STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385148	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royale Gardens Health & Rehabilitation Center	2075 NW Highland Avenue Grants Pass, OR 97526

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 35855 Based on interview and record review it was determined the facility failed to accommodate resident needs for 1 of 5 sampled residents (#242) reviewed for environment. This placed residents at risk for unmet needs. Findings include: Resident 242 admitted to the facility in 7/2021 with diagnoses including anxiety and dementia. A revised 2/20/24 care plan indicated Resident 242 had an ADL self-care performance deficit, and occasionally required one-person assist with toileting. An 4/10/24 MDS indicated Resident 242 was frequently incontinent of bladder and always continent of bowel. On 4/24/24 the State Survey agency received a public complaint which indicated in 4/2024 Resident 242's bedside commode was not emptied or cleaned and she/he attempted the task by her/himself. On 10/22/24 at 12:52 PM Witness 2 (complainant) confirmed the 4/24/24 public complaint allegations. On 10/24/24 at 7:52 AM Staff 22 (CNA) stated in 4/2024 there was an issue with CNA staff not cleaning bedside commodes and toilet risers for residents. Staff 22 stated there were multiple instances she cleaned Resident 242's bedside commode because assigned CNA staff did not complete the task. On 10/29/24 at 7:39 AM Staff 50 (Housekeeping) stated she remembered in the Spring of 2024 a concern with CNA staff not cleaning bedside commodes timely. Staff 50 stated it was an ongoing concern because she went into a rooms, and the bedside commode was dirty and the room smelled, and she informed the CNAs. Sometimes the CNA did not come and clean the commode so she told the CMA. Staff 50 stated at times she saw a meal tray delivered to a resident, their bedside commode had urine or feces in it, and the CNA left the meal tray and did not clean the bedside commode. On 10/29/24 at 10:08 AM Staff 1 (Administrator) stated the expectation of staff was to clean the bedside commode when completing their rounds of checking on the residents, if a resident did not notify the CNA the bedside commode needed cleaned. When assisting a resident, the expectation was to clean the bedside commode right away.

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

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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. 26991 Based on interview and record review it was determined the facility failed to ensure residents' grievances were addressed for 2 of 2 sampled residents (#s 52 and 70) reviewed for personal property. This placed residents at risk for unresolved grievances. Findings include: 1. Resident 52 admitted to the facility in 9/2023 with a diagnosis of diabetes. A 9/10/24 annual MDS revealed Resident 52 was cognitively intact. A 7/3/24 Grievance Report revealed Resident 52 reported a missing or misplaced heavy jacket. The grievance indicated staff looked in laundry but the jacket was not found. There was no resolution to the missing jacket. On 10/21/24 12:58 PM Resident 52 stated she/he was missing a heavy jacket and there was no follow-up. On 10/22/24 at 12:23 PM Staff 53 (CNA) stated Resident 52 reported a missing jacket and it was sentimental to her/him because a friend gifted it to her/him. On 10/24/24 at 11:54 AM Staff 2 (DNS) acknowledged there was no resolution for the missing jacket. On 10/25/24 at 10:32 AM Staff 27 (Social Services Director) stated if a resident was missing clothing, staff looked for it for about one week to see if it was found in laundry. If the item was not found then a grievance was filed to determine if it would be replaced. 2. Resident 70 admitted to the facility in 9/2024 with a diagnosis of pneumonia. An undated Inventory of Resident 70's personal items revealed Resident 70 had a gold ring. An 10/4/24 Progress Note indicated Resident 70 reported she/he lost her/his wedding ring. The note indicated staff did not locate the ring. On 10/22/24 at 5:05 PM Staff 2 (DNS) acknowledged progress notes indicated Resident 70 reported a gold ring was missing and her/his inventory list included a gold ring. Staff 2 also stated social services and the LPN Unit Manager was not aware of a missing ring and a grievance was not filed.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41455 Based on interview and record review it was determined the facility failed to protect a resident's right to be free from mental and physical abuse by a resident for 1 of 3 sampled residents (#291) reviewed for abuse. This placed residents at risk for abuse. Findings include: Resident 53 admitted to the facility in 12/2023 with diagnoses including stroke and muscle weakness Resident 291 admitted to the facility in 7/2024 with diagnoses including PTSD (Post-Traumatic Stress Disease) and respiratory failure. A 7/8/24 Admission MDS revealed Resident 291 was cognitively intact. A 7/9/24 care plan revealed Resident 291 had PTSD due to a history of sexual abuse, and staff were to provide interventions and redirect and monitor for trauma triggers. A 7/10/24 SS (Social Services) Post-Traumatic Checklist indicated triggers for Resident 291's PTSD included being jumpy or easily startled when approached and it was helpful to feel safe by others when upset. On 7/14/24 at 6:46 PM the State Survey Agency received a facility reported incident and investigation which indicated on 7/14/24 there was a resident-to-resident incident when Resident 53 approached Resident 291, who was outside smoking. Resident 53 complained that the smoke from Resident 291's cigarette impacted her/his time in the activity room because of an open window where she/he smelled Resident 291's cigarette smoke. Resident 53 was observed through security camera footage to place her/his hand on Resident 291's shoulder and push her/him while they were both outside. Resident 291 was assessed and had no injuries. The conclusion of the investigation indicated abuse for Resident 291 was not ruled out. A 7/14/24 Nursing Note indicated Resident 291 was interviewed about the 7/14/24 incident and stated Resident 53 pushed me, this upset me drastically. On 10/28/24 at 4:04 PM Staff 10 (Unit Manager-LPN) stated Resident 291 was triggered by closed places so was often outside. Staff 10 indicated Resident 291's normal activities did continue after the incident, but the resident was concerned about not causing problems in the facility and kept to herself/himself. On 10/28/24 at 5:42 PM Staff 1 (Administrator) stated during a follow-up conversation with Resident 291 about the 7/14/24 incident the resident indicated she/he was fearful of Resident 53 and abuse could not be ruled out because the altercation did occur.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 35855 Based on observation, interview and record review it was determined the facility failed to assess the use of a physical restraint for 1 of 1 sampled resident (#15) reviewed for physical restraints. This placed residents at risk for potential abuse or neglect. Findings include: The Freedom from Abuse Neglect and Exploitation Physical Restraint policy and procedure indicated the following: An example of a facility practice which may meet the definition of a physical restrain included placing a resident on a concave mattress so a resident may not independently get out of bed. Resident 242 admitted to the facility in 3/2024 with diagnoses including anxiety and catatonic schizophrenia (subtype of schizophrenia characterized by extreme changes in motor activity). A review of Resident 15's revised care plan dated 3/12/24 revealed she/he sustained a fall on 3/11/24 and was at risk for falls. No documentation was found on the care plan for Resident 15's scoop mattress. On 10/22/24 at 7:30 AM Resident 15 was observed in her/his bed laying on a scoop mattress. No documentation was found in Resident 15's clinical record she/he was assessed for the application of the scoop mattress to determine if the mattress was a restraint. On 10/3/24 at 11:05 AM and 1:35 PM Staff 2 (DNS) stated the scoop mattress was added in the care plan in 2023. Staff 2 stated Resident 15 could not get out of bed on her/his own, and since Resident 15 could not get out of bed no assessment of the mattress was completed. Staff 2 stated she checked with therapy later and Resident 15 could get out of bed on her/his own.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 26991 Based on interview and record review it was determined the facility failed to ensure a report of misappropriation was reported to the State Survey Agency for 1 of 2 sampled residents (#52) reviewed for personal property. This placed residents at risk for abuse. Findings include: Resident 52 admitted to the facility in 9/2023 with a diagnosis of diabetes. Resident 52's 9/10/24 annual MDS revealed Resident 52 was cognitively intact. A 7/3/24 Grievance Report revealed Resident 52 was missing or misplaced a wallet. The investigation revealed Resident 52 reported money was missing from her/his bank account. A police report was filed. On 10/24/24 at 11:54 AM Staff 2 (DNS) stated an allegation of a missing wallet and money could be misappropriation. Staff 2 stated social services filed a police report on behalf of Resident 52 but a FRI was not submitted.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 26991 Based on interview and record review it was determined the facility failed to ensure a resident was referred to the state agency authority for Level II PASARR (preadmission screening and resident review: assessment to ensure individuals with serious mental illness) evaluation for 1 of 1 sampled resident (#52) reviewed for PASARR. This placed residents at risk for lack of mental health services. Findings include: Resident 52 admitted to the facility from another facility on 9/2023 with a diagnosis of mental illness. A 9/10/23 admission MDS revealed Resident 52 was not administered antidepressants or mood stabilizing medications and she/he was at risk for ongoing social isolation and depression. A plan was to refer Resident 52 to behavioral health services. 9/2023, 10/2023 and 11/2023 MARs and DARs (Diabetic Administration Records) revealed Resident 52 accepted medications and allowed CBG testing. 12/2023, 1/2024 and 2/2024 MARs and DARs revealed Resident 52 refused to take certain medications, cooperate by providing pain levels, and allow staff to obtain CBGs. Progress Notes revealed the following: -1/11/24 Resident 52 refused medication every morning. -2/22/24 a physician note indicated Resident 52 was easily agitated. Staff reported Resident 52 felt staff were playing games with her/him and administered medications which were not prescribed. -2/26/24 Resident 52 refused blood pressure medications and stated she/he thought staff were trying to kill her/him by taking medication she/he did not need. Resident 52's blood pressure was noted to be much higher in the past few days and the physician was notified. -2/28/24 Resident 52 continued to have angry outbursts -2/28/24 Resident 52 continued to have high blood pressure, but refused to take blood pressure medication and refused to have her/his blood pressure checked. -5/9/24 Resident 52 refused blood pressure medications and only accepted two doses so far that month. Resident 52 had a history of refusing medications and treatments. -5/9/24 a physician note indicated the resident was accusatory of staff. Interdisciplinary Team Care Plan/Conference/Welcome Meeting forms revealed the following: -9/11/23 and 12/11/23 no concerns were identified for Resident 52 (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/26/24 Resident 52 reported she/he was not happy in the facility, refused care, and she/he wanted to move. Staff informed Resident 52 her/his behaviors could impact a transfer. -9/9/24 Resident 52 was identified to refuse care, meals, and did not trust staff. Resident 52 continued to make accusations that staff do not do things she/he asked for. -10/18/24 Resident 52 did not trust staff, refused care, and made accusations against staff. Resident 52's record did not indicate a PASARR level II was requested related to her/his mental health diagnosis, refusal of cares, and mood changes. On 10/23/24 at 9:51 AM Staff 43 (CNA) stated Resident 52 often refused care including blood pressure monitoring. On 10/23/24 at 10:27 AM Staff 46 (CMA) stated Resident 52 absolutely refused medications and blood pressure monitoring even when the resident had high blood pressure readings. Resident 52 also became very anxious with care and did not trust staff. On 10/23/24 at 4:47 PM Staff 27 (Social Service Director) stated if a resident had a mental health diagnosis, increased behaviors, and refusal of cares a PASAAR II was usually requested or a request was made to the facility psychologist to assess a resident. Staff 27 stated this was not done for Resident 52.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on interview and record review it was determined the facility failed to ensure baseline care plans were developed for 2 of 9 sampled residents (#s 24 and 243) reviewed for accidents and discharge. This placed residents at risk for unmet needs. Findings include: 1. Resident 24 readmitted to the facility on [DATE] with a diagnosis of type 1 diabetes with complications including high blood sugar levels. 9/24/24 hospital Discharge orders revealed Resident 24 was admitted for diabetic ketoacidosis (a complication of diabetes in which acids build up in the blood to levels that can be life threatening) and was discharged to the facility with insulin orders. Resident 24's baseline care plan initiated 9/24/24 did not include Resident 24 was diabetic with history of high blood sugar levels, symptoms to monitor, and interventions to provide if needed. On 10/24/24 at 12:52 PM Staff 2 (DNS) stated when a resident was discharged to the hospital her/his care plan was discontinued and a new care plan was initiated upon her/his return. Staff 2 acknowledged there was no baseline care plan related to Resident 24's diabetes, insulin, and what symptoms staff should monitor related to high and low blood sugar levels. 35855 2. Resident 243 admitted to the facility on [DATE] with diagnoses including altered mental status and fracture of the lower back. A review of Resident 243's hospital History and Physical dated 2/13/24 indicated she/he had an admission to the hospital for recurrent falls. Resident 243's baseline care plan dated 2/16/24 did not contain information regarding her/his risk for falls or fall interventions. On 10/29/24 at 10:17 AM Staff 1 (Administrator) and Staff 2 (DNS) stated they expected fall interventions to be included in the baseline care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41455 Based on observation, interview and record review it was determined the facility failed to involve residents and/or representatives in the care planning process for 1 of 2 sampled residents (#8) reviewed for care plans. This placed residents at risk for lack of care plan interventions. Findings include: Resident 8 admitted to the facility in 9/2024 with diagnoses including stroke. A 9/25/24 through 10/22/24 (CNA) Task: Shower/Bathe Self Saturday and Wednesday document indicated Resident 8 refused or did not receive bathing for six of nine opportunities. A 9/26/24 Admission MDS indicated Resident 8 was moderately cognitively impaired. The 10/4/24 IDT (Interdisciplinary Team) Care Plan Conference/Welcome Meeting Form indicate Resident 8 was present but Witness 8 (Family Member) was not present during a discussion of Resident 8's care needs. The 10/22/24 contact list for Resident 8 indicated Witness 8 was her/his first emergency contact and POA (Power of Attorney) for care. On 10/21/24 at 3:44 PM Witness 8 stated because of Resident 8's memory issues, the resident wanted her involved in her/his care planning especially because Resident 8 continued to refuse showers. Witness 8 stated she was not aware who to contact related to her concerns for Resident 8 even though she visited Resident 8 often. On 10/22/24 at 2:00 PM Staff 27 (Social Services) stated it was important to involve Resident 8's POA in her/his care planning because the resident's cognition was moderately impaired. Staff 27 acknowledged she did not involved Resident 8's representative in the care planning process even though it was needed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49677 Based on observation, interview and record review it was determined the facility failed to evaluate a resident for an augmentative and alternative communication device (AAC, a tablet, board or laptop that uses pictures or a speech-generating device to assist in communication) for 1 of 1 sampled resident (#49) reviewed for communication. This placed residents at risk for unmet communication needs. Findings include: Resident 49 admitted to the facility on [DATE] with diagnoses including Aphasia (a disorder in speaking and understanding language). On 10/21/24 at 11:32 AM, an interview with Resident 49 revealed her/his verbal communication was severely impaired (nonverbal with the use of pointing and gestures). At that time Staff 5 (CNA) reported Resident 49 often confused no for yes which decreased staff's understanding of how to meet Resident 49's communication and care needs. Staff 5 confirmed there was no picture communication board for Resident 49 to point to for more specific requests and communication. On 10/22/24 at 12:41 PM, Staff 3 (speech therapist and clinical supervisor) confirmed three separate speech therapy evaluations, dated 6/30/23, 12/30/23, and 6/27/24, were conducted for Resident 49. The evaluation dated 6/30/23 indicated resident 49's primary mode of communication was nonverbal; Recomended primary mode of communication=Non-Speech Generating Device. Staff 3 confirmed she completed the three evaluations and Resident 49 was not evaluated for an AAC device as recommended or provided one in the facility.

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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. 35855 Based on interview and record review it was determined the facility failed to ensure dependent residents received required assistance with ADLs for 2 of 5 sampled residents (#s 31 and 240) reviewed for ADLs. This placed resident at risk for unmet needs. Findings include: 1. Resident 31 admitted to the facility in 8/2018 with diagnoses including stroke and dementia. An 8/23/24 MDS revealed Resident 31's BIMS score was seven which indicated severe cognitive impairment. Resident 31 required substantial to maximal assistance with toilet transfers and was dependent on staff for assistance with toileting hygiene. Resident 31 was frequently incontinent of bladder and bowel. The urinary incontinence CAA indicated Resident 31 required significant assistance with most ADLs. Resident 31 was at risk for complications resulting from bowel and bladder incontinence. Staff were to provide assistance with toileting and incontinence, frequent checks and assistance with incontinent care, and to encourage toileting independence as safely able. A review of Resident 31's care plan revised 2/23/23 indicated Resident 31 was incontinent of bowel and bladder with interventions including check and change frequently and toilet as requested, observe the pattern of incontinence, initiate a toileting schedule if indicated, and for staff to take Resident 31 to the bathroom at the same time each day she/he usually had a bowel movement. A review of the Documentation Survey Report (DSR) for 3/2024 revealed the following for Resident 31's bowel elimination out of 95 opportunities: -Day shift: 20 no bowel movement, five continent, three refused, and four incontinent. -Evening shift: 12 no bowel movement, five continent, three refused, six incontinent and five no documentation. -Night shift: 21 no bowel movement, six refused, four no documentation and one not applicable. A review of the DSR for 4/2024 revealed the following for Resident 31's bowel elimination out of 92 opportunities: -Day shift: 24 no bowel movement, six continent, one refused, and one incontinent. -Evening shift: 19 no bowel movement, five continent, four incontinent and two no documentation. -Night shift: 23 no bowel movement, one continent, three refused, and three no documentation. On 4/24/24 the State Survey Agency received a public complaint which indicated while Resident 31 was in the hallway she/he asked staff to assist her/him to the bathroom. Staff stood in the hallway and ignored her/him. Resident 31 crapped [her/his] pants. On 10/22/24 at 12:52 PM Witness 2 (Complainant) confirmed the 4/24/24 public complaint allegations. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/24 at 9:56 AM Staff 9 (CNA) stated there were one or two instances where Resident 31 requested to use the toilet and the staff were busy passing meal trays or getting ready to go into a resident room which required PPE and Resident 31 had a bowel incontinence episode. On 10/29/24 at 10:08 AM Staff 1 (Administrator) and Staff 2 (DNS) stated it was expected one staff assisted the Resident 31 when she/he needed to use the toilet, and the remaining staff continue with passing trays or other tasks. 2. Resident 240 admitted to the facility in 10/2017 with diagnoses including stroke and anxiety. A review of Resident 240's care plan dated 6/28/23 indicated she/he had an ADL self-care performance deficit and required extensive assistance of one staff. Resident 240 could have a shower upon her/his request. A review of the Documentation Survey Report (DSR) for 3/2024 revealed Resident 240's bathing days were Monday and Thursday. The DSR indicated Resident 240 received bathing on 3/16/24, 3/18/24, and 3/28/24. On 3/4/24, 3/14/24, and 3/25/24 there was no documentation Resident 240 received any type of bathing. On 3/7/24, 3/11/24, and 3/21/24 documentation indicated Resident 240 refused bathing. Resident 240 did not receive any type of bathing for 15 days from 3/1/24 through 3/15/24 and nine days from 3/22/24 through 3/27/24. The DSR from 4/4/24 through 4/23/24 revealed Resident 240's bathing days were Monday and Thursday. The DSR indicated on 4/4/24 bathing was not attempted due to illness, exacerbation, or injury. No additional documentation was found on the DSR Resident 240 received bathing from 4/4/24 through 4/23/24. On 4/24/24 the State Survey agency received a public complaint which indicated Resident 240 was denied showers. The complaint indicated staff stated I am not dealing with [her/him] today. The staff informed Resident 240 it was not her/his shower day when she/he was scheduled for a shower. On 10/22/24 at 12:52 PM Witness 2 (Complainant) confirmed the public complaint allegations. Witness 2 stated some CNAs did not assist a resident if they did not like her/him. On 10/29/24 at 10:11 AM Staff 2 (DNS) stated the expectation for a refusal was for CNAs to ask a resident three times and to notify the nurse. The nurse then checked with the resident and the refusal was documented on the shower sheet. Staff 2 reviewed Resident 240's shower sheets. No additional information was provided.

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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** 35855 Based on observation, interview and record review it was determined the facility failed to ensure a residents were provided meaningful activity programs for 4 of 4 sampled residents (#s 14, 48, 52, and 68) reviewed for activities. This placed residents at risk for decreased quality of life and isolation. Findings include: 1. Resident 14 admitted to the facility in 3/2024 with diagnoses including depression and dementia. A review of Resident 14's care plan dated 3/25/24 revealed she/he desired one-on-one activities at least once a month for 30 minutes, and to focus on her/his preferred activity interests. The care plan indicated Resident 14 had little to no activity involvement, but the reason why field was blank. Interventions included to monitor for and document the impact of medical problems on the resident's activity level, and the resident's preferred activities were documented as (SPECIFY). Staff were to converse with the resident while providing care, invite the resident to scheduled activities, and provide activity calendars and notify of any changes. A review of Resident 14's MDS dated [DATE] revealed Resident 14's BIMS score was four, which indicated severely impaired cognitive function. It was very important for Resident 14 to do her/his favorite activities, somewhat important to go outside to get fresh air when the weather was good, and to participate in religious services or practices. Resident 14's Activities CAA was blank with no information documented. Observations of Resident 14 from 10/21/24 through 10/23/24 revealed no activities were provided. Resident 14's TV was observed to be on and muted in four instances, but she/he was not observed looking at the TV. A review of the 9/2024 Documentation Survey Report revealed on 9/14/24 Resident 14 attended a snack social event and she/he was active during the activity. A review of the 10/1/24 through 10/24/24 Documentation Survey Report revealed on 10/18/24 Resident 14 was provided a manicure and talked during the activity. On 10/25/24 at 10:09 AM Staff 24 (Activities Director) stated she was in the position for a few weeks and did not realize there was missing documentation in Resident 14's CAA and care plan. On 10/29/24 at 10:18 AM Staff 1 (Administrator) stated she expected Resident 14 to be assessed and care planned for activities. 34703 2. Resident 48 admitted to the facility in 10/2024 with diagnoses including rib fractures and respiratory failure. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During five separate observations between 10/21/24 and 10/29/24 Resident 48 was not observed participating in activities. Resident 48's 10/7/24 activities care plan indicated she/he used to read a lot, but now her/his glasses were not working. Resident 48 stated she/he felt every day was the same. Staff were to encourage her/him to come down to activities of interest. The 10/7/24 Admission MDS indicated Resident 48 enjoyed activities with a group of people, and liked to go outside and participate in activities of interest. On 10/21/24 at 12:33 PM Resident 48 stated there were no staff on the weekends to do activities, so she/he stayed in her/his room. Resident 48 stated staff did not take her/him to activities during the day. On 10/23/24 at 10:34 AM Staff 24 (Activities Director) stated she saw Resident 48 when she/he arrived in the facility, but had not spoken to her/him for a while regarding activities she/he would like to participate in and did not offer any activities to Resident 48. 26991 3. Resident 52 admitted to the facility in 9/2023 with a diagnosis of diabetes. A 9/10/23 admission MDS revealed Resident 52 was cognitively intact but was not assessed for activity preferences. Resident 52 was identified to be at risk for social isolation, depression, and had blindness to both eyes. The assessment also indicated Resident 52 preferred to visit with her/his significant other. Activities/Recreation reviews revealed the following: -12/23/23 Resident 52 participated in 1:1 activities and her/his favorite activity was smoking outside with others. There was no identified activity goal or focus. -3/13/24 Resident 52 participated in 1:1 activities and enjoyed to smoke with others. There was no identified goals or focus. -6/23/24 Resident 52 reported she/he felt staff did not allow visits with her/his significant other and reported she/he could not do anything because she/he was going blind. The form indicated the resident used to like audio books. New interventions included to offer audio books. -10/3/24 Resident 52 at times went to activities to socialize but otherwise stayed in her/his room. The goal was to engage Resident 52 with audio books and information related to dealing with blindness. Interdisciplinary Team Care Plan Conference/Welcome Meeting forms revealed the following: -12/11/23 Resident 52 did not participate in activities due to vision loss. Resident 52 refused independent activities or supplies and stated she/he was very limited and can't participate. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3/19/24 Resident 52 did her/his own in-room activities and visited with the other residents who smoked. -9/9/24 Resident 52 was independent with her/his activities, liked to go outside to smoke, and on some days went on outings with her/his significant other. Activity Participation documentation from 9/30/24 through 10/23/24 revealed Resident 52 participated in one activity, which was reminiscing. On 10/21/24 at 12:53 PM Resident 52 stated she/he could not see, but would like audio books or music. Resident 52 stated the television did not have music programs. Observations revealed: -10/22/24 at 4:14 PM Resident 52 was in her/his room looking toward the television. -10/23/24 at 9:50 AM Resident 52 propelled in the hall. -10/23/24 at 5:12 PM Resident 52 propelled outside and stated she/he was getting fresh air. On 10/24/24 at 12:03 PM Staff 52 (Activities) stated she worked in the facility since 6/2024. Staff 52 stated she was not sure the reason Resident 52 was initially not assessed for activities, indicated Resident 52 did not have 1:1 visits in the last 30 days, and she did not obtain audio books for Resident 52 or other activities which a visually impaired person may enjoy. Staff 52 indicated she did not have experience working with visually impaired residents. 49676 4. Resident 68 admitted to the facility in 11/2023 with diagnoses including anoxic brain damage (lack of oxygen to the brain). An Admission MDS dated ,d+[DATE] indicated preferences for activities were not assessed. A 9/2/24 activities care plan indicated Resident 68 was to maintain involvement in cognitive stimulation during social activities. The care plan included an intervention of one-on-one bedside in-room visits if unable to attend out-of-room events. From 10/21/24 through 10/24/24, during four separate observations, Resident 68 was not observed participating in activities. On 10/22/24 at 8:15 AM Resident 68 stated activities were not offered. On 10/28/24 at 3:07 PM Staff 24 (Activities Director) acknowledged the resident did not participate in activities and was not offered any activities.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41455 Based on observation, interview and record review it was determined the facility failed to administer bowel care and follow therapy recommendations for 4 of 7 sampled residents (#s 8, 30, 70 and 191) reviewed for pressure ulcers, unnecessary medications, and positioning. This placed residents at risk for unmet care needs. Findings include: 1. Resident 8 admitted to the facility in 9/2024 with diagnoses including stroke and heart disease. A 9/26/24 Admission MDS indicated Resident 8 required setup assistance for eating. An 10/15/24 revised care plan indicated Resident 8 required extensive assistance of one staff for eating, and to encourage the resident to sit upright after meals. An 10/18/24 Occupational Therapy Treatment Encounter Note indicated therapy staff spoke to nursing to ensure Resident 8 was in her/his wheelchair for all meals and communication would be provided to CNAs. On 10/21/24 at 1:35 PM Resident 8 was observed sitting in her/his bed with her/his head in a slouched position. A meal was on a bedside table in front of the resident. Witness 8 (Family Member) stated she spoke with therapy who indicated Resident 8 was to be up in her/his wheelchair for meals. On 10/23/24 at 12:43 PM Staff 9 (CNA) stated he delivered Resident 8's meal while she/he was in bed, and did not provide meal assistance for Resident 8 because the need for meal assistance was not discussed during the change of shift meeting. Staff 9 reviewed the Kardex (CNA care plan) and verified Resident 8 required one staff to assist with her/his meals. On 10/23/24 at 12:59 PM Staff 8 (Therapy) stated she observed staff did not assist Resident 8 with her/his meals in the morning on 10/23/24, and encouraged the resident to be up for meals due to changes in her/his blood pressure. On 10/23/24 at 5:34 PM Staff 10 (Unit Manager-LPN) acknowledged Resident 8's care plan interventions for eating were not followed. 26991 2. Resident 30 admitted to the facility in 2018 with a diagnosis of depression. Bowel records from 9/23/24 through 10/21/24 revealed Resident 52 had a bowel movement on 10/8/24, but did not have a bowel movements on 10/9/24, 10/10/24, 10/11/24, 10/12/24, and 10/13/24. An 10/2024 MAR revealed Resident 30 was to receive bowel care every 24 hours as needed for constipation. The physician was to be notified if there was no bowel movement for four days. Resident 30 did not receive PRN bowel care until 10/13/24 (five days without a bowel movement). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/23/24 at 9:06 AM Staff 30 (LPN) stated if a resident did not have a bowel movement for three days bowel care was to be provided and if the resident did not have a bowel movement on the fourth day the physician was to be notified. On 10/23/24 at 9:06 AM Staff 30 (LPN) stated if a resident did not have a bowel movement for three days bowel care was to be provided, and if the resident did not have a bowel movement on the fourth day the physician was to be notified. On 10/23/24 at 2:11 PM Staff 10 (LPN Unit Manager) stated Resident 30 was on scheduled bowel care, but did not receive PRN bowel care until 10/13/24. A request was made of Staff 10 to provide documentation PRN bowel care was administered prior to 10/13/24. No additional information was provided. 3. Resident 70 admitted to the facility in 9/2024 with a diagnosis of pneumonia. Bowel records from 9/25/24 though 10/22/24 revealed Resident 70 had bowel a movement on 9/26/24. Resident 70 did not have a bowel movement on 9/27/24, 9/28/24, 9/29/24, 9/30/24, 10/1/24, 10/2/24, and 10/3/24. 9/2024 and 10/2024 MARs indicated PRN bowel care was administered on 10/7/24, but was ineffective, and also on 10/9/24 which was documented as results unknown. On 10/23/24 at 9:06 AM Staff 30 (LPN) stated if a resident did not have a bowel movement for three days bowel care was to be provided, and if the resident did not have a bowel movement on the fourth day the physician was to be notified. On 10/22/24 at 5:05 PM Staff 2 (DNS) stated if a resident did not have a bowel movement and the PRN bowel care was not effective, there should be an assessment in the resident's record, and the physician should be notified. A request was made to Staff 2 to provide documentation additional PRN bowel care was provided or an assessment was completed. No additional information was provided. 34703 4. Resident 191 admitted to the facility in 6/2024 with diagnoses including pressure ulcer and genital wounds. A public compliant was received on 6/25/24 which indicated Resident 191 discharged from the hospital on 6/12/24 with a small tissue wound to her/his genitals. The 6/27/24 care plan indicated Resident 191 had potential for skin impairments related to fragile skin. Staff were to identify and document potential causative factors and eliminate and resolve where possible. The 6/12/24 Admission Skin and Wound Evaluation revealed no documentation regarding the wound to the genitals. The 6/13/24 Skin and Wound Evaluation indicated Resident 191 had an unknown wound to the genitals. There was no documentation of the wound size, description of the wound or wound care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 6/16/24 Nursing Progress Note indicated Resident 191 had a new open area to her/his right buttocks. No Skin and Wound Evaluation or incident report was found in the resident's medical record. A 6/18/24 Nursing Progress Note indicated Resident 191's right buttock had an open area that was dark red, moist, and had purple bruising surrounding the wound. There were two similar openings to the genitals. Resident 191 complained the wounds were painful and burning. No documentation of the wounds or incident report was found. On 10/29/24 at 10:45 AM Staff 2 (DNS) stated the physician was not notified of the new open wounds to the resident's genitals and there was no skin evaluation or assessment completed.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34703 Based on interview and record review it was determined the facility failed to accurately assess, care plan, implement, follow and maintain pressure ulcer treatments and care plans for 1 of 1 sampled resident (#191) reviewed for pressure ulcers. Resident 191 developing an avoidable unstageable (obscured full-thickness skin and tissue loss) pressure ulcer. Findings include: Resident 191 admitted to the facility in 6/2024 with diagnoses including kidney failure. The 6/17/24 Admission MDS indicated Resident 191 had pressure ulcers and was at risk for pressure ulcers due to incontinence and decreased mobility. Resident 191 admitted with a Stage 2 (shallow open wound) pressure ulcer to the coccyx. A public compliant was received on 6/25/24 which indicated Resident 191 discharged from the hospital on 6/12/24 with a Stage 2 (shallow open wound with red or pink base) pressure ulcer on her/his coccyx (tailbone) measuring 2 cm by 0.1 cm. Resident 191 returned to the hospital on 6/19/24 with worsening wounds to her/his coccyx. The 6/27/24 care plan indicated Resident 191 had potential for skin impairments related to fragile skin. Staff were to identify and document potential causative factors, and resolve them where possible. The 6/12/24 Skin and Wound Evaluation indicated the resident had a Stage 2 pressure ulcer, but did not identify where the wound was located. The picture of the resident's pressure in wound the electronic record revealed the wound bed had slough (a layer of dead tissue on the base of a pressure wound) which indicated an unstageable (covered by necrotic tissues making it impossible to determine the depth of the wound) pressure ulcer. A 6/16/24 Nursing Progress Note indicated Resident 191 had a new open area to her/his right buttocks. No Skin and Wound Evaluation or incident report was found in the resident's electronic record. A 6/18/24 Nursing Progress Note indicated Resident 191's right buttock had a wound that was open, dark red, moist, and had purple bruising surrounding the wound. Resident 191 complained the wounds were painful and burning. No documentation of the wounds or incident report was found in the resident's electronic record. The 6/24/24 Skin and Wound Evaluation indicated Resident 191 had a Stage 2 pressure ulcer to the coccyx but there was no documentation or description of the wound or wound care treatment. Resident 191's pressure ulcer was an unstageable pressure wound to the buttocks, not the coccyx. There was no documented description or treatment for an unstageable pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/27/24 at 1:25 PM Staff 12 (RN) stated she remembered the resident and the pressure wound she/he had. Staff 12 stated the resident admitted to the facility with a Stage 2 pressure ulcer to her/his coccyx which became worse and she/he returned to the hospital. Staff 12 stated the resident acquired an unstageable pressure ulcer to her/his buttocks which never should have happened. Staff 12 stated the treatments were not working, nurses were not documenting on the Skin and Wound Evaluation documents, and the doctor was not notified. On 10/29/24 at 10:45 AM Staff 2 (DNS) stated wound measurements are part of the admission process. The admission nurse did not complete a Skin and Wound Evaluation, and did not provide a thorough Skin and Wound Evaluation for the coccyx wound. Staff 2 stated the physician was not notified of the resident's worsening unstageable pressure ulcer to her/his buttocks and should have been before the wound became worse.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35855 Based on observation, interview and record review it was determined the facility failed to ensure a resident was thoroughly assessed after a fall, failed to update care plans, and ensure the environment remained free from accident hazards for 5 of 7 sampled residents (#s 14, 52, 70, 85 and 292) reviewed for accidents and dementia care. This placed resident at risk for accidents. Findings include: 1. Resident 14 admitted to the facility in 3/2024 with diagnoses including dysphagia (difficulty swallowing). A review of a Speech Discharge Summary signed on 5/9/24 revealed Resident 14 required supervision or assistance at mealtime because of swallow safety zero to 25 percent of the time. Strategies included it was recommended Resident 14 use general swallow techniques and precautions. A review of Resident 14's revised care plan dated 7/8/24 revealed Resident 14 had a swallowing problem because of dysphagia with interventions including the following: diet as ordered, monitor, document, and report PRN any signs or symptoms of pocketing, choking, coughing, drooling or holding food in the mouth or if there were several attempts at swallowing, refusing to eat or appearing concerned during meals. Additionally the plan indicated to refer to a speech therapist for a swallowing evaluation, and Resident 14 was to eat only with supervision. On 10/21/24 at 12:54 PM Resident 14 was observed with a Styrofoam container with food in it with a concerned appearance on her/his face. No staff were observed in the room. On 10/23/24 at 12:09 PM during a continuous observation Resident 14's Styrofoam container was delivered to her/his room. After the delivery of the tray and set up of her/his meal the door was closed. At 12:11 PM Resident 14 pushed her/his bedside table about a foot from her/his bed. When asked if she/he wanted to eat she/he shook her/his head no while presenting with a concerned appearance on her face. On 10/23/24 at 12:15 PM Staff 11 (CNA) stated Resident 14's supervision during meals was because she/he threw items and staff needed to stand there and watch to make sure she/he did not throw items during a meal. On 10/28/24 at 12:37 PM Staff 7 (Regional Director of Therapy Operations) stated Resident 14's supervision was for cueing while eating and supervision on the care plan meant frequent checks. Resident 14 was physically capable to eat on her/his own, but needed reminders to eat. Staff 7 stated frequent meant staff were to set tray in front of her/him, remind her/him to eat, and then repeat the reminder once during the meal and again at the end of the meal. Staff 7 stated most residents who required supervision wer up for meals and in the dining room so staff could watch and cue residents as needed. On 10/29/24 at 10:22 AM Staff 1 (Administrator) and Staff 2 (DNS) confirmed Resident 14's care plan should be followed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 52 admitted to the facility in 9/2023 with diagnoses including blindness and muscle weakness. A 3/3/24 Fall Risk Evaluation indicated Resident 52 had one to two falls in the last three months, had visual impairment and was independent and continent. Resident 52 used an assistive device. A review of Resident 52's 3/12/24 quarterly MDS revealed Resident 14's BIMS score was 14 which indicated she/he was cognitively intact. Resident 52 did not fall since admission or previous the MDS assessment. A 3/15/24 an Un-witnessed Fall report indicated one of the CNAs went to the nursing station to report Resident 52 fell . Resident 52 stated she/he tried to sit up from a lying down position and screwed up. The conclusion of the investigation indicated Resident 52 was found on the floor next to her/his bed by Staff 9 (CNA). On 4/24/24 the State Survey agency received a public complaint which indicated Resident 52 wheels to her/his wheelchair were never locked and she/he fell as a result. A review of Resident 52's care plan dated 10/4/24 revealed she/he was at risk for falls. Resident 52 had impaired balance, blindness, generalized fatigue, generalized weakness, pain, and decreased awareness. Interventions included to place the call light within reach and ensure the resident was aware of it, and encourage its use to call for assistance. Additionally the plan indicated to remind Resident 52 to use her/his mobility aides, ensure commonly used items were within reach before leaving the room, to let her/him know where items were placed, and to ensure she/he was wearing appropriate footwear prior to any transfers, ambulation or mobilizing in her/his wheelchair. Resident 52 needed a safe environment with floors free of spills clutter. A review of Resident 52's Weight Summary report revealed on 3/15/24 Resident 52 was weighed in her/his wheelchair. An 4/8/24 Nursing Note indicated Staff 19 (LPN Unit Manager) discussed Resident 52's placement of her/his wheelchair in her/his room. Resident 52 stated she/he remembered to check the locks on the wheelchair prior to transferring and the care plan was updated. No documentation was found on Resident 52's care plan regarding placement of Resident 52's wheelchair or staff and Resident 52 to ensure wheelchair brakes were locked prior to transfers. On 10/22/24 at 12:52 PM Witness 2 (Complainant) confirmed the 4/24/24 public complaint. On 10/25/24 at 10:01 AM Staff 9 stated he vaguely remembered the fall, but he was the first person in the room. Staff 9 could not remember any details about Resident 52's fall. On 10/25/24 at 10:21 AM Resident 52 stated when she/he fell on [DATE] staff took her/his wheelchair away to weigh it, and when they brought the wheelchair back to the room staff did not set the brakes on the wheelchair. When she/he went to transfer to her/his wheelchair the wheelchair rolled back and she/he fell to the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 at 10:13 AM Staff 19 (LPN Unit Manager) stated when she interviewed Resident 52 she/he was unsure if she/he locked the brakes. Staff 19 stated staff knew where Resident 52's wheelchair should be placed. Staff 19 stated she/he was not sure if she updated the care plan regarding the orange tape by Resident 52's bed to let staff know where to place Resident 52's wheelchair. On 10/29/24 at 10:16 AM Staff 1 and Staff 2 (DNS) stated they expected the care plan to be updated. 26991 3. Resident 70 admitted to the facility in 9/2024 with a diagnosis of pneumonia. A 9/25/24 Fall Risk Evaluation Tool revealed Resident 70 was at risk for falls. A care plan dated 9/25/24 indicated Resident 70 was at risk for falls related to confusion and balance problems. Interventions included staff were to anticipate and meet the resident's needs. An 10/7/24 Unwitnessed Fall investigation revealed Resident 70 attempted to go to the bathroom and fell . Resident 70 reported she/he hit her his head. No additional interventions were identified to be implemented to prevent falls. Neurological Assessments (assessment to identify head injuries) for the 10/7/24 fall indicated assessments were to be performed at the time of the fall then every 15 minutes for three assessments, every 30 minutes for two assessments, every one hour for four assessments, every four hours for four assessments, and every eight hours for three assessments (a total of 17 assessments). The form indicated the initial assessment, one of three 15 minute checks, one of the three 30 minutes checks and two of the four hourly checks were completed. An 10/17/24 Unwitnessed Fall investigation revealed on 10/17/24 Resident 70 was found on the ground. Resident 70 reported she/he reached for her/his phone and fell . No additional care plan interventions were identified to be implemented. No neurological assessments were done after the 10/17/24 fall. On 10/22/24 at 12:13 PM Resident 70 was observed in bed and mats were observed on the floor on both sides of the bed. On 10/23/24 at 9:06 AM Staff 30 (LPN) stated if a resident had an unwitnessed fall, neurological checks should be done even if the resident denied a head injury. On 10/23/24 at 10:01 AM Staff 19 (LPN Unit Manager) stated Resident 70's care plan was not updated to include mats. Staff 19 stated if a resident had an unwitnessed fall neurological assessments were to be completed. A request was made to Staff 19 to provide documentation all neurological assessments were completed for the 10/7/24 and 10/17/24 fall. No additional information was provided. 41455 4. Resident 85 admitted to the facility in 9/2024 with diagnoses including dementia, repeated falls and orthostatic hypotension (a sudden drop in blood pressure when standing). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 9/30/24 Admission MDS and Fall CAA indicated Resident 85 was severely cognitively impaired and had multiple falls prior to admission and within the facility. An 10/11/24 revised care plan indicated Resident 85 had orthostatic hypotension with interventions which included to assess for shortness of breath and monitor for symptoms of heart disease. The care plan also indicated Resident 85 had impulsive behaviors and falls with interventions including to ensure the resident's call light and commonly used items were within reach, ensure she/he wore appropriate footwear, to anticipate and meet the resident's needs and keep the resident's routine consistent to decrease confusion. An 10/14/24 physician order indicated Resident 85 required an abdomen binder which was to be on at night and removed in the morning. On 10/25/24 at 10:09 AM Staff 10 (Unit Manager-LPN) stated because of Resident 85's dementia, repeat falls and inability to remember to use her/his call light, staff were to check on her/him routinely which was not in the care plan. Staff 10 identified Resident 85's abdomen binder was used as an intervention for the resident's hypotention which was a fall prevention and the information was not in the resident's care plan. Staff 10 acknowledged Resident 85's care plan needed to be more personalized to address the resident's specific needs. 5. Resident 292 admitted to the facility in 1/2024 with diagnoses including dementia and a displaced fracture of a right femur (hip bone). A 1/27/24 Nursing Pain Evaluation indicated Resident 292 had no history of pain, her/his current pain level was a five out of 10 due to her/his hip fracture, and pain increased when she/he ambulated. A 1/30/24 Nursing Bowel and Bladder Screener indicated Resident 292 was a candidate for scheduled toileting, and she/he was not currently on a toileting program. The 1/31/24 Admission MDS indicated Resident 292 was severely cognitively impaired and was at risk for falls due to her/his generalized fatigue, decreased ROM to her/his right lower extremity and impaired safety awareness. A 2/12/24 initiated care plan indicated fall interventions for Resident 292 included to wear appropriate footwear when ambulating or in her/his wheelchair, have her/his call light within reach, ensure the floor was free of clutter, ensure her/his bed was in the lowest position, and personalized items were within reach. No interventions or changes were made to Resident 292's fall care plan until 3/12/24. The 2/2024 and 3/2024 MAR indicated oxycodone (narcotic pain medication) was provided every four hours as needed for pain. Documented pain levels ranged from five out of 10 to 10 out of 10 one to three times daily when the medication was administered. Unwitnessed Fall investigations for Resident 292 indicated the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 2/18/24 at 12:30 AM the resident was found sitting on a fall mat in vomit and stated she/he tried to get up to vomit. No injuries were found or pain indicated by the resident, neurological checks (assessment of the nervous system) were initiated and frequent rounding was to be implemented to prevent further occurrences. -On 2/21/24 at 3:15 AM the resident had a fall in her/his room and was found on the floor with a fall mat next to her/his bed. Resident 292 could not recall her/his fall and denied any pain. No injuries were found or pain indicated by the resident and neurological checks were initiated. The resident was last toileted at 2:00 AM and educated to ask for assistance to prevent further occurrences. -On 3/1/24 at 1:00 AM the resident was found with her/his brief at her/his knees and urine on the floor. No lights were on and the resident was last toileted at 10:15 PM on 2/29/24. No injuries were observed at the time of the accident or pain indicated by the resident and neurological checks were initiated. The first responder report indicated the fall mat was in place and the call light was within reach. The resident was educated to ask for assistance to prevent further occurrences (no additional change were made from the 2/21/24 fall). -On 3/3/24 at 10:50 PM the resident was found sitting in the center of the floor with blankets around her/him. No apparent injury or fall related pain was noted and the fall mat was at the bedside (not under the resident). Neurological checks were initiated and the current fall interventions did not change to prevent further occurrences. A 3/3/24 First Responder/Witness Form indicated there were no interventions identified at the time of the fall. The 3/2024 Documentation Survey Report indicated Resident 292 refused her/his shower on 3/3/24 (no skin sheet completed). A 3/5/24 Discharge Assessment indicated Resident 292 discharged to a memory care facility and no skin assessment was completed. A 3/9/24 Communication to Physician Note (from Resident 292's memory care) revealed the resident was assessed by a hospice nurse who found a goose egg on top of Resident 292's scalp with a yellowish-colored border. The physician note indicated the coloring of the head injury was approximately a week old that coincided with a fall which occurred at a previous facility according to the resident's family. On 10/24/24 at 8:57 PM Staff 54 (LPN) stated she completed an investigation related to one of Resident 292's many falls in the facility. Staff 54 stated education was given to Resident 292 to wait for assistance or use her/his call light to prevent her/his falls, but it was ineffective due to her/his dementia. On 10/28/24 at 5:27 PM Staff 19 (Unit Manger-LPN) stated she relied on First Responder reports from staff to determine what actually occurred at the time of Resident 292's falls and was only able to walk around after the fact to ensure the fall mat and other fall interventions were in place. Staff 19 acknowledged the resident's falls occurred mainly at night and confirmed there was no evidence of scheduled toileting or frequent checks by staff as interventions to reduce Resident 292's falls. Staff 19 acknowledged since Resident 292's care plan for falls was not updated, interventions to prevent further falls did not occur. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 at 9:15 AM Witness 7 (Executive Director) stated on 2/29/24 she assessed Resident 292 in her/his room within the facility prior to her/his planned discharged on [DATE] and found no fall mat in place, no call light within the resident's reach, and she/he wore footwear that was not slip resistant. Witness 7 confirmed Resident 292 was not able to assess her/his own pain accurately or ask for pain medication (which would impact fall investigations). Witness 7 stated a few days after Resident 292's admission to memory care, a hospice nurse discovered a goose egg that was indicative of an earlier fall. On 10/29/24 at 10:20 AM Staff 19 stated there was no documentation of a skin check completed by the facility after Resident 292's fall on 3/3/24. Staff 19 acknowledged Resident 292 was already in pain due to her/his hip injury and pain due to a fall would be difficult to assess because of the resident's dementia. Staff 19 acknowledged an alternative pain assessment was needed and not used for Resident 292.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 34703 Based on observation, interview and record review it was determined the facility failed to provide respiratory care and services for 2 of 2 sampled residents (#s 21 and 48) reviewed for respiratory services. This placed residents at risk for unmet respiratory needs. Findings include: 1. Resident 21 admitted to the facility in 9/2024 with diagnoses including respiratory failure. An 10/1/24 physician order revealed Resident 21 utilized a CPAP (continuous positive airway pressure) machine at bedtime. An 10/4/24 physician order indicated staff were to wash the CPAP mask in warm water with baby shampoo, rinse well, air dry, and refill the humidifier with distilled water. Random observations on day and evening shifts from 10/21/24 through 10/23/24 revealed Resident 21's CPAP mask was in her/his opened nightstand drawer, on top of the nightstand, and hanging over the edge of the nightstand. A review of the resident's medical record revealed no information regarding cleaning the CPAP mask, adding distilled water to the humidifier chamber, or storing the CPAP mask in a sanitary manner. On 10/23/24 at 2:37 PM Staff 2 (DNS) confirmed the CPAP mask was not stored in a sanitary manner, there were no instructions in the resident's 10/2024 TAR for cleaning the CPAP mask, and confirmed there was no system in place for the care of Resident 21's respiratory equipment. 2. Resident 48 admitted to the facility in 10/2024 with diagnoses including respiratory failure. An 10/2/24 physician order revealed Resident 48 utilized a CPAP (continuous positive airway pressure) machine at bedtime. A physician order dated 10/4/24 indicated staff were to wash the CPAP mask in warm water with baby shampoo, rinse well, air dry, and refill the humidifier with distilled water. Random observations on day and evening shifts from 10/21/24 through 10/23/24 revealed Resident 48's CPAP mask was on her/his opened nightstand, on top of the nightstand, and hanging over the edge of the bed. On 10/21/24 at 12:22 PM Resident 48 stated staff did not clean her/his CPAP mask or store the mask in a bag so the mask stayed clean. On 10/23/24 at 2:37 PM Staff 2 (DNS) confirmed Resident 48's the CPAP mask was not stored in a sanitary manner.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on interview and record review it was determined the facility failed to ensure a resident received trauma informed care for 1 of 1 sampled resident (#52) reviewed for behavioral-emotional care. This placed residents at risk for re-traumatization. Findings include: Resident 52 admitted to the facility ,d+[DATE] with a diagnosis of a mental health illness. A [DATE] Psychosocial History revealed Resident 52 had trauma related to a child's death and had nightmares about the incident. A [DATE] annual MDS revealed Resident 52 was cognitively intact. A [DATE] Grievance Summary Report revealed staff assisted Resident 52 with a shower. Resident 52 agreed to have her/his beard shaved. The CNA started to shave Resident 52's mustache. Resident 52 stated the CNA was in a hurry to leave the room after the shower and shave. A [DATE] Statement form revealed Staff 51 (CNA) offered to shower Resident 52, shave her/his beard, and trim her/his hair. Resident 52 agreed and Staff started to shave her/his mustache. Halfway through the shave Resident 52 stated don't shave my mustache. Staff 51 reported she was not aware Resident 52's mustache was not to be shaved. On [DATE] at 1:03 PM Resident 52 stated staff shaved her/his mustache and it upset her/him. Resident 52 stated one of her/his children died when the child was a toddler. The child used to always play with her/his mustache. Resident 52 stated the day the child died , the last interaction she/he had was the child was playing with her/his mustache. Resident 52 stated the mustache reminded her/him of the child. On [DATE] at 11:54 AM Staff 2 (DNS) acknowledged Resident 52's mustache was shaved against her/his preference. On [DATE] at 4:47 PM Staff 27 (Social Service Director) stated she was not sure the reason staff did not trigger Resident 52 for trauma related to a child's death since she/he reported nightmares. Former social services staff should have completed an assessment to determine the resident's trauma triggers, if the resident wanted to talk to staff about the incident, and how staff were to monitor the resident for negative outcomes.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 50930 Based on interview and record review it was determined the facility failed to ensure physician orders were reviewed and signed by a physician for 4 of 4 sampled residents (#s 2, 29, 31, and 35) reviewed for physician orders. This placed residents at risk for unassessed medical needs and adverse side effects of medication. Findings Include: 1. Resident 2 admitted to the facility in 9/2021 with diagnoses including arthritis and heart disease. During a review of Resident 2's clinical record on 10/28/24, no signed physician orders were found for 1/2023 through 12/2023, 1/2024 through 3/2024, 5/2024, and 6/2024. On 10/28/24 at 4:00 PM Staff 1 (Administrator) and Staff 52 (Regional Director of Clinical Services) stated no further signed physician orders were available, and acknowledged the months without signed physician orders in Resident 2's clinical record. 2. Resident 29 admitted to the facility in 1/2024 with diagnoses including breast cancer and diabetes. During a review of Resident 29's clinical record on 10/28/24, no signed physician orders were found after 4/2023. On 10/28/24 at 4:00 PM Staff 1 (Administrator) and Staff 52 (Regional Director of Clinical Services) stated no further signed physician orders were available, and acknowledged the months without signed physician orders in Resident 29's clinical record. 3. Resident 31 admitted to the facility in 8/2018 with diagnoses including left sided paralysis and COPD. During a review of Resident 31's clinical record on 10/28/24, no signed physician orders were found for 8/2023 through 12/2023, 1/2024 though 3/2024, and 5/2024 through 10/2024. On 10/28/24 at 4:00 PM Staff 1 (Administrator) and Staff 52 (Regional Director of Clinical Services) stated no further signed physician orders were available, and acknowledged the months without signed physician orders in Resident 31's clinical record. 4. Resident 35 admitted to the facility in 11/2023 with diagnoses including diabetes and heart disease. During a review of Resident 35's clinical record on 10/28/24, no signed physician orders were found after 6/2023. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/28/24 at 4:00 PM Staff 1 (Administrator) and Staff 52 (Regional Director of Clinical Services) stated no further signed physician orders were available, and acknowledged the months without signed physician orders in Resident 35's clinical record.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 50930 Based on interview and record review it was determined the facility failed to ensure residents were seen by a physician every 60 days for 4 of 4 sampled residents (#s 2, 29, 31, and 35) reviewed for physician visits. This placed residents at risk for unmet medical needs. Findings include: 1. Resident 2 admitted to the facility in 9/2021 with diagnoses including arthritis and heart disease. During a review of Resident 2's clinical record on 10/28/24, no physician visit notes were found for 1/2024 through 3/2024, 5/2024, 6/2024, and 8/2024. On 10/28/24 at 4:00 PM Staff 1 (Administrator) and Staff 52 (Regional Director of Clinical Services) stated no further physician visit notes were available, and acknowledged there was no evidence to indicate Resident 2 had a physician visit every 60 days relative to the above timeframes. 2. Resident 29 admitted to the facility in 1/2024 with diagnoses including breast cancer and diabetes. During a review of Resident 29's clinical record on 10/28/24, no physician visit notes were found after 4/2023. On 10/28/24 at 4:00 PM Staff 1 (Administrator) and Staff 52 (Regional Director of Clinical Services) stated no further physician visit notes were available, and acknowledged there was no evidence to indicate Resident 29 had a physician visit every 60 days relative to the above timeframe. 3. Resident 31 admitted to the facility in 8/2018 with diagnoses including left sided paralysis and COPD. During a review of Resident 31's clinical record on 10/28/24, no physician visit notes were found for 6/2024, 7/2024, and 9/2024. On 10/28/24 at 4:00 PM Staff 1 (Administrator) and Staff 52 (Regional Director of Clinical Services) stated no further physician visit notes were available, and acknowledged there was no evidence to indicate Resident 31 had a physician visit every 60 days relative to the above timeframes. 4. Resident 35 admitted to the facility in 11/2023 with diagnoses including diabetes and heart disease. During a review of Resident 35's clinical record on 10/28/24, no physician visit notes were found for 5/2023 through 7/2024, 9/2024, and 10/2024. On 10/28/24 at 4:00 PM Staff 1 (Administrator) and Staff 52 (Regional Director of Clinical Services) stated no further physician visit notes were available, and acknowledged there was no evidence to indicate Resident 35 had a physician visit every 60 days relative to the above timeframes.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 35855 Based on interview and record review it was determined the facility failed to provide sufficient staffing to meet the needs of residents on 3 of 4 halls (A, B and G wings) reviewed for staffing. This placed residents at risk for unmet needs. Findings include: On 4/24/24 the State Survey agency received a public complaint which indicated in 4/2024 call light wait times frequently exceeded 30 minutes. On 10/21/24 the following interviews occurred: -12:32 PM Resident 48 stated she/he had to wait a long time for staff and she/he wanted to go to complete some exercises, but staff did not assist her/him with her/his oxygen. -12:36 PM Resident 18 stated CNAs told nurses what she/he needed, but it took so long for the nurse to respond Resident 18 forgot what she/he needed. -12:52 PM Resident 12 stated sometimes call light wait times were an hour or two. Staff took too long to respond to the call lights. -1:11 PM Resident 63 stated she/he had to wait a long time for staff to help, a couple of times it was a couple of hours, and this occurred mostly on day shift. Resident 63 stated the facility changed staff so often residents did not know the staff and staff did not know what the residents' needs were. Resident 63 stated about half the time the facility was short-staffed. -1:29 PM Resident 70 stated call light wait times were long, up to 30 minutes, and mornings were the worst time. On 10/22/24 at 12:52 PM Witness 2 (complainant) confirmed the public complaint allegation. On 10/24/24 at 7:52 AM Staff 22 (CNA) stated in 9/2024 the facility was short-staffed, and she was assigned 10 to 14 residents on day and evening shifts. Staff 22 stated she was disappointed in herself and it was embarrassing not to answer call lights timely. Staff 22 stated she could not complete resident showers and could not get residents up for meals when the facility was short-staffed. On 10/24/24 at 11:27 AM Staff 28 (CNA) stated the facility was short-staffed at times and she had one to three residents more than the state staffing requirements allowed. Staff 28 stated if she knew she was assigned an entire hall of residents she started her resident checks earlier, and stayed late to finish her required tasks. On 10/25/24 at 10:14 AM Witness 10 (Staff) stated staffing at the facility was not good. The facility did not have a good system in place to cover for staff who called off work or did not show up to their shift. The facility had to scramble to try and find people. At times there was only one nurse assigned for the entire facility on day shift, so the night shift nurse had to stay over until another nurse could be found. Residents did not always get their showers according to the schedule. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 at 10:06 AM Staff 1 (Administrator) and Staff 2 (DNS) stated the facility was still working with agency staff and at times they did not show up to work. The facility reached out to all staff and attempted to have staff stay late or come in early.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 35855 Based on interview and record review it was determined the facility failed to staff a registered nurse for eight consecutive hours per day seven days per week for 6 out of 55 days reviewed for staffing. This placed residents at risk for unmet assessment needs. Findings include: A review of the Direct Care Staff Daily Reports dated 4/1/24 through 4/24/24, 9/20/24 through 9/30/24 and 10/1/24 through 10/20/24 revealed there were six days without eight consecutive hours of registered nurse coverage on any shift in a 24-hour period. On 10/29/24 at 10:03 AM Staff 1 (Administrator) and Staff 2 (DNS) stated at times the facility had RNs call off work and a replacement was difficult to find.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 35855 Based on interview and record review it was determined the facility failed to ensure CNA staff annual performance reviews were completed for 1 of 5 sampled CNA staff (#35) reviewed for staffing. This placed residents at risk for a lack of competent staff. Findings include: During a review of the most recent performance reviews for CNA staff no documentation was provided for Staff 35 (CNA) who was hired on 5/22/22. On 10/29/24 Staff 1 (Administrator) confirmed there was no performance review for Staff 35.

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Royale Gardens Health & Rehabilitation Center	2075 NW Highland Avenue Grants Pass, OR 97526

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 35855 Based on interview, and record review, it was determined the facility failed to post accurate and complete staffing information for 1 of 1 facility reviewed for staffing. This placed residents at risk for incomplete and inaccurate staffing information. Findings include: Observations of the Direct Care Staff Daily Reports (DCSDR) from 10/21/24 through 10/25/24 revealed the following: -10/21/24 at 11:52 AM no census was documented for day shift. -10/22/24 at 6:51 AM the 10/22/24 DCSDR was not posted. -10/23/24 at 8:09 AM the 10/23/24 DCSDR was not posted. -10/25/24 at 10:31 AM no census was documented for day shift. A review of the DCSDR from 10/1/24 through 10/20/24 revealed no census was documented on evening and night shift. On 10/29/24 at 10:04 AM Staff 1 (Administrator) and Staff 2 (DNS) stated the reports would be reviewed and adjustments made as needed. Staff 1 stated she would collect in the morning for the previous day and would try to complete before the morning meetings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34703 Based on interview and record review it was determined the facility failed to provide timely pharmaceutical services for 3 of 7 sampled residents (#s 198, 21, and 78) reviewed for medication administration, and failed to ensure narcotic medication management systems were in place to account for and reconcile narcotics for 2 of 5 narcotic books reviewed for medication administration. The facility failed to administer Resident 198's antiseizure medication placing her/him at risk for grand mal seizures (a type of seizure which involves the loss of consciousness and violent muscle contractions,) hospitalization , and death. This constituted an Immediate Jeopardy (IJ) situation. Findings include: On 6/24/24 at 5:19 PM the facility administrative staff, including Staff 1 (Administrator), Staff 2 (DNS), Staff 51 (Vice President of Operations), Staff 65 (Regional Director of Business Development) and Staff 64 (Senior Regional Reimbursement Specialist) were notified of the IJ situation and provided a copy of the IJ Template related to the facility's failure to provide timely pharmaceutical services for Resident 198. On 10/24/24 at 6:41 PM an acceptable facility plan to remove the IJ situation was received from the facility. The plan indicated the facility would implement the following actions: -Resident 198's provider was notified of the medication error of missed lacosamide (an antiepileptic medication for seizures) dose, and symptoms the resident reported on 10/21/24. -Lacosaminde was initiated on 2/1/24. -A medication error incident rate report was completed and an investigation initiated on 10/24/24. -Resident 198 was placed on alert charting for 72 hours to monitor for effectiveness of lacosamide and resolution or symptoms reported by the resident. -Other residents in the facility with orders for antiseizure medications were to be reviewed to validate their medication was available in the facility and being administered as ordered on 10/24/24. -Resident admitted to the facility since 10/1/24 were to be reviewed to validate that medications ordered were available in the facility and being administered as ordered. -Findings of the above audits will be reviewed with the medical director and the facility consultant pharmacist to review for recommendations. -Licensed nurses and CMAs were to be educated on requirements related to ensuring medications for new admissions were delivered and available for administration, and the steps to take were when a medication was not delivered or available, including steps related to medications that required a prescription for pharmacy dispensation. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The facility admission process was updated to include a review of medications ordered by the hospital to identify any medications that required a prescription to be filled by the pharmacy. Admissions staff would communicate with the hospital to ensure that prescriptions were sent with the resident and/or sent directly to the pharmacy effective 10/25/24. -Morning clinical review processes were updated to include a review of admissions from the prior day to ensure medications were available in the facility. Prescriptions noted as not yet on-hand would receive follow-up by nursing to include calling the pharmacy to inquire about the status of the medication, notification of the status to be communicated to the provider, appropriate documentation as evidence of the follow-up actions. Additionally a review of a report of medications not administered would occur to identify any medications not administered due to availability issues. -Audits would be done for 14 days, weekly for four weeks and monthly for two months to ensure prescription medications were available in the facility and administered as ordered. Audits results would be reported to QAPI Committee for three month and ongoing as indicated. From 10/24/24 through 10/25/24 the IJ removal plan was verified independently by the survey team. No additional concerns related to the IJ situation were noted. 1. Resident 198 admitted to the facility in 10/11/24 with a history of seizures. The 10/2024 MAR instructed staff to administer two times a day for seizures, with a start date of 10/11/24. From 10/11/24 through 10/21/24 the MAR referred the reader to progress notes. Administration Notes revealed the following for lacosamide administrations: -10/12/24 at 7:37 AM waiting for medication delivery. -10/12/24 at 7:17 PM the medication was unavailable. -10/13/24 at 8:44 AM the medication was unavailable. -10/14/24 at 10:01 AM an Administration Note revealed the medication was unavailable in the facility's automated electronic medication dispensing unit. At 7:40 PM the Administration Note indicated the medication was unavailable. -10/15/24 at 8:01 AM and 7:13 PM the medication was unavailable. -10/16/24 at 7:23 AM and 7:58 PM the medication was unavailable. -10/17/24 at 10:03 AM and 7:53 PM the medication was ordered and not available. -10/18/24 at 8:39 AM the medication was still not in the facility. -10/19/24 at 8:05 AM and 9:33 PM the medication was unavailable. -10/20/24 at 8:11 AM and 7:21 PM the medication was unavailable and nurse was aware. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 10/14/24 Encounter Provider Note revealed nursing indicated the pharmacy was unavailable to deliver the lacosamide for Resident 198's seizures. The 10/21/24 at 11:06 AM Nursing Note indicated the facility received signed orders for lacosamide and the pharmacy was faxed. No documentation was found in Resident 198's clinical record the facility contacted the pharmacy to follow up on the medication. On 10/24/24 on 1:31 PM Resident 198 stated when she/he had a seizure it felt like an out of body experience. Resident 198 stated she/he always took her/his seizure medication. Resident 198 stated she/he felt shaky and had an electrical current feeling form at the base of her/his skull to the top of her/his head and had headaches everyday lately. On 10/24/24 at 2:04 PM Witness 5 (Pharmacy Technician) stated on 10/11/24 the pharmacy sent a request for Resident 198's lacosamide to her/his physician. The pharmacy was not provided a new prescription until 10/21/24. On 10/24/24 at 2:50 PM Staff 2 (DNS) stated she was not aware there were issues with Resident 198's admission medications. Staff 2 indicated the process was for the admission nurse to notify the pharmacy if a medication was not delivered, and every shift was to follow up with the pharmacy until the medications arrived. Epocrates.com indicated patients should not stop lacosamide suddenly due to risk for increased seizures. The National Library of Medicine indicated uncontrolled seizures have deleterious consequences, including brain damage, cognitive decline, decreased quality of life and increased mortality. The facility failed to provide timely pharmaceutical services and ensure Resident 198 received their antiseizure medication from 10/11/24 to 10/21/24, which increased the likelihood of a seizure event for Resident 198. 2. Resident 21 admitted to the facility in 9/2024 with diagnoses including high blood pressure and lung disease. A 9/27/24 physician order indicated staff were to administer Atorvastatin (for high cholesterol) once a day at bedtime. The 10/2024 MAR indicated Resident 21 missed doses of her/his medication on 10/1/24, 10/2/24 and 10/3/24. The MAR referred the reader to the Nursing Progress Notes. Nursing Progress Notes dated 10/1/14 through 10/5/24 revealed the medication was unavailable. No documentation was found which indicated the physician or the pharmacy were notified of the unavailable or missed doses of Atorvastatin. On 10/24/24 at 2:50 PM Staff 2 (DNS) indicated the process was for the admission nurse to notify the pharmacy if a medication was not delivered, and every shift was to follow up with the pharmacy until the medications arrived. 3. Resident 78 admitted to the facility in 9/2024 with diagnoses including respiratory failure. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. An 10/14/24 physician order indicated Resident 78 was to receive dexamethasone (for seizures) two times a day. The 10/1/24 MAR indicated the following: -Resident 78's dexamethasone was to be administered twice a day at 8:00 AM and 8:00 PM. -On 10/14/24 and 10/15/24 the MAR referred the reader to Nursing Progress Notes. Nursing Progress Notes dated 10/14/24 through 10/15/24 indicated dexamethasone was not available, No documentation was found which indicated the physician or the pharmacy were notified of the unavailable and missed doses medications. b. An 10/17/24 physician order indicated staff were to administer Advair (used in the treatment of chronic obstructive pulmonary disease) aerosol powder inhaler BID. Review of the 10/2024 MAR indicated Resident 78 missed doses of her/his inhaler on 10/18/24 10/19/24, and 10/20/24. On 10/21/24 and 10/22/24 Resident 78 missed two doses of her/his inhaler. The MAR referred the reader to Nursing Progress Notes. Progress Notes from 10/8/24 through 10/22/24 revealed the Advair inhaler was unavailable. No documentation was found which indicated the physician or the pharmacy were notified of the unavailable or missed doses of the inhaler. On 10/24/24 at 2:50 PM Staff 2 (DNS) indicated the process was for the admission nurse to notify the pharmacy if a medication was not delivered, and every shift was to follow up with the pharmacy until the medications arrived. 3. On 10/23/24 at 12:38 PM the narcotic reconciliation records were reviewed with Staff 2 (DNS) for the two narcotic books on the B and G halls. The reconciliation records revealed many blank signature areas. Staff 2 stated staff should sign the narcotic reconciliation book at every shift change when narcotic medications were counted. Staff 2 acknowledged the blank signature areas and acknowledged the expected process was not followed.

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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. 41455 Based on interview and record review it was determined the facility failed to monitor a resident on a psychotropic medication for 1 of 5 sampled residents (#85) reviewed for medications. This placed residents at risk for receiving unnecessary psychotropic medications. Findings include: Resident 85 admitted to the facility in 9/2024 with diagnoses including dementia and depression. The 9/30/24 Admission MDS and CAA indicated Resident 85 was severely cognitively impaired and had multiple falls prior to admission and within the facility. An 10/7/24 physician order indicated to administer trazodone (antidepressant medication) to Resident 85 at bedtime for insomnia. An 10/16/24 Psychotropic Medication Review indicated Resident 85 was a new admission and her/his trazodone would be monitored to establish baseline. There was no indication for the use of trazodone for Resident 85. An 10/22/24 revised care plan revealed no indication Resident 85 had insomnia or received medication to address her/his sleep. On 10/24/24 at 8:57 PM Staff 54 (LPN) stated Resident 85 was difficult to arouse in the morning and her/his sleep was not monitored. On 10/25/24 at 10:09 AM Staff 10 (Unit Manager-LPN) stated there was a lack of indication for Resident 85's use of trazadone and acknowledged there should be a monitor in place for her/his sleep, especially since the resident had multiple falls and received trazadone for sleep.

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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. 34703 Based on observation, interview, and record review it was determined the facility failed to ensure a medication error rate of less than 5 percent. There were five errors out of 44 medication administration opportunities resulting in a 11.36 percent error rate. This placed residents at risk for an ineffective medication regimen. Findings include: 1. Resident 21 admitted to the facility in 9/2024 with a diagnoses including respiratory failure. An 10/7/24 physician order indicated staff were to administer Advair powder inhaler, inhale one puff and then rinse her/his mouth after each administration. On 10/23/24 at 8:37 AM Staff 36 (CMA) handed Resident 21 her/his inhaler and the resident inhaled twice, but she/he did not rinse her/his mouth after the medication administration. On 10/23/24 at 8:40 AM Resident 21 stated she/he inhaled the medication twice but did not rinse her/his mouth after the medication administration. On 10/23/24 at 8:45 AM Staff 36 stated the resident should inhale the medication one time then rinse her/his mouth after inhaling the medication. On 10/24/24 at 2:50 PM Staff 2 (DNS) acknowledged staff should have residents rinse and spit after inhaler use to avoid mouth infections, and follow physician orders. 2. Resident 198 admitted to the facility in 10/2024 with a diagnoses including heart failure, lung disease and anorexia. An 10/11/24 physician order indicated staff were to administer Combivent inhaler (for chronic lung disease) three times a day. An 10/12/24 physician order indicated staff were to administer iron oral solution daily, metoprolol (for high blood pressure) daily and, Incruse Ellipta inhaler (to treat chronic lung disease) daily. Per WebMD, after administration of Combivent and Incruse Ellipta inhalers, the resident should rinse her/his mouth and spit to avoid mouth infections. On 10/23/24 at 8:48 AM Staff 36 (CMA) administered Resident 198's medication. The resident was not observed to rinse her/his mouth out after she/he used the inhaler medication. Staff 36 stated there was no iron oral solution in the facility and the pharmacy did not deliver the metoprolol to the facility for a few days. Staff 36 acknowledged she did not have the resident rinse her/his mouth after the inhaler medications, and the resident did not receive iron oral solution or metoprolol. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/24/24 at 2:50 PM Staff 2 (DNS) stated she was not aware there were issues with Resident 198's admission medications. Staff 2 indicated the admission process was for the admission nurse to notify the pharmacy and every shift was to follow up with the pharmacy until the medications arrived. Staff 2 also acknowledged staff should have the residents rinse and spit after inhaler use to avoid mouth infections.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. 34703 Based on observation, interview and record review it was determined the facility failed to ensure residents were free from significant medication errors for 1 of 1 sampled resident (#198) reviewed for medication administration. The facility failed to administer Resident 198's antiseizure medication placing her/him at risk for grand mal seizures (a type of seizure which involves the loss of consciousness and violent muscle contractions,) hospitalization , and death. This constituted an Immediate Jeopardy (IJ) situation. Findings include: On 10/24/24 at 5:19 PM the facility administrative staff, including Staff 1 (Administrator), Staff 2 (DNS), Staff 51 (Vice President of Operations), Staff 65 (Regional Director of Business Development) and Staff 64 (Senior Regional Reimbursement Specialist) were notified of the IJ situation and were provided a copy of the IJ Template related to the facility's failure to ensure residents were free from significant medication errors for Resident 198. On 10/24/24 at 6:41 PM an acceptable plan to remove the IJ situation was submitted by the facility. The plan indicated the facility would implement the following actions: -Resident 198's provider was notified of the medication error of missed lacosamide (for seizure) doses, and symptoms resident reported on 10/21/24. -Lacosaminde was initiated on 2/1/24. -A medication error incident rate report was completed and an investigation initiated on 10/24/24. -Resident 198 was placed on alert charting for 72 hours to monitor for effectiveness of lacosamide and resolution or symptoms reported by the resident. -Other residents in the facility with orders for antiseizure medications were to be reviewed to validate their medication was available in the facility and being administered as ordered on 10/24/24. -Resident admitted to the facility since 10/1/24 were to be reviewed to validate that medications ordered were available in the facility and being administered as ordered. -Findings of the above audits will be reviewed with the medical director and the facility consultant pharmacist to review for recommendations. -Licensed nurses and CMAs were to be educated on requirements related to ensuring medications for new admissions were delivered and available for administration, and the steps to take were when a medication was not delivered or available, including steps related to medications that required a prescription for pharmacy dispensation. -The facility admission process was updated to include a review of medications ordered by the hospital to identify any medications that required a prescription to be filled by the pharmacy. Admissions staff would communicate with the hospital to ensure that prescriptions were sent with the resident and/or sent directly to the pharmacy effective 10/25/24. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Morning clinical review processes were updated to include a review of admissions from the prior day to ensure medications were available in the facility. Prescriptions noted as not yet on-hand would receive follow-up by nursing to include calling the pharmacy to inquire about the status of the medication, notification of the status to be communicated to the provider, appropriate documentation as evidence of the follow-up actions. Additionally a review of a report of medications not administered would occur to identify any medications not administered due to availability issues. -Audits would be done for 14 days, weekly for four weeks and monthly for two months to ensure prescription medications were available in the facility and administered as ordered. Audits results would be reported to QAPI Committee for three month and ongoing as indicated. From 10/24/24 through 10/25/24 the IJ removal plan was verified independently by the survey team. No additional concerns related to the IJ situation were noted. Resident 198 admitted to the facility in 10/11/24 with history of seizures. The 10/2024 MAR instructed staff to administer two times a day for seizures, with a start date of 10/11/24. From 10/11/24 through 10/21/24 the MAR referred the reader to progress notes. Administration Notes revealed the following for lacosamide administrations: -10/12/24 at 7:37 AM waiting for medication delivery. -10/12/24 at 7:17 PM the medication was unavailable. -10/13/24 at 8:44 AM the medication was unavailable. -10/14/24 at 10:01 AM an Administration Note revealed the medication was unavailable in the facility's automated electronic medication dispensing unit. At 7:40 PM the Administration Note indicated the medication was unavailable. -10/15/24 at 8:01 AM and 7:13 PM the medication was unavailable. -10/16/24 at 7:23 AM and 7:58 PM the medication was unavailable. -10/17/24 at 10:03 AM and 7:53 PM the medication was ordered and not available. -10/18/24 at 8:39 AM the medication was still not in the facility. -10/19/24 at 8:05 AM and 9:33 PM the medication was unavailable. -10/20/24 at 8:11 AM and 7:21 PM the medication was unavailable and nurse was aware. The 10/14/24 Encounter Provider Note revealed nursing indicated the pharmacy was unavailable to deliver the lacosamide for Resident 198's seizures. The 10/21/24 at 11:06 AM Nursing Note indicated the facility received signed orders for lacosamide and the pharmacy was faxed. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	No documentation was found in Resident 198's clinical record the facility contacted the pharmacy to follow up on the medication. On 10/24/24 on 1:31 PM Resident 198 stated when she/he had a seizure it felt like an out of body experience. Resident 198 stated she/he always took her/his seizure medication. Resident 198 stated she/he felt shaky and had an electrical current feeling form at the base of her/his skull to the top of her/his head and had headaches everyday lately. On 10/24/24 at 2:04 PM Witness 5 (Pharmacy Technician) stated on 10/11/24 the pharmacy sent a request for Resident 198's lacosamide to her/his physician. The pharmacy was not provided a new prescription until 10/21/24. On 10/24/24 at 2:50 PM Staff 2 (DNS) stated she was not aware there were issues with Resident 198's admission medications. Staff 2 indicated the process was for the admission nurse to notify the pharmacy if a medication was not delivered, and every shift was to follow up with the pharmacy until the medications arrived. Resident 198 admitted to the facility with a history of seizures. Epocrates.com indicated patients should not stop lacosamide suddenly due to risk for increased seizures. National Library of Medicine resources indicated uncontrolled seizure have deleterious consequences, including brain damage, cognitive decline, decreased quality of life and increased mortality. The facility failed to provide timely pharmaceutical services and ensure Resident 198 received her/his antiseizure medication from 10/11/24 to 10/21/24. This increased the likelihood of a seizure event for Resident 198.

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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 resident was provided dental services for 1 of 4 sampled residents (#30) reviewed for dental. This placed residents at risk for dental pain. Findings include: Resident 30 admitted to the facility with a diagnosis of diabetes. A 9/5/24 quarterly MDS revealed Resident 30 was cognitively intact. On 10/23/24 at 11:28 AM Resident 30 was observed to have a missing left upper tooth. Resident 30 stated Witness 6 (Family Member) visited about one month prior and noticed her/his tooth was broken. Resident 30 stated the tooth fragment remained in her/his gums. On 10/23/24 12:19 PM Witness 6 stated in 9/2024 she visited Resident 30 and asked her/him What's up with your tooth? Witness 6 stated she notified one of the CNAs who was in Resident 30's room about the newly identified broken tooth. Shortly after she visited Resident 30 a dental office called her to set up an appointment for Resident 30's tooth. Witness 6 stated she informed the dental office to call the facility to set up the appointment and transportation. Witness 6 stated she did not hear from the facility about any additional dental appointments. On 10/23/24 02:15 PM Staff 10 (LPN Unit Manager) stated no one informed him Resident 30 had a broken tooth. On 10/23/24 at 11:38 AM Staff 50 (Agency CNA) stated most of the facility residents had missing teeth and she really did not pay very much attention to missing teeth. On 10/23/24 at 12:33 PM Staff 27 (Social Service Director) stated generally she scheduled dental appointments, but at times the nurses scheduled appointments. Staff 27 stated she was not aware Resident 27 required a dental appointment.

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	385148	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 41455 Based on observation, interview and record review it was determine the facility failed to follow modified textured diets as ordered for 1 of 1 kitchen and 1 of 6 sampled residents (#8) reviewed for food. This place residents at risk for medical complications and aspiration. Findings include: Resident 8 admitted to the facility in 9/2024 with diagnoses including stroke and intestinal obstruction. A 9/26/24 Admission MDS indicated Resident 8 required set-up assistance for eating. A 9/29/24 Order Details revealed Resident 8's diet texture was an Easy to Chew texture. An 10/21/24 Lunch Day 23 Diet Guide instructed staff to serve Minced Dijon Pork Loin with brown gravy for Easy to Chew and Soft and Bite Size diet textures. Staff were also instructed to serve Bite-Sized Moistened Citrus Glazed Angel Food Cake for Soft and Bite Size diet textures. On 10/21/24 at 1:36 PM Resident 8 stated she/he often did not receive the modified textured diet as ordered. Resident 8's partially eaten plate of food was observed which included one inch cubed pieces of cooked pork with no gravy as part of her/his meal. On 10/21/24 at 1:43 PM Staff 13 (Dietary Manager) and Staff 55 (Dietary District Manager) observed the lunch meal plate of Resident 8 and acknowledged minced pork was not available for service or provided during the meal for those who required modified textured diets. On 10/22/24 at 2:20 PM Staff 4 (SLP) stated she observed multiple residents within the last week who did not received the correct modified textured diets during meals including Resident 8. Staff 4 stated she removed a dessert from a resident who required Soft and Bite Size texture because the pieces of cake were too large and a choking hazard. Staff 4 stated she was concerned dietary staff lacked understanding related to modified texture diets.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 35855 Based on observation, interview and record review it was determined the facility failed to provide assistive devices for 1 of 3 sampled residents (#15) reviewed for nutrition. This placed residents at risk for unmet dining needs. Findings include: Resident 242 admitted to the facility in 3/2024 with diagnoses including anxiety and catatonic schizophrenia (subtype of schizophrenia characterized by extreme changes in motor activity). A revised care plan dated 8/26/24 indicated Resident 15 had a nutritional problem and need for assistance with food and fluids. Interventions included Resident 15 was to be provided a non-weighted built-up spoon with each meal. On 10/22/24 at 8:09 AM Resident 15 was in the dining room and was eating her/his breakfast with her/his hands. On 10/23/24 at 11:54 AM Resident 15 was in the dining room and was provided a spoon which was not a non-weighted built-up spoon. At 12:01 PM Staff 11 (CNA) stated CNAs did not have access to the resident's specialized equipment and confirmed the kitchen did not provide Resident 15 the non-weighted built-up spoon for her/his meal. On 10/29/24 at 10:24 AM Staff 7 (Regional Director of Therapy Operations) confirmed staff should provide Resident 15 her/his non-weighted built-up spoon as care planned during meals.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41455 Based on observation, interview and record review it was determined the facility failed to provide a sanitary kitchen environment for 1 of 1 facility kitchen. This placed residents at risk for food-borne illness. Findings include: An 10/2024 Sanitizer Bucket Log indicated the facility's Multi-Quat Sanitizer had a broad efficacy range of 150-400 PPM (parts per million), staff were to complete testing of the sanitizer levels a minimum of every four hours and more often as needed, and to keep the water clean to keep the sanitizer in use effective. On 10/25/24 at 9:23 AM Staff 47 (Dietary Aide) was observed to sanitize a soiled dish cart with a rag that was removed from a red bucket that contained sanitizing solution. The rag and sanitizing solution was observed to contain black flecks. Staff 47 was asked to test the concentration of the sanitizer in the bucket and confirmed the sanitizer solution used to sanitize the soiled dish cart was ineffective at 100 PPM. Staff 47 indicated the sanitizer in the bucket was changed every four hours. On 10/25/24 at approximately 9:30 AM Staff 37 acknowledged the system in the kitchen to ensure the effectiveness of the sanitizer in use was inadequate. On 10/24/24 at 11:16 AM the kitchen walk-in refrigerator pass-through doors were observed to have black specks around and on white gaskets surrounding the doors. The kitchen cleaning list was observed and there was no task identified for the cleaning of refrigerators within the kitchen. On 10/24/24 at approximately 11:30 AM the resident snack refrigerator was observed to have a white gasket around the refrigerator door which was torn. Dried brown particles were in the creases of the refrigerator door gasket. The top shelf of the refrigerator was also observed with dried brown participles. On 10/24/24 at 11:49 AM Staff 37 (Operational Manager) acknowledged the refrigerators in the kitchen and snack area were not cleaned and the task should be added to the kitchen cleaning list to ensure compliance.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 35855 Based on multiple immediate jeopardy situations and numerous citations including antibiotic stewardship, staffing, care plan revisions, professional standards of practice, accidents, significant medication error, and pressure ulcer treatments, it was determined the facility was not managed in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This resulted in multiple occurrences of immediate jeopardy and substandard quality of care. Findings include: 1. The facility failed to implement, follow, and maintain pressure ulcer treatments for Resident 191 resulting in harm due to a worsening pressure ulcer. Refer to F686 2. The facility failed to ensure residents were thoroughly assessed after a fall and ensure the environment remained free from accident hazard for Residents 14, 52, 70, 85 and 292. Refer to F689 3. The facility failed to provide nursing services to ensure adequate RN and CNA staffing to meet the needs of the residents. Refer to F725 and F727 4. The facility failed to ensure residents were seen by a physician and physician orders were reviewed and signed by a physician. Refer to F711 and F712 5. The facility failed to provide timely pharmaceutical services for Residents 21, 78, and 198. This consitituted an Immediate Jeopardy situation. Refer to F755 6. The facility failed to ensure residents were free from significan medication errors for Resident 198. This consitituted an Immediate Jeopardy situation and Substandard Quality of Care. Refer to F760 7. The facility failed to follow infection control standards for Resident 37 and for four halls. Refer to F880 9. The facility failed to ensure an appropriate antibiotic was administered for UTIs for Residents 29, 30 and 242. This consitituted an Immediate Jeopardy situation. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refer to F881

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34703 Based on observation, interview, and record review it was determined the facility failed to follow infection control standards for 1 of 1 sampled resident (#37) and 4 of 4 halls during random observations. This placed residents at risk for exposure and contraction of infectious diseases. Findings include: 1. A public complaint was received on 3/13/24 which indicated there was a Norovirus outbreak in the facility in 3/2024. On 10/29/24 at 8:24 AM Staff 36 (CMA) stated in 3/2024 the facility had an outbreak of some illness and residents experienced vomiting and diarrhea on all halls, but nobody indicated the illness was Norovirus. On 10/29/24 at 8:28 AM Staff 9 (CNA) and Staff 58 (CNA) stated there was an illness in the facility in 3/2024 and residents experienced vomiting and diarrhea on all halls. On 10/29/24 at 8:30 AM Staff 12 (RN) stated there was an outbreak in the facility in 3/2024, but staff did not verify if the illness was Norovirus. Staff 12 stated the outbreak was on all halls with multiple residents ill, and it lasted approximately 48 hours. Staff 12 stated some residents were tested for Norovirus, but the facility sent the wrong specimen container and there was no follow-up testing. Staff 12 stated she was not aware if the outbreak was reported. On 10/29/24 at 11:09 AM Staff 2 (DNS) stated the facility had multiple residents experience vomiting and diarrhea in 3/2024, and it lasted approximately 48 hours. Staff 2 stated she did not believe it was Norovirus and did not test residents to rule out Norovirus. Staff 2 acknowledged she did not report the outbreak. 49676 2. Resident 37 admitted to the facility on ,d+[DATE] with diagnoses including acute kidney failure with an indwelling catheter. An 10/28/24 revised care plan instructed staff to check the resident's catheter to keep the collection bag off the floor. On 10/22/24 at approximately 9:40 AM Resident 37 was observed with her/his catheter tubing on the ground. On 10/22/24 at 9:45 AM Staff 56 (Wound Nurse) acknowledged the expectation was to keep the catheter tubing off the floor.