STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375246	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Care Center	1202 West Gilmore Shawnee, OK 74804

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 20960 Based on observation, record review, and interview, the facility failed to provide meals in the assisted dining room in a dignified manner for two (#28 and #47) of three sampled residents reviewed for assisted dining. The Administrator identified ten residents who required asssistance with their meals and had their meals in the assisted dining room. Findings: 1. Resident #28 had diagnosis to include dementia, schizoaffective disorder, depression, and cerebral infarction. A care plan, last updated 05/31/2024, documented Resident #28 required one person extensive assistance with eating. An annual assessment dated /31/2024, documented Resident #28 cognition was severely impaired and required moderate assistance with eating. 2. Resident # 47 had diagnosis to include Malignant neoplasm of prostate, Shortness of breath, erythema conditions, Xerosis cutis, primary thrombocytopenia, Need for assistance with personal care, Cognitive communication deficit, and contracture of knee. A significant change assessment, dated 06/21/2024, documented Resident #47 cognition was severely impaired, and required substantial assistance with eating. On 07/07/24 at 8:25 a.m., Resident #28 and #47 were observed in the assisted dining area waiting for their morning meal. Resident #28 was yelling he needed help and was cold. Resident #28 said he wanted a jacket. Three additional residents were heard complaining about it being cold in the assisted dining room. No staff were present in the assisted dining room to assist the resident and addresses the complaints of being cold. On 07/07/24 from 8:25 a.m., through 8:43 a.m., Resident #28 and three additional three additional residents continued complaining it was cold and no staff was present in the room to assist the residents. (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 - Some	On 07/07/24 at 8:43 a.m. a certified nurse aide was observed brining a Resident to the dining room, Resident #28 and three additional residents continued to say it was cold. Resident #28 continued to ask for a jacket, and the aide left the dining room without assisting the residents who were complaining it was cold in the dining room. On 07/07/24 from 8:43 a.m., through 8:48 a.m., Resident #28 and three additional residents continued to complain it was cold in the room with Resident #28 asking for a jacket. On 07/07/24 at 8:48 a.m., the infection preventionist was observed coming into the assisted dining room with drinks and lutenists. The infection preventionist places a plate guard in front of Resident #28 who continued to yell for help they were cold and wanted a jacket, and three additional residents also continued to complain it was cold in the assisted dining room. The infection preventionist continued passing drinks and placing utensils in front of the residents without assessing any of the residents who were complaining it was cold. On 07/07/24 at 8:51 a.m., the infection preventionist acknowledged the complaints from Resident #28 and stated they would go and see if they could get something for them. The infection preventionist then continued to pass drinks and utensils to the residents in the assisted dining room. On 07/07/24 from 8:51 a.m. through 9:00 a.m. Resident #28 and three additional residents continued complaining it was cold and no asssistance was provided to address the concerns. On 07/07/24 at 9:00 a.m., the infection preventionist went to get an aide and requested blankets be brought into the residents that were complaining about being cold and adjusted the temperature in the assisted dining room. Resident #28 and three additional residents were observed from 8:25 a.m. until 9:00 a.m., (35 minutes) complaining of being cold without anyone assisting them. On 07/07/24 at 9:05 a.m., the infection preventionist was observed providing the first meal tray to Resident #28 and at 9:15 a.m., to Resident #47. The meal was served over one and half hours past the scheduled meal service time in the assisted dining room. On 07/09/24 at 9:30 a.m., the infection preventionist stated they started with drinks and silverware first, and then assisted the residents who were cold. When asked why they did not assist residents who were cold sooner, the infection preventionist stated they were waiting for more staff to come into the room and assist with the meal. They then stated it was not right for residents to wait that long and be cold and it was a dignity issue. On 07/09/24 at 9:59 a.m., the administrator and Corporate Nurse Consultant #1 were made aware of the issues with meal service and residents being cold in the assisted dining room. Both the administrator and Corporate Nurse Consultant #1 stated that was a dignity issue with residents waiting that long and being cold.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 43023 Based on observation, record review, and interview, the facility failed to ensure call devices were within reach for one (#34) of one sampled resident reviewed for call lights. The corporate nurse reported 49 residents resided in the facility. Findings: Res #34 admitted to the facility with diagnoses of heart failure and need for assistance with personal care. On 07/09/24 at 10:05 a.m., Res #34 was observed resting in bed with eyes closed. The call light was observed out of reach and placed inside the top drawer of the bedside dresser. On 07/09/24 at 10:49 a.m., Res #34 was observed resting in bed with eyes closed. The call light was observed out of reach and placed inside the top drawer of the bedside dresser On 07/09/24 at 2:34 p.m., Res #34 was observed resting in bed with eyes closed. The call light was observed out of reach and placed inside the top drawer of the bedside dresser. On 07/09/24 at 2:48 p.m., Res #34 was observed resting in bed with eyes closed. The call light was obsrved out of reach and placed inside the top drawer of the bedside dresser. On 07/09/24 at 2:52 p.m. the DON was walking down the hall and was asked her to observe resident's call light. The DON reported the call light should always be in the resident's reach.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 20960 Based on observation, record review, and interview, the facility failed to ensure residents had access to their trust account money on nights and weekends for three (#1, #12 and #50) of three residents reviewed for access to their trust account money. The Business office manger identified 24 residents that have money in the trust account and were current residents. Findings: A review of the Resdient trust policy did not address residents access to their funds from their trust account. On 07/07/24 during the initial tour of the facility and sign was observed posted on the business office indicating banking hours for obtaining money from the trust account was Monday through Friday 1:00 p.m. through 3:00 p.m. There were no documented times funds were available at any times in the evening or on the weekends. On 07/07/24 at 9:25 a.m. Resident #50 stated the business office manager was here Monday through Friday from 8:00 a.m. through 5:00 p.m., and that was when they could get their money. Resident #50 then stated they had no way of getting money on the weekends. On 07/08/24 at 1:30 p.m., Resident #12 stated they can only get money when the business office manager was working. They stated they could not get any money on the weekends or in the evenings. On 07/09/24 at 10:48 a.m., the business office manager was asked about residents access to their funds. The business office manager stated the residents could get their money Monday through Friday between 1:00 p.m. through 3:00 p.m. The business office manager than stated they were the only one to access the funds for the residents and they only worked Monday through Friday.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 20960 Based on record review and interview the facility failed to provide notices to Medicaid recipients trust account holder when balances was within $200 of the resource limit for a medicaid recipient resident for one (#1) of three sampled residents reviewed for active trust account balances. The Business office manger identified 24 residents that have money in the trust account, were current residents and had Medicaid as their payer source. Findings: A review of the current trust account ledger dated 07/08/24, documented Resident # 1 had a current balance in their trust account of $2,874.59. Resident #1 face sheet documented they were a Medicaid recipient. There was no documentation to indicate the facility had notified the resident when they were within $200 of the $2,000 resource limit. On 07/09/24 at 10:48 a.m., the business office manager stated the resource limit for medicaid recipient residents was $2,000. They were asked to provide the notification provided to Resident #1 when they were within the $200 of the resource limit. They stated they had not provided and had no documentation a notice was provided.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20960 Based on record review and interview the facility failed to ensure resident trust accounts were closed out with funds conveyed within 30 days for three (#106. #107 and #108) of three residents who expired and were no longer in the facility over 30 days. The business office manager identified five residents who have been gone from the facility over 30 days and had open trust accounts. Findings: An undated Nursing Home Resident Trust Fund policy, read in part, If the resident leaves the home for any reason or passes away, funds must be returned to the resident or the resident's estate within 30 days . discharged residents with accounts still open: 1. A review of Resident #106 face sheet documented they expired on [DATE]. A review of the recipient trust account balance, dated [DATE], indicated Resident #106 had a current balance of $6,890.62. Resident #106 trust account remained open 131 days after they had expired. 2. A review of Resident #107 face sheet documented they were discharged from the facility on [DATE]. A review of the recipient trust account balance, dated [DATE], indicated Resident #107 had a current balance of $682.44. Resident #107 trust account remained open 228 days after they had expired. 3. A review of Resident #108 face sheet documented they were discharged from the facility on [DATE]. A review of the recipient trust account balance, dated [DATE], indicated Resident #108 had a current balance of of $205.15. Resident #108 trust account remained open 243 days after they had expired. On [DATE] at 10:48 a.m., the business office manager stated cooperate trained them to wait 90 days to close out trust account and then convey the funds to the family.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 20960 Based on record review and interview the facility failed to secure a surety bond with sufficient coverage for the account balance. The Business office manger identified 24 residents that have money in the trust account and were current residents. Findings: A review of the current surety bond for the resident trust account documented the surety bond had coverage of $20,000 The resident trust account monthly bank statement, 04/30/24, documented the account balance was $26,681. 86. The resident trust account monthly bank statement, dated 05/31/24, documented the account balance was $32, 329.75. On 07/09/24 at 10:48 a.m., the business office manager confirmed the surety bond was only for $20,000. They then stated they had noticed the account balance had gone up and there was no system in place to ensure the surety bond was sufficient for the account balance.

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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. 43023 Based on record review and interview the facility failed to ensure residents: a. were offered the choice to formulate an advanced directive for one (#21) of two sampled resident for advanced directives, b. DNR (Do Not Resuscitate) forms were filled out correctly. The corporate nurse reported 49 residents resided in the facility. Findings: 1. Res #21 admitted to the facility with diagnoses of vascular dementia, and malignant neoplasm of uterine adnexa. A review of the resident's record did not contain an advance directive acknowledgement. On 07/09/24 at 9:00 a.m., the administrator was asked to provide the resident's advanced directive acknowledgment. On 07/09/24 at 9:32 a.m., the Administrator reported the resident does not have an advanced directive acknowledgment. 2. Res #33 admitted to the facility with diagnoses of dementia, hypertension, and anemia. On 07/07/24 at 2:04 p.m., a DNR was located in the resident's chart. The form does not have a resident name on it. On 07/08/24 10:35 AM DNR is not located in the resident's paper chart 07/08/24 at 10:41 a.m., the corporate nurse was asked to look at the resident's DNR and asked if it was valid, she reported it is not valid without the resident's name. The corporate nurse reported the form was not filled out correctly.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20960 Based on record review and interview it was determined the facility failed to notify a family of falls for one (#29) of three sampled residents reviewed for notification of a change in condition. The corporate nurse reported 49 residents resided in the facility. Findings: An undated policy, Change in a Resident's Condition or Status, read in part, .in addition to notifying the resident and/or their representative .of a change . Resident #29 had diagnosis to include abnormalities of gait, history of falling, and cognitive communication deficit. An incident report dated 05/17/24 documented the resident had a fall while in the shower. A nursing progress note, dated 05/17/24 at 2:25 p.m., read in part, .While getting a shower this morning, upon standing to transfer to shower chair . There was no documentation on the incident report or in the clinical record the family had been notified of the fall. An incident report dated 05/27/24 documented the resident had a fall while in the shower. A nursing progress note, dated 05/28/24 at 12:14 p.m., read in part, .On 5/27, while in the shower and being transferred to shower chair, [NAME] stated I'm going down, my foot turned! CNA eased him to the floor . Family has been notified of event . There was no documentation on the incident report or in the clinical record the family had been notified of the fall until 24 hours after the fall had occurred. On 07/10/24 at 11:19 a.m., the corporate nurse consultant #1 stated families should be notified right away after a fall once the resident was stabilized. The corporate nurse consultant #1, then stated the notification of a fall should be documented in the progress notes and occur the same day as the fall. They then stated the family did not get notified of the fall in the shower on 05/17/24 and was not notified timely when they fell on [DATE].

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 43023 Based on record review and interview, the facility failed to refer a resident with a new mental health diagnosis to OHCA for a PASRR level II evaluation for one (#34) of one sampled residents reviewed for PASRR. The corporate nurse reported 49 residents resided in the facility. Findings: Res #34 admitted to the facility with diagnoses of heart failure, chronic pain, other recurrent depressive disorders, and anxiety. A review of the Resident #34's record documented a PASSR level I was completed on 2/17/22. On 02/21/22, the resident received a new diagnosis of delusions. The resident's record contained no documentation that OHCA was notified of the new mental health diagnosis no documentation of On 07/10/24 at 9:22 a.m., the corporate nurse reported that OHCA was not notified of the new mental health diagnosis.

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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. 46582 Based on observation, record review, and interview, the facility failed to ensure comprehensive care plans were developed and/or implemented to address the residents' needs related to a urinary catheter for one (#32) and activities of daily living, and anticoagluant therapy for one (#35) of residents whose care plans were reviewed. The corporate RN identified 49 residents who resided in the facility. The corporate RN identified five residents with a urinary catheter. Findings: A Comprehensive Person-Centered Care Plan policy, revised December 2016, read in part, .The comprehensive, person-centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . 1. Res #32 had diagnoses which included stage III sacral pressure ulcer, dementia, and fracture of right femur. A care plan, revised 05/07/24, documented the resident was occasionally incontinent of bladder due to inability to move fast. The care plan documented the resident wore adult undergarments while out of bed for dignity. A quarterly assessment, dated 05/21/24, documented the resident was cognitively intact, required partial to moderate assistance with toileting, was frequently incontinent of bladder, and did not have an indwelling catheter. A nurse note, dated 06/04/24, documented Res #32 had an indwelling urinary catheter placed. A 5-day assessment, dated 06/05/24, documented the resident was cognitively intact, dependent with toileting, and had an indwelling catheter. There was no documentation related to an indwelling urinary catheter, catheter maintenance, or infection prevention interventions documented on the care plan. On 07/07/24 at 9:02 a.m., Res #32 was observed sitting in a wheelchair. An indwelling catheter was observed attached to the bottom of the wheelchair. Res #32 stated they had the catheter for a while but did not know why it was placed. On 07/08/24 at 1:22 p.m., the corporate RN stated the catheter was placed due to wounds on Res #32's coccyx. They stated a comprehensive care plan should have been developed to reflect the catheter, catheter maintenance, and infection prevention interventions. 43023 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Res #35 dmitted to the faciit with diagnoses of metabolic encephalopathy, acute kidney failure, unspecified, morbid (severe) obesity due to excess calories, and generalized anxiety disorder. A physican order, dated 08/11/23, documented Eliquis 5mg every 12 hours. A physician's order, dated 01/02/24, documented Toresemide 20mg once a day. A Point of Care ADL category report, dated July 2024, documented the resident requires limited assist of 1 with showers/baths. A care plan, dated 05/31/24, was reviewed and contained no documentation for activies of daily living, diuretic therapy or anticoagulant therapy. On 07/10/24 at 9:05 a.m., the corporate nurse wasasked to review the care plan for ADL's, diuretic therapy and anticoagulant therapy. They reported neither was care planned and should have been.

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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. 46582 Based on observation, record review, and interview the facility failed to update the care plan related to pressure ulcers for one (#32) of one resident reviewed for pressure ulcers. The infection preventionist identified two residents with pressure ulcers. Findings: Res #32 had diagnoses which included stage III sacral pressure ulcer, dementia, and fracture of right femur. A quarterly assessment, dated 02/21/24, documented the resident was cognitively intact, required partial to moderate assistance with mobility, and did not have a pressure ulcer. A care plan, revised 05/07/24, documented the resident was at risk for pressure ulcers due to the inability to walk far, malnutrition, and a bony appearance. The care plan documented a goal of intact skin without evidence of redness, irritation, maceration, or open areas. A quarterly assessment, dated 05/21/24, documented the resident was cognitively intact, required partial to moderated assistance with mobility, and had one stage II pressure ulcer not present upon admission. There was no documentation related to the presence of a pressure ulcer or treatment documented on the care plan. On 07/07/24 at 9:01 a.m., Res #32 was observed sitting in a wheelchair. Res #32 stated they had wounds on their tailbone that developed while in the facility. Res #32 stated they received wound care from the staff. On 07/08/24 at 11:25 a.m., LPN #1 was observed performing wound care on Res #32. LPN #1 stated the resident received wound care every other day of the week per physician orders. LPN #1 stated the wound care and interventions should be documented on the care plan. On 07/08/24 at 1:37 p.m., the corporate RN stated the care plan should have been updated to reflect the pressure ulcer and treatment.

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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. 43023 Based on record review and interview, the facility failed to ensure residents were bathed according to standards of care for two (#31 and #35) of three sampled residents reviewed for bathing. The corporate nurse reported 49 residents resided in the facility. Findings: 1. Res #31 admitted to the faiclity with diagnoses of cerebral infarction, unspecified, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and muscle wasting and atrophy. On 07/07/24 at 9:25 a.m., the resident reported there isn't enough CNAs on her showers nights so she is going to take them during the day. A care plan last revised on 05/09/24 documented the resident requires extensive assist of 1 person with bathing. A Point of Care ADL category report documented the resident had a partial bath on 06/09/24, the report contained no other documentation of bathing from 06/09/24 to 07/08/24. On 07/10/24 at 9:02 a.m., the corporate nurse reported the residenrt did not received showers according to standards of care. 2. Res #35 dmitted with metabolic encephalopathy, acute kidney failure, unspecified, morbid (severe) obesity due to excess calories, and generalized anxiety disorder. A care plan, revised on 05/31/24, contained no documentaion of activities of daily living. On 07/08/24 at 9:01 a.m., resident #35 was observed sitting in her wheelchair in her room. The resident reported she did not get showers as scheduled. On 07/09/24 at 11:09 a.m., the resident's ADL documentation reviewed including shower/bath logs. The log documented the resident received a partial bath on 06/09/24 and no other showers were documented until 07/01/24. Point of Care ADL category report documented the resident requires limited assist of 1 with showers/bath. On 07/10/24 at 9:05 a.m., the corporate nurse reported the resident did not receive showers per standards of care nad the resident's activities of daily living was not care planned.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46582 Based on observation, record review, and interview, the facility failed to perform weekly skin assessments and wound care per physician order for one (#32) of one resident reviewed for pressure ulcers and failed to obtain weekly weights for one (#35) of one sampled residents. The corporate RN identified 49 residents who resided in the facility. The infection preventionist identified two residents with pressure ulcers. Findings: 1. Res #32 had diagnoses which included stage III sacral pressure ulcer, dementia, and fracture of right femur. A physician order, dated 12/28/23, documented weekly skin assessment to be completed every Friday. A care plan, revised 05/07/24, documented the resident was at risk for pressure ulcers due to the inability to walk far, malnutrition, and a bony appearance. The care plan documented a goal of intact skin without evidence of redness, irritation, maceration, or open areas. A nurse note, dated 05/08/24, documented a stage II pressure wound was discovered during assessment. The note documented treatment of the wound was initiated. A quarterly assessment, dated 05/21/24, documented the resident was cognitively intact, required partial to moderated assistance with mobility, and had one stage II pressure ulcer not present upon admission. A physician order, dated 06/19/24, documented hydrocolloid dressing to the coccyx every other day of the week. On 07/07/24 at 9:01 a.m., Res #32 was observed sitting in a wheelchair. Res #32 stated they had wounds on their tailbone that developed while in the facility. Res #32 stated they did not receive wound care consistently. On 07/08/24 at 11:25 a.m., LPN #1 was observed performing wound care on Res #32. LPN #1 stated the resident received wound care every other day of the week per physician orders. LPN #1 was observed applying santyl ointment to the wound prior to placing the hydrocolloid dressing. On 07/08/24 at 1:00 p.m., the medical record was reviewed. The medical record documented a skin assessment was completed on 06/01/24 and 06/21/24. There were no additional weekly skin assessments documented for the months of June 2024 or July 2024. There was no physician order for santyl ointment found in the medical record. On 07/08/24 at 1:30 p.m., the corporate RN stated the weekly skin assessments had not been completed routinely. They stated Res #32's wound care treatment had not been completed according to physician orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43023 2. Res #35 admitted to the facility with diagnoses of morbid obesity and hypertensive heart disease with heart failure. A physician's order, dated 02/14/24, documented weekly weight once a day on Thursday. A review of the resident's record documented weights on the following dates: 02/22/24, 03/13/24, 04/08/24, 05/10/24, 05/14/24, 05/21/24 and 06/06/24. On 07/10/24 at 10:24 a.m., the corporate nurse reported the weekly weights were not being completed

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46582 Based on observation, record review, and interview, the facility failed to ensure a physician order for an indwelling urinary catheter and failed to ensure a resident with an indwelling urinary catheter received services to help prevent urinary tract infections for one (#32) of three residents reviewed for catheters. The corporate RN identified five residents with a urinary catheter. Findings: Res #32 had diagnoses which included stage III sacral pressure ulcer, dementia, and fracture of right femur. A care plan, revised 05/07/24, documented the resident was occasionally incontinent of bladder due to inability to move fast. The care plan documented the resident wore adult undergarments while out of bed for dignity. A quarterly assessment, dated 05/21/24, documented the resident was cognitively intact, required partial to moderate assistance with toileting, was frequently incontinent of bladder, and did not have an indwelling catheter. A nurse note, dated 06/04/24, documented Res #32 had an indwelling urinary catheter placed. A 5-day assessment, dated 06/05/24, documented the resident was cognitively intact, dependent with toileting, and had an indwelling catheter. There was no physician order for an indwelling urinary catheter found in the medical record. There was no documentation related to urinary catheter maintenance or infection prevention interventions documented in the medical record or the care plan. On 07/07/24 at 9:02 a.m., Res #32 was observed sitting in a wheelchair. An indwelling catheter was observed attached to the bottom of the wheelchair. Res #32 stated they had the catheter for a while but did not know why it was placed. On 07/08/24 at 1:22 p.m., the corporate RN stated a physician order should have been documented prior to the placement of the catheter. The corporate RN stated interventions for catheter maintenance and infection prevention should have been documented in Res #32's medical record. They stated there was no way to know if regular maintenance and monitoring of the catheter had been completed due to a lack of documentation.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 43023 Based on observation, record review, and interview, the facility failed to ensure snacks were offered between meals and at bedtime as ordered and weights were documented weekly on a resident who experienced a significant weight loss for one (#21) of two sampled residents reviewed for nutrition. The corporate nurse reported 49 residents resided in the facility. Findings: Res #21 admitted to the facility with diagnoses of abnormal weight loss and muscle waisting and atrophy. A physician's order, dated 12/16/24, documented Regular diet Regular Texture, Thin liquids. House supplement with meals. A physician's order, dated 01/05/24, documented to offer snacks between meals and HS, Special Instructions: between meals and HS After Meals 10:00, 14:00, 20:00 A physician's order, dated 02/20/24, documented Weekly Weights on Thursdays Once A Day on Thu 07:00 - 15:00. On 07/07/24 at 9:00 a.m., Res #21 was observed sitting in the assisted dining room. The resident was observed to have liquids, including a healthshake but does not have meal yet. Resident's weights were reviewed, on 01/05/2024, the resident weighed 124 lbs. on 06/13/2024, the resident weighed 104 pounds, which is a -16.13 % weight loss. The resident's record did not contain any documentation of her snacks between meals and at bedtime. On 07/10/24 at 9:19 a.m., the corporate nurse was asked to review the resident's documentatin for snacks and weights. reported she could not say the resident for sure is receiving her snacks On 07/10/24 10:24 a.m., the corporate nurse reported she could not say for sure the resident received snacks and they reported the weekly weights were not being completed as ordered.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 46582 Based on observation, record review, and interview, the facility failed to change oxygen tubing per physician order and best standard practice for one (#10) of one resident reviewed for oxygen therapy. The corporate RN identified four residents who received oxygen therapy. Findings: A Respiratory Therapy - Prevention of Infection policy, revised November 2011, read in part, .Change the oxygen cannulae and tubing every seven days, or as needed . Res #10 had diagnoses which included acute respiratory disease, asthma, and nasal congestion. A physician order, dated 06/26/23, documented to change and date oxygen tubing weekly on Tuesdays. A quarterly assessment, dated 03/18/24, documented the resident was cognitively intact, short of breath with exertion, and received oxygen therapy. A care plan, reviewed 04/16/24, documented the resident had episodes of shortness of breath and was at risk of respiratory distress/failure. The care plan documented to change oxygen tubing per the orders and date and time when changing. On 07/07/24 at 10:39 a.m., Res #10 was observed wearing oxygen per nasal cannula. The oxygen tubing was dated 06/10/24. Res #10 stated the staff changed the oxygen tubing but wasn't sure how often. On 07/08/24 at 8:13 a.m., Res #10 was observed wearing oxygen per nasal cannula. The oxygen tubing was dated 06/10/24. On 07/08/24 at 1:40 p.m., the corporate RN was made aware of the observations. The corporate RN stated the oxygen tubing should have been changed weekly per physician order.

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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. 20960 Based on observation, record review, and interview, the facility failed to ensure meals were served as scheduled for three (#28, #47 and #40) of three sampled residents reviewed for meal service in the assisted dining room. The Administrator identified 49 residents received services from the kitchen and ten required asssistance with their meals. Findings: An undated schedule of meal times, documented breakfast was to be served at 7:30 a.m. and lunch at 12:30 p.m. On 07/07/24 at 8:05 a.m., eleven residents were observed in the main dining room waiting for there morning meal. During the initial tour of the kitchen on 07/07/24 at 8:07 a.m., the steam table was observed with the food ready to be served. The dietary manager was asked when meal service was and they stated 7:30 a.m They the morning meal was ready to be served they were waiting on nursing to be able to serve the meal. On 07/07/24 at 8:20 a.m. the dietary staff was observed serving the first meal tray to the main dining room. The main dining room was served 50 minutes past the scheduled time. On 07/07/24 at 8:25 a.m., Resident #28 and #47 were observed in the assisted dining area waiting for their morning meal. On 07/07/24 at 9:05 a.m., the infection preventionist was observed providing the first meal tray to Resident #28 and at 9:15 a.m., to Resident #47. The meal was served over one and half hours past the scheduled meal service time in the assisted dining room. On 07/07/24 at 9:53 a.m., Resident #40's family member stated the residents often have to wait long periods of time before being served their meals in the assisted dining area. They stated some of the residents get anxious from waiting so long to be served. On 07/07/24 at 12:00 P.M., Resident #40 was observed being placed, while in a geri-chair, at the dining table in the assisted dining area by staff. On 07/07/24 at 1:00 p.m., Resident #40 was observed sitting at the dining table. The resident's lunch meal had not been served. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/07/24 at 1:39 p.m., staff were observed serving Resident #40 their lunch meal. The meal was served one hour and nine minutes passed the scheduled time. On 07/08/24 at 11:22 a.m., in an confidential family interview, the family stated meals were always late and never served at scheduled times. On 07/08/24 at 1:03 p.m., Resident #29 stated their meals were never on time and they had to wait 30 minutes to an hour to get their food. During a resident council meeting interview, on 07/08/24 at 1:58 p.m., twelve out of twelve residents stated meals were to be served at 7:30 a.m., 12:30 p.m., and 5:30 p.m. All twelve agreed that meals were served late every meal by 30 minutes to an hour. All residents in attendance indicated they received their meals in the main dining room. On 07/09/24 at 8:04 a.m., the dietary manager stated meals were always ready to be served at the posted times but were always late due to nursing staffing. They stated there are not enough staff to be in the dining room for service and have care provided at the same time. They stated all meals are served late including the assisted dining room. The dietary manager then stated that once the morning meal is late it causes the noon meal to be late also. On 07/09/24 at 8:25 a.m., CNA #1 stated meals were to be served at 7:30, 12:30 and 5:30. The CNA then stated meals are late because they were get everyone to the dining room and the nurses were helping on the floor. CNA #1 stated residents were taken into the assisted dining room and they have to wait over an hour for their meal which is too long. On 07/09/24 at 8:29 a.m., CNA #2 stated meals were scheduled at 7:30; 12:30 and 5:30 for dinner. CNA #2 stated meals were late because staff were trying to get residents to the dining room and the nurses were helping. CNA #2 stated they felt bad for residents in the assisted dining room waiting over an hour because they would not want to wait that long. On 07/09/24 at 9:30 a.m., the infection preventionist stated during the week meals are not served as late as on the weekends. The infection preventionist then stated the nursing staff was holding up the meal service because they had to get everyone up before the meal can be served. 46582

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46582 Based on observation, record review, and interview, the facility failed to maintain an infection control program for enhanced barrier precautions for three (#5, 32, and #43) of three residents reviewed for infection control. The corporate RN identified two residents with pressure ulcers and five residents with urinary catheters. Findings: An Enhanced Barrier Precautions policy, dated 05/10/24, read in parts, .Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) .High-contact resident activities include: dressing, bathing, providing hygiene, changing linens, changing briefs, assisting with toileting, device care or use: urinary catheter, and wound care: any skin opening requiring a dressing .Gowns and gloves will be available immediately near or outside of the resident's room .Enhanced barrier precautions should be used for the duration of the resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk . 1. Res #32 had diagnoses which included stage III sacral pressure ulcer, dementia, and fracture of right femur. A nurse note, dated 05/08/24, documented a stage II pressure wound was discovered during assessment. The note documented treatment of the wound was initiated. A physician order, dated 05/14/24, documented to clean the wound with wound cleanser, pat dry, apply a small amount of ointment, and cover with dressing daily until necrotic tissue is gone. A quarterly assessment, dated 05/21/24, documented the resident was cognitively intact, required partial to moderated assistance with mobility, and had one stage II pressure ulcer not present upon admission. A physician order, dated 06/19/24, documented hydrocolloid dressing to the coccyx every other day of the week. On 07/07/24 at 9:01 a.m., Res #32 was observed sitting in a wheelchair. Res #32 stated they had wounds on their tailbone that developed while in the facility. Res #32 stated the staff provided wound care. On 07/08/24 at 11:25 a.m., LPN #1 was observed performing wound care on Res #32. LPN #1 was observed to have worn gloves during the treatment. LPN #1 was not observed to have worn a personal protective gown during the wound care treatment. No personal protective equipment was observed outside or near Res #32's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/08/24 at 11:40 a.m., LPN #1 was asked if enhanced barrier precautions including the use of a personal protective gown was utilized in the facility for wound care and the care of indwelling devices such as catheters. LPN #1 stated they always wore gloves for these procedures but did not usually wear a gown. They stated having been unfamiliar with enhanced barrier precautions and stated they didn't think the precautions had been implemented in the facility. On 07/08/24 at 12:00 p.m., the infection preventionist was asked if enhanced barrier precautions were utilized in the facility. The infection preventionist stated they had not implemented enhanced barrier precautions yet in the facility. They stated the precautions would be utilized going forward for wound care and indwelling devices such as catheters. 43023 2. Res #5 admitted to the facility with diagnoses of urine retention. A physician order, dated 04/26/24, documented a foley catheter in place for urinary retention. On 07/07/24 at 11:42 a.m., an obsevation of the resident's door and room contained no indication or PPE for enhanced barrier precautions. On 07/10/24 at 9:03 a.m., the corporate nurse was asked if the facility had enhanced barrier precautions in place. They reported they do not. 20960 3. Resident # 43 was admitted to the facility on [DATE] with diagnosis to include Benign prostatic hyperplasia without lower urinary tract symptoms. An admission assessment dated [DATE], documented Resident #43 cognition was intact and they had a urinary catheter. Resident #43 care plan dated 04/04/23, documented they had an indwelling catheter. On 07/07/24 at 10:38 a.m., Resident #43 was observed in his room. The resident was observed with a catheter bag hanging from their wheelchair. There were no signs or any indications staff was to provide care utilizing enhanced barrier precautions. The resident stated staff changed the catheter bag monthly and provided care daily. Resident #43 indicated staff wore gloves only while providing the care to the catheter. On 07/09/24 at 8:25 a.m., CNA #1 stated Resident #43 as provided catheter care every shift and they only wore gloves. They were asked if they had received any training regarding enhanced barrier precautions. CNA #1 stated, Is that something new. On 07/09/24 at 8:29 a.m., CNA #2 stated Resident #43 had a catheter and was provided catheter care every time care was being provided to the resident. CNA #2 stated they only wore gloves while providing catheter care unless they had any infections which would require gowns, masks and a face shield. CNA #2 stated they had not had any training on enhanced barrier precautions and was not sure what that meant. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/09/24 at 9:00 a.m., corporate nurse #1 stated the facility was not currently doing enhanced barrier precautions.