score of 20 (20-27 indicates severe depression). Interview with Physical Therapy Assistant #315 and Occupational Therapy Assistant #305 on 02/20/25 at 8:20 A.M. revealed they both work with Resident #78. They stated she does have some anxiety related to her condition. Review of physician progress notes for 01/31/25, 02/04/25, and 02/11/25 revealed depression was not addressed. Review of a social service progress note on 02/03/25 at 1:00 P.M. by Social Service Designee #439 revealed discharge plans were discussed. Resident goal is to return home where she and her mother live together. She is her mother's caregiver. Resident sees a psychiatrist and psychologist and would like the facility to schedule an appointment with them. Resident did trigger on the trauma informed assessment and has a diagnosis of PTSD. She has been abused in the past. She prefers not to have any males provide personal care like bathing, toileting. Review of the plan of care dated 02/04/25 revealed Resident #78 had a history of trauma that affects her negatively from a past abuse. Suffers from really bad nightmares at times. Prefers not to have male caregivers. Has a counselor and psychiatrist that she sees and would like appointment scheduled with them. An intervention on the plan of care dated 02/04/25 stated to arrange for resident to receive services from a Licensed Mental Health Provider as indicated. Interview with Resident #78 on 02/18/25 at 10:58 A.M. revealed she has feelings of depression. She stated she is worrying about where she will live when she leaves the facility. She stated she has feelings of fogginess and losing her memory since her recent brain surgery. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Admissions Coordinator #457 (covering for Social Service Designee #439 who was unavailable) on 02/20/25 at 9:45 A.M. confirmed Resident #78's mood assessment indicated severe depression. She confirmed that the social service note 02/03/25 documented the resident wanted an appointment with mental health services. She confirmed there was no evidence of any follow up to attempt to schedule an appointment for mental health services for Resident #78. Interview with Resident #78 on 02/20/25 at 9:55 A.M., with Admissions Coordinator #457 present, revealed Resident #78 stated she wanted to see her psychiatrist or counselor due to feeling depressed. She confirmed the resident had not seen a mental health professional since admission.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review and staff interview, the facility failed to ensure pharmacy recommendations were responded to timely by the physician and/ or the physician provided a rationale as to why the pharmacy recommendations were not acted upon. This affected two residents (#5 and #36) of five residents reviewed for unnecessary medications. Findings include: 1. Review of Resident #5's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, dementia, and depression. Review of Resident #5's monthly medication regimen reviews documented under the progress notes of the electronic medical record (EMR) revealed the resident's medications had been reviewed for any irregularities monthly in the past 12 months. The medication regimen review completed on 08/22/24 noted an irregularity with the resident's prescribed medications and a recommendation was made to the physician for review. Review of Resident #5's consultation report dated 08/22/24 revealed a recommendation was made to the physician by the pharmacist for the physician to consider a gradual dose reduction (GDR) attempt for the resident's use of Zoloft, unless it was clinically contraindicated. The resident was indicated to have been on Zoloft 50 milligrams (mg) daily since February 2024. The physician did not respond to the pharmacy recommendation until 10/01/24 (40 days after the recommendation had been made). The physician accepted the pharmacist's recommendation and gave an order to reduce the resident's Zoloft from 50 mg daily (what the resident was on at the time the recommendation was made) to 25 mg by mouth daily. A hand written note dated 10/02/24 that was added at the bottom of the consultation report revealed the resident's current order for Zoloft was for her to receive 100 mg daily. The nurse adding the note indicated they had reached out to the nurse practitioner on that date and a new order was given for a GDR to 50 mg daily, which was the dose ordered at the time the pharmacy recommendation was originally made. On 02/25/25 at 11:15 A.M., an interview with the Director of Nursing (DON) confirmed Resident #5's pharmacy recommendation made on 08/22/24 regarding a GDR for the use of Zoloft was not addressed timely by the physician. She acknowledged the consultation report regarding the GDR for the use of Zoloft showed the physician did not address the recommendation until 10/01/24. 47985 2. Record review revealed Resident #36 was admitted to the facility on [DATE] with diagnoses including unspecified psychosis, dementia, obsessive-compulsive disorder, depression, and delusional disorders. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a pharmacy recommendation dated 04/24/24 revealed Resident #36 was receiving mirtazapine 15 milligrams (mg) , an antidepressant, for appetite stimulation and her weight was continuing to trend down. Pharmacy recommended discontinuing mirtazapine. There was no acknowledgment, signature, or evidence the provider reviewed the pharmacy recommendation. Review of a care plan dated 06/10/24 revealed Resident #36 took psychotropic medications for delusional disorder, depression, anxiety, and panic disorder/obsessive-compulsive disorder/psychosis. The goal included to reduce the use of psychoactive medications through the goal date of 02/24/25. Goals included abnormal involuntary movement testing as needed (07/01/24), gradual dose reduction as indicated (07/01/24), consult with pharmacy and physician to consider dosage reduction when clinically appropriate (06/10/24), participate in the music and memory program (06/10/24), monitor and record occurrences of delusions (06/10/24), monitor/record/report to physician as needed side effects and adverse reactions to psychoactive medications (06/10/24), psychiatric consult as needed (06/10/24), non-pharmacological interventions include redirection, reassurance, engage in activity, and offer food/fluids (07/01/24). Review of a pharmacy recommendation dated 08/27/24 revealed Resident #36 had received Quetiapine 37.5 mg, an antipsychotic medication, twice daily for delusional disorders since 06/2024 with a dose increase. The pharmacy recommended documenting a dose reduction would be contraindicated at this time. Instructions for the document stated to check option one or two AND write a resident-specific rationale in the space provided. Provider #335 selected option one, continued use is in accordance with the current standard of practice and a gradual dose reduction attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder as documented below. The space provided for the rationale was left blank. Provider #335 signed and dated the document for 08/29/24. Interview on 02/24/25 at 3:50 P.M. with Director of Nursing (DON) confirmed there was no resident-specific rationale to decline the gradual dose reduction recommendation from 08/27/24 and there was no evidence the pharmacy recommendation from 04/24/24 was reviewed by a provider.

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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** 28923 Based on record review and staff interview, the facility failed to ensure antihypertensive medications used in the treatment for hypertension were held as needed in accordance with the physician's orders. This affected one resident (#5) of five residents reviewed for unnecessary medications. Findings include: Review of Resident #5's medical record revealed she was originally admitted to the facility on [DATE] with a readmitted [DATE]. Her diagnoses included essential hypertension, chronic atrial fibrillation, and congestive heart failure. Review of Resident #5's physician's orders revealed the resident had an order to receive Metoprolol Tartrate 50 milligrams (mg) by mouth twice a day for high blood pressure. The order included parameters to hold the medication if the resident's systolic blood pressure (SBP) was less than 100 millimeters of mercury (mmHg). Review of Resident #5's medication administration record (MAR) for January 2025 revealed the nurses were documenting the resident's blood pressure at the time the Metoprolol Tartrate was being administered. The resident's blood pressure was documented as having been 97/61 mmHg on 01/10/25 for the evening dose of Metoprolol Tartrate given at 7:00 P.M. The nurse initialed the MAR to reflect the Metoprolol Tartrate was given on that date. It was not documented as having been held as per the parameters included in the order. Review of Resident #5's MAR for February 2025 revealed the resident's blood pressure was documented as being 98/56 on 02/08/25, when the evening dose of Metoprolol Tartrate 50 mg was given around 7:00 P.M. The nurse initialed the MAR to reflect the Metoprolol Tartrate was given despite the resident's SBP being below the parameters given by the physician in which the medication should have been held. On 02/25/25 at 11:15 A.M., an interview with the Director of Nursing (DON) confirmed the MAR's for January and February 2025 showed Resident #5 did receive her Metoprolol Tartrate on a couple of occasions when her SBP was less than 100 mmHg. She was not able to find any evidence of the medication being held as ordered when the SBP was below 100 mmHg.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review and staff interview, the facility failed to ensure a resident did not receive an anxiolytic medication on an as needed (prn) basis longer than 14 days, without the physician providing the necessary documentation required for an extended use. This affected one resident (#28) of five residents reviewed for unnecessary medications. Findings include: Review of Resident #28's medical record revealed the resident was admitted to the facility on [DATE]. She was readmitted to the facility on [DATE]. Her diagnoses included anxiety disorder. Review of a consultation report for Resident #28 dated 07/17/24 revealed the consulting pharmacist noted an irregularity in the resident's medications when reviewing the resident's medications as part of a monthly medication regimen review. The pharmacist identified the resident had an order for Xanax 0.25 milligrams (mg) with directions to give one tablet by mouth every eight hours as needed for anxiety. The pharmacist asked the physician to please discontinue the prn Xanax, or if the medication could not be discontinued at that time, to please document the indication for use, the intended duration of therapy, and the rationale for the extended time period. The rationale for the recommendation indicated Centers for Medicare and Medicaid Services (CMS) required that prn orders for non-antipsychotic psychotropic drugs (such as anxiolytics) be limited to 14 days unless the prescriber documented the diagnosed specific condition being treated, the rationale for the extended time period, and the duration for the prn order. There was not a physician's response on the consultation report providing the required documentation as requested by the consulting pharmacist. Review of a physician's order dated 07/23/24 revealed an order was given for Xanax 0.25 mg with instructions to give one tablet by mouth every eight hours as needed for anxiety. The order was to continue until 08/15/24, which exceeded the 14 days a prn anxiolytic medication could be ordered unless providing a rationale for the extended time period. On 02/24/25 at 5:46 P.M., an interview with the Director of Nursing (DON) revealed she acknowledged prn anxiolytic medications were only supposed to be used on a prn basis for up to 14 days. Any prolonged use longer than that required the physician to provide a rationale as to why the medication was required to be used longer. She was not able to provide any documentation from the physician supporting it's longer use. She further acknowledged the order they received on 07/23/24, that instructed them to continue to use the prn Xanax until 08/15/24, exceeded a 14 day period, and a rationale was not provided to support the extended use.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, record review, staff interview, and resident interview, the facility failed to ensure medical records were accurately documented for a resident with a pressure ulcer. This affected one resident (#66) of three residents reviewed for pressure ulcers. The facility census was 75. Findings include: Review of the medical record for Resident #66 revealed an admitted [DATE] and diagnoses including acute kidney failure, hypertension, and stage four pressure ulcer. A Minimum Data Set assessment completed 12/28/24 documented a brief interview for mental status (BIMS) score of 11 (moderately impaired cognition). The resident was dependent upon staff for lower body dressing, required substantial/maximal assistance from staff with bed to chair transfers, and required partial/moderate assistance from staff with rolling in bed. The resident was unable to walk. The resident was noted to have a Stage 4 pressure ulcer present upon admission. (Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur). Upon admission, the Stage 4 pressure ulcer on the sacrum measured 13 by 10 by 1.8 centimeters deep. The most recent skin assessment on 02/19/25 revealed the sacrum measured 2 by 1 by 0.1 centimeters deep. The resident had physician's orders 02/08/25 to cleanse sacrum with wound cleanser, pat dry, apply calcium alginate with silver to wound bed, cover with telfa, then secure with hypafix every day shift. The resident had physician's orders dated 11/25/24 to cleanse right heel with wound cleaner, pat dry, and apply skin prep topically daily as preventative and 10/30/24 same treatment for left heel. On 08/06/24 heel protectors were ordered for bilateral lower extremities in bed as tolerated. Observations on 02/19/25 at 10:41 A.M. revealed Resident #66 to be in bed without heel protectors on. The resident stated he had not had his dressing to sacrum changed yet that day. Review of the treatment administration record on 02/19/25 at 10:55 A.M. revealed the treatment to the sacrum was signed off as completed and the heel protectors were signed off as in place. On 02/19/25 at 11:00 A.M. Resident #66's nurse (Licensed Practical Nurse (LPN) #493) stated that it was reported by the aides that the resident's dressing to his sacrum had come off. The surveyor and LPN #493 went to the resident's room to check. The resident had a dressing covering the sacrum. However, it was not dated to indicate when it had been changed. LPN #493 stated that he had not yet changed the dressing. When the surveyor asked LPN #493 why he had signed the treatment off as completed on the treatment administration record, he then said he had already changed the dressing that morning, but did not remember when. (He came on duty at 6:00 A.M.). He stated that he had put a date on the dressing but it had already smudged off. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the time stamp on the treatment administration record revealed LPN #493 signed the treatment of the sacrum completed on 02/19/25 at 10:32 A.M. (approximately 30 minutes before going in the room and saying he had not changed it that day). In addition, on 02/19/25 at 11:00 A.M. Resident #66 was noted in bed with no heel protectors on. LPN #493 confirmed the resident did not have heel protectors on, even though he had signed off on the treatment administration record that they were in place. He stated the resident took them off. When asked where the heel protectors were, LPN #493 stated how am I supposed to know. Interview with the two nursing assistants working on Resident #66's hallway on 02/19/25 at 11:14 A.M. (Nursing Assistants #471 and #491) confirmed the resident had not had heel protectors on that day. Nursing Assistant #471 stated she worked on that hall often and had never seen him have heel protectors on. Interview with Assistant Director of Nursing #417 on 02/19/25 at 11:30 A.M. confirmed Resident #66 did not have heel protectors on. She stated the resident required a hoyer lift for transfers and if he had taken heel protectors off by himself they could not be very far away. She checked the room and could not find any heel protectors.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 32801 Based on review of the water management (Legionella) control plan, review of the infection control log, review of CMS QSO memo, observation, interview, and policy review the facility failed to ensure infection control practices were maintained to prevent the spread of infectious disease and failed to ensure infections were monitored for trends. This had the potential to affect all 75 residents residing in the facility. Findings included: 1. Observation of the laundry process on 02/25/25 at 8:01 A.M. with Laundry Assistant (LA) #542 revealed the LA goes to each of the four soiled linen rooms five times a day to collect laundry. Staff are supposed to put linens in bags and place the linens in the soiled linen room on each hallway. The facility doesn't mark the laundry, so she doesn't know what linens were isolation or enhanced barrier precaution (EBP). LA #542 reported she was told there was no more residents on isolation and the chemicals in the machine would kill everything, so the linens don't have to marked to indicate isolation. LA #542 confirmed she doesn't know what kills Clostridium difficile (C-diff) or methicillin-resistant staphylococcus aureus (MRSA). Most of linen collected from the soiled linen rooms were not bagged. LA #542 confirmed staff sometimes just carry the linens to the soiled linen rooms if the rooms were close to the soiled linen room instead of bagging the linen. The LA returned to the laundry room in the basement after collecting all the linens from the soiled linen rooms. The LA #542 entered on the dirty side of the laundry room and washed her hands and applied gloves. She removed the linens from the washing machine. As she was scooping the clean linens out of the washing machine the linens were touching the front of her smock. After she placed the washed linens in the dryer she returned to the dirty side of the laundry room and washed her hands and applied new gloves. The LA did not apply a gown or goggles. Next the LA #542 opened the big plastic bin and started to remove the linens from the bin. The LA opened the two plastic bags of linens and mixed them with the linens that were not bagged in the bin. The LA was shorter in nature and had to lean into the bin to get the clothing out touching the inside of the bins with her arms and clothing. The LA confirmed again she didn't' know which linens were isolation or from EBP rooms. She separated the linens into two wash machines. One for colors and one for whites. There was a sign above the washing machines indicating the cycle numbers. LA #542 confirmed #1 was for whites and #2 was for colors. LA#542 confirmed #4 was the isolation cycle but she doesn't use it. LA #542 confirmed she didn't wear gowns or gloves during the process, and she was handling contaminated linen that could have possibly been from isolation or EBP rooms. Interview on 02/25/25 at 1:41 P.M. and 2:07 P.M., with Laundry Supervisor (LS)/Human Resource (HR) #423 revealed she had called the supply company for the washing machines to determine what chemicals were in each cycle. The #1 cycle contains a destainer (bleach), the #2 cycle doesn't contain bleach, and the isolation cycle (#4) contains a high concentration of bleach for isolation linens. LS/HR #423 confirmed all isolation linens should be washed either on cycle #1 (whites) or #4 (isolation). The company reported they had a bleach alternative for colors, and she was going to look into purchasing for colored isolation linens moving forward. (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 02/25/25 at 10:45 A.M., with Assistant Director of Nursing (ADON)/Infection Preventionist (IP)/Wound Nurse (WN) #417 and Unit Manager (UM)/Registered Nurse (RN) #540 confirmed per the facility's policy linens should be taken to the linen room in bags and color coded according to isolation precautions type. The ADON/IP/WN #417 confirmed the policy doesn't address a color for EBP and she was going to look into that. ADON/IP/WN #417 confirmed isolation items should be washed separate from non-isolation items and LA should wear a gown when sorting laundry that possibly contained isolation linen. Review of facility policy titled Laundry Contaminated (dated 03/2010) revealed soiled laundry contaminated with blood or other infectious material shall be handled as little as possible and with a minimum of agitation. Contaminated laundry should be placed in a bag or container at the location where it was used and should not be sorted or rinsed in the location of use. Contaminated laundry should be placed and transported in bags or containers that were labeled or color-coded in accordance with our established policies. Employees who handle soiled laundry must wear protective gloves and other appropriate personal protective equipment to prevent occupational exposure during handling or sorting. 2. Observation of contact isolation room (Resident #13) on 02/25/25 at 11:09 AM with ADON/IP/WN #417 revealed the resident was in contact isolation for C-diff per staff. There was a sign for contact isolation . There was only one trash can with a white bag for trash. There was no bag or container for the residents' linens. Certified Nursing Aide (CNA) #491 reported she would double bag the linens in white trash bag and take them to the soiled linen room. CNA #491 confirmed that the facility doesn't mark the bags to alert staff the linens were for residents in isolation. ADON/IP/WN #417 reported per the facility's policy the residents should have containers for linen and color coated bags to alert staff the linens were isolation linens. Review of the infection control log dated 02/2025 revealed there were three confirmed cases of C-diff. Resident #13 was admitted with C-diff in January 2025 and was treated until 01/28/25 and tested positive again 02/20/25. There was a fourth resident being treated prophylactic for C-diff. 3. Review of the infection control log dated 02/2024 to 02/2025 revealed no evidence the facility was tracking and assessing for trends in infections. Interview on 02/25/25 at 10:45 A.M., with Assistant Director of Nursing (ADON)/Infection Preventionist (IP)/Wound Nurse (WN) #417 and Unit Manager (UM)/Registered Nurse (RN) #540 confirmed the facility was not tracking and assessing for trends in infections. Review of the facility's policy titled Infection Control Plan/Program (dated 06/06/23) revealed the facility would identify and analyze clusters/trends of infections. 4. Review of the facility's water management control plan dated 12/13/24 revealed the management team consisted of the Administrator, Director of Environment Services, Regional Facility Manager, the Director of Nursing, and the Maintenance Assistant. The building was constructed in 1960 with additions being completed 1995 and 2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility water control plan included monitoring and documentation of control measure and control points. The Quality Assurance Performance Improvement (QAPI) would monitor the water management program for implementation and effectiveness. The facility upper-level monitoring included: -Disinfectant levels are checked and documented at main water entrance, dietary sinks, water fountain, sinks, and shower room. -The water temperatures are checked and documented at water heater, storing tank, sinks, showers and at circulation pump for the hot water. -The visual inspection occurs at the main and ice machine. The facility lower-level monitoring included: -Disinfectant levels are checked and documented at the main water entrance, sink, showers, spa. -Laundry and three water fountains are checked. -The water temperatures are checked and documented at the water heaters, sink, showers, spa, laundry, and circulation pumps. -The visual inspection is at main water entrance. Further review of the water management control documentation revealed no evidence the monitoring of the upper and lower levels was conducted per the facility water management plan. Interview on 02/19/25 at 3:29 P.M., with the Maintenance Director (MD) confirmed there was no documented evidence that the water management monitoring had been completed in the last year. The facility was without a MD for three or four months and he just started a few months ago. The MD reported he does check water temperatures in the residents' rooms but not in the areas listed as part of the monitoring. The MD confirmed that since he started he has not done the water management monitoring except on 02/13/25 he collected water samples for the yearly Legionella testing, however the test results were still pending. Additional review revealed the facility conducted annual Legionella testing on 02/21/24 and all results were negative. The facility collected 2025 annual water testing samples on 02/13/25. The results returned on 02/21/25 revealed no Legionella was detected. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Centers for Medicare and Medicaid (CMS) QSO dated 06/02/17 and revised 07/06/18 revealed the facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease of patient and personnel. CMS expects certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system. Develop and implement a water management program that considers the ASHRAE industry standards and the Center of Disease Control (CDC) toolkit. Specifies testing protocols sand acceptable ranges for control measures. and document the results of testing and corrective actions taken when control measures are not maintained. Legionella testing protocols are at the discretion of the provider and not required by CMS.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on review of the infection control log, medical record review, interview, and policy review the facility failed to ensure antibiotics were monitored and failed to ensure antibiotics met criteria for administration. This affected one resident (#184) of five residents reviewed for infections and had the potential to affect all 75 residents residing in the building. Findings included: 1. Review of the infection control log dated 02/2024 to 02/2025 revealed no evidence the facility was monitoring antibiotics to ensure the antibiotic usage met criteria and failed to ensure a SBAR was completed. Review of the facility's policy titled Antibiotic Stewardship (dated 06/13/23) revealed the Infection Preventionist (IP) would be responsible to lead the team and to conduct monitoring and reporting. All antibiotics orders would come with the following: A specific prescribing order with dose and duration, a progress note explaining the reason for antibiotic, and a culture and sensitivity if performed. The IP would ensure the antibiotic had a stop date, a SBAR (Situation, Background, Assessment, and Recommendation- a form used for information to share between health care entities) was completed, update the infection control log, and follow up with symptoms post stop date. Interview on 02/25/25 at 10:45 A.M., with Assistant Director of Nursing (ADON)/Infection Preventionist (IP)/Wound Nurse (WN) #417 and Unit Manager (UM)/Registered Nurse (RN) #540 confirmed the facility was not monitoring infections to ensure the antibiotic usage met criteria for treatment. The ADON/IP/WN #417 reported she was to complete the SBAR to ensure the residents met criteria and to monitor the antibiotics, however she was not completing the SBAR. 2. Medical record review revealed Resident #184 was admitted to the facility on [DATE] with diagnoses including aftercare following joint replacement, osteoarthritis, and muscle weakness. Review of Resident #184's hospital discharge records dated 02/16/25 revealed to ask your doctor how to take Keflex 500 milligrams (mg). There was no documentation for indication for use. Review of Resident #184's history of physical dated 02/16/25 revealed no evidence the Keflex order was clarified or indication for use. Review of Resident #184's progress notes dated 02/16/25 to 02/18/24 revealed no evidence the Keflex order was clarified or indication for use. Review of Resident #184's orders dated 02/2025 revealed the resident was ordered Keflex 500 milligrams (mg) every eight hours for post-surgical elevated leukocytes. There was no evidence of a stop date. Review of Resident #184's medication administration record (MAR) dated 02/2025 revealed the resident received six doses of Keflex 500 milligrams (mg) from 02/16/25 to 02/18/25. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the infection control log dated 02/2025 revealed Resident #184 had an unknown infection on 02/16/25 and was treated with Keflex 500 milligrams. Review of Resident #184's pharmacy review dated 02/17/25 revealed a recommendation to add a duration of therapy or stop date for the Keflex 500 mg every eight hours. The physician discontinued the Keflex on 02/18/25 Interview on 02/25/25 at 10:45 A.M., with Assistant Director of Nursing (ADON)/Infection Preventionist (IP)/Wound Nurse (WN) #417 and Unit Manager (UM)/Registered Nurse (RN) #540 confirmed there was no indication for use of the Keflex for Resident #184. The ADON/IP/WN confirmed they didn't have any documented evidence of leukocytes nor was there a stop date on the Keflex. UM/RN #540 reported she recalled the facility physician had seen the resident on the day she was admitted , and he wanted staff to follow up with the hospital doctor regarding a stop date on Keflex, however, there was no documented evidence that was done. The pharmacist reviewed Resident #184's record on 02/17/25 and identified the Keflex did not have a stop date and wrote a recommendation to document a duration of therapy or stop date. The facility physician reviewed the recommendation on 02/18/25 and stopped the Keflex. Review of the facility's policy titled Antibiotic Stewardship (dated 06/13/23) revealed the IP would be responsible to lead the team and to conduct monitoring and reporting. All antibiotics orders would come with the following: A specific prescribing order with dose and duration, a progress note explaining the reason for antibiotic, and a culture and sensitivity if performed. The IP would ensure the antibiotic had a stop date, a SBAR was completed, update the infection control log, and follow up with symptoms post stop date.