STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375107	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand at Bethany Skilled Nursing and Therapy	7000 Northwest 32nd Street Bethany, OK 73008

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48344 Based on observation, record review, and interview, the facility failed to ensure a resident was safe to self-administer medications for one (#5) of one sampled resident reviewed for self-administration of medications. The Administrator identified 117 residents resided in the facility. Findings: The Self-Administration and Storage of Bedside Medications policy, dated 02/07/02, read in part, Beside medication storage is permitted for residents who are able to self-administer medications, upon the written order of the prescriber and when it is deemed appropriate in the judgement of the facility's interdisciplinary resident assessment team. An assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility during the care planning process. Resident #5 had diagnoses which included vascular dementia and hypertension. On 08/26/24 at 10:09 a.m., observed three bottles of eye drops in Resident #5's room. The Resident stated one of the eye drop bottles was missing a cap and they were using a tissue to wrap the opening. Two out of the three eye drop medications were used. Resident #5 stated they used the eye drops at least four times a day. There was no documentation the Resident had a physician's order to self-administer medications and no self-administration assessment was completed. On 08/26/24 at 10:25 a.m., LPN #6 retrieved the three eye drops from Resident #5's room. On 08/26/24 at 10:28 a.m., LPN #6 reviewed Resident #5's health record. They stated the Resident did not have a physician's order to self-administer medications and no assessment was completed. On 08/27/24 at 10:57 a.m., the DON stated self-administration of medications required a physician's order and completion of a self-administration assessment.

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 35389 Based on observation, record review and interview, the facility failed to ensure the results of the most recent surveys of the facility were available to residents, family members, and legal representatives. The Administrator identified 117 residents resided in the facility. Findings: On 08/27/24 at 2:44 p.m., a book labeled survey results was observed located on a brown table on Hall 100. Inside the book, the latest survey results were dated 12/07/20. The results documented a Covid-19 focused infection control survey was conducted on 12/07/20 and the facility was in substantial compliance. The front page of the survey results was dated 12/09/20. On 08/27/24 at 2:54 p.m., the Administrator stated the facility kept a book with the most recent surveys in it down by human resources. On 08/27/24 at 2:55 p.m., the Administrator walked down to hall 100 and looked at the book labeled survey results and stated the latest survey results in the book were dated 12/09/20. The Administrator stated they believed they were the person responsible for ensuring the survey book was up to date. On 08/28/24 at 2:06 p.m., the Resident Council Group stated no, the results of the State inspections were not available to read.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on record review and interview, the facility failed to ensure: a. an Advance Directive DNR Consent Admission Acknowledgement form was complete for two (#10 and #69) of 32 sampled residents reviewed for Advance Directives. b. the DNR order was properly executed for one (#77) of 32 sampled residents reviewed for Advance Directives. The DON identified 117 residents resided in the facility. Findings: A DNR, Advance Directives and End of Life Decisions Policy, revised [DATE], read in part, .It is the policy of this Facility to comply with a Resident's Advanced Directive and Do Not Resuscitate Consent .Upon admission the Facility will ask every new Resident and/or the Resident's Representative, if the Resident has a written advance directive, Durable Power of Attorney for Health Care, DNR Consent, or related form .If the Resident has one .the Facility should request a copy be brought to the Facility .it cannot act upon any document until a copy has been provided to the Facility .Advanced Directives .To be valid, the Directive must be signed in the presence of two witnesses who are [AGE] years old and who will not inherit from the resident .cardiopulmonary resuscitation (CPR) should be administered to a Resident .unless the Resident has a properly executed DNR order . The Oklahoma Do-Not-Resuscitate (DNR) Consent form, read in part, Signature of Representative (Limited to an attorney-in-fact for health care decisions acting under the Durable Power of Attorney Act, a health care proxy acting under the Oklahoma Rights of the Terminally Ill or Persistently unconscious Act, or a guardian of the person appointed under the Oklahoma Guardianship and Conservatorship Act) . 1. Resident #69 had diagnoses which included aphasia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. A Quarterly Resident Assessment, dated [DATE], documented Resident #69's cognition was intact. An Advanced Directive DNR Consent form for Resident #69, undated, documented a check next to I currently Have and Advance Directive and I currently Have a DNR Consent. The form documented a check next to A copy of my advanced directive and/or DNR has been given to the facility. The form was not dated or signed by anyone. On [DATE] at 8:54 a.m., there was no advanced directive for Resident #69 observed in their hard chart or their electronic chart. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:07 a.m., the Admissions Coordinator stated residents who had an Advance Directive usually would provide it to the facility upon admission. They stated each resident received information on Advance Directive with their admission paperwork. They stated if the resident had one, the facility would request a copy. They stated a copy of it would be scanned into their file. They stated they scanned it under the MR record. They stated staff would have to have a nurse manager to access the record, and it would be in the resident's chart. On [DATE] at 9:13 a.m., the Admissions Coordinator stated an Advance Directive was mainly residents' wishes. On [DATE] at 9:14 a.m., the Administrator stated the facility was switching to electronic medical records. They stated a copy of the residents' Advance Directives were provided at the time they admitted to the facility. They stated it would go in the resident's paper chart and get scanned into the electronic record. The Administrator stated it should be uploaded under documents. On [DATE] at 9:19 a.m., the Administrator stated the consent form documented the resident had an Advance Directive and had a DNR, but the DNR had been revoked. On [DATE] at 9:20 a.m., the Administrator stated they did not know the reason the Advance Directive DNR consent form for Resident #69 was not signed. They stated they were unable to locate the resident's Advance Directive under documents in the electronic record. The Administrator accessed Resident #69's Advance Directive under a MR Program. 45462 2. Resident #10 had diagnoses that included Alzheimer's and age-related osteoporosis. A Quarterly Resident Assessment, dated [DATE], documented Resident #10's cognition was intact. An Advanced Directive DNR Consent Admission Acknowledgement form for Resident #10, documented a check next to I currently DO NOT have an Advance Directive and I currently DO NOT have a DNR Consent. The form was not dated or signed by anyone. On [DATE] at 8:56 a.m., the DON was asked if there was a signed copy of the Advanced Directive DNR Consent Admission Acknowledgement form. The DON checked the medical record in EHR and it was also blank. The DON was asked if the Advanced Directive had been offered to Resident #10 on admission. They stated they could not be sure. 3. Resident #77 had diagnoses that included atherosclerotic heart disease. A Quarterly Resident Assessment, dated [DATE], documented Resident #77's cognition was intact. A 'physician's order', dated [DATE], documented Resident #77's code status as DNR. The Facesheet in the EHR and documentation on Resident #77's physical chart listed Resident #77's code status as DNR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Oklahoma Do-Not-Resuscitate (DNR) Consent form for Resident #77, was signed by resident's spouse. The form was not dated or witnessed by anyone. There was no POA, health care proxy, nor guardianship paperwork for Resident #77's spouse in their electronic record. On [DATE] at 8:56 a.m., the DON was asked the code status for Resident #77. They stated Resident #77 was a DNR. The DON was asked if there was a completed copy of the Oklahoma DNR Consent form on file for Resident #77. The DON checked the electronic medical record and stated the DNR had been signed by the spouse. The DON was asked if the DNR Consent form was dated or witnessed. They stated no. The DON was asked if an incomplete DNR Consent form was considered valid. They stated no. When asked if there was a signed POA, health care proxy, or guardianship paperwork for Resident #77's spouse in their medical record, the DON reviewed the record and stated no. The DON was asked if Resident #77 had a properly executed DNR order. They stated no Resident #77 should be a full code.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 35389 Based on record review and interview, the facility failed to notify the physician when they held a routine insulin for one (#103) of five sampled residents reviewed for unnecessary medications. Regional Nurse Consultant #2 identified 32 residents who received insulin resided in the facility. Findings: A Resident's Family or Physician Notification of Change policy, dated 12/01/09, read in part, .The facility will inform the resident; consult with the resident's physician .of the following events .A significant change in the resident's physical, mental, or psychosocial status A need to alter treatment significantly . Resident #103 had diagnoses which included type two diabetes mellitus without complications. A Physician Order, dated 03/29/24, documented Tresiba Flextouch subcutaneous solution pen injector 200 unit/ml inject eight units subcutaneously one time a day related to type two diabetes mellitus without complications. The July 2024 Insulin record documented a 13 for the following Tresiba administrations on: a. 07/02/24 for a BS of 89; b. 07/03/24 for a BS of 77; and c. 07/05/24 for a BS of 82. The August 2024 Insulin record documented a 13 for the following Tresiba administrations on: a. 08/02/24 for a BS of 72; b. 08/06/24 for a BS of 74; c. 08/13/24 for a BS of 66; d. 08/15/24 for a BS of 79; and e. 08/21/24 for a BS of 72. The chart code for 13 documented Sliding Scale Insulin Not Required. There was no documentation the physician was notified when Resident #103's Tresiba insulin was held. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/30/24 at 10:12 a.m., LPN #3 stated a 13 code meant sliding scale insulin was not required. On 08/30/24 at 10:16 a.m., LPN #3 stated Resident #103's Tresiba order did not contain and parameters for holding the medication. On 08/30/24 at 10:21 a.m., LPN #3 stated they were unsure of the reason staff did not administer the scheduled Tresiba in July and August 2024. They stated they marked 13 because it was low and they didn't give the insulin. LPN #3 stated they would have notified the physician if they were going to hold insulin that did not have parameters to hold. On 08/30/24 at 10:26 a.m., LPN #3 stated staff would document in progress notes if they notified the physician when they held the Tresiba. LPN #3 reviewed Resident #103's progress notes and stated, I don't see anything. On 08/30/24 at 10:38 a.m., the DON stated staff would notify the nurse, the nurse would notify the physician and put in a note anytime a medication was held. On 08/30/24 at 10:38 a.m., the DON reviewed Resident #103's Tresiba order and stated there were no hold parameters in the order. On 08/30/24 at 10:41 a.m., the DON stated a 13 code meant the sliding scale insulin was not required. The DON reviewed the Tresiba administration for August 2024 and stated they did not see where the physician was notified when the Tresiba was held.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45462 Based on record review and interview, the facility failed to implement fall interventions for three (#10, 62, and #82) of four sampled residents reviewed for accidents. The Administrator identified 117 residents resided in the facility. Findings: 1. Resident #10 had diagnoses that included Alzheimer's disease, age-related osteoporosis and rheumatoid arthritis. A 'Fall Risk Assessment', dated 07/03/24, documented Resident #10 was at high risk for falls. A 'Care Plan' for Resident #10 documented the following interventions related to falls: concave mattress 07/16/20 and when resident is in bed, keep bed in lowest position 10/05/17. On 08/26/24 at 10:02 a.m., Resident #10 was observed in bed with bed in high position. On 08/28/24 at 6:30 a.m., Resident #10 was observed in bed asleep with bed in high position. On 08/28/24 at 6:40 a.m., the Administrator and CNA #4 were taken to Resident #10's room and asked if bed was in low position. CNA #4 and the Administrator stated no. 2. Resident #62 had diagnoses that included morbid (severe) obesity and major depressive disorder A 'Fall Risk Assessment', dated 06/09/24, documented Resident #62 was at high risk for falls. A 'Care Plan' for Resident #62 documented the following interventions related to falls: bed in low position when in bed 11/22/23 and follow facility fall protocol 02/10/23. On 08/26/24 at 10:51 a.m., Resident #62 was observed in bed with bed in high position. On 08/28/24 at 6:33 a.m., Resident #62 was observed in bed asleep with bed in high position. On 08/28/24 at 6:41 a.m., the Administrator and CNA #4 were taken to Resident #62's room and asked if bed was in low position. CNA #4 and the Administrator stated no. 3. Resident #82 had diagnoses that included acute kidney failure. A 'Fall Risk Assessment', dated 08/20/24, documented Resident #82 was at high risk for falls. A 'Care Plan' for Resident #82 documented the following interventions related to falls: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/4/24 ensure [Resident #82] is in a comfortable position in center of bed and fall mat at bedside 02/04/24 and when [Resident #82] is in bed, keep bed in lowest position 05/29/24. On 08/26/24 at 10:20 a.m., Resident #82 was observed in bed with bed at medium height. A fall mat was observed folded and standing beside their cupboard. On 08/27/24 at 9:16 a.m., Resident #82 was observed in bed with bed at medium height. A fall mat was observed folded up on the side of cupboard. On 08/28/24 at 6:42 a.m., the Administrator and CNA #4 were taken to Resident #82's room and asked if the bed was in low position. CNA #4 and the Administrator stated no. On 08/28/24 at 6:45 a.m., the Administrator was asked if the care plans had been implemented for Resident #10, Resident #62, and Resident #82. They stated no.

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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** 35389 Based on record review and interview, the facility failed to revise a resident's care plan for four (#10, 62, 82 and #103) of 27 sampled residents reviewed for care plans. The Administrator identified 117 residents resided in the facility. Findings: 1. Resident #103 had diagnoses which included cerebral infarction and transient alteration of awareness. Resident #103's Care Plan was initiated on 03/29/24 and had a next review date of 06/27/24. The care plan had not been updated with the quarterly resident assessment. The care plan documented the resident had a urinary tract infection, and was receiving skilled nursing and therapy. Resident #103 had a Quarterly Resident assessment dated [DATE]. On 08/28/24 at 9:43 a.m., Regional Nurse Consultant #2 was asked to verify the surveyor was looking at the latest care plan for Resident #103. They stated it was the right care plan, but it looked like it hadn't been updated because it was showing overdue. On 08/28/24 at 9:56 a.m., MDS Coordinator #1 stated they were new to the facility, however they had been in an MDS role since around 2018. On 08/28/24 at 9:58 a.m., MDS Coordinator #1 stated they updated care plans with significant changes in their function. They stated they would have corporate look over MDS information when they had a question. On 08/28/24 at 9:59 a.m., MDS Coordinator #1 stated they would look through every new order and every discontinued order every day. They stated if they were made aware of anything that changed with a resident, they would update the care plan right then. On 08/28/24 at 10:00 a.m., MDS Coordinator #1 and MDS Coordinator #2 reviewed Resident #103's record and stated the last care plan documented the next review was 06/27/24. On 08/28/24 at 10:02 a.m., MDS Coordinator #2 stated the resident was not receiving skilled services and the care plan documented the resident was receiving skilled services. MDS Coordinator #2 stated Resident #103 did not have a urinary tract infection and the care plan documented they did. 45462 2. Resident #10 had diagnoses that included Alzheimer's disease, age-related osteoporosis and rheumatoid arthritis. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 'Fall Risk Assessment', dated 07/03/24, documented Resident #10 was at high risk for falls. A 'Care Plan' for Resident #10 documented the following interventions related to falls: concave mattress 07/16/20 and when resident is in bed, keep bed in lowest position 10/05/17. On 08/26/24 at 10:02 a.m., Resident #10 was observed in bed with bed in high position. On 08/28/24 at 6:30 a.m., Resident #10 was observed in bed asleep with bed in high position. 3. Resident #62 had diagnoses that included morbid (severe) obesity and major depressive disorder A 'Fall Risk Assessment', dated 06/09/24, documented Resident #62 was at high risk for falls. A 'Care Plan' for Resident #62 documented the following interventions related to falls: bed in low position when in bed 11/22/23 and follow facility fall protocol 02/10/23. On 08/26/24 at 10:51 a.m., Resident #62 was observed in bed with bed in high position. On 08/28/24 at 6:33 a.m., Resident #62 was observed in bed asleep with bed in high position. 4. Resident #82 had diagnoses that included acute kidney failure. A 'Fall Risk Assessment', dated 08/20/24, documented Resident #82 was at high risk for falls. A 'Care Plan' for Resident #82 documented the following interventions related to falls: 2/04/24 ensure [Resident #82] is in a comfortable position in center of bed and fall mat at bedside 02/04/24 and when [Resident #82] is in bed, keep bed in lowest position 05/29/24. On 08/26/24 at 10:20 a.m., Resident #82 was observed in bed with bed at medium height. A fall mat was observed folded and standing beside their cupboard. On 08/27/24 at 9:16 a.m., Resident #82 was observed in bed with bed at medium height. A fall mat was observed folded up on the side of cupboard. On 08/28/24 at 6:42 a.m., CNA #4 was asked if the care plans had been followed for Resident #10, Resident #62, or Resident #82. They stated these residents did not like their beds in the low position and they would complain if staff tried to put them there. CNA #4 was asked if these complaints had been reported to anyone. They stated yes, the nurses and the administrator are aware. On 08/28/24 at 6:43 a.m., the Administrator reported they were aware of the residents refusing to have their beds put in the low position and acknowledged that care plan updates should have been done.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 35389 Based on observation, record review and interview, the facility failed to ensure residents received bathing assistance as scheduled for three (#1, 60, and #103) of four sampled residents reviewed for ADLs. The Administrator identified 117 residents resided in the facility. Findings: A Showers policy, dated 10/01/01, read in part, .Showering is important because it gets rid of surface dirt, eliminates body odors, stimulates circulation and gives you the opportunity to inspect the skin for any abnormalities or breakdown . 1. Resident #1 had diagnoses which included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side. A Quarterly Resident Assessment, dated 05/21/24, documented Resident #1's cognition was severely impaired for cognitive skills for daily decision making. It documented the resident had functional limitation in range of motion on both sides for upper and lower extremities. It documented the resident was dependent for the task of shower/bath. A Hall 200 Bath Schedule, undated, documented Resident #1's bathing schedule was Monday, Wednesday, Friday on the 7:00 a.m. to 3:00 p.m. shift. Resident #1's bathing records for June 2024 was blank on the 14th. Resident #1's bathing record for July 2024 was blank for the 5th, 8th, 17th, 24th, and 29th. Resident #1's bathing record for August 2024 was blank for the 2nd and the 19th. The facility also utilized shower sheets for documentation of bathing. There were no shower sheets provided for the above missed dates. On 08/26/24 at 1:44 p.m., Family Member #1 stated the facility was too short handed to provide bathing assistance to Resident #1. They stated the resident was scheduled to receive a bath/shower on Monday, Wednesday, and Friday. They stated the issue was ongoing. On 08/26/24 at 2:12 p.m., Family Member #2 stated sometimes the facility was good at bathing their loved one and sometimes they were not. On 08/30/24 at 12:08 p.m., Resident #1 was observed being wheeled down to their room by CNA #6. The resident's hair was observed to be wet. On 08/30/24 at 12:09 p.m., CNA #6 stated Resident #1 was able to wash their face in the shower, but staff did everything else. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/30/24 at 12:11 p.m., CNA #6 stated today was the resident's shower day. They stated the resident's scheduled days were Monday, Wednesday, and Friday on the 7:00 a.m. to 3:00 p.m. shift. On 08/30/24 at 12:12 p.m., CNA #6 stated they had not identified any concerns with the resident receiving bathing assistance as scheduled. On 08/30/24 at 12:37 p.m., the DON stated Resident #1 was total dependence of one staff member for the task of bathing. They stated the resident was scheduled to receive bathing assistance on Monday, Wednesday, and Friday on the 7:00 a.m. to 3:00 p.m. shift. The DON reviewed the above bathing records and stated the resident did not receive bathing assistance as scheduled. 2. Resident #103 had diagnoses which included cerebral infarction and transient alteration of awareness. A Quarterly Resident Assessment, dated 06/28/24, documented Resident #103's cognition was intact and they required substantial/maximal assistance for the task of shower/bath. A Hall 200 Bath Schedule, undated, documented Resident #103's bathing schedule was Tuesday, Thursday, Saturday on the 3:00 p.m. to 11:00 p.m. shift. Resident #103's bathing record for June 2024 documented a blank on the 8th. Resident #103's bathing record for July 2024 documented blanks for the 11th, 23rd, 25th, and the 27th. Resident #103's bathing record for August 2024 documented blanks for the 3rd, 8th, 10th, 13th, 17th, 24th, and the 27th. The facility also utilized shower sheets for documentation of bathing. There were no shower sheets provided for the above missed dates. On 08/26/24 at 11:56 a.m., Family Member #3 approached the surveyor and stated it had been days since Resident #103 was bathed. On 08/26/24 at 11:57 a.m., Resident #103 stated it had been well over a week since they had been bathed last. They stated they were scheduled to be bathed in the evening every other day. They stated it took one staff member to bathe them. They stated, That's my main complaint is not having regular showers. The resident was observed with disheveled hair. They stated, It's just nasty. They stated they didn't know how the facility could get by with no showers what so ever. On 08/29/24 at 8:56 a.m., CNA #4 stated Resident #103 required limited assistance for bathing. They stated the resident liked to do their upper body themselves, and staff would do their legs, back, feet, and bottom. On 08/29/24 at 8:58 a.m., CNA #4 stated they allowed residents to do what they could for bathing and then assisted them as needed. They stated there was a bathing schedule for the hall. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/29/24 at 9:01 a.m., CNA #4 reviewed the bathing schedule and stated Resident #103 was scheduled on Tuesday, Thursday, and Saturday on the 3:00 p.m. to 11:00 p.m. shift. CNA #4 stated they worked all shifts and were unaware of any bathing concerns with the resident. On 08/30/24 at 10:30 a.m., the DON stated staff were to follow resident bathing preferences. They stated residents were able to choose what shift and what days they preferred to be bathed. They stated if a resident refused to bathe, they have them sign a shower sheet. On 08/30/24 at 10:36 a.m., the DON and Regional Nurse Consultant #2 reviewed the bathing records for June, July and August 2024 and stated the resident did not receive their bath/shower as scheduled. 48344 3. Resident #60 had diagnoses which included age-related osteoporosis without current pathological fracture. Resident #60's quarterly resident assessment, dated 06/05/24, documented Resident #60's cognition was intact and they were dependent on another person for bathing. A Documentation Survey Report v2, dated August 2024, documented Resident #60's bathing schedule was Monday, Wednesday, and Friday. The report documented the Resident had not received a bath, six out of 12 opportunities. The report documented blanks for 08/02/24, 08/05/24, 08/21/24, 08/23/24, 08/26/24, and 08/28/24. On 08/26/24 at 10:16 a.m., Resident #60 stated their bath schedule was Monday, Wednesday, and Friday. They stated they did not get their baths as scheduled. They sometimes get a bath once a week. On 09/03/24 at 9:21 a.m., CNA #7 stated baths given and refusals were documented on the shower sheets and electronic health record. On 09/03/24 at 9:23 a.m., CNA #7 stated the blanks on the August survey report meant the baths were not documented. On 09/03/24 at 9:24 a.m., LPN #3 stated bath refusals were documented in the progress notes. There was no documentation Resident #60 refused baths in the progress notes. On 09/03/24 at 10:22 a.m., the ADON stated baths were to be documented on the shower sheets, and the electronic health record. All refusals were to be documented on the residents' progress notes. On 09/03/24 at 10:24 a.m., the ADON stated the blanks meant the baths were not given.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48344 Based on observation, record review, and interview, the facility failed to ensure wound care was completed for one (#266) of one sampled resident reviewed for wound care. The Corporate Nurse Consultant identified 25 residents received wound care in the facility. Findings: Resident #266 had diagnoses which included displaced subtrochanteric fracture of left femur and subsequent encounter for closed fracture with routine healing. A physician's order, dated 08/22/24, cleanse left trochanter with normal saline, pat dry, apply skin prep around wound bed, fill wound bed with black foam cut to fit and cover with drape entirely. Place suction dome after cutting nickel sized hole in drape on top of black foam, skin prep drape after placement. Connect machine set at 125 mmHg. Change every Monday, Wednesday, Friday, and PRN. Every day shift related to displaced subtrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing. A physician's order, dated 08/22/24, cleanse left trochanter with normal saline, pat dry, apply normal saline wet to dry gauze, abdominal pad and secure with tape as needed for if wound vac becomes soiled or dislodged. On 08/27/24 at 8:39 a.m., Resident #266 stated they had a broken left hip and femur. They stated they had a wound vac on the incision which was discontinued on 08/23/24. They stated the staff put a new dressing on the incision and it was the last time any staff had checked on her wound. Upon observation, noted small greenish drainage on the dressing. On 08/27/24 at 8:53 a.m., LPN #6 made observations of Resident #266's wound dressing. On 08/27/24 at 8:56 a.m., LPN #6 asked the Resident if the wound care nurse had come by. The Resident informed LPN #6 no one came by since the wound vac was removed. On 08/27/24 at 8:58 a.m., LPN #6 stated the wound drainage was greenish. They reviewed the Resident's current wound care orders. On 08/27/24 at 9:03 a.m., LPN #6 stated the Resident did not have wound care orders for the dressing they currently had on the wound incision. On 08/27/24 at 9:04 a.m., LPN #6 stated the dressing needed to be changed because it can lead to infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/24 at 10:48 a.m., Wound Care Nurse #1 stated they discontinued the wound vac on 08/23/24 and put the new dressing on the Resident. They stated they were waiting on wound care orders from the Resident's Surgeon because the wound vac was no longer needed. They stated they should have updated the Resident's orders with the new dressing. They stated they received an order this morning for wound care.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 46216 Based on observation and interview, the facility failed to ensure staffing information was posted with the required components and was accessible to all residents. The Administrator identified 117 residents resided in the facility. Findings: On 08/27/24 at 2:48 p.m., a tour of the facility was conducted. The nursing staffing boards were located on each hall. The nursing staffing boards did not document the facility name, the census, or the actual hours worked for each staff member. On 08/27/24 at 2:58 p.m., Regional Nurse Consultant #2 stated that the census and facility name were not on the board. They stated they did not have a policy for nursing staff postings. On 08/27/24 at 3:09 p.m., Payroll Clerk #1 stated they only kept staffing information one pay period at a time. They stated they did not have 18 months of posted staffing information.

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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. 35389 Based on record review and interview, the facility failed to administer medication as ordered for two (#37 and #103) of five sampled residents reviewed for unnecessary medications. The Administrator identified 117 residents resided in the facility. Regional Nurse Consultant #2 identified 32 residents who received insulin resided in the facility. Findings: A Preparation for Medication Administration policy, revised 12/01/12, read in part, .Medications are administered as prescribed in accordance with good nursing principals and practices .Medications are administered within 60 minutes of scheduled time .unless otherwise specified by the prescriber .The resident's MAR is initialed by the person administering the medication . 1. Resident #103 had diagnoses which included type two diabetes mellitus without complications. A Physician Order, dated 03/29/24, documented Tresiba Flextouch subcutaneous solution pen injector 200 unit/ml inject eight units subcutaneously one time a day related to type two diabetes mellitus without complications. A Physician Order, dated 05/23/24, documented Novolog flexpen subcutaneous solution pen injector 100 unit/ml inject 20 units subcutaneously two times a day related to type two diabetes mellitus. It documented do not give if glucose reading is less than 125. The July 2024 Insulin record documented a 13 for the following Tresiba administrations on: a. 07/02/24 for a BS of 89; b. 07/03/24 for a BS of 77; and c. 07/05/24 for a BS of 82. The chart code for 13 documented Sliding Scale Insulin Not Required. The July 2024 Insulin record documented Novolog insulin was administered at 8:00 a.m. on the following dates: a. 07/02/24 for a BS of 84; b. 07/03/24 for a BS of 112; c. 07/09/24 for a BS 108; d. 07/10/24 for a BS of 108; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. 07/11/24 for a BS of 111; f. 07/12/24 for a BS of 112; g. 07/22/24 for a BS of 112; and h. 07/31/24 for a BS of 81. The August 2024 Insulin record documented a 13 for the following Tresiba administrations on: a. 08/02/24 for a BS of 72; b. 08/06/24 for a BS of 74; c. 08/13/24 for a BS of 66; d. 08/15/24 for a BS of 79; and e. 08/21/24 for a BS of 72. The chart code for 13 documented Sliding Scale Insulin Not Required. The August 2024 Insulin record documented Novolog insulin was administered at 8:00 a.m. on the following dates: a. 08/01/24 for a BS of 98; b. 08/08/24 for a BS of 110; c. 08/09/24 for a BS of 111; d. 08/12/24 for a BS of 81; e. 08/16/24 for a BS of 114; f. 08/20/24 for a BS of 86; g. 08/21/24 for a BS of 87; and h. 08/26/24 for a BS of 86. There was no documentation a hold order was obtained when Resident #103's Tresiba insulin was held. On 08/30/24 at 10:09 a.m., LPN #3 stated staff were to look at the MAR, check the medication three times, make sure it was the right time, right resident, and right medication before administering medications to residents. They stated staff were to ensure the resident took all of their medications while in the residents' room. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/30/24 at 10:12 a.m., LPN #3 stated a 13 code meant sliding scale insulin was not required. On 08/30/24 at 10:15 a.m., LPN #3 stated hopefully staff would let them know if they were holding a medication. They stated there would need to be a reason they were holding it. On 08/30/24 at 10:16 a.m., LPN #3 stated Resident #103's Tresiba order did not contain and parameters for holding the medication. They stated the Novolog had orders to hold if the glucose reading was less than 125. On 08/30/24 at 10:18 a.m., LPN #3 reviewed Resident #103's Novolog administration and stated, That would be me. They stated they clicked it off as administered. They stated they know they didn't give it at the time. They stated they waited until the resident ate breakfast and would recheck the BS and give the insulin. LPN #103 did not produce additional BS documentation for the resident for the above administrations of Novolog insulin. On 08/30/24 at 10:21 a.m., LPN #3 stated they were unsure of the reason staff did not administer the scheduled Tresiba in July and August 2024. They stated they marked 13 because it was low and they didn't give the insulin. LPN #3 stated they would have notified the physician if they were going to hold insulin that did not have parameters to hold. On 08/30/24 at 10:26 a.m., LPN #3 stated staff would document in progress notes if they notified the physician when they held the Tresiba. LPN #3 reviewed Resident #103's progress notes and stated, I don't see anything. On 08/30/24 at 10:38 a.m., the DON stated staff would notify the nurse, the nurse would notify the physician and put in a note anytime a medication was held. On 08/30/24 at 10:38 a.m., the DON reviewed Resident #103's Tresiba order and stated there were no hold parameters in the order. They stated the Novolog documented do not give if BS was below 125. On 08/30/24 at 10:41 a.m., the DON stated a 13 code meant the sliding scale insulin was not required. The DON reviewed the Tresiba administration for August 2024 and stated they did not see where the physician was notified when the Tresiba was held. On 08/30/24 at 10:43 a.m., the DON stated they did not have any knowledge of staff administering Novolog outside of ordered parameters. 45462 2. Resident #37 had diagnoses that included Stage 3 CKD and infection of amputation stump, left lower extremity. A 'physician's order', dated 08/01/24, documented Resident #37 was to receive meropenem 1 GM reconstituted in 50ml of sodium chloride and administered intravenously every 12 hours for 30 days. The August 2024 MAR documented Resident #37 was to receive meropenem 1 GM reconstituted in 50ml of sodium chloride via IV at 9 a.m. and at 9 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/28/24 at 6:50 a.m., LPN #1 was observed starting meropenem 1gm/50ml 0.9% sodium chloride at 100ml/hour via PICC line for Resident #37. LPN #1 was asked why the medication was being administered 3 hours before the scheduled administration time. LPN #1 stated he was administering the medication early because the resident had to leave the facility for an appointment this morning. There was no order in Resident #37's clinical record for a change or adjustment in administration time. On 08/28/24 at 9:30 a.m., a review of Resident #37's August MAR had documentation meropenem 1gm/50ml 0.9% sodium chloride at 100ml/hour via PICC line was administered 08/28/24 at 8:23 a.m. by LPN #2. On 08/28/24 at 10:30 a.m., LPN #2 was asked if they had administered Resident #37's IV antibiotic this am. They stated no, the night nurse gave it around 7 a.m. When asked if facility policy allowed for signing medications given by someone else, LPN #2 stated no it did not. On 08/28/24 at 10:41 a.m., the DON was asked the facility policy on giving medications outside of scheduled times written on the MAR. They reported the facility had a 1 hour before and 1 hour after window in which to give the medication if it was scheduled for a specific time. The DON was asked the procedure if a medication had to be administered outside of the 1 hour before or 1 hour after timeframe. They stated the nurse would need to notify the physician to obtain a one-time order to give the medication outside of the established timeframe. The DON was asked the facility policy on signing for medications you did not give. They stated that was against facility policy, only the person who gave it can sign. The DON was informed of the observations detailed above and they acknowledged the staff who hung the medication and the staff that signed the MAR did not follow facility policy for administering medications as ordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462 Based on record review, observation, and interview, the facility failed to ensure medications were properly labeled and stored in one medication room (Hall 200) and two nurse medication carts (Hall 200 and Hall 300) of two sampled medication rooms and five sampled medication carts reviewed for medication storage and handling. The administrator identified 117 residents resided in the facility. Findings: A 'Medication Storage in the Facility- Storage of Medications' policy, effective January 2022, read in parts, . All medications are maintained within the temperature ranges noted .Refrigerated 36 [degrees] F to 46 [degrees] F .Controlled-substances that require refrigeration are stored within a locked box within the refrigerator . A 'Preparation and General Guidelines- Vials and Ampules of Injectable Medications' policy, effective January 2022, read in parts, .USP<797> guidelines recommend discarding multidose vials .at 28 days after opened. The date opened and the triggered expiration date should be recorded on a label for such purpose affixed to the vial . A 'Disposal of Medications and Medication-Related Supplies- Discontinued Medications' policy, effective January 2022, read in parts, .Medications are removed from the medication cart or active supply immediately upon receipt of an order to discontinue . On 08/29/24 at 11:25 a.m., the medication room on Hall 200 was reviewed with CMA #1 and LPN #3. These were my findings: a. There was no lock on the refrigerator. b. The lock box inside refrigerator was locked, but when opened controlled medications that were supposed to be inside were not there. c. Medication for a resident who expired on 06/26/24 was still in the refrigerator. d. A box of arformoterol inh soln with exp date on rx label 11/18/23 and exp date on actual packets 07/2024 was still in the refrigerator. e. A large container of various types of insulin pens for multiple residents was in refrigerator some used and some new had the following used flexpens inside: 1. Resident #82 insulin aspart flexpen- 1/2 full no open date and no discard date on pen. 2. Resident #79 Tresiba flexpen- 1/2 full no open date and no discard date on pen. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #25 Novolin R flexpen- 1/4 full no open date and no discard date on pen. On 08/29/24 at 11:29 a.m., CMA #1 was asked the facility policy for discarding discontinued and/or expired medications. They stated the medications should have been removed from the refrigerator and given to the DON to discard. On 08/29/24 at 11:30 a.m., LPN #3 was asked where the contents of the refrigerator lock box were. They stated they had taken all the controlled drugs out when they arrived this am to count them, and they were currently still on the medication cart on the hall. When asked if they were supposed to remain refrigerated, LPN #3 stated yes. LPN #3 was asked the policy for opening and storing insulin? They stated it should be dated when opened and discarded after 30 days. LPN #3 acknowledged this was not done. On 08/29/24 at 11:45 a.m., the nurse's medication/treatment cart on Hall 200 was reviewed with LPN #3. These were my findings: a. Opened insulin flexpens and vials currently in use on the medication cart included: b. Resident #69 insulin glargine-yfgn soln flexpen & insulin aspart 10ml multiple dose vial no open date and no discard date on pen nor on vial. c. Resident #103 Novolog flexpen & insulin degludec flexpen no open date and no discard date on pens. d. Resident #25 basaglar flexpen & Novolin R flexpen no open date and no discard date on pens. e. Resident #81 Lantus 10ml multiple dose vial no open date and no discard date on vial. On 08/29/24 at 1:26 p.m., the nurse's medication/treatment cart on Hall 300 was reviewed with LPN #2. These were my findings: Medication for the following discharged residents was still on the medication cart: a. Unnamed Resident #1 discharged [DATE] b. Unnamed Resident #2 discharged [DATE] c. Unnamed Resident #3 discharged [DATE] On 08/29/24 at 1:27 p.m., LPN #2 was asked the policy for handling medications after a resident is discharged . They stated the medication should be removed from the medication cart and given to the DON for disposal. LPN #2 acknowledged this was not done. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/29/24 at 3:24 p.m., the DON was made aware of the findings for the medication room on Hall 200, the nurses medication/treatment cart on Hall 200, the nurses medication/treatment cart on Hall 300, as outlined above. The DON reported facility policy dictated that medications are to be keep refrigerated as indicated on the RX label, open insulin pens and vials were to be labeled with the date first used and discarded after 30 days, and discontinued and expired medications were to be immediately pulled off the medication cart and given to the DON to discard unless it was being sent home with the resident. The DON acknowledged facility policy had not been followed.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on observation and interview, the facility failed to ensure snacks were offered to all residents in the facility for one of one snack observation. Regional Nurse Consultant #1 identified 115 residents who received services from the kitchen resided in the facility. Findings: On 08/28/24 at 2:00 p.m., the Resident Council Group stated the facility had snacks out, but you have to go get them. They stated if residents asked for snacks they would receive them, but staff did not pass snacks. They stated snacks were available at 7:00 p.m. and at 7:00 a.m. On 08/28/24 at 6:30 p.m., snacks were observed being placed at the nurses' station on Hall 100. On 08/28/24 at 6:31 p.m., Dietary Aide #1 delivered a bucket of ice with various snacks in it to the nurses' station located on Hall 200. On 08/28/24 at 6:43 p.m., the snack container was observed on the lower counter of the nurses' station on Hall 200. On 08/28/24 at 6:48 p.m., LPN #4 was observed taking two bags of Doritos into room [ROOM NUMBER]. On 08/28/24 at 6:52 p.m., a second container of snacks was observed on the bottom shelf of the white hydration cart on Hall 200. The container had various items including cheese-its, crackers, applesauce, and soda. On 08/28/24 at 7:22 p.m., the Housekeeping Supervisor was observed offering two residents at the nurses' station on Hall 200 a snack. On 08/28/24 at 7:44 p.m., CNA #2 was observed pushing the hydration cart with snacks on it down hall 200 and began offering ice/water to the residents. On 08/28/24 at 7:44 p.m., CMA #4 picked up the snacks on Hall 100 and carried them behind the nurses' station. On 08/28/24 at 8:10 p.m., CMA #4 was observed opening a package of peanut butter crackers for Resident #2 on Hall 100. On 08/28/24 at 8:18 p.m., the Admission Coordinator joined CNA #2 and began offering ice/water to the residents on Hall 200. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/28/24 at 8:37 p.m., both residents in room [ROOM NUMBER] asked CNA #2 for a snack, they exited the room, walked up to the nurses' station and obtained two peanut butter crackers and two graham crackers and took them to room [ROOM NUMBER]. On 08/28/24 at 8:42 p.m., the residents in the last room on Hall 200 were offered water/ice by the Admission Coordinator. Staff were observed going from room to room on Hall 200 from 7:44 p.m. through 8:43 p.m. offering ice/water to each resident. Staff did not offer snacks to each of the residents. The only residents observed to receive a snack were those who asked for it themselves. On 08/28/24 at 8:43 p.m., CNA #2 stated staff usually passed ice water on each shift to keep residents hydrated. On 08/28/24 at 8:44 p.m., CNA #2 stated staff put out snacks on the 7:00 a.m. to 3:00 p.m. shift and the 3:00 p.m. to 11:00 p.m. shift. They stated most of the residents would go up and ask for the snacks, or staff would offer them after supper. On 08/28/24 at 8:46 p.m., CNA #2 stated they should have offered residents snacks when they were passing water. The CNA acknowledged there was a bucket of snacks on the cart that contained apple sauce, jello, water bottles, cheese-its, pudding, and graham crackers. Hall 100 was observed for the passing of snacks from 6:30 p.m. through 8:48 p.m. Staff were not observed going room to room offering snacks to all residents on the hall. On 08/28/24 at 8:49 p.m., CNA #1 stated staff usually brought snacks at seven, but most residents had snacks in their rooms because family brought them. On 08/28/24 at 8:50 p.m., CNA #1 stated some resident would come up and ask for snacks. On 08/28/24 at 8:51 p.m., CNA #1 stated they would ask residents when they were in their room if they wanted a snack. On 08/28/24 at 8:51 a.m., the Administrator stated the facility always had snacks available. They stated snacks were put out every shift. They stated most of the residents would cruise by and get them themselves. They stated a few of the residents would hit their call lights if they knew snacks were out and staff would offer them as they went to resident rooms. The Administrator stated there was not a set snack pass at the facility. They stated snacks were out all the time on the water cart. On 08/28/24 at 8:52 p.m., CNA #1 stated they had not obtained snacks from the nurses' station to pass to the residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48344 Based on observation and interview, the facility failed to ensure: a. the kitchen was kept clean and maintained in good repair; and b. expired foods were removed from circulation. The Corporate Nurse Consultant identified 115 residents received services from the kitchen. Findings: On [DATE] at 8:26 a.m., a tour of the kitchen was conducted. The following observations were made; a. baseboards were missing on the walls in the dish machine area, b. there was black and brown residue along the wall in the dish machine area, c. there was black and brown residue along the floor on the dish machine area, d. the paint on the floor in the dish machine area was chipped and peeled, e. rusted metal pipes and stained white pipes in the dish machine area, f. used baking powder with expiration date of [DATE], g. used raspberry dessert topping with expiration date of [DATE], h. used barbeque sauce with expiration date of [DATE]. On [DATE] at 8:45 a.m., [NAME] #1 stated the baking powder, raspberry dessert topping and barbeque sauce were expired, and should not be on the shelf. They stated foods in the dry storage were checked weekly for expirations. On [DATE] at 12:19 p.m., the Assistant CDM stated the dish machine area needed new paint or new flooring. They stated the baseboards were missing. They stated the facility is aware of the repair needs. On [DATE] at 12:19 p.m., the Assistant CDM stated the dish machine area should be cleaned after every shift. On [DATE] at 11:09 a.m., the Administrator made observations of the dish machine area. They stated they were not aware of the repair needs.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 48344 Based on interview and record review, the facility failed to ensure physical therapy services were offered to restore highest practicable level of physical function for one (#60) of two residents reviewed for specialized rehabilitation. The Administrator identified 117 residents resided in the facility. Findings: Resident #60 had diagnoses which included age-related osteoporosis without current pathological fracture. Resident #60's quarterly resident assessment, dated 06/05/24, documented Resident #60's cognition was intact and they needed assistance with activities of daily living. A physician's order, dated 06/03/24, documented PT to eval and treat if indicated. A physician's order, dated 06/05/24, documented PT clarification order: Patient to be seen for three days a week times 60 days due to muscle wasting and atrophy and lack of coordination with treatment approaches that include therapeutic exercises, therapeutic activities, gait training, neuro re-education techniques, manual therapy, and group therapy. On 08/26/24 at 9:44 a.m., Resident #60 stated they were supposed to receive physical therapy after transferring to the facility but had not received any. They stated they called their insurance company and were told they were qualified to receive PT. The Resident stated no one at the facility was communicating with them about getting PT. They stated their goal was to start walking again. A PT Evaluation and Plan of Treatment, dated 06/05/24, documented Resident #60 had good rehab potential with 60 days of therapy, three times a week. It documented the Resident's goal was to improve their strength and be able to walk again. A PT Discharge Summary, dated 07/01/24, documented discharge from the evaluation completed on 06/05/24. It documented no further intervention approved by payor source. On 08/30/24 at 9:41 a.m., OTA #1 stated once an evaluation is completed and the resident is approved for PT, they provided the plan to the facility. The facility provided the PT company payments prior to starting the planned therapy. They stated no PT would be completed without payments. On 08/30/24 at 9:43 a.m., OTA #1 stated they never received payments for Resident #60's PT evaluation and plan of treatment completed on 06/05/24. On 08/30/24 at 9:51 a.m., the BOM stated if a resident had an order for PT evaluation, the business office provided PT with a consent verification. Upon receiving a resident's PT evaluation and plan of treatment, it is sent to the insurance company for payment authorization. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/30/24 at 9:53 a.m., the BOM stated PT was provided with an evaluation only consent on 06/03/24. They stated they had not received the 06/05/24 PT evaluation and plan of treatment for Resident #60. On 08/30/24 at 9:55 a.m., the BOM stated they were not sure what the facility's process was on following up with PT evaluations. On 08/30/24 at 10:34 a.m., OTA #1 stated the PT discharge summary on 07/01/24 meant they must have waited for insurance approval and payment for PT and never received them. On 08/30/24 at 1:28 p.m., Regional Nurse Consultant #1 stated Resident #60's insurance company denied the 06/05/24 PT evaluation and plan of treatment. They stated the Resident filed a grievance on 08/19/24 for not receiving PT services. They stated another evaluation order was submitted to PT on 08/19/24. They stated Resident #60 was approved for PT services by the insurance on 08/30/24. Surveyor requested documentation on the insurance denial for the 06/05/24 PT evaluation and treatment plan. The facility was unable to provide documentation on Resident #60's insurance denial for PT services.

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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. 35389 Based on record review and interview, the facility failed to ensure Resident Advance Directives were accessible to direct care staff for one (#69) of 32 sampled residents reviewed for Advance Directives. The Administrator identified 117 residents resided in the facility. Findings: 1. Resident #69 had diagnoses which included aphasia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. A Quarterly Resident Assessment, dated 05/23/24, documented Resident #69's cognition was intact. An Advanced Directive DNR Consent form for Resident #69, undated, documented a check next to I currently Have and Advance Directive and I currently Have a DNR Consent. The form documented a check next to A copy of my advanced directive and/or DNR has been given to the facility. The form was not dated or signed by anyone. On 08/27/24 at 8:54 a.m., there was no advanced directive for Resident #69 observed in their hard chart or their electronic chart. On 08/27/24 at 9:07 a.m., the Admissions Coordinator stated residents who had an Advance Directive usually would provide it to the facility upon admission. They stated each resident received information on Advance Directive with their admission paperwork. They stated if the resident had one, the facility would request a copy. They stated a copy of it would be scanned into their file. They stated they scanned it under the MR record. They stated staff would have to have a nurse manager to access the record, and it would be in the resident's chart. On 08/27/24 at 9:14 a.m., the Administrator stated the facility was switching to electronic medical records. They stated a copy of the residents' Advance Directives were provided at the time they admitted to the facility. They stated it would go in the resident's paper chart and get scanned into the electronic record. The Administrator stated it should be uploaded under documents. On 08/27/24 at 9:19 a.m., the Administrator stated the consent form for Resident #69 documented the resident had an Advance Directive. On 08/27/24 at 9:20 a.m., the Administrator was unable to locate the resident's Advance Directive under documents in the electronic record. The Administrator accessed Resident #69's Advance Directive under a MR Program. They stated Administration, the DON, ADONs, Medical Records, and Human Resources had access to the program. They stated direct resident care staff did not have access to the program.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48344 Based on observation, record review, and interview, the facility failed to maintain infection control during the provision of incontinent care for two (#15 and #40) of two sampled residents observed for incontinent care. The DON identified 69 residents required assistance with incontinent care in the facility. Findings: 1. Resident #40 had diagnoses which included cerebral infarction and chronic pain. Resident #40's annual resident assessment, dated 06/30/24, documented the Resident had moderate cognitive impairment and required physical assistance with toileting hygiene. On 08/28/24 at 6:41 a.m., CNA #8 donned gloves and provided incontinent care on Resident #40. The Resident had a bowel movement. CNA #8 had on the same gloves during the provision of incontinent care. On 08/28/24 at 6:48 a.m., CNA #8 completed incontinent care, provided the resident with clean clothes, new bed pad, adjusted the resident's pillow, grabbed bed remote and lowered the bed. CNA #8 had on the same gloves used in the provision of incontinent care. On 08/28/24 at 6:51 a.m., CNA #8 removed their gloves and discarded them, tied the trash bag, put the bedside table and call light within reach of the Resident. They removed soiled linens and trash from the Resident's room and washed their hands. 2. Resident #15 had diagnoses which included dementia and protein calorie malnutrition. Resident #15's quarterly resident assessment, dated 06/07/24, documented the Resident had severe cognitive impairment and required physical assistance with toileting hygiene. On 08/28/24 at 7:02 a.m., CNA #8 donned gloves and provided incontinent care on Resident #15. The Resident's pad was wet. CNA #8 cleansed the Resident front and back with cleanser, removed the wet pad and put in plastic bag. CNA #8 cleansed the Resident lower body with cleanser, put new brief and pad under the Resident. CNA #8 had on the same gloves during the provision of incontinent care. On 08/28/24 at 7:08 a.m., CNA #8 removed gloves and discarded them. They donned new gloves and retrieved Resident #8's outfit from their closet and got them dressed for the day. They adjusted the Resident in bed, covered with blanket, and lowered the bed. They removed soiled linens and trash from the Resident's room and cleaned hands with hand sanitizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/28/24 at 7:13 a.m., CNA #8 stated they were not sure how often they should change their gloves during incontinent care. They stated they did not change their gloves while providing incontinent care for Resident #40 but had changed them once while providing incontinent care for Resident #15. On 08/28/24 at 7:21 a.m., the DON stated gloves should be changed as needed during incontinent care, between dirty and clean tasks.