STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385121	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Health Center	3320 SE Holgate Blvd Portland, OR 97202

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 47000 Based on observation, interview and record review it was determined the facility failed to ensure dignified language was used to address residents and their equipment for 1 of 1 facility and 1 of 2 sampled residents (#14) reviewed for dignity. This placed residents at risk for a decreased quality of life. Findings include: The Alzheimer's Association's Greater Missouri Chapter's 7/2017 Person Centered Care in Nursing Homes and Assisted Living revealed language is important in the change to person centered care. Language can either support change efforts or undermine them. Concepts of personalization and relationship-building cannot take root when a resident requiring assistance at mealtime is referred to as a feeder or when the act of walking is referred to as ambulation. Purposeful lives unfold in communities, not in facilities. The widely used language of long-term care continues to reflect an institutional orientation. Part of a change effort must be thoughtful consideration of the words and expressions used to describe the care provided and the way people and spaces are referred to in long term care communities. 1. On 10/7/24 at 11:54 AM three metal meal tray carts on the facility's second floor and on 10/15/24 at 10:47 AM one metal meal tray cart on the facility's first floor were observed with a sign posted on each above an open container that read: For bibs/cloth protectors and green wipes only. On 10/15/24 at 9:13 AM Staff 1 (Administrator) acknowledged the findings and did not provide any additional information. 2. Resident 14 was admitted to the facility in 12/2020 with diagnoses including Parkinson's disease (a chronic brain disorder that causes movement problems, mental health issues and other health concerns). A 9/16/24 Progress Note revealed Resident 14 was identified as a 1:1 feeder. On 10/7/24 at 1:04 PM an unidentified CNA entered Resident 14's room with the resident's meal tray and stated the resident was a feeder. On 10/14/24 at 10:48 AM Staff 26 (CNA) stated the facility used the term feeder to describe residents who needed supervision at mealtimes and Resident 14 was considered a feeder. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/24 9:13 AM Staff 1 (Administrator) acknowledged the findings and did not provide any additional information.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 26991 Based on interview and record review it was determined the facility failed to obtain consents for the use of psychotropic medications for 2 of 6 sampled residents (#s 1 and 77) reviewed for medications. This placed residents at risk for the loss of the right to decline the use of psychotropic medications. Findings include: 1. Resident 1 was admitted to the facility in 5/2024 with a diagnosis of severe malnutrition. An 8/26/24 quarterly MDS revealed Resident 1 was cognitively intact. A 10/2024 MAR revealed Resident 1 was administered the following psychotropic medications: -Sertraline (antidepressant) with a start date of 5/24/24. -Trazodone (antidepressant also used to assist with sleep) with a start date of 5/24/24. Resident 1's clinical record did not include consents for the use of the psychotropic medications. On 10/10/24 at 12:38 PM Staff 2 (DNS) stated social services was to obtain consents for psychotropic medications. Staff 2 acknowledged consents were not completed for Resident 1's psychotropic medications. 43690 2. Resident 77 was admitted to the facility in 3/2024 with diagnoses including anemia and major depressive disorder. Resident 77's 3/22/24 Physician Order indicated the resident was prescribed Celexa (antidepressant) for depression. Resident 77's 3/2024 MAR revealed the resident received Celexa daily starting on 3/22/24. Review of Resident 77's health record revealed no documentation to indicate the resident was informed in advance of the risks and benefits of Celexa. On 10/10/24 at 1:30 PM Staff 2 (DNS) reviewed Resident 77's health record, acknowledged there was no documentation the resident was informed of the risks and benefits of Celexa and confirmed a consent was not obtained prior to the resident starting the medication.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on observation, interview, and record review it was determined the facility failed to honor a resident's preference for room layout for 1 of 2 sampled residents (#16) reviewed for choices. This placed residents at risk for depression. Findings include: 1. Resident 16 was admitted to the facility in 2/2020 with a diagnosis of diabetes. A 2/29/24 annual MDS revealed Resident 16 was cognitively intact, had weakness, and was in the facility for long term care. On 10/10/24 at 9:08 AM and 10/10/24 at 11:55 AM Resident 16 was observed in her/his room, a transfer pole was positioned on the left side of her/his bed, and Resident 16's spouse was observed in the bed to the right of the transfer pole. Resident 16 stated she/he was in a significant relationship with her/his spouse for [AGE] years. Resident 16 stated she/he wished the two beds were closer together to allow her/him to hold hands with her/his spouse. Resident 16 also stated she/he had PTSD (post traumatic stress disorder) and her/his spouse was able to calm her/him when she/he woke with vivid dreams. Resident 16 stated she/he requested a bed change and nothing was done. On 10/10/24 at 9:15 AM Staff 9 (Social Services Coordinator) stated in the past she heard Resident 16 wanted her/his bed closer to her/his spouse's bed. Staff 9 stated she was not aware if it was assessed. Staff 9 stated Staff 2 (DNS) would need to approve the move, involve therapy, and other departments to ensure it was safe. On 10/10/24 at 10:39 AM Staff 2 stated she was not aware of Resident 16's desire to be closer to her/his spouse. Staff 2 stated it could be done but an assessment would need to be done to ensure it was safe.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 26991 Based on interview and record review it was determined the facility failed to ensure residents had an advance directive for 2 of 4 sampled residents (#s 1 and 16) reviewed for advance directives. This placed residents at risk for end-of-life choices not being honored. Findings include: 1. Resident 1 was admitted to the facility in 5/2024 with a diagnosis of severe malnutrition. An 8/26/24 quarterly MDS revealed Resident 1 was cognitively intact. An 8/29/24 Care Conference Meeting form revealed Resident 1 did not have an advance directive. The form did not indicate if staff provided Resident 1 information related to an advance directive or if the resident wanted to fill out an advance directive. On 10/10/24 at 11:38 AM Resident 1 stated she/he used to have an advance directive but did not know where it was and did not recall if the facility talked to her/him about an advance directive. Resident 1 also stated she/he definitely would not want tube feedings. On 10/10/24 at 9:11 AM Staff 9 (Social Services Coordinator) stated advance directive information was reviewed during care conferences and if a resident was provided information it was to be documented in the resident's record. Staff 9 stated there was no indication information was provided to Resident 1. 2. Resident 16 was admitted to the facility in 2/2020 with a diagnosis of diabetes. An 8/11/24 quarterly MDS revealed Resident 16 was cognitively intact. An 8/8/24 Care Conference Meeting form revealed Resident 16 did not have an advance directive. On 10/10/24 at 9:11 AM Staff 9 (Social Services Coordinator) stated advance directive information was reviewed with residents during care conferences. If a resident was offered advance directive information it was documented in the clinical record. Staff 9 stated there was no indication an advance directive was offered.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 26991 Based on interview and record review it was determined the facility failed to ensure a resident's emergency contact was notified of a resident's hospitalization for 1 of 2 sampled residents (#16) reviewed for hospitalization . This placed residents' representatives at risk for not being informed of a resident's change in medical condition. Finding include: Resident 16 was admitted to the facility in 2/2020 with a diagnosis of diabetes. Resident 13 was admitted to the facility 2/2020 with a diagnosis of dementia. An undated Admission Record revealed Resident 13 was Resident 16's first emergency contact and Witness 1 (Acquaintance) was Resident 16's second emergency contact. An 8/4/24 quarterly MDS revealed Resident 13 was cognitively impaired. An 8/11/24 quarterly MDS revealed Resident 16 was cognitively intact. Progress Notes revealed on 6/24/24 Resident 16 vomited, was pale, clammy, and did her/his mental status was not at baseline. Resident 16 was transported to the local hospital for evaluation and treatment. There was no note to indicate Resident 16's first or second emergency contact was notified. On 10/7/24 at 10:25 AM Resident 16 stated Resident 13 was her/his first emergency contact and had dementia. Resident 16 sated no one was called when she/he was hospitalized in 6/2024. On 10/10/24 at 8:05 AM Staff 28 (LPN) stated Resident 16's spouse had dementia. Staff notified Resident 13 when Resident 16 was hospitalized but Resident 13 only understood Resident 16 was not in the room but did not know why. On 10/10/24 at 12:51 PM Staff 2 (DNS) stated there was no indication in Resident 16's clinical record her/his emergency contacts were notified of her/his hospitalization .

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41458 Based on interview and record review it was determined the facility failed to ensure NOMNC (Notice of Medicare Non-Coverage) notifications were provided to 2 of 3 sampled residents (#s 75 and 290) and failed to provide SNF ABN (Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage) notifications to 2 of 3 sampled residents (#s 49 and 75) reviewed for Beneficiary Notification. This placed residents and their representatives at risk for lack of knowledge regarding their right to appeal and unknown financial liabilities. Findings include: 1. Resident 75 was admitted to the facility on [DATE] with Medicare Part A benefits. Resident 75's SNF Beneficiary Protection Notification Review provided by the facility indicated the resident's last covered day for Medicare Part A services was 5/27/24 and Resident 75 remained in the facility. According to the SNF Beneficiary Protection Notification form, the resident did not receive the required NOMNC notification to notify the resident or their representative when their Medicare Part A coverage ended and provided them the opportunity to appeal, and was not provided with a SNF ABN notification to inform them or their representative of potential out-of-pocket expenses. On 10/14/24 at 1:15 PM and 2:54 PM Staff 9 (Social Services Coordinator) stated the facility did not issue SNF ABN notifications to residents when they were discharged from Medicare Part A services and remained in the facility and confirmed Resident 75 did not receive the required SNF ABN notifications. Staff 9 also confirmed Resident 75 did not receive the required NOMNC notification to notify the resident or their representative when their Medicare Part A coverage ended. On 10/15/24 at 9:01 AM Staff 1 (Interim Administrator) acknowledged the facility was not consistently issuing NOMNC and SNF ABN notifications to residents and their representatives as required. 2. Resident 290 was admitted to the facility on [DATE] with Medicare Part A benefits. Resident 290's SNF Beneficiary Protection Notification Review provided by the facility indicated the resident's last covered day for Medicare Part A services was 7/11/24 and Resident 290 discharged home. According to the SNF Beneficiary Protection Notification form, the resident did not receive the required NOMNC notification to notify the resident or their representative when their Medicare Part A coverage ended and provided them the opportunity to appeal. On 10/14/24 at 1:15 PM and 2:54 PM Staff 9 (Social Services Coordinator) stated Resident 290 did not receive the required NOMNC notification to notify the resident or their representative when their Medicare Part A coverage ended. On 10/15/24 at 9:01 AM Staff 1 (Interim Administrator) acknowledged the facility was not consistently issuing NOMNC and SNF ABN notifications to residents and their representatives as required. 3. Resident 49 was admitted to the facility on [DATE] with Medicare Part A benefits. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 49's SNF Beneficiary Protection Notification Review provided by the facility indicated the resident's last covered day for Medicare Part A services was 8/15/24 and Resident 49 remained in the facility. According to the SNF Beneficiary Notification form, the resident was not provided with a SNF ABN notification to inform them or their representative of potential out-of-pocket expenses. On 10/14/24 at 1:15 PM and 2:54 PM Staff 9 (Social Services Coordinator) stated the facility did not issue SNF ABN notifications to residents when they were discharged from Medicare Part A services and remained in the facility and confirmed Resident 49 did not receive the required SNF ABN notification. On 10/15/24 at 9:01 AM Staff 1 (Interim Administrator) acknowledged the facility was not consistently issuing NOMNC and SNF ABN notifications to residents and their representatives as required.

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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** 38140 Based on observation, interview and record review it was determined the facility failed to provide a homelike environment for 1 of 1 resident (#340) reviewed for hospice and in 1 of 1 facility reviewed for environment. This placed residents at risk for a lack of autonomy and living in an unkempt environment. Findings include: The facility's revised 7/3/23 Safe and Homelike Environment Policy directed staff in accordance with residents' rights, the facility would provide a safe, clean, comfortable and homelike environment. The facility would create and maintain, to the extent possible, a homelike environment that de-emphasizes the institutional character of the setting. 1. Resident 340 was admitted to the facility in 8/2024 with diagnoses including dementia. On 10/7/24 at 12:01 PM Resident 340 was observed in her/his room with no personalized items or decorations in the room. On 10/10/24 at 1:47 PM Resident 340 stated she/he would like something good to look at in her/his room. On 10/14/24 at 9:50 AM Staff 7 (Activities Coordinator) stated it was up to the residents' family to bring in items to personalize a residents' room. On 10/14/24 at 11:16 AM Staff 9 (Social Services Coordinator) stated she provided social services for Resident 340's room. Staff 9 stated if the long-term residents wanted to decorate the residents' room, they could have their family bring personal items into the facility and she would check with administration first to see if it was okay. To her knowledge, Resident 304's family had not been contacted and the facility had not provided personalized decorations for her/him to look at in her/his room. On 10/15/24 at 9:13 AM Staff 1 (Interim Administrator) acknowledged he expected resident rooms' to be personalized. 43690 Observations of the facility's general environment and residents' rooms from 10/7/24 through 10/15/24 identified the following issues: -Hall C had 2 missing handrail end caps on each side of the hall exposing sharp/jagged edges. -The west hall outside the kitchen entrance had a missing handrail end cap. -The handrails across from therapy room had an approximate 2 inch open gap exposing metal. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The sitting area on the 1st floor surrounding the nurses station had four couches made from synthetic material that were torn and tattered. -The library on the 2nd floor had a couch and chair made from synthetic material that were torn and tattered. -Large sections of missing brown paint on the door frames for rooms 135, 144, 156, 169, 183, 184, 260, and the housekeeping closet (1st floor) door across from room [ROOM NUMBER]. -room [ROOM NUMBER]'s door had an approximate 4 inch piece of wood missing on the lower section exposing sharp/jagged edges. -Dirty light fixtures outside room [ROOM NUMBER] and outside the 1st floor elevator on the west hall. -room [ROOM NUMBER] had large sections of missing paint on the door. -The lower sections of the corner walls outside Rooms 237, 243, 253, 256, 283 had an approximate 4 inch gouge with missing paint and exposed drywall. On 10/15/24 at 8:20 AM Staff 1 (Administrator) and Staff 10 (Director of Facility Services) acknowledged the identified rooms and maintenance concerns needed to be repaired.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 38140 Based on interview and record review it was determined the facility failed to ensure a system was in place to resolve resident grievances promptly for 1 of 1 resident (#57) reviewed for abuse. This placed residents at risk for unresolved grievances. Findings include: Resident 57 was admitted to the facility in 5/2022 with diagnoses including osteoarthritis (degenerative joint disease) and lower back pain. On 10/7/24 at 4:22 PM Resident 57 expressed she/he had concerns with her/his caregiver the other day. Resident 57 stated she/he told Staff 19 (RN) and Staff 38 (LPN) about her/his concerns and requested a grievance form be completed. On 10/9/24 at 8:23 AM Staff 1 (Interim Administrator) was unaware of Resident 57's concerns about the caregiver and at 9:51 AM Staff 1 confirmed a grievance form was not created for Resident 57's expressed concerns. On 10/9/24 at 11:03 AM Staff 19 confirmed Resident 57 spoke to her about her/his concerns regarding the caregiver on 10/7/24 and she told Staff 17 (Social Services Director) to complete a grievance form. On 10/14/24 at 5:43 AM Staff 38 confirmed Resident 57 told her about the caregiver concerns and she provided Staff 19 with the information. On 10/15/24 at 9:13 AM Staff 1 acknowledged he expected grievance forms to be completed promptly for resident concerns.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 26991 Based on interview and record review it was determined the facility failed to ensure a bed hold policy was provided to a resident when transferred to the hospital for 2 of 2 sampled residents (#s 16 and 33) reviewed for hospitalization . This placed residents at risk for lack of knowledge related to the right to return to the facility. Findings include: 1. Resident 16 was admitted to the facility in 2/2020 with a diagnosis of diabetes. Progress Notes revealed Resident 16 was discharged to the hospital on 6/24/24. Resident 16's clinical record did not indicate Resident 16 was provided a facility bed hold policy. An 8/11/24 quarterly MDS revealed Resident 16 was cognitively intact. On 10/7/24 at 10:25 AM Resident 16 stated she/he did not recall staff providing her/him a bed hold policy when she/he went to the hospital. On 10/10/24 at 12:51 PM Staff 2 (DNS) stated upon admission to the facility residents were provided a bed hold policy. Staff 2 stated usually the admission director provided a bed hold policy upon discharge, but currently there was no admission director. No additional information was provided. 41458 2. Resident 33 was admitted to the facility in 12/2021 with diagnoses including chronic respiratory failure with hypoxia (a condition in which the body does not have enough oxygen in the blood). A review of Resident 33's health record revealed she/he was transferred to the hospital on 6/1/24, 6/14/24, 7/11/24, 9/8/24 and 10/2/24. No evidence was found in Resident 33's health record to indicate a written notice of the facility's bed hold policy was provided to Resident 33 when she/he was transferred to the hospital on 6/1/24, 6/14/24, 7/11/24, 9/8/24 and 10/2/24. On 10/11/24 at 9:32 AM Staff 3 (Medical Records) stated the facility did not provide residents with a written bed hold policy prior to transferring them to the hospital. On 10/15/24 at 10:27 AM Staff 1 (Interim Administrator) acknowleged residents were not provided with written bed hold policies upon transfer to the hospital.

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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. 26991 47000 Based on observation, interview and record review it was determined the facility failed to accurately assess residents for communication, dental, and transfers for 3 of 9 sampled residents (#s 1, 14 and 20) reviewed for communication, dental, and rehabilitation. This placed residents at risk for inaccurate assessments and unmet care needs. Findings include: 1. Centers for Medicare & Medicaid Services 10/2024 Resident Assessment Instrument (RAI) Version 3.0 Manual directed the following: -A resident who was able to express requests and ideas clearly should be assessed as understood. -A resident who experienced difficulty communicating some words or finishing thoughts but was able to be understood if prompted or given time, experienced delayed responses or required some prompting to make self understood should be assessed usually understood. -A resident who was able to clearly comprehend the speaker's message and demonstrated comprehension by words or actions/behaviors should be assessed as understands. -A resident who missed some part or intent of the speaker's message but comprehended most of it or who may have periodic difficulties integrating information but generally demonstrated comprehension by responding in words or actions should be assessed as usually understands. Resident 14 was admitted to the facility in 12/2020 with diagnoses including Parkinson's disease (a chronic brain disorder that causes movement problems, mental health issues and other health concerns). Resident 14's 9/8/24 Quarterly MDS revealed the resident was cognitively intact, had unclear speech, was able to make her/himself understood without difficulty and was able to understand others without difficulty. On 10/7/24 at 12:56 PM Resident 14 was observed in her/his room in bed. Resident 14 spoke slowly and softly, experienced delayed responses and required time to express her/himself. Resident 14 frequently repeated her/himself in order to be understood and she/he stated staff needed to be patient with [her/him]. The State Surveyor repeated questions on a number of occasions during the interview in order to improve the resident's understanding. On 10/14/24 at 10:23 AM Staff 25 (CNA) stated Resident 14 was very soft spoken and when she interacted with the resident, she always turned the television off and listened closely. Staff 25 stated the resident needed a second to understand and communicate her/his responses. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/14/24 at 10:48 AM Staff 26 (CNA) stated Resident 14's communication was sometimes really good and sometimes [the resident] was really out of it. Staff 26 stated she often asked Resident 14 to repeat her/his message or question, and if she still had trouble understanding, she would get another staff person to help with understanding. On 10/14/24 at 11:21 AM Staff 17 (Social Services Director) stated Resident 14 varied in [her/his] communication abilities as she/he went through different moods and alertness levels. Staff 17 stated she frequently repeated statements to Resident 14, asked the resident if she/he understood her question or message and gave the resident time to answer questions. On 10/14/24 at 1:10 PM Staff 2 (Interim DNS) acknowledged Resident 14's MDS was inaccurately assessed and stated Resident 14's difficulties with communication were not of recent onset. 2. Resident 20 was admitted to the facility in 9/2022 with diagnoses including a history of falls. Resident 20's 9/1/24 Annual MDS indicated the resident required partial-to-moderate assistance from staff with transfers. Resident 20's 9/11/24 ADL Performance Deficit Care Plan revealed the resident required assistance from two staff and the use of a hoyer lift (a mobile device that helps caregivers safely transfer patients with limited mobility from one place to another) for all transfers. On 10/10/24 at 10:36 AM Staff 23 (Agency CNA) and at 10:46 AM Staff 24 (CNA) stated Resident 20 required a hoyer lift for all transfers. On 10/10/24 at 4:37 PM Staff 2 (Interim DNS) acknowledged Resident 20's 9/1/24 Annual MDS was inaccurately assessed as the resident required assistance from two staff and the use of a hoyer lift for all transfers. 3. Resident 1 was admitted to the facility in 5/2024 with a diagnosis of severe malnutrition. On 10/7/24 at 10:46 AM Resident 1 was observed to have no teeth. A 6/7/24 significant change MDS indicated Resident 1 did not have dental issues including not having teeth. On 10/10/24 at 5:01 PM Staff 2 (DNS) acknowledged Resident 1's dental status was not accurately assessed.

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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. 26991 Based on observation, interview, and record review it was determined the facility failed to ensure care plans were revised to accurately reflect the needs of residents for 4 of 13 sampled residents (#s 5, 7, 35, and 73) reviewed for accidents, pressure ulcers, position and mobility. This placed residents at risk for unmet needs. Findings include: 1. Resident 5 was admitted to the facility in 4/2024 with a diagnosis of paralysis. A 7/17/24 Pressure Injury investigation revealed a new DTI (Deep tissue injury: damage to the soft tissue beneath the skin caused by pressure or shear. Often appears as a dark purple or maroon area) to the inner knee. The cause of the injury was determined to be from her/his bedside table putting pressure on the knee. Resident 5's care plan was not updated to direct staff to monitor pressure on Resident 5's leg from the bedside table. On 10/11/24 at 9:11 AM Staff 2 (DNS) stated Resident 5 did not have sensation in her/his legs. When the wound nurse performed wound care to the resident's sacral region she found the inner knee DTI. The wound nurse identified the bedside table was pressing on the area. Staff 2 acknowledged the care plan was not updated to ensure pressure was not applied to the resident's legs. 41458 2. Resident 73 was admitted to the facility in 9/2023 with diagnoses including a fractured hip. a. Resident 73's 9/21/23 Care Plan indicated the resident was incontinent of bowel and bladder. Resident 73's 9/15/24 Annual MDS indicated the resident was always continent of bowel and bladder. On 10/10/24 at 12:04 PM and 12:54 PM Staff 24 (CNA) and Staff 26 (CNA) reported Resident 73 was independent with most care and was continent of bowel and bladder. On 10/11/24 at 10:55 AM Staff 2 (Interim DNS) reviewed Resident 73's current care plan and reported the resident was not incontinent, and the resident's current care plan did not accurately reflect her/his continence status. She stated she expected residents' care plans to accurately reflect current interventions. b. A 7/9/24 Facility Incident report indicated Resident 73 left the facility around 1:00 PM on 7/8/24 and did not return until 7:00 AM on 7/9/24. New interventions were identified which included ensuring the resident took her/his cell phone and water bottle with her/him when leaving the facility. Also, Staff 17 (Social Service Director) would provide Resident 73 with a fanny pack to carry her/his cell phone and wallet, and facility key personnel names and phone contact information would be placed in the fanny pack. Resident 73 was to take her/his fanny pack when she/he left the facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 73's 9/5/24 Care Plan indicated the following: -The resident was to sign out and tell staff when she/he was leaving the facility. -The resident would take her/his cell phone when going out. Resident 73's 9/15/24 Annual MDS indicated the resident was able to make her/his own decisions and direct her/his own care. On 10/10/24 at 9:51 AM Resident 73 was able to locate her/his fanny pack in her/his room and stated she/he was supposed to take the fanny pack when leaving the facility. On 10/10/24 at 1:55 PM Staff 2 (Interim DNS) reviewed Resident 73's care plan and confirmed the resident's care plan did not accurately reflect her/his current care plan interventions related to leaving the facility. She stated she expected residents' care plans to accurately reflect current interventions. 3. Resident 35 was admitted to the facility in 1/2018 with diagnoses including a stroke and difficulty swallowing. Resident 35's 3/19/22 Care Plan indicated the following: -No straws allowed (due to difficulty swallowing). Resident 35's 5/14/24 SLP Discharge Summary did not indicate the resident was unsafe using straws. Resident 35's 9/8/24 Quarterly MDS indicated the resident had no choking or coughing during the assessment period. Multiple observations from 10/7/24 through 10/14/24 between the hours of 8:00 AM and 4:30 PM revealed Resident 35 used straws to drink liquids. On 10/7/24 at 1:24 PM Staff 25 (CNA) stated the resident used straws when drinking. On 10/14/24 at 10:42 AM Staff 2 (Interim DNS) stated she reviewed Resident 35's care plan interventions and the resident's care plan was inaccurate regarding the resident's safety using straws. She stated she expected residents' care plans to accurately reflect current interventions. 50927 Resident 7 was admitted to the facility in 11/2019 with diagnoses including multiple sclerosis and depression. Resident 7's health record revealed she/he had contractures to the left shoulder, hips, and knees upon admission. A 3/17/24 annual MDS revealed Resident 7 had impaired mobility of her/his upper and lower extremities. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 9/23/24 Care Plan revealed Resident 7 had an RA program related to maintaining baseline ROM to her/his bilateral upper extemities as long as possible. Random observations of Resident 7 from 10/7/24 through 10/11/24 from 11:31 AM to 4:16 PM revealed Resident 7 in bed with her/his left arm contracted. The resident had difficulty turning her/his neck to see who was in the room. On 10/11/24 at 1:56 PM Staff 2 (Interim DNS) stated the RA program for Resident 7 was discontinued on 10/18/23 when she/he was admitted to the hospital. Staff 2 acknowledged the care plan had not been revised.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 47000 Based on observation, interview and record review it was determined the facility failed to provide appropriate treatment and services in the area of communication for 1 of 4 sampled residents (#53) reviewed for communication. This placed residents at risk for diminished quality of life and potential decline in their ability to carry out activities of daily living. Findings include: Resident 53 was admitted to the facility in 7/2021 with diagnoses including dementia. Resident 53's 9/22/24 Quarterly MDS revealed the resident was severely cognitively impaired and her/his ability to hear was highly impaired. Resident 53's 10/1/24 Communication Problem Care Plan revealed the following: -Use a dry erase board as needed to facilitate communication and understanding. -Use alternative communication tools as needed, such as a communication book/board, writing pad, gestures, signs and pictures. -9/15/21: The resident was not a candidate for hearing aids per family report. On 10/7/24 at 12:37 PM Resident 53 was observed in her/his room in bed. Resident 53 stated she/he was a little bit deaf and wore hearing aides but [she/he] did not know where they were. The State Surveyor needed to repeat questions to the resident, even when speaking at an elevated volume, in order to improve understanding. At this time, no accessible communication tools, including a communication board or dry erase board, were observed in the resident's room. Random observations of Resident 53 conducted from 10/7/24 through 10/14/24 from 5:09 AM to 3:54 PM revealed the resident to be in her/his room either in bed or in her/his wheelchair. No accessible communication tools were observed in the resident's room. On 10/11/24 at 10:15 AM Staff 25 (CNA) stated communicating with Resident 53 was very hard, interactions were often a guessing game and it was difficult to determine what the resident was trying to say. Staff 25 stated she had never utilized any communication tools or devices to improve interactions with the resident, including a communication board, dry erase board or a hearing amplification device. On 10/14/24 at 11:15 AM Staff 17 (Social Services Director) stated Resident 53 was very hard of hearing and she used a white board when she interacted with the resident to improve communication. Staff 17 stated she did not know if Resident 53 had a communication board or white board available in her/his room for other staff to use during their interactions and she was unaware if the resident would benefit from alternative amplification devices or if they had been tried. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/14/24 at 12:44 PM Staff 2 (Interim DNS) acknowledged the findings of this investigation and stated she was unsure which communication interventions had been trialed with Resident 53 to improve communication and did not know if current care plan interventions were accurate.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 38140 Based on observation, interview and record review it was determined the facility failed to provide the necessary care and services to maintain personal hygiene for 1 of 5 sampled residents (#51) reviewed for ADLs. This placed residents at risk for poor personal hygiene. Findings include: Resident 51 was admitted to the facility in 6/2024 with a dignoses including dementia. Resident 51's 9/15/24 Quarterly MDS indicated her/his cognition was moderately impaired and she/he required assistance or supervision with personal hygiene. Resident 51 was observed from 10/7/24 at 1:30 PM to 10/11/24 at 12:08 PM with a significant amount of chin hairs. On 10/9/24 at 8:37 AM Resident 51 stated she/he did not want chin hairs and needed help to shave them. The 10/11/24 Kardex (bedside care plan) directed staff to shave Resident 51 as necessary. On 10/11/24 at 9:57 AM Staff 43 (CNA) stated she obtained information to care for Resident 51 from the Kardex. On 10/11/24 at 11:30 AM Staff 28 (LPN) confirmed Resident 51 had long chin hairs and staff should assist the resident. Resident 51 told Staff 28 I want my beard shaved off. On 10/11/24 at 12:08 PM Staff 2 (Interim DNS) stated she expected Resident 51 to be shaven on the scheduled days of Monday and Friday.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38140 Based on observation, interview and record review, it was determined the facility failed to provide an ongoing program to support individual activity interests and preferences for 4 of 4 sampled residents (#s 38, 51, 53 and 340) reviewed for activities. This placed residents at risk for isolation, lack of social interaction and engagement. Findings include: The facility's 2023 Activities Policy indicated the facility was to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan and preferences. Facility-sponsored group, individual and independent activities were designed to meet the interests of each resident, as well as support their physical, mental and psychosocial well-being. Special considerations would be made for developing meaningful activities for residents with dementia and/or special needs. 1. Resident 51 was admitted to the facility in 6/2024 with diagnoses including dementia. Resident 51's 7/1/24 Activity Care Plan revealed the following: -The resident was able to communicate verbally and able to make her/his needs known. -The resident was able and preferred to direct her/his own activities of choice. -The resident preferred to visit with family on the phone in her/his room. -The resident preferred the following activities: to read books and magazines; to listen country and Christian music; to read books and magazines; to watch television football, basketball games, news channel 8 and the Hallmark channel. Resident 51's 7/3/24 Admission MDS revealed the resident was severely cognitively impaired. The MDS revealed it was somewhat important for Resident 51 to have books, newspapers and magazines to read, listen to music, to be around pets/animals, to keep up with the news, to do things with groups of people, go outside and participate in religious activities. It was very important for her/him to do her/his favorite activities. The facility's 10/2024 Activity Calendar revealed the following scheduled activities: -10/7/24 8:00 AM Daily Chronicle (passed a daily information sheet to resident rooms) 11:00 AM Mail time and One-on-Ones (delivered mail and talked to residents in their rooms) 3:00 PM Bingo -10/8/24 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8:00 AM Daily Chronicle 11:00 AM Mail time and One-on-Ones 3:00 PM Bible study (five residents in attendance) -10/9/24 8:00 AM Daily Chronicle 11:00 It's Mail time and [NAME] from Holy Family 2:30 PM One-on-Ones with Joy 3:00 PM Wii Bowling -10/10/24 8:00 AM Daily Chronicle 11:00 AM Mail time 2:00 April Trivia and popcorn (one resident in attendance) -10/11/24 8:00 AM Daily Chronicle 11:00 AM It's Mail time 3:00 PM Bingo A review of Resident 51's Activity participation documentation in progress notes from 6/27/24 through 10/14/24 revealed the resident had the following activity involvement: -9/17/24 Staff 7 (Activity Director) talked to the resident about her/his family; -9/19/24 attended a music session prior to lunch; -10/3/24 was provided a magazine and talked about the Hallmark channel; -10/10/24 was invited to a cards group and resident declined. On 10/8/24 at 9:38 AM Resident 51 stated she/he gets bored and has nothing to do. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Random observations of Resident 53 from 10/8/24 through 10/11/24 from 8:37 AM to 3:52 PM revealed the resident to be in her/his room either in bed or in her/his wheelchair. The resident's television was turned on with a low volume to a cartoon channel, the blinds were sometimes closed, no books or magazines were available, and no music played. The resident was observed to go to lunch in the dining room two times. The 10/11/24 Kardex (bedside care plan) directed staff to report to the nurse of any changes in unusual activity attendance patterns or refusals to attend activities. On 10/14/24 at 9:16 AM Staff 7 (Activity Director) stated residents with a dementia diagnosis received one-to-one visits. Staff 7 stated Resident 51 was unable to self-initiate activities and for her one-to-one visits with the resident she primarily provided a magazine, talked to the resident about her/his family and talked about the Hallmark channel. Staff 7 stated she had gone in there a couple of times to visit and invite her/him to an activity. Staff 7 also confirmed all activity department resident participation was documented in the progress notes. On 10/15/24 at 9:13 AM Staff 1 (Administrator) acknowledged the findings of this investigation and did not provide any additional information. 2. Resident 340 was admitted to the facility in 8/2024 with diagnoses including dementia. Resident 340's 8/16/24 Admission MDS revealed the resident was severely cognitively impaired. The MDS also revealed Resident 340 considered it was very important to do her/his favorite activities, to have books, newspapers and magazines to read, to listen to music, to be around animals, to keep up with the news and to go outside. It was not very important to do things with groups of people. Resident 340's 10/11/24 Kardex (bedside care plan) revealed the following: -The resident was able to communicate physically but not verbally. -The resident was able to direct her/his own activities. -The resident could communicate very well verbally but could actively listen and tried to engage in conversation with peers. -The resident's preferred activities were the following: watch television baseball, football, other sports and the news. On 10/7/24 at 12:01 PM Resident 340 was observed to lie in her/his bed with no television, no music and said loudly if you give me an idea to a CNA. No sensory stimulation was provided in the room. On 10/10/24 at 10:44 AM Resident 340 was observed in bed with her/his television set on a Spanish speaking cartoon. Resident 304 stated she/he does not speak or understand Spanish and never watched cartoons in the past. The resident then attempted to use a television remote unsuccessfully. She/he talked about going to work and she/he wanted something to do and later pointed out her/his window to the beautiful weather. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Random observations of Resident 340 from 10/7/24 through 10/10/24 from 8:34 AM to 3:54 PM revealed the resident to be in her/his room in bed. The television was often set to a cartoon channel and no reading materials or music were available. The weather was observed to be warm and not raining. On 10/14/24 at 9:16 AM Staff 7 (Activity Director) stated residents with a dementia diagnosis received one-to-one visits. Staff 7 stated she was unfamiliar with Resident 340 and thought maybe the Activity Assistant staff visited her/him once after her/his admission. Staff 7 confirmed all the activity department resident participation was documented in the progress notes. A review of Resident 340's Progress Note Activity documentation from 8/8/24 through 10/11/24 revealed the resident had no activity department involvement or visits. On 10/15/24 at 9:13 AM Staff 1 (Administrator) acknowledged the findings of this investigation and did not provide any additional information. 47000 3. Resident 38 was admitted to the facility in 7/2021 with diagnoses including dementia. Resident 38's 6/30/24 Annual MDS revealed the resident was cognitively intact and The resident's preferred activities were the following: to read books, magazines and newspapers to, listen to music, spend time around animals, do things with groups of people, go outside and participate in her/his favorite activities and religious practices. Resident 38's 9/26/24 Activity Care Plan revealed the following: -The resident spent most of her/his time in bed and occasionally participated in facility group activities. -Ask the resident if she/he wanted to participate in bingo. -The resident needed assistance/escort to activity functions. -The resident's preferred activities included visits with her/his family, television, music, group activities such as music and bingo, religious visits and to get her/his nails done. The facility's Activity Calendar revealed the following scheduled activities: -10/7/24 8:00 AM Daily Chronicle 11:00 AM Mail time and One-on-Ones 3:00 PM Bingo -10/8/24 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8:00 AM Daily Chronicle 11:00 AM Mail time and One-on-Ones 3:00 PM Bible study -10/9/24 8:00 AM Daily Chronicle 11:00 It's Mail time and [NAME] from Holy Family 2:30 PM One-on-Ones with Joy 3:00 PM Wii Bowling -10/10/24 8:00 AM Daily Chronicle 11:00 AM Mail time 2:00 April Trivia and popcorn -10/11/24 8:00 AM Daily Chronicle 11:00 AM It's Mail time 3:00 PM Bingo A review of Resident 38's Activity Task Log and activity documentation from 9/15/24 through 10/11/24 revealed the resident did not participate in any out-of-room or group activities and no documentation was found to indicate she/he was invited to participate. Random observations of Resident 38 conducted between 10/7/24 to 10/11/24 from 5:07 AM through 3:57 PM revealed the resident to be in her/his room in bed with the blinds closed and the television off. On 10/7/24 at 10:59 AM Resident 38 stated she/he did not participate in activities at the facility because she/he did not get invited. Resident 38 stated she/he went to bingo once, and it was fun, but [she/he] did not get invited back. Resident 38 stated she/he would like the opportunity to participate in musical activities as well as other games but thought she/he was not invited as it was a big deal with me because I need the Hoyer [a mechanical device designed to lift and transfer residents from one place to another] and a chair. Resident 38 further stated she/he enjoyed reading large print newspapers, magazines and books when [she/he] could get them. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/8/24 at 11:56 AM Resident 38 stated she/he did not go to bingo yesterday because no one invited her/him. On 10/9/24 at 1:42 PM Resident 38 stated she/he wanted to participate in the 3:00 PM scheduled activity of Wii Bowling as it sounded fun. On 10/10/24 at 8:51 AM Resident 38 stated she/he did not participate in Wii Bowling yesterday because no one invited her/him. On 10/11/24 at 10:09 AM Staff 44 (Agency CNA) stated she had never seen Resident 38 do anything and was not aware of any of the resident's activity interests. On 10/11/24 at 10:23 AM Staff 25 (CNA) stated Resident 38 spent her/his day in bed and she had never seen the resident engaged in an activity. Staff 25 stated she knew the resident liked cats but was unsure of any additional activity interests. On 10/11/24 at 3:15 PM Staff 26 (CNA) stated Resident 38 spent her/his days in bed, never really watched television and did not go outside. On 10/14/24 at 9:16 AM Staff 7 (Activity Director) stated Resident 38 was hard to get to engage. Staff 7 stated she stopped inviting the resident to group activities because of the resident's repeated refusals. Staff 7 stated the resident's activity care plan did not include all of her/his activity interests and she had not attempted additional person-centered ideas to get Resident 38 engaged in activities. On 10/15/24 at 9:13 AM Staff 1 (Administrator) was informed of the findings and no additional information was provided. 4. Resident 53 was admitted to the facility in 7/2021 with diagnoses including dementia. Resident 53's 6/30/24 Annual MDS revealed the resident was severely cognitively impaired and her/his ability to hear was highly impaired. The MDS also revealed the following activities were important to Resident 53: to read books, newspapers and magazines, listen to music, be around animals, keep up with the news, do things with groups of people, go outside, do her/his favorite activities and participate in religious practices. Resident 53's 10/1/24 Activity Care Plan revealed the following: -The resident preferred independent and in-room activities. -The resident was able to direct her/his own activities of choice. -The resident preferred to visit with family on the phone in her/his room, read romance books or magazines and watch the news. -The resident would come out of her/his room to stroll the hallway and visit with staff. The facility's Activity Calendar revealed the following scheduled activities: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-10/7/24 8:00 AM Daily Chronicle 11:00 AM Mail time and One-on-Ones 3:00 PM Bingo -10/8/24 8:00 AM Daily Chronicle 11:00 AM Mail time and One-on-Ones 3:00 PM Bible study -10/9/24 8:00 AM Daily Chronicle 11:00 It's Mail time and [NAME] from Holy Family 2:30 PM One-on-Ones with Joy 3:00 PM Wii Bowling -10/10/24 8:00 AM Daily Chronicle 11:00 AM Mail time 2:00 April Trivia and popcorn -10/11/24 8:00 AM Daily Chronicle 11:00 AM It's Mail time 3:00 PM Bingo A review of Resident 53's Activity Task Log and activity documentation from 9/15/24 through 10/13/24 revealed the resident had a conversation with a visitor or received a one-to-one on six occasions but did not participate in a group activity, go outside or participate in a religious practice or animal visit. No evidence was found in the resident's clinical record to indicate the resident was invited to any of her/his preferred or favorite activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Random observations of Resident 53 from 10/7/24 through 10/14/24 from 5:07 AM to 3:54 PM revealed the resident to be in her/his room either in bed or in her/his wheelchair. The resident's television was turned on with a low volume, the blinds were closed, no reading material was available and the lights were either off or low. On 10/8/24 at 3:54 PM Resident 53 was unable to answer questions about her/his activity interests and stated I still can't get you in response to the State surveyor's questions. On 10/11/24 at 10:15 AM Staff 25 (CNA) stated she had never seen Resident 53 participate in an activity and she was unaware of the resident's activity interests. Staff 25 stated Resident 53 usually spent all day in bed. Staff 25 further stated activity staff told her if she was supposed to get a resident ready so they could attend an activity and she had never been asked to assist Resident 53 to get ready for an activity. On 10/14/24 at 9:!6 AM Staff 7 (Activity Director) stated residents with a dementia diagnosis received one-to-one visits. Staff 7 stated Resident 53 was unable to self-initiate activities, the resident was not real talkative and her one-to-one visits with the resident primarily consisted of trying to talk. Staff 7 stated she previously offered the resident a painting activity on one occasion but had not attempted any additional sensory activities with the resident. Staff 7 stated the last time she offered the resident any reading material was last month, the resident had not been invited to a group activity in over a week and all of the resident's activity interests were not included in her/his care plan. On 10/15/24 at 9:13 AM Staff 1 (Administrator) acknowledged the findings of this investigation and did not provide any additional information.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on observation, interview, and record review it was determined the facility failed to ensure residents' change of condition was assessed for 2 of 6 sampled residents (#s 38 and 89) reviewed for hospitalization and unnecessary medications. This failure, determined to be an immediate jeopardy situation, resulted in the delayed assessment of Resident 89 when she/he was experiencing a significant change in condition, resulting in delayed treatment, and contributed to the death of Resident 89. This placed all residents at risk for delayed assessments and treatments and constituted substandard quality of care. Findings include: Per National Library of Medicine online resource: Bleeding in the upper stomach and intestinal region carries a high morbidity (sudden onset of a health condition) and mortality (death) which can be lowered by timely evaluation and treatment. Signs of this condition include vomit which looked like coffee grounds. 1. Resident 89 was admitted to the facility [DATE] with a diagnosis of lung cancer with metastasis (cancer spreads to other body systems). Resident 89's [DATE] physician orders revealed Resident 89 was a full code (life sustaining treatment provided if there was no respirations or heart beat). Vital signs from [DATE] to [DATE] revealed Resident 89's vital signs were last obtained on [DATE] at 2:22 PM. Resident 89's pulse was 81 (normal healthy adult range ,d+[DATE]) and respirations were 18 breaths per minute (normal healthy adult range ,d+[DATE]). On [DATE] Resident 89's blood pressure was not obtained. Progress Notes revealed the following: -[DATE] Resident 89 was admitted to the facility for therapy. Resident 89 was alert to person, place, time, and situation and was able to make her/his needs known. Resident 89 was continent of bowel and bladder and was able to eat independently. -[DATE] Resident 89 was able to make her/his needs known. -[DATE] Resident 89 was assessed by her/his physician and was assessed to be a full code. Resident 89 reported she/he wanted to get stronger and go home. Resident 89 was assessed to have a normal thought process, was in no distress, and interacted during the exam. Resident 89's abdomen was soft and nontender. Resident 89 was also assessed to have normal range of motion to her/his arms, had weakness to the left ankle, and her/his skin was normal in appearance and temperature. Resident 89 was a candidate for hospice but prefers to be a full code. -[DATE] and [DATE] Resident 89 participated with therapy without issue and was alert with some forgetfulness. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-[DATE] note written at 3:40 AM by Staff 30 (LPN) indicated Resident 89 vomited once, Zofran (treats nausea) was administered, and Resident 89 did not have continued vomiting. Resident 89 was placed on alert charting. There was no documented assessment of the resident, including vital signs, and if the resident's physician was notified of the characteristics of the vomit. -[DATE] note written at 10:09 AM revealed at 6:50 AM Resident 89 was observed by a nurse to be in bed and was sleeping. At 7:20 AM a CNA summoned the nurse urgently and Resident 89 was found without a pulse or respirations. Staff initiated CPR (cardiopulmonary resuscitation: chest compressions and manual ventilations), emergency services were notified, and at 8:00 AM Resident 89 was transported to the local hospital. -[DATE] note written at 12:13 PM and 12:20 PM by Staff 2 (DNS) revealed she called Staff 34 (CNA) who worked the night shift on [DATE] and Staff 34 stated Resident 89 reported nausea and vomited once. The vomit looked like coffee grounds. The note indicated Staff 34 reported to Staff 30 (LPN) Resident 89 vomited but nothing else. Staff 34 reported Resident 89 was a little pale, not acting her/himself, and maybe a little lethargic. Staff 34 stated on [DATE] at 5:15 AM she checked on the resident and Resident 89 was pale and sleeping. The note indicated Staff 34 was educated to inform the nurse the color and consistency of fluids even if the nurse did not ask. Staff 30, who worked [DATE], reported the CNA informed her Resident 89 vomited at about 1:30 AM. Staff 30 stated she assessed the resident, the resident was able to talk, was able to report nausea, had good color and no other signs or symptoms. On [DATE] at 12:41 PM Staff 34 stated prior to [DATE] Resident 89 was usually very talkative and engaged when she provided care. On [DATE] at approximately 11:00 PM Resident 89 was clammy, tired, and did not talk much. Staff 34 stated she requested Staff 30 check on Resident 89. Staff 34 stated she was not sure if Staff 30 checked on Resident 89 because Staff 34 was busy caring for other residents. Staff 34 stated at approximately 1:00 AM, when she next checked on Resident 89, she found the resident with vomit coming out of her/his mouth and on her/his gown, the resident was incontinent of a large bowel movement, and she/he did not respond very much. Staff 34 stated she notified Staff 30. Staff 34 also stated she told Staff 30 Resident 89 had coffee ground vomit. Staff 34 indicated she was in the room with Resident 89 for about 10 minutes providing care after she notified the nurse and the nurse did not come into the room. Staff 34 stated she was not sure when Staff 30 checked on the resident. Staff 34 stated she did not obtain vital signs and the next time she saw Resident 89 was at about 5:15 AM and she/he was breathing but was still pale and clammy. On [DATE] at 1:21 PM Staff 33 (Nurse Practitioner) stated if a resident was a full code, no matter their medical condition, staff needed to treat a resident's change of condition. If a resident had coffee ground vomit and a medical provider was not on site to assess the resident, staff were to send the resident out to the hospital because staff were limited in the interventions they would be able to provide at the facility. On [DATE] at 2:00 PM Staff 35 (Physician) stated if a resident had coffee ground vomit and was stable the facility could monitor the resident in the facility. Monitoring would include vital signs. Staff 35 stated if a resident had a change in mental status, was pale and clammy, in addition to the coffee ground vomit, the resident would not be stable, the physician should be notified for guidance, and the resident should be sent to the hospital for evaluation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 3:55 PM Staff 30 stated she did not recall Resident 89, but stated if a resident had coffee ground vomit the resident should be sent to the hospital because it could indicate internal bleeding. Staff 30 also stated if a resident's physician was called to obtain orders a note should be made in the progress notes regarding the resident's condition which required communication with the physician. On [DATE] at 12:01 PM and 3:58 PM Staff 2 (DNS) stated when she walked into the building on [DATE] staff were already performing CPR on Resident 89. Staff 2 stated she spoke to staff who worked the night shift and the day shift nurse who found Resident 89 without pulse or respirations. The day nurse stated Staff 30 reported the resident had nausea, vomiting, and nothing else. Staff 30 stated the resident was nauseated, she gave Zofran and it helped. Staff 2 stated Staff 30 reported she did not evaluate or see the vomit. Staff 2 indicated she called Staff 34 and she stated you won't believe it, but it looked just like coffee grounds. Staff 2 stated she educated the Staff 34 to always describe to the nurse what the vomit looked like. Staff 2 also educated Staff 30 to always do more of an assessment and ask what the vomit looked like. Staff 2 acknowledged on [DATE] at approximately 1:00 AM Resident 89 was administered Zofran and the resident was found without a pulse or respirations at about 7:00 AM. Staff 2 verified there were no vital signs obtained on [DATE] and there was no assessment of the resident and resident's vomit. Staff 2 stated Staff 30 reported she did an assessment but did not document it. Staff 2 confirmed on [DATE] at approximately 11:40 AM Resident 89 died at the hospital. On [DATE] at 10:18 AM Staff 2 (Administrator) was notified of the immediate jeopardy (IJ) situation and provided the IJ template related to the facility failure to assess, monitor, and document a resident's significant change of condition. As a result of the deficient practice, treatment was delayed for Resident 89. On [DATE] at 3:27 PM, an acceptable facility IJ removal plan was submitted by the facility. The plan indicated the facility would implement the following: -On [DATE] a review of other resident's change of condition, over the past week that may be affected, was completed by the DNS and designated staff. Other residents identified with a change of condition were to have assessments completed by the end of the day and residents' primary care physicians would be notified as appropriate. -Education for the Nurse and CNA was completed by the assistant DNS after the incident on [DATE]. Further education would be completed on [DATE] with every employee (clinical, administrative, social service, activities, housekeeping, dietary and maintenance) to communicate changes in condition. Employees not on shift would be trained prior to starting shift with review of policy and procedure , then signing off on understanding and implementation. Once notified of a change of condition, the nurse would document, complete an assessment that day, and notify the primary care physician as appropriate. - Performance Improvement Project for change of condition would be initiated by the DNS or designee to audit 1.) Resident change of condition and 2.) Nurse assessments were completed the day of reported change of condition. The audits would be conducted weekly for one month, then twice a month for two months, and randomly thereafter. Results would be shared with Quality Assurance and Performance Improvement committee until substantial compliance was achieved. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The IJ was removed on [DATE] at 10:15 AM as confirmed by onsite verification by the survey team. 47000 2. Resident 38 was admitted to the facility in ,d+[DATE] with diagnoses including hypertension (a condition where the pressure of blood in the blood vessels is consistently too high), coronary artery disease (heart disease) and peripheral vascular disease (a circulatory condition that occurs when blood vessels outside of the brain and heart narrow, spasm or become blocked). Resident 28's [DATE] Annual MDS revealed the resident was cognitively intact and received a diuretic (a medication used to treat fluid retention [edema] and swelling caused by congestive heart failure, liver disease, kidney disease and other medical conditions). The Dehydration/Fluid Maintenance CAA indicated the resident had adequate fluid intake and did not appear dehydrated. In response to the question in the CAA which asked whether or not dehydration/fluid maintenance would be addressed in the resident's care plan, not assessed was checked. A review of Resident 38's weights revealed the following: -On [DATE] the resident weighed 154.5 pounds. -On [DATE] the resident weighed 163.4 pounds. This represented an 8.9 pound weight gain from her/his weight on [DATE]. -On [DATE] the resident weighed 171.5 pounds. This represented an 8.1 pound weight gain from her/his weight on [DATE] and a 17 pound weight gain from her/his weight on [DATE]. Resident 38's [DATE] Physician Progress Note indicated the resident experienced brawny edema (a type of edema that does not indent when pressure is applied, unlike pitting edema, when a swollen part of your body has a dimple [or pit] after you press it for a few seconds) of her/his lower legs. A [DATE] Physician's Order directed Resident 38 to receive furosemide (a diuretic) one time daily for edema. No evidence was found in Resident 38's clinical record to indicate the resident's weight gains had been reported to the resident's physician or the underlying cause of the weight gain had been assessed, any systems were in place to monitor changes in the resident's edema or the potential for fluid overload (indicative of too much water in a person's body which can raise blood pressure and force the heart to work harder) had been assessed. On [DATE] at 12:24 PM Staff 2 (DNS) stated Resident 38's edema was not being monitored and should be and she did not know if Resident 38's physician had been notified of the resident's weight gains. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 12:52 PM Resident 38 was observed in her/his room in bed. Staff 40 (RN) removed the resident's socks in order to assess her/his legs and feet. An indent in each of the resident's legs was observed once the socks were removed. When Staff 40 pushed on the resident's ankles, she/he yelled out and stated Staff 40 was hurting her/him. Staff 40 stated the resident's ankles were a plus 1 for edema (a barely visible dent that immediately rebounded after pressure was applied) but the top of her/his feet were a plus 2 (a slight pit that went away within 15 seconds). Staff 40 stated the resident did not have scheduled monitoring for her/his edema, the top of her/his foot was not normally like that, the change in swelling was not reported to her and the physician had not been notified of this change. On [DATE] at 2:03 PM Staff 41 (Agency RN) stated she was the charge nurse for day shift and was responsible for Resident 38's care. Staff 41 stated she did not receive any reports of Resident 38's edema. On [DATE] at 3:05 PM Staff 2 acknowledged the findings and provided no additional information.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 26991 Based on observation, interview, and record review it was determined the facility failed to ensure a resident was provided restorative services and a resident with limited range of motion received appropriate treatment and services to prevent further decreases in range of motion for 4 of 10 sampled residents (#s 5, 7, 16 and 50) reviewed for ADLs and mobility. This placed residents at risk for decrease in range of motion and worsening contractures. Findings include: 1. Resident 5 was admitted to the facility in 4/2024 with a diagnosis of paralysis. A 6/5/24 Therapy RA Referral form revealed staff were to assist Resident 5 with exercises three times a week. Exercises included weights for upper body strength and edge of bed exercises. A 7/28/24 quarterly MDS revealed Resident 5 was cognitively intact. On 10/10/24 at 11:49 AM Resident 5 stated she/he was no longer getting therapy and was weaker. On 10/10/24 at 8:11 AM Staff 36 (RA) stated Resident 5 was just restarted on therapy on 10/8/24. Staff 36 stated initially Resident 5 was not able to sit at the edge of the bed because she/he had a pressure ulcer to the coccyx region but was able to do arm exercises in bed. On 10/10/24 at 1:14 PM Staff 2 (DNS) stated initially Resident's RA program was designed to have her/him sit at the bedside and do arm weights. Staff 2 stated due to the pressure ulcer, Resident 5 did not want to sit at the bedside. Staff 2 stated she was not sure the reason the resident was not reassessed to implement in-bed exercises. 2. Resident 16 was admitted to the facility in 2/2020 with a diagnosis of diabetes. A 9/9/24 through 10/8/24 RA Program documentation revealed Resident 16 was to be seen two to three times a week for arm exercises. The form revealed resident 16 refused once and was not available on 16 occasions. Two times it was documented as Not Applicable. On 10/7/24 at 10:22 AM Resident 16 stated staff did not assist with exercises and she/he felt weaker. On 10/10/24 at 8:13 AM Staff 36 (RA) stated if she marked not available it meant the resident was not assisted up by the CNA staff and therefore she was not able to assist the resident to go to to the therapy gym. Staff 36 stated she could assist Resident 16 in a wheelchair but she had other RA appointments and would not be able to see all the other residents. Staff 36 also stated Resident 16 did not refuse to exercise. On 10/10/24 at 10:32 AM Staff 21 (Director of Therapy) stated Resident 16 was in the RA program for quite a while and RA should always try to assist the resident to be up at a specific time to do her/his exercise. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47000 3. Resident 50 was admitted to the facility in 11/2021 with diagnoses including hemiplegia (a total or partial paralysis of one side of the body that results from disease of or injury to the motor centers of the brain) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs and facial muscles). Resident 50's 7/14/24 Annual MDS indicated the resident was severely cognitively impaired, experienced upper extremity impairment on one side and an active or passive range of motion program was not provided to the resident in the prior seven days. Resident 50's 7/19/23 through 8/15/23 OT Evaluation and Plan of Treatment indicated the resident exhibited contractures in all right upper extremity joints and pain with ROM. Resident 50's 8/4/24 Care Plan revealed the following: -The resident had an RA program in place to prevent right upper extremity contractures, pain and compromised skin integrity. -Monitor the resident's progress towards an RA program goal of three times daily. -Review the resident's RA program as needed. Resident 50's 8/15/24 OT Discharge Summary directed the resident to receive a restorative program which included gentle passive range of motion to the resident's right shoulder, elbow, wrist and digits with the goal of prevention of further contracture and pain in her/his right upper extremity. No evidence was found in Resident 50's clinical record to indicate the resident's upper extremity impairment was comprehensively assessed, ongoing monitoring of her/his upper extremity impairment was provided or the resident's RA program was re-evaluated for appropriateness. On 10/8/24 at 11:50 AM Resident 50 was observed in her/his room in bed. The resident's right arm was bent at the elbow and her/his right hand rested on the top of her/his chest. The resident's right thumb was tucked into the palm of her/his hand and the right pointer and little finger rested on top of the middle and ring finger. The fingers on Resident 50's left hand were observed to be in a loose fist. Resident 50 stated she/he was unable to move or straighten her/his fingers or thumb on her/his right hand and her/his right hand hurt a little bit. The resident was able to somewhat straighten her/his fingers on her/his left hand with verbal prompting but was unable to straighten them completely. On 10/10/24 at 9:06 AM Staff 20 (CNA/RA) stated she was the facility's RA and she completed restorative exercises with Resident 50 one to two times weekly. Staff 20 further stated she had seen Resident 50's contractures slowly get worse. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/24 at 9:50 AM Staff 21 (Director of Therapy) stated Resident 50 received a therapy evaluation in 2023 for contracture management and she would expect the resident to be referred back to therapy if she/he experienced new or worsening contractures. At 2:01 PM the State Surveyor and Staff 21 observed Resident 50 in her/his room in bed. Staff 21 stated she thought the right hand seemed more contracted, the left hand had maybe mild contractures, she was unaware of her/his new and worsening contractures and she would have expected to see a referral to therapy to address the resident's contractures. On 10/10/24 at 3:57 PM Staff 2 (Interim DNS) stated she expected the nurses and the RA to report new or worsening contractures to the DNS. Staff 2 further stated Resident 50's contractures had not been assessed, there was no on-going monitoring of the resident's contractures, she could not tell if the resident's contractures had worsened and nothing was being done to prevent contractures from developing in the resident's left hand. 50927 4. Resident 7 was admitted to the facility in 11/2019 with diagnoses including multiple sclerosis and depression. A 3/17/24 annual MDS revealed Resident 7 had impaired mobility of the upper and lower extremities. Resident 7's 9/23/24 Care Plan included the following: -The resident had an RA program related to maintaining baseline ROM to bilateral upper extremity as long as possible. -The resident had contractures to left shoulder, hips, and knees upon admission. -The goal of the RA program was to maintain baseline ROM to bilateral upper extremity. -Evaluate for therapy as appropriate. -RCC/RCM would review RA program as needed. A restorative note dated 7/18/23 revealed a new order was received for a restorative program for bilateral upper extremity ROM and the care plan was updated. Random observations of Resident 7 from 10/7/24 through 10/11/24 from 11:31 AM to 4:16 PM revealed Resident 7 in bed with her/his left arm contracted. Staff 20 indicated Resident 7 refused RA when she last worked with the resident. On 10/11/24 at 9:39 AM Staff 20 (CNA/RA) stated she had not worked with Resident 7 for about a year. Staff 20 indicated Resident 7 refused RA when she last worked with the resident. Staff 20 stated the resident's contractures had worsened over the years since she/he was admitted . On 10/11/24 at 1:56 PM Staff 2 (Interim DNS) stated the RA program for Resident 7 was discontinued on 10/18/23 when resident was admitted to the hospital. Staff 2 confirmed the program should have restarted when Resident 7 returned to the facility but was not.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 26991 Based on interview and record review it was determined the facility failed to ensure residents were free from accident hazards for 3 of 6 sampled residents (#s 6, 50 and 60) reviewed for accidents. This placed residents at risk for falls and adverse medication consequences. Findings include: 1. Resident 6 was admitted to the facility 12/2022 with a diagnosis of diabetes. A care plan revised on 6/8/24 revealed Resident 6 was to be transferred by two staff. A 9/29/24 quarterly MDS revealed Resident 6 was cognitively intact. On 9/18/24 Witness 2 (Complainant) reported facility staff was observed to transfer Resident 6 with one staff and not two. It was reported Resident 16 was fearful during the transfer but did not fall. On 10/8/24 at 10:42 AM Witness 2 stated on 9/18/24 Witness 3 (Community Nurse) was entering Resident 6's room and a CNA who was already in the room was transferring Resident 6 with a mechanical device and no additional staff were in the room. On 10/8/24 at 8:11 PM Staff 31 (CNA) stated she recalled a day when she transferred Resident 6, the resident's legs became weak and Resident 6 almost fell . Staff 31 stated another person walked into the room and Staff 31 requested assistance. Staff 31 did not recall if Resident 6 was a one person or a two person transfer at that time. Staff 2 acknowledged on 9/18/24 Resident 6 required two staff for transfers. 41458 2. Resident 60 was admitted to the facility in 8/2023 with diagnoses including acute respiratory failure with hypoxia (a condition in which the body does not have enough oxygen in the blood). Resident 60's 8/4/24 Annual MDS indicated the resident was cognitively intact. Observations from 10/7/24 through 10/10/24 between the hours of 8:00 AM and 4:30 PM, Triad Hydrophilic Wound Dressing (a sterile, zinc-oxide based wound dressing) and a bottle of 10% iodine (a topical antiseptic agent used for treatment and prevention of infection in wounds) sat out in the open, on the counter-top, next to the sink in Resident 60's room. On 10/7/24 at 12:39 PM Resident 60 stated the Triad Hydrophilic Wound Dressing and iodine was always on the counter-top for staff to use when they treated wounds on her/his legs and toes. On 10/10/24 at 1:35 PM Staff 14 (LPN) confirmed Trial Hydrophilic Wound Dressing and iodine was on the counter, unsecured and out in the open in Resident 60's room. Staff 14 stated wound care medications should be out of sight, secured in a closed drawer or cabinet so they were not easily grabbed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/14/24 at 12:34 PM Staff 2 (Interim DNS) acknowledged medications left out in the open, unsecured in residents' rooms would be an accident hazard. 47000 3. Resident 50 was admitted to the facility in 11/2021 with diagnoses including dementia. Resident 50's 7/13/24 Fall Risk Assessment indicated the resident was considered at moderate risk to fall. Resident 50's 7/14/24 Annual MDS revealed the resident was severely cognitively impaired and experienced two falls without injury since her/his prior assessment. Resident 50's 8/4/24 At Risk For Falls Care Plan revealed the resident's bed was to be in a low position and fall mats were to be placed on both sides of the bed when the resident was in bed. On 10/7/24 at 2:18 PM and on 10/8/24 at 11:50 AM Resident 50 was observed in her/his room in bed. On both occasions, the resident's bed was at knee height and no fall mat was placed on the right side of the resident's bed. On 10/9/24 at 8:19 AM Resident 50 was observed in her/his room in bed. The resident's legs hung off of the right side of the bed, her/his left foot was caught in the sheet and the resident yelled help me get out of bed. On 10/9/24 at 9:21 AM Staff 16 (Agency CNA) stated Resident 50 was considered at risk to fall and she/he needed fall mats sometimes in the evening. On 10/10/24 at 12:35 PM Staff 15 (LPN) stated Resident 50 had occasional falls as she/he would put her/his legs out of bed and then slide. Staff 15 stated the resident's bed was to be in a low position and a fall mat placed on each side of the bed when occupied. At this time, Staff 15 observed the resident in bed, stated her/his bed should be lower than this and lowered the bed to the floor. On 10/10/24 at 3:57 PM Staff 2 (Interim DNS) stated she expected Resident 50's bed to be in a low position with a fall mat on each side of the bed when the resident was in bed.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 47000 Based on observation, interview and record review it was determined the facility failed to provide treatment and services to correct ongoing signs of depressive behavior for 1 of 1 sampled resident (#20) reviewed for behaviors. This placed residents at risk for not maintaining their highest practicable physical, mental and psychosocial well-being. Findings include: Resident 20 was admitted to the facility in 9/2022 with diagnoses including depression and adjustment disorder (a group of symptoms, such as stress, anxiety, feeling sad or hopeless, and physical symptoms that can occur after you go through a stressful life event). A review of Resident 20's Patient Health Questionnaire-9 (PHQ-9, a nine-item diagnostic tool used to assess for the presence and severity of depressive symptoms and a possible depressive disorder in adult patients in primary care settings) from 3/2024 through 9/2024 revealed the following: -On 3/10/24 the resident scored a 3, indicating she/he felt little interest or pleasure in doing things nearly every day. This score indicated minimal depression. -On 6/9/24 the resident scored a 6, indicating she/he felt little interest or pleasure in doing things nearly every day and felt down, depressed or hopeless nearly every day. This score indicated mild depression. -On 9/1/24 the resident scored an 8, indicating she/he felt little interest or pleasure in doing things nearly every day, felt down, depressed or hopeless nearly every day, had trouble falling or staying asleep or sleeping too much on several days and felt tired or had little energy on several days. This score indicated mild depression. Resident 20's 9/1/24 Annual MDS indicated the resident was moderately cognitively impaired. The CAAs indicated the resident's psychosocial well-being would be addressed in her/his care plan with a goal of improvement in well-being. Resident 20's 9/11/24 Depression Care Plan revealed the following: -The resident's depressed behaviors included feelings of loneliness, negative self-talk and withdrawn behavior. -Monitor, record and report to the resident's physician prn any risk for harm to self. -Monitor, record, report to the resident's physician prn any risk for harming others. -Routine and prn pharmacy review per protocol. -Specific Interventions: encourage the resident to attend group activities as able and assist with calling family. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The problems and interventions listed in Resident 20's 9/11/24 Depression Care Plan reflected the same problems and interventions listed in the resident's 6/19/24 Depression Care Plan. No evidence was found in Resident 20's clinical record to indicate any new or additional interventions to address or monitor the resident's deteriorating mood state and/or new mood symptoms were added or trialed. On 10/7/24 at 12:23 PM and 10/10/24 at 1:43 PM Resident 20 was observed in her/his room in bed. Resident 20 stated the staff did not give a shit about her/him, she/he pretty much just stayed in bed and waited for friends to come and visit, she/he spent all her/his time laying down and she/he would do exercises and games, all of those things, but [she/he] was not invited. Resident 20 further stated she/he wanted to talk to the social worker about her/his mood but thought they had written me off. On 10/9/24 at 9:21 AM Staff 16 (Agency CNA) stated Resident 20 did nothing but watch television in her/his room in bed. On 10/11/24 at 10:21 AM Staff 25 (CNA) stated Resident 20 was negative and not happy to be here. Staff 25 further stated she had not seen the resident out of bed for months and she/he spent all of her/his time in bed watching television. On 10/14/24 at 11:40 AM Staff 17 (Social Services Director) stated she used to report changes in resident PHQ-9 scores and/or new mood symptoms to the former resident care manager, but at present, the facility probably did not have a good system. Staff 17 stated she could not recall if she reported the resident's new mood symptoms and/or worsening mood to the facility's current resident care manager and she did not know if any new interventions or monitoring of the resident's mood was put in place following her/his 9/1/24 PHQ-9 evaluation and MDS Assessment. On 10/14/24 at 12:44 PM Staff 2 (Interim DNS) stated she was also the facility's resident care manager. Staff 2 stated she was made not aware of Resident 20's worsening scores on the PHQ-9 or new mood symptoms and she should have been.

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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. 41458 Based on observation, interview, and record review it was determined the facility failed to obtain and provide routine medication for 2 of 5 sampled residents (#s 33 and 49) reviewed for unnecessary medications. This placed residents at risk for not receiving prescribed medications. Findings include: 1. Resident 33 was admitted to the facility in 12/2021 with diagnoses including chronic respiratory failure with hypoxia (a condition in which the body does not have enough oxygen in the blood). a. Resident 33's 9/17/24 Physician Order indicated the resident was prescribed Vitamin B12, one time a day due to a vitamin deficiency. Resident 33's 9/2024 MAR indicated Vitamin B12 was not available on 9/18/24, 9/19/24, 9/20/24, 9/21/24, 9/22/24 and 9/23/24 which resulted in the resident not receiving the medication. On 10/10/24 at 12:50 PM Staff 19 (RN) reviewed Resident 33's MAR and stated when medications were not available, the charge nurse should be notified. Staff 19 stated Resident 33 went too many days without her/his Vitamin B12 and that's a problem. Staff 19 stated she was unaware Resident 33's Vitamin B12 was not available. On 10/11/24 at 8:55 AM Staff 18 (CMA) reviewed Resident 33's 9/2024 and confirmed the resident's Vitamin B12 was not available on 9/18/24, 9/19/24, 9/20/24, 9/21/24, 9/22/24 and 9/23/24. Staff 18 was unable to recall why Resident 33's Vitamin B12 was unavailable but stated medications should be ordered approximately one week in advance, and if not available, then the charge nurse should be notified so the pharmacy could be contacted. Staff 18 was unsure if he notified the charge nurse that Resident 33's Vitamin B12 was not available. On 10/11/24 at 2:49 PM Staff 2 (Interim DNS) confirmed Resident 33's Vitamin B12 was not available. She stated she expected nursing staff to contact the pharmacy to determine why the medication was unavailable and then call the provider to get direction regarding the missed doses. Staff 2 acknowledged neither the pharmacy nor the provider was contacted. b. Resident 33's 9/17/24 Physician Order indicated the resident was prescribed folic acid (works closely with Vitamin B12 to help make red blood cells and help iron work properly in the body), one time a day. Resident 33's 9/2024 MAR indicated folic acid was not available on 9/19/24, 9/20/24, 9/21/24 and 9/22/24 which resulted in the resident not receiving the medication. On 10/10/24 at 12:50 PM Staff 19 (RN) reviewed Resident 33's MAR and stated when medications were not available, the charge nurse should be notified. Staff 19 stated Resident 33 went too many days without her/his folic acid and that's a problem. Staff 19 stated she was unaware Resident 33's folic acid was not available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/24 at 8:55 AM Staff 18 (CMA) reviewed Resident 33's 9/2024 MAR and confirmed the resident's folic acid was not available on 9/19/24, 9/20/24, 9/21/24 and 9/22/24. Staff 18 was unable to recall why Resident 33's folic acid was unavailable but stated medications should be ordered approximately one week in advance, and if not available, then the charge nurse should be notified so the pharmacy could be contacted. Staff 18 was unsure if he notified the charge nurse Resident 33's folic acid was not available. On 10/11/24 at 2:49 PM Staff 2 (Interim DNS) confirmed Resident 33's folic acid was not available. She stated she expected nursing staff to contact the pharmacy to determine why the medication was unavailable and then call the provider to get direction regarding the missed doses. Staff 2 acknowledged neither the pharmacy nor the provider were contacted. c. Resident 33's 9/17/24 Physician Order indicated the resident was prescribed Invokana (a medication to lower blood sugar levels), one time a day for diabetes. Resident 33's 9/2024 MAR indicated Invokana was not available on 9/18/24 and 9/19/24 which resulted in the resident not receiving the medication. On 10/10/24 at 12:50 PM Staff 19 (RN) reviewed Resident 33's MAR and stated when medications were not available, the charge nurse should be notified. Staff 19 stated Resident 33 went too many days without her/his Invokana and that's a problem. Staff 19 stated she was unaware Resident 33's Invokana was not available. On 10/11/24 at 8:55 AM Staff 18 (CMA) reviewed Resident 33's 9/2024 MAR and confirmed the resident's Invokana was not available on 9/18/24 and 9/19/24. Staff 18 was unable to recall why Resident 33's Invokana was unavailable but stated medications should be ordered approximately one week in advance, and if not available, then the charge nurse should be notified so the pharmacy could be contacted. Staff 18 was unsure if he notified the charge nurse Resident 33's Invokana was not available. On 10/11/24 at 2:49 PM Staff 2 (Interim DNS) confirmed Resident 33's Invokana was not available. She stated she expected nursing staff to contact the pharmacy to determine why the medication was unavailable and then call the provider to get direction regarding the missed doses. Staff 2 acknowledged neither the pharmacy nor the provider were contacted. 43691 2. Resident 49 was admitted to the facility in 5/2024 with diagnoses including hyperlipidemia (high cholesterol) and kidney failure. A 5/31/24 BIMS indicated Resident 49 had normal cognitive function. a. A 5/30/24 Physician Order indicated Resident 49 was to receive 20 mg of pravastatin at bedtime for cholesterol. Review of a 10/2024 MAR revealed Resident 49 did not receive pravastatin on the following dates: - 10/1/24, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 10/3/24, - 10/4/24, - 10/5/24, - 10/7/24, - 10/8/24, - 10/9/24, - 10/10/24, - 10/11/24, - 10/12/24 and - 10/13/24 On 10/14/24 at 11:16 AM Staff 13 (LPN) was unable to locate Resident 49's pravastatin in the medication cart. Staff 13 stated he would communicate with the physician about renewing orders when a medication was found to be out of stock. On 10/14/24 at 11:51 AM Staff 2 (Interim DNS) stated she had not been informed Resident 49's pravastatin was not available to be administered until 10/14/24. Staff 2 confirmed Resident 49 had not received pravastatin on the dates listed and no action had been taken to obtain the medication. b. A 5/30/24 Physician Order indicated Resident 49 was to receive five mg of oxycodone every three hours as needed. Review of a 10/2024 MAR revealed Resident 49 did not receive oxycodone on 10/12/24 and 10/13/24. On 10/14/24 at 10:57 AM Resident 49 stated she/he had experienced moderate pain on 10/12/24 and 10/13/24, she/he requested oxycodone to assist with pain reduction, and was told the medication was not available. On 10/14/24 at 11:16 AM Staff 13 (LPN) attempted to locate Resident 49's oxycodone and stated it was not located in the medication cart. Staff 13 did locate a sticky note with information that appeared to be related to Resident 49's oxycodone but stated it was unclear and he was unable to determine if Resident 49 had any extra prescribed doses of oxycodone available. On 10/14/24 at 11:51 AM Staff 2 (Interim DNS) confirmed Resident 49 did not receive her/his oxycodone medication when requested on 10/12/24 and 10/13/24, as it was not available.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 26991 Based on interview and record review it was determined the facility failed to ensure a resident was monitored for side effects of antidepressants for 1 of 5 sampled residents (#1) reviewed for unnecessary medications. This placed residents at risk for an adverse medication regimen. Findings include: Resident 1 was admitted to the facility in 5/2024 with a diagnosis of severe malnutrition. Resident 1's 10/2024 MAR revealed Resident 1 was administered trazodone (antidepressant which can also help with sleep) daily with a start date of 5/24/24 and sertraline (antidepressant) daily with a start date of 5/24/24. A care plan initiated 5/31/24 revealed Resident 1 was administered antidepressants and potential side effects included drowsiness, suicidal thoughts, confusion, and increased falls. Review of Resident 1's clinical record did not indicate staff monitored her/him for psychotropic medication side effects. On 10/10/24 at 12:38 PM Staff 2 (DNS) stated staff were to document psychotropic medication side effect monitoring on the MARs. Staff 2 acknowledged staff did not monitor Resident 1 for possible side effects.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on observation, interview and record review it was it was determined the facility failed to ensure a medication error rate of less than 5%. The facility administration error rate was 19.23% with 5 errors in 26 opportunities. This placed residents at risk for an ineffective medication regimen. Findings include: Resident 343 was admitted to the facility in,d+[DATE] with a diagnosis of heart disease. Epocrates Online (web based pharmacy resource) revealed levothyroxine (hormone replacement)should be taken 15 to 60 minutes before breakfast with a full glass of water at the same time daily. It also indicated the following drug to drug interactions: -levothyroxine and metformin (treats diabetes): deceases antidiabetic agent. -levothyroxine and metoprolol (treats high blood pressure) may decrease antihypertensive. -levothyroxine and sucubitril (treats heart failure and high blood pressure) may decrease antihypertensive. -levothyroxine and omeprazole (treats acid reflux) may decrease thyroid hormone levels. A current Order Summary Report revealed Resident 343 was to be administered levothyroxine 30 minutes before meals. On [DATE] at 8:49 AM Resident 343 was observed with her/his meal tray being removed from her/his room. Resident 343 stated she was done eating. Resident 343's hot cereal bowl was observed to be empty. Staff 32 (Agency LPN) was observed to administer the following medications to Resident 343: -levothyroxine -sucubitril -metformin -omeprazole Staff 32 stated she asked other staff if it was okay to administer levothyroxine with other medications and after meals and staff told her it did not matter. On [DATE] at 5:09 PM Staff 2 (DNS) acknowledged Resident 343's physician's order was to administer levothyroxine without food and levothyroxine had drug to drug interactions with multiple medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 26991 Based on observation and interview it was determined the facility failed to ensure medications and biologicals were secured and accessible only to authorized personnel for 5 of 6 halls (1B, 1C, 1D, 2C and 2D) observed for secure medication and treatment carts. This placed residents at risk for misappropriation of medications and adverse medication consequences. Findings include: 1. On 10/8/24 the following occurred: -8:02 AM a treatment cart on 1D was observed to be unlocked, a CNA walked by the cart but did not lock the cart. -8:07 AM Staff 15 (LPN) locked the cart. Staff 15 stated she was not responsible for the the treatment cart which was unlocked and it was the night shift cart. Staff 15 stated the cart contained medicated creams and should be locked. 2. On 10/10/24 at 5:40 PM a medication cart located on the 1B hall was observed to be unlocked with no staff within sight of the cart. Staff 17 (Social Services Director) indicated the cart was to be locked and she informed a nurse who was in a resident's room. 43690 3. On 10/8/24 at 3:53 PM a treatment cart was observed to be unlocked on 2C. The nurse was not in view of the cart. On 10/8/24 at 4:09 PM Staff 6 (LPN) confirmed the cart was unlocked. 4. On 10/10/24 at 8:22 AM a medication cart was observed to be unlocked on 2C. The nurse was not in view of the cart. On 10/10/24 at 8:26 AM Staff 14 (LPN) confirmed the cart was unlocked. 5. On 10/14/24 at 9:41 AM a medication cart was observed to be unlocked on 2C. The nurse was not in view of the cart. On 10/14/24 at 9:46 AM Staff 8 (CMA) confirmed the cart was unlocked. 6. On 10/14/24 at 9:59 AM a medication cart was observed to be unlocked on 1C. The nurse was not in view of the cart. On 10/14/24 at 10:05 AM Staff 13 (LPN) confirmed the cart was unlocked. 7. On 10/15/24 at 8:06 AM a treatment cart was observed to be unlocked on 1D. The nurse was not in view of the cart. (continued on next page)

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Friendship Health Center	3320 SE Holgate Blvd Portland, OR 97202

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/24 at 8:13 AM Staff 2 (DNS) confirmed the cart was unlocked. On 10/15/24 at 8:13 AM Staff 2 stated it was her expectation for the medication and treatment carts to remain locked when unattended.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 26991 Based on observation, interview, and record review it was determined the facility failed to ensure a follow-up dental exam was scheduled for 1 of 4 sampled residents (#16) reviewed for dental. This placed residents at risk for delayed treatment. Findings include: Resident 16 was admitted to the facility in 2/2020 with a diagnosis of diabetes. A 7/23/24 Progress Note indicated all of Resident 16's teeth were extracted. An 8/11/24 quarterly MDS revealed Resident 16 was cognitively intact. An 10/2024 Upcoming Appointment Requests list revealed Resident 16 was not on the list to be seen by a dentist. On 10/7/24 Resident 16 stated her/his teeth were pulled a few months prior, there were no follow-up appointments made and she/he wanted dentures. On 10/11/24 at 9:53 AM and 10/11/24 at 10:20 AM Staff 17 (Social Services Director) stated a dentist came to the facility two to three times a year. Staff 17 stated after teeth were pulled a resident's gums healing time varied from resident to resident and a resident needed to to be examined to determine if denture fitting was appropriate. Staff 17 stated Resident 16 was not on the current list to be seen and she would call to see when Resident 16 required an exam. On 10/16/24 at 11:22 AM Witness 4 (Dentist) stated he pulled Resident 16's teeth and on average, after teeth were pulled, gums healed in approximately eight weeks and the denture process could start.

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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. 38140 Based on observation, interview and record review it was determined the facility failed to ensure foods were labeled and stored to ensure proper food storage practices were followed in 1 of 1 kitchen reviewed. This placed residents at risk for foodborne illness. Findings include: Review of the US FDA 2022 Food Code revealed: -food prepared and held cold must be clearly marked with date prepared or by day which the food shall be consumed or discarded. During the initial tour of the kitchen on 10/7/24 at 9:40 AM Staff 39 (Dietary Manager) verified and threw away the following undated and unlabeled items: Reach-in refrigerator: -A gyro sandwich wrapped in foil; -Prune juice poured into multiple glasses; -Three green salads. Walk-in refrigerator: -An opened container of chicken stock base; -Olives stored in a plastic container; -Cut tomatoes in a plastic container partially covered with plastic wrap; -Shredded carts stored in a plastic container. On 10/7/24 at 9:54 AM Staff 39 stated he expected all items in the refrigerators to be labeled, dated and covered, especially the opened items. On 10/7/24 at 10:00 AM Staff 1 (Interim Administrator) acknowledged he expected all food in the refrigerator to be dated.

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F 0825 Level of Harm - Actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 47000 Based on observation, interview and record review it was determined the facility failed to ensure residents received timely specialized rehabilitative services (PT and OT services) for 1 of 1 sampled resident (#20) reviewed for rehabilitation and restorative. This failure resulted in Resident 20 displaying a depressed mood, verbalizing feelings of frustration and a decline in physical functioning. Findings include: The facility's 1/2023 Therapy Evaluation Policy indicated the following: -The Rehabilitation Department was to be notified when a physician order was written for therapy evaluation and treatment. -The licensed therapist was to perform a chart review and initiate the evaluation. -The initial evaluation was to be completed within two to three days from the time the referral was written. Resident 20 was admitted to the facility in 9/2022 with diagnoses including a history of falls. A review of Resident 20's clinical record revealed she/he was hospitalized from 10/23/23 to 10/27/23 related to sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection, causing inflammation, blood clots and leaky blood vessels) secondary to a urinary tract infection. Resident 20's 10/26/23 PT Treatment Note completed during the resident's hospital stay indicated the resident was able to complete a stand-pivot transfer to a chair, bedside commode or wheelchair with a gait belt, front-wheeled walker and contact guard assist (a type of assistance where a caregiver places one or two hands on a patient to help with balance but does not provide any other help with a task). The note further indicated the resident required standby assistance from a caregiver for bed mobility. Resident 20's 10/27/23 ICF Admission Orders directed nursing staff to continue with the functional mobility and ADL levels established in the hospital as allowed per weightbearing status until the resident was seen by PT. Resident 20's 10/27/23 Physician Orders indicated PT and OT was to assess and treat the resident. Resident 20's 10/27/23 Readmission Form indicated the resident required limited assistance from staff with transfers. No evidence was found in Resident 20's clinical record to indicate she/he was assessed and treated by PT or OT since she/he readmitted to the facility from the hospital on 10/27/23. (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Few	Resident 20's 9/1/24 Modification of Annual MDS Assessment indicated the resident was moderately cognitively impaired, dependent on staff assistance for transfers and experienced mild depression. The CAAs further indicated the resident required extensive assistance with bed mobility as she/he experienced deconditioning (a decline in physical and mental function that occurs due to a lack of physical activity or extended bed rest), pain and weakness. Resident 20's 9/11/24 ADL Performance Deficit Care Plan revealed the following: -The resident required assistance from two staff and the use of a Hoyer lift (a mobile device that helps caregivers safely transfer patients with limited mobility from one place to another) for all transfers. -The resident was unable to use a bedside commode or toilet. On 10/7/24 at 12:01 PM Resident 20 was observed in her/his room, in bed. Resident 20 stated she/he did not receive any therapy, no one does any exercises with me and she/he pretty much just stayed in bed and waited for friends to come and visit. Resident 20 stated no one at the facility gave a shit and she/he thought all the staff had written [her/him] off. On 10/10/24 at 1:43 PM Resident 20 stated she/he felt as if she/he had physically declined and was weaker all over. Resident 20 stated she/he did not sit up very well anymore because she/he spent all her/his time laying down, she/he wanted to be able to stand again and she/he did not like feeling weaker and dependent. On 10/10/24 at 10:00 AM Staff 20 (CNA/RA) stated she was not responsible for assisting the resident with any restorative exercises and the resident did not currently receive any therapy services. On 10/10/24 at 10:36 AM Staff 23 (Agency CNA) stated Resident 20 required a Hoyer lift for transfers and the resident no longer used the toilet or bedside commode but had incontinent care provided in bed instead. Staff 23 stated the resident was a more active participant in her/his ADLs a few months ago but right now she had to do everything for [the resident's] lower body. On 10/10/24 at 10:46 AM Staff 24 (CNA) stated she had not seen Resident 20 get out of bed since 2/2024. Staff 24 further stated in 2/2024 the resident required the assistance of one to two staff with transfers but now she/he used a Hoyer lift. On 10/10/24 at 2:12 PM Staff 21 (Director of Therapy) stated she was not aware of Resident 20's order for PT and OT from 10/27/2023 and the last time the resident received therapy services was in 5/2023. On 10/10/24 at 4:37 PM Staff 2 (Interim DNS) acknowledged the findings and confirmed the resident should have received therapy services following her/his hospitalization in 10/2023 but did not.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 43690 Based on interview and record review it was determined the facility failed to ensure residents were fully informed and understood the binding arbitration agreement for 1 of 1 facility reviewed for binding arbitration agreements. This placed residents at risk of being uninformed regarding their legal rights. Findings include: On 10/14/24 at 1:01 PM Staff 1 (Administrator) stated the facility offered a Mediation and Arbitration Clause to residents upon admission. Staff 1 stated he and Staff 5 (Bookkeeper) were responsible for the process of explaining the agreement to residents upon admission. On 10/14/24 at 1:06 PM Staff 5 stated she was responsible to provide residents with information related the facility's Mediation and Arbitration Clause. Staff 5 stated the information was part of the admission handbook, she did not explain the arbitration process to residents nor did she obtain signatures with dates. On 10/14/24 at 1:06 PM Staff 1 acknowledged the facility did not have a clear process for providing information regarding binding arbitration agreements to residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 26991 Based on observation, interview, and record review it was determined the facility failed to ensure community use CBG monitors were cleaned with an approved disinfectant for 3 of 6 sampled units (2, 2D and 1B) observed during medication administration and random observations, failed to implement EBP (enhanced barrier precautions: gloves and gowns worn during high contact for wounds and indwelling devices) timely for 1 of 2 sampled residents (#5) reviewed for pressure ulcers, failed to transport linens in a sanitary manner, and failed to ensure a legionella water management plan for 1 of 1 facility. This placed residents at risk for cross contamination. Findings include: 1. On 10/8/24 at 8:34 AM Staff 15 (LPN) was observed to clean a community use CBG with an alcohol swab. Staff 15 was stopped prior to entering a resident's room to perform a CBG check. Staff 15 stated she used alcohol swabs to clean CBG machines and at times used bleach wipes. On 10/8/24 at 9:05 AM Staff 37 (LPN) sated she cleaned the community use CBG on the 1B hall with alcohol wipes. All residents with CBG orders were reviewed and were found to not have any bloodborne pathogen diagnoses. On 10/8/24 2:35 PM Staff 2 (DNS) acknowledged alcohol wipes were not effective against blood borne pathogens. 2. Resident 5 was admitted to the facility in 4/2024 with a diagnosis of a chronic pressure ulcer. Resident 5's TARs revealed wound care was provided from 4/24/24, date of admission, to the current date. Progress Notes by Staff 29 (IP) revealed the following: -4/25/24 Resident 5 was identified to have a urostomy tube (surgical tube to drain urine from the bladder), an advanced bone infection from a chronic pressure ulcer, and had a history of a drug resistant organism. The note also indicated Resident 5 does not require any Transmission Based Precautions (EBP) at this time. Resident 5's care plan was not updated with EBP until 8/2024. On 10/11/24 at 9:34 AM Staff 29 stated when a resident was admitted to the facility she looked at the admission paperwork to identify if a resident had a clinical need for EBP, including chronic wounds, a care plan was implemented, signage placed on the resident's door and the PPE was placed by the resident's room. Staff 29 acknowledged Resident 5 was admitted to the facility in 4/2024 and EBP was not implemented until 8/2024. 50927 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. On 10/10/24 at 12:16 PM Staff 22 (Laundry Services) was observed to deliver clean resident clothing throughout wings B and C on the 2nd floor. A small sheet was draped over a portion of the cart but did not cover all of the clean clothing as staff went from room to room. On 10/10/24 at 12:16 PM Staff 22 indicated she always delivered clean laundry in this manner. On 10/11/24 at 2:10 PM Staff 1 (Administrator) acknowledged the findings of this investigation and did not provide any additional information. 4. On 10/10/24 at 8:45 AM Staff 10 (Campus Director of Facility Services) was asked about the facility's water management program related to potential areas of Legionella growth. Staff 10 stated she was not aware of a program. Staff 10 stated she had not monitored for areas of potential Legionella growth since taking the position in March 2024. On 10/10/24 at 4:19 PM Staff 1 (Administrator) confirmed the facility had not developed and implemented a water management program. No further information was provided.