STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385228	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portland Health & Rehabilitation Center	12441 SE Stark Street Portland, OR 97233

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 38140 Based on interview, and record review it was determined the facility failed to ensure a resident was treated in a dignified manner and free from a derogatory slur for 1 of 4 sampled residents (#110) reviewed for dignity. This placed residents at risk for being treated in a disrespectful manner. Findings include: Resident 110 was admitted to the facility in 6/2023 with diagnoses including after care for surgical amputation and was assessed as cognitively intact. Review of the 6/15/23 FRI and facility investigation revealed on 6/14/23 Staff 20 (LPN) called Staff 18 (Former DNS) at 6:00 PM to report during the dinner service, Resident 110 overheard Staff 19 (Former Hospitality Aide) use the homophobic slur of faggot in conversation and Staff 21 (Former CNA) observed the comments. Staff 20 reported he interviewed Resident 110 who reported feeling afraid to be at the facility. Resident 110 did not want to be a whistle blower as she/he had experienced similar incidents in the past and she/he was later retaliated against. Staff 18 also interviewed Resident 110 who stated she/he overheard Staff 19 complaining to several other CNAs about work bonuses and she used the f word several times. Resident 110 stated she/he did not want to get anyone in trouble, experienced homophobic issues at another facility and she/he felt retaliated against when she/he reported to management. Staff 18 also interviewed Staff 21 who observed the event. Staff 21 confirmed she heard Staff 19 loudly use the word faggot several times in conversation with other staff and Resident 110 overheard. Staff 21 stated she noticed Resident 110 was upset and she spoke to her/him. Staff 21 confirmed Resident 110 said she/he overheard the slur of faggot. The resident appeared uncomfortable, talked about how she/he took it in a negative manner and stated she/he was afraid. Staff 18 also interviewed Staff 20 who confirmed when Resident 110 spoke to him the evening prior, the resident stated she/he overheard the term of faggot, interpreted it as a homophobic slur, felt uncomfortable about being at the facility, did not feel safe and feared retaliation for talking about it. The 6/15/23 investigation revealed Staff 18 also interviewed Staff 19 whom did not recall using the word faggot and confirmed she was upset when she talked to staff and used swear words in conversation. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 110's Progress Notes form 6/15/23 through 6/28/23 revealed she/he was placed on alert monitoring for psychosocial well-being with no negative outcomes to the resident reported. In an interview on 10/23/24 at 11:44 AM Resident 110 recalled her/his stay at the facility and would not comment about overhearing homophobic language. On 10/24/24 at 12:30 PM Staff 1 (Administrator) stated he expected all residents to be treated with dignity and respect and to live in an environment free from homophobic slurs.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 41458 Based on interview and record review it was determined the facility failed to ensure residents were provided with the opportunity to organize and participate in Resident Council for 1 of 1 facility reviewed for Resident Council. This placed residents at risk for a lack of participation in group discussions regarding facility policies, procedures and resident rights. Findings include: The facility's Resident Council policy dated 5/2002 indicated the following: -Resident Council was intended to promote resident interest and involvement in the Center as well as, a forum for residents to voice concerns and to suggest changes. -Resident Council was to meet monthly or at the frequency determined by the Council members. -Resident Council was open to residents of the Center. On 10/23/24 the facility had a census of 55 residents. A review of the facility's Resident Council Minutes revealed the last Resident Council meeting was on 3/20/24. On 10/25/24 at 10:53 AM Staff 14 (Activities Director) stated she was hired in 5/2024. She stated Resident Council meetings did not occur because residents were not interested in having Resident Council meetings. On 10/25/25 at 1:30 PM Resident 25 stated she/he was the Resident Council president. Resident 25 stated the facility used to have Resident Council meetings but after the previous Activities Director left sometime before 5/2024, the meetings stopped. Resident 25 stated nobody asked her/him if she/he wanted to continue with Resident Council meetings. In addition, interviews with Resident 18, Resident 24 and Resident 43 indicated they wanted to have Resident Council meetings but no meetings had been organized since the last Activities Director left. On 10/25/24 at 2:20 PM Staff 1 (Administrator) confirmed there had been no Resident Council meetings since 3/2024. Staff 1 stated he started his position in 8/2024 and the previous DNS told him no residents wanted to have Resident Council, which he took at face value.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41458 Based on observation, interview and record review it was determined the facility failed to ensure residents' bed mattresses were in good repair for 1 of 1 sampled resident (#5) reviewed for restraints and a comfortable environment free from offensive odors for 1 of 1 facility observed for environment. This placed residents at risk for an uncomfortable environment. Findings include: 1. Resident 5 was admitted to the facility in 8/2010 with diagnoses including abnormal posture, cognitive deficits and depression. Observations from 10/23/24 through 10/25/24 between the hours of 7:39 AM and 3:30 PM revealed Resident 5's bed mattress had a large divot in the center, covering approximately 3/4's of the entire mattress and was several inches deep. On 10/25/24 at 9:49 AM Staff 5 (CNA) reported Resident 5's bed mattress had a large divot in the center for at least the last year. On 10/25/24 at 10:23 AM Staff 23 (CNA) stated Resident 5's bed mattress was played out, old and needed to be replaced. Staff 23 stated Resident 5 had to fight the divot to roll over. On 10/25/24 at 11:24 AM Staff 20 (Maintenance Director) looked at Resident 5's bed mattress and stated the mattress had a big divot, was old and broken down. Staff 20 confirmed Resident 5's mattress needed to be replaced. 38140 2. On 9/5/23 the State agency received a public complaint which alleged residents' bathrooms in the facility were not clean and smelled of urine. On 9/13/23 the State agency received a public complaint which alleged the facility had offensive odors in all three halls during multiple visits to the facility. On 10/23/24 at 11:17 AM Room eight's shared bathroom smelled of urine, the toilet base had old caulking which was dark in color, and the flooring tiles were cracked. On 10/24/24 at 4:41 PM Witness 2 (Family) confirmed the public complaint. He worked in long term care facilities previously and the facility smelled rancid from urine and fecal matter on multiple visits to the facility. On 10/24/24 at 11:19 AM there was a very strong smell of urine in the south hallway near room nine. On 10/25/24 at 12:11 PM Room eight's shared bathroom smelled of urine, the toilet base had old caulking which was dark in color, and the flooring tiles were cracked. On 10/25/24 at 2:37 PM the south hallway near room two had a strong smell of urine. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/24 at 10:53 AM room [ROOM NUMBER]'s shared bathroom had a strong smell of urine. On 10/28/24 at 11:01 AM the hallway near rooms three and four smelled of urine. Multiple housekeeping staff were observed multiple times from 10/23/24 though 10/28/24 between 7:30 AM to 4:30 PM to clean hallways, resident rooms and resident bathrooms with appropriate cleaning products and procedures. On 10/28/24 at 12:33 PM Staff 20 (Maintenance Director) during a facility walkthrough, acknowledged the floor of the toilet in room nine appeared clean but cracked tiles and the lack of a seal around the base of the toilet could contribute to the odor and the cracks in the hallway between rooms one and two needed to be sealed. On 10/28/24 at 12:47 PM Staff 1 (Administrator) confirmed the smell of urine in room eight's bathroom and the cracked tiles in the hallway between room one and two where odors were observed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 46053 Based on observation, interview and record review it was determined the facility failed to ensure accurate assessments for 3 of 7 sampled residents (#s 14, 22 and 45) reviewed for communication, dental and ADLs. This placed residents at risk for unmet care needs. Findings include: 1. Resident 14 was admitted to the facility in 6/2023 with a diagnosis of chronic respiratory failure with hypoxia (a respiratory disorder that results in less oxygen entering the blood stream and less carbon dioxide getting out). A review of Resident 14's 7/22/24 Significant Change MDS revealed she/he was cognitively intact and had adequate hearing. On 10/23/24 at 10:30 AM Resident 14 was observed interacting with her/his roommate and Staff 27 (LPN) about sharing her/his extra oatmeal. Resident 14 was not able to hear her/his roommate or Staff 27 when they were speaking with normal to elevated vocal intensity. Resident 14 reported, I have to tell them to talk real loud to me. A review of Resident 14's Care Plan revealed no there were no interventions in place to address Resident 14's impaired hearing ability. On 10/25/24 at 2:31 PM Resident 14 stated, I am very, very hard of hearing and was observed to have difficulty hearing Staff 13 (MDS Coordinator) who spoke with Resident 14 using typical vocal intensity. Resident 14 occasionally responded to Staff 13 stating she/he could hear and understand her but also asked her to repeat questions saying she/he could not hear what was asked. Resident 14 stated she/he wanted to have her/his hearing aids brought to the facility. On 10/25/24 at 2:42 PM Staff 13 confirmed she completed Resident 14's 7/22/24 Significant Change MDS assessment and did not accurately capture her/his hearing ability. She added accurately assessing and coding Resident 14's hearing abilities would have triggered a CAA for communication and her/his care plan would have been revised to indicated her/his needs for interventions related to impaired hearing. On 10/28/24 at 11:57 AM Staff 27 stated he worked with Resident 14 regularly since her/his admission to the facility. He confirmed she/he had difficulty hearing him and he had to lean in close and speak loudly so she/he could hear him. On 10/28/24 at 12:20 PM Staff 40 (RN) stated she worked with Resident 14 regularly since her/his admission to the facility. She stated Resident 14 was hard of hearing and she had to lean in and speak loudly for Resident 14 to hear her. She added she was not aware of anything in Resident 14's care plan related to her/his hearing impairment. On 10/28/24 at 12:34 PM Staff 28 (CNA) stated he worked with Resident 14 and she/he cannot hear well. He added he never saw her/him use hearing aids and added, You have to speak up for [her/him] to hear. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 1:02 PM Staff 1 (Administrator) stated he expected the MDS assessments related to hearing to be accurate. 2. Resident 45 was admitted to the facility in 10/2024 with a diagnosis of gram-negative sepsis (a condition caused by bacteria or their products in the bloodstream). A review of Resident 45's 10/13/2024 Admission MDS revealed she/he was cognitively intact and was not edentulous (without teeth). On 10/23/24 at 3:22 PM Resident 45 was observed to be edentulous. She/he stated her/his swallowing was not assessed since admitting to the facility and she/he received soft food which she/he did not like. Resident 45 stated she/he did not have teeth prior to admitting to the facility and she/he ate regular food at home without problems. On 10/25/24 at 3:27 PM Staff 13 (MDS Coordinator) stated she should have coded Resident 45 as edentulous and she probably just pressed the wrong button. On 10/28/24 at 12:38 PM Staff 27, LPN stated he worked with Resident 45 regularly since her/his admission to the facility. He stated she/he was edentulous and did not know if she/he had dentures. On 10/29/24 1:02 PM Staff 1 (Administrator) acknowledged Resident 45's MDS was coded inaccurately for her/his dental status. He stated he expected the assessments to be completed accurately. 47000 3. Resident 22 was admitted to the facility in 11/2022 with diagnoses including stroke. Resident 22's 10/10/24 Annual MDS Assessment indicated the resident was able to make her/himself understood and understand others without difficulty and required supervision or touch assistance with eating. Resident 22's 10/10/24 Nutrition Note revealed the resident was able to eat independently after she/he received set-up assistance. On 10/23/24 at 11:28 AM Resident 22 stated she/he needed assistance with removing lids, opening packages at meal times and spreading condiments but was otherwise able to eat independently. On 10/24/24 at 12:52 PM and 10/25/24 at 8:49 AM unidentified staff were observed to deliver a meal tray to Resident 22 in her/his room. The staff member was observed to provide set-up assistance to the resident on each occasion. No supervision or touch assistance was provided. On 10/24/24 at 3:54 PM Staff 32 (CNA) stated Resident 22 did not need supervision at meal times and she/he did not like help. Staff 32 stated she provided set-up assistance at mealtimes for the resident, which included cutting food items and spreading condiments. On 10/25/24 at 9:46 AM Staff 22 (CNA) stated Resident 22 was able to eat independently after she/he was provided set-up assistance. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/24 at 3:36 PM Staff 2 (DNS) stated Resident 22's MDS was inaccurately coded as the resident required set-up and not supervision or touch assistance at mealtimes.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 47000 Based on interview and record review it was determined the facility failed to complete a PASARR (Preadmission Screening and Resident Review) Level II evaluation for residents with a positive Level I PASARR for 1 of 1 resident (#22) reviewed for PASARR. This placed residents at risk for unmet behavioral and emotional needs and a decrease in their quality of life. Findings include: Resident 22 was admitted to the facility in 11/2022 with diagnoses including bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), depression and panic disorder (an anxiety disorder characterized by unexpected and repeated episodes of intense fear accompanied by physical symptoms that may include chest pain, heart palpitations, shortness of breath, dizziness or abdominal distress). Resident 22's 11/9/22 PASARR Level I identified the resident to have indicators of a serious mental illness. Resident 22's 2/13/23 Quarterly Social Services Evaluation indicated the resident experienced difficulty coping with stress, her/his depression had increased tremendously and she/he received risperdal (an antipsychotic medication used to treat schizophrenia, bipolar disorder) for her/his diagnosis of bipolar disorder. A review of Resident 22's clinical record revealed the resident was hospitalized from 3/12/23 to 3/15/23. An additional PASARR Level I was completed on 3/15/23 following this hospitalization which indicated the resident did not have any indicators of a serious mental illness. Resident 22's 7/23/24 Quarterly Social Services Evaluation indicated the resident had a current psychiatric diagnosis and the resident's depression had increased. Resident 22's 10/3/24 Care Plan revealed the following: -The resident demonstrated behaviors related to depression, panic disorder and bipolar disorder and a behavior monitor was in place. -The resident's behaviors included verbal and physical aggression, swearing, yelling at staff, false accusations, threats and resisting care. -A psychiatric consult was to be arranged. Resident 22's 10/10/24 Annual MDS Assessment revealed the resident was able to make her/himself understood, understood others without difficulty and exhibited physical and verbal behavioral symptoms that significantly interfered with her/his care and with her/his participation in activities or social interactions. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No evidence was found in Resident 22's clinical record to indicate a PASARR Level II was completed following the Level I completed on 11/9/22, which indicated the resident experienced indicators of a serious mental illness, or if the second Level I completed on 3/15/23 was accurate. On 10/24/24 at 12:28 PM Witness 8 (Family Member) stated Resident 22 had dealt with her/his bipolar disorder for decades and it usually manifested itself through increased depression. Witness 8 stated he asked staff at the facility on multiple occasions for a mental health evaluation for Resident 22, but one had not been done. On 10/25/24 at 11:58 AM Staff 15 (Social Services Director) stated she had not received any formal training about the PASARR process. Staff 15 stated she did not know if anything was done following Resident 22's initial 11/9/22 PASARR Level I which indicated the resident experienced indicators of a serious mental illness, or if the second Level I completed on 3/15/23 was accurate. On 10/25/24 at 3:50 PM Staff 1 (Administrator) stated Resident 22 should have received a PASARR Level II evaluation following the 11/9/22 Level I screen and the resident's second Level I screen from 3/15/23 should have been clarified for accuracy.

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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. 41458 Based on observation, interview and record review it was determined the facility failed to provide an ongoing person-centered activity program for 2 of 3 sampled dependent residents (#s 40 and 48) reviewed for activities. This placed residents at risk of a decline in psychosocial well-being and diminished quality of life. Findings include: The facility's 5/2002 Specialized Activities Policy indicated the activity staff offered specialized activities to meet the specific resident needs. 1. Resident 40 was readmitted to the facility in 5/2024 with diagnoses of diabetes, pneumonia and metabolic encephalopathy (brain dysfunction caused by an underlying illness or organs not working well). Resident 40's 5/2024 (revised on 9/17/24 and 10/22/24) Care Plan revealed the following: -Resident 40 preferred to communicate in Korean. The facility was to provide a translator as necessary to communicate with the resident. -Invite the resident to scheduled activities. -Encourage the resident to go to activities as tolerated. -Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as exercise class. -Use task segmentation to support short-term memory deficits. Break tasks into one step at a time. -Provide one-to-one activities if bed bound. -Enhanced activities for fall prevention. -Daily activities per activity calendar. Resident 40's 6/5/24 Admission MDS revealed the resident had cognitive impairments in short term memory, long term memory and in making decisions regarding tasks of daily life. The MDS also revealed Resident 40 considered it was somewhat to very important to do the following activities: listen to music, be around animals, keep up with the news, do things with groups of people, do favorite activities and go outside when the weather permitted. The facility's Activity Calendar revealed the following scheduled activities: -10/23/24 11:30 AM Shopping (Activities Director shopped for residents) (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2:00 PM Murder Mystery -10/24/24 11:30 Paint Therapy 2:00 PM Bingo -10/25/24 11:30 AM One-to-ones 2:00 PM Popcorn Social -10/28/24 National Chocolate Day Send A Gram -10/29/24 Pink Out Breast Cancer Awareness A review of Resident 40's Activity Attendance Log and activity documentation from 9/29/24 through 10/29/24 revealed the following: -The resident attended a one-to-one session on 10/21/24 and 10/25/24. -The resident attended bingo on 10/24/24. Random observations of Resident 40 conducted from 10/23/24 through 10/29/24 between the hours of 7:30 AM and 3:30 PM revealed the resident had meals in the dining room, sat around the nursing station or in the hallway in her/his wheelchair or was in bed. Resident 40 was not observed in any group or one-to-one activity sessions. On 10/25/24 at 9:30 Staff 22 (CNA) reported Resident 40 loved to do exercise classes. He stated he had not seen the resident involved in activities over the past several months and the only activity he noticed was Resident 40 carried her/his phone everywhere. Staff 22 stated he did not see one-to-one activities conducted with Resident 40. On 10/25/24 at 9:41 Staff 5 (CNA) reported Resident 40 enjoyed watching television and movies. Staff 5 stated Resident 40 spoke Korean with limited English and her/his television only broadcast in English. Staff 5 stated she did not see one-to-one activities conducted with Resident 40. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/24 at 9:31 AM Staff 14 (Activities Director) stated she had minimal experience and no training in developing or implementing an activities program with the adult population residing in a nursing facility. Staff 14 stated Resident 40 doesn't do any of the groups. Resident 40 was brought to a bingo group but was very disruptive and started taking the tops off of the juice bottles. Staff 14 stated she thought Resident 40 attended an exercise class last month, sometime. Staff 14 stated she did not have an enhanced activity program developed for Resident 40 and one-to-one activities with the resident were not a frequent thing. On 10/28/24 at 2:34 PM Staff 1 (Administrator) reported Staff 14 did not receive much training and he and Staff 2 (DNS) were working with her on activity ideas. Staff 1 acknowledged they needed to develop an activity program for Resident 40 which included one-to-one activities. 47000 2. Resident 48 was admitted to the facility in 5/2024 with diagnoses including traumatic subdural hemorrhage (condition that occurs when blood pools between the skull and the brain after a head injury). Resident 48's 9/24/24 Significant Change in Status MDS Assessment and CAAs revealed the resident was cognitively intact, enrolled in hospice care and going outside to get fresh air, keeping up with the news and listening to music were important activity preferences identified by the resident. Resident 48's 9/24/24 Activity Progress Note revealed the following: -The resident did not participate in scheduled calendar activities due to a significant change in condition. -The resident's favorite activities included watching television and visiting with her/his spouse. -The resident was to receive scheduled one-to-one visits and daily invitations to group to one-to-one visits. Resident 48's 10/8/24 Activity Care Plan revealed the resident preferred self-directed or independent activities in her/his room including watching television, reading and games on the iPad (a a touchscreen tablet computer). The facility's 10/2024 Activity Calendar revealed the following activities: -10/23/24 11:30 AM Shopping 2:00 PM Murder Mystery -10/24/24: 11:30 AM Paint Therapy (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2:00 PM Bingo -10/25/24: 11:30 AM One-to-Ones 2:00 PM Popcorn Social -10/26/24: 8:00 AM Coffee & Radio 2:00 PM Activity Cart -10/27/24: 8:00 Coffee & Radio 2:00 PM Activity Cart -10/28/24: National Chocolate Day: Send a Gram A review of Resident 48's Activity Task logs from 9/29/24 through 10/28/24 revealed the resident did not participate in a group activity or receive a one-to-one visit. Random observations of Resident 48 from 10/23/24 through 10/28/24 between 9:26 AM to 3:45 PM revealed the resident to be in her/his room in bed with the television on tuned to a news channel. Neither reading material nor an iPad was observed in the resident's room. On 10/25/24 at 10:05 AM Staff 5 (CNA) stated Resident 48 spent her/his days in her/his room in bed. Staff 5 stated she had not seen the resident participate in either an in-room or out-of-room activity, the resident was unable to self-initiate activities and she was unaware of any of the resident's activity interests outside of watching television. Staff 5 further stated she had never seen the resident go outside, listen to music or use an iPad. On 10/25/24 at 10:34 AM Staff 23 (CNA) and on 10/28/24 at 8:47 AM Staff 22 (CNA) stated they did not know any of Resident 48's activity interests and had never seen the resident use an iPad, listen to music or go outside. On 10/25/24 at 2:40 PM Resident 48 was in her/his room in bed and stated she/he liked to watch football on television, listen to rock music and read books. Resident 48 further stated she/he enjoyed to go outside if someone invited her/him. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/24 at 9:32 AM Staff 14 (Activity Director) stated Resident 48 has not ever participated with me for anything and she did not offer the resident one-to-one visits because she had not been instructed to do so. Staff 14 stated she had no idea if the resident had an iPad, could not remember if she had ever provided reading material to the resident, was unaware of what kind of music the resident enjoyed, had never put on any music in the resident's room and had never assisted the resident outside. Staff 14 further stated Resident 48 was unable to self-direct her/his activities. On 10/28/24 at 12:30 PM Staff 1 (Administrator) acknowledged the findings and stated he expected Resident 48 to be offered one-to-one activity visits.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 41458 Based on interview and record review it was determined the facility failed to provide a qualified professional to direct the activities program for 1 of 1 facility reviewed for activities. This placed residents at risk for unmet physical, mental and psychosocial needs. Findings include: The facility's Key Personnel list provided on 10/23/24, indicated Staff 14 was the facility's Activities Director. On 10/28/24 at 9:31 AM Staff 14 stated she was hired in 5/2024 and had minimal experience and no training in developing or implementing an activities program with the adult population residing in a nursing facility. Staff 14 stated she did not receive training when she was hired regarding developing an activities program or how to structure a daily program. Staff 14 stated she pretty much developed the activities program by using resources on the Internet. Staff 14 reported she was given no training or direction on how to work with residents with dementia or those who were unable to speak, and the previous administrator was supposed to enroll her in an activity training course but that did not happen. She reported the activity involvement in the facility was low. On 10/28/24 at 2:34 PM Staff 1 (Administrator) confirmed Staff 14 was hired as the Activities Director in 5/2024. Staff 1 reported Staff 14 did not receive training on developing and implementing an activities program, and he and Staff 2 (DNS) were working with her on activity ideas until she was trained. Refer to F679.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 47000 Based on observation, interview and record review it was determined the facility failed to ensure residents' change of condition was assessed timely for 2 of 2 residents (#s 8 and 22) reviewed for skin conditions. This failure resulted in Resident 8 experiencing untreated and significant pain, sustaining multiple fractures and receiving treatment at the hospital. Findings include: 1. Resident 8 was readmitted to the facility in 10/2018 with diagnoses including hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (a mild or partial loss of strength on one side of the body) following a stroke. a. Resident 8's 1/7/24 Quarterly MDS Assessment revealed the resident was usually able to make her/himself understood and understand others, experienced upper and lower extremity impairment on one side of her/his body and required substantial-to-maximal assistance with transfers. A review of Resident 8's clinical record revealed the following: -On 2/25/24 at 6:59 AM a Progress Note written by Staff 34 (Former LPN) indicated the resident experienced increased pain to her/his right knee, the knee was painful to the touch and the resident refused to move it. Staff 34 contacted the resident's provider to request an order for PRN Tylenol (pain reliever used to treat minor aches and pains). The note indicated Staff 34 would pass this information on to the day shift nurse to follow up. -On 2/25/24 at 11:16 AM a Progress Note indicated an X-ray was to be completed stat due to symptoms and per the provider's verbal orders. -On 2/25/24 at 11:20 AM the resident received her/his first dose of PRN Tylenol for ankle pain rated as a four out of 10. -On 2/25/24 at 2:21 PM X-ray results were reported to the resident's provider which indicated the resident had fractures involving the distal fibula (the lower end of the fibula bone in the leg) and the medial malleolus (the bony prominence on the inner side of the ankle). -On 2/26/24 at 1:21 AM a Progress Note written by Staff 34 stated the resident possibly hit her/his right ankle and the facility was waiting for the provider to review the X-ray results. -On 2/26/24 at 3:09 PM a Progress Note written by Staff 35 (LPN) indicated a call was placed to the resident's provider as Staff 35 was concerned about the resident's right ankle and leg pain and noted the resident was unable to move her/his right leg. Non-emergency transportation was called as the resident agreed to go to the emergency department for evaluation. -On 2/26/24 at 3:20 PM the resident received PRN Tylenol for ankle pain rated as a nine out of 10. -On 2/26/24 at 3:42 PM a Progress Note indicated the resident was transported to the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2/26/24 to 2/27/24 Emergency Department Provider Notes indicated the resident experienced significant pain in the right ankle and her/his ankle required splinting (a medical procedure that involves immobilizing the ankle joint with a rigid device to treat injuries or other conditions) in the emergency department. A 3/1/24 Injury of Unknown Origin Investigation of Resident 8's distal fibula and medial melleolus fractures revealed the following: -On 2/25/24 the resident complained her/his right ankle hurt. -An unidentified nurse assessed the resident's ankle on 2/25/24 and noted it to be swollen and tender to the touch. -The resident confirmed her/his ankle was injured and indicated the injury occurred in the last couple days. -Immediate actions included: an X-ray was completed, the resident's provider was notified of the X-ray results, the resident was placed on alert charting and the facility waited for further orders from the provider. The investigation did not indicate any times for these action items. -The resident declined to go to the hospital at this time. The investigation did not indicate what time the resident was offered to go to the hospital, if the resident was informed she/he had fractured multiple bones or if the resident was re-offered the opportunity to go to the hospital. No evidence was found in Resident 8's clinical record to indicate any pain relief alternatives were offered or provided to the resident following the resident's first documented report of pain on 2/25/24 at 6:59 AM until she/he received Tylenol at 11:20 AM on 2/25/24 or any action was taken by the facility between 2/25/24 at 2:21 PM through 2/26/24 at 3:09 PM following the receipt of the X-ray that confirmed the resident experienced multiple fractures. On 10/23/24 at 2:53 PM Resident 8 was observed in her/his room in her/his wheelchair. Resident 8 was able to answer yes or no questions and confirmed she/he broke her/his ankle during a transfer from her/his wheelchair to bed when she/he was assisted by an unidentified staff person in 2/2024. Resident 8 further confirmed she/he experienced a great deal of pain during this time period, indicated she/he reported her/his pain to multiple staff and it took a long time until any one at the facility realized she/he was hurt. On 10/28/24 at 3:31 PM Staff 37 (CNA) stated she assisted Resident 8 with restorative exercises on Friday, 2/23/24, and at this time, the resident was great. Staff 37 stated she worked as a CNA on Saturday, 2/24/24, and recalled Resident 8 did not get out of bed for either breakfast or lunch on this day, which was unusual for the resident as she/he was usually always up and in her/his wheelchair by 5:00 AM. Staff 37 stated she asked Staff 5 (CNA), the resident's assigned day shift CNA on 2/24/24, about Resident 8 and was told the resident did not feel well. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/28/24 at 3:51 PM Staff 5 stated she recalled Resident 8 was totally fine on 2/23/24. Staff 5 stated she was the resident's assigned day shift CNA on 2/24/24, and when she started her shift, the resident complained her/his foot hurt and she/he would not let me do anything with [her/his] leg. Staff 5 stated the resident would yell no, no, no any time she tried to touch her/his leg know and she let the nurse know immediately. Staff 5 stated Resident 8 was normally a a very active resident and on 2/24/24 she/he refused to be touched or do anything. Staff 5 stated she reported this change of condition to multiple nurses on 2/24/24 many, many times. On 10/29/24 at 10:08 AM Staff 35 (LPN) stated she worked evening shift on 2/25/24. Staff 35 stated she asked CNAs how long Resident 8 had been in pain and nobody gave me answers. Staff 35 stated she had worked with Resident 8 for years and knew she/he was not her/himself and she/he just seemed like she/he was in pain. Staff 35 stated she was not told much about what happened and she did not know when Resident 8's injury occurred. Staff 35 stated she recalled asking the resident if she/he wanted to go to the emergency room to which she/he was agreeable. On 10/29/24 at 11:00 AM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged the findings and confirmed Resident 8's change of condition was not addressed timely. b. Resident 8's 8/11/23 Care Plan revealed the following: -Staff were to ask the resident yes or no questions in order to determine her/his needs. -The resident required extensive assistance from one staff with dressing and personal hygiene and extensive assistance from one-to-two staff with showers. -CNAs were to monitor for changes in skin integrity during dressing, personal care and showers and alert the licensed nurse immediately of any changes. An 8/14/23 Progress Note revealed the following: -Staff 36 (CNA) reported to the nurse Resident 8's right fifth toe was black. -The nurse assessed Resident 8's fifth toe and noted the black area covered the entire bottom of her/his toe and the wound measured approximately 1.5 cm long and 1 cm wide. -Staff 36 observed a red blister on Resident 8's fifth toe last week and didn't tell anyone then. -Staff 36 was educated on the importance of reporting abnormal skin impairments right away. An 8/14/23 Incident and Investigation determined the facility failed to ensure identification of a skin issue and provide needed care and services in a timely manner. On 10/23/24 at 2:50 PM Resident 8 was observed in her/his room and sat in her/his wheelchair. The resident was able to indicate through yes or no questions her/his toe was black months ago but was unable to provide any additional details about this skin impairment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/28/24 at 7:43 AM Staff 36 stated she recalled she assisted Resident 8 with range of motion in 2/2024 when she noticed the resident's right fifth toe was a different color. Staff 36 stated the toe really looked different and was black the second time she observed it a few days later. Staff 36 stated she thought she informed a nurse of the resident's toe discoloration after her initial observation but could not recall for sure but stated she did report it to Staff 18 (Former DNS) after her second observation. On 10/29/24 at 11:00 AM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged the findings and did not provide any additional information. 2. Resident 22 was admitted to the facility in 11/2022 with diagnoses including stroke. Resident 22's 9/2024 and 10/2024 Physician's Orders revealed the following: -All wounds must be evaluated by the physician or NP at first opportunity. -The resident was to receive a weekly skin evaluation and each skin impairment was to be evaluated. Resident 22's 9/24/24 Weekly Skin Evaluation identified the resident to have self-inflicted scratches and dry scabs all over her/his bilateral upper extremities. The evaluation did not indicate if the resident's physician or NP was notified of the wounds or if a treatment was to be implemented. Resident 22's Weekly Skin Evaluations from 9/30/24 through 10/22/24 made no mention of the resident's bilateral upper extremity wounds, including any measurements, number of wounds or whether or not they had improved, worsened or stayed the same. Resident 22's 10/3/24 Potential/Actual Impairment to Skin Integrity Care Plan indicated weekly treatment documentation of skin breakdown was to include the width, length and depth of the skin impairment as well as any other notable changes or observations. Resident 22's 10/10/24 Annual MDS Assessment revealed the resident was able to make her/himself understood and understood others without difficulty and received application of nonsurgical dressings and ointments/medications other than to her/his feet. The CAAs revealed the resident recently had open skin on her/his left shin area which was partially due to her/his scratching, a wound culture was completed that indicated the wound was positive for Methicillin-resistant Staphylococcus aureus (MRSA, a type of bacteria that is resistant to certain antibiotics and an infection that can be serious and difficult to treat, especially if left untreated), the resident was treated with antibiotics and she/he refused several doses. On 10/23/24 at 11:33 AM Resident 22 was observed in her/his room in bed. The resident's arms were observed to have numerous scattered scabs, some of which were opened and revealed streaks of blood. Resident 22 stated she/he was recently treated with antibiotics for a staph infection related to the wounds on her/his legs. Resident 22 stated the scabs on her/his arms had been there for weeks, the scabbing on her/his arms looked like the wounds on her/his legs, her/his arms itched regularly and the facility was not doing anything to treat the scabs on her/his arms. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/24/24 at 12:28 PM Witness 8 (Family Member) stated he discussed Resident 22's leg and arm wounds with Staff 4 (LPN Resident Care Manager) in 9/2024 but thought only the leg wounds were addressed. Witness 8 wondered if the continued itching and scabbing of the resident's arms was a result of an allergic reaction but never got a resolution. On 10/25/24 at 10:11 AM Staff 5 (CNA) stated the scabs on Resident 22's arms had been there for at least a month and the resident complained about and scratched them. Staff 5 stated she reported these scabs to the nurse and was not sure if anything was done. On 10/25/24 at 10:34 AM Staff 23 (CNA) stated she noticed the resident's arms were scratched up really bad about a week or two ago and stated she reported this to the nurse. On 10/25/24 at 11:07 AM Staff 31 (LPN) observed Resident 22's arms and confirmed the resident had scattered scabbing throughout her/his bilateral upper extremities. Staff 31 stated the resident did not have these scabs the last time she worked with the resident last month and the scabbing had not been reported to her. Staff 31 stated a resident's physician or NP was to be notified in the case of any new skin issue in order to obtain a treatment. Staff 31 reviewed the resident's electronic record and stated it did not look like the doctor had been notified of the resident's arm wounds. On 10/25/24 at 2:52 PM Staff 4 observed Resident 22's arms. Staff 4 stated she was not aware of the resident's arm wounds and neither was the resident's physician. On 10/25/24 at 3:28 PM Staff 33 (NP) stated she was not aware of any new skin issues for Resident 22, including any wounds or scabs on her/his arms. On 10/25/24 at 3:42 PM Staff 2 (DNS) confirmed the wounds on Resident 22's arms had not been reported to the resident's physician or NP and were not being monitored or treated and should have been.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38140 Based on observation, interview and record review it was determined the facility failed to assess for care plan effectiveness, identify and implement new fall interventions or provide adequate supervision needed to prevent falls for 3 of 3 sampled residents (#s 40, 48 and 108) reviewed for falls. This failure resulted in Resident 108's hospitalization and placed residents at risk for falls and injury. Findings include: 1. Resident 108 was admitted to the facility in 9/2023 with diagnoses including cancer, severe protein-calorie malnutrition, abnormal weight loss, chronic fatigue, and weakness. Resident 108's 9/9/23 Admission MDS indicated she/he was cognitively intact and while she/he moved about her/his room and facility, she/he required supervision with the assistance of one other person. The MDS indicated Resident 108 experienced falls prior to admission to the facility. Review of Resident 108's 9/2/23 care plan indicated she/he was a high risk for falls. The care plan directed staff to provide a safe environment free from clutter or spills, adequate and glare-free light, a reachable call light which worked, encouragement to participate in activities, physical therapy, and have her/his bed in a low position. The 9/2/23 Visual Bedside Individual Service Plan (bedside care plan) indicated Resident 108 was independent with ambulation, used a wheelchair and mobility was with a wheelchair which required one person to assist with mobility. A 10/4/23 at 1:25 PM Progress Note revealed Resident 108 walked independently in the hallway and fell face-forward. The resident was transported to the hospital. A 10/4/23 at 8:59 PM Progress Note revealed Resident 108 returned from the hospital with a fractured orbital wall (break in one or more of the eye socket bones), which was swollen, bruised with a small laceration (cut). Review of Resident 108's 10/4/23 fall investigation provided was not a thorough investigation or assessment of the fall. The investigation was not completed until 10/13/23 (three days after discharge). No fall care plan revisions were found as completed or implemented. A 10/5/23 at 8:57 PM Progress Note revealed Resident 108 tripped and fell walking in the hallway. The resident acquired 1 cm bilateral scrapes on both knees. Review of Resident 108's 10/5/23 fall investigation provided was not a thorough investigation or assessment of the fall. The investigation was not completed until 10/15/23 (five days after discharge). No fall care plan revisions were found as completed or implemented. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a 10/6/23 fall investigation revealed Resident 108 fell in her/his room and was found on the floor. The resident believed the wheelchair brakes did not work and the facility found one of the brakes was loose and the facility repaired the wheelchair brake. No evidence of the 10/6/23 fall was found in the resident's electronic health record, progress notes or alert charting, no revision of care plan interventions, the investigation was not a thorough investigation or assessment of the fall. The investigation was completed 10/15/23 (five days after discharge). A 10/10/23 at 3:02 AM Progress Note revealed Resident 108 was found on the floor next to her/his bed face-forward and bled from her/his nose and mouth. Resident 108 was sent to the hospital. On 10/11/23 at 12:59 AM Staff 4 (LPN) received a phone call from the hospital to inform the facility Resident 108 passed away in the hospital. No evidence was found to reflect Resident 108's care plan interventions were revised prior to her/his discharge. The fall investigations were not timely, did not identify all known, foreseeable and unforeseeable accident hazards in her/his environment. No evidence was found of a plan for attempts to reduce fall risks or identify possible assistance to prevent an avoidable accident. On 10/29/24 at 9:51 AM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged the lack of care plan revisions for Resident 108's falls. Staff 1 and Staff 2 acknowledged the fall investigations were not comprehensive and were completed after the resident's discharge to the hospital. Staff 1 and Staff 2 would expect thorough fall investigations and care plan revisions for falls to be completed and implemented timely. No additional information was provided. 41458 2. Resident 40 was readmitted to the facility in 5/2024 with diabetes, pneumonia and metabolic encephalopathy (brain dysfunction caused by an underlying illness or organs not working well). From 5/30/24 through 10/16/24, 10 fall risk assessments were completed. Resident 40 was identified to be at high risk for falling on all assessments. Resident 40's 5/30/24 Fall Care Plan, with revisions on 6/10/24, 9/17/24, 9/30/24, 10/14/24, 10/22/24 and 10/23/24, indicated the resident was a high fall risk due to gait/balance problems and impaired cognition. The following fall precautions were in place: -Anticipate and meet the resident's needs. Initiated 5/30/24. -Be sure the resident's call light was within reach and encourage the resident to use it for assistance. Initiated 5/30/24. Revised 9/30/24. -Ensure the resident was wearing appropriate footwear such as rubber soled shoes or non-skid socks when ambulating or mobilizing in her/his wheelchair. Initiated 5/30/24. Revised 6/10/24. -Follow facility fall protocol. Initiated 5/30/24. -PT evaluation and treatment as ordered or PRN. Initiated 5/30/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter or remove any potential causes, if possible. Provide education to the resident/family/caregivers/IDT (interdisciplinary team) as to causes. Initiated 5/30/24. -The resident needed a safe environment with even floors free from spills and/or clutter, adequate glare free light, a working and reachable call light and personal items within reach. Initiated 5/30/24. Revised 6/10/24. -For no apparent acute injury, determine and address causative factors of the fall. Initiated 9/17/24. -Provide one-to-one activities that promote exercise and strength building where possible. Provide one-to-one activities if bed bound. Initiated 9/17/24. -PT consultation for strength and mobility. Initiated 9/17/24. -The resident had frequent falls due to self-transferring. Initiated 9/30/24. -Place a full sized mattress on the floor by Resident 40's bed when she/he was in bed. The bed was to be in the lowest position. Initiated 10/14/24. Revised 10/23/24. -Keep Resident 40's wheelchair out of her/his view. Initiated 10/14/24. -Enhanced activities for fall prevention. Initiated 10/22/24. Resident 40's 8/4/24 Significant Change MDS indicated Resident 40 had moderately impaired cognition and the resident required substantial to maximal assistance for bed mobility and standing. Resident 40's 10/10/24 Discharge with Return Anticipated MDS indicated Resident 40 had short term memory deficits, severe impairment making decisions regarding tasks of daily life and required substantial to maximal assistance for bed mobility and partial to moderate assistance for standing. From 7/12/24 through 10/16/24, Resident 40 sustained 12 non-injury falls in the facility. Fall investigations revealed the following: -7/12/24 at 4:50 AM: Resident 40's fall investigation revealed Resident 40 was found kneeling on the floor in front of her/his bed. The report indicated Resident 40 tried to pick something up off the floor. According to the report, at the time of the fall, the resident required one person assistance for standing, had a fall mat, high/low bed and the bed was against the wall. The resident was reminded that staff needed to pick up items if she/he dropped them. No new fall care plan interventions were put into place. -9/17/24 at 4:00 AM: Resident 40's fall investigation revealed Resident 40 was found on the floor in her/his room, next to her/his bed. The resident's bed was in the lowest position, she/he had on non-skid socks and the call light was by the resident but not activated. The resident was educated regarding the importance of using the call light. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-9/26/24 at 7:00 AM: Resident 40's fall investigation revealed the resident was found sitting on the floor in her/his room leaning on the right side of her/his bed. Resident 40 was alert with confusion and exhibited impulsivity with poor safety judgement. No new fall care plan interventions were put into place. -9/26/24 at 9:55 PM: Resident 40's fall investigation revealed the resident was found on the floor in her/his room on the right side of her/his bed. The resident was wearing non-skid socks. No new fall care plan interventions were put into place. -9/29/24 at 12:40 PM: Resident 40's fall investigation revealed the resident was found on her/his floor. The resident's bed was in the lowest position and the resident was wearing non-skid socks. Resident 40 tried to transfer herself/himself to the wheelchair. Resident 40's call light was within reach and the area was free from clutter. The resident was very confused. No new fall care plan interventions were put into place. -10/5/24 at 7:35 AM: Resident 40's fall investigation revealed the resident was found down on her/his room floor. The resident was wearing non-skid socks and the lights were on in her/his room. The resident had impaired memory, gait and balance. Resident 40 had a history of self-transferring. No new fall care plan interventions were put into place. -10/7/24 at 8:30 PM. Resident 40's fall investigation revealed the resident was found on the floor in her/his room very close to the bed. The resident's bed was in the lowest position and she/her wore non-skid socks. The resident had impaired memory and a history of self-transferring. No new fall care plan interventions were put into place. -10/10/24 at 7:00 AM: Resident 40's fall investigation revealed the resident was found on the floor in her/his room leaning against the bed. The resident had on non-skid socks and the lights were on in her/his room. The call light was within reach and the area was free of clutter. Resident 40 had a history of self-transferring and impaired gait/balance. No new fall care plan interventions were put into place. -10/14/24 at 11:00 AM: Resident 40's fall investigation revealed the resident was found on the floor in her/his room by the bed after attempting to self-transfer. Resident had on non-skid socks and the floor was dry. A new intervention was identified to have Resident 40's wheelchair put away and out-of-sight to prevent the resident from self-transferring. -10/14/24 at 2:48 PM: Resident 40's fall investigation revealed the resident was found on the floor in her/his room. The resident wore non-skid socks, the fall mat was in place, the resident's bed was in the lowest position and the call light was within reach and not activated. Resident 40 indicated via pointing that she/he was attempting to reach her/his wheelchair. A new intervention was care planned to have a full sized mattress next to Resident 40's bed while she/he was in bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 40's care plan was not followed as her/his wheelchair was supposed to be put away and out-of-sight to prevent the resident from self-transferring. -10/14/24 at 11:26 PM: Resident 40's fall investigation revealed the resident was found sitting on the floor mat by her/his bed. The resident had on non-skid socks, the room was free of clutter and Resident 40's call light was within reach. A new intervention was care planned for Activities to develop a structured activities plan for the resident. -10/16/24 at 12:05 PM: Resident 40's fall investigation revealed the resident was found on the floor in her/his room, attempting to get to her/his wheelchair which was located on the other side of the room. The resident had multiple falls due to attempts to self-transfer in her/his room. Resident 40's care plan was not followed as her/his wheelchair was supposed to be put away and out-of-sight to prevent the resident from self-transferring. No new fall care plan interventions were put into place. Random observations from 10/23/24 through 10/29/24 between the hours of 7:30 AM and 3:30 PM revealed the following concerns: -Resident 40 was in her/his wheelchair in her/his room being interviewed by the State surveyor and attempted to get up from the wheelchair without assistance. -Resident 40 was observed multiple times resting in her/his bed, at times appearing to be asleep and other times awake, with the curtains drawn which resulted in staff being unable to visualize the resident from the hallway. -On two separate observations, Resident 40 was observed in her/his bed with her/his wheelchair parked next to the end of the bed, visible to the resident. -Resident 40 was not observed engaged in one-to-one or group activities during any observations. On 10/25/24 at 9:30 AM Staff 22 (CNA) stated Resident 40 fell a lot so he tried to keep the resident up. He stated if the resident was in bed then he put the full sized mattress next to the bed. Staff 22 stated he did not see Resident 22 engaged in group or one-to-one activities. On 10/25/24 at 9:41 AM and 10:44 AM Staff 5 (CNA) reported Resident 40 liked to have meals in the dining room and then get back into bed. Staff 5 stated Resident 40 had many falls and her/his fall precautions included having a full sized mattress at the resident's bedside and ensuring the resident's bed was in the lowest position. At 10:44 AM, Staff 5 entered Resident 40's room and the resident was sitting on the edge of the bed with her/his wheelchair parked at the end of the bed, in full view. Staff 5 acknowledged that Resident 40's wheelchair was supposed to be put away, out-of-sight. On 10/25/24 at 10:13 AM Staff 23 (CNA) stated Resident 40's falls always occurred in her/his room. Staff 23 stated she had not seen any one-to-one activities occurring with Resident 40 and thought the resident liked activities such as playing volleyball and painting. Staff 23 stated the resident was supposed to have a fall mat at the bedside and the wheelchair should be out-of-sight but sometimes co-workers aren't doing things right which resulted in Resident 40 falling. Staff 23 stated Resident 40 did not use the call light to summon assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/28/24 at 8:05 AM Staff 25 (RN) stated Resident 40 was at risk for falling and had many falls because the resident attempted to get to her/his wheelchair and fell . Staff 25 stated Resident 40's wheelchair was supposed to be put away and out-of sight. Staff 25 entered Resident 40's room and confirmed the resident's wheelchair was parked at the end of the resident's bed, in full view, and the wheelchair was not supposed to be in her/his sight. On 10/28/24 at 9:31 AM Staff 14 (Activities Director) stated Resident 40 rarely went to group activities and doing one-to-one activities with the resident was not a frequent thing. On 10/28/24 at 10:40 AM Staff 4 (LPN Care Manager) stated Resident 40 was a frequent faller and will try to stand-up and go right down. Staff 4 stated Resident 40 was supposed to be engaged in group or one-to-one activities and have her/his wheelchair out-of-sight. Staff 4 stated Resident 40 did not use her/his call light. Staff 4 reviewed Resident 40's falls and acknowledged staff did not consistently follow the resident's care plan including providing group and one-to-one activities and ensuring the resident's wheelchair was out-of-sight when she/he was in bed. Staff 4 confirmed there were multiple falls where no new fall care plan interventions were identified or implemented. Staff 4 stated she expected other care plan interventions to be attempted and put into place. On 10/28/24 at 2:34 PM Staff 1 (Administrator) stated he was aware Resident 40 experienced frequent falls. Staff 1 stated they needed to do more root cause analysis regarding the resident's falls and look into what else we can do to prevent the falls. Refer to F679. 47000 3. Resident 48 was admitted to the facility in 5/2024 with diagnoses including traumatic subdural hemorrhage (condition that occurs when blood pools between the skull and the brain after a head injury). Resident 48's 9/24/24 Significant Change in Status MDS Assessment revealed the resident was cognitively intact and had not experienced any falls since her/his prior assessment. Resident 48's 10/18/24 Fall Investigation revealed the resident experienced a non-injury fall out of bed on 10/18/24. The investigation concluded a perimeter mattress (a mattress with raised edges used to help prevent residents from rolling out of bed) to define bed perimeter would be implemented to reduce the risk of the resident rolling out of bed. Resident 48's 10/21/24 At Risk for Falls Care Plan indicated the following: -The resident was considered a high risk to fall related to a history of falls. -The resident's bed was to be kept at an appropriate height. -A perimeter mattress was to be placed on the resident's bed when it became available. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Random observations of Resident 48 from 10/23/24 at 12:35 PM through 10/25/24 at 9:26 AM revealed the resident to be in her/his room in bed. The resident laid on a regular mattress and her/his bed was at approximately waist height and no fall mats were observed on the ground. The resident was unable to answer any questions about her/his care. On 10/25/24 at 10:05 AM Staff 5 (CNA) stated she was unsure if Resident 48 was considered at risk to fall or if the resident had experienced any recent falls. On 10/25/24 at 10:34 AM Staff 23 (CNA) stated she thought Resident 48 was considered at risk to fall but was not aware of any recent falls or interventions. On 10/28/24 at 11:48 AM Staff 4 (LPN Care Manger) stated Resident 48 fell out of bed on 10/18/24, following which she ordered a perimeter mattress for the resident's bed to help with safety. Staff 4 stated staff were supposed to use wedges to help keep the resident safe until the perimeter mattress arrived at the facility but she did not care plan the use of wedges. On 10/28/24 at 12:14 PM Staff 2 (DNS) stated the facility's interdisciplinary team determined a perimeter mattress was the best intervention to implement following the resident's fall on 10/18/24. Staff 2 stated the resident's bed was to be kept in a low position when occupied with a fall mat in place until the perimeter mattress was put in place. Staff 2 confirmed these temporary safety interventions should have been care planned and were not.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 47000 Based on observation, interview and record review it was determined the facility failed to provide appropriate and timely pain management for 1 of 3 sampled residents (#22) reviewed for pain. This placed residents at risk for pain. Findings include: Resident 22 was admitted to the facility in 11/2022 with diagnoses including right upper quadrant pain, low back pain and arthritis. Resident 22's 10/10/24 Annual MDS Assessment and CAAs revealed the resident was able to make her/himself understood and understand others without difficulty, had left hand contractures and received scheduled and PRN pain medication. Resident 22's 10/2024 Physician Orders directed the resident to receive daily wound care to her/his left hand and to administer PRN oxycodone (a narcotic drug used to treat moderate to severe pain) 30 minutes to an hour prior to treatment was provided. The orders also indicated the resident's fingers on her/his left hand were very contracted and painful to move. On 10/23/24 at 11:16 AM Resident 22 was observed in her/his room in bed. The resident's fingers on her/his left hand were observed to be contracted and gripped a rolled up wash cloth. Resident 22 stated she/he was unable to open the fingers on her/his left hand. Resident 22 further stated when the nurses at the facility provided treatment to her/his left hand, the pain was ridiculous and they always gave her/him pain medicine just prior to or sometimes even after the treatment was completed which was stupid. On 10/24/24 at 12:28 PM Witness 8 (Family Member) stated Resident 22 experienced excruciating pain in her/his left hand any time the fingers were moved. Witness 8 stated he had spoken with facility staff about administering pain medication prior to completing any treatments to the resident's left hand and to allow enough time for the medication to take effect but facility staff continued to administer pain medication immediately before working on [her/him] which did not give it [the pain medication] time to work. On 10/24/24 at 3:54 PM Staff 32 (CNA) stated Resident 22 complained about pain in her/his left hand and she was careful with the resident's hand when she assisted the resident with personal care. On 10/25/24 at 11:07 AM Staff 31 (LPN) stated she did not offer Resident 22 pain medication prior to completing treatments to her/his left hand because the resident did not complain about [her/his] left hand and the resident did not have pain in her/his hand. At 11:21 AM Staff 31 entered Resident 22's room to provide a treatment to the resident's left hand. Staff 31 placed a disposable incontinent pad under the resident's left arm and when she reached for the resident's left hand, the resident yelled no you are not goddammit, give me an oxy [oxycodone] before! On 10/25/24 at 11:31 AM Staff 31 re-entered the resident's room to offer a pain pill. On 10/25/24 at 3:46 PM Staff 2 (DNS) stated he expected nurses to ask about Resident 22's level of pain and to offer pain medication prior to providing treatments.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 50927 Based on interview and record review it was determined the facility failed to complete nurse aide performance reviews every twelve months for 5 of 5 sampled CNAs (#s 5, 6, 7, 8 and 9) reviewed for staffing. This placed residents at risk for a lack of care by competent staff. Findings include: Review of personnel records found the following employees had not received their annual performance evaluations: -Staff 5 (CNA), hire date 8/31/23: no annual performance review was completed. -Staff 6 (CNA), hire date 5/1/23: no annual performance review was completed. -Staff 7 (CNA), hire date 8/9/22: no annual performance review was completed. -Staff 8 (CNA), hire date 6/14/19: no annual performance review was completed. -Staff 9 (CNA), hire date 6/20/17: no annual performance review was completed. On 10/25/24 at 3:52 PM Staff 11 (Business Office Manager) confirmed annual performance reviews for Staff 5, Staff 6, Staff 7, Staff 8 and Staff 9 were not completed. On 10/28/24 at 12:08 PM Staff 1 (Administrator) stated his expectation was annual CNA performance reviews would be completed every 12 months, and confirmed Staff 5, Staff 6, Staff 7, Staff 8 and Staff 9 did not have annual performance reviews completed.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 47000 Based on observation, interview and record review it was determined the facility failed to obtain necessary services for the behavioral health care needs of residents and review and revise behavioral health care plan interventions to ensure interventions were appropriate and effective for 1 of 1 resident (#22) reviewed for PASARR (Preadmission Screening and Resident Review). This placed residents at risk for unmet behavioral health care needs and for not attaining their highest practicable well-being. Findings include: Resident 22 was admitted to the facility in 11/2022 with diagnoses including bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), depression and panic disorder (an anxiety disorder characterized by unexpected and repeated episodes of intense fear accompanied by physical symptoms that may include chest pain, heart palpitations, shortness of breath, dizziness or abdominal distress). Resident 22's 2/13/23 Quarterly Social Services Evaluation indicated the resident experienced difficulty coping with stress, her/his depression had increased tremendously and she/he received risperdal (an antipsychotic medication used to treat schizophrenia, bipolar disorder) for her/his diagnosis of bipolar disorder. Resident 22's 7/10/24 Quarterly MDS Assessment revealed the resident was able to make her/himself understood and understand others without difficulty, the resident did not provide a response to the questions on the mood interview and declined to answer if she/he felt lonely or isolated from those around him/her. Resident 22's 7/23/24 Quarterly Social Services Evaluation indicated the resident had no interest in relating with other residents at the facility, had difficulty coping with stress and the loss of independence and her/his depression had increased. Resident 22's 10/3/24 Behavior Monitor, Activity and Bipolar/Depression Care Plans revealed the following: -The resident demonstrated behaviors related to depression, panic disorder and bipolar disorder and a behavior monitor was in place. -The resident's behaviors included verbal and physical aggression and refusals of care. Behavior triggers included pain, time of day, approach and over stimulation. Interventions included to address pain, reapproach, listen to concerns and reduce stimulation. -The goal was for the resident to have reduced and manageable behaviors. -Introduce the resident to residents with a similar background and encourage/facilitate interactions. -Invite the resident to scheduled activities. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Arrange for a psychiatric consult and follow-up as indicated. -Encourage time out of room. -Monitor, document and report PRN any signs or symptoms of depression. Resident 22's 10/10/24 Annual MDS Assessment revealed the resident was able to make her/himself understood and understand others without difficulty, the resident did not provide a response to the questions on the mood interview, declined to answer if she/he felt lonely or isolated from those around him/her and had active diagnoses of depression, anxiety and bipolar disorder. The Behavioral Symptoms CAA indicated the Social Services Director was to assist the resident with depression and anxiety, the interdisciplinary team would review PRN and a referral to another discipline was warranted. No evidence was found in Resident 22's clinical record to indicate any mood symptoms for the resident were monitored, a referral to another discipline was made to address the resident's on-going mood symptoms and behaviors or documentation to indicate if current mood and behavior interventions were effective. Random observations of Resident 22 from 10/23/24 to 10/25/24 between 8:26 AM to 3:41 PM revealed the resident to be in her/his room in bed. Resident 22 stated she/he never left her/his room, did not participate in any activities at the facility and was unhappy. On 10/24/24 at 12:28 Witness 8 (Family Member) stated Resident 22 dealt with her/his bipolar disorder for decades and it usually manifested itself through increased depression. Witness 8 stated Resident 22 had asked for a gun to kill [her/himself] several times since she/he admitted to the facility. Witness 8 stated he reported these comments to the facility, requested a mental health evaluation and nothing had been done. On 10/24/24 at 3:54 PM Staff 32 (CNA) stated Resident 22 was verbally and physically aggressive, which included spitting, punching, yelling at and making racist comments to staff. Staff 32 further stated the resident did not get out of bed or participate in any activities outside of watching television in her/his room and these behaviors were not of recent onset. On 10/25/24 at 10:34 AM Staff 23 (CNA) stated the resident yelled and was very foul even when staff were as nice as they could be with her/him and you just had to put up with [her/his] verbal abuse. On 10/25/24 at 11:58 AM Staff 15 (Social Services Director) stated Resident 22 did not generally seem happy and was prone to care refusals and being verbally aggressive towards staff. Staff 15 stated Resident 22 refused to talk to her so she assessed the resident's mood and behaviors from reports from staff and by reviewing the resident's behavior monitor. Staff 15 stated the resident's behavior monitor, completed by CNAs, focused the resident's verbal and physical aggression and refusals of care and did not allow for monitoring of mood symptoms and it should have since she/he showed signs and symptoms of depression. Staff 15 stated interventions in place to address the resident's depression included encouraging out-of-room activities and just trying to talk to [her/him]. Staff 15 stated she was not aware of any additional interventions that had been tried to address the resident's depression and further stated encouraging out-of-room activities was not an appropriate intervention since the resident did not like to leave her/his room. Staff 15 stated the resident should have been referred to the facility's in-house psychiatrist, had not been referred and she did not know why. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/24 at 2:52 PM Staff 4 (LPN Resident Care Manager) stated Resident 22 was not happy about being here [the facility], very difficult and abusive to staff and just laid there and wouldn't get up. Staff 4 stated she encouraged the resident to take her/his prescribed antibiotics last month and told the resident it could be fatal if she/he continued to refuse the antibiotics. Staff 4 stated the resident's response was good, maybe that will get me out of here. On 10/25/24 at 3:50 PM Staff 1 (Administrator) acknowledged the findings and confirmed Resident 22's mood and behavioral needs had not been fully addressed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47000 Based on interview and record review it was determined the facility failed to ensure the correct POLST was readily available and accessible to enable staff to provide the appropriate interventions for 1 of 5 residents (#42) reviewed for choices. This placed residents at risk for not receiving care per their current wishes. Findings include: Resident 42 admitted to facility in 10/2023 with a diagnosis of chronic obstructive pulmonary disease. Resident 42's 10/5/23 admission MDS indicated she/he was cognitively intact. A public complaint received on 6/4/24 alleged Resident 42 wanted to be full code (all life saaving measures provided). The 6/4/24 public complaint alleged the resident's POLST was filled out incorrectly. Resident 42's clinical record revealed two signed POLST documents. The 10/4/23 POLST for Resident 42 indicated she/he wished to be full code. The 10/27/23 POLST for Resident 42 indicated she/he wished to be Do not resuscitate (DNR). On 10/28/24 Staff 4 (LPN care manager) interviewed resident 42, at which time Resident 42 indicated she/he was to be full code. Staff 4 confirmed Resident 42's code status was currently documented DNR which was not accurate. On 10/29/24 at 7:31 AM Resident 42's code status was still DNR. On 10/29/24 at 7:38 AM and 7:42 AM Staff 27(LPN) and Staff 25(RN) indicated where to locate Resident 42's code status. The code status at the designated location was DNR. On 10/29/24 at 10:13 AM Staff 2 (DNS) confirmed Resident 42's Code status should reflect her/his desired status.

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 47000 Based on observation, interview and record review it was determined the facility failed to establish an effective communication process between the facility and hospice provider in order to ensure the needs of the resident were addressed and met 24 hours per day for 1 of 1 resident (#48) reviewed for hospice. This placed residents at risk for unmet needs. The facility's 9/2017 Hospice Policy revealed the following: -The hospice and facility communicate, establish and agree upon a coordinated Plan of Care (POC) reflecting the hospice philosophy and based on an evaluation of the individual needs of the resident. -Hospice establishes the POC related to the terminal illness, related conditions, directives for management of pain and other uncomfortable symptoms. -The facility maintains a POC that is consistent with the hospice POC. The plan is reviewed and updated as needed but no less often then quarterly. -The hospice provider is responsible for notifying the facility of changes in provision of care. Resident 48 was admitted to the facility in 5/2024 with diagnoses including traumatic subdural hemorrhage (condition that occurs when blood pools between the skull and the brain after a head injury). Resident 48's 9/24/24 Significant Change in Status MDS Assessment and CAAs revealed the resident was cognitively intact, experienced pain or hurt and was enrolled in hospice care. Resident 48's 9/24/24 Terminal Prognosis Care Plan indicated the following: -Observe the resident closely for signs of pain, administer pain medications as ordered and notify the physician immediately if there was breakthrough pain. -Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs were met. Resident 48's 10/1/24 Physician Order from the resident's hospice provider directed the resident to receive a fentanyl patch (used to relieve severe and persistent pain in people who are tolerant to narcotic pain medications and who cannot be treated with other medications) to be placed on the skin of the upper chest and changed every 72 hours for pain. Resident 48's 10/2024 MAR revealed the resident's fentanyl patch was started on 10/5/24. On 10/23/24 at 12:35 PM Resident 48 was observed in her/his room in bed. A clear patch was observed on Resident 48's upper right arm that was dated 10/20/24. Resident 48 was unable to answer any questions about her/his care at this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385228	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 1:11 PM Witness 1 (Family Member) stated the communication between the hospice team and the facility was not strong and there was a time lag from when hospice wrote an order to when it was implemented at the facility. Witness 1 further stated she was told by hospice that a fentanyl patch was going to be used to treat Resident 48's pain and it was to be placed on the resident's upper chest on 10/1/24 but the fentanyl patch was still being placed on the resident's arms. On 10/25/24 at 11:34 AM Witness 2 (Hospice RN) stated she had experienced problems in general with hospice orders being implemented timely for Resident 48. Witness 2 stated hospice provided the facility with an order for Resident 48 to start a fentanyl patch on 10/1/24 but the order was not started until 10/5/24. Witness 2 further stated she spoke with Staff 4 (LPN Care Manager) last week about placing the fentanyl patch on the resident's upper chest instead of the arm and this issue was still not resolved. On 10/25/24 at 2:40 PM Resident 48 was observed in her/his room in bed. A clear patch was observed on Resident 48's upper right arm dated 10/23/24. On 10/28/24 at 7:32 AM Staff 25 (RN) stated she placed Resident 48's fentanyl patches on her/his arms and had not been instructed to do otherwise. On 10/28/24 at 11:48 AM Staff 4 stated Resident 48 received an order from hospice to start a fentanyl patch on 10/1/24 and she did not know why the order was not implemented until 10/5/24. Staff 4 further stated Resident 48's fentanyl patch was to be placed on her/his chest and she had observed it on one occasion on the resident's shoulder. On 10/28/24 at 12:14 PM Staff 2 acknowledged the findings and stated he was not aware of the delay in the start of Resident 48's fentanyl patch or the order for the patch to be placed on the resident's upper chest.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46053 Based on observation and interview it was determined the facility failed to properly store laundry to prevent cross contamination for 1 of 1 facility reviewed for infection control. This placed residents at risk for cross contamination and the potential spread of infection. Findings include: On 10/24/24 at 2:22 PM during a tour of the facility's laundry room, a metal rack containing towels, fabric room divider curtains and sheets was observed against the wall opposite from the washing machines. The rack was draped with a cloth sheet that was held in place by metal binder clips. The top of the rack was completely uncovered. Staff 26 (Housekeeping / Laundry) stated the items on the rack were extra, new and clean items. When asked if this section of the laundry room was considered soiled or clean, Staff 26 reported the racks were on the soiled side of the room. She stated the rack had been in the soiled section for as long as she could remember. On 10/25/24 at 8:09 AM the rack with the same items was observed to still be stored on the soiled side of the laundry room. Staff 26 stated the clean items should not be stored on the soiled side of the room and she would talk to her coworker about a location for the rack and items on the clean side of the laundry room to avoid cross contamination from soiled laundry items. On 10/25/24 at 10:37 AM Staff 11 (Business Office Manager) who was overseeing the Housekeeping and Laundry departments confirmed the clean items should not be stored on the soiled side of the laundry room. She stated she was developing a solution to move the current storage location to the clean side of the laundry room. On 10/25/24 at 10:51 AM Staff 1 (Administrator) acknowledged the clean and new linens needed to be moved and stated, They should not have been stored on the dirty side.