STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375451	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Valley Health Care Center	1120 Illinois Street Muskogee, OK 74403

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 35389 Based on observation, record review, and interview, the facilty failed to ensure staff members assisted residents with eating in a dignified manner for two (#12 and #75) of nine sampled residents observed during meal service in the assisted dining room. The DON identified 15 residents who required feeding assistance resided in the the facility. Findings: A Promoting/Maintaining Resident Dignity During Mealtimes policy, revised 07/04/24, read in part, It is the practice of this facility to treat each resident with respect and dignity .All staff members involved in providing feeding assistance to residents promote and maintain resident dignity during mealtimes .All staff will be seated, if possible, while feeding a resident . 1. Resident #12 had diagnoses which included vascular dementia and obsessive-compulsive behavior. An Annual Resident Assessment, dated 06/09/24, documented Resident #12 had severe cognitive impairment and was dependent on staff for the task of eating. On 08/13/24 at 12:14 p.m., CMA #3 was observed standing over Resident #12 and giving them a bite of their lunch meal. On 08/13/24 at 12:15 p.m., CMA #3 gave Resident #12 a bite of mechanical soft barbeque chicken while standing over the resident on their right side. CMA #3 gave a drink of a pink liquid and instructed the resident to take a drink while standing over the resident. CMA #3 gave the resident a bite of beans instructing them to take a bite while standing to the right of them. 2. Resident #75 had diagnoses which included unspecified dementia and mild neurocognitive disorder. A Quarterly Resident Assessment, dated 07/27/24, documented Resident #75 had severe cognitive impairment and required supervision or touching assistance for the task of eating. On 08/13/24 at 12:28 p.m., CNA #1 walked over to Resident #75, helped the resident move their tray back towards them, and gave the resident bites of beans while standing to the right side of the resident. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/13/24 at 12:30 p.m., CNA #1 continued to stand over Resident #75 feeding them bites of beans and attempting to give them a bite of bread. On 08/13/24 at 12:31 p.m., CNA #1 continued to stand over Resident #75 on their right side giving them a bite of chicken and a bite of beans. There was an empty chair observed to the left of the resident. On 08/13/24 at 12:34 p.m., CNA #1 continued to stand over Resident #75 while feeding them a bite of mechanical textured meat. On 08/13/24 at 12:48 p.m., CNA #1 stated they would make sure if a resident needed assistance with their meal, they would help them. On 08/13/24 at 12:49 p.m., CNA #1 stated they were not aware of any policy on where staff were situated while assisting a resident with eating. On 08/14/24 at 10:09 a.m., the DON stated staff should assist residents with eating when needed. They stated staff should be seated while assisting residents with eating.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 21731 Based on observation and interview, the facility failed to ensure information to file a formal complaint to the state agency and ombudsman were readily available to 10 of 10 residents that attended the resident group interview. The Administrator reported the census was 83. Findings: On 08/14/24 at 3:15 p.m., ten residents were asked if they knew their Ombudsman. several of the residents questioned what was an Ombudsman. The residents were introduced, then asked if they were familiar with where information was posted to call the ombudsman if they had a concern or complaint. They stated they did not know but the information may be on the bulletin board on C Hall. The residents were asked if they knew how to report a complaint to the state survey office. They stated they did not know, the information may have been posted on the bulletin board on C Hall. On 08/14/24 at 3:46 p.m., the bulletin board on C Hall was observed to have the information to report a complaint to the state office and posting of the Ombudsman. The forms were near the top of the bulletin board, with the bottom of the forms approximately 5 feet above the floor. On 08/14/24 at 3:50 p.m., the Administrator was asked if the information for residents to file a formal complaint to the state agency or contact the Ombudsman were readily available for all residents to view. They stated the forms needed to be lowered.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 21731 Based on observation and interview, the facility failed to ensure past survey results were readily available to residents to review for 10 of 10 residents that attended the resident group interview. The Administrator reported the census was 83. Findings: On 08/14/24 at 3:15 p.m., ten residents were asked if they knew where the previous survey results were posted and if the reports were readily available to them, without having to request the information The residents stated they did not know they could look at the reports and did not know where to locate the previous reports. On 08/14/24 at 3:46 p.m., the bulletin board on C Hall was observed to have a binder labeled, Survey Results, in a file bin mounted to the wall. The lower part of the bin was approximately five feet above the floor. The binder was attached to a chain that limited the binder to be lowered approximately three feet above the floor. On 08/14/24 at 3:50 p.m., the Administrator was asked if the previous survey results were readily available to the residents to review, without the assistance of staff. They stated the binder may be too high and needed to be lowered or in a different place.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 21731 On 08/16/24 at 9:35 a.m., the Oklahoma State Department of Health identified the presence of an immediate jeopardy related to the facility failed to evaluate Residents #51 and #18 for the capacity to consent to sexual activity. Resident #18 had known sexually inappropriate behaviors and there was no evidence the facility identified these events as sexual abuse or evaluated the resident's capacity to consent. A Progress Note, dated 06/21/24 at 7:16 p.m., documented Resident #51 was observed with their legs opened and Resident #18 was sitting in front of Resident #51, rubbing on Resident #51's vagina. The nurse told the residents they could not do that. The nurse observed them kissing, went to speak with Resident #51, who was leaned forward while trying to pull their pants down, and Resident #18 had partial of their penis out. The nurse told them they could not do that in the hallway. On 08/16/24, there had been no documentation of evaluation of capacity to consent, care plans or assessments for Residents #51 and #18 regarding sexual activity. On 08/16/24 at 11:10 a.m., the Administrator was notified of the presence of an immediate jeopardy related to residents had not been evaluated for the capacity to consent to sexual activity. A plan of removal was requested. On 08/16/24 at 5:41 p.m., the following POR for abuse was submitted to OSDH for review: A [Name of facility and address withheld] Plan of Removal, read in parts, .1. Al staff are inserviced on sexual behaviors with residents with decreased BIMS and when to report incidents .2. Designee began assessing all BIMS greater than 9 in the facility for any sexual abuse from resident #18. All residents assessed had not had any form of sexual abuse while in the facility .3. Compliance with reporting allegations of abuse/neglect/exploitation policy has been reviewed with all staff. All staff have been inserviced and all new hires will continue to be inserviced upon hire .r. MDS updated Resident #18 care plan for sexual behaviors. Monitoring order in place q [every] shift .5. Designee will review 24 hour reports and will report any new behaviors in M-F morning meetings .6. Nurse Practitioner to eval and treat Resident #51 [amended to be Resident #18]. On this day resident eval to consent to sexual activity and sexual activity [sic] and sexual consent form was completed on Resident #18 and Resident #51 .7. DON reviewed all behavior notes for the past 6 months assessing for any resident to resident sexual abuse. No other instances were found .8. Resident #18 and Resident #51 were educated on sexual activity .Completion Date/Time: 8/16/24 at 1640 [4;40 p.m.] .9. Nursing staff will initiate the Evaluation for Sexual Consent Form upon any observed sexual behaviors between residents .Completion Date/Time: Ongoing .10. Follow up regarding Resident #18 sexual consent, family consented to companionship but not the act of sex itself .Follow up regarding [Resident #51]: Family consented to companionship but not the act of sex its self .What are your steps to ensure the residents are evaluated for consent regarding sexual activity? All residents exhibiting sexual behaviors will be screened with the Evaluation for sexual consent form upon noted behaviors, assessment will be performed by witnessing nurse of other designee . On 08/19/24 at 8:25 a.m., the facility was notified the POR was approved. The IJ was lifted, effective 08/19/24 at 11:00 a.m., when all components of the plan of removal had been completed. The deficiency remained at a level of potential for more than minimal harm. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Based on observation, record review, and interview, the facility failed to ensure an evaluation was completed to assess the capacity to consent to sexual activity for two (#51 and #18) of five sampled residents reviewed for abuse. The Administrator identified 83 residents resided in the facility. Findings: An Abuse, Neglect and Exploitation policy, dated 07/01/24, received and reviewed on 08/14/24 at 1:42 p.m., read in part, .includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act .Sexual Abuse is non-consensual sexual contact of any type with a resident .Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse .identifying when, how and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded .Ensuring the health and safety of each resident with regard to visitors such as family members or resident representatives, friends and other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions . 1. Resident #18 had diagnosis which included unspecified dementia. Resident #18's quarterly assessment dated , 04/20/24, documented Resident #18's cognition was severely impaired. A Behavior Note, dated 09/20/19 at 5:24 p.m., documented, Another resident informed this nurse that resident was in hallway touching penis. List Interventions Attempted: Educated [Resident #18] that resident will need to go inside room in private to do so. A Behavior Note, dated 10/18/19 at 4:49 p.m., documented, ACMA was giving resident eternal feedings when resident got penis out of pants and started touching [themselves]. ACMA asked resident respectfully to wait until after feeding was administered. List Interventions Attempted: ACMA asked resident respectfully to wait until after feeding was administered. This nurse spoke [with] resident and asked if it could wait until after feeding due to being unable to stop feeding. A Behavior Note, dated 10/22/23 at 8:56 p.m., documented, [Resident #18] had penis out during 2030 [8:30 p.m.] smoke break. List Interventions Attempted: CNA [name withheld] firmly told [Resident #18] to put [Resident #18] penis away. A Behavior Note, dated 10/23/23 at 1:01 p.m., documented, During 11 a.m. smoke break resident exposed penis. List Interventions Attempted: CNA/Activities assist [name withheld] instructed resident to put it away now. A Behavior Note, dated 04/21/24 at 10:02 a.m., documented CMA had was finishing feeding [Resident 18] when [Resident 18] ran [Resident 18's] hand up [CMA's] leg and tried to touch [CMAs] private area. List Interventions Attempted: CMA firmly told [Resident #18] to keep [Resident 18's] hands to [themselves]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A Behavior Note, dated 06/21/24 at 7:25 p.m.,, documented, This nurse was coming out of a resident room and [Resident #18] sitting in WC in front of [Resident #51] rubbing on her vagina. This nurse told residents that they can not do that in the hallway and they stopped. This nurse was sitting a [sic] nurses station and seen [Resident #18] and [Resident #51] kissing. This nurse went to talk to residents; [Resident #18] had partial of [their] penis out and Resident #51 was leaning forward trying to pull pants down. This nurse told resident they can not do that in the hallway and [Resident 51] voiced understand and got up and sat in front of nurses station. Resident #18's care plan, dated 08/06/24, did not address sexual activity or prevent the risk of sexual abuse. The clinical record did not contain an assessment Resident #18 had been assessed to ensure the capacity to engage in sexual activity, or sexual activity behaviors. 2. Resident #51 had diagnosis to include Alzheimer's Disease and malignant neoplasm of bronchus and lung. A Quarterly Assessment, dated 06/14/24, documented Resident #51 had clear speech, understands, is understood, has severe cognitive impairment for daily decision making, displayed inattention and disorganized thinking, and required supervision and cues to perform ADLs. A Progress Note, dated 06/21/24 at 7:16 p.m., read in part, .This nurse was coming out of a resident room and seen [Resident #51] sitting in a chair .with legs opened and [Resident #18] was sitting in front of [Resident #51], rubbing on [Resident #51's] vagina. This nurse told residents that the [sic] can not do that and they stopped. This nurse was sitting a nurses station and seen [Resident #51] and [Resident #18] kissing this nurse went to talk to resident and {Resident #51 was leaning forward trying to pull pants down while [Resident #18] had partial of [their] penis out. This nurse told resident they can not do that in the hallway. Resident got up and sat in front of nurses station .interventions Attempted: told resident they were not allowed to do that in hallway . A Care Plan, dated 08/13/24, documented Resident #51 had the potential to be physically aggressive .was aggressive toward another resident. and that a CNA had reported to the nurse at 2:30 p.m., Resident #51 had become physically aggressive to another female resident during lunch. The clinical record did not contain an assessment Resident #51 had been assessed to ensure the capacity to engage in sexual activity, or sexual activity behaviors. The care plan did not contain documentation Resident #51 had interventions in place to address sexual activity or prevent the risk of sexual abuse. No documentation was provided to support the sexual activity between Residents #51 and #18 had been assessed to ensure the resident were cognitively intact to consent to sexual activity. The facility did not provide an incident report or reportable incident to OSDH. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 08/15/24 at 4:24 p.m., the DON was asked to explain the events surrounding the progress note dated 06/21/24 at 4:27 p.m. The DON stated it appeared the nurse came out and seen Resident #51 sitting in a chair with their legs opened and Resident #18 was sitting in a wheelchair and were observed to be engaged in sexual touching. The DON was asked what was the facilities response to this allegation. The DON stated if residents wanted to sexual, they have the right to be as long as it is not in a public place. The DON was asked if a state reportable incident had been completed as a result of this behavior. The DON stated, they understood the residents have a right, so nothing else was put in place. The DON was asked if the care plan was updated an interventions put into place. They stated only what was in the progress note. The DON was asked if Resident #51 or #18 had been able to consent to sexual activities. The DON stated both residents had been assessed to have severely impaired cognitive impairment for daily decision making. The DON was asked if the residents had severe cognitive impairment, how was it determined they could consent to sexual activity. No information was provided. The DON was asked if the residents' care plans had been updated to reflect the sexual behavior. The don stated the care plan was updated on 06/27/24 to monitor for wandering, there is not a care plan for sexual activity. The DON was asked how staff would be able to identify if the residents were able to consent to sexual behaviors. They stated they would refer to the care plan and policies. The DON was asked if the care plan for Resident #51 had been updated. They stated the care plan did not appear to have an update. The DON was asked if this had been the only event of sexual activity for either of the residents. They stated, I don't see anything. 46216

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46216 Based on interview and record review, the facility failed to ensure the results of abuse investigations were submitted to the State within 24 hours for three (#15, 44, and #51) of five residents reviewed for abuse. The Administrator identified 83 residents resided in the facility. Findings: Resident #15 had diagnoses which included cognitive communication deficit and chronic kidney disease, stage 3. Resident #15's admission assessment, dated 05/22/24, documented Resident #15's cognition was intact. An Initial State Reportable Incident form, faxed on 07/08/24 at 4:37 p.m., documented CNA# 5 reported to administration Resident #15 had reported to them that on 07/03/24 CNA #4 had called Resident #15 an expletive word in the shower room. A Final State Reportable Incident form, faxed on 07/11/24 at 12:57 p.m., documented CNA #4 was immediately put on a three day suspension for verbal abuse allegation during this investigation. All staff were immediately in-serviced over abuse on 07/08/24. On 08/14/24 at 1:17 p.m., RN #1 stated the facility policy for reporting abuse was to report verbal and physical abuse immediately. On 08/14/24 at 1:34 p.m. the DON stated the incident had occurred on 07/03/24. They stated it was report to OSDH within two hours or sooner. On 08/14/24 at 1:37 p.m., the DON stated the incident had occurred on 07/03/24 and was reported to CNA #4 on 07/05/24, the CNA stated that they had forgotten to report it. The DON stated CNA #4 had not reported in a timely manner. On 08/14/24 at 1:40 p.m., the Administrator stated the CNA had not reported the incident to them until 07/08/24. 21731 2. Resident #44 had diagnoses to include mild intellectual disabilities, vascular dementia, hearing loss, visual loss, behavioral and emotional disorder with childhood onset, schizophrenia, and bipolar. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Quarterly Assessment, dated 07/19/24 documented Resident #44 had moderate cognitive impairment, displayed verbal behavioral symptoms toward others and required some substantial to maximum assistance with ADLs. An Incident Report Form, dated 06/26/24 documented a hospice nurse reported Resident #44 stated a staff member was too rough with Resident #44. The resident had reported they had urinated on themselves in the dining room at lunch and the aide had to take the resident out of the dining room to provide care. Resident #44 stated They just jerked me around . The investigative file, documented the event occurred on 06/26/24. A Xerox Confirmation Report documented the initial report was filed on 06/26/24 at 2:18 p.m. A Notification of Nurse Aide/Nontechnical Service Worker Abuse, Neglect, Mistreatment of Misappropriation of Property form documented the an allegation of abuse had been received on 06/26/24 but the Nurse Aide Registry had not been notified until 07/02/24. On 08/15/24 11:35 a.m., in the presence of the administrator, the DON was asked to clarify items on the incident report, dated 06/26/24. The DON stated a hospice nurse had reported to staff Resident #44 reported an allegation of abuse with the staff were too rough. The DON was asked when was the nurse aide registry notified of the abuse allegation and an investigation had been initiated for the nurse aide. The DON stated we have five days to report. An Incident Report Form, dated 08/18/24, documented at approximately 8:30 p.m., Resident #44 was being provided care alleged a CNA had molested Resident #44. The investigative file, contained a Xerox Confirmation Report, that documented an initial report to OSDH had been sent on 08/20/24 at 7:59 a.m., and the Nurse Aide Registry form documented the Nurse Aide Registry had been notified on 08/20/24. On 08/20/24 at 11:17 a.m., the ADON was asked when did facility staff become aware of the allegation of abuse regarding the event on 08/18/24. They stated, management was made aware just after noon on 08/19/24. The ADON was asked when did the facility send a report to OSDH. The ADON stated on 08/19/24, the charge nurse had been aware but did not report to management. The ADON was asked when did the facility report to the Nurse Aide Registry a CNA had an allegation of abuse. They stated on 08/20/24 just be fore 8:00 a.m. The ADON was asked if the LPN had been reported to their licensing board. The ADON stated, they had not. 3. Resident #51 had diagnosis to include Alzheimer's Disease and malignant neoplasm of bronchus and lung. A Progress Note, dated 09/19/23 at 1:17, read in part, .[resident] yelling and swatting at other resident during activities . The clinical record did not contain an incident report to OSDH or other required agencies. A Progress Note, dated 04/04/24 at 6:03 p.m., read in part, .Resident wanted to sit in chair in front of nurse station. Another resident was sitting in the chair Resident {#51] attempted to pull other resident out of chair while insulting [them] . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record did not contain an incident report to OSDH or other required agencies. A Quarterly Assessment, dated 06/14/24, documented Resident #51 had clear speech, understands, is understood, has severe cognitive impairment for daily decision making, displayed inattention and disorganized thinking, and required supervision and cues to perform ADLs. A Progress Note, dated 06/21/24 at 7:16 p.m., read in part, .This nurse was coming out of a resident room and seen [Resident #51] sitting in a chair .with legs opened and [Resident #18} was sitting in front of [Resident #51], rubbing on [Resident #51's] vagina. This nurse told residents that the [sic] can not do that and they stopped. This nurse was sitting a nurses station and seen [Resident #51 and [Resident #18] kissing this nurse went to talk to resident and {Resident #51 was leaning forward trying to pull pants down while {Resident #18 had partial of [their] penis out. This nurse told resident they can not do that in the hallway. Resident got up and sat in front of nurses station .interventions Attempted: told resident they were not allowed to do that in hallway . The clinical record did not contain an incident report sent to OSDH of a sexual interaction between Resident #51 and Resident #18. The facility did not provide an incident report or reportable incident to OSDH. On 08/13/24 at 11:46 a.m., during the noon meal, Resident #51 was seated a a dining table in the main dining room. Resident #72, entered the area from a side door and approached the table where Resident #51 was seated. Resident #51 began to swing their arms, and hit Resident #72. CNA #1 calmly separated the residents and assisted Resident #51 to another table for the noon meal. 08/13/24 at 2:10 p.m., CNA #1 was asked to verify if they had assisted Resident #51 during the noon meal when an altercation occurred between two female residents. They stated they had separated the residents. They stated they did not know what triggered the event but turned and seen Resident #51 hitting Resident #72. CNA #1 was asked if they had reported the event to anyone. They stated not yet, was trying to charge to they could go home at 2:00 p.m., On 08/15/24 at 4:24 p.m., the DON was asked to explain the events surrounding the progress note dated 06/21/24 at 4:27 p.m. The DON stated it appeared the nurse came out and seen Resident #51 sitting in a chair with their legs opened and Resident #18 was sitting in a wheelchair and were observed to be engaged in sexual touching. The DON was asked if a state reportable incident had been completed as a result of the sexual behavior between two cognitively impaired residents. The DON stated, they understood the residents have a right, so nothing else was put in place. The DON was asked to review the progress notes dated 09/19/23 and 04/02/24 and if the events of resident to resident altercations had been reported to OSDH or other required agencies. They stated they had not. been reported.

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	375451	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Valley Health Care Center	1120 Illinois Street Muskogee, OK 74403

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 21731 2. Resident #44 had diagnoses to include mild intellectual disabilities, vascular dementia, hearing loss, visual loss, behavioral and emotional disorder with childhood onset, schizophrenia, and bipolar. A Quarterly Assessment, dated 07/19/24 documented Resident #44 had moderate cognitive impairment, displayed verbal behavioral symptoms toward others and required some substantial to maximum assistance with ADLs. An Incident Report Form, dated 06/26/24 documented a hospice nurse reported Resident #44 stated a staff member was too rough with Resident #44. The resident had reported they had urinated on themselves in the dining room at lunch and the aide had to take the resident out of the dining room to provide care. Resident #44 stated They just jerked me around . The investigative file, contained documented of two Nurse Aides, a visitor, the resident's room mate, and a hospice nurse were interviewed. There was no documentation other staff or residents in the facility had been interviewed to ensure the safety of all residents. On 08/15/24 11:35 a.m., in the presence of the administrator, the DON was asked how was it determined the allegation was fully investigated. The DON stated they interviewed the resident, the other people that were in the resident room at the time, a hospice nurse , as well as the resident's room mate at the time - which has since passed away. The DON was asked if the alleged CNA involved had access to other residents. The don stated yes and the CNA that had assisted was from another hall. The DON was asked how was the event fully investigated if other residents being provided care from the staff involved were not interviewed, or if other staff were not interviewed. The DON stated, I thought I had a good investigation at the time, with a lot of interviews, but they are not with the information provided to the surveyor. No further information was provided. 3. Resident #51 had diagnosis to include Alzheimer's Disease and malignant neoplasm of bronchus and lung. A Progress Note, dated 09/19/23 at 1:17, read in part, .[resident] yelling and swatting at other resident during activities . The clinical record did not contain an incident report or investigative notes. A Progress Note, dated 04/04/24 at 6:03 p.m., read in part, .Resident wanted to sit in chair in front of nurse station. Another resident was sitting in the chair Resident {#51] attempted to pull other resident out of chair while insulting [them] . The clinical record did not contain an incident report or investigative notes. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Quarterly Assessment, dated 06/14/24, documented Resident #51 had clear speech, understands, is understood, has severe cognitive impairment for daily decision making, displayed inattention and disorganized thinking, and required supervision and cues to perform ADLs. A Progress Note, dated 06/21/24 at 7:16 p.m., read in part, .This nurse was coming out of a resident room and seen [Resident #51] sitting in a chair .with legs opened and [Resident #18} was sitting in front of [Resident #51], rubbing on [Resident #51's] vagina. This nurse told residents that the [sic] can not do that and they stopped. This nurse was sitting a nurses station and seen [Resident #51 and [Resident #18] kissing this nurse went to talk to resident and {Resident #51 was leaning forward trying to pull pants down while {Resident #18 had partial of [their] penis out. This nurse told resident they can not do that in the hallway. Resident got up and sat in front of nurses station .interventions Attempted: told resident they were not allowed to do that in hallway . The clinical record did not contain an incident report or investigative notes. On 08/15/24 at 02:17 p.m., the DON was asked how resident to resident altercations are handled. They stated usually like all other reportable events. The DON was asked if an investigation was initiated for Resident #51. They were asked to provide a copy of the event and items reported. No further information was provided. On 08/15/24 at 4:24 p.m., the DON was asked if the resident to resident altercations on 09/19/23, 04/02/24, and 06/21/24, had been investigated. They stated there was not a report made so there was not an investigation. 35389 Based on record review and interview, the facility failed to: a. ensure an allegation of abuse was fully investigated for two (#14 and #51); and b. prevent the potential for further abuse while an investigation was in progress for one (#44) of five sampled residents reviewed for abuse. The Administrator identified 83 residents resided in the facility. Findings: An Abuse Policy, revised 03/24/22, read in part, .Any allegation of abuse will be investigated by the DON, ADON, administrator or designated representative by use of the Abuse Packet. At a minimum they will . Interview any witnesses to the incident .interview the resident .Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident if necessary .Interview the roommate, family members, and visitors as able and necessary .Interview other residents to whom the accused employee provides care or services .Employees of this facility who have been accused of resident abuse will be suspended from duty. This action will remain in effect until the investigation has been completed .Any licensed nurse found unfit for service will be reported to the Oklahoma Board of Nursing . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident #14 had diagnoses which included cognitive communication deficit, anxiety, and persistent mood disorder. A Quarterly Resident Assessment, dated 05/30/24, documented Resident #14's cognition was intact. An Initial State Reportable Incident form, dated 08/04/24, documented on 08/05/24 at 11:35 a.m. the charge nurse reported that resident #14 told hospice nurse that LPN #3 flipped off Resident #14 and stated [explicit word] on 08/04/24. It documented LPN #3 was placed on suspension. A Final State Reportable Incident form, faxed 08/06/24, documented upon interviewing Resident #14, the resident told the Administrator and the ADON they had asked the nurse to complete wound care and the nurse couldn't because they were unable to locate the key to the wound care cart. It documented the resident was mad because the nurse was careless and lost the key. It documented the resident told the nurse [explicit word] and flipped [them] off because [they] were careless to lose the key. It documented Resident #14 said they shouldn't have said anything because they didn't want to get anyone in trouble. The facility completed a referral to APS, notified the police department who did not feel the need to complete a report, and unsubstantiated the complaint because the resident admitted they were the one who told the nurse (explicit word) and flipped them off. It documented witness statements were attached. The report was completed by the Administrator. The investigation included an interview with Resident #48, LPN #3, ADON, and LPN #4. The statements contained the following information: a. Resident #48's statement, undated, documented they were happy with the care LPN #3 provided them. It documented Resident #48 did not have any issues with LPN #3 and was happy with the care they received. b. Resident #14's interview contained the above information on the final report. c. LPN #3's statement, dated 08/05/24, documented Resident #14 had flipped them off and said (explicit word); d. ADON's statement, dated 08/06/24, documented they were informed on 08/04/24 of the misplaced keys to the wound care cart. It documented the ADON arrived at the facility at 12:00 p.m. and provided the keys to the nurse. It did not document any information regarding the allegation of abuse. e. LPN #4's statement, dated 08/05/24, documented the hospice nurse had reported to them that Resident #14 told them they were flipped off over the weekend, and LPN #4 reported the situation to the Administrator and the ADON. It did not document any other staff members or residents were interviewed regarding the abuse allegation involving LPN #3 and Resident #14. A Follow Up State Reportable Incident form, faxed 08/07/24, documented the following additional information: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. on 08/06/24 at approximately 2:00 p.m., the Ombudsman came to the facility and interviewed Resident #14. It documented the resident told the Ombudsman LPN #3 flipped them off and said (explicit word) to the resident. It documented the resident did not want LPN #3 fired. It documented the Ombudsman and the Administrator went to interview Resident #14 who again reported LPN #3 had flipped them off and said (explicit word) to the resident. It documented the resident did not want the nurse fired and the nurse would remain on suspension with possible termination; b. on 08/07/24 at 11:12 a.m. the Administrator spoke to the Ombudsman who talked with their supervisor and they agreed the facility could bring LPN #3 back because the resident was oriented and the resident did not want the nurse fired; c. on 08/07/24 at 11:45 a.m., the Administrator asked Resident #14 if LPN #3 returned to the facility, would the resident be comfortable with LPN #3 providing wound treatment to the resident. It documented the resident stated yes; and d. 08/07/24 would be LPN #3's third day of suspension. It documented the nurse would return to their regular schedule on 08/10/24. There was no documentation the facility conducted any additional interviews with staff or other residents LPN #3 cared for after they received the follow up information where Resident #14 reported it was LPN #3 who flipped them off and cursed at them. There was no documentation LPN #3 had been reported to the Oklahoma State Board of Nursing for this abuse allegation. There was no documentation any additional interviews were held with LPN #3 regarding the incident prior to them returning to work. On 08/12/24 at 8:43 a.m., Entrance Conference was held with the Administrator was asked to provide a copy of the facility's Abuse Prohibition Policy and Procedures. The Abuse Policy revised 03/24/22 was provided to the survey team. On 08/12/24 at 10:21 a.m., Resident #14 stated their abuse concern was over kinda. They stated there was a nurse at the facility that told them (explicit word) last week. They stated it was LPN #3. They stated the facility spoke with the nurse and were going to fire them. Resident #14 stated they didn't want the employee to lose their job. They stated LPN #3 hadn't been in their room since the incident, but they still saw them in the facility. They stated staff had come in and spoke to Resident #14 about the incident, reprimanded LPN #3, and they believed it went down in their record. They stated they didn't think anyone else was around when LPN #3 did it. On 08/14/24 at 9:59 a.m., CMA #2 stated they would report any allegation of abuse to the DON. On 08/14/24 at 10:06 a.m., CNA #6 stated the facility did not tolerate any yelling, screaming, or getting loud. They stated they were to stay calm and collected and approach each resident nicely. They stated they were to report any allegation of abuse to their charge nurse, their supervisor, or anyone above them. On 08/14/24 at 10:10 a.m., the DON stated staff were to notify the charge nurse, if unavailable notify their supervisor, if unavailable the DON, ADON, or Administrator with any allegation of abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/14/24 at 10:13 a.m., the Administrator stated the facility didn't allow any abuse or mistreatment. They stated any allegation of abuse was to be reported immediately and the facility would report it within the two hour maximum window as required. On 08/14/24 at 10:15 a.m., the Administrator and the DON stated they shared the responsibility of investigating allegations of abuse. The DON stated if a nurse reported abuse, they would go investigate by interviewing other residents, the aides on the hall, medication aides, the roommate if applicable, and anyone in the vicinity of the incident. They stated they could also review camera footage. On 08/14/24 at 10:17 a.m., the DON stated if a staff member was involved, it would be the same process and they would usually suspend the staff member during the investigation. On 08/14/24 at 10:18 a.m. the DON stated they would report the staff member to the licensing board while completing the State Reportable. The Administrator stated as they were completing the State Reportable, they would report the staff member. On 08/14/24 at 10:18 a.m., the DON stated once they had completed the investigation and determine whether the event did or did not occur and see what the police said to determine if it was safe for a staff member to return to work. On 08/14/24 at 10:19 a.m., the Administrator stated on the abuse investigation involving Resident #14, a hospice staff member had reported the incident to the facility. They stated the resident had reported to hospice a staff member said (explicit word) and flipped them off. They stated it was reported to the charge nurse who reported it to the ADON and Administrator immediately on 08/05/24. On 08/14/24 at 10:24 a.m., the DON stated the allegation was against LPN #3, they were suspended three days and then returned to work after the Administrator spoke to the Ombudsman who told them what to do. On 08/14/24 10:25 a.m., the Administrator stated they did not notify the licensing board of the allegation of abuse involving LPN #3. On 08/14/24 at 10:26 a.m., the Administrator stated they along with the ADON interviewed the resident, the nurse, and then interviewed another resident that the nurse provided care to. The DON stated they did not see any other resident interviews in there. On 08/14/24, at 10:31 a.m., the Administrator stated they did not think any other staff were interviewed. On 08/14/24 at 10:32 a.m. the Administrator and DON stated they believed another resident who had wounds was interviewed but they could not find it in the investigation. On 08/14/24 at 10:34 a.m. the Administrator stated they completed a follow up report because the Ombudsman came to the facility and spoke with Resident #14. They stated the resident reported staff had flipped them off and said (explicit). The Administrator stated at that point, they along with the Ombudsman went to speak to the resident who reported that the nurse said it to [them]. They stated the resident did not want the staff member fired. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/14/24 at 10:37 a.m., the Administrator stated they had spoken with the Ombudsman who stated it was safe to bring the staff member back after their suspension. They stated the Ombudsman reported the resident was oriented, they were there for the residents, and that was what the resident wanted. On 08/14/24 at 10:39 a.m., the DON reported LPN #3 was educated by the DON, ADON and Administrator to take a staff member in with them anytime they were providing care to Resident #14. They stated it was verbal and there was no documentation of the conversation. On 08/14/24 at 1:42 p.m., the Administrator provided a new abuse policy revised 07/01/24.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 35389 Based on record review and interview, the facility failed to ensure Resident Assessments were accurately coded for two (#58 and #85) of 21 residents reviewed for assessments. The Administrator identified 83 residents resided in the facility. Findings: 1. Resident #58 had diagnoses which included dysphagia following cerebral infarction. A Physician Order, dated 07/17/23, documented admit to hospice for CVA. An Annual Resident Assessment, dated 07/18/24, did not document hospice care was received while the resident was at the facility. On 08/15/24 at 2:16 p.m., MDS Coordinator #1 stated they started with evaluating the resident's cognition, went through the resident's chart, pain, completed all of their interview questions, and reviewed progress notes and assessments to ensure Resident Assessments were accurately coded. On 08/15/24 at 2:17 p.m., MDS Coordinator #1 stated the life expectancy less than six months section and hospice should be checked yes when a resident received hospice care. They stated Resident #58 was receiving hospice care. On 08/15/24 at 2:19 p.m., MDS Coordinator #1 stated the annual resident assessment for Resident #58 did have life expectancy less than six months marked but did not have hospice marked. 2. Resident #85 had diagnoses which included displaced intertrochanteric fracture of the left femur. A Nurses' Note, dated 06/22/24, documented Resident #85 discharged from the facility to home accompanied by family. A Discharge Resident Assessment, dated 06/22/24, documented Resident #85's discharge status was a short-term general hospital. On 08/16/24 at 9:34 a.m., MDS Coordinator #2 stated Resident #85's skilled days were up and the resident discharged home with family. On 08/16/24 at 9:36 a.m., MDS Coordinator #2 reviewed Resident #85's discharge assessment and stated I put hospital.

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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. 46216 Based on interview and record review, the facility failed to revise care plans for two (#18 and #51) of 21 residents reviewed for care plans. The Administrator identified 83 residents resided in the facility. Findings: A Care Plan Revisions Upon Status Change policy, revised 07/02/24, read in part, The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change .The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change .The care plan will be updated with the new or modified interventions . Resident #18 had diagnosis which included unspecified dementia. Resident #18's quarterly assessment dated , 04/20/24, documented Resident #18's cognition was severely impaired. A Behavior Note, dated 09/20/19 at 5:24 p.m., documented, Another resident informed this nurse that resident was in hallway touching penis. List Interventions Attempted: Educated [Resident #18] that resident will need to go inside room in private to do so. A Behavior Note, dated 10/18/19 at 4:49 p.m., documented, ACMA was giving resident eternal feedings when resident got penis out of pants and started touching [themselves]. ACMA asked resident respectfully to wait until after feeding was administered. List Interventions Attempted: ACMA asked resident respectfully to wait until after feeding was administered. This nurse spoke [with] resident and asked if it could wait until after feeding due to being unable to stop feeding. A Behavior Note, dated 10/22/23 at 8:56 p.m., documented, [Resident #18] had penis out during 2030 [8:30 p.m.] smoke break. List Interventions Attempted: CNA [name withheld] firmly told [Resident #18] to put [Resident #18] penis away. A Behavior Note, dated 10/23/23 at 1:01 p.m., documented, During 11 a.m. smoke break resident exposed penis. List Interventions Attempted: CNA/Activities assist [name withheld] instructed resident to put it away now. A Behavior Note, dated 04/21/24 at 10:02 a.m., documented CMA had was finishing feeding [Resident 18] when [Resident 18] ran [Resident 18's] hand up [CMA's] leg and tried to touch [CMAs] private area. List Interventions Attempted: CMA firmly told [Resident #18] to keep [Resident 18's] hands to [themselves]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Behavior Note, dated 06/21/24 at 7:25 p.m.,, documented, This nurse was coming out of a resident room and [Resident #18] sitting in WC in front of [Resident #51] rubbing on her vagina. This nurse told residents that they can not do that in the hallway and they stopped. This nurse was sitting a [sic] nurses station and seen [Resident #18] and [Resident #51] kissing. This nurse went to talk to residents; [Resident #18] had partial of [their] penis out and Resident #51 was leaning forward trying to pull pants down. This nurse told resident they can not do that in the hallway and [Resident 51] voiced understand and got up and sat in front of nurses station. On 08/15/24 at 5:36 p.m., Resident #18's care plan was reviewed, there was no documentation of sexual behaviors in the care plan. On 08/19/24 at 2:15 p.m., the DON stated the care plan had last been updated on 08/06/24. 21731 3. Resident #51 had diagnosis to include Alzheimer's Disease and malignant neoplasm of bronchus and lung. A Progress Note, dated 09/19/23 at 1:17, read in part, .[resident] yelling and swatting at other resident during activities . The clinical record did not contain an a care plan to address Resident #51's behaviors. A Progress Note, dated 04/04/24 at 6:03 p.m., read in part, .Resident wanted to sit in chair in front of nurse station. Another resident was sitting in the chair Resident {#51] attempted to pull other resident out of chair while insulting [them] . The clinical record did not contain a care plan to address Resident #51's behaviors. A Quarterly Assessment, dated 06/14/24, documented Resident #51 had clear speech, understands, is understood, has severe cognitive impairment for daily decision making, displayed inattention and disorganized thinking, and required supervision and cues to perform ADLs. A Care Plan, last reviewed on 07/05/24, did not address resident specific behaviors or interventions for behaviors. A Progress Note, dated 06/21/24 at 7:16 p.m., read in part, .This nurse was coming out of a resident room and seen [Resident #51] sitting in a chair .with legs opened and [Resident #18] was sitting in front of [Resident #51], rubbing on [Resident #51's] vagina. This nurse told residents that the [sic] can not do that and they stopped. This nurse was sitting a nurses station and seen [Resident #51 and [Resident #18] kissing this nurse went to talk to resident and [Resident #51] was leaning forward trying to pull pants down while [Resident #18] had partial of [their] penis out. This nurse told resident they can not do that in the hallway. Resident got up and sat in front of nurses station .interventions Attempted: told resident they were not allowed to do that in hallway . The clinical record did not contain a care plan to address Resident #51's behaviors (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/13/24 at 11:46 a.m., during the noon meal, Resident #51 was seated a a dining table in the main dining room. Resident #72, entered the area from a side door and approached the table where Resident #51 was seated. Resident #51 began to swing their arms, and hit Resident #72. CNA #1 calmly separated the residents and assisted Resident #51 to another table for the noon meal. On 08/15/24 at 4:24 p.m., the DON was asked if Resident #51's care plan addressed behaviors that were displayed by Resident #51. They stated, No.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 46216 Based on observation, record review, and interview, the facility failed to ensure RN coverage for eight consecutive hours seven days per week. The Administrator identified 83 residents resided in the facility. Findings: On 08/14/24 at 10:58 a.m., Human Resource #1, provided the requested RN hours for May, June, and July. Review of the RN time punch details documented, the facility did not have RN coverage for eight consecutive hours on the following dates: a. 05/04/24 - 7.68 hours worked, b. 05/05/24 - 7.72 hours worked, c. 05/12/24 - 7.47 hours worked, d. 05/18/24 - 7.45 hours worked, e. 05/19/24 - 7.43 hours worked, f. 05/27/24 - 7.80 hours worked, g. 06/08/24 - 7.60 hours worked, h. 06/23/24 - 7.67 hours worked, i. 07/05/24 - 4.93 hours worked, j. 07/06/24 - 7.60 hours worked, k. 07/07/24 - 7.53 hours worked, l. 07/13/24 - 7.45 hours worked and, m. 07/26/24 - 7.47 hours worked. On 08/15/24 at 11:37 a.m., Human Resource #1 stated if the facility did not have RN coverage, the DON or ADON would need to come in to cover. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/15/24 at 11:48 a.m., Human Resource #1 stated the dates listed above did not meet the 8 consecutive RN hours required.

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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. 21731 Based on observation, record review, and interview, the facility failed to follow their policy to administer medications via enteral tube for one (#13) of one sampled resident reviewed for medication administration via gastrostomy tube. The Administrator stated 83 residents resided in the facility. The Resident Matrix, dated 08/12/24, documented four residents with a gastric tube resided in the facility. Findings: A Medication Administration via Enteral Tube policy, dated 07/02/24, documented, .flush enteral tube with water per orders prior to administering medications .dilute the solid or liquid medication as appropriate and administer using a clean oral syringe .Flush tube again with water per orders taking into account resident's volume status .repeat with the next medication .flush the tube with a final flush of water . Physician Orders for Resident #13 included: a. On 07/06/23, may crush medications; b. On 08/08/23, clopidogrel bisulfate 75 mg by mouth every day for hypertension; lactulose 10 gm/15 ml give 30 ml by mouth daily; Mylanta maximum strength oral suspension 400-400-40 mg/5 ml give 15 ml by mouth two times a day; c. On 08/14/23, trospium chloride ER 60 mg by mouth every day; d. On 12/05/23, CoQ-10 100 mg by mouth one time a day; docusate 100 mg by mouth every day; e. On 12/18/23, famotidine 40 mg by mouth twice a day; f. On 09/01/23, furosemide 40 mg by mouth every day; g. On 01/25/24, glycolax powder, give 17 gram in orange juice, by mouth every day; h. On 05/02/24, hydroxyzine 50 mg by mouth two times a day; i. On 05/20/24, lorazepam 0.5 mg by mouth two times a day; and j. On 06/12/24, Jevity 1.5 Cal/Fiber one can via gastrostomy tube four times a day, flush with 60 cc of water before and after. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/14/24, at 9:00 a.m., CMA #1 was observed to prepare the above orders to be administered to Resident #13. CMA #1 placed the tablets into a medication cup, poured the tablets into a pouch and crushed the medications to a fine powdery substance, and placed the contents into a plastic water cup. No liquids were added into the cup of crushed medications. The lactulose was poured into a medication cup for administration. CMA cleansed their hands, donned gloves and a gown, entered the resident room, and arranged the cups on the bedside table. CMA #1 obtained an eight ounce container of tap water. CMA #1, checked the residual of contents of the gastrostomy tube, removed the plunger from the syringe, placed the syringe into the gastrostomy tube, poured approximately 60 cc of water into the syringe, added water to parts of the Jevity, poured a small amount of the mixture into the syringe and gastrostomy tube, followed by an undetermined amount of dry fine powder substance of the crushed medications, added water, dry crushed medications, Jevity, and repeated the process until the medications and Jevity was been administered through the gastrostomy tube. The tube was then flushed with approximately 60 cc of water. On 08/14/24, at 1:28 p.m., CMA #1 was asked if there was a reason the medications had not been diluted in liquids prior to placing the dry crushed medications in the syringe attached to the gastrostomy tube. CMA #1 stated, I forgot to bring a spoon, CMA #1 stated they were aware the medications could be cocktailed and diluted with water.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 21731 Based on observation, record review, and interview, the facility failed to ensure the medication error rate was less than 5%. A total of 37 medications opportunities were observed, with three errors, for a total error rate of 8.11%. This affected two (#13 and #43) of six residents observed during the medication administration. The Administrator stated 83 residents resided in the facility. Findings: 1. A Physician Order, dated 03/09/24, documented Resident #43 was to be administered a chewable aspirin one time a day for atherosclerotic heart disease. On 08/14/24 at 8:50 a.m., CMA #1 prepared and administered oral medications for Resident #43, to include a chewable aspirin as ordered. CMA placed the chewable aspirin in the same medication cup with other medications for a total of 10 medications. CMA #1 did not provide instruction to Resident #43 regarding the chewable aspirin to be chewed and not swallowed. 2. Physician Orders for Resident #13 included: a. On 07/06/23, may crush medications; b. On 08/08/23, administer Mylanta Maximum Strength oral suspension by mouth two times a day for pneumonitis; and c. On 08/29/23, administer Potassium Chloride ER tablet by mouth one time a day for extremity edema. On 08/14/24 at 9:00 a.m., CMA #1 asked Resident #13 if they preferred their medications to be given by mouth or via gastrostomy tube. Resident #13 requested all medications to be via gastrostomy tube. CMA #1 prepared the medications for Resident #13, and removed the Potassium Chloride ER from the medication cup. CMA #1 stated they needed to obtain Mylanta from the medication room. The CMA went to the medication room in search of the medication, stated the medication must not have been delivered, there was no Mylanta to be offered or administered to Resident #13. On 08/14/24 at 1:28 p.m., CMA #1 was asked why Resident #43 was administered a chewable aspirin and not instructed to chew the tablet as ordered. They stated the resident has always just swallowed it. CMA #1 was asked why resident #1 did not receive the Potassium Chloride as ordered. CMA #1 stated, the medication is coated and cannot be crushed. They were asked if there was an order to hold the medication or to provide a liquid potassium if given through the gastrostomy tube. CMA #1 stated there were no further orders to hold or different form of the medication. Three medication error occurred out of 37 opportunities, which resulted in an error rate of 8.11%.

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F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided. 35389 Based on record review and interview, the facility failed to ensure physician ordered labs were obtained for one (#14) of 12 sampled residents reviewed for lab services. The Administrator identified 83 residents resided in the facility. Findings: A Laboratory Services policy, reviewed 07/02/24, read in part, .The facility must provide or obtain laboratory services when ordered .The facility is responsible for the timeliness of the services. Resident #14 had diagnoses which included stage four pressure wound of the left heel. Wound Evaluation and Management Summary notes, dated 05/15/24, documented HBA1C recommended. The note was signed by the Wound Care Physician. Wound Evaluation and Management Summary notes, dated 05/22, 05/29, 06/05, 06/12, 06/19, 06/28, 07/17, 07/24, 07/31, 08/07, and 08/14/24 documented the HBA1C was pending. The notes were signed by the Wound Care Physician. There was no documentation the HBA1C was ever obtained. On 08/15/24 at 8:40 a.m., the ADON was asked to clarify the recommendation of a HBA1C on Resident #14's wound care notes. On 08/15/14 at 9:32 a.m., the Administrator stated the Wound Care Physician had put the HBA1C under recommendations not orders so the wound care nurse did not see it. They stated they ordered it today. They stated the facility went ahead and did a QA on the HBA1C that started in May and continued on the wound care notes but was never drawn.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35389 Based on observation, record review, and interview, the facility failed to: 1. ensure bare hand contact with food did not occur during the lunch meal service. 2. monitor the dish washing machine to ensure proper sanitation was being conducted. Findings: A Food Service policy, undated, read in part, .All staff in the dining room will wash/sanitize hands with any resident contact, touching other surface or contact with your own person before serving a resident meal tray . 1. Resident #75 had diagnoses which included unspecified dementia and mild neurocognitive disorder. A Quarterly Resident Assessment, dated 07/27/24, documented Resident #75 had severe cognitive impairment and required supervision or touching assistance for the task of eating. On 08/13/24 at 12:19 p.m., CNA #1 picked up Resident #75's slice of bread with their bare hands and asked the resident if they wanted a bite. On 08/13/24 at 12:30 p.m., CNA #1 picked up Resident #75's slice of bread with their bare hands and tried to feed it to them. The resident took the piece of bread from CNA #1 and started feeding themselves. On 08/13/24 at 12:49 p.m., CNA #1 stated they would have to ask another staff member the policy for bare hand contact with food. They stated they would make sure they washed and sanitized their hands. On 08/14/24 at 10:08 a.m., the DON stated staff just had to sanitize their hands before touching food with their bare hands. They stated staff were allowed to touch food with their bare hands to butter toast or something like that. 46216 2. On 08/13/24 at 11:20 a.m., dietary aide #1 obtained a chlorine test strip and placed it in the outer basin of the dish machine to moisten the strip. The strip turned a light lavender in color. On 08/13/24 at 11:24 a.m., dietary aide #1 stated it read 10 ppm. They stated it should read between 50-100 ppm. On 08/13/24 at 11:29 a.m., the dietary manager obtained a chlorine test strip and placed it in the outer basin of the dish machine to moisten the strip. The strip again turned a light lavender in color. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The dietary manager stated it should read 120 ppm. On 08/13/24 at 11:34 a.m., the dietary manager stated they had called maintenance and they would be on there way. On 08/13/24 at 11:35 a.m., the dietary manager stated they would use paper serving containers and plastic utensils for lunch service as the dishes were not sanitized properly.

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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. 35389 Based on observation, record review, and interview, the facility failed to: a. handle soiled linens in a manner that prevented cross contamination for one (#14) of one sampled resident observed during wound care; and b. ensure enhanced barrier precautions were utilized when accessing a resident's gastric tube for one (#13) of one sampled resident observed with a gastric tube. The Administrator identified 83 residents resided in the facility. The Resident Matrix, dated 08/12/24, documented four residents with a gastric tube resided in the facility. Findings: A Laundry Services policy, undated, read in part, .All soiled linen should be bagged or put into carts at the location where used .If laundry barrels are used, all linens should be bagged . An Enhanced Barrier Precautions policy, dated 07/24/24, read in part, .Enhanced barrier precautions .(EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities .enhanced barrier precautions .for residents with .feeding tubes .necessary when performing high-contact care activities . donned prior to entering the resident's room activities include .feeding tubes .Additional epidemiologically important MDROs may include .ESBL -producing Enterobacterales . 1. Resident #14 had diagnoses which included cognitive communication deficit, anxiety, and persistent mood disorder. A Quarterly Resident Assessment, dated 05/30/24, documented Resident #14 was cognitively intact, dependent on staff for the task of toileting, and always incontinent of bowel and bladder. On 08/12/24 at 9:56 a.m., CNA #7 provided incontinent care to Resident #14. CNA #7 turned Resident #14 on their right side and large soft brown stool was observed on their buttock and up their back. The resident stated Can you believe it went all the way up my back? On 08/12/24 at 10:00 a.m., CNA #7 stated, That's what you have me for, to help you. Stool was observed on the sling that was located under the resident and on the bottom of their shirt. On 08/12/24 at 10:03 a.m., CNA #7 stated, We will get you a new shirt ok. The CNA removed the resident's soiled shirt and sling, and tossed them on the ground by the foot of the bed. Both items had brown stool on them. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/12/24 at 10:07 a.m., CNA #7 removed the sling and black shirt from off the ground, and placed the items on the lid of a yellow soiled linen barrel located outside in the hallway. CNA #7 lifted the items off the lid, lifted the lid, and placed the soiled shirt and sling in the yellow barrel. The CNA failed to place the soiled items in a bag prior to transporting them out of the resident's room. On 08/12/24 at 10:08 a.m., CNA #7 stated if items got wet, they would place them in the yellow barrel. They stated if it had diarrhea on it, they would blow it out. They stated the only diarrhea today was on the resident's brief. On 08/14/24 at 10:10 a.m., the DON stated staff should hold soiled items away from the body and of course wear gloves. 21731 2. Resident #13 had diagnoses to include diffuse large B-cell lymphoma, metastatic cancer, ESBL resistance, gastrostomy status, and chronic kidney disease -Stage 4. Physician Orders, dated 06/27/24 documented Resident #13 was to be admitted to hospice services, medications and nutrition could be administered by mouth or gastrostomy tube. On 08/14/24 at 9:00 a.m., CMA #1 was observed to don gloves and gown, enter Resident #13's room with prepared medications, administer medications and a nutritional supplement, remove the gloves and gown, and begin to clean the work area. Resident #13 stated, they did not believe all of the contents placed in the gastrostomy tube had gone in. CMA #1, washed their hands, donned gloves, and opened the cap of the gastrostomy tube. The CMA was asked if there was a reason they did not don a gown when they returned to check the gastrostomy tube. The CMA stated there was not a gold star on the Resident's door to indicate the need for a gown, as they pointed to a green star on the door. The CMA was asked what was the meaning of the green star. They stated, I don't know. On 08/14/24 at 1:34 p.m., LPN #1 was asked how the medication aides were to know what type of PPE was to be worn while administering medications for a resident with a gastrostomy tube. LPN #1 stated, I don't know. The LPN was asked what was the meaning of the green star on the doors. They stated, I would have to ask. On 08/14/24 at 1:39 p.m., LPN #2, having overheard the conversation with LPN #1, stated the green star is to identify EBP and the medication aides are to wear gloves and a gown prior to providing any care to the resident. LPN #2 stated if there had been a gold star, the staff are to don gloves and gowns prior to entering the resident room. The medication aide should have donned gloves and a gown when they check the gastrostomy tube each time the care was provided to Resident #13.