STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375502	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	3804 North Barr Oklahoma City, OK 73122

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 46216 Based on record review and interview, the facility failed to provide a SNF ABN to one of three residents reviewed for beneficiary notification. LPN #3 identified 51 residents resided in the facility. Findings: The Regional MDS Specialist identified 12 residents who had been discharged from a Medicare Part A covered stay with benefit days remaining in the past 6 months. Resident #206 admitted to Part A skilled services on 11/16/23 and discharged from Part A services on 12/05/24. There was no documentation a SNF ABN was provided to resident #25. On 05/20/24 at 2:23 p.m., the Regional MDS Specialist stated they had completed the SNF benefit review and Resident #206 did not have a notice issued. They stated there should have been a notice issued for Resident #206.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20960 Based on observation and interview, the facility failed to ensure room [ROOM NUMBER] was free of odors for one (#29) of 30 rooms observed for odors. The facility operations manager identified 30 rooms in the facility that were occupied by residents. Findings: On 05/19/24 from 8:30 a.m., through 1:15 p.m., there was a strong odor of urine coming from room [ROOM NUMBER]. When the rooms door was open it could be detected down the hall approximately six feet from the room. On 05/20/24, 05/21/24, 05/22/24 and 05/23/24, the same observations were made of the room. On 05/23/24 at 1:10 p.m., Housekeeper #1 stated room [ROOM NUMBER] has had a strong urine odor since they stated work at the facility the first of March, 2024. They stated the room is cleaned twice a day and the tile has been replaced and they still can not keep up with the urine odor in the room. On 05/23/24 at 1:18 p.m., the Housekeeping Supervisor stated they made rounds twice a day to ensure rooms were being cleaned. The supervisor stated they clean room [ROOM NUMBER] twice a day and smell of urine still remained. They stated they used chemicals in the room while cleaning to eliminated odors, changed the bathroom tile and the odors continued to strong. The housekeeping supervisor stated the issues had been going on for several months. On 05/23/24 at 1:47 p.m., the operations manger stated she was aware of the urine odor in the room and it had been an on going issues before they were at the facility.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20960 Based on record review and interview, the facility failed to ensure the cognitive pattern, section (C), of the minimum data set was coded for one (#42) of 13 sampled residents whose MDS were reviewed. LPN #3 identified 51 residents currently resided in the facility. Findings: Resident # 42 had diagnosis to include schizophrenia, angina, cerebral infarction, restlessness and agitation, hypertension, acute kidney disease, psychosis and diabetes mellitus. A quarterly assessment dated [DATE], under section C cognitive patterns had dashes located in every box. There were no documented answerers to any of the questions located in section C of the assessment. On 05/22/24 at 1:02 p.m., [NAME] Nurse Consultant #2, the intern DON, stated sections C should have been completed and the Regional MDS coordinator would be able to tell why it was not. He stated without it being filled out it was not accurate. On 05/23/2024 at 10:09 a.m., The Regional MDS coordinator stated section C had dashes which indicated the section was not coded and Resident #42 was not assessed for cognition. They then stated the assessment is not accurate when sections were left blank and not filled out.

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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. 20960 Based on record reciew and interview, the facility failed to ensure care plans were reviewed every three months for three (#12, #42, and #48) of 13 resident care plans reviewed. LPN #3 identified 51 residents resided in the home. Findings: 1. Resident #12 had diagnosis to include unspecified skin condition, peripheral vascular disease, and non-pressure ulcers. Resident #12 care plan was last reviewed on 03/11/23. 2. Resident # 42 had diagnosis to include schizophrenia, angina, cerebral infarction, restlessness and agitation, hypertension, acute kidney disease, psychosis and diabetes mellitus. Resident #42 care plan was last reviewed on 05/04/2023. 3. Resident #48 had diagnosis that included Schizophrenia, Diabetes Mellitus, unspecified psychosis, abnormal coagulation, and acute kidney failure. Resident #48 care plan was last reviewed on 08/14/23. On 05/23/24 at 11:06 a.m., the Regional MDS Coordinator was asked how often care plans were to be reviewed. They stated quarterly, every three months and a comprehensive care plan annually. The Regional MDS Coordinator reviewed the care plans for Resident #12, Resident #42 and Resident #48, and stated we have been doing the best we can and have been trying to fill this position. They then stated they had been doing the care plans for over a year because the facility did not have a full time care plan coordinator. When asked how many were not current or up dated, they stated just about all of them.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 20960 Based on record review and interview the facility failed to ensure discharge planning was completed prior to discharge for one (#55) of one sampled resident discharged from the facility into the community. The Regional Nurse Consultant #1, identified four residents who discharged into the community in the last six months. Findings: A communication progress note, dated 03/20/24 at 9:45 a.m., documented Resident #55 wanted to discharge from the facility at the end of the month into the community with a friend. There was no documentation in the clinical record the facility made arrangements for medical services, pharmacy services and or any other follow up appointments. An activity progress note, dated 03/27/24 at 12:23 p.m., documented Resident #55 was looking forward to their discharge from the facility. A nurse's progress note, dated 04/01/24 at 1:49 p.m., documented the resident discharged from the facility in the morning with all belongings and medications. A social service progress note, dated 04/01/24 at 2:09 p.m., documented the facility had filled a report with adult protective services and the local police department about the discharge into the community. A social service progress note, dated 04/01/24 at 2:31 p.m., an email was sent to the power of attorney with the residents medication list and that all medication scripts were transferred to a local pharmacy. The note further documented the power of attorney received the list of medications. A discharge summary, dated 04/08/24 at 10:08 a.m., documented Resident #55 was discharged from the facility on 04/01/24. There were notes on the discharge summary that read in part, .filed APS report post discharge, referral #37898 .also spoke with .PD department to notify them of the APS report filed and address of discharge. SSD to assist APS as needed. SSD attempted to contact family, no contact was made at this time. MD notified . There was no documentation the facility had planned for necessary services, equipment and other services until after Resident #55 had been discharged into the community on the morning of 04/01/24. On 05/21/24 at 7:41 a.m., the business office manager stated Resident #55 discharged into the community on April 1, 2024. The business office manager stated the social service director was responsible for the discharge planning and arranging everything for the resident. The business office manager stated they would look for any documentation the facility had completed the discharge planning prior to Resident #55 leaving the facility. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/24 at 8:10 a.m., the corporate human resource specialist stated Resident #55 had discharged into the community and they called adult protective services and the police after he was discharged because they did not know if the home was safe for Resident #55. The corporate human resource specialist then stated they would look for any documentation of discharge planning prior to leaving the facility on 04/01/24. On 05/21/24 at 11:4 a.m., the corporate human resource specialist stated there was nothing documented that services were set up such as pharmacy prior to Resident #55 leaving the facility. They then stated the facilty sent medications with the resident and transferred all scripts after they left. They also stated services were not se up prior to leaving and they were trying to complete everything that should have been completed before the discharge.

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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. 20960 Based on observation, record review, and interview, the facility failed to: a. ensure a trauma wound to the left second toe was changed as needed when viably soiled and not intact for one (#12) of one sampled resident reviewed for trauma injury to the feet.; and b. accurately document behaviors to support the administration of as needed antianxiety medication for one (#29) of one sampled resident receiving as needed antianxiety medication. LPN #3 identified 51 residents resided in the facility. Findings: An Administering Medications policy, revised April 2019, read in parts, As required or indicated for a medication, the individual administering the medication records in the resident's medical record .any complaints or symptoms for which the drug was administered .any results achieved and when those results were observed . 1. Resident #12 had diagnosis to include unspecified skin condition, peripheral vascular disease, and non-pressure ulcers. The current physician orders for Resident #12 documented the following treatment order: cleanse left second toe area with non-saline, apply Medihoney and SilverAlg, cover with an ABD wrap with Kerlix every day shift on Monday, Wednesday, and Friday. A second order for Resident #12, read in part, .Observe dressing, if soiled or dislodged - Cleanse left second Toe with NS and pat dry, apply Medihoney and SilverAlg, cover with ABD (absorbent dressing) and wrap with Kerlix every shift . On 05/19/24 at 8:15 a.m., Resident #12 was observed up in his wheelchair in the hallway near the dining room. The resident did not have a show on the left foot. The resident had a soiled dressing wrapped around the ankle. The second toe had an absorbent dressing without any Kerlix over it. There was visible dried blood and drainage soaked through the absorbent pad. On 05/19/24 at 10:06 a.m., Resident #12 was observed in his room with his left shoe off. The The resident had a soiled dressing wrapped around the ankle. The second toe continued to have an absorbent dressing without any Kerlix over it. with visible dried blood and drainage soaked through the pad. On 05/19/24 at 10:15 a.m., two aides were observed transferring Resident #12 to bed and no one alerted a nurse to the condition of the dressing. On 05/19/24 at 11:25 a.m., Resident #12 was observed being transferred to the wheelchair and the dining room. Resident #12 continued to have no left shoe on and the dressing had not been changed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/19/24 at 12:30 p.m., Resident #12 was again observed up in the dining room without the dressing being changed. On 05/19/24 at 1:30 p.m., Resdient #12 was observed up in his wheelchair with no changes to the left toe dressing. On 05/19/24 at 1:55 p.m., Resident #12 was observed in his wheelchair in his room. The left toe continued to have viable dried blood and drainage soaked through the pad without any Kerlix. On 05/19/24 at 2:30 p.m., LPN #4 was observed leaving the resident room. The resident was observed in bed with a new dressing on dated 05/19/24. The resident was observed for over six hours without the soiled dressing being changed. On 05/19/24 at 3:12 p.m., LPN #4 stated they had noticed while cleaning a urine mess under a dining room table that Resident #12 dressing was saturated and needed to be changed. The LPN stated the dressing was changed after 2:00 p.m., because they were not able to get to it sooner. LPN #4 than stated the dressing should have been changed earlier in the day but they did not know about it. 45462 2. Resident #29 had a physician's order, dated 05/17/24, to receive Vistaril Oral Capsule 25mg one capsule by mouth every eight hours as needed for anxiety for 14 Days. April 2024 MAR documented Resident #29 received PRN doses of Vistaril on 04/05/24 at 9:41 a.m. and 4:55 p.m.; 04/15/24 at 12:25 p.m.; 04/22/24 at 11:42 a.m.; and 04/25/24 at 11:02 a.m. April 2024 MAR documented Resident #29 had no behaviors warranting the administration of PRN Vistaril on any shift for the dates listed above. Progress Notes dated 04/01/24 through 05/22/24 documented no occurrences of behaviors on any shift warranting the administration of PRN Vistaril. On 05/22/24, at 10:55 a.m., PA, the assistant to Resident #29's Psych MD, was asked what the conditions should be for administering Resident #29's PRN Vistaril. They stated, It should be given for an episode of anxiety after attempts to redirect or calm resident have been unsuccessful. Episodes, measures attempted, and effectiveness should be documented to help us determine if the medication should be continued, adjusted, or stopped. On 05/22/24, at 10:57 a.m., Regional Nurse Consult. #1 stated a PRN anxiety medication would only be given after the resident was assessed by a nurse and acknowledged that behaviors warranting administration of the medication should have been documented on the MAR and in the progress notes. On 05/22/24, at 11:36 a.m., LPN #1 reported PRN anxiety medications would only be given by the CMA after the resident was examined by the nurse and that documentation would include why they needed the medication and what else was done to help them.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 20960 Based on observation, record review, and interview, the facility failed to ensure: a. falls were evaluated for cause and interventions implemented to prevent falls with injuries for one (#48) of three sampled residents reviewed for accident hazards and falls. Resident #48 had a fall with a major injury in December 2023 which resulted in staples to the head. The facility did not assess the fall and implement changes in interventions to aide in the prevention of falls. Resident #48 had two additional falls one in March 2024 and one in April 2024 that also resulted in injuries without any implemented changes to interventions to aide in the prevention of falls. b. care plan interventions were implemented for one (#32) of three sampled residents reviewed for accident hazards and falls. The facility Centers for Medicaid and Medicare from 802 , documented 6 residents had falls with injuries and two had falls with major injuries. Findings: 1. Resident #48 had diagnosis that included Schizophrenia, dementia, unspecified psychosis, abnormal coagulation, and acute kidney failure. Residents #48 care plan, last revised on 05/18/23, read in part, .Focus .[Resident #48] is at risk for falls r/t history of falls, poor safety awareness, impaired cognition/dementia, confusion and delusional thought processes, amnesia, impaired balance, and medication use/side effects . .goal .will be free of minor injuries related to falls through the review date . .Interventions Administer medications as ordered by MD. Monitor/document/report PRN for side effects and effectiveness of medications Anticipate and meet [Resident #48] needs .At times, [Resident #48] uses a walker to assist with walking. Remind/encourage/cue him to use his walker when ambulating to reduce risk of falling .Be sure the resident's call light is within reach and encourage the resident to use it for assistance . Check on resident every 2 hours and .PRN .Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs .Encourage the resident to participate in activities that promote exercise and physical activity for strengthening and improved mobility . Ensure the resident is wearing appropriate footwear when up and out of bed. (nonslip socks or shoes) .Fall Assessment quarterly and with each fall PRN .Falling Leaves Fall Prevention Program . Remind resident to ask for assistance with toileting, transfers and ADL's Resident needs a safe environment with even floors free from spills and/or clutter, .adequate, glare free light, a working call light, bed in lowest position, etc .The resident needs prompt response to all requests for assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Morse Fall Scale, dated 10/31/23, documented the resident was a high risk for falls with a score of 55. A score of 45 or greater indicated a high risk for falls. A progress note, dated 12/02/23 at 1:39 a.m., read in part, .This nurse heard the CNA holler out for help to get res out of another res room. As I was walking down the hall I witnessed the res fall backwards into the hall hitting his head on the floor. Res began to bleed profusely. Pressure and ice applied immediately .sent to ER .for eval and treat . A progress note, dated 12/02/23 at 2:04 p.m., read in part, .Aide took report from the wife and left a note stating, He has staples in his head and has a brain bleed . The emergency department notes, dated 12/02/24, read in part, .assessment .subdural hematoma .CT 3mm acute subdural hematoma over right posterior parietal lobe .chef complaint .fall 5cm head lac .right scalp laceration, stapled . There was no documentation the facilty evaluated the fall for cause and potential ways to prevent further falls with injuries. Resident #48 care plan was not reviewed and there were no implemented changes in fall preventions after the fall that resulted in staples to the head and a brain bleed. The last documented update to fall interventions was dated 05/18/23. A quarterly assessment, dated on 01/24/24, documented the resident had two falls one with no injury and one with a major injury. A Morse Fall Scale, dated 01/24/24, documented the resident was a high risk for falls with a score of 55. A score of 45 or greater indicated a high risk for falls. An incident report, dated 03/03/24 at 8:45 a.m., read in part, .Resident was noted sitting in room floor on his bottom with his back facing the bed .unable to give description .injury type abrasion .left hand . A Morse Fall Scale, dated 03/03/24, documented the resident was a high risk for falls with a score of 80. A score of 45 or greater indicated a high risk for falls. There was no documentation the facilty evaluated the fall for cause and potential ways to prevent further falls with injuries. Resident #48 care plan was not reviewed and there were no implemented changes in fall preventions after the fall on 03/03/24 which resulted in an abrasion to the left pinky. The last documented update to fall interventions was dated 05/18/23. An incident report, dated 04/01/24 at 6:30 p.m., read in part, . This nurse was called to resident room by another nurse, upon entering the room resident was sitting on the floor, on buttocks. Upon body assessment noted blood flowing from the crown of resident's head .unable to give description .Upon assessment of resident's room, noted water on the floor, that resident had spilled .resident's assistive device a cane, in the bathroom . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. Resident #32 had documented falls on 05/17/24 and on 05/19/24 with injury. Fall interventions on Resident #32's care plan included fall mat at bedside (dated 05/17/24) and environmental check and removal of rug (dated 05/19/24). On 05/21/24 at 9:50 a.m., Resident #32 was observed in bed asleep. Two throw rugs were observed on the floor in the path to the bathroom and no fall mat was at the bedside. On 05/21/24 at 9:58 a.m., Operations Manager was taken to Resident #32's room and was asked if fall precautions were being observed and if fall hazards had been removed from resident's room. They stated, There is so much wrong in here. [Resident #32] should have a fall mat. These rugs should not be here. On 05/21/24 at 12:20 p.m., Operations Manager acknowledged the accident hazards had not been removed from Resident 32's room and the care plan intervention had been implemented.

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	375502	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	3804 North Barr Oklahoma City, OK 73122

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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. 20960 Based on observation, record review, and interview, the facility failed to implement a weight loss intervention of shakes three times a day timely for one (#48) of one resident reviewed for weight loss. The facility Centers for Medicaid and Medicare from 802 , documented 3 residents had excessive weight loss. Findings: Resident #48 had diagnosis that included Schizophrenia, Diabetes Mellitus, unspecified psychosis, abnormal coagulation, and acute kidney failure. A care plan last updated on 05/18/23, documented the resident was at risk for weight loss and had a history of severe weight loss. A documented intervention was to have the registered dietician to evaluate and make diet change recommendations. A review of Resident #48 weight record, dated 03/29/24, documented the resident weighed 158.2 pounds. The weight record also documented the resident had a severe weight loss of 32 pounds (16.8%) in 180 days from 10/25/23 to 03/29/24; and a severe weight loss of 11 pounds (6.5%) in 30 days from 02/23/24 to 03/29/24. A consulting dietician recommendation, dated 04/01/24, documented Resident #48 had a significant weight loss in one month and recommended an increase in the house shake from twice a day to three times a day. The consulting dietician recommendation, dated 04/01/24, was not signed by the facility director of nursing and physician until 05/14/24. A review of the Medication administration record and Treatment Administration record, documented the resident did not receive the shakes three times a day until 05/14/24. On 05/23/24 at 10:01 a.m., the dietary manager reviewed the consulting dieticans recommendations dated 04/01/24 and the implementation date of the recommendation. The dietary manager stated they facility did not act upon the recommendation timely. On 05/23/24 at 10:32 a.m., Regional Nurse Consultant #2, the intern director of nursing, stated the facility did not act upon the recommendations timely.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 20960 Based on observation, record review, and interview, the facility failed to ensure there was sufficient staff and supervison for the needs of the residents. LPN #3 identified 51 residents resided in the facility. Findings: 1. Resident #48 had diagnosis that included Schizophrenia, dementia, unspecified psychosis, abnormal coagulation, and acute kidney failure. Residents #48 care plan, last revised on 05/18/23, read in part, .Focus .[Resident #48] is at risk for falls r/t history of falls, poor safety awareness, impaired cognition/dementia, confusion and delusional thought processes .Interventions .Remind/encourage/cue him to use his walker when ambulating to reduce risk of falling .Check on resident every 2 hours and .PRN . A progress note, dated 12/02/23 at 1:39 a.m., read in part, .This nurse heard the CNA holler out for help to get res out of another res room. As I was walking down the hall I witnessed the res fall backwards into the hall hitting his head on the floor. Res began to bleed profusely. Pressure and ice applied immediately .sent to ER .for eval and treat . A progress note, dated 12/02/23 at 2:04 p.m., read in part, .Aide took report from the wife and left a note stating, He has staples in his head and has a brain bleed . The emergency department notes, dated 12/02/24, read in part, .assessment .subdural hematoma .CT 3mm acute subdural hematoma over right posterior parietal lobe .chef complaint .fall 5cm head lac .right scalp laceration, stapled . An incident report, dated 03/03/24 at 8:45 a.m., read in part, .Resident was noted sitting in room floor on his bottom with his back facing the bed .unable to give description .injury type abrasion .left hand . An incident report, dated 04/01/24 at 6:30 p.m., read in part, . This nurse was called to resident room by another nurse, upon entering the room resident was sitting on the floor, on buttocks. Upon body assessment noted blood flowing from the crown of resident's head .unable to give description .Upon assessment of resident's room, noted water on the floor, that resident had spilled .resident's assistive device a cane, in the bathroom . On 05/21/24 at 6:34 a.m., LPN #5 stated Resident #48 is a high risk for falls. They stated there are two aides and herself and it is hard to supervise all the residents and provide the care that is needed. LPN #5 stated Resident #48 does not use a walker or cane to ambulate when up because they forget about it. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/21/24 at 7:12 a.m., CNA #5, stated Resident #48 does not remember to ask for asssistance and was at risk for falls. They stated their are two aides and one nurse at night at they can not get their work done and monitor residents that need close supervison. On 05/21/24 at 7:37 a.m., CNA #6 stated they do not have enough staff to provide supervison to those needing supervison and provide the care. CNA #6 stated Resident #48 was at risk for falls and did not use a walker or cane to ambulate with. 2. Resident #12 had diagnosis to include unspecified skin condition, peripheral vascular disease, and non-pressure ulcers. A physician's order for Resident #12, read in part, .Observe dressing, if soiled or dislodged - Cleanse left second Toe with NS and pat dry, apply Medihoney and SilverAlg, cover with ABD (absorbant dressing) and wrap with Kerlix every shift . On 05/19/24 at 8:15 a.m., Resident #12 was observed up in his wheelchair in the hallway near the dining room. The resident did not have a shoe on the left foot. The resident had a soiled dressing wrapped around the ankle. The second toe had an absorbent dressing without any Kerlix over it. There was visible dried blood and drainage soaked through the absorbent pad. On 05/19/24 at 10:06 a.m., Resident #12 was observed in his room with his left shoe off. The The resident had a soiled dressing wrapped around the ankle. The second toe continued to have an absorbent dressing without any Kerlix over it. with visible dried blood and drainage soaked through the pad. On 05/19/24 at 10:15 a.m., two aides were observed transferring Resident #12 to bed and no one alerted a nurse to the condition of the dressing. On 05/19/24 at 11:25 a.m., Resident #12 was observed being transferred to the wheelchair and the dining room. Resident #12 continued to have no left shoe on and the dressing had not been changed. On 05/19/24 at 12:30 p.m., Resident #12 was again observed up in the dining room without the dressing being changed. On 05/19/24 at 1:30 p.m., Resident #12 was observed up in his wheelchair with no changes to the left toe dressing. The left toe continued to have visible dried blood and drainage soaked through the pad without any Kerlix. On 05/19/24 at 1:55 p.m., Resident #12 was observed in his wheelchair in his room. The left toe continued to have visible dried blood and drainage soaked through the pad without any Kerlix. The resident was observed for over six hours without the soiled dressing being changed. On 05/19/24 at 3:12 p.m., LPN #4 stated they had noticed while cleaning a urine mess under a dining room table that Resident #12 dressing was saturated and needed to be changed. The LPN stated the dressing was changed after 2:00 p.m., because they were not able to get to it sooner. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/21/24 during the resident council interview with five alert and oriented residents, all in attendance stated there were not enough staff to take care of the residents and care is not provided timely as a result. They stated the night time was the worse.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 20960 Based on observation and interview, the facility failed to ensure staffing information was posted with the required components and was accessible to all residents. LPN #3 identified 51 residents who resided in the facility. Findings: On 05/19/24 at 8:00 a.m., there was no staff information observed posted in the facility. On 05/20/24 from 8:00 a.m. through 2:30 p.m., there was no staff information observed posted in the facility. On 05/21/24 at 6:15 a.m., there was no staff information observed posted in the facility. On 05/21/24 at 6:57 a.m., the operations manager stated the staffing should be posted on the large white dry erase board near the nurses station. The operations manager than stated after observing the blank board they did not know it was a requirement the information had to be posted. 46216

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 46216 Based on record review and interview, the facility failed to submit accurate payroll based journal staffing data to CMS for FY quarter 1 2024. LPN #3 identified 51 residents resided in the facility. Findings: A PBJ Staffing Data Report dated 10/01/24 through 12/31/24, documented the facility did not have RN hours for 10/22, 10/23, 11/03, 11/10, 11/17, 11/30, 12/01, 12/04, 12/07, 12/08, 12/09, 12/10, 12/22, 12/23, 12/24, 12/25, and 12/30/24. The report documented the facility did not have licensed nursing coverage for 24 hours/day for 12/09, 12/10, 12/23, and 12/24/24. On 05/23/24 at 8:31 a.m., Corporate Nurse Consultant #1 stated we had the hours they just didn't get on the report. On 05/23/24 at 1:14 p.m., the Operations Manager provided documentation of coverage for the dates above.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 45462 Based on record review and interview, the facility failed to provide education and consent before administration of the influenza vaccine for four (#12, 15, 23, and #32) of five residents reviewed for immunizations. LPN #3 identified 51 residents resided in the facility. Findings: (a) Resident #12's signed consent for influenza shot was dated 10/04/23. Their immunization record documented influenza shot was given to resident on 10/03/23. (b) Resident #15's signed consent for influenza shot was dated 04/19/24. Their immunization record documented influenza shot was given to resident on 10/03/23. (c) Resident #23's signed consent for influenza shot was dated 10/04/23. Their immunization record documented influenza shot was given to resident on 10/03/23. (d) Resident #32's signed consent for influenza shot was dated 10/04/23. Immunization record documented influenza shot was given to resident on 10/03/23. On 05/23/24 at 11:05 a.m., Regional Nurse Consultant #1 was asked when residents or their responsible parties are offered the influenza vaccine and educated on the risk and benefits. They stated we talk to residents or their representatives on admit or at the start of the flu season. Regional Nurse Consultant #1 was asked if, according to facility policy, vaccines could be administered before education was provided and consent was obtained. They stated no. On 05/23/24 at 2:15 p.m., Regional Nurse Consultant was asked to review the immunization records and the consent forms for the residents listed above and acknowledged that, based on the documentation, these vaccines were given before education was provided and consent was obtained.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 45462 Based on record review and interview, the facility failed to provide education and consent before administration of the COVID-19 vaccine for three (#12, 23, and #32) of five residents reviewed for immunizations. LPN #3 identified 51 residents resided in the facility. Findings: (a) Resident #12's immunization record documented a COVID-19 vaccination was administered to resident on 04/23/24. There was no signed consent nor documentation that education on the risks and benefits of the vaccination had been provided to the resident or their representative in the clinical record for Resident #12. (b) Resident #23's immunization record documented a COVID-19 vaccination was administered to resident on 04/23/24. There was no signed consent nor documentation that education on the risks and benefits of the vaccination had been provided to the resident or their representative in the clinical record for Resident #23. (c) Resident #32's immunization record documented a COVID-19 vaccination was administered to resident on 11/30/22. There was no signed consent nor documentation that education on the risks and benefits of the vaccination had been provided to the resident or their representative in the clinical record for Resident #32. On 05/23/24 at 11:05 a.m., Regional Nurse Consultant #1 was asked when residents or their responsible parties are offered the COVID-19 vaccine and educated on the risk and benefits. They stated we talk to residents or their representatives on admit or when boosters are available. Regional Nurse Consultant #1 was asked if vaccines could be administered before education was provided and consent was obtained. They stated no. On 05/23/24 at 2:15 p.m., Regional Nurse Consultant #1 was asked to review the immunization records and clinical records for the residents listed above. They stated no education or consent forms were found. Regional Nurse Consultant #1 was asked if this meant these vaccines were given without the proper representative consent. They stated yes, it appears that way, but not by me.