STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385222	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Park Care	75 Shore Drive Saint Helens, OR 97051

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 38138 Based on observations and interviews the facility failed to ensure the state survey inspection results were readily accessible for 1 of 1 facility reviewed for resident council. This placed residents and the public at risk of not being informed of the facility's survey history. Findings include: On 1/14/25, 1/15/25 and 1/16/25 a notice of survey results was observed located near the front entrance on the wall approximately five feet high up on the wall. The notice indicated the state survey binder was in the basket below the notice. The basket was dark in color and angled in a way that protruded from the wall at the top. There was no state survey binder in the basket. The notice was not visible to someone in a wheelchair. During a resident council interview on 1/15/25 at 3:11 PM, seven resident attendees indicated they did not know where to find the state survey inspection results in the facility. On 1/16/25 at 8:49 AM Staff 1 (Executive Director) stated the state survey books were located at the nurses station. She was observed to pull two four-inch binders off of a shelf, which were about six feet high, from behind the nurses station. Staff 1 confirmed residents in wheelchairs would not be able to see the notice or the binders.

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

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 38140 Based on interview and record review, it was determined the facility failed to provide documentation that Notification of Medicare Non-Coverage (NOMNC) letters were provided in a timely manner for 1 of 3 sampled residents (# 205) reviewed for liability and appeal notices. This placed residents at risk of being uninformed of their right to appeal. Findings include: Resident 205's NOMNC letter indicated services were scheduled to end on 8/9/24. There was no documented evidence the resident was notified of her/his services ending. On 1/16/25 at 5:20 PM, Staff 1 (Executive Director) verified there was no documentation that Resident 205 was informed of her/his services ending. On 1/17/25 at 8:14 AM, Staff 5 (Social Services Director) confirmed there was no documentation that Resident 205 was informed of her/his services ending.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 35855 Based on interview and record review it was determined the facility failed to ensure residents were free from misappropriation for 1 of 1 resident (#50) reviewed for misappropriation. This placed residents at risk for lack of medication efficacy and loss of property. Findings include: Resident 50 was admitted to the facility in 1/2024 with diagnoses including arthritis and stroke. A 1/4/24 signed admission physician orders instructed staff to administer Oxycodone (to treat pain) one to two tablets every six hours as needed for moderate pain. Sixty tablets were physician ordered with no refills. The Admission MDS with an assessment review date of 1/11/24, revealed Resident 50 had a BIMS score of 15, which indicated the resident was cognitively intact. Resident 50 had frequent pain and received PRN pain medications. A 1/18/24 signed physician order instructed staff to administer Oxycodone one to two tablets by mouth every six hours as needed for pain with a quantity of 56 tables ordered. A review of Resident 50's 1/2024 MAR instructed staff to administer Resident 50 the following Oxycodone medications: -One tablet every six hours as needed for moderate pain with a start date of 1/4/24 and discontinued on 1/20/24 with five administrations. -One tablet every six hours as needed for pain with a start date of 1/20/24 through 2/3/24 with 39 administrations. -Two tablets every six hours as needed for moderate pain with start date of 1/4/24 and discontinued on 1/20/24 with 62 tablets administered. A review of Resident 50's narcotic logbook for Oxycodone revealed the following: -A page dated 1/5/24 with typed information indicating Oxycodone one to two tablets every six hours as needed for moderate pain with a quantity of 30. All 30 tablets were administered in one or two doses from 1/5/24 through 1/12/24. -A page dated 1/7/24 with typed information indicating Oxycodone one to two tables every six hours as needed for moderate pain with a quantity of 15. All 15 tablets were administered from 1/9/24 through 1/14/24. -A page dated 1/14/24 with handwritten information indicating Oxycodone with directions to see the MAR and the quantity of 22. All 22 tablets were administered from 1/15/24 through 1/19/24. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A Page dated 1/25/24 with typed information indicating Oxycodone one to two tablets every six hours as needed for moderate pain with quantity of 30. All 30 tablets were administered from 1/25/24 through 1/31/24. The MAR dated 1/4/24 through 2/3/24 revealed106 tablets were administered to Resident 50, while the narcotic logbook indicated 97 tablets of Oxycodone were administered to Resident 50. A 1/19/24 Care Conference Note indicated Resident 50 had a grievance regarding her/his Oxycodone not being administered timely manner. Staff 5 (Social Service Director) spoke to Staff 22 (Former DNS) to ensure Resident 50 received the correct medication. Resident 50 reported to Staff 5 a CMA informed Resident 50 her/his Oxycodone did not come in from the pharmacy because of an ice storm. A family member brought in her/his Oxycodone from home and a nurse removed them from Resident 50's room. The note indicated Staff 22 was investigating the concern and Staff 5 would complete a grievance. A 1/25/24 Social Services Note indicated Staff 5 spoke to Resident 50 about her/his Oxycodone. Resident 50 stated the medication bottle was missing and staff administered the medication from her/his bottle instead of the medication cards. Staff 5 spoke to Staff 22 and an investigation would be completed. On 2/27/24 the State Survey agency received a public complaint which indicated Resident 50's Oxycodone 5/325 medication was brought into the facility from her/his home. There were 30 pills in the bottle and facility staff removed the bottle and started using the Oxycodone out of the medication cart. The facility did not return Resident 50's bottle of Oxycodone. On 1/13/25 at 8:58 AM Witness 4 (Complainant) stated she reported her/his Oxycodone was removed from her/his room. Witness 4 stated the medication was administered to Resident 50 out of the medication cart. Resident 50 did not receive her/his personal medication back when she/he was discharged from the facility. On 1/14/25 Staff 5 stated she remembered an investigation was completed by Staff 22 for the 1/2024 Oxycodone, but it was not found and she did not remember the outcome of the investigation. Staff 5 stated she also could not find any grievance form was completed for Resident 50's missing Oxycodone. On 1/16/25 at 11:27 AM Staff 9 (LPN) stated if a narcotic medication was removed from a resident room it would be stored in the medication cart and would be counted in the narcotic log. Staff 9 also stated the facility did not administer narcotics brought from home. No documentation was provided to indicate Resident 50's Oxycodone from home was stored in the medication cart, counted in the narcotic log or returned to Resident 50 upon discharge. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interviews on 1/13/24 at 2:26 PM and 1/15/24 at 11:20 AM with Staff 2 (DNS) and on 1/17/25 at 8:18 AM with Staff 1 (Administrator) Staff 2 and Staff 3 (Regional Director of Clinical Operations), Staff 3 stated she saw the note in Resident 50's clinical records indicating an investigation and grievance should have been completed for Resident 50's missing Oxycodone and she could not find either. Staff 3 stated she would expect to see a grievance and follow up investigation for the concern. Staff 3 stated there was no facility policy or procedures regarding the removal of medications from a resident's room. Staff 1 stated if a family member brings in medications the expectation would be to send them back home and make a note in progress notes indicating the medication was sent home. Staff 1 stated she remembered Resident 50 having missing Oxycodone but did not remember the outcome. Staff 3 stated the facility could have a more streamlined way to handle medications brought into the facility by family members.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 38138 Based on interviews and record review it was determined the facility failed to implement written policies and procedures to thoroughly investigate all alleged violations, retain documents showing that all alleged violations were thoroughly investigated, to further prevent abuse and failed to establish coordination with the QAPI program regarding alleged staff and resident abuse for 3 of 7 sampled residents (#s 19, 23 and 202) reviewed for abuse. This placed residents at risk for verbal and physical abuse by staff. Findings include: The facility's 8/2022 Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injures of Unknown Source and Misappropriation of Resident Property policy revealed the following: - Thoroughly investigate all alleged violations and retain documents showing that all alleged violations are thoroughly investigated. - Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress . - Coordination with QAPI: Coordination of allegations of abuse will be completed monthly by the QAPI committee, and will utilize Point Click Care and Shift-to-Shift report to communicate across all shifts allegations, and necessary care and further information. The facility's undated QAPI/QAA Plan revealed the following: - Systems Monitoring, Feedback & Data Systems regarding abuse was to be collected weekly; analyzed by the facility's leadership team weekly; communicated with Board members, QAPI committee and state reporting agency; and to communicate data analysis via reporting requirements via weekly meetings. - Performance Improvement Plans (PIPs): The QAA committee will review data and input on a quarterly basis to look for potential topics for PIPs. 1. On 11/15/24 at 5:30 PM a FRI was received by the State Survey Agency (SSA) for an allegation of staff to resident physical abuse which occurred on 11/15/24 at 5:00 PM. The alleged perpetrator was Staff 33 (CNA) and the resident was identified as Resident 16. The facility's 11/15/24 Alleged Abuse investigation did not include a statement from the alleged perpetrator or the family witness identified in the internal investigation. The investigation conclusion was dated 11/20/24 and revealed Staff 33 was terminated due to multiple complaints regarding his caregiving. A review of Staff 33's personnel file found one concern related to an unsafe transfer dated 11/14/24. There was no evidence in Staff 33's personnel file related to the multiple complaints and no follow up documentation from the 11/14/24 safe transfer concern. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/16/25 at 5:00 PM Staff 2 (Director of Nursing) stated he did not have witness statements from the alleged perpetrator or the family member present during the alleged physical abuse. Staff 2 confirmed there was no disciplinary action documentation in Staff 33's personnel file. During an interview with Staff 2 and Staff 3 (Regional Director of Clinical Operations) on 1/21/25 at 2:32 PM Staff 2 stated Staff 5 (Social Services) will go around and talk to residents to see if they feel safe from abuse. If it happened in a specific area she will follow up in that area. Staff 2 stated there were no staff trainings related to abuse after the 11/15/24 allegation of staff to resident abuse. Staff 2 stated he did not have a tracking system in place to monitor identified concerns of abuse to share with the facility's QAPI committee. He added the facility had incident reports and if something happened once or twice a month for three months it was not a trend. When asked how he tracked issues needing to be addressed Staff 2 said he wrote them down but did not keep the paperwork. When asked how he knew if a concern was a trend, he pointed to his head. Staff 2 and Staff 3 confirmed there were no root cause analyses or trend tracking for abuse allegations for coordination with QAPI. On 1/21/25 at 3:50 PM Staff 3 confirmed there were no PIPs in place for abuse. At 4:08 PM Staff 3 confirmed there were no abuse audits completed by Staff 5 related to staff to resident verbal and physical abuse allegations which occurred on 11/15/24. 38140 2. On 8/6/24 at 9:12 AM a FRI was received by the State Survey Agency (SSA) for an allegation of staff to resident physical abuse which occurred on 8/3/24 at an unknown time. The alleged perpetrator was Staff 41 (CNA) and the resident was identified as Resident 202. The facility's 8/3/24 Alleged Abuse investigation did not include a statement from the alleged perpetrator, Staff 41. The investigation conclusion was dated 8/7/24 and revealed Staff 41 was terminated due to multiple complaints. During an interview with Staff 2 and Staff 3 (Regional Director of Clinical Operations) on 1/21/25 at 2:32 PM Staff 2 stated Staff 5 (Social Services) will go around and talk to residents to see if they feel safe from abuse. If it happened in a specific area she will follow up in that area. Staff 2 stated there were no staff trainings related to abuse after the 8/3/24 allegations of staff to resident abuse. Staff 2 stated he did not have a tracking system in place to monitor identified concerns of abuse to share with the facility's QAPI committee. He added the facility had incident reports and if something happened once or twice a month for three months it was not a trend. When asked how he tracked issues which needed to be addressed, Staff 2 said they were often written on a post-it note and he did not keep the paperwork. When asked how he knew if a concern was a trend, he pointed to his head. Staff 2 and Staff 3 confirmed there were no root cause analyses or trend tracking for abuse allegations for coordination with QAPI. On 1/21/25 at 3:50 PM Staff 3 confirmed there were no PIPs in place for abuse. At 4:08 PM Staff 3 confirmed there were no abuse audits completed by Staff 5 related to staff to resident verbal and physical abuse allegations which occurred on 8/3/24. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 8/6/24 at 9:12 AM a FRI was received by the State Survey Agency (SSA) for an allegation of staff to resident physical abuse which occurred on 8/5/24 prior to 11:00 AM. The alleged perpetrator was Staff 41 (CNA) and the resident was identified as Resident 23. The facility's 8/5/24 Alleged Abuse investigation did not include a statement from the alleged perpetrator, Staff 41. The investigation conclusion was dated 8/8/24 and revealed Staff 41 was terminated due to multiple complaints. During an interview with Staff 2 and Staff 3 (Regional Director of Clinical Operations) on 1/21/25 at 2:32 PM Staff 2 stated Staff 5 (Social Services) will go around and talk to residents to see if they feel safe from abuse. If it happened in a specific area she will follow up in that area. Staff 2 stated there were no staff trainings related to abuse after the 8/5/24 allegations of staff to resident abuse. Staff 2 stated he did not have a tracking system in place to monitor identified concerns of abuse to share with the facility's QAPI committee. He added the facility had incident reports and if something happened once or twice a month for three months it was not a trend. When asked how he tracked issues which needed to be addressed, Staff 2 said they were often written on a post-it note, he did not keep the paperwork. When asked how he knew if a concern was a trend, he pointed to his head. Staff 2 and Staff 3 confirmed there were no root cause analyses or trend tracking for abuse allegations for coordination with QAPI. On 1/21/25 at 3:50 PM Staff 3 confirmed there were no PIPs in place for abuse. At 4:08 PM Staff 3 confirmed there were no abuse audits completed by Staff 5 related to the staff to resident verbal and physical abuse allegations which occurred on 8/5/24.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38138 Based on interviews and record review it was determined the facility failed to report allegations of verbal and physical abuse within the mandated timeframe for 3 of 7 sampled residents (#s 19, 23, and 202) reviewed for abuse. This placed residents at risk for verbal and physical abuse from staff. Findings include: 1. Resident 19 was admitted to the facility on [DATE] with diagnoses including cirrhosis of the liver (chronic liver damage), mild cognitive impairment and obesity. The facility's 11/15/24 Verbal Aggression Received investigation revealed Resident 19 arrived at the facility for admission by private vehicle on 11/15/24 at 4:30 PM. The investigation alleged Staff 33 (CNA) verbally abused Resident 19 by yelling at her/him while Staff 33 assisted Resident 19 out of the vehicle. Staff 30 (CNA) witnessed the event and reported it to Staff 31 (LPN). A FRI for the 11/15/24 alleged verbal abuse from Staff 33 to Resident 19 was submitted to the state agency on 11/18/24 (three days after the alleged verbal abuse occurred). On 1/14/25 at 7:05 PM Staff 30 (CNA) stated she reported the 11/15/24 alleged verbal abuse incident to Staff 31 immediately after witnessing the incident. On 1/16/25 at 11:53 AM Staff 31 stated she notified Staff 2 of the alleged verbal abuse by Staff 33 to Resident 19 on 11/15/24. On 1/16/25 at 4:00 PM Staff 2 (DNS) confirmed he did not send the FRI report to the state agency until 11/18/24. 38140 2. Resident 23 was admitted to the facility in 2021 with diagnoses including stroke and mild cognitive impairment. The facility's Alleged Abuse investigation revealed Resident 23 reported potential abuse on 8/5/24 at 11:30 AM. A FRI for the 8/5/24 alleged abuse was submitted to the state agency on 8/6/24 at 9:12 AM (one day after the alleged verbal abuse occurred). On 1/16/25 at 4:00 PM Staff 2 (DNS) confirmed he did not send the 8/5/24 allegation of abuse FRI report to the state agency until 8/6/24 and not within the two-hour required reporting. 3. Resident 202 was admitted to the facility in 5/2024 with diagnoses including stroke and mild cognitive impairment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Alleged Abuse investigation revealed on 8/3/24 at 4:00 PM Resident 202 may have experienced potential verbal abuse. A FRI for the 8/3/24 alleged abuse was submitted to the state agency on 8/6/24 at 9:12 AM (three days after the alleged verbal abuse occurred). On 1/16/25 at 4:00 PM Staff 2 (DNS) confirmed he did not send the 8/3/24 allegation of abuse FRI report to the state agency until 8/6/24 and not within the two-hour required reporting.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38138 Based on interviews and record review it was determined the facility failed to thoroughly investigate alleged physical and verbal abuse from staff for 3 of 7 sampled residents (#s 16, 19 and 202) reviewed for abuse. This placed residents at risk for physical and verbal abuse from staff. Findings include: The facility's 8/2022 Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injures of Unknown Source and Misappropriation of Resident Property policy revealed the following: - Thoroughly investigate all alleged violations and retain documents showing that all alleged violations are thoroughly investigated. 1. Resident 19 was admitted to the facility on [DATE] by a family member in a private vehicle, with diagnoses including cirrhosis of the liver (chronic liver damage), mild cognitive impairment and obesity. The facility's 11/15/24 Verbal Aggression Received investigation revealed Resident 19 arrived at the facility for admission with family by private vehicle on 11/15/24 at 4:30 PM. The investigation alleged Staff 33 (CNA) verbally abused Resident 19 by yelling at her/him while Staff 33 assisted Resident 19 out of the vehicle. The investigation did not include a statement from Staff 33 or the family witness. On 1/14/25 at 12:41 PM Witness 5 (family member) stated she was present with another family member when Staff 33 assisted Resident 19 out of the vehicle and into a wheelchair. Witness 5 stated multiple times, in no way was Staff 33 verbally abusive or rushed and he did not say anything rude or mean to Resident 19. Witness 5 said she was not asked to provide a statement regarding what happened. On 1/15/25 at 3:40 PM Staff 33 stated he remembered Resident 19 and her/his arrival to the facility on [DATE]. He said he assisted the resident out of the car and stated I was talking to her to get out of the car. She said she was going to fall and she did not want to fall and I keep telling her I won't let you fall. We got her transferred into the wheelchair safely and into the building. Staff 33 denied yelling at or speaking loudly to Resident 19. Staff 33 stated he was not provided an opportunity to explain what happened and did not know there was a problem until he was walked out of the facility and later fired by Staff 2 (Director of Nursing) for abuse. On 1/16/25 at 5:00 PM Staff 2 stated he did not have witness statements from the alleged perpetrator or a family member who was present during the alleged verbal abuse. During an interview with Staff 2 and Staff 3 (Regional Director of Clinical Operations) on 1/21/25 at 2:32 PM, Staff 2 stated Staff 5 (Social Services) will go around and talk to residents to see if they feel safe from abuse. If it happened in a specific area she will follow up in that area. On 1/21/25 at 4:08 PM Staff 3 confirmed there were no abuse audits completed by Staff 5 related to the staff to resident abuse allegations which occurred on 11/15/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 16 was readmitted to the facility in 8/2024 with diagnoses including diabetes and dementia. The facility's 11/15/24 Alleged Abuse investigation revealed Resident 16 returned to the facility on [DATE] at 5:00 PM from an outing with a family member. The family member requested Resident 16 be put to bed. The investigation alleged Staff 33 (CNA) physically abused Resident 16 by pushing the resident down on the bed telling the resident she/he had to go to sleep because Resident 16's family member wanted her/him to. The investigation did not include a statement from Staff 33 or the family witness. On 1/14/25 at 6:40 PM Witness 6 (family member) stated she was present while Staff 33 helped Resident 16 to get into bed. Witness 6 said Staff 33 was not rough and did not act like he was in a rush. Witness 6 stated Staff 31 (LPN) jumped on him [Staff 33] and could have managed her approach differently because Staff 33 didn't do anything wrong. Witness 6 confirmed she was not asked by the facility to submit a statement regarding what she witnessed. On 1/15/25 at 3:40 PM Staff 33 stated he remembered Resident 16 and her/his return to the facility on [DATE]. He said he assisted the resident into the bed from the wheelchair and the resident's family member was present during the transfer. Staff 33 denied pushing or abusing the resident. Staff 33 stated he was not provided an opportunity to explain what happened and did not know there was a problem until he was walked out of the facility and later fired by Staff 2 (DNS) for abuse. On 1/16/25 at 5:00 PM Staff 2 stated he did not have witness statements from the alleged perpetrator or a family member who was present during the alleged physical abuse. During an interview with Staff 2 and Staff 3 (Regional Director of Clinical Operations) on 1/21/25 at 2:32 PM Staff 2 stated Staff 5 (Social Services) will go around and talk to residents to see if they feel safe from abuse. If it happened in a specific area she will follow up in that area. On 1/21/25 at 4:08 PM Staff 3 confirmed there were no abuse audits completed by Staff 5 related to staff to the resident abuse allegations which occurred on 11/15/24. 38140 3. Resident 202 was admitted to the facility in 5/2024 with diagnoses including stroke and mild cognitive impairment. The facility's 8/3/24 Alleged Abuse investigation revealed Witness 7 (former resident) made a statement on 8/6/24 which alleged Staff 41 (CNA) and another unknown staff member abused Resident 202. The investigation did not indicate who the other staff member was or provide any other statements. On 1/14/24 at 6:17 PM Staff 41 stated she/he had no opportunity to provide a written or verbal statement for the 8/3/24 abuse allegation with Resident 202. Staff 41 stated they were told to come to the facility, when they arrived, she/he was told not to return to the premises and was never given an opportunity to give a statement. Staff 41 stated she/he was very thankful to be given chance to tell her/his side of story. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/15/24 at 8:52 AM Staff 41 provided a written statement for the 8/3/24 incident with Resident 202. Staff 41 described the incident and how she/he assisted another colleague and the difficult time they had to assist Resident 202 into her/his bed. On 1/16/25 at 3:57 PM Staff 1 (Executive Director) confirmed the facility provided all the information for the Resident 202's 8/3/24 abuse allegation investigation. The file provided included the following: -Resident general information sheet; -An Alleged Abuse investigation, a statement from Witness 7, Staff 2 (DNS) indicated he attempted contact with Staff 41 for a statement, no other interviews; -Grievance for Resident 202, dated 8/3/24, for alleged abuse by Staff 41, completed by an unknown person, included the word over with no additional information; -Resident 205's care plan; -Two disciplinary action reports for Staff 41 dated 7/3/24 and 8/8/24; -Grievance form for another staff person's behavior with Resident 202, unknown date or time, person completing the form or who receivedthe form; -FRI form; -A hand written statement on 8/5/24 by unknown person who worked an evening shift on an unknown date, with an unknown resident and the information did not alledge any abuse by Staff 41. During an interview with Staff 2 and Staff 3 (Regional Director of Clinical Operations) on 1/21/25 at 2:32 PM Staff 2 stated Staff 5 (Social Services) will go around and talk to residents to see if they feel safe from abuse. If it happened in a specific area she will follow up in that area. On 1/21/25 at 4:08 PM Staff 3 confirmed the investigation was not through and there was no additional information and no abuse audits completed related to the alledged staff to resident abuse which occurred on 8/3/24

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38138 Based on observation, interviews and record review it was determined the facility failed to ensure a comprehensive care plan addressed dental needs for 1 of 1 sampled resident (#28) reviewed for dental. This placed residents at risk for unmet dental needs. Findings include: Resident 28 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (lung disease) and dental caries (permanently damaged areas in teeth). The 1/23/24 Food Preference Record revealed Resident 28 had .all broken teeth no dentures can't chew most or all foods, NSM (Nutrition Services Manager) will continue to monitor & follow up as needed. The 1/29/24 Admission MDS Assessment revealed Resident 28 had a BIMS of 14 (cognitively intact) and had dental caries. An 8/27/24 Nutrition/Therapy Communication revealed the resident's diet was downgraded to mechanical soft. The 10/28/24 Nutrition Evaluation revealed Resident 28 had missing, broken teeth with dental caries and she/he required a soft diet. There was no evidence Resident 28's dental care needs were addressed in her/his care plan. On 1/13/25 at 10:12 AM and throughout the facility's recertification survey, Resident 28 was observed to have broken blackish and missing front teeth on both top and bottom gumlines. Resident 28 stated she/he told staff about her/his teeth and nobody did anything about it. She/He stated her/his teeth were also broken at the gum line in the back of her/his mouth which were observed by the state surveyor. On 1/16/25 at 9:58 AM Staff 34 (CNA) stated information about the resident's care should be on the care plan. She was aware of Resident 28's missing and broken teeth and stated a request was made several months prior for the resident to see a dentist. On 1/16/25 at 11:14 AM Staff 5 (Social Services) stated she was familiar with Resident 28 and her/his dental needs. She remembered talking about the resident's dental needs in the past but was not sure if she documented the conversations. On 1/17/25 at 9:10 AM Staff 3 (Regional Director of Clinical Operations) provided a copy of Resident 28's dental care plan and confirmed it was dated 1/16/25 (almost one year after the resident was admitted to the facility). On 1/17/25 at 9:40 AM Staff 4 (Resident Care Coordinator) confirmed the resident should have had a comprehensive dental care plan one month after she/he admitted to the facility and did not have one until 1/16/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/17/25 at 10:00 AM findings of this investigation were shared with Staff 1 (Executive Director). No additional information was provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38138 Based on observation, interview, and record review it was determined the facility failed to provide care and treatment as care planned and physician ordered for 3 of 5 residents (#s 15, 100 and 202) reviewed for skin, monitoring and labs. This placed residents at risk for delayed treatment and unmet needs. Findings include: 1. Resident 15 was initially admitted to the facility in 2018 and readmitted on [DATE] after hospitalization with diagnoses including cerebral palsy, epilepsy with seizures and phenytoin (Dilantin) toxicity. Resident 15 had a 1/16/24 physician order to obtain a Dilantin level every day shift every 1 month(s) for 4 day(s) for a Dilantin level with a start date of 2/6/24. A review of Resident 15's MAR/TAR from April 2024 through August 2024 revealed the following: April 2024 - 4/6/24 and 4/7/24 were documented 8 (Other / See Nurse Notes). - 4/8/24 and 4/9/24 were documented with a checkmark (indicating task completed). May 2024 - 5/6/24 was documented 8. - 5/7/24 was left blank. - 5/8/24 and 5/9/24 were documented with a checkmark. June 2024 - 6/6/24 was left blank. - 6/7/24, 6/8/24 and 6/9/24 was documented with a checkmark. July 2024 - 7/6/24 and 7/7/24 were documented 8. - 7/8/24 was documented with a checkmark. - 7/9/24 was left blank. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility progress notes revealed no evidence bloodwork was drawn for labs related to Dilantin levels from 4/2024 through 7/2024. Progress notes related to the MAR/TAR documentation included the following: - 4/6/24 and 4/7/24 no labs on weekends - 4/8/24 and 4/9/24 there was no documentation revealing the resident had lab work completed or if the results were sent to her/his physician. - 5/6/24 need order clarification. - 5/7/24 there was no documentation revealing the blank on the MAR/TAR, if the resident had lab work completed or if results were sent to her/his physician. - 5/8/24 and 5/9/24 there was no documentation revealing the resident had lab work completed or if the results were sent to her/his physician. - 6/6/24 there was no documentation revealing the blank on the MAR/TAR, or if the resident had lab work completed or if results were sent to her/his physician. - 6/7/24, 6/8/24 and 6/9/24 there was no documentation revealing the resident had lab work completed or if the results were sent to her/his physician. - 6/10/24 progress note revealed Lab appt set up at legacy lab in St. Helens on June 12,2024 @ 9:15am North west ride to p/u resident from facility @ 8:30-9am and drop back off at facility between 9:30am-10:00am. Resident made aware of appointment. There was no follow up documentation revealing the resident had lab work completed or if the results were sent to her/his physician. - 7/6/24 and 7/7/24 not done; waiting for supplies. - 7/8/24 there was no documentation revealing the resident had lab work completed or if the results were sent to her/his physician. - 7/9/24 there was no documentation revealing the blank on the MAR/TAR, if the resident had lab work completed or if results were sent to her/his physician. There was no evidence in the resident's health record revealing bloodwork was drawn for labs related to Dilantin levels per the 1/16/24 physician order. An 8/26/24 provider note revealed Resident 15 was hospitalized from 8/17/24 to 8/23/24 for Dilantin toxicity. The provider note revealed Resident 15 had a Dilantin level of 19 on 3/15/24. There were no Dilantin or phenytoin levels until 8/17/24 when the resident's phenytoin level was 42 at the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/17/24 at 1:36 PM Staff 40 (Medical Director) stated Resident 15's case was very complex with a long-standing epileptic history and a history of break through seizure activity with normal Dilantin levels between 17 and 19. Staff 40 was unable to provide dates of Dilantin lab levels taken from 4/2024 through 7/2024. Staff 40 stated Resident 15 was hospitalized in 7/2024 for heart surgery and returned to the facility with a physician ordered increase in dosage for Dilantin which was followed by the facility. He stated the increased dosage may have been normal for the resident while she/he was in the hospital and the resident was discharged with those orders. Staff 40 went on to add, Resident 15 was admitted to the hospital on 8/17/24 for symptoms of phenytoin toxicity and her/his phenytoin levels at the hospital were 41, with 50 and above considered very toxic. Staff 40 again stated the facility followed the orders the resident readmitted with. On 1/21/25 at 7:43 AM Staff 3 (Regional Director of Clinical Services) stated no labs were done. Staff 3 stated she called the lab and the resident's neurologist, and both stated no labs were done. Staff 3 confirmed the checkmark documentation on the MAR/TAR indicated the task was complete and lab results or communication to the neurologist was found. At 1:35 PM Staff 3 stated she spoke to one nurse responsible for documenting check marks on the MAR/TAR and was informed they must have been done in error. Staff 3 stated the other nurse responsible for the documentation no longer worked for the facility and confirmed labs were not done from 4/2024 through 7/2024. 35855 2. A facility Wound Documentation-Wound Rounds Policy dated 9/2023 indicated at the time of a new admission or readmission the resident would have a head-to-toe skin assessment by the wound nurse, charge nurse or designee within eight hours of admission. If a skin issue was noted the area would be entered in wound rounds which includes, but is not limited to, measurements, drainage and wound descriptors. The nurse's note was completed to document findings and summarize the initial assessment or findings. A care plan would be initiated. Skin check frequency would be indicated on the TAR weekly and was to be completed by a licensed staff. If skin issues were noted, orders would be written and transferred to the TAR as appropriate. Resident 100 was admitted to the facility in 1/2025 with diagnoses including disorder of circulatory system and chronic total occlusion (blockage or closing of an opening, blood vessel or hollow organ) of an artery of the extremities. A review of signed admission orders dated 1/8/25 instructed staff to administer Pradaxa (a blood thinner that prevents blood clots) one tablet two times a day for peripheral arterial (narrowing of the arteries) occlusive disease. A review of Resident 100's Admission Evaluation dated 1/8/25 revealed Resident 100 had bruising to the left and right forearms and hands. A 1/8/25 Progress note indicated Resident 100 had multiple bruises to her/his upper and lower extremities. A review of Resident 100's care plan revised on 1/9/25 revealed she/he was on anticoagulant therapy with interventions which included to report any signs or symptoms of bleeding. Resident 100 had bruises on her/his upper and lower extremities bilaterally due to hospitalization . Interventions included to assess the area until healed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 100's 1/2025 MAR instructed staff to administer Pradaxa two times a day for occlusion. A review of the 1/2025 TAR revealed no monitoring for Resident 100's bruising. On 1/12/25 at 12:13 PM Resident 100 had a dark purple bruise on the inside of her/his right forearm. The bruise was approximately three inches wide and 10 to 12 inches long. On the inside of her/his left elbow, there was a large round purple bruise approximately three inches wide. On the top of Resident 100's hand by her/his thumb, there was a round bruise approximately two inches wide. Resident 100 stated she/he came from the hospital and she/he did not know where she/he received the bruising. On 1/15/25 at 5:48 AM Staff 11 (LPN) stated monitoring of bruises would be completed in the Skin and Wound evaluations. Staff 11 also stated he did not know about any large bruises on Resident 100's arms. On 1/15/25 at 11:15 AM Staff 4 (Resident Care Coordinator) stated she did not know until 1/15/24 she should have put in a nursing order to monitor Resident 100's bruising until the bruises resolved. Staff 4 further stated she completed the initial nursing admission assessment for Resident 100 and knew about the bruising. In interviews on 1/15/24 at 11:20 AM with Staff 2 (DNS) and on 1/17/25 at 8:18 AM with Staff 1 (Administrator) Staff 2 and Staff 3 (Regional Director of Clinical Operations), Staff 2 stated it was the expectation of staff to do weekly skin checks and monitor on the TAR. If a resident was on an anti-coagulant, the staff should monitor the resident daily for bleeding. The staff who completed the initial skin assessment for a resident was responsible for placing the nursing order for the bruise monitoring. 38140 3. Resident 202 was admitted to the facility in 5/2024 with diagnoses including stroke and mild cognitive impairment. An 8/3/24 Alleged Abuse investigation reveled Resident 202 obtained an abrasion to her/his right iliac crest (rear). Staff 2 (DNS) wrote he concluded Resident 202 was mistreated by a CNA. Review of Resident 202's health record revealed no skin assessment, monitoring or treatments were completed. No assessment or monitoring for psychosocial impact was completed. During an interview on 1/17/25 Staff 1 (Executive Director), Staff 2 (DNS) and Staff 3 (Regional Director of Clinical Operations) reviewed Resident 202's health record. Staff 2 stated the facility documented new skin concerns in the alert charting progress notes. Staff 2 confirmed Resident 205's abrasion on the 8/3/24 investigation report. Staff 1 and Staff 3 acknowledged they would expect behavior monitoring in alert charting after a resident may have been a victim of abuse. No evidence was found to indicate Resident 202's skin abrasion or behavior was monitored or assessed after the 8/3/24 incident. No additional information was provided.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 38140 Based on observation, interview and record review it was determined the facility failed to provide appropriate treatment and services to prevent further decreases in range of motion for 1 of 1 sampled resident (# 37) reviewed for rehab and restorative services. This placed residents at risk for decreased range of motion and a decreased physical condition. Findings include: Resident 37 admitted to the facility in 9/2024 with a diagnosis of lupus (immune system attacks own organs), depression and obesity. Resident 37's 1/8/25 Quarterly MDS indicated she/he was cognitively intact and she/he received zero hours or days of active or passive RA services. On 1/12/25 at 3:04 PM Resident 37 stated she/he does not get the opportunity to do any exercises and she/he would like to exercise to gain strength to be able to discharge from the facility. Resident 37 was observed in her/his bed with no exercise equipment available for use in the room. Record review of Resident 37's health records provided no indication she/he received RA services. On 1/16/25 at 11:37 AM Staff 24 (CNA) stated Resident 37 was not offered any RA services since Resident 37 moved to her/his room many months ago. Staff 24 stated the facility does not provide RA services because they do not have enough staff to provide. On 1/16/25 at 3:19 PM Staff 4 (Resident Care Coordinator) confirmed Resident 37 did not receive RA services or have a RA services plan. Staff 4 acknowledged the facility does not have a RA program at this time. On 1/17/25 at 9:37 AM Staff 1 (Administrator) confirmed Resident 37 did not receive RA services and acknowledged the facility should offer RA services to maintain physical strength of the residents.

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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. **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 adequate incontinence care for 1 of 1 sampled resident (#8) reviewed for incontinence care. This placed residents at risk for unmet incontinence needs. Resident 8 was admitted to the facility in 7/2014 with diagnoses including traumatic brain injury and contractures of the left and right ankles. Resident 8's care plan revised on 12/9/21 indicated the resident had an ADL self-care performance deficit and needed frequent checks. Resident 8 had an alteration in bowel elimination and incontinence. Resident 8 needed to be checked every two hours and provided with peri care after each incontinent episode. Resident 8's Annual MDS dated [DATE] identified the resident was always incontinent of both bowel and bladder and required staff assistance with toileting. Resident 8 was rarely to never understood when communicating. The 12/31/24 Urinary Incontinence CAA identified the type of incontinence as functional, meaning the resident could not get to the toilet in time due to physical disability or problems thinking or communicating. According to the CAA, Resident 8 depended on staff for incontinent care. On 1/13/25 at 7:39 AM Witness 1 (Family Member) stated the facility staff did not always clean Resident 8 appropriately during incontinent care. Witness 1 stated she requested Resident 8's groin area be trimmed of hair so feces would not be left on her/him. On 1/15/25 at 7:34 AM Staff 10 (CNA) stated that each time she came on her shift, she would provide Resident 8 with incontinent care and find feces in her/his groin hair. Staff 10 stated it was a problem throughout the facility as staff were not cleaning feces out of women's vaginas and under men's testicles. Staff 10 mentioned there was a peri care spray that helped loosen feces from residents, but the facility did not always have this spray in supply. Staff 10 stated she had reported this concern to the administration. On 1/15/24 at 8:47 AM Staff 7 (CNA) stated there were a few times she had observed Resident 8 not being cleaned well during incontinent care. In an interview on 1/17/25 at 8:25 AM with Staff 1 (Administrator) Staff 2 (DNS) and Staff 3 (Regional Director of Clinical Operations), Staff 1 stated the facility completed rounds and monitored staff for their care and competence in the care of the residents. Staff 2 stated in 8/2024 there was a resident who had a concern for lack of incontinent care. Staff 1 stated she was not aware there were any current concerns about other residents in the facility not being cleaned properly during incontinent care. Staff 1 and Staff 2 further stated they did not see a grievance from the family regarding a concern with incontinent care for Resident 8.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 38140 Based on interview and record review it was determined the facility failed to ensure an RN was available for at least eight consecutive hours per day seven days per week for 4 of 68 days reviewed for staffing. This placed residents at risk for lack of timely RN assessments and care. Findings include: Review of the PBJ (payroll based journal) Staffing Data Report for Quarter 4 (July 1, 2024 - September 30, 2024) revealed the facility reported on 7/7/24, 7/13/24, 7/20/24, 7/28/24, 8/4/24, 9/1/24, and 9/2/24, RN coverage was not available for at least eight consecutive hours per day. Review of the Direct Care Staff Daily Reports from 12/13/24 through 1/13/25 revealed on 12/22/24, RN coverage was not available for at least eight consecutive hours per day. On 1/16/25 at 11:41 AM Staff 23 (Staffing Coordinator) acknowledged the facility lacked RN coverage on the identified days on the PBJ and Direct Care Staff Daily Reports. On 1/17/25 at 8:48 AM Staff 1 (Executive Director) acknowledged the facility's failure to meet RN coverage for eight consecutive hours per day on the dates provided. No additional information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50930 Based on observation and interview it was determined the facility failed to ensure expired medications were removed from 1 of 1 medication storage rooms and 3 of 4 medication carts reviewed for medication storage. This put residents at risk for reduced efficacy of medications. Findings include: During a review of the medication storage room on 1/14/25 at 9:38 AM Staff 26 (CMA) verified the following expired medications were found: - one bottle of Latanoprost eyedrops (eye pressure relief drops) with an expiration date of 12/2024 - one bottle of Zioptan eyedrops (eye pressure relief drops) with an expiration date of 8/2024 - 10 vials of powdered Cephazolin (an antibiotic medication) with an expiration date of 10/2024 On 1/14/25 at 9:53 AM Staff 26 stated the expectation for expired medications was for them to be removed per the facility policy. The facility Storage and Expiration Dating of Medications, Biologicals Policy, with revision date 7/21/22, stated the facility should ensure all expired medications and biologicals were stored separately from other medications until destroyed or returned to the pharmacy or supplier. During a review of the Hall B medication cart on 1/14/25 at 10:22 AM Staff 27 (CMA) verified the following expired medications were found: - one bottle of MiraLAX (medication for treatment of constipation) with an expiration date of 12/2024 - one vial of Lispro insulin (medication for diabetes management) with an expiration date of 12/25/24 On 1/14/25 at 10:34 AM Staff 27 stated she was not sure if there was a facility policy for expired medications, but the expectation for expired medications was for them to be removed from the medication cart. During a review of the Hall A room one to five medication cart on 1/14/25 at 10:36 AM Staff 28 (LPN) verified the following expired medication was found: - one bottle of mucus relief (medication to thin mucus in air passages) with an expiration date of 10/2024 On 1/14/25 at 10:39 AM Staff 28 stated she thought there was a facility policy for expired medications and the expectation was for all expired medications to be removed from the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the treatment cart for Hall A and C on 1/15/25 at 12:05 PM Staff 29 (RN) verified the following expired medications were found: - one tube hemorrhoid cream (medication to decrease swelling and discomfort) with an expiration date of 8/2024 - one tube of Miconazole 7 cream (an antifungal medication) with an expiration date of 6/2024 - one tube of triple antibiotic ointment (an antibiotic medication) with an expiration date of 6/2024 On 1/15/25 at 12:22 PM Staff 29 stated she was not sure if a policy existed for expired medications, but the expectation was for expired medications to be reordered and removed from the medication cart. On 1/16/25 at 1:35 PM Staff 2 (DNS) stated the facility medication storage policy directed staff to remove expired medications from medication carts and medication storage rooms. He stated the expectation was for every nurse and CMA to check the medication carts and the medication storage room on a regular basis to remove and replace expired medications.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38138 Based on observation, interviews and record review it was determined the facility failed to ensure prompt routine and emergency dental services were obtained for 1 of 1 sampled resident (#28) reviewed for dental. This placed residents at risk for unmet dental needs. Findings include: Resident 28 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (lung disease) and dental caries (permanently damaged areas in teeth). The 1/23/24 Food Preference Record revealed Resident 28 had .all broken teeth no dentures can't chew most or all foods, NSM (Nutrition Services Manager) will continue to monitor & follow up as needed. The 1/29/24 Admission MDS Assessment revealed Resident 28 had a BIMS of 14 (cognitively intact) and had dental caries. The 5/16/24 Social Services Quarterly Evaluation revealed Dental will be at the facility on May 30th. There was no additional documentation or evidence in Resident 28's electronic health record she/he was seen by the dentist on 5/30/24. A 7/15/24 progress note by Staff 28 (LPN) revealed a request for a dental appointment for broken missing teeth. The 7/31/24 Care Conference revealed the Hearing, Vision and Dental section was noted Vision will be out 9/3. There was no documentation referencing Resident 28's dental needs. An 8/27/24 Nutrition/Therapy Communication revealed the resident's diet was downgraded to mechanical soft. The 10/28/24 Nutrition Evaluation revealed Resident 28 had missing, broken teeth with dental caries and she/he required a soft diet. The 12/17/24 Social Services Evaluation revealed the Hearing, Vision and Dental section was noted NA. There was no documentation referencing Resident 28's dental needs. On 1/13/25 at 10:12 AM Resident 28 was observed to have broken blackish and missing front teeth on both top and bottom gumlines. Resident 28 stated she/he told staff about her/his teeth when she/he admitted to the facility a year ago and nobody made her/him a dental appointment or did anything about it. She/He stated her/his teeth were also broken at the gum line in the back of her/his mouth which were observed by the state surveyor. On 1/13/25 at 3:48 PM no evidence was found addressing Resident 28's dental care needs in her/his care plan. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at Resident 28 stated the staff knew her/his mouth hurt and added I haven't seen a dentist yet. I just want to be able to smile again nobody wants to look at this [pointed to mouth] it's embarrassing. I know it's bad. I just want it fixed. On 1/16/25 at 9:58 AM Staff 34 (CNA) stated she was aware of Resident 28's missing and broken teeth and stated a request was made several months prior for the resident to see a dentist, but she was not aware of any follow up. On 1/16/25 at 10:11 AM Staff 7 (CNA) stated she was familiar of Resident 28 and aware of her/his broken and missing teeth. On 1/16/25 at 11:14 AM Staff 5 (Social Services) stated she was familiar with Resident 28 and her/his dental needs. She said dental would be in the facility soon. She stated she remembered talking about the resident's dental needs in the past but was not sure if she documented the conversations. Staff 5 stated she made Resident 28 a dental appointment on 12/19/24 and the appointment was scheduled for 1/28/25 (more than one year after the resident admitted to the facility). On 1/17/25 at 9:40 AM Staff 4 (Resident Care Coordinator) confirmed Resident 28 did not have a care plan related to her/his dental needs. On 1/17/25 at 10:00 AM findings of this investigation were shared with Staff 1 (Executive Director). No additional information was provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38138 Based on observation, interviews and record review it was determined the facility failed to ensure dishwasher temperatures were monitored daily to ensure the dishwasher functioned properly during an influenza outbreak for 1 of 1 dishwasher reviewed for the kitchen. This placed residents at risk for communicable diseases, un-sanitized dishware and utensils. Findings include: On 1/12/25 at 10:20 AM the facility was observed to have one low temperature dishwasher in the kitchen. A dishwasher temperature log was observed to have blanks for the month and year and the spaces to fill in temperatures for three cycles of washes were blank for the following dates: - 1/3/25 last cycle wash, rinse, parts per million (PPM) (a unit of measurement used to express very small concentrations of a solute within a solvent) and initials - 1/4/25 first and second cycles wash, rinse, PPM and initials - 1/8/25 through 1/12/25 all three cycles wash, rinse, PPM and initials On 1/12/25 at 10:20 AM Staff 39 (Cook) confirmed the facility was in an influenza outbreak and the dishwasher temperature logs were to be filled out daily but were not. On 1/12/25 at 10:45 AM the facility's undated Low Temperature Dish Machine instructions revealed All staff take temps and log on sheet as well as sign of sheet. On 1/12/25 at 10:50 AM Staff 35 (Dietary Aide) confirmed the dishwasher temperature log with the missing temperatures was for January 2025. Staff 35 stated the dishwasher temperature logs were to be completed daily and when the dishwasher was not working the three-sink method was used. He added the dishwasher was working during his shifts in the last week. Staff 35 added the kitchen manager held a training for all kitchen staff before she went on leave which included logging the dishwasher temperatures. On 1/16/25 at 3:16 PM Staff 37 (Dietary Manager) stated all kitchen staff were in-serviced on 12/24/24. She stated she expected the kitchen staff to fill in the dishwasher temperature logs. On 1/16/25 at 4:00 PM Staff 1 (Executive Director) confirmed the kitchen staff were in-serviced by Staff 37 and provided no additional information.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 38140 Based on interview and record review it was determined the facility failed to conduct and complete a comprehensive facility wide assessment for 1 of 1 sampled facility. This placed residents at risk for lack of quality of care and reduced quality of life. Findings include: On 1/21/25 at 3:16 PM Staff 3 (Regional Director of Clinical Operations) provided a copy of the facility's assessment. The assessment lacked evaluation and information for the following areas: -Listing of contracts, memorandums of understanding and other agreements with third parties who provide services or equipment to the facility during both normal operations and emergencies. -A facility-based and community-based risk assessment was not identified in the plan and there was no assessment or plan to address continuity of care during an emergency. -The care required by the resident population, using evidence-based, data-driven methods that considered the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that were present within that population, consistent with and informed by individual resident assessments. -Evaluation of any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility. -Infection Control specific information related to current infection control standards, evaluation of the provision of services related to communicable diseases, including Covid-19, Influenza or a plan to ensure immunizations were provided timely. On 1/21/25 at 2:25 PM Staff 3 and Staff 2 (DNS) acknowledged the facility assessment was not comprehensive. The facility assessment provided, with attached handwritten notes including a resident medication and discharge charge order, were reviewed with Staff 3 and Staff 2 (DNS). Staff 2 and Staff 2 acknowledged the facility assessment did not include all aspects of a comprehensive facility assessment. No additional information was provided.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 50930 Based on interview and record review it was determined the facility failed to ensure residents understood the meaning of an arbitration agreement (disputes are resolved with a neutral party and not in court) for 3 of 3 sampled residents (#s 44, 201, 300) reviewed for arbitration. This placed residents at risk for being uninformed of their legal rights. Findings include: 1. Resident 44 admitted to the facility in 12/2024 with diagnoses including Fibromyalgia and asthma. Review of a 1/10/25 Admission MDS indicated Resident 44 was cognitively intact. Resident 44's chart revealed she/he signed a facility Voluntary Arbitration Agreement form on 12/16/24. On 1/16/25 at 1:49 PM Resident 44 stated she/he knew what arbitration meant and remembered signing a lot of paperwork on admission but did not remember signing a facility Voluntary Arbitration Agreement form. On 1/16/25 at 5:18 PM Staff 25 (Business Office Manager) stated the facility Voluntary Arbitration Agreement form was explained to residents and signed by residents on admission. She stated a paper copy of all signed paperwork was available upon request, and she informed all residents she was available to answer any questions about arbitration. 2. Resident 201 admitted to the facility in 1/2025 with diagnoses including Fibromyalgia and COPD. Review of a 1/14/25 BIMS assessment (an assessment to determine cognitive status) indicated Resident 201 was cognitively intact. Resident 201's chart revealed she/he signed a facility Voluntary Arbitration Agreement form on 1/10/25. On 1/16/25 at 1:23 PM Resident 201 stated she/he did not know what arbitration was and she/he thought their daughter signed all the admission paperwork. On 1/16/25 at 5:18 PM Staff 25 (Business Office Manager) stated the facility Voluntary Arbitration Agreement form was explained to residents and signed by residents on admission. She stated a paper copy of all signed paperwork was available upon request, and she informed all residents she was available to answer any questions about arbitration. 3. Resident 300 admitted to the facility in 1/2025 with diagnoses including diabetes and skin infection. Review of a 1/13/25 BIMS assessment (an assessment to determine cognitive status) indicated Resident 300 was cognitively intact. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 300's chart revealed she/he signed a facility Voluntary Arbitration Agreement form on 1/13/25. On 1/16/25 at 11:01 AM Resident 300 stated she/he did not know what arbitration was and did not remember signing a facility Voluntary Arbitration Agreement form. On 1/16/25 at 5:18 PM Staff 25 (Business Office Manager) stated the facility Voluntary Arbitration Agreement form was explained to residents and signed by residents on admission. She stated a paper copy of all signed paperwork was available upon request, and she informed all residents she was available to answer any questions about arbitration.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 38140 Based on interview and record review the facility failed to implement a Quality Assessment and Performance Improvement (QAPI) program which identified quality deficiencies, developed and implemented action plans to correct identified quality of care deficiencies. The facility failed to initiate a QAPI review related to abuse, investigations, timely reporting and immunizations. This placed residents at risk of not receiving care and services for optimal resident outcomes. Findings include: The facility's QAPI policy and procedure, created in 4/2021 and reviewed 5/2023, stated the facility's QAPI is a data driven and proactive approach to quality improvement. continuously identifying opportunities for improvement. Gaps in systems are addressed through planned interventions with goal of improving the overall quality of life and quality of care and services delivered to nursing home residents. The Executive Director will ensure that the QAPI plan is reviewed minimally on an annual basis by the QAA (quality assessment and assurance) committee. On 1/21/25 at 2:32 PM Staff 2 (DNS) and Staff 3 (Regional Director of Clinical Operations) stated there was no QAPI program in place that addressed the current identified concerns of the QA process related to abuse, investigations, timely reporting and immunizations. Refer to F607, F609, F610 and F883.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38140 Based on interview and record review it was determined the facility failed to ensure effective systems were in place to identify problems, and take action to improve and monitor its performance for 1 of 1 facility reviewed for quality assessment and assurance. This failure placed residents at risk for worsening care. Findings include: On 1/21/25 at 2:15 PM the facility's undated 2024 Quality Assurance and Performance Improvement (QAPI) Plan for [NAME] Care (Meadow Park Care facility) included oversight of Administration, Clinical Care Services, Nutrition Services, Pharmacy Services, Quality of Life and Engagement, Maintenance Services, Housekeeping, and Training And Orientation. The plan included use of a QAPI Committee, Analytics, Core Processes, and Medical Oversight for purposes of Performance Improvement Projects, Systematic Analysis, Communication, QAPI Self-Assessment, as well as Feedback and Data Monitoring. A review of the facility's Quality Assessment and Assurance (QAA) 2024 records revealed no evidence the facility enacted procedures related to problem identification, analysis, performance improvement, and monitoring. On 1/21/25 at 2:32 PM Staff 2 (DNS) and Staff 3 (Regional Director of Clinical Operations) acknowledged the lack of evidence of an effective QAA program.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 35855 Based on interview and record review it was determined the facility failed to ensure vaccines were offered for 2 of 5 sampled residents (#s 8 and 301) reviewed for immunizations. This placed residents at risk for respiratory infections. Findings include: A review of the facility's Influenza Vaccine Policy Statement revised in 2019 indicated all residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The facility shall provide pertinent information about the risks and benefits of vaccines to residents or their legal representatives. 1. Resident 8 was admitted in 7/2014 with diagnoses including traumatic brain injury and contractures of the left and right ankles. A Pneumococcal, COVID-19 and Annual Influenza Vaccine Information and Request form indicated on 9/25/23 Resident 8's representative consented to request influenza vaccine annually. No additional documentation was found in Resident 8's clinical record annual influenza vaccine was offered or received in 2024. In interviews on 1/14/25 at 11:56 AM with Staff 2 (DNS) and 1/17/25 at 8:26 AM with Staff 1 (Administrator) Staff 2 and Staff 3 (Regional Director of Clinical Operations), Staff 2 stated he did not find recent consents for Resident 8, annual consents should be completed at a resident's care conference and it was his responsibility to have them completed yearly. 2. Resident 301 was admitted to the facility 12/2024 with diagnoses including chronic obstructive pulmonary disease (lung condition caused by damage to the airways which limits airflow and oxygen exchange) An undated typed document received from the facility indicated Resident 301 did not have any current vaccine consents. A review of Resident 301's immunization records revealed she/he received her/his last influenza vaccine on 10/3/23. No additional documentation was found in Resident 301's clinical record the annual influenza vaccine was offered or received in 2024. In interviews on 1/14/25 at 11:56 AM with Staff 2 (DNS) and 1/17/25 at 8:26 AM with Staff 1 (Administrator) Staff 2 and Staff 3 (Regional Director of Clinical Operations), Staff 2 stated he did not find recent consents for Resident 301. Staff 2 stated it is expected of staff to obtain vaccine consents on admission and the facility had difficulty with agency staff not completing them.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 35855 Based on interview and record review it was determined the facility failed to ensure residents received risk and benefit of the COVID-19 vaccine information for 2 of 5 sampled residents (#s 8, and 301) reviewed for immunizations. This placed residents at risk for lack of information regarding vaccines. Findings include: A review of the facility policy COVID-19 Policy and Procedure revised 12/2022 revealed all residents would be offered COVID-19 vaccines to aid in preventing COVID-19 and COVID like illness. Prior to, or upon admission, residents would be assessed for eligibility to receive the COVID-19 vaccine series, and when indicated, would be offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident was already vaccinated. Assessments of the COVID-19 vaccination status would be conducted within five working days of the resident's admission if not conducted prior to admission. Residents should receive the risks and benefits and have the right to refuse the vaccination. If refused, staff would reapproach the resident or representative annually to offer the opportunity to accept or refuse the vaccine. 1. Resident 8 was admitted to the facility in 7/2014 with diagnoses including traumatic brain injury and contractures of the left and right ankles. A Pneumococcal, COVID-19 and Annual Influenza Vaccine Information and Request form indicated on 9/25/23 Resident 8's representative refused the COVID-19 vaccination. No additional documentation was found in Resident 8's clinical record the COVID-19 risks and benefits were offered or received in 2024. In interviews on 1/14/25 at 11:56 AM with Staff 2 (DNS) and 1/17/25 at 8:26 AM with Staff 1 (Administrator) Staff 2 and Staff 3 (Regional Director of Clinical Operations), Staff 2 stated he did not find recent consents for Resident 8, annual consents should be completed at a resident's care conference and it was his responsibility to have them completed yearly. 2. Resident 301 was admitted to the facility 12/2024 with diagnoses including chronic obstructive pulmonary disease (lung condition caused by damage to the airways which limits airflow and oxygen exchange) An undated typed document received from the facility indicated Resident 301 did not have any current vaccine consents. A review of Resident 301's immunization records revealed she received her last COVID-19 booster on 12/20/22. No additional documentation was found in Resident 301's clinical record the COVID-19 vaccination or risk and benefits were offered or received in 2024. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In interviews on 1/14/25 at 11:56 AM with Staff 2 (DNS) and 1/17/25 at 8:26 AM with Staff 1 (Administrator) Staff 2 and Staff 3 (Regional Director of Clinical Operations), Staff 2 stated he did not find recent consents for Resident 301. Staff 2 stated it is expected of staff to obtain vaccine consents on admission and the facility had difficulty with agency staff not completing them.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 38140 Based on observation and interview it was determined the facility failed to ensure a functional and comfortable environment for 1 of 3 shower rooms reviewed for environment. This placed residents at risk for an uncomfortable bathing experience. Findings include: On 1/12/25 at 2:31 PM a resident stated the ambient air in the shower room near resident room one was cold when she/he bathed and the heater in there could not be used. On 1/15/25 at 1:42 PM the State surveyor stood in the shower room between rooms one and two for about 10 minutes. The surveyors' fingertips became cold. A DO NOT turn heater on! fire hazard!! handwritten sign was observed posted in the shower room. On 1/17/25 at 8:03 AM Staff 1 (Executive Director) was aware of the lack of a heat source in the shower room. Staff 1 confirmed the shower room heater between rooms one and two was an issue and needed to be replaced.