STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375534	A. Building B. Wing	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Extended Care & Rehab	9221 Harmony Drive Midwest City, OK 73130

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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 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 35389 Based on record review and interview, the facility failed to ensure the total amount of resident funds in the facility trust account did not exceed the amount covered under the facility surety bond. The DON identified 11 residents in the facility trust account resided in the facility. Findings: An undated facility form titled, Personal Funds Authorization, read in part, The facility maintains one trust fund account for both private and Medicare resident/patients .The facility has purchased a surety bond, or otherwise provided assurance satisfactory to the Secretary of the Department of Health and Human Services, to assure the security of all personal deposited with the facility. The facility trust account showed the following balances: a. statement date 06/30/24 beginning balance $39,450.07 ending balance $40,587.06; b. statement date 08/31/24 beginning balance $32,086.12; c. statement date 02/28/25 ending balance $28,346.24; and d. statement date 03/31/25 beginning balance $28,346.24. The facility surety bond, current bond term 08/20/22 through 08/20/25, showed the bond amount was $25,000. On 04/18/25 at 9:24 a.m., the administrator stated the purpose of the surety bond was to protect the money that was in the trust. On 04/18/25 at 9:25 a.m., the administrator stated the facility surety bond amount was $25,000 and the term was August of 2022 to August of 2025. The administrator reviewed the above balances that exceeded the $25,000 amount covered under the surety bond and stated the FDIC limit of $100,000 per account with the bank protected the resident funds which exceeded the surety bond limit. The administrator stated, The surety bond is redundant protection. (continued on next page)

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/18/25 at 9:28 a.m., the administrator stated the facility had more residents than normal and they probably should have looked into it as the account amounts had gone up.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on observation, record review, and interview, the facility failed to post the most recent state survey results of the facility in a place readily accessible to residents, family members, and legal representatives of the residents. The administrator identified 68 residents resided in the facility. Findings: On 04/17/25 at 9:17 a.m., a framed form that showed Copies of all [NAME] surveys and results are available to view on the table at the north end of our main entrance was observed on the wall directly outside of the dining room. On 04/17/25 at 9:21 a.m., the surveyor walked to the front entrance and did not observe the survey results on any table at the north end of the main entrance. A Survey Results policy, revised 04/2007, read in part, A copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports .along with the state approved plans of correction of noted deficiencies, is maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room. An undated facility form titled, Resident's/Patient's Rights, read in part, You have the right to examine that [sic] last facility state survey .Anyone who denies any of these rights is punishable by fine and/or imprisonment .If you are denied your rights, you may also be allowed punitive damages. On 04/17/25 at 11:38 a.m., the resident council stated they had never seen the State survey results. They stated they could request to see them, however, staff then wanted to know why they were wanting to see them and what was going on. The resident council stated the facility did not discuss them. On 04/17/25 at 12:54 p.m., the activity director stated they had been responsible for resident council for almost a year. On 04/17/25 at 12:58 p.m., the activity director stated they believed survey results were available somewhere in the building. The activity director walked over to the sign that showed survey results were available on a table at the north end of the main entrance. On 04/17/25 at 1:00 p.m., the activity director walked over to the main entrance and stated, I don't see any table with anything on it. They stated the survey results were supposed to be in the front lobby area. On 04/17/25 at 1:01 p.m., the activity director asked the administrator where the survey results were. The administrator stated they were usually on the table, and pointed to a table in the front lobby area. The administrator stated they did not know where they were. (continued on next page)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/17/25 at 1:02 p.m., the administrator handed the surveyor a red three ring binder they obtained from an office. As the surveyor began to open the binder, the administrator stated, There's nothing in it. The binder did not contain survey results, rather several empty clear page protector sleeves.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 35389 Based on record review and interview, the facility failed to ensure residents had the right to voice grievances to the facility without fear of discrimination or reprisal and failed to promptly resolve grievances the residents had in the resident council group. The administrator identified 68 residents resided in the facility. Findings: An undated facility form, Resident's/Patient's Rights, read in part, You have the right to voice problems that you are concerned about regarding your treatment .Anyone who denies any of these rights is punishable by fine and/or imprisonment .If you are denied your rights, you may also be allowed punitive damages .There can be no retaliation of any type by the facility staff because of a complaint presented to the staff. The resident council minutes, dated 01/27/25, showed old business: still out of dietary items and everything they ordered or requested was usually out. The resident council minutes showed to see the 01/29/25 meeting for how the issue was resolved. The minutes showed new business: dietary rush when asking for orders and are always out of things, and the residents wanted squash and greens more seasoned. The resident council minutes, dated 01/29/25, showed old business: follow up meeting from 01/27/25 dietary present to explain the state and federal regulation on diet portions and explain budget and cost and how things had to be ordered. The resident council minutes, dated 02/25/25, showed old business: still all the same issues and would like another meeting with the dietary manager. The How are these issues being resolved section was blank. The resident council minutes showed new business: the dining room got worse, food was late, food was still being out of stock of items, meals were not on time, breakfast and lunch was not good, and they were not getting what they ordered. It showed second meeting was requested and held by the dietary manager. The resident council minutes, dated 03/25/25, showed old business: dietary staff still need improvement. The resident council minutes showed the dietary manager had spoken to their team and the issue was resolved. The resident council minutes showed new business dietary: food was lukewarm, the service was not prompt and seemed slower, and the orders were not right after waiting a long time for it. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/17/25 at 11:07 a.m., the resident council stated they had complained about receiving greens everyday with their meal. They stated the facility then cut back on a lot of foods after this concern was voiced. They stated they could not have one piece of bacon and a piece of sausage. They stated the facility came up with some strange processes for dining. They stated after they complained about food, their breakfast items were cut from four pieces of bacon to two pieces of bacon. The resident council stated, It was to make us understand if we complained, this was going to happen. The resident council stated if they ordered a hamburger, they had to wait 30 to 45 minutes. They stated the facility served the hall trays first, and if they did not run out of the special for the day, the dining room would be allowed to have the special. They stated they ran out of the scheduled meal often. On 04/17/25 at 11:19 a.m., the resident council stated, It's a big problem anytime we complain. They stated, It's a big mistake. They stated, We get hell if we complain, it's a simple fact. They stated, Retribution, it happens big time. They stated dietary staff would not even let them complete their whole order before moving to the next resident. They stated, We are old, what can I say, we are a little slow. On 04/17/25 at 12:54 p.m., the activity director stated the resident council's complaints generally were related to dining. They stated depending on the complaint, they would take it to the administrator and the department head to try to get a resolution. They stated the dining complaints were reviewed by the administrator. The activity director stated the administrator called in the dietary manager and went over the concerns and held a separate meeting with the residents who had complaints about the dietary department and dining. The activity director stated they would get back with them and say the issue had been resolved, but the same complaints would happen at the next resident council meeting. On 04/17/25 at 12:58 p.m., the activity director stated they did not know the process if a resident felt retaliated against, because they had never had that issue. They stated they would more than likely take the concern to the administrator.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 35389 Based on record review and interview, the facility failed to ensure residents were free from misappropriation for 1 (#177) of 3 sampled residents reviewed for abuse. The administrator identified 68 residents resided in the facility. Findings: The facility abuse, neglect, exploitation and misappropriation prevention program, revised 04/2021, read in part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation .Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. A new employee form showed CNA #2 had a hire date of 12/06/24. A quarterly resident assessment, dated 02/24/25, showed Resident #177 had severe cognitive impairment (BIMS 07). An email correspondence to the administrator, dated 03/17/25, showed the family of Resident #177 discovered six unauthorized charges to the resident's debit card during their stay at the facility. The email correspondence showed there were four withdrawals made and deposited to a cash app account on 01/01/25 for a total of $2900. The email correspondence showed the bank reported the name on the cash app account was CNA #2. The email correspondence showed the card was also used at a food establishment and a gas station on 12/27/24. The email correspondence showed there was a police report filed. The email correspondence showed the family was not aware of Resident #177 leaving the facility or having unknown visitors during the time. A combined intital and final facility reported incident, dated 03/17/25, showed it was reported to the DON on 03/17/25 that Resident #177, who had been discharged , discovered unauthorized charges to the resident's missing bank debit card. The incident report showed Resident #177's family reported four withdrawals were made and deposited in a cash app account belonging to CNA #2. The report showed the facility removed CNA #2 from the schedule. The incident report showed a total of $2900 was sent to CNA #2's cash app along with two charges to a food establishment and a gas station. It showed a police report was filed. It showed CNA #2 had previously been removed from the schedule due to not showing up for work. It showed management staff had been educated to report to the administrator or DON if CNA #2 was seen entering the facility. The report was signed as completed by the DON. A termination form, dated 03/17/25, showed CNA #2 had been terminated on 03/17/25. An order summary report, dated 04/18/25, showed Resident #177 had diagnoses which included encephalopathy, chronic kidney disease, and dysphagia oral phase. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/18/25 at 11:06 a.m., CNA #1 stated the facility monitored for sexual abuse, physical abuse, and verbal abuse. They stated they monitored for all of the types of abuse in the facility. They stated if abuse was observed or reported to them, they would report it to the nurse. On 04/18/25 at 11:12 a.m., LPN #1 stated staff monitored for all types of abuse including verbal, mental, and physical abuse. They stated abuse was taking something from a resident they felt they should have. They stated there was financial abuse and exploitation as well. On 04/18/25 at 11:13 a.m., LPN #1 stated if abuse was observed or reported to them they would go straight to the DON and then the administrator. They stated if the abuse involved staff, they would immediately be removed from the resident's care and the building pending the investigation. They stated they would walk the staff member up to the exit to ensure they left the building. They stated they would also remove residents from dangerous situations. On 04/18/25 at 11:14 a.m., LPN #1 stated the DON, administrator, family, police, and if needed state were notified of the allegation of abuse. On 04/18/25 at 1:45 p.m., the DON was asked to provide all documentation related to the abuse investigation for Resident #177. They stated the only thing they thought they had were some statements. On 04/18/25 at 1:54 p.m., the DON stated the facility reported incident was initiated based on the email received on 03/17/25. They stated the resident discharged from the facility on 03/12/25. They stated CNA #2 had not worked at the facility since 02/22/25. The DON stated it was initiated because the resident's family member was already investigating two people, one of which was the facility employee, misappropriating Resident #177's funds. On 04/21/25 at 12:29 p.m., the DON stated the facility was notified by email after Resident #177 had discharged , the family was investigating charges that were known to be from CNA #2. They stated the employee was still on the prn rotation but had not worked at the facility since February. They stated CNA #2 was completely removed from the roster and was reported to the appropriate licensing board. They stated it had already been reported to the police. On 04/21/25 at 12:33 p.m., the DON stated the facility did not interview any other residents because most of the residents did not have the same kind of bank cards and stuff Resident #177 had. They stated no staff were interviewed related to this misappropriation allegation. They stated the only inservice the facility had related to misappropriation was the one from 01/22/25. On 04/21/25 at 12:34 p.m., the DON stated the administrator or the business office would be able to say what measures the facility put in place to keep a resident's money/property from being misappropriated since the allegation involving Resident #177. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/21/25 at 12:37 p.m., the administrator stated they reinforced the policy they had in place following the abuse allegation. They stated Resident #177 was no longer a resident when they were notified. The administrator stated they went ahead and completed a state reportable, but they weren't required to do one since they were no longer a resident. The administrator stated during the police investigation, they had identified charges that were paid to CNA #2 and they were removed from the schedule. They stated they had called the police and told them if they had anything else they needed from the facility to let them know. The administrator stated it was an ongoing investigation with APS and they let APS know they could contact them directly if they needed anything. The administrator stated no other resident's CNA #2 cared for were interviewed because Resident #177 was already discharged . They stated the resident was no longer at the facility and CNA #2 was no longer an employee.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35389 Based on record review and interview, the facility failed to ensure: a. an abuse allegation was reported to APS for 2 (#8 and #21); and b. an initial abuse allegation was reported to the state agency within two hours for 1 (#21) of 3 sampled residents reviewed for abuse. The administrator identified 68 residents resided in the facility. Findings: An Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, revised 09/2022, read in part, If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law .The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies .The stated licensing/certification agency responsible for surveying/licensing the facility .Adult protective services .Immediately .within two hours of an allegation involving abuse. 1. A quarterly resident assessment, dated 02/13/25, showed Resident #21's cognition was intact (BIMS 15). A final facility reported incident, dated 02/27/25, showed an allegation of misappropriation involving Resident #21. The incident report showed Resident #21 reported they were missing $75 to the BOM that was in their purse in their room and was no longer there. It showed the BOM had witnessed Resident #21 having the money on 02/25/25. The incident report showed the resident denied using the money or giving the money to anyone. The incident report showed the police, administrator, family, and physician were notified. The report was signed as completed by the DON. There was no initial facility reported incident located for this allegation of abuse. There was no documentation APS had been notified of this allegation of abuse. On 04/15/25 at 11:14 a.m., Resident #21 stated they had money taken out of their billfold twice at the facility and they had reported it. Resident #21 stated the police were called both times. They stated they had gotten money out at the bank and placed it in their billfold. On 04/15/25 at 11:16 a.m., Resident #21 stated $200 was taken the first time and $100 was taken the second time. On 04/15/25 at 11:17 a.m., Resident #21 stated the first time it happened was before Christmas and the last time was early March. They stated they reported it to the BOM and they reported it to the police. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An order summary report, dated 04/18/25, showed Resident #21 had diagnoses which included diabetes mellitus and angina pectoris. On 04/18/25 at 11:06 a.m., CNA #1 stated if abuse was observed or reported to them, they would report it to the nurse. On 04/18/25 at 11:13 a.m., LPN #1 stated if abuse was observed or reported to them they would go straight to the DON and then the administrator. They stated if the abuse involved staff, they would immediately be removed from the resident's care and the building pending the investigation. They stated they would walk the staff member up to the exit to ensure they left the building. They stated they would also remove residents from dangerous situations. On 04/18/25 at 11:14 a.m., LPN #1 stated the DON, administrator, family, police, and if needed state were notified of the allegation of abuse. On 04/18/25 at 11:29 a.m., the DON stated they could not find an initial state reportable for the 02/27/25 allegation of misappropriation involving Resident #21. They stated the timeline for completing the initial reportable incident was two hours. On 04/18/25 at 12:07 p.m., the BOM stated they did take Resident #21 to the bank. They stated they went once a month when the resident's vender payment was due. They stated the resident took out their payment and additional money for personal use. On 04/18/25 at 12:11 p.m., the BOM stated they had taken Resident #21 to the bank and they took out $75. They stated the resident reported the money was missing to them. They stated the DON and administrator were notified and they were the ones who notified the police and completed everything. The BOM stated the resident never reported to them if the money was ever found. On 04/18/25 at 12:13 p.m., the administrator stated the money had not been found to their knowledge. On 04/18/25 at 12:20 p.m., the DON stated if abuse was observed or reported to staff, they would notify the DON or the administrator. They stated they would follow their policy, investigate it, and report it. On 04/18/25 at 12:21 p.m., the DON stated they had not notified APS on abuse allegations. They reviewed the above facility reported incident where APS was an option under notifications made and stated, I guess it would be for an abuse allegation. The DON stated honestly they had not ever notified APS of abuse allegations. On 04/18/25 at 12:25 p.m., the DON stated the BOM had witnessed Resident #21 having money one day, and one day later it came up missing. The DON stated the money was never found. 49701 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A Combined Initial and Final Incident Report Form, dated 03/24/25, showed an allegation of misappropriation of resident property. The report showed the facility was notified by Resident #8's family member Resident #8's phone had been missing since the previous week. Staff stated the phone was last seen on the bedside table the prior Friday. The family member told the DON they had reported the phone stolen to the police. A police officer told the DON the phone was last pinged in close proximity to the facility dumpster on the prior Friday 03/21/25. The phone was unable to be pinged on 03/24/25 due to being dead or turned off. It was believed the phone accidentally fell into the waste basket next to the bed. Family, physician, Resident #8 and the police were notified. There was no initial facility reported incident located for this allegation of abuse. There was no documentation APS had been notified of this allegation of abuse. On 04/16/25 at 11:49 a.m., the Combined Initial and Final Incident Report Form, dated 03/24/25 was faxed to the Oklahoma State Department of Health. The fax stated it was received successfully. On 04/21/25 at 1:05 p.m., the administrator stated the family reported the phone missing and the police pinged it. Seems to have been in the dumpster of the facility. The admission contract states the facility is not responsible for stolen or missing items. On 04/21/25 at 1:07 p.m., the DON stated they were unaware that the regulation required Adult Protective Services to be notified with any type of abuse/misappropriation situation, so it was not reported to them.

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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. 49701 Based on record review and interview, the facility failed to ensure resident assessments were coded for 2 (#1 and #48) of 19 sampled residents reviewed for accuracy of resident assessments. The administrator identified 68 residents resided in the facility. Findings: 1. A hospice services contract, dated 11/08/24, showed Resident #1 had started hospice services on that date. A significant change MDS assessment, dated 11/19/24, was completed due to Resident #1 beginning hospice services. The assessment showed Resident #1 had a diagnosis of heart disease and a BIMS score of 12, indicating they were moderately cognitively impaired. A care plan, dated 01/20/25, showed Resident #1 had a terminal diagnosis and was receiving hospice services. A quarterly MDS assessment, dated 02/19/25, showed that Resident #1 was not on hospice services. On 04/17/25 at 11:05 a.m., the MDS coordinator stated the quarterly assessment was coded incorrectly and should have shown that Resident #1 was receiving hospice services. On 04/17/25 at 11:08 a.m., the DON stated the MDS assessments are supposed to be accurate. 2. A care plan, dated 02/26/24, showed Resident #48 required dialysis every Monday, Wednesday, and Friday due to renal failure. A physician's order, dated 07/22/24, showed Resident #48 was to go to dialysis every Monday, Wednesday, and Friday. An annual MDS assessment, dated 03/06/25, showed Resident #48 had not required dialysis while in the facility over the last 14 days. On 04/17/25 at 2:29 p.m., the MDS coordinator stated Resident #48's annual assessment was inaccurate and should have indicated they were on dialysis while in the facility.

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	375534	A. Building B. Wing	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Extended Care & Rehab	9221 Harmony Drive Midwest City, OK 73130

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 35389 Based on observation, record review, and interview, the facility failed to complete skin assessments as ordered for 3 (#1, 12, and #24) of 5 sampled residents reviewed for non-pressure skin conditions. The administrator identified 68 residents resided in the facility. Findings: 1. Resident #1's order summary report, dated 04/2025, had diagnoses which included peripheral autonomic neuropathy, protein-calorie malnutrition, and need for assistance with personal care. Resident #1's quarterly resident assessment, dated 02/19/25, showed the resident had moderate cognitive impairment with a BIMS of 12. A physician's order, dated 11/04/24, showed weekly skin assessments on Tuesdays from 7 a.m. to 3 p.m. Skin only evaluation (in assessments) was to be filled out. Document all findings. Obtain treatment order if needed one time a day every Wednesday. The last skin assessment for Resident #1 was dated 08/07/24. On 04/21/25 at 9:18 a.m., LPN #1 stated the last skin only evaluation they see in Resident #1's medical records was dated 08/07/24. 2. On 04/16/25 at 8:28 a.m., Resident #12 had moderate white, dry flakes on their face and frontal region of their head. On 04/17/25 at 11:17 a.m., LPN #2 made observation of Resident #12's face and head. Resident #12's quarterly resident assessment, dated 02/27/25, showed the resident had moderate cognitive impairment with a BIMS of 15. Resident #12's order summary report, dated 04/2025, showed the resident had a diagnosis of chronic obstructive pulmonary disease. A physician's order, dated 11/19/24, showed weekly skin assessments on Wednesdays from 7 a.m. to 3 p.m. Skin only evaluation (in assessments) was to be filled out. Document all findings. Obtain treatment order if needed one time a day every Wednesday. The last skin assessment for Resident #12 was dated 02/26/25. On 04/16/25 at 8:28 a.m., Resident #12 stated they always had the dryness on their face. They stated they did not know if they had a treatment order. On 04/17/25 at 11:20 a.m., LPN #2 stated the Resident had white flakiness on their face. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/25 at 11:21 a.m., LPN #2 stated they were not sure how long the Resident had the dry flakiness on their skin. They stated skin assessments were completed once a week or every two weeks. They stated they were not aware of any treatment order for it, but would inform the provider. On 04/17/25 at 11:28 a.m., LPN #2 stated the dry flakiness on the resident's skin could require a treatment order, but the provider had to give them the order. On 04/17/25 at 1:29 p.m., the DON stated weekly assessments were to be completed as ordered. They stated the assessment included head to toe, any new skin issues or treatment documentation. On 04/17/25 at 1:30 p.m., the DON stated skin assessments were documented as skin checks. They stated the last skin assessment completed for Resident #12 was on 02/26/25. The DON stated the wound nurse was responsible for weekly skin assessments but the task was reverted to nurses. They stated it seemed the nurses were not completing them. 48344 3. On 04/15/25 at 1:14 p.m., Resident #24's right lower leg was observed to have an open area with active bleeding present was approximately the size of a quarter. A physician order, dated 12/17/24, showed weekly skin assessments on Tuesdays was to be filled out. It showed staff were to document all findings and obtain a treatment order if needed. A skin check note, dated 02/18/25, showed Resident #24 had a skin issue that needed addressed on the front right lateral lower leg. The note showed the venous skin issue was acquired in house. A physician order, dated 04/02/25, showed cleanse skin tear to right lower extremity with wound cleanser, pat dry, apply xeroform, cover with dry dressing every evening shift for wound care. A wound physician history and physical note, dated 04/21/25, showed Resident #24 had diagnoses which included an unspecified open wound to the right lower leg. A wound care progress note, dated 04/21/25, showed Resident #24 had an unspecified open wound to the right lower leg initial encounter. The note showed the wound was first noted on 04/04/25 and it was first noted by the wound care provider on 04/21/25. The note showed the wound measured 1cm by 1cm by 0. 1cm with serous drainage. There were no weekly skin assessments located in Resident #24's clinical record between the skin check note dated 02/18/25 and the wound care progress note dated 04/21/25. On 04/21/25 at 2:18 p.m., the DON stated they had identified a system error related to wound care. They stated the person responsible for weekly skin assessments stopped working as a wound care nurse in February 2025. They stated the facility had just hired a new wound care nurse. The DON stated they had identified the weekly skin assessments were not being generated to be completed by the nurses on the floor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/21/25 at 2:19 p.m., the DON stated the previous wound care nurse was completing the weekly skin assessments, but they were currently on leave. The DON stated they had spoken to LPN #1 on 04/21/25, and identified the skin assessments were not even populating. The DON stated they had a system error they needed to correct. The DON stated there were shower sheets completed that monitored residents' skin. They stated the shower sheets were completed by the CNAs. On 04/21/25 at 2:22 p.m. the DON reviewed Resident #24's shower sheets for April 2024 and stated they did not document the resident's current skin tear wound. On 04/21/25 at 2:34 p.m., LPN #1 stated apparently the facility had been doing the skin assessments wrong. They stated it was the wound care nurse's responsibility to their knowledge. LPN #1 stated the wound care nurse had left and the weekly skin assessments were not populating. On 04/21/25 at 2:36 p.m., LPN #1 stated the wound care nurse had went on leave around February/March 2025. They stated Resident #24 had a wound to their right lower leg from picking at it. They stated it had resolved at one time, but came back. On 04/21/25 at 2:38 p.m., LPN #1 stated they believed the wound had come back on 04/03/25. They stated the resident's wound care was completed every evening. On 04/21/25 at 2:39 p.m., LPN #1 stated the wound was getting better, but it would be reoccurring as long as the resident picked at their skin. On 04/21/25 at 2:53 p.m., the DON stated they could not find anything else on the resident's skin since the 02/18/25 note. On 04/21/25 at 3:14 p.m., the DON stated they called the previous wound care nurse who stated the 02/18/25 assessment was wrong. They stated the resident did not have a wound during that time. 49701

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48344 Based on observation, record review, and interview, the facility failed to administer a resident's oxygen as ordered for 1 (#12) of 3 sampled residents reviewed for respiratory care. The DON identified seven residents received continuous oxygen in the facility. Findings: On 04/16/25 at 8:24 a.m., Resident #12's oxygen concentrator was observed to be at a flow rate of 2 liters per minute via a nasal cannula. On 04/17/25 at 11:16 a.m., LPN #2 made observation of the oxygen flow rate on resident #12's concentrator. A policy titled Oxygen Administration, dated 2001, read in part, The purpose of this procedure is to provide guidelines for safe oxygen administration .Review the physician's orders or facility protocol for oxygen administration. Resident #12's order summary report, dated 04/2025, showed the resident had a diagnosis of chronic obstructive pulmonary disease. A physician's order, dated 02/05/24, showed oxygen via nasal cannula at 5 liters continuously. May titrate to keep saturation above 90%. On 04/17/25 at 11:20 a.m., LPN #2 stated the resident's concentrator was set to deliver oxygen at 2 liters per minute. On 04/17/25 at 11:25 a.m., LPN #2 stated they had checked Resident #12's oxygen saturation this morning, but did not check how many liters the oxygen was set to on the concentrator. They stated the resident's oxygen saturation was 93%. On 04/17/25 at 11:26 a.m., LPN #2 stated the resident's oxygen order was for 5 liters and to titrate up if they had trouble breathing. On 04/17/25 at 1:27 p.m., the DON stated the nurses were to follow the physician's order for the use of oxygen.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35389 Based on observation, record review, and interview, the facility failed to ensure residents' medications were only accessible to qualified staff. The administrator identified 68 residents resided in the facility. The administrator identified the facility had three medication rooms. Findings: On 04/16/25 at 10:55 a.m., life safety was on tour with the maintenance supervisor. The maintenance supervisor used their key to open the medication storage room by the DONs office. No other staff were present at the time. The maintenance supervisor walked over to the medication room on hall 500 and opened the door using their key. No other staff were present at the time. On 04/16/25 at 12:17 p.m., LPN #1 opened the medication storage room by the DONs office. There were numerous containers of residents' medications observed in the room. On 04/16/25 at 12:35 p.m., ACMA #1 opened the medication storage room on hall 500. There were numerous containers of residents' medications observed in the room. On 04/16/25 at 2:45 p.m., the maintenance supervisor had the medication room door by the DONs office open for life safety. There were no nurses observed. The maintenance supervisor asked another staff member to send a nurse up since they had the medication storage door open. On 04/16/25 at 3:40 p.m., the maintenance supervisor opened the medication storage room on hall 500 with their own key which contained medications for residents residing on hall 500. The maintenance supervisor called a nurse over to spot him during this observation. The maintenance supervisor stated the medication room had an attic access in it. A medication storage in the facilty policy, revised 01/2018, read in part, The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. On 04/16/25 at 12:23 p.m., LPN #1 stated nurses, medication aides, the DON and the maintenance supervisor had access to the medication storage room. LPN #1 stated the maintenance supervisor had keys to everything in the building. On 04/16/25 at 12:43 p.m., ACMA #1 stated the nurses, medication aides, and maintenance had access to the medication storage room. On 04/16/25 at 1:52 p.m., the DON stated the maintenance supervisor had access to the front hall medication storage room (by the DON's office) because there was a fire panel control in the room. The DON stated the maintenance supervisor was supposed to get one of us. They stated there were medications in the medication storage rooms, but no controlled medications.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 49701 Based on record review and interview, the facility failed to ensure the dietary manager completed certification as a certified dietary manager within three years of beginning employment per state requirement. The administrator identified 68 residents resided in the facility and 66 residents ate from the cafeteria. Findings: The DM was hired on 11/22/2011. There was no documentation the DM had completed certification as a certified dietary manager. On 04/16/25 at 1:23 p.m., the dietary manager stated they had worked in the role of dietary manager since 2011 and had not been certified. They stated they started the classes, but never completed them. They also denied having the other qualifiers accepted by the regulations to be considered certified. On 04/21/25 at 10:04 a.m., the administrator stated the DM was supposed to get certified within 3 years. The administrator stated, I was told they did the class.

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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. 48344 Based on observation, record review, and interview, the facility failed to: a. follow EBP during the provision of care for 1 (#14) of 3 sampled residents reviewed for activities of daily living; and b. transport dirty linen appropriately and sanitize their hands between meal set up for different residents on hall 200. The administrator identified 68 residents resided in the facility. The DON identified 18 residents were on EBP. Findings: 1. On 04/15/25 at 12:42 p.m., CNA #4 entered Resident #14's room to answer their call light. The resident's representative informed CNA #4 the resident was wet. On 04/15/25 at 12:43 p.m., CNA #4 donned gloves. There was an EBP sign on the resident's closet. Gowns were observed on top of the resident's closet. There was an EBP sign, gloves, and hand sanitizer by the resident's room entrance. Resident #14 ambulated to the bathroom with CNA #4's supervision. There was a yellow ring on the center of the resident's sheet. On 04/15/25 at 12:50 p.m., CNA #4 assisted the resident with toileting and changed their clothing. CNA #4 did not have a gown on. On 04/15/25 at 12:51 p.m., CNA #4 left the room with a bag of soiled clothing. On 04/15/25 at 12:53 p.m., CNA #4 came back with a tan brief and a pair of blue socks. They donned gloves and went into the bathroom to assist the resident into the new brief and socks. On 04/15/25 at 1:01 p.m., CNA #4 stripped Resident #14's bedding and took them out of the room in a yellow barrel. The yellow barrel was placed outside of the residents door. CNA #4 did not have a gown on. An undated policy titled Enhanced Barrier Precautions (EBP), read in part, EBP is defined as the targeted use of gowns and gloves during high-contact resident care activities .These include, but not limited to: Dressing/undressing, Transferring, Changing Linens, Providing hygiene, Assisting with toileting or assisting with toilet. A care plan, dated 04/01/25, showed Resident #14 had diagnoses which included dysphagia, oral phase and unspecified protein-calorie malnutrition. The care plan showed the resident had a peg tube placed. On 04/15/25 at 1:34 p.m., CNA #4 stated they had to wash their hands, put on a gown, and gloves for care of residents on enhanced barrier precautions. They stated they were to wear a mask if needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/15/25 at 1:35 p.m., CNA #4 stated Resident #14 was on enhanced barrier precautions due to their peg tube. They stated they did not follow the facility's enhanced barrier precaution process. On 04/16/25 at 1:17 p.m., the DON stated anyone with a peg tube, indwelling catheter, or chronic wounds was put on enhanced barrier precautions. On 04/16/25 at 1:18 p.m., the DON stated the required personal protective equipment for care of residents on enhanced barrier precautions was a gown and gloves. 2. On 04/16/25 at 8:06 a.m., CNA #1 was observed taking dirty clothing that was not bagged to dirty linen room and wearing gloves through the hallway. On 04/16/25 at 8:10 a.m., CNA #1 stated they did not know what the policy was for washing or sanitizing hands after taking care of a resident. They stated they would get back to me on that policy. They stated they are allowed to wear gloves in the hallway to transport linen. On 04/16/25 at 1:32 p.m., CNA #1 was observed passing out lunch trays to residents on hall 200. They did not wash their hands or wear gloves between setting up trays for residents. They were observed moving a bedside table, opening a milk carton, and taking the plastic off of the food. On 04/16/25 at 2:37 p.m., CNA #1 stated they had been too busy to find out the policy for handwashing or sanitizing hands between residents when providing care or passing trays. On 04/21/25 at 10:09 a.m., the administrator stated the policy was to transport dirty linen in a bag, never wear gloves in the hall, and wash or sanitize hands between residents when providing care. 49701

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 48344 Based on record review and interview, it was determined the facility failed to ensure dementia management education was provided to 1 (LPN #2) of 1 staff member who cared for residents with dementia. The administrator identified 18 residents had diagnosis of dementia in the facility. Findings: 1. Resident #3 had diagnoses which included vascular dementia. An annual resident assessment, dated 02/07/25, showed the resident's cognition was severely impaired (BIMS 00). Resident #3's care plan, dated 03/08/24, showed the resident had behavioral issues related to yelling out, throwing food, and was combative at times. 2. Resident #15's care plan, dated 03/24/25, showed the resident had diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. It showed the resident had impaired cognitive function or impaired thought processes related to dementia. Resident #15's quarterly resident assessment, dated 03/28/25, showed the resident's cognition was severely impaired with a BIMS of 03. It showed the resident had inattention and disorganized thinking behaviors. There was no documentation of staff in-service or training on dementia management between 04/2024 through 04/2025. On 04/18/25 at 12:41 p.m., LPN #2 stated they had been at the facility for a year. They stated they had not received dementia management training in 2024 and 2025. On 04/18/25 at 1:58 p.m., the DON stated they have not had an in-service for care of residents with dementia from 04/2024 to 04/2025. On 04/21/25 at 12:50 p.m., the administrator stated the facility does not have a mandatory requirement that all staff participate in dementia management training. 35389