STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385168	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Lebanon	350 S. 8th Lebanon, OR 97355

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35855 Based on interview and record review it was determined the facility failed to provide risk and benefit information related to the use of antipsychotic medications to residents/responsible parties prior to administration for 1 of 5 sampled residents (#10) reviewed for medications. This placed resident responsible parties at risk for lack of informed consent. Findings include: Resident 10 admitted to the facility in 5/2024 with diagnosis including dementia. A review of the 5/2024 MAR revealed instruction staff to administer Haloperidol (an antipsychotic used to treat mental and mood disorders) four times a day for anxiety and agitation with a start date of 5/9/24. The Admission MDS dated [DATE] revealed Resident 10 had a BIMS score of 10, which indicated the resident was moderately impaired cognitively. A review of Resident 10's clinical record revealed Witness 2 (Family Member) was Resident 10's responsible party. A review of a Consent for use of Psychotropic Medication Therapy dated 5/16/24 revealed Resident 10 was prescribed haloperidol for anxiety. Resident 10 was informed about the risk and benefits of the medication. In an interview on 7/19/24 at 12:42 PM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) confirmed staff were expected to have medication consent forms signed before the medications were administered.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 47001 Based on interview and record review it was determined the facility failed to ensure care conferences were completed for 1 of 5 sampled residents (#15) reviewed for ADLs. This placed residents at risk for unmet needs. Findings include: Resident 15 admitted to the facility in 11/2021 with diagnoses including dementia. On 7/18/24 at 1:30 PM Witness 6 (family member) stated the facility scheduled a care conference on 5/27/24. Witness 6 stated the care conference did not occur and no one contacted her to reschedule. On 7/18/24 at 3:01 PM Staff 15 (LPN Assistant RCM) confirmed Resident 15 had a care conference scheduled on 5/27/24. Staff 15 stated on 5/27/24 Witness 6 came down to the social services office to inquire about the scheduled care conference. Staff 15 stated she spoke with Witness 6 and Witness 6 had no concerns. Staff 15 confirmed Resident 15 was not in attendance. On 7/18/24 at 3:09 PM Staff 33 (Social Service Coordinator) stated on 5/27/24 Witness 6 came to her office to inquire about the scheduled care conference. Staff 33 stated she spoke with Witness 6 and Witness 6 had no concerns. Staff 33 confirmed Resident 15 was not in attendance. On 7/19/24 at 7:55 AM Staff 32 (LPN RCM) stated the care conferences should include the resident, family and the interdisplinary team (IDT) which included nursing, social services, therapy (if applicable), dietary and activities. On 7/19/24 at 8:24 AM Staff 31 (SSD) stated care conference should include the resident, family and IDT. Staff 31 confirmed Resident 15 did not have a care conference and stated she was working on rescheduling the care conference.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 41455 Based on observation, interview and record review it was determined the facility failed to include a resident in shower schedule decisions for 1 of 4 sampled residents (#36) reviewed for choices. This placed residents at risk for lack of independent choices. Findings include: Resident 36 admitted to the facility in 2024 with diagnoses including diabetes and a foot ulcer. A 5/22/24 revised care plan indicated Resident 36 required two staff to assist with transfers and was dependent on staff with dressing. A 6/25/24 Census for Resident 36 indicated a room move. On 7/16/24 at 9:09 AM a communication board in Resident 36's room indicated her/his shower days were Monday and Thursday. Resident 36 stated the schedule for her/his showers were recently changed without a conversation with the resident. Resident 36 stated the current shower schedule interferred with her/his weekly medical appointment which was not acceptable. On 7/18/24 at 5:11 PM Staff 28 (LPN-Resident Care Manager) stated when Resident 36 moved to a new room her/his shower scheduled automatically changed. Staff 28 acknowledged Resident 36's shower schedule should have been discussed with Resident 36 prior to any changes.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 47001 Based on interview and record review it was determined the facility failed to notify provider of CBG check and orthostatic blood pressure refusals for 1 of 5 sampled residents (# 17) reviewed for medications. This placed residents at risk for unmet needs. Findings include: Resident 17 admitted to the facility in 9/2019 with diagnoses including diabetes. A review of Resident 17's Physician Orders revealed a 9/26/23 order to check her/his CBG every Tuesday morning and a 5/11/22 order to check her/his orthostatic blood pressure (blood pressure check when laying down, sitting and standing) every month. A review of Resident 17's 5/2024 MAR revealed she/he refused CBG checks on 5/21/24 and 5/28/24 and she/he refused orthostatic blood pressures on 5/12/24. A review of Resident 17's 6/2024 MAR revealed she/he refused CBG checks on 6/4/24, 6/11/24, 6/18/24 and 6/25/24 and she/he refused orthostatic blood pressures on 6/12/24. A review of Resident 17's MAR from 7/1/24 through 7/18/24 revealed she/he refused CBG checks on 7/2/24, 7/9/24 and 7/16/24 and there was no evidence of documentation for orthostatic blood pressures on 7/12/24. A 7/18/24 review of Resident 17's medical record revealed no evidence the provider was notified of Resident 17's refusals for CBG checks and orthostatic blood pressures. On 7/19/24 at 10:23 AM Staff 23 (RN Regional Nurse Consultant) confirmed Resident 17's provider was not notified of Resident 17's refusals for CBG checks and orthostatic blood pressures.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35855 Based on observation and interview it was determined the facility failed to provide a clean homelike environment for 7 of 10 sampled residents (#s 6, 19, 27, 29, 37, 46 and 58) and 1 of 2 halls (North) reviewed for environment. This placed residents at risk for an unclean and unhomelike environment. Findings include: 1. Resident 19 admitted to the facility in 6/2023 with diagnosis including reduced mobility. On 7/15/24 at 10:41 AM approximately 50 dents with black marks were observed on the floor at the foot of Resident 19's bed. Resident 19's roommate mentioned ongoing cleaning efforts by housekeeping that did not remove the marks. Additionally, in the bathroom, there were two gray substance lines, each approximately four inches by 12 inches on an aged and dingy floor. On 7/19/24 at 8:00 AM Staff 19 (Maintenance Lead) confirmed completion of some work was needed near the toilet and acknowledged flooring damage. 2. Resident 58 admitted to the facility in 4/2024 with diagnosis including end-of-life care. On 7/15/24 at 10:32 AM multiple square dents with black marks were observed under the foot of Resident 58's bed. There was gray substance around the toilet in the bathroom with cracking, and an unclean base with black substance in several areas. The flooring appeared aged and dingy. On 7/19/24 at 8:00 AM Staff 19 (Maintenance Lead) confirmed the flooring damage. 3. On 7/15/24 at 10:14 AM and 12:12 PM two strips of white tape, approximately two inches wide and six inches long, were observed outside room [ROOM NUMBER] on the carpeted floor. In the hallway between rooms [ROOM NUMBERS] a large dark stain was observed. The carpet outside room [ROOM NUMBER] showed a black coloration extending approximately four to six inches from the door threshold and spanning the door's full width. On 7/19/24 at 8:00 AM Staff 19 (Maintenance Lead) confirmed the flooring damage. 34703 4. Resident 6 admitted to the facility in 2024 with diagnosis including heart disease. On 7/16/24 at 10:01 AM missing flooring was observed by the resident's nightstand. On 7/19/24 at 8:00 AM Staff 19 (Maintenance Lead) acknowledged the flooring damage. 5. Resident 27 admitted to the facility in 6/2023 with diagnosis including stroke. On 7/16/24 at 10:25 AM a gray putty or cement rectangular area was observed on the floor by Resident 27's transfer pole. Resident 27 stated staff used putty to fix holes in the floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/19/24 at 8:00 AM Staff 19 (Maintenance Lead) acknowledged the flooring damage. 6. Resident 29 admitted to the facility in 2024 with diagnosis including stroke. On 7/16/24 at 11:10 AM the ceiling by Resident 29's TV appeared to have leakage damage and was coming apart in areas. There was also dark brown dried debris on the wall where the roof leaked. On 7/19/24 at 12:59 PM AM Staff 19 (Maintenance Lead) confirmed the ceiling damage. 7. Resident 37 was admitted to the facility in 2024 with diagnoses including weakness. On 7/16/24 at 10:48 AM Resident 37's bathroom flooring was observed chipped and missing pieces. Resident 37's toilet had dark brownish black debris around the base of the toilet. On 7/19/24 at 8:00 AM Staff 19 (Maintenance Lead) confirmed the dark brownish black debris around the base of the toilet and acknowledged the flooring damage. 8. Resident 46 admitted to the facility in 2024 with diagnosis including anxiety disorder. On 7/16/24 at 11:46 AM approximately 10-15 dents with black marks were observed on the floor at the foot of Resident 46's bed. Resident 46 stated the floors were bad and needed to be fixed. On 7/19/24 at 8:00 AM Staff 19 (Maintenance Lead) confirmed the flooring damage.

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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. 34703 Based on interview and record review it was determined the facility failed to ensure residents were free from abuse for 1 of 1 resident (#46) reviewed for abuse. This placed residents at risk for abuse. Findings include Resident 46 admitted to the facility in 2024 with diagnoses including PTSD (post traumatic stress disorder) and anxiety disorder. The 4/5/24 Admission MDS indicated Resident 46 had a BIMS of 15 which indicated she/he was cognitively intact. The 4/1/24 care plan indicated Resident 46 was on behavior monitoring related to a history of PTSD, depression, and anxiety. Resident 46's triggers for PTSD included: -overwhelmed -feeling loss of control -upset with situation On 6/13/24 a public complaint was received which indicated Resident 46 was being harassed and intimidated by Resident 29. The facility was not doing enough to keep her/him safe and it was an ongoing issue. Witness 8 (Complainant) stated on 6/2/24 Resident 29 came into the dining room and was disruptive. Resident 46 politely asked her/him to to not be disruptive while they were having their meal. Resident 29 became angry and began yelling and cursing, and ever since then Resident 29 continued to come in the dining room on her/his electric scooter, ride around Resident 46 and stare at her/him. Resident 46 told Witness 8 she/he felt harassed and caused her/him anxiety. Witness 8 stated Resident 46 used to come out of her/his room to read and socialize but now spent time in her/his room. Witness 8 stated the residents lived on separate halls and there was no reason Resident 29 needed to come down the 400 hall where Resident 46 resided. Witness 8 stated Resident 29 came to Resident 46's room, stood in the door way and stared at her/him. Witness 8 stated she was concerned for Resident 46's safety and was worried the situation would escalate. Multiple observations from 7/16/24 through 7/19/24 on day and evening shifts revealed Resident 29 on the 400 hall by Resident 46's room staring at her/him. Staff intervened and Resident 29 began cursing. On 7/16/24 at 11:05 AM Resident 29 stated Resident 46 was mean and yelled at her/him in the dining room and when she/he was in the 400 hall. Resident 29 sated Resident 46 started the argument not her/him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 3: 09 PM Resident 46 stated Resident 29 came into the dining room on 6/2/24 and started yelling at staff and banged on the tables. Resident 46 stated she/he politely asked Resident 29 to not be disruptive while residents ate their meal. Resident 46 stated Resident 29 became angry, left the dining, room, but came back and started cursing at her/him. Resident 46 stated after the incident Resident 29 continued to come down the 400 hall, stand in her/his doorway and stare at her/him. Resident 46 stated she/he felt scared, intimidated, and uncomfortable. Resident 46 stated she/he spoke with management but nothing was done. On 7/18/24 at 3:01 PM Staff 32 (LPN-RCM) stated Resident 29 was targeting and making Resident 46 uncomfortable by coming down the 400 hall and staring at her/him. Staff 32 stated there are multiple doors Resident 29 can exit from but chose the 400 hall door. Staff 32 stated management indicated if Resident 29 talked to Resident 46 staff can intervene otherwise there was noting staff could do because Resident 29 had a right to be wherever she/he wanted. Staff 32 stated Resident 46 had become more anxious, PTSD was intensified, and stated she/he felt targeted by Resident 29. Staff 32 stated management was aware of the incident but nothing was done to protect Resident 46. On 7/18/24 at 3:15 PM Staff 46 (CNA) stated Resident 29 intimidated Resident 46 all day. Resident 29 came down Resident 46's hall and stalked her/him. Staff 46 stated management told staff when Resident 29 came down the 400 hall to encourage her/him to go somewhere else, but Staff 46 indicated this caused Resident 29 to yell at staff. Staff 46 stated Resident 46 was more anxious and now stayed in her/his room due to Resident 29's behavior. Staff 46 stated management was aware of the situation but nothing was done to protect Resident 46. On 7/19/24 at 12:34 PM Staff 16 (CMA) stated Resident 29 never came down the 400 hall until the 6/2/24 incident. Staff 16 stated management told staff there was nothing they could do because Resident 29 had the right to go wherever she/he wanted to go. Staff 16 stated staff saw Resident 29 outside Resident 46's window staring at her/him. Staff 16 stated Resident 46 stated she/he felt scared, anxious, not protected, and her/his rights were violated. Staff 16 stated management was aware of the situation but nothing was done to protect Resident 46. On 7/19/24 at 2:22 PM Staff 1 (Administrator) stated Resident 46 indicated she/he felt intimidated by Resident 29, and Resident 29 glared and made faces at her/him. Staff 1 stated staff were instructed to redirect Resident 29 but this angered Resident 29. Staff 1 stated staff were to continue redirecting Resident 29.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34703 Based on observation, interview, and record review it was determined the facility failed to investigate allegations of abuse for 1 of 1 sampled resident (#46) reviewed for abuse. This placed residents at risk for abuse. Findings include: Resident 46 admitted to the facility in 2024 with diagnoses including PTSD (post traumatic stress disorder) and anxiety disorder. The 4/5/24 Admission MDS indicated Resident 46 had a BIMS of 15 which indicated she/he was cognitively intact. The 4/1/24 care plan indicated Resident 46 was on behavior monitoring related to a history of PTSD, depression, and anxiety. Resident 46's triggers for PTSD included: -overwhelmed -feeling loss of control -upset with situation On 6/13/24 a public complaint was received which indicated Resident 46 was being harassed and intimidated by Resident 29. The facility was not doing enough to keep her/him safe and it was an ongoing issue. Witness 8 (Complainant) stated on 6/2/24 Resident 29 came into the dining room and was disruptive. Resident 46 politely asked her/him to to not be disruptive while they were having their meal. Resident 29 became angry and began yelling and cursing, and ever since then Resident 29 continued to come in the dining room on her/his electric scooter, ride around Resident 46 and stare at her/him. Resident 46 told Witness 8 she/he felt harassed and caused her/him anxiety. Witness 8 stated Resident 46 used to come out of her/his room to read and socialize but now spent time in her/his room. Witness 8 stated the residents lived on separate halls and there was no reason Resident 29 needed to come down the 400 hall where Resident 46 resided. Witness 8 stated Resident 29 came to Resident 46's room, stood in the door way and stared at her/him. Witness 8 stated she was concerned for Resident 46's safety and was worried the situation would escalate. Multiple observations from 7/16/24 through 7/19/24 on day and evening shifts revealed Resident 29 on the 400 hall by Resident 46's room staring at her/him. Staff intervened and Resident 29 began cursing. On 7/16/24 at 11:05 AM Resident 29 stated Resident 46 was mean and yelled at her/him in the dining room and when she/he was in the 400 hall. Resident 29 sated Resident 46 started the argument not her/him. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 3: 09 PM Resident 46 stated Resident 29 came into the dining room on 6/2/24 and started yelling at staff and banged on the tables. Resident 46 stated she/he politely asked Resident 29 to not be disruptive while residents ate their meal. Resident 46 stated Resident 29 became angry, left the dining, room, but came back and started cursing at her/him. Resident 46 stated after the incident Resident 29 continued to come down the 400 hall, stand in her/his doorway and stare at her/him. Resident 46 stated she/he felt scared, intimidated, and uncomfortable. Resident 46 stated she/he spoke with management but nothing was done. On 7/18/24 at 3:01 PM Staff 32 (LPN-RCM) stated Resident 29 was targeting and making Resident 46 uncomfortable by coming down the 400 hall and staring at her/him. Staff 32 stated there are multiple doors Resident 29 can exit from but chose the 400 hall door. Staff 32 stated management indicated if Resident 29 talked to Resident 46 staff can intervene otherwise there was noting staff could do because Resident 29 had a right to be wherever she/he wanted. Staff 32 stated Resident 46 had become more anxious, PTSD was intensified, and stated she/he felt targeted by Resident 29. Staff 32 stated management was aware of the incident but nothing was done to protect Resident 46. On 7/18/24 at 3:15 PM Staff 46 (CNA) stated Resident 29 intimidated Resident 46 all day. Resident 29 came down Resident 46's hall and stalked her/him. Staff 46 stated management told staff when Resident 29 came down the 400 hall to encourage her/him to go somewhere else, but Staff 46 indicated this caused Resident 29 to yell at staff. Staff 46 stated Resident 46 was more anxious and now stayed in her/his room due to Resident 29's behavior. Staff 46 stated management was aware of the situation but nothing was done to protect Resident 46. On 7/19/24 at 12:34 PM Staff 16 (CMA) stated Resident 29 never came down the 400 hall until the 6/2/24 incident. Staff 16 stated management told staff there was nothing they could do because Resident 29 had the right to go wherever she/he wanted to go. Staff 16 stated staff saw Resident 29 outside Resident 46's window staring at her/him. Staff 16 stated Resident 46 stated she/he felt scared, anxious, not protected, and her/his rights were violated. Staff 16 stated management was aware of the situation but nothing was done to protect Resident 46. On 7/19/24 at 2:22 PM Staff 1 (Administrator) stated Resident 46 indicated she/he felt intimidated by Resident 29, and Resident 29 glared and made faces at her/him. Staff 1 stated staff were instructed to redirect Resident 29 but this angered Resident 29. Staff 1 stated staff were to continue redirecting Resident 29. Staff 1 stated he was not made aware of the 6/2/24 incident until 6/5/24 and the police were not called until 6/5/24. Staff 1 acknowledged the investigation should have started on 6/2/24 the date of the incident.

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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. **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 revise care plan interventions for 3 of 13 sampled residents (#s 10, 17 and 24) reviewed for ADLS, medications, positioning and mobility. This placed residents at risk for unmet needs. Findings include: 1. Resident 10 admitted to the facility in 5/2024 with diagnoses including a broken arm. The Admission MDS dated [DATE] revealed Resident 10 had a BIMS score of 10, which indicated the resident was moderately impaired cognitively. Resident 10 was at risk for contracture to the left fingers. A review of a TAR for 7/2024 instructed staff to soak and wash her/his hand in warm water every shift and apply a hand brace every day and evening shift for the hand contracture with a start date of 6/11/24. Review of Resident 10's current care plan revealed no documentation related to the hand contracture. On 7/19/24 at 7:54 AM Staff 16 (CMA) stated she was the one who started soaking Resident 10's hand as her/his hand was crusty and smelled bad. She requested the brace and she used to apply it, but now Staff 43 (Restorative Aide) applied the brace. On 7/19/24 at 8:07 AM Staff 43 stated everyone soaks Resident 10's hand and applied her/his brace. Staff 43 stated Resident 10's fingernail broke off into the palm of her/his hand due to the hand contracture. In an interview on 7/19/24 at 12:42 PM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) confirmed Resident 10's hand contracture should have been added to the care plan. 2. Resident 24 admitted to the facility in 1/2024 with diagnoses including aphasia (damage or injury to the language area of the brain) and stroke. A review of the care plan dated 1/23/24 indicated Resident 24 had deficits in ADL performance and nutritional issues due to dysphagia (difficulty in swallowing), poor intake and leaving 25 percent of food uneaten. Interventions included easy-to-chew textures, nutritional supplement four times a day. There was no documentation specifying whether Resident 24 required supervision or assistance with eating. On 7/18/24 at 10:54 AM, Staff 14 (CNA) stated Resident 24 did not require assistance with eating she/he just needed some cues to eat at times. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/19/24 at 8:35 AM Resident 24 was observed eating breakfast in her/his room. Staff 43 (Restorative Aide) stated Resident 24 did not require assistance with eating and she/he usually ate breakfast in her/his room. In an interview on 7/19/24 at 12:12 PM, Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) acknowledged that supervision and cueing for eating assistance should have been specified on Resident 24's care plan. 47001 3. Resident 17 admitted to the facility in 9/2019 with diagnoses including alcohol dependency and narcissistic personality disorder (a mental health condition in which people have an unreasonably high sense of their own importance). A review of Resident 17's care plan revealed a behavior care plan related to a history of behaviors and a diagnosis of narcissistic personality disorder. On 7/19/24 at 10:16 AM Staff 2 (DNS) stated any alcohol consumption by Resident 17 would result in worsening behaviors. A 7/19/24 care plan review revealed no evidence Resident 17 was care planned for alcohol dependency or worsening behaviors with alcohol consumption. On 7/19/24 at 1:02 PM Staff 32 (LPN RCM) stated alcohol consumption by Resident 17 made her/his behaviors worse. Staff 32 confirmed Resident 17 was not care planned for alcohol dependency or for worsening behaviors with alcohol consumption. On 7/19/24 at 1:12 PM Staff 2 confirmed Resident 17 was not care planned for alcohol dependency or worsening behaviors with alcohol consumption.

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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. **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 dependent residents received required assistance with ADLs for 3 of 6 sampled residents (#s 16, 24, and 40) reviewed for ADLs. This placed resident at risk for unmet needs. Findings include: 1. Resident 16 admitted to the facility in 2/2017 with diagnoses including a fractured pelvis. The quarterly MDS dated [DATE] revealed Resident 16 had a BIMS score of 15 indicating the resident was cognitively intact. The resident required substantial to maximal assistance with transfers related to toileting. A review of Resident 16's care plan revised 7/5/21 revealed Resident 16 had bladder incontinence. Interventions included to notify staff of toileting needs. Resident 16 was occasionally incontinent before reaching the bathroom and required one-person assistance for toilet transfers. On 5/30/24 the State Survey Agency received a public complaint which indicated staff were busy with dinner one night the week of 5/20/24. Resident 16 activated her/his call light for toileting assistance, but staff did not respond for 45 minutes. A review of a 5/2024 Documentation Survey Report revealed the week of 5/20/24 to 5/27/24, on the evening shift, Resident 16 was continent twice, was both continent and incontinent seven times, and incontinent once. Witness 1 (Staff) was interviewed on 7/17/24 at 9:31 AM and confirmed the complaint that Resident 16 did not receive timely toileting assistance the week of 5/2024, and was upset she/he had an incontinent episode. During an interview on 7/17/24 at 9:58 AM Resident 16 confirmed that in 5/2024, during dinner time, she/he waited 45 minutes after activating her/his call light for toileting assistance. Resident 16 indicated she/he could not wait and had an incontinent episode. During an interview on 7/18/24 at 12:00 PM Staff 13 (CNA) stated when toileting assistance was documented as both continent and incontinent during a shift it indicated a resident was continent one time and incontinent another time on the same shift. In an interview on 7/19/24 at 12:12 PM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated the expectation for a call light to be answered was 15 to 20 minutes. 2. Resident 24 admitted to the facility in 1/2024 with diagnoses including stroke and dementia. The quarterly MDS dated [DATE] revealed Resident 24 was rarely or never understood and experienced short-term and long-term memory issues. Resident 24 was dependent on staff for bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plan dated 1/23/24 indicated Resident 24 had deficits in ADL performance and required two-person physical assistance for bathing. A review of the 4/2024 and 5/2024 Documentation Survey Reports indicated Resident 24 refused showers eight times and received nine showers. On 5/17/24 there was no documentation that Resident 24 received a shower. On 5/30/24 the State Survey Agency received a public complaint which indicated staff were unable to complete showers for all residents. Resident 24 missed showers and developed body odor due to lack of bathing. A review of a 6/2024 Documentation Survey Report indicated Resident 24 refused showers four instances and received four showers. On 7/17/24 at 10:59 AM Staff 18 (CNA) stated not all tasks for residents, including showers, could always be completed due to time constraints. On 7/17/24 at 11:53 AM, Witness 1 (Staff) stated when showers could not be completed she/he documented that the resident refused, as there was no option to document that the shower was not completed. In an interview on 7/19/24 at 12:12 PM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated staff were expected to not document if a shower was not completed and for the next shift to complete the shower if a shower was not completed. 41455 3. Resident 40 admitted to the facility in 2022 with diagnoses including dementia and depression. The 5/2024 Documentation Survey Report indicated Resident 40 received two showers during the month on 5/24/24 and 5/28/24 and refused showers on 5/2/24, 5/3/24, 5/21/24 and 5/31/24. A 6/6/24 revised care plan indicated Resident 40 needed physical assistance for personal hygiene and bathing. The CNA Tasks: Bathe/Shower on 7/15/24 revealed Resident 40 received four showers in the past 30 days on 6/21/24, 7/5/24, 7/9/24 and 7/15/24, and refused showers on 6/18/24, 6/25/24 and 7/2/24. On 7/16/24 at 9:24 AM Resident 40 was observed to have dry flakes on her/his head and hair which appeared to stick together. On 7/17/24 at 10:07 AM Staff 27 (LPN) stated showers for Resident 40 were not completed two times each week as assigned to CNAs due to lack of available staff. On 7/18/24 at 12:32 PM Staff 30 (CNA) stated Resident 40 rarely refused showers when she/he was properly approached. Staff 30 acknowledged staffing was a challenge in order to accomplish evening showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 6:09 PM Staff 28 (LPN-Unit Manager) acknowledged improved training for CNAs was necessary in order for Resident 40 to accept her/his needed showers.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 41455 Based on observation, interview and record review it was determined the facility failed to assess and provide meaningful activities for 2 of 2 sampled resident (#s 36 and 42) reviewed for activities. This placed residents at risk for lack of social interaction. Findings include: 1. Resident 36 admitted to the facility in 2024 with diagnoses including diabetes and a foot ulcer. A 5/21/24 Admission MDS revealed Resident 36 was cognitively intact and it was very important to choose activities which were important to her/him. A 5/28/24 Activity Profile indicated Resident 36 desired group activities which included exercise. A 5/29/24 care plan indicated Resident 36 wanted staff to discuss her/his likes and dislikes related to activities. The 7/15/24 [CNA] Tasks: Activity revealed Resident 36 did not engage in any group or one on one activities during the previous 30 days. On 7/16/24 at 8:42 AM Resident 36 was observed in bed and stated she/he was bored and there were no exercise options presented. On 7/17/24 at 3:09 PM Staff 37 (Activities Director) stated Resident 36 had no interest in current activities. Staff 37 stated in room activities were offered to Resident 36 although Staff 37 was aware of Resident 36's interest in exercise. Staff 37 acknowledged current activities did not include exercise programming. 49676 2. Resident 42 admitted to the facility in 2024 with diagnoses including anxiety disorder. A 6/27/24 care plan indicated Resident 42 had no activity care plan. The 7/19/24 [CNA] Tasks: Activity revealed Resident 42 did not engage in any group or one on one activities during the previous 30 days. On 7/19/24 at 12:04 PM Staff 31 (Social Services) stated she did not find any activity preferences in the care plan for Resident 42. On 7/19/24 at 12:30 PM Staff 37 (Activities Director) stated she did not get an activity preference sheet completed for Resident 42.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 47001 Based on interview and record review it was determined the facility failed to implement bowel care, notify the physician and follow physician orders for 2 of 8 sampled residents (#s 17 and 33) reviewed for skin, change of condition, and medications. This placed residents at risk for unmet needs. Findings include: 1. Resident 17 admitted to the facility in 9/2019 with diagnoses including diabetes. A review of Resident 17's medical record revealed 5/7/24 orders to increase Lisinopril (a medication used to treat high blood pressure). A 6/20/24 Progress Note stated Resident 17's provider wrote orders on 5/7/24 to increase her/his Lisinopril and the order was not entered into Resident 17 chart. On 7/17/24 at 1:31 PM Staff 25 (LPN) stated she discovered the pharmacy sent Lisinopril 7.5 mg, but the order in Resident 17's chart was for Lisinopril 5 mg. Staff 25 stated she checked the orders written by the provider and discovered Resident 17's Lisinopril was increased from 5 mg daily to 7.5 mg daily on 5/7/24. Staff 25 stated she was unsure when the pharmacy sent the correct dose. On 7/17/24 at 1:42 PM Staff 24 (CMA) stated she would have given Resident 17 Lisinopril 5 mg as indicated in the resident's chart. On 7/19/24 at 10:17 AM Staff 2 (DNS) stated Resident 17's Lisinopril order changed on 5/8/24 but was not input into the resident's chart until 6/15/24. Staff 2 stated the pharmacy sent the correct dose for Lisinopril but acknowledged she was unable to determine if and how long Resident 17 received the wrong dose of Lisinopril. 35855 2. Resident 33 admitted to the facility in 6/2024 with a diagnosis including arthritis. A review of the Documentation Survey Report for 6/2024 revealed from 6/7/24 through 6/13/24 Resident 33 did not have a bowel movement. A review of the 6/2024 MAR indicated staff were instructed to administer milk of magnesia every 24 hours as needed for constipation. Resident 33 received the medication on 6/12/24, five days after not having a bowel movement. In an interview on 7/19/24 at 11:48 AM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) confirmed Resident 33 should have received bowel care sooner.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 41455 Based on observation, interview, and record review it was determined the facility failed to replace hearing aids in a timely manner for 1 of 3 sampled residents (#40) reviewed for sensory needs. This placed residents at risk for a decline in hearing and impaired communication. Findings include: Resident 40 admitted to the facility in 2022 with diagnoses including dementia and depression. A 5/17/24 Quarterly MDS indicated Resident 40's hearing was adequate and she/he was assessed for the use of hearing aids or a hearing appliance. A 6/6/24 revised care plan indicated Resident 40 was to wear hearing aids in both ears in order to address her/his mild hearing deficit. On 7/16/24 at 9:24 AM Resident 40 was observed seated at a dining room table with no hearing aid in either ear. Staff 29 (CNA) stated Resident 40 did not use her/his hearing aids because they were broken for the last three to four months, and the resident was on a list to have her/his hearing aids repaired. On 7/17/24 at 10:07 AM Staff 27 (LPN) stated Resident 40 had no hearing aids since the resident moved to a new hall on 4/19/24. On 7/17/24 at 3:35 PM Staff 31 (Social Service Director) stated she believed Resident 40 chose not to wear hearing aids and acknowledged she was not aware her/his hearing aids were missing or broken.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 35855 Based on interview and record review it was determined the facility failed to implement pressure ulcer treatments and care plans for 2 of 2 sampled residents (#s 1 and 3) reviewed for pressure ulcers and incontinent care. This placed residents at risk for pressure ulcers. Findings include: 1. Resident 3 admitted to the facility in 7/2021 with diagnoses including stroke. A 5/31/24 Weekly Skin Audit revealed Resident 3 had new skin irregularities with significant redness to the peri area and sacral (large, triangular bone at the base of the spine) area. There was no documentation indicating the physician was informed. Review of the 6/2024 TAR instructed staff to conduct bi-weekly skin checks and document in the assessment tab which was discontinued on 6/16/24. The TAR indicated the task was completed on 6/2/24, 6/5/24, 6/12/24, and 6/16/24. On 6/13/24 it referred the reader to notes. There were no corresponding assessments found in the assessment tab for those dates. A 6/12/24 Order Note revealed the weekly skin check was not completed as it was completed on 6/9/24. A review of External Visit physician notes dated 6/20/24 indicated Resident 3's only concern was her/his buttocks soreness. Resident 3 reported a sore on her/his buttocks. Visit diagnoses included an unstageable pressure injury of the back and buttock. The physician requested an off-loading mattress and a facility skin assessment. No documentation was found in clinical records Resident 3 received a skin assessment in 6/2024. In an interview on 7/19/24 at 11:48 AM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated it was expected of staff to complete skin and wound checks and evaluations. 47001 2. Resident 1 admitted to the facility in 3/2016 with diagnoses including anoxic brain injury (brain damage related to a lack of oxygen). A 7/17/24 medical record review revealed Resident 1 had an in-house acquired Stage 4 pressure ulcer (a wound caused by pressure resulting in full thickness tissue loss with exposed bone, tendon or muscle) on her/his left upper abdomen. On 7/18/23 at 3:20 PM Staff 23 (RN Regional Nurse Consultant) stated there was no investigation completed for Resident 1's in-house acquired pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/19/24 at 7:55 AM Staff 32 (LPN RCM) stated Resident 1's left arm was contracted, and the in-house pressure ulcer was caused from her/his left elbow pressing against her/is left upper abdomen. Staff 32 confirmed there was no investigation completed for Resident 1's in-house acquired pressure ulcer.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 ensure a resident's environment remained free from accident hazards for 1 of 1 sampled resident (#66) reviewed for accidents, and respond to changes in condition in a timely manner for 1 of 1 sampled resident (#65) reviewed for change of condition. This placed residents at risk for injury and untimely care needs. Findings include: 1. Resident 65 admitted to the facility in 2024 with diagnoses including leg fracture. A progress note dated 12/15/23 at 5:33 PM indicated Resident 65 had a recent fall and her/his right lower extremity was swollen, bruised, and and painful. A STAT (immediate) x-ray was ordered to rule out injury. A progress note dated 12/16/23 at 2:41 AM indicated the x-ray revealed Resident 65 had a right ankle fracture. A progress note dated 12/18/23 at 9:40 AM indicated Staff 41 (LPN) sent a message to the physician that Resident 65 had a fractured ankle. The physician replied the x-ray was noted on 12/16/23. Staff 41 indicated Staff 42 (LPN) sent a message to the physician but did not call the on-call physician regarding Resident 65's fracture. Resident 65 was sent to the emergency roiagnom on [DATE] two days after the right ankle fracture was verified. On 7/19/24 at 1:34 PM Staff 42 stated she did not call the on-call physician she only sent a message through the hospital messaging system. Staff 42 acknowledged she should have called the on-call physician to get Resident 65 the care she/he needed. On 7/19/24 at 2:39 PM Staff 1 (Administrator) stated he did not know why the resident was not sent to the emergency roiagnom on [DATE] when the fracture was verified. Staff 1 stated his expectation is for nurses to call the on-call physician for after hour emergencies and notify the physician in a message through the hospital messaging system. 49677 2. Resident 66 admitted to the facility in 2023 with diagnoses including COPD (chronic obstructive pulmonary disease), generalized muscle weakness, and Transient Ischemic Attack (slight stroke). An Incident Report dated 11/11/23 indicated Resident 66 required two staff to assist with all mechanical lift transfers. The Incident Report revealed Resident 66 fell out of the lift sling while a CNA was transferring the resident. The incident report also indicated the care plan was not followed as indicated for two staff at all times for in and out of bed transfers. Review of hospital notes dated 11/13/23 indicated Resident 66 did not have any acute traumatic abnormalities. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/18/24 at 7:20 AM Staff 1 (Administrator) stated he was aware of Staff 43 (RA) not following the care plan that indicated the resident was to be transferred by two people. Staff 1 indicated that Staff 43 communicated to Staff 1 that she knew she wasn't following the care plan and she should have waited for an additional staff member to assist in the Hoyer transfer. In an interview on 7/18/24 at 7:46 AM Staff 43 (RA) stated she attempted to transfer Resident 66 by herself. As the mechanical lift was elevated, she heard the sling rip, the resident slid out of the sling backwards hitting her head on the floor. Resident 66 was painful and crying and was sent to the hospital. Staff 43 stated she was aware of the care plan indicated the resident was to be transferred by two people, however she was rushed and thought she could transfer the resident alone.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 41455 Based on interview and record review it was determined the facility failed to provide adequate catheter care for 1 of 2 sampled residents (#14) reviewed urinary catheter. This placed residents at risk for urinary infections. Findings include: Resident 14 admitted to the facility in 2023 with diagnoses including chronic kidney disease and displacement of a nephrostomy catheter (tube that diverts urine from kidney). A 6/14/23 Discharge Summary indicated Resident 14 had a nephrostomy tube placed. An 10/13/23 through 3/13/24 physician order indicated to cover Resident 14's nephrostomy tube site and change the bandage daily. The 4/2024 TAR indicated to ensure catheter straps were attached to the lower left extremely for the nephrostomy bag. Treatments were discontinued on 4/30/24. A 5/9/24 physician order indicated to change Resident 14's nephrostomy tube dressing, remove the old dressing, cleanse, dry and apply a new dressing. A 7/2/24 revised care plan indicated Resident 14 had a left nephrostomy related to end stage kidney disease, the goal was to have no infections, and interventions included to monitor for complications related to seizures. No other interventions related to Resident 14's nephrostomy were indicated. On 7/15/24 at 11:31 AM Resident 14 stated she/he had concerns about the placement and staff knowledge related to her/his nephrostomy bag. Resident 14 stated the bag burst or leaked because it was not checked or properly closed. On 7/17/24 at 9:32 AM Staff 29 (CNA) stated for a period of time it was not clear who was responsible for changing or addressing the needs of Resident 14's nephrostomy bag. Staff 29 stated the correct placement or strap to be used for Resident 14's nephrostomy bag was unclear and at times nephrostomy bag supplies were unavailable. On 7/17/24 at 10:07 AM Staff 27 (LPN) acknowledged there were previous challenges with Resident 14's nephrostomy supplies and CNAs began to monitor supplies within the last two weeks. Staff 27 stated the placement of Resident 14's nephrostomy bag was important for her/his comfort and not all CNAs knew how or where to position the nephrostomy bag. On 7/18/24 at 5:42 PM and 7/19/24 at 12:11 PM Staff 28 (LPN-Resident Care Manager) acknowledged a systematic method to maintain the preferred nephrostomy supplies for Resident 14 was needed, CNAs needed more training, and a detailed care plan related to Resident 14's nephrostomy bag care and placement was necessary. On 7/19/24 at 3:25 PM Staff 23 (Regional Nurse Consultant) acknowledged there were no orders for Resident 14's nephrostomy care from 3/13/24 through 5/9/24 as expected.

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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. 47001 Based on observation, interview, and record review it was determined the facility failed to obtain orders for oxygen for 2 or 2 sampled residents (#s 30 and 63) reviewed for respiratory care. This placed residents at risk for unmet respiratory needs. Findings include: 1. Resident 30 admitted to the facility in 4/2022 with diagnoses including chronic obstructive pulmonary disease (a lung disease which causes restricted airflow and breathing problems). A review of Resident 30's care plan revealed a 12/21/23 care plan for oxygen use as needed. A 7/18/24 review of Resident 30's medical record revealed no evidence of a current order for oxygen use. On 7/18/24 at 11:49 AM Staff 17 (CNA) stated Resident 30 used oxygen as needed almost daily. On 7/18/24 at 3:37 PM Staff 32 (LPN RCM) stated Resident 30 used oxygen as needed when she/he was short of breath. Staff 32 confirmed Resident 30 had no orders for oxygen use. 34703 2. Resident 63 admitted to the facility in 2024 with diagnoses including COPD (chronic obstructive pulmonary disease). A physician order dated 6/2/24 indicated Resident 63 received oxygen via nasal cannula (nasal tube allowing continuous oxygen delivery) at three liters a minute (LPM) as needed. A review of Resident 63's medical record revealed from 5/29/24 through 6/26/24 Resident 63 had oxygen on every day except for six days she/he was on room air. There was no documentation the resident was on three LPM of oxygen as ordered and no documentation of how often oxygen tubing was to be changed. On 7/17/24 at 10:49 AM Witness 7 (Caregiver) stated Resident 63 wore continuous oxygen on three LPM due to COPD. On 7/17/24 at 11:38 AM Staff 39 (CNA) stated she took care of the resident and she/he wore continuous oxygen or she/he became short of breath. On 7/17/24 at 11:11 AM Staff 26 (RN) and Staff 24 (CMA) stated Resident 63 wore continuous oxygen. On 7/18/24 Staff 28 (RCM-LPN) stated Resident 63 wore continuous oxygen. Staff 28 acknowledged the resident did not have an order for continuous oxygen, and no documentation could be found in the resident's medical record that oxygen tubing was changed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 34703 Based on observation, interview, and record review it was determined the facility failed to ensure residents received proper dialysis care and services after dialysis for 1 of 1 sampled resident (#55) reviewed for dialysis. This placed residents at risk for dialysis complications. Findings include: Resident 55 admitted to the facility in 2024 with diagnoses including end stage kidney disease. On 7/17/24 at 12:37 PM Resident 55 was observed to have a fistula (surgically created connection between an artery and a vein to provide access for dialysis) in her/his left arm. Resident 55 stated she/he had dialysis three times a week, when she/he returned staff were not checking her/his access site for thrill and bruit (two ways to check for good blood flow in a dialysis fistula). The 2/7/24 care plan for dialysis indicated the resident had dialysis three times a week, staff were to monitor the access site for infection and bleeding. Staff were to also obtain and document weights. Resident 55 had six weights documented in the electronic record from 2/7/24 through 6/29/24. No evidence was found in the resident's clinical record to indicate monitoring of the resident's access site or monitoring of weights were completed. On 7/18/24 at 11:41 AM Staff 28 (RCM-LPN) acknowledged there was nothing on the resident's care plan to indicate the type of dialysis access site the resident had or care needs for the site, and Resident 55 should have daily weights documented.

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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. **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 provide sufficient staffing to meet the needs of residents for 1 of 8 sampled residents (#16) and 2 of 2 halls (North and 2nd South) reviewed for staffing. This placed residents at risk for unmet needs. Findings include: 1. A review of Council Minutes revealed the following: -4/29/24 Staff were overworked. Staff left a resident unattended during care resulting in the resident being stuck in the bathroom. Another resident was left in the shower for an extended period. Staff checked on one resident in a room but not their roommate. Call light response times were too long while residents were in the bathroom. -5/29/24 staff lacked the time to spend with residents and had poor attitudes. Call lights went unanswered for 20 minutes or more. Staff did not assist each other. If a staff member was not assigned to a resident, they did not answer their call light. On 7/15/24 the following interviews occurred: -8:46 AM, Resident 36 reported waiting 45 minutes for incontinent care three times during the week of 7/8/24. On 7/14/24 she/he waited 45 minutes to be assisted off the bedside commode and experienced pain as a result. -10:12 AM, Resident 42 reported staff did not respond promptly to call lights and frequently apologized for being too busy. -10:30 AM, Resident 27 reported waiting up to an hour for assistance. -10:33 AM, Resident 55 expressed dissatisfaction with call light wait times across all shifts, particularly night shift. -11:03 AM, Resident 14 stated the week of 7/8/24 she/he waited for staff to answer her/his call light when needing to use the bathroom for over 20 minutes -12:29 PM Witness 5 (Family Member) stated Resident 3 was supposed to go to the dining room for meals to be supervised but she/he refused and there was not enough staff to supervise her/him in her/his room. On 7/17/24 at 9:31 AM Witness 1 (Staff) stated insufficient staffing led to new skin issues for a resident due to delayed incontinent care. Witness 1 sometimes could not complete resident showers because of time constraints. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/24 at 10:59 AM Staff 18 (CNA) stated the facility was consistently short-staffed. Staff 18 could not complete all her required tasks, including assisting with showers. After Staff 18's 30-minute lunch break the same call lights remained unanswered. Staff 18 witnessed residents with skin breakdown due to prolonged exposure to soaked incontinent briefs. Shift change was often disorganized, sometimes taking 30 to 40 minutes to determine staff assignments. Staff 18 stated staff did not receive breaks due to short staffing. On 7/17/24 at 12:03 PM Staff 38 (LPN) stated completing assigned tasks was a struggle as staff called off work two hours before the shift which resulted in CNA shortages. Staff 38 assisted CNAs during short-staffed periods but fell behind on her own work. The facility did not staff according to the residents' needs. Staff 38 stated short staffing occurred approximately three to four days a week. On 7/18/24 at 9:42 AM Staff 10 (CNA) stated the residents' needs exceeded the available staff capacity. Staff 10 sometimes struggled to complete her required daily tasks. The facility instructed CNA staff not to stay beyond their shifts to finish tasks. Some residents experienced skin issues due to delayed incontinent care by CNAs. Staff 10 reported when a fall-risk resident attempted to get up, she could not simultaneously monitor them and perform checks on other residents. On 7/18/24 at 10:54 AM Staff 14 (NA) stated understaffing was a significant issue at the facility. Staff continued to request additional staff. Staff experienced burnout because of ongoing understaffing. Staff 14 stated she faced challenges providing showers to residents due to short staffing. On 7/18/24 at 12:00 PM Staff 13 (CNA) reported ongoing concerns about short staffing in the facility. Residents become agitated waiting for their call lights to be answered. Short staffing occurred one or two days a week. Staff 13 stated many staff quit because of burnout. On 7/19/24 at 11:05 AM Staff 17 (CNA) stated sometimes she did not have enough time to complete resident showers. When she started her shift she found residents soaked in urine or bowel movements because the previous shift did not have time to complete incontinent care. Staff 17 stated she observed residents with skin redness because of sitting in urine or bowel movement. In an interview on 7/19/24 at 11:48 AM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) confirmed staffing issues. 2. Resident 16 admitted to the facility in 2/2017 with diagnosis including a fractured pelvis. The quarterly MDS dated [DATE] revealed Resident 16 had a BIMS score of 15 indicating the resident was cognitively intact. The resident required substantial to maximal assistance with transfers for toileting. Review of Resident 16's care plan revised 7/5/21 revealed Resident 16 had bladder incontinence. Interventions included to notify staff of toileting needs. Resident 16 was occasionally incontinent before reaching the bathroom and required one-person assistance for toilet transfers. On 5/30/24 the State Survey Agency received a public complaint which indicated staff were busy with dinner one night the week of 5/20/24. Resident 16 activated her/his call light for toileting assistance, but staff did not respond for 45 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a 5/2024 Documentation Survey Report revealed the week of 5/20/24 to 5/27/24, on the evening shift, Resident 16 was continent twice, was both continent and incontinent seven times, and incontinent once. Witness 1 (Staff) was interviewed on 7/17/24 at 9:31 AM and confirmed the complaint that Resident 16 waited 45 minutes for toileting assistance one evening the week of 5/20/24. During an interview on 7/17/24 at 9:58 AM Resident 16 confirmed in 5/2024, during dinner time, she/he waited 45 minutes after activating her/his call light for toileting assistance. Resident 16 stated that about once a week she/he waited 20 minutes or more for the call light to be answered, with the afternoons being the worst. During an interview on 7/18/24 at 12:00 PM Staff 13 (CNA) reported call wait times sometimes were up to 30 minutes and residents became agitated. Staff 13 stated when toileting assistance was documented as both continent and incontinent during a shift it indicated a resident was continent one time and incontinent another time on the same shift. In an interview on 7/19/24 at 12:12 PM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated the expectation for a call light to be answered was 15 to 20 minutes.

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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 7 days per week for 34 out of 126 days reviewed for staffing. This placed residents at risk for unmet assessment needs. Findings include: Review of the Direct Care Staff Daily Report sheets from 1/1/24 through 1/28/24, 2/3/24 through 2/25/24, 3/10/24 through 3/24/24, 5/1/24 through 5/30/24, 6/14/24 through 6/30/24, 7/1/24 through 7/14/24 revealed the facility did not have RN coverage for eight consecutive hours on the following days: 1/20/24, 1/21/24, 1/28/24, 2/3/24, 2/4/24, 2/5/24, 2/7/24, 2/8/24, 2/10/24, 2/11/24, 2/13/24, 2/16/24, 2/17/24, 2/18/24, 2/19/24, 2/21/24, 2/23/24, 3/10/24, 3/11/24, 3/12/24, 3/13/24, 3/14/24, 3/15/24, 3/16/24, 3/17/24, 3/18/24, 3/19/24, 3/20/24, 3/21/24, 3/22/24, 3/23/24, 3/24/24, 6/30/24 and 7/3/24. In an interview on 7/19/24 at 11:48 AM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated they thought RN coverage was better than what was documented and reported two RN's employment was terminated.

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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 (#9) reviewed for staffing. This placed residents at risk for a lack of competent staff. Findings include: A review of the facility's performance review records revealed the following: -Staff 9 (CNA) was hired on 3/23/21, the provided performance review was dated 4/30/22. In an interview on 7/19/24 at 12:02 PM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated the missed review occurred during a staffing transition.

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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 observation, 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 and visitors at risk for incomplete and inaccurate staffing information. Findings include: On 7/15/24 at 9:41 AM the DCSDR (Direct Care Staff Daily Report) was observed posted on the wall. The DCSDR did not have any staff hours documented for LPNs or CNAs. On 7/16/24 at 7:38 AM and 8:25 AM the 7/15/24 DCSDR was still posted on the wall. On 7/17/24 at 7:57 AM the DCSDR was observed on posted on the wall with no LPN or CNAs documented on the form. On 7/17/24 at 11:53 AM Witness 1 (Staff) stated in the last few months the nurses were informed to just fill in the staff numbers without staff hours and the administration would complete the form the next day. On 7/18/24 at 7:51 AM and 9:11 AM the 7/18/24 DCSDR was observed posted on the wall with no LPN or CNA hours documented for all three shifts. On 7/18/24 at 8:40 AM a text message was received from Witness 1 which was a photo of the DCSDR for 6/1/24 which was posted behind glass showing day shift and evening shift with LPN's signatures. Day shift was missing hours worked for RN, LPN, and CNAs, Evening shift was missing resident census, number of CNA staff and hours worked for RN, LPN, and CNA staff. On 7/19/24 at 8:43 AM the 7/19/24 DCSDR was observed posted on the wall with no CNA or LPN hours documented. In an interview on 7/19/24 at 11:48 AM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated completing the DCSDR was an ongoing issue with staff not adding up the hours.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 35855 Based on interview and record review it was determined the facility failed to address pharmacy recommendations for 2 of 5 sampled residents (#s 10 and 17) reviewed for medications. This placed residents at risk for adverse medication side effects. Findings include 1. Resident 10 admitted to the facility in 5/2024 with diagnosis including dementia. The 5/31/24 and 6/28/24 Note to Attending Physician Prescriber indicated Resident 10 was prescribed trazodone (an antidepressant to treat depression) PRN and promethazine (an antihistamine to prevent and treat nausea and vomiting) for agitation, both limited to 14 days. The note requested either discontinuation or a rationale for extended use, but lacked the physician's signature, date, or clinical justification. The 7/2024 MAR instructed staff to administer trazodone every 12 hours as needed for agitation starting on 5/9/24. The MAR also indicated to administer Promethazine every four hours as needed for agitation, nausea and vomiting starting 5/8/24. In an interview on 7/19/24 at 11:48 AM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated there was a communication breakdown between the provider and the facility. 47001 2. Resident 17 admitted to the facility in 9/2019 with diagnoses including diabetes. A review of Resident 17's 5/2024 pharmacy recommendation revealed recommendations for laboratory testing. A 7/17/24 review of Resident 17's medical record revealed the last lab tests completed were on 4/26/23. A 7/17/24 review of Resident 17's medical record revealed no evidence of documentation related to Resident 17's 5/2024 pharmacy recommendations for laboratory testing. On 7/18/24 at 3:43 PM Staff 32 (LPN RCM) stated Resident 17 often refused lab testing due to a fear of needles. Staff 32 confirmed there was no documentation related to Resident 17's 5/2024 pharmacy recommendation for lab testing.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 34703 Based on interview and record review it was determined the facility failed to monitor anticoagulant medication for 1 of 5 sampled residents (#27) reviewed for medications. This placed residents at risk for adverse side effects of medications. Findings include: Resident 27 admitted to the facility in 2023 with diagnoses including stroke and blood clot. A 3/28/24 signed physician order indicated Resident 27 received Apixaban (anticoagulant medication used to treat and prevent blood clots). There was no monitoring in the resident's electronic record for adverse side effects for Apixaban. On 7/18/24 at 9:41 AM Staff 28 (RCM-LPN) acknowledged there was no monitoring for adverse side effects of Apixaban in Resident 27's electronic record.

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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. 35855 Based on interview and record review it was determined the facility failed to consistently monitor residents on psychotropic medications and ensure residents did not receive unnecessary medications for 3 of 5 sampled residents (#10, 17 and 27) reviewed for psychotropic medications. This placed residents at risk for receiving unnecessary psychotropic medications. Findings include: 1. Resident 10 admitted to the facility in 5/2024 with diagnoses including dementia. A review of 7/2024 MAR revealed Resident 10 was administered haloperidol (antipsychotic medication) daily. A review of monitors revealed no daily documentation of daily monitoring for antipsychotic side effects. In an interview on 7/19/24 at 12:43 PM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated the expectation was to monitor daily for adverse side effects. 47001 2. Resident 17 admitted to the facility in 8/2019 with diagnoses including narcissistic personality disorder (a mental health condition in which people have an unreasonably high sense of their own importance). A review of Resident 17's Physician Orders revealed she/he took four psychotropic medications (medications that affect the mind, emotions and behaviors), olanzapine (an antipsychotic medication), diazepam (an anti-anxiety medication), and duloxetine and trazodone (antidepressant medications). A review of Resident 17's care plan revealed a 5/27/21 care plan to monitor for adverse side effects of antipsychotic medications, and to monitor for anti-anxiety and antidepressant medications. A 7/18/24 review of Resident 17's medical record revealed no evidence of documentation for monitoring for adverse side effects of psychotropic medications. On 7/18/24 at 3:43 PM Staff 32 (LPN RCM) stated she expected monitoring for adverse side effects to psychotropic medications to be documented daily on the MAR. Staff 32 confirmed there was no documentation related to monitoring for adverse side effects of psychotropic medications. 34703 3. Resident 27 admitted to the facility in 2023 with diagnosis including depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 12/30/23 signed physician order indicated Resident 27 received Zoloft (antidepressant), and a 1/4/24 signed physician order indicated Resident 27 received Remeron (antidepressant). There was no monitoring in the resident's electronic record for adverse side effects of Zoloft and Remeron. On 7/18/24 at 9:41 AM Staff 28 (RCM-LPN) acknowledged there was no monitoring for adverse side effects of Zoloft and Remeron in Resident 27's electronic record, and stated the expectation was to monitor daily for adverse side effects.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41455 Based on observation and interview it was determined the facility failed to follow recipes to meet menu and therapeutic standards for 1 of 1 kitchen. This place residents at risk for lack of meal satisfaction and compromised nutrition. Finding include: The 7/18/24 posted lunch menu included breaded pork cutlet, au gratin potatoes, cauliflower and the alternative menu was sloppy joes, cheddar mash potatoes and broccoli. On 7/18/24 at 11:20 AM Staff 35 (Cook) was observed to assemble lunch and was asked to provide the recipes used to prepare the meal. Staff 35 stated he worked in the facility for three weeks and no recipes were provided during his training. Staff 35 stated no recipes were followed to prepare any of the foods served for lunch. On 7/18/24 at 12:03 PM and 12:53 PM Staff 5 (Certified Dietary Manager) stated a new menu system with recipes was introduced to the facility in 6/2024 and recipes should have been printed for all therapeutic diets and followed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41455 Based on observation, interview, and record review it was determined the facility failed to ensure proper flavor and food temperatures were maintained for meals served for 1 of 5 sampled resident (#27) and 1 of 1 facility kitchen reviewed for dining services. This placed residents at risk for food that was not palatable, safe, or appetizing. Findings include: 1. The 7/18/24 posted lunch menu included breaded pork cutlet, au gratin potatoes, cauliflower and the alternative menu was sloppy joes, cheddar mash potatoes and broccoli. The desert was ice cream. On 7/18/24 at 1:20 PM two sample plates were received. The first plate included minced and moist textured sloppy joes, mashed potatoes and gravy and broccoli. The second sample plate included easy to chew textured au gratin potatoes and cauliflower. The au gratin potatoes had crunchy pieces of dried potatoes, the moist and minced broccoli was cold with pieces that were firm to chew, the ice cream was melted and the milk was served warm. On 7/18/24 at 1:27 PM Staff 5 (Certified Dietary Manager) acknowledged the au gratin potatoes were cold and underdone, the broccoli was cold with no flavor, the ice cream should not be melted and milk was too warm and served at 64 degree. Staff 5 acknowledged the meal temperatures, flavors and palatability were not appropriate. 34703 2. Resident 27 admitted to the facility in 2023 with diagnoses including malnutrition and diabetes. On 7/16/24 at 10:16 AM Resident 27 stated the flavor of the food was bland with no taste, the bananas were over-ripe, the meat was dry and tough, and the food was always cold. On 7/18/24 at 9:43 AM Resident 27 was observed in the dining room during breakfast which included eggs, sausage, muffin, and an over-ripe banana. Resident 27 stated breakfast was cold and had no flavor. On 7/18/24 at 1:12 PM Resident 27 was in the dining room for lunch which included sloppy joe, broccoli, and mashed potatoes. Resident 27 stated the food was cold and tasted bad. On 7/18/24 at 1:29 PM Staff 28 (RCM-LPN) observed Resident 27's meal and stated the meal did not appear appetizing or appealing.

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **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 ensure physician ordered diets were provided as ordered for 3 of 5 sampled residents (#s 3, 39 and 57) reviewed for nutrition. This deficient practice was determined to be an immediate jeopardy situation. Resident 57 was provided food not prepared according to their physician ordered diet texture, and this resulted in a severe coughing episode and risk of choking and/or aspiration. Staff were aware the food they were providing the resident was not appropriate. Findings include: 1. Resident 57 admitted ,d+[DATE] with a diagnosis of pneumonitis (inflamation of lung tissue) due to inhalation of food and vomit, and CVA (cerebral vascular accident) with severe expressive aphasia (non-verbal) as well as severe oropharyngeal dysphagia (difficulty swallowing). Resident 57 was physician ordered for minced and moist textured food and care planned to be supervised for all oral intake. She/he had a recent history of aspiration (food or fluid enters the lungs), and pneumonia related to aspiration. Resident 57 was non-verbal and required total assistance from staff for eating. On 7/15/24 at 1:04 PM Resident 57's midday meal was observed. The chicken on the meal tray prepared by the kitchen was white meat with no gravy. While Staff 4 (CNA) assisted Resident 57 with eating a bite of chicken, she/he had a severe coughing episode for approximately three minutes. Resident 57's eyes became large, watery and she/he appeared panicked, and her/his face became flushed. Staff intervened and altered Resident 57's posture forward to assist with coughing until the coughing episode subsided. The resident's meal was discontinued. She/he had an elevated respiratory rate and appeared fatigued. On 7/15/24 at 1:08 PM Staff 4 stated she knew Resident 57's diet texture order was minced and moist, but no gravy was on or mixed in to the minced chicken. Staff 4 stated she was aware of the diet texture error, but did not obtain the necessary gravy because the kitchen was busy and chaotic. On 7/15/24 at 5:27 PM the faciity administrative staff including Staff 1 (Administrator), Staff 2 (DNS)and Staff 3 (Regional Support Lead)were notified of the immediate jeopardy (IJ) situation related to the facility's failure to provide a physician ordered diet. On 7/15/24 at 6:44 PM an acceptable immediate risk removal plan to to address the serious risk to residents' health and welfare was received from and implemented by the facility. The plan indicated the following facility actions: -Resident 57 was assessed for s/sx of aspiration, her/his physician was notified, and the resident was placed on alert charting. -Staff 4 was suspended and slated for 1:1 inservice training prior to returning to work related to food textures, ensuring food textures served matched the meal ticket, and the process for what to do if there was a discrepency. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Kitchen staff currently working were trained regarding proper diet textures. Other kitchen staff were slated to be educated prior to the start of their next shift until 100% were inserviced. Inserving was scheduled to be provided by a Certified Dietary Manager independent of the facility. -Nursing staff were slated to be inserviced regarding appropriate food textures and ensuring residents received the correct texture. -All residents with mechanically altered diets would have their meal tickets audited for correct texture prior to leaving the kitchen by the Certified Dietary Manager or designee, and a second check would occur by IDT team members in collaboration with CNAs prior to meals being served to residents. -Audits would be conducted of each meal for two weeks, then daily for four weeks, then weekly for four weeks. All findings were to be reported to the QAPI committee. Audits were to be conducted by the Certified Dietary Manager or designee. 35855 2. Resident 3 admitted to the facility in 7/2021 with diagnoses including difficulty swallowing. A 9/5/21 physician order instructed staff to provide Resident 3 with easy-to-chew textured diet. Review of Resident 3's care plan dated 4/18/24 indicated Resident 3 had impaired swallowing and was at risk for aspiration following a choking incident. Interventions included providing meals as ordered, ensuring Resident 3 remained upright for 30 minutes after eating, and serving an easy-to-chew texture diet. It was recommended to encourage Resident 3 to eat outside of bed; if in bed, the bed should be elevated to 90 degrees with the TV off. A Nursing Care Note on 4/18/24 documented Resident 3 choked on a piece of meat during lunch, which became lodged in the throat. Resident 3 was unable to clear the obstruction and was unable to swallow anything else. The physician was notified, was onsite at the facility at the time of the incident, and recommended transfer to the emergency department for treatment. An 4/18/24 physician Progress Notes indicated Resident 3 choked on a piece of pork during lunch, aspirating for approximately 20 minutes before medical intervention. The physician adjusted the bed to 90 degrees and attempted to provide water, which was coughed back up. The decision was made to transfer Resident 3 to the emergency department. A review of an 4/18/24 Emergency Department Encounter indicated Resident 3 sought medical attention for a feeling of a foreign body in the throat after eating pork. A review of the Documentation Survey Report from 7/1/24 through 7/17/24 revealed Resident 3 was to be supervised in the dining room for all meals. For day and evening shift Resident 3 refused 16 instances on day shift and one instance had no documentation, refused 10 times on evening shift, accepted two times and for five instances there was no documentation. Documentation revealed staff were to encourage Resident 3 to be out of bed for meals to decrease risk for aspiration with 16 refusals for breakfast and one accepted, 14 refusals for lunch with three accepted, nine refusals for dinner, and five instances with no documentation and three accepted. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 7/15/24 at 12:29 PM Witness 5 (Family Member) stated Resident 3 had a choking episode while she/he was lying down and had to go to the hospital. Witness 5 stated Resident 3 was supposed to go to the dining room for meals to be supervised but she/he refused and there was not enough staff to supervise her/him in her/his room. During observation and interview on 7/18/24 at 1:20 PM an easy-to-chew test tray was provided to the survey team and found to have inadequately cooked potatoes with crunchy pieces, and tough portions in the breaded pork. At 1:27 PM Staff 5 (Certified Dietary Manager) confirmed these findings. During an interview on 7/19/24 at 7:47 AM Staff 16 (CMA) stated Staff 17 (CNA) reported Resident 3 was choking and staff rushed into her/his room. Staff could hear Resident 3 trying to expel a piece of pork out of her/his throat. When she/he tried to swallow it made a horrible sound. Staff 16 stated everyone complained that day about how dry the pork was. On 7/19/24 at 10:54 AM Staff 17 stated on 4/18/24 she delivered Resident 3's tray and cut up everything on her plate and she remembered the pork being dry. 47001 3. Resident 39 admitted to the facility in 4/2022 with diagnoses including a stroke and dysphagia (swallowing difficulties). A review of Resident 39's record revealed a 4/14/22 order for easy chew 7 diet texture (foods the require less chewing and reduce the risk of choking). A review of a 5/13/24 Physician Progress Note revealed Resident 39 had an episode of post-tussive emesis (vomiting produce by coughing) while eating her/his lunch. A review of Resident 39's record revealed a 5/22/24 care plan for dysphagia and an 4/14/22 intervention to monitor and document ability to chew and swallow, and if presenting with problems obtain an order for ST to evaluate and treat. Resident 39 was observed eating lunch on 7/15/24. At approximately 1:00 PM Resident 39 was observed coughing on a tortilla for about 20 seconds. On 7/15/24 at 2:03 PM Staff 5 (Certified Dietary Manager) confirmed Resident 39 should have received a piece of bread instead of a tortilla based on her/his diet texture of easy chew 7.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 34703 Based on observation, interview and record review it was determined the facility failed to ensure residents' food preferences were honored for 1 of 1 sampled resident (#27) reviewed for nutrition. This placed residents at risk for unmet needs. Findings include: Resident 27 admitted to the facility in 2023 with diagnoses including malnutrition and diabetes. Resident 27's dietary card had lactose intolerant listed in two places. On 7/17/24 at 1:34 PM Resident 27 was observed to have a glass of milk on her/his meal tray. On 7/18/24 at 1:12 PM Resident 27 was observed to have a glass of milk on her/his meal tray. Resident 27 became angry regarding the milk and asked staff to remove the milk immediately. On 7/18/24 at 1:29 PM Staff 28 (RCM-LPN) acknowledged the resident's dietary card indicated she/he was lactose intolerant and should not receive milk.

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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 ensure sanitation processes were followed for 1 of 1 observed kitchen. This placed residents at risk for food borne illnesses. Findings include: A 7/2024 Dishwasher Temperature Log revealed a low-temperature dishwasher was monitored from 7/1/24 through 7/14/24, but with no evidence chemical concentration levels were documented. On 7/15/24 at 10:02 AM Staff 44 (Dietary Aide) was observed loading dishes into a low-temperature dishwasher that used chlorine to sanitize dishes. Staff 44 stated she cleaned dishes routinely, monitored the wash and rinse temperatures daily, but was never instructed to monitor the chemical concentration of the dish machine. On 7/15/24 at 10:17 AM Staff 45 (Dietary Services Manager) acknowledged she was aware the dish machine chemical concentration was to be monitored with the use of chemical test strips, which did not occur, and relied on monthly dish machine inspections by the chemical supplier to ensure the dish machine operated correctly. On 7/15/24 at 10:55 AM Staff 5 (Certified Dietary Manager) stated the form used to monitor the dish washer was incorrect since it provided no place to document any evidence of chemical sanitizer concentration. Staff 5 acknowledged he expected dish machine sanitation levels should be monitored and logged daily to ensure dishes were properly sanitized.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34703 Based on observation, interview, and record review it was determined the facility failed to follow infection control standards for 1 of 2 sampled residents (#30) and 2 of 2 unsampled residents (#s 6 and 11) reviewed for respiratory care. This placed residents at risk for exposure and contraction of infectious diseases. Findings include. 1. Resident 6 admitted to the facility in 2024 with diagnoses including sleep apnea (sleep related breathing disorder). On 7/16/24 at 9:55 AM Resident 6's CPAP mask was observed under her/his pillow against her/his mattress. On 7/17/24 at 1: 53 PM Resident 6's CPAP mask was observed resting on her/his bedrail. On 7/18/24 at 9:33 AM Resident 6's CPAP mask was observed on the floor. On 7/19/24 at 10:50 AM Staff 27 (LPN) stated Resident 6's CPAP mask should be stored in a sanitary manner. 2. Resident 11 admitted to the facility in 2024 with diagnoses including sleep apnea (sleep related breathing disorder). On 7/16/24 at 9:55 AM Resident 11's CPAP mask was observed on her/his nightstand. On 7/17/24 at 1:53 PM Resident 11's CPAP mask was observed hanging off her/his nightstand. On 7/18/24 at 9:33 AM Resident 11's CPAP mask was observed resting against her/his commode. On 7/19/24 at 10:50 AM Staff 27 (LPN) stated Resident 11's CPAP mask should be stored in a sanitary manner. 47001 3. Resident 30 admitted to the facility in 4/2022 with diagnoses including chronic obstructive pulmonary disease (a lung disease which causes restricted airflow and breathing problems). On 7/15/24 at 2:21 PM Resident 30 stated she/he used oxygen as needed; an oxygen concentrator was observed next to her/his bed. A review of Resident 30's care plan revealed a 12/21/23 care plan for oxygen use as needed. On 7/18/24 at 11:49 AM Staff 17 (CNA) stated Resident 30 used oxygen as needed, almost daily. Staff 17 stated Resident 30 applied oxygen by her/himself when needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 3:37 PM Staff 32 (LPN RCM) stated Resident 30 used oxygen as needed when she/he was short of breath. On 7/19/24 at 9:18 AM Resident 30's oxygen tubing was observed to be on the floor. Staff 32 confirmed Resident 30's oxygen tubing was on the floor. Staff 32 stated oxygen tubing should be placed in a bag to prevent it from falling to the floor.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 41455 Based on observation, interviews and record review it was determined the facility failed to ensure resident rooms were free from pests for 1 of 10 sampled residents (#36) and 1 of 3 dining rooms reviewed for environment. This placed residents at risk for pest infestation. Findings include: Resident 36 admitted to the facility in 2024 with diagnoses including diabetes and foot ulcer. A 7/6/24 Work Order indicated there was an excessive amount of flies in the main area and resident rooms in the south part of the building. A 7/13/24 at 6:10 AM SBAR (Situation, Background, Assessment, Recommendation) Change of Condition note indicated on 7/13/24 Staff 26 (RN) reported at 5:00 AM to Staff 27 (LPN) Resident 36 had maggots (fly larva) on her/his bed that came from her/wound dressing. Resident 36 was transported to the hospital. On 7/15/24 at 12:30 PM five flies were observed in the resident dining room around residents' food. Residents continued to swat the flies away from their meals. On 7/16/24 at 8:50 AM Resident 36 stated around 7/4/24 she/he complained about flies in her/his room that continued to land on her/his food and foot. Resident 36 stated she/he asked if something could be done about the flies and the answer was no. On 7/17/24 at 9:48 AM Staff 27 stated she found maggots in the early morning in Resident 36's room on 7/13/24, and administration was contacted but did not arrived until after 12:30 PM. Staff 27 stated staff were directed to deep clean Resident 36's room. Resident 36 remained in the room during the deep cleaning so it was necessary for the process to be completed a second time. Staff 27 stated when Resident 36 returned from the hospital that same day, Resident 36 was placed in her/his room with flies still present. On 7/18/24 at 9:09 AM Staff 19 (Maintenance Lead) confirmed he received a work order related to flies on 7/6/24 and did not address the issue until after the weekend on 7/8/24 when Staff 19 walked around the building. Staff 19 stated he saw no issue with flies on 7/8/24. On 7/19/24 at 10:48 AM Staff 2 (DNS) and Staff 23 (Regional Nurse Consultant) stated an investigation was completed for the 7/13/24 issue with Resident 36's maggots. Staff 23 acknowledged the facility was not aware there was a 7/6/24 work order related to flies in the building that was addressed days later when pest control arrived on 7/10/24.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 35855 Based on interview and record review it was determined the facility failed to have a system in place to ensure CNA staff received 12 hours of in-service training annually for 5 of 5 randomly selected staff members (#s 6, 7, 8, 9, and 10) reviewed for evidence of in-service training. This placed residents at risk for lack of competent staff. Findings include: A review of the facility's staff training records revealed the following: - Staff 6 (CNA), hired 5/30/22, had 15 minutes of documented training from 5/30/23 through 5/30/24. - Staff 7 (CNA), hired 6/20/19, had one hour of documented training from 6/20/23 through 6/20/24. - Staff 8 (CNA), hired 5/14/20, had two hours of documented training from 5/14/23 through 5/14/24. -Staff 9 (CNA), hired 3/23/21, had 7.25 hours of documented training from 3/23/23 through 3/23/24 -Staff 10 (CNA) hired 6/16/21, had 15 minutes of documented training from 6/16/23 through 6/16/24. In an interview on 7/19/24 at 12:03 PM Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional Support Lead), and Staff 23 (Regional Nurse Consultant) stated staff were not obtaining the sign-up sheets for the trainings to keep track of staff training hours.