STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366099	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Nursing & Independent Living	404 E McCreight Ave Springfield, OH 45503

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on medical record review, observation, staff interviews, and policy review, the facility failed to ensure all residents were treated with dignity and respect. This affected one (#1) of one resident reviewed for dignity and respect. The facility census was 61. Findings include: Review of the medical record for Resident #1 revealed an admitted [DATE]. Diagnoses included unspecified psychosis not due to a substance or known physiological condition, bipolar two disorder, schizoaffective disorder, aphasia, post traumatic seizures, other specified intracranial injury without loss of consciousness, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had severe cognitive impairment and was non-verbal. No behaviors were noted on the assessment. Resident #1 was assessed to require setup assistance for eating, maximal assistance for bed mobility and transfer, and was dependent on staff for oral hygiene, toileting, bathing, dressing, and personal hygiene. Review of the plan of care revised on 07/20/18 revealed Resident #1 was at risk for altered behavior related to depression and psychosis. Interventions included administer medications as ordered, always approach in a calm and relaxed manner, attempt to re-direct when resistive to care, and if unable to re-direct, ensure Resident #1 is safe and leave for a short time and reapproach to assist to complete care. Observation on 05/19/24 at 11:45 A.M. revealed Resident #1's door was open, and the privacy curtain was pulled around. Further observation revealed Resident #1 was receiving care, and the unknown staff member made statements that included, you're not laying down and sit down in a loud and abrasive tone. The unknown staff member then exited the room with Resident #1. Interview on 05/19/24 at 11:47 A.M. with the unknown staff member, who identified themselves as State tested Nursing Assistant (STNA) #526, stated they were hard of hearing and denied interacting with Resident #1 in an unprofessional manner. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews on 05/19/24 from 11:52 A.M. to 11:55 A.M. with Housekeeping Staff #550 and #551 verified they overheard the interaction between Resident #1 and STNA #526, and that the interaction was unprofessional. Review of the facility policy titled, Promoting/Maintaining Resident Dignity, dated 01/01/24, revealed it was the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 34291 Based on observation, medical record review, staff and resident interview, and policy review, the facility failed to provide a homelike environment for the residents. This affected three (Residents #18, #21, #31) of three reviewed for homelike environment. This also affected 27 (Residents #56, #21, #07, #19, #110, #18, #05, #08, #55, #54, #25, #50, #22, #28, #43, #41, #45, #02, #210, #26, #44, #06, #37 #01, #03, #10, #51) of 27 residents who resided on the behavioral unit. The census was 61. Findings included: 1. Observation of the activity room for the behavioral unit on 05/19/24 at 2:10 P.M. revealed the seven window ledges were sticky and dusty. The seven window sills in the room were covered with a black substance. The three blinds in the room were covered with a sticky yellow substance. The floor under the two heaters in the room had a thick black substance under them. The baseboards had a black substance on them. There were three lights going down the west hall of the behavioral unit that had light coverings missing and some of the light bulbs were burned out. Also going down this hall there were ceiling tiles that were missing at the end of the hall. 2. Observation of the shower room on the behavioral unit on 05/19/24 at 2:30 P.M. revealed the windowsill had black substance with dead bugs in it and the blind had a sticky yellow substance on it. 3. Observation and interview on 05/19/24 at 3:40 P.M. of Resident #21's room who resides on the behavioral unit, revealed his blind was broken with a sticky yellow substance on it. The window ledge had sticky substance on it and the windowsill had black substance and bugs in it. The shower had rust spots on the floor of it. The resident would like to have these fixed and cleaned. 4. Observation of Resident #18's room on the behavioral unit on 05/20/24 at 8:21 A.M. revealed his window ledge was sticky with a built up yellow substance. The window sill was full of black substance with bugs in it and the blind had a sticky yellow substance on it. This resident was not alert and oriented to interview. Interview with the Maintenance Man (MM) on 05/20/24 at 10:42 A.M. confirmed the coverings for the lights, the burned out light bulbs and the broken blinds. Interview with Housekeeping Supervisor (HS) on 05/20/24 at 11:49 A.M. confirmed the activity room and the Residents #21 and #18's rooms should have been cleaned better when the housekeepers did the deep cleaning of the behavioral unit. 45751 5. Observation and interview on 05/19/24 at 10:35 A.M. of Resident #31's bathroom revealed stagnant water around the base of the toilet. Resident #31 stated the toilet had been leaking for days now and no one has fixed the toilet. Resident #31 stated she would like the toilet fixed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/20/24 at 10:33 A.M. of Resident #31's bathroom revealed stagnant water remained around the base of the toilet. The water came out approximately five inches from the toilet. Interview on 05/20/24 at 10:36 A.M. with Maintenance Assistant #650 verified water around the base of the toilet and the water on the floor. Maintenance Assistant #650 stated they would have to change the toilet. Observation on 05/21/24 at 8:49 A.M. of Resident #31's bathroom revealed the stagnant water still observed around the base of the toilet approximately five inches from the toilet. Interview on 05/21/24 at 12:05 P.M. with Maintenance Director (MD) #573 stated the toilet in Resident #31's bathroom was not a maintenance issue. MD #573 stated that the area had not been cleaned and the substance around the toilet was not water but urine. MD #573 stated that he went into room with housekeeping and they scrubbed the area. MD #573 verified that he changed the wax seal on the toilet out of precaution. Observation on 05/22/24 at 1:02 P.M. of Resident #31's bathroom revealed no water/urine noted around the base of the toilet. Review of the policy titled, Safe and Homelike Environment, dated 01/01/24 revealed in accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on medical record review, staff interview, and policy reviews, the facility failed to develop a care plan for smoking and activities. This affected one (Resident #55) of five residents reviewed for care planning. The facility census was 61. Findings include: Review of the medical record for Resident #55 revealed an admitted [DATE]. Diagnoses included unspecified dementia, unspecified severity, with other behavioral disturbance, mild protein-calorie malnutrition, anxiety disorder, myelodysplastic syndrome, heart failure, alcohol dependence with unspecified alcohol-induced disorder, adult failure to thrive, and major depressive disorder recurrent severe with psychotic symptoms. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 had severely impaired cognition. Resident #55 was assessed to require supervision for bathing, dressing, and personal hygiene, and was independent for eating, oral hygiene, toileting, bed mobility, and transfer. Review of the plan of care initiated on 06/27/23 revealed no care plan related to smoking. Review of the plan of care initiated on 01/03/24 revealed Resident #55 could be dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits. Interventions included preferred activities, which had not been specified and were blank. Review of the facility assessment titled, Safe Smoking Assessment, dated 05/08/24 revealed Resident #55 smoked. Interview on 05/21/24 at 5:50 P.M. with the Director of Nursing (DON) confirmed Resident #55 smoked and had no care plan for smoking, and the activities care plan was blank for Resident #55's activity preferences. Review of the facility policy titled, Resident Smoking, dated 01/01/24, revealed all safe smoking measures would be documented on each resident's care plan. Review of the facility policy titled, Comprehensive Care Plans, dated 01/01/24, revealed it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 34291 Based on medical record review, staff and resident interview, and policy review, the facility failed to ensure care conferences were provided quarterly for four (Residents #39, #21, #32, #33) of four reviewed for care conferences. The census was 61. Findings included: 1. Medical record review for Resident #39 revealed an admitted [DATE] with a diagnosis of chronic obstructive pulmonary disease. Review of the quarterly MDS dated [DATE] revealed Resident #39 was cognitively intact. His functional status was set-up or clean-up assistance for eating and toileting. He was independent for bed mobility and transfers. Review of Resident #39's care conference history since 05/01/23 revealed he only had one care conference on 03/28/24. Interview with Resident #39 on 05/19/24 at 10:02 A.M. revealed he didn't know what a care conference was. Interview with the Social Services Designee (SSD) #592 on 05/20/24 at 2:53 P.M. confirmed there was only one care conference for Resident #39. 2. Medical record review for Resident #21 revealed an admitted [DATE] with a diagnosis of Parkinson's disease. Review of the quarterly MDS dated [DATE] revealed Resident #21 was cognitively intact. His functional status was set-up or clean up assistance for eating, dependent for toileting, and substantial/maximal assistance for bed mobility and transfers. Review of Resident #21's care conference history revealed he only had care conferences on 06/20/23, 12/07/23, and 04/18/24. Interview with Resident #21 on 05/19/24 at 3:40 P.M. revealed he hasn't had any care conferences. Interview with the SSD #592 on 05/20/24 at 2:53 P.M. confirmed the care conferences were not quarterly. 3. Medical record review for Resident #32 revealed an admitted [DATE] with a diagnosis of chronic obstructive pulmonary disease. Review of the quarterly MDS dated [DATE] revealed Resident #32 was cognitively intact. His functional status was set-up or clean-up assistance for eating, toileting, bed mobility and transfers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #32's care conference history revealed he only had one care conference on 03/28/24. Interview with Resident #32 on 05/19/24 at 11:32 A.M. revealed he didn't remember if there had been a care conference. Interview with SSD #592 on 05/20/24 at 1:27 P.M. revealed she has worked at the facility since May 2023 and confirmed Resident #32 only had one care conference since she has been at the facility. 45751 4. Review of medical record for Resident #33 revealed an admitted [DATE] with diagnoses including but not limited to epidural hemorrhage with loss of consciousness, major depressive disorder, hypertension, psychosis, type two diabetes, paranoid schizophrenia, and dementia with behavioral disturbance. Review of MDS assessment dated [DATE] revealed Resident #33 had severe cognitive impairment. Resident #33 required extensive assistance for activities of daily living. Review of care conference documentation revealed care conferences held on 06/05/23 and 01/03/24. No documentation of family representatives in attendance for care conference on 01/03/24. Review of care conference documentation for 06/05/23 revealed the resident's brother on the phone for care conference. Review of Resident #33's profile revealed the resident's son as emergency contact number one and the resident's brother as next of kin. Interview on 05/19/24 at 3:52 P.M. via phone with Resident #33's son revealed he had not been notified of any care conferences that he was aware of. Interview on 05/22/24 at approximately 1:40 P.M. with the Administrator revealed Resident #33's son lives out of state which is the reason he was not notified of the care conferences. The Administrator verified that the son should be notified and could attend the care conferences via phone. Additionally, care conferences were only held on 06/05/23 and 01/03/24. Review of policy titled, Care Planning-Resident Participation, revised on 01/01/24 revealed the facility will discuss the plan of care with the resident and/or representative at regularly scheduled care conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on medical record review, staff interview, and policy review, the facility failed to complete discharge summaries. This affected two (Residents #57 and #59) of two residents reviewed for discharge. The facility census was 61. Findings include: 1. Review of the closed medical record for Resident #57 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included malignant neoplasm of central portion of right female breast, chronic obstructive pulmonary disease, anxiety disorder, posttraumatic stress disorder, major depressive disorder, dementia, and hypokalemia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 had moderately impaired cognition. Resident #57 was assessed to require setup assistance for eating oral hygiene, and personal hygiene, supervision for toileting, bathing, and dressing, and was independent for bed mobility and transfer. Review of the progress note dated 05/09/24 revealed Resident #57 discharged home. Review of the assessment titled, Discharge Instructions, dated 05/06/24 revealed the assessment was not completed for Resident #57. Review of the assessment titled, Discharge Summary, dated 05/06/24 revealed the assessment was not completed for Resident #57. 2. Review of the closed medical record for Resident #59 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included chronic obstructive pulmonary disease, epilepsy, chronic kidney disease, type two diabetes mellitus without complications, emphysema, hyperlipidemia, and major depressive disorder. Review of the admission MDS assessment dated [DATE] revealed Resident #59 had intact cognition. Resident #59 was assessed to require setup assistance for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene, and was independent for bed mobility and transfer. Review of the progress note dated 03/06/24 revealed Resident #59 discharged to an assisted living facility. Review of the assessment titled, Discharge Instructions, dated 03/04/24 revealed the assessment was not completed for Resident #59. Review of the assessment titled, Discharge Summary, dated 03/07/24 revealed the assessment was not completed for Resident #59. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/21/24 at 9:20 A.M. with Social Services Staff #592 confirmed there were no completed discharge summaries for Residents #57 and #59. Review of the facility policy titled, Transfer and Discharge, reviewed 01/01/24, revealed a member of the Interdisciplinary Team completes relevant sections of the discharge summary, and then the nurse caring for the resident at the time of discharge would ensure the discharge summary was completed.

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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** 34291 Based on observation, medical record review, staff and resident interview, and policy review, the facility failed to ensure a resident who couldn't perform Activities of Daily Living (ADL) independently was provided with bathing, beard trimming, and nail trimming, This affected one (Resident #32) of three reviewed for ADL care. The census was 61. Findings included: Medical record review for Resident #32 revealed an admitted [DATE] with a diagnoses of chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 was cognitively intact. His functional status was set-up or clean-up assistance for eating, toileting, bed mobility, and transfers. Review of the care plan dated 05/01/24 revealed Resident #32 had a self-care deficit for ADLs. He has been supervision for all ADLs but at times required hands on assistance. The resident used a powered wheelchair to move about the facility. He refused showers at times. Review of shower sheets for Resident #32 revealed out of 12 opportunities since 04/10/24, there was one shower given and two refused. Observation and interview with Resident #32 on 05/19/24 at 11:39 A.M. revealed his beard was long and unkept and fingernails were long. He stated he doesn't get his nails trimmed unless he asked for it and he asked on this day to get his beard trimmed and it wasn't done yet. He stated he wasn't getting his regular showers and only a refused a couple of times to be bathed. Interview with State tested Nursing Aide (STNA) #520 on 05/21/24 at 11:16 A.M. revealed she worked on 05/19/24 day shift and took care of Resident #32. She stated the resident asked for his beard to be trimmed and revealed the facility used to have shavers, but they were thrown away and she didn't have anything to shave off his bead. Interview with the Director of Nursing (DON) on 05/21/24 at 11:29 A.M. revealed the shavers for the residents got old and they were thrown away and people are not getting shaved. She stated the showers and the nail care wasn't completed for Resident #32 and it was a work in progress. Review of the policy titled, Activities of Daily Living, dated 01/01/24 revealed care and services will be provided for bathing, dressing, grooming and oral care. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain grooming, and personal care.

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 44069 Based on review of personnel records and staff interviews, the facility failed to ensure the activity department was overseen by a qualified activity professional. This had the potential to affect all residents residing in the facility. The census was 61. Findings include: Review of the personnel file for Activity Director #502 revealed they were hired on 03/15/23 and promoted to Activity Director on 06/12/23. Further review of the personnel file for Activity Director #502 revealed no certification or employment experience that qualified them to oversee the activity department. Interview on 05/21/24 at 10:46 A.M. with Activity Director #502 revealed they were currently enrolled in a course to become a certified activity professional. Interview on 05/21/24 at 5:20 P.M. with the Administrator confirmed Activity Director #502 was not certified and had no previous employment experience to oversee the activity department.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on observation, interview, and policy review, the facility failed to assess side rails and/or enabler bars for entrapment risk. This affected one (Resident #33) of two residents reviewed for side rails/enabler bars. The facility census was 61. Findings include: Review of medical record for Resident #33 revealed an admitted [DATE] with diagnoses including but not limited to epidural hemorrhage with loss of consciousness, major depressive disorder, hypertension, psychosis, type two diabetes, paranoid schizophrenia, and dementia with behavioral disturbance. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33 had severe cognitive impairment. Resident #33 required extensive assistance for activities of daily living. Review of assessments revealed no side rail and/or enabler bar assessments completed. Observation on 05/21/24 at 1:49 P.M. of enabler bar on Resident #33's bed revealed approximately three and half to four inch gap between the enabler bar and mattress. Interview on 05/21/24 at 1:49 P.M. with Resident #33 revealed the resident had no issues regarding the enabler bar having a gap. Resident #33 denied getting stuck in the rail. Interview on 05/21/24 at 2:45 P.M. with Maintenance Director #573 verified he does not put enabler bars on the hospital beds. MD #573 verified he does not assess the enabler bars to ensure they are the proper fit for the beds. Interview on 05/21/24 at 2:47 P.M. with Assistant Director of Nursing (ADON) #507 verified Resident #33's enabler bar had a three and half to four inch gap between the mattress and the rail. ADON #507 stated therapy and nursing would assess a resident upon admission for the need for enabler bars. ADON #507 verified no assessments were completed for Resident #33 and that nursing should be assessing the residents with enabler bars routinely. Interview on 05/21/24 at 3:36 P.M. with Director of Nursing (DON) verified no side rail and/or enabler bar assessments have been completed. The DON stated the assessments are on the list of things that need to be addressed throughout the facility. Review of the policy titled, Proper Use of Bed Rails, dated 01/01/24 revealed if bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Review of medical records, late medication reports, physician orders, interview, and policy review the facility failed to ensure medications were administered in a timely manner and according to physician instruction. This affected four (Residents #13, #30, #31, and #33) of four residents reviewed for late medications. Findings include: 1. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including but not limited to unspecified convulsions, dementia, mild intellectual disabilities, epilepsy, post-traumatic stress disorder, hypothyroidism, major depressive disorder, cognitive communication disorder, and bipolar disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had severe cognitive impairment. Resident #13 required supervision/touching assistance for ADLs. Review of the late medication report for 05/18/24, revealed the following medications due at 8:00 A.M. were not administered until 12:00 P.M. levothyroxine 50 mcg (thyroid), keppra 250 mg (seizures), midodrine 5 mg (blood pressure), daily vitamin (supplement), megestrol oral suspension 40 mg/ml 10 ml (weight). On 05/19/24, the following medications due at 8:00 A.M. were not administered until 10:44 A.M. megestrol oral suspension 40 mg/ml 10 ml, daily vitamin, midodrine 5 mg, keppra 250 mg, and levothyroxine 50 mcg. 2. Review of the medical record for Resident #30 revealed an admitted [DATE] with diagnoses including but not limited to adult failure to thrive, anemia, dementia, paranoid schizophrenia, type two diabetes, major depressive disorder, cognitive communication deficit, dysphagia, and gastrointestinal hemorrhage. Review of the MDS assessment dated [DATE] revealed Resident #30 was cognitively intact. Resident #30 required extensive to partial assistance for ADLs. Review of lthe ate medication report revealed on 05/18/24, the following medications were scheduled at 8:00 A.M. and weren't administered until 11:12 A.M. folic acid 400 mcg, cardizem 240 mg, pantoprazole 40 mg, calcium carbonate 600 mg, amiodarone 200 mg, ferrex 150 mg, docusate sodium 100 mg, magnesium oxide 400 mg, lidocaine external patch. Interview on 05/22/24 at 8:48 A.M. with Resident #30 verified she had received her medications late on more than one occasion. 3. Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including but not limited to schizoaffective disorder, type two diabetes, extrapyramidal and movement disorder, hypertension, conversion disorder with seizures or convulsions, and anxiety. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the late medication report revealed on 05/19/24, the following medications were scheduled at 8:00 A.M. and weren't administered until 11:20 A.M. gabapentin 100 mg 2 capsules, loratadine 10 mg, aspirin 81 mg, lisinopril 20 mg, benztropine 0.5 mg, vitamin D3 25 mcg, glipizide 10 mg 2 tablets, sitagliptin 100 mg, haloperidol 2 mg, and metformin 1000 mg. On 5/19/24 the following medication was scheduled at 2:00 P.M. and wasn't administered until 5:28 P.M. gabapentin 100 mg 2 capsules. Interview on 05/22/24 at 8:49 A.M. with Resident #31 verified she has received her medications late the last couple of days in the morning. 4. Review of the medical record for Resident #33 revealed an admitted [DATE] with diagnoses including but not limited to epidural hemorrhage with loss of consciousness, major depressive disorder, hypertension, psychosis, type two diabetes, paranoid schizophrenia, and dementia with behavioral disturbance. Review of the MDS assessment dated [DATE] revealed Resident #33 had severe cognitive impairment. Resident #33 required extensive assistance for ADLs. Review of late medication report revealed on 05/19/24 the following medications were scheduled at 8:00 AM and weren't administered until 11:09 A.M. risperdal 0.5 mg give 2 tablets, sodium chloride, metoprolol succinate extended release (ER) 50 mg, atorvastatin calcium 40 mg, metformin 500 mg, divalproex ER 500 mg, bisacodyl EC 5 mg, tylenol 325 mg 2 tabs three times daily, miralax 17 grams, tamsulosin 0.4 mg, and lisinopril 20 mg. Interview on 05/21/24 at 1:15 P.M. with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) revealed they both offered to help Licensed Practical Nurse (LPN) #563 during her medication pass on 05/19/24 because they knew the LPN was running behind and she declined the help and said she would be ok with getting the medications to the residents. Interview on 05/22/24 at 9:40 AM with the DON verified the late medications on the late medication report for Residents #13, #30, #31, and #33. The DON verified the nursing staff have one hour before medication is scheduled to one hour after medication is scheduled to administer medications. Review of policy titled, Medication Administration, revised 01/01/24 revealed administer medications within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on medical record review, staff interview, and policy review, the facility failed to reconcile medications following a hospital re-admission. This resulted in Actual Harm when Resident #210 was admitted to the psychiatric hospital on 03/25/24 and upon return to the facility on [DATE], the facility failed to continue the psychiatric medications resulting in a change in condition and hospitalization . This affected one (Resident #210) of one resident reviewed for medication reconciliation. The facility census was 61. Findings include: Review of the medical record for Resident #210 revealed an admitted [DATE]. Diagnoses included schizophrenia, bipolar disorder, type two diabetes mellitus without complications, chronic obstructive pulmonary disease, anxiety disorder, anemia, major depressive disorder, schizoaffective disorder, heart failure, hypokalemia, and hypothyroidism. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #210 had intact cognition. Resident #210 had delusions and displayed verbal behaviors towards others. Resident #210 was assessed to require setup assistance for eating, oral hygiene, bathing, dressing, and personal hygiene, and was independent for toileting, bed mobility, and transfer. Review of the plan of care revised 04/29/24 revealed Resident #210 had diagnoses of schizophrenia, anxiety, and depression. Resident #210 also had a history of suicidal thoughts and hearing voices, refusing medications, being religiously preoccupied and verbally inappropriate with others. Interventions included administer medications as ordered, allow to vent thoughts and feelings, always approach in a calm and relaxed manner, attempt to re-direct when resistive to care, attempt to set limits on behavior by trying to re-direct, re-focus when experiencing altered thoughts, moods, or behaviors, and send for mental health evaluation as needed. Review of the progress note dated 03/25/24 revealed Resident #210 was sent to a psychiatric hospital for evaluation following an increase in behaviors. Review of the progress note dated 04/04/24 revealed Resident #210 was readmitted to the facility on this date from the psychiatric hospital. Review of the discharge medication list dated 04/04/24 revealed Resident #210 was to take alogliptin 25 milligram (mg) once daily for diabetes, metformin 1,000 mg twice a day for diabetes, paliperidone 6 mg extended release once daily for schizoaffective disorder, ziprasidone 80 mg every evening for psychosis, ziprasidone 20 mg once daily for psychosis, divalproex sodium extended release 1,000 mg at bedtime for schizoaffective disorder, and hydroxyzine pamoate 25 mg twice a day for anxiety. Review of the physician orders from 04/04/24 to 04/12/24 revealed the above orders were not entered into the electronic health record following Resident #210's re-admission to the facility. Review of the progress notes dated 04/06/24 and 04/07/24 revealed Resident #210 had an increase in verbal outbursts. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of the progress notes dated 04/11/24 revealed Resident #210 was experiencing religious ideations, manic behaviors, and having verbal outbursts with redirection unsuccessful. Resident #210 was to be transferred for a psychiatric evaluation but refused and became combative. Review of the progress note dated 04/12/24 revealed Resident #210 continued to have behaviors and was noted to be on less medications since returning to the facility from the psychiatric hospital on 04/04/24. Review of the progress note dated 04/12/24 revealed Resident #210's medications were not reconciled following discharge from the psychiatric hospital and re-admission to the facility on [DATE]. The note indicated the orders were verified and confirmed with the physician, and Resident #210's guardian was notified. Review of the progress notes dated 04/13/24 and 04/14/24 revealed Resident #210 continued to have behaviors, which included screaming at others and pinching her arms until they bruised. The police were called, and Resident #210 was transported to the emergency room for evaluation. Review of the progress notes from 04/14/24 through 04/20/24 revealed Resident #210 was admitted to a psychiatric hospital and returned to the facility on [DATE]. Interview on 05/21/24 at 2:32 P.M. with the Director of Nursing (DON) verified Resident #210's medications were not reconciled and continued upon re-admission. Interview on 05/30/24 at 11:22 A.M. via phone with the DON confirmed Resident #210 was transferred to the local emergency roiagnom on [DATE] and then transferred to a psychiatric hospital after the medications had not been reconciled. Review of the facility policy titled, Consulting Physician/Practitioner Orders, dated 01/01/24, revealed the attending physician should authenticate orders for the care and treatment of residents. The policy indicated the nurse was to contact the attending physician to verify orders received from consulting physicians/practitioners and follow facility procedures that included noting the order, submitting to the pharmacy, and transcribing to the administration record.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 34291 Based on observations, review of the menu, staff and resident interviews and policy review the facility failed to ensure the menu was followed and failed to let the residents know the menu changed. This had the potential to affect all 61 residents residing in the facility. The census was 61. Findings included: Review of the menu dated 05/19/24 revealed apple pork chop, onion roasted potatoes, dilled carrots, roll, and pumpkin crisp. Observation on 05/19/23 at 11:53 A.M. of the lunch meal revealed the residents were served an apple pork chop, mashed potatoes and gravy, dilled carrots, roll and a brownie. Interview with Dietary Manager DM #546 on 05/19/24 at 12:09 P.M. confirmed there was a menu change and she didn't let the residents know of the change. Dietary Manager #546 stated she didn't have the roasted potatoes or the pumpkin crisp. Dietary Manager #546 revealed she wasn't aware she had to let the residents know when a substitution was going to be made. Observation of her substitution list revealed there wasn't anything for this date. Dietary Manager #546 confirmed all 61 residents residing in the facility receive their meals from the kitchen. Interview with the Resident Council President Resident #31 on 05/21/24 at 11:09 A.M. revealed the dietary department didn't always follow the menu and didn't let the residents know when the menu was going to be changed. Resident #31 stated two nights ago she wanted the meal that was on the menu and she got cheeseburgers. Review of policy titled Meal Substitutions dated 01/01/24 revealed menu substitutions/ changes shall be made to the planned menu in an emergency situation only and not for the convenience of the facility. Food and Nutrition Services staff shall notify the Director of Food and Nutrition Services or designee regarding the necessity for a menu substitution/ change. The facility will attempt to notify the residents of the substitutions in advance when able to. There may be times when the facility is unable to notify the residents in a timely manner and will offer alternatives as able.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44069 Based on observations, staff interviews, and policy reviews, the facility failed to store food properly and maintain a sanitary kitchen. This had the potential to affect all 61 residents residing in the facility, as the facility reported every resident consumed food from the kitchen. The census was 61. Findings include: Observations on 05/19/24 at 8:25 A.M. revealed three white plastic tubs of cereal with white labels marked Cereal with no dates. There was also a gray trash can/bucket in the dry storage area that was filled with a few inches of water. The reach-in freezer had a plastic bag of hamburger patties open with no label or date, vegetarian burgers with no label or date, and a box of hamburger patties open with the inside plastic bag unsealed and no date. The walk-in refrigerator had a box of bacon thawing on the bottom shelf that was open with the inside plastic bag unsealed and a piece of bacon sticking out of the packaging. The ice machine had various red, yellow, and black stains on the inside of the lid and sides of the ice machine. The observations were confirmed by Dietary Staff #544. Interview on 05/20/24 at 11:34 A.M. with Maintenance Director #573 revealed the bucket was collecting steam from the boiler system in the ceiling, which had been turned off in the last two weeks, but he had not been able to remove the bucket. Observations on 05/21/24 at 12:00 P.M. revealed a carton of milk was temping at 45 degrees Fahrenheit, which was confirmed by Dietary Staff #539. The walk-in refrigerator was observed to be at 45 degrees Fahrenheit, which was confirmed by Dietary Manager #546. Dietary Manager #546 stated the milk and other items would not be served. The items in the walk-in refrigerator included milk, cheese, condiments, and vegetables. Dietary Manager #546 confirmed all 61 residents residing in the facility receive meals from the facility kitchen. Observation on 05/21/24 at 12:25 P.M. of tray line revealed dust on the light fixture above the tray line area and on the wall near the plate warmer, which was confirmed by Dietary Staff #544. Observation on 05/22/24 at 9:35 A.M. revealed the door to the walk-in refrigerator was not shut properly and the temperature gauge read 44 degrees Fahrenheit, which was confirmed by Dietary Staff #545. Review of the facility policy titled Date Marking for Food Safety, dated 01/01/24, revealed perishable food should be held at a temperature of 41 degrees Fahrenheit, and the individual opening or preparing food should be responsible for date marking the food at the time the food is opened or prepared. Review of the facility policy titled Sanitation Inspection, dated 01/01/24, revealed all food service areas should be kept clean and sanitary.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 45751 Based on Quality Assurance and Performance Improvement (QAPI) documentation, staff interview, and policy review, the facility failed to have the required members at QAPI meetings. This had the potential to affect all 61 residents residing in the facility. The facility census was 61. Findings include: Review of QAPI for January 2023, March 2023, June 2023, July 2023, and October 2023 revealed no sign in sheets noted for the meetings. Sign in sheets were located in the March and April 2024 QAPI documentation. No documentation of the medical director attending the meetings in March 2024 or April 2024. Interview on 05/22/24 at 1:27 P.M. with Administrator verified no sign in sheets were located for the QAPI meetings held in 2023. Administrator verified that the medical director did not attend the QAPI meetings in March 2024 and April 2024. Review of the QAPI committee provided by the facility revealed the committee members included but not limited to Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, and facility interdisciplinary team. Review of policy titled Quality Assurance and Performance Improvement (QAPI) Plan not dated revealed the QAPI committee which includes the medical director, is ultimately responsible for assuring compliance with federal and state requirements and continuous improvement in quality of care and resident satisfaction.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 44069 Based on record review, staff interviews, and policy review, the facility failed to have a developed water management plan in place. This had the potential to affect all 61 residents residing in the facility. The census was 61. Findings include: Review of the facility's water management binder revealed no water management plan, including a description and diagram of the water system or control measures to prevent Legionella. Interview on 05/21/24 at 10:05 A.M. with the Administrator confirmed the facility lacked a water management plan. Interview on 05/21/24 at 10:32 A.M. with Maintenance Director #573 revealed they only checked hot water temperatures and had no water management plan to follow. Review of the facility policy titled Legionella Surveillance, dated 01/12/24, revealed Legionella surveillance is one component of the facility's water management plans for reducing the risk of Legionella and other opportunistic pathogens in the facility's water system.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on medical record review, staff interviews and policy review, the facility failed to ensure the residents were offered and/or administered the Coronavirus Disease 2019 (COVID-19) vaccine. This affected (#32, #110, #58 and #19) of five reviewed for the COVID-19 vaccinations during the annual survey. The census was 61. The facility also failed to ensure staff were offered COVID-19 vaccinations. Findings included: 1. Medical record review for Resident #32 revealed an admitted [DATE]. Medical diagnoses included chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #32 was cognitively intact. His functional status was set-up or clean-up assistance for eating, toileting, bed mobility and transfers. Review of the medical record from 07/01/23 through 05/19/24 revealed there wasn't any evidence of education, consent or medication administration for COVID-19 vaccination. Interview with Resident #32 on 05/22/24 at 11:08 A.M. revealed he had not been offered a COVID-19 vaccination in a long time. 2. Medical record review for Resident #110 revealed an admitted [DATE]. His medical diagnoses included Schizoaffective disorder. Review of the quarterly MDS dated [DATE] revealed Resident #110 was moderately cognitively impaired. Review of the medical record from 07/01/23 through 05/19/24 revealed there wasn't any evidence of education, consent or medication administration for COVID-19 vaccination. 3. Medical record review for Resident #58 revealed an admitted [DATE]. Medical diagnoses included human immunodeficiency virus (HIV). Review of quarterly MDS dated [DATE] revealed Resident #58 was cognitively intact. Review of the medical record from 07/01/23 through 05/19/24 revealed there wasn't any evidence of education, consent or medication administration for COVID-19 vaccination. 4. Medical record review for Resident #19 revealed an admitted [DATE]. Medical diagnoses included respiratory failure. Review of the quarterly MDS dated [DATE] revealed Resident #19 was severely cognitively impaired. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record from 07/01/23 through 05/19/24 revealed there wasn't any evidence of education, consent or medication administration for COVID-19 vaccination. 5. Review of the records for Activity Aide (AA) #501, Registered Nurse (RN) #585 and RN #588 revealed no documentation of a COVID-19 vaccination that was offered. Interview with the Director of Nursing (DON) on 05/22/24 6:53 A.M. confirmed Resident #32, #110, #58 and #19 had no documentation about being offered and/or receiving the COVID-19 vaccination. Review of the policy entitled COVID-19 Vaccination dated 01/01/24 revealed it is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 (SAR'S-CoV-2) by educating and offering our residents and staff the COVID-19 vaccine.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on record review, interview, and policy review the facility failed to assess the use of side rails/enabler bars. This affected two (#33 and #58) of two residents reviewed for side rails/enabler bars. The facility census was 61. Findings include: 1. Review of medical record for Resident #33 revealed admitted [DATE] with diagnoses including but not limited to epidural hemorrhage with loss of consciousness, major depressive disorder, hypertension, psychosis, type two diabetes, paranoid schizophrenia, and dementia with behavioral disturbance. Review of minimum data set (MDS) dated [DATE]. Resident #33 had a brief interview of mental status (BIMS) score of three which indicated severe cognitive impairment. Resident #33 required extensive assistance for activities of daily living. Review of care plan dated 04/24/24 revealed at risk for falls with intervention of mobility bar to right side of bed when in bed to assist with mobility. Review of assessments revealed no side rail and/or enabler bar assessments completed. 2. Review of medical record for Resident #58 revealed admitted [DATE] with diagnoses including but not limited to human immunodeficiency virus, squamous cell carcinoma of skin, anemia, anxiety, major depressive disorder, and spinal stenosis. Review of significant change MDS dated [DATE] revealed Resident #58 had moderate cognitive impairment. Resident #58 was dependent on staff for activities of daily living. Review of care plan dated 04/12/24 revealed at risk for falls and intervention included mobility bar to left side of the bed. Review of assessments revealed no side rail and/or enabler bar assessments completed. Interview on 05/21/24 at 2:45 P.M. with Maintenance Director #573 verified he does not put enabler bars on the hospital beds. MD #573 verified he does not assess the enabler bars to ensure they are the proper fit for the beds. Interview on 05/21/24 at 2:47 P.M. with Assistant Director of Nursing (ADON #507) stated that therapy and nursing would assess a resident upon admission for the need for enabler bars. ADON #507 verified that no assessments were completed for Resident #33 and that nursing should be assessing the residents with enabler bars routinely. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 05/21/24 at 3:36 P.M. with Director of Nursing (DON) verified Resident #33 and #58 had enabler/side rails on their beds. The DON verified that no side rail and/or enabler bar assessments have been completed for Resident #33 and #58 or any enabler/side rails. DON stated that the assessments are on the list of things that need to be addressed throughout the facility. Review of policy titled Proper Use of Bed Rails dated 01/01/24 revealed bed rails are adjustable metal or rigid plastic bars that are attached to the bed. Examples of bed rails include but are not limited to side rails, bed side rails, safety rails, grab bars and assist bars. A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rail.