STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Norton	3600 South Norton Avenue Sioux Falls, SD 57105

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 43021 Based on record review and interview, the provider failed to ensure the proper Medicare notices were filled out completely and were in the required format for three of three sampled residents (12, 13, and 354) prior to their discharge from Medicare Part A skilled services. Findings include: 1. Review of the three Entrance Conference Worksheets completed by the provider on 2/25/25 revealed 50 residents were identified as having been discharged from Medicare Part A skilled services: *Twenty-five of those residents remained in the facility following their discharge from Medicare Part A skilled services. *Twenty-five of those residents were discharged to home or to a lesser care level following their discharge from Medicare Part A skilled services. 2. Review of resident 354's CMS (Centers for Medicare and Medicaid Services) SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review form completed by Minimum Data Set (MDS) coordinator H on 2/26/25 revealed: *Resident 354's Medicare Part A Skilled Services Episode start date was 9/25/24. *Her last covered day on Medicare Part A Skilled Service was 11/5/24. *The form's first question: Was a SNF ABN [Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage], Form CMS-10055 provided to the resident? was answered No with the explanation, The resident was discharged from the facility and did not receive non-covered services. *The form's second question: Was a NOMNC [Notice of Medicare Non-Coverage], Form CMS-10123 provided to the resident? was answered Yes and a copy of the form that was signed by resident 354 was provided. Review of the 12/31/11 NOMNC Form CMS 10123 signed by resident 354 on 11/1/24 revealed: *The provider's name and address were typed above the form's title. (continued on next page)

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 - Some	*The provider's phone number was not listed as required. *The Effective Date Coverage of Your Current Medicare Part A Services Will End section had the date 11/5/24 handwritten on it. *Resident 354 was provided the notice four days before the date her Medicare Part A skilled services ended, which met the required two-day notice. 3. Review of resident 12's CMS SNF Beneficiary Protection Notification Review form completed by MDS coordinator H on 2/26/25 revealed: *His Medicare Part A Skilled Services Episode start date was 11/20/24. *His last covered day on Medicare Part A Skilled Service was 11/26/24. *The form's questions included: -Was a SNF ABN, Form CMS-10055 provided to the resident? -Was a NOMNC, Form CMS-10123 provided to the resident? -Both of those questions were answered Yes and copies of those forms that were signed by resident 12 were provided. Review of the 2018 SNF ABN Form CMS-10055 signed by resident 12 on 11/22/24 revealed: *The form was outdated and was not the revised 2024 Form CMS-10055, CMS required to be used beginning on 10/31/24. *The provider's name, address, and phone number were handwritten appropriately in an approximately 12-point font above the form's title. *The Care section that described the care that would not be covered by Medicare Part A after 11/26/24 had R&B handwritten on it. -There was no description of what R&B meant. *The Reason Medicare May Not Pay section that provided a brief explanation to help understand why Medicare may deny payment had @ [at] prior level of function handwritten on it. -That explanation was not easily understandable as it used technical jargon used by physical and occupational therapists. Review of the 12/31/11 NOMNC Form CMS-10123 signed by resident 12 on 11/22/24 revealed: *The provider's name and address were typed above the form's title. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The provider's phone number was not listed as required. *The Effective Date Coverage of Your Current Medicare Part A Services Will End section had the date 11/26/24 handwritten on it. *Both forms above provided resident 12 with a four-day notice before his Medicare Part A skilled services ended, which met the required two-day notice. 4. Review of resident 13's CMS SNF Beneficiary Protection Notification Review form completed by MDS coordinator H on 2/26/25 revealed: *Her Medicare Part A Skilled Services Episode start date was 1/7/25. *Her last covered day on Medicare Part A Skilled Service was 2/4/25. *The form's questions included: -Was a SNF ABN, Form CMS-10055 provided to the resident? -Was a NOMNC, Form CMS-10123 provided to the resident? -Both of those questions were answered Yes and copies of the forms that indicated they were explained verbally on a 1/31/25 phone call to resident 13's son/power of attorney (POA) were provided. Review of the 2018 SNF ABN Form CMS-10058 for resident 13 that noted the 1/31/25 phone call to her son/POA revealed: *The form was outdated and was not the required revised 2024 Form CMS-10055. *The provider's name was handwritten above the title of the form. *The provider's address and phone number were not listed as required. *The Care section that described the care that would not be covered by Medicare was handwritten R&B. -There was no description of what R&B meant. *The Reason Medicare May Not Pay section was completed with a handwritten explanation of plateaued [reached a state of little or no change]. -That reason used technical jargon and was not easily understandable. *The outdated form's signature box contained a handwritten note spoke to [resident 13's son] [on] 1/31/25 [at] 12:30p [p.m.] no appeal with MDS coordinator H's signature. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The form did not indicate if a copy of the annotated SNF ABN form had been mailed to resident 13's son/POA to confirm the telephone contact was made or if any attempts had been made to obtain his signature on the form. Review of the 2025 NOMNC form CMS 10123 for resident 13 revealed: *It was the revised CMS form required to be used beginning on 1/1/25. *The provider's name, address, and phone number were typed in a small 8-point font above the form's title. -This had not met the Form Instructions for the NOMNC, which required that notice entries must be at least as large as 12-point type and legible. *The Medicare Coverage of Your Current Skilled Services Will End section had the date of 2/4/25 handwritten on it. *The form's Additional information section indicated an explanation of the notice was provided to resident 13's son/POA on 1/31/25 at 12:30 p.m., four days before her Medicare Part A skilled services ended. *The form did not indicate if a copy of the annotated NOMNC form had been mailed to resident 13's son/POA on 1/31/25 to confirm the telephone contact was made. 5. Interview on 3/4/25 at 9:02 a.m. with administrator A regarding beneficiary notification revealed: *They did not have a policy regarding the NOMNC and SNF ABN notices. *The MDS coordinators were responsible for the beneficiary notifications. *She expected the requirements, guidelines, and instructions for the forms to be followed. 6. Interview on 3/4/25 at 11:44 a.m. with MDS Coordinator H and MDS Coordinator I regarding beneficiary notification revealed: *They completed training on the Medicare notices in May 2024. *They had been responsible for providing the required Medicare notices to residents ending their Medicare Part A stay since June 2024. *They attended a weekly Medicare meeting during which the provider's therapy department discussed the residents who were nearing the end of Medicare Part A coverage and needed to be provided the required Medicare notice(s). *They were aware of and had used the new 2025 NOMNC form CMS 10123. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Business office manager N had made them aware of the revised 2024 SNF ABN Form CMS-10055 that morning, 3/4/25. -They agreed resident 12 and resident 13 had received the outdated 2018 SNF ABN notice and they should have used the revised 2024 SNF ABN form that was required for use as of 10/31/24. *The Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 and Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 were provided and reviewed with them including: -Instructions that the name, address and telephone number of the provider must appear above the title of the form. -They both agreed that: --Resident 13's SNF ABN notice had not included the provider's address or phone number. --Resident 354's and resident 12's NOMNC notice did not include the provider's phone number. --The SNF ABN notice forms filled out by MDS Coordinator I for residents 12 and 13 that contained the care description R&B and the explanations for the reason Medicare was ending were not easily understood and did not include an explanation of what R&B meant. 7. Interview on 3/4/25 at 12:22 p.m. with DON B regarding beneficiary notices revealed: *The MDS coordinators were responsible for delivering those Medicare notices. *He agreed that the description of the services ending and the explanation of why those services would no longer be covered by Medicare needed to be provided in a way that was easily understood. *He expected the requirements, guidelines, and instructions for the forms to be followed. 8. Review of the Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 and Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 provided to the MDS Coordinators on 3/4/25 at 11:44 a.m. revealed: *Completing the SNF ABN indicated the following: -Entries may be typed or legibly hand-written and should be large enough for easy reading (approximately 12 point font). -The SNF must include the SNF's name, address, and phone number, at a minimum. -In the Care section, the SNF lists the care that it believes may not or won't be covered by Medicare. The description must be written in plain language that the beneficiary can understand. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In the Reason Medicare May Not Pay section the SNF must give . a brief explanation of why the beneficiary's medical needs or condition do not meet Medicare coverage guidelines. The reason must be sufficient and specific enough to enable the beneficiary to understand why Medicare may deny payment. *The NOMNC form's instructions included: -For the Heading . The name, address and telephone number of the provider that delivers the notice must appear above the title of the form . notice entries must be at least as large as 12- point type and legible. -The provider must ensure that the beneficiary of representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. -If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered. The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. 9. Review of the 8/1/24 Medicare Claims Processing Manual Chapter 30 revealed: *Section 50 - Advance Beneficiary Notice of Non-coverage (ABN) provided the guidance that required the healthcare provider to notify a beneficiary in advance of furnishing a service that will likely be denied by Medicare as not reasonable and necessary because the service constitutes custodial care. -Section 50.8.1-Options for Delivery Other than In-Person indicated that when in-person delivery is not possible, the provider may deliver the form by the following methods: --Direct telephone contact. --Mail. --Secure fax machine. --Internet e-mail. --Telephone contacts should be followed immediately by either a hand-delivered, mailed, e-mailed, or a faxed notice. --The notifier [provider] must keep a copy of the unsigned notice on file while awaiting receipt of the signed notice . the notifier should document the initial contact and subsequent attempts to obtain a signature . on the notice itself. *Section 70 - Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) provided the standards and instructions required by the SNF healthcare provider that included: (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-When completing and delivering the SNF ABN, SNFs must meet the written notice standards in . 50.8 noted above. -Written Notification must be given . During the inpatient stay, the SNF timely furnishes to the beneficiary [resident] a SNF ABN notifying the beneficiary that the covered . service(s) will no longer be covered. *Section 260.3 - Notice of Medicare Non-Coverage (NOMNC) provided the standards and instructions required that included: -The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. -Section 260.3.8 - NOMNC Delivery to Representatives indicated acceptable Exceptions to in person notice delivery which detailed The provider must complete the NOMNC as required and telephone the representative at least two days prior to the end of covered services . --The NOMNC must be annotated . --Note the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called. --A copy of the annotated NOMNC should be mailed to the representative the day telephone contact is made and a dated copy should be placed in the beneficiary's medical file. 10. Review of the CMS website revealed: *An 8/28/24 post stated, With the help of our contractors, we revised the SNF ABN, Form CMS-10055, and the form instructions. The SNF ABN form and instructions are located in the download section and are available for immediate use, but will be mandatory for use on 10/31/2024. *An 11/18/24 post stated, The Office of Management and Budget (OMB) has approved a revised Notice of Medicare Non-Coverage (NOMNC / CMS-10123) . Providers must use the revised NOMNC beginning January 1, 2025.

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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** 51472 Based on observation, interview, record review, and policy review, the provider failed to ensure resident care plans reflected the current individualized needs for: *One of one sampled resident (54) who utilized oxygen and a respiratory device. *One of one sampled resident (64) who had his indwelling feeding tube removed. 1. Observation and interview on 2/25/25 at 6:49 a.m. with resident 54 revealed: *An oxygen concentrator (a machine that takes surrounding air and purifies it into breathable oxygen) was at his bedside. *A continuous positive airway pressure (CPAP) machine (a machine to treat sleep-related breathing issues) was on his bedside table. *He had lived in the facility for about three weeks. *He indicated he wore the oxygen as needed. *He stated he was supposed to wear the CPAP every night, but he had only been using it intermittently at night. *He was admitted to the facility with the oxygen and CPAP. Review of resident 54's EMR revealed: *He was admitted on [DATE]. *His 2/2/25 BIMS assessment score was 15, which indicated he was cognitively intact. *His diagnoses included chronic (long term) respiratory failure with hypoxia (low oxygen levels in the blood), diabetes, and heart failure. *There was a 1/22/25 physician's order for 2L [2 liters] [of] O2 [oxygen] as needed for hypoxia. *There was no physician's order for the CPAP use. Review of resident 54's 2/25/25 care plan revealed: *There was no focus area regarding resident 54's respiratory status. *The use of oxygen was not addressed in his care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*The use of a CPAP was not addressed in his care plan. 2. Observation and interview on 2/25/25 at 9:04 a.m. with resident 64 in his room revealed: *On the counter beside the sink there was: -Three syringes and two plastic containers used to measure liquid. --One of those containers was labeled with the resident's name. -An opened bottle labeled wound cleanser without a resident name or date on it. *Resident 64 indicated the bottle of wound cleanser was used to clean around his feeding tube. *He stated that he had the tube removed from his stomach about one week ago. *He lifted his shirt and pointed to a gauze dressing on his abdomen that was dated 2/24. *He indicated the tube was put in after he had surgery on his tongue and neck, but he was able to eat now so he had it taken out. Review of resident 64's EMR revealed: *He was admitted to the facility on [DATE]. *His 2/19/25 BIMS assessment score was 12, which indicated he had moderate cognitive impairment. *His diagnoses included malignant neoplasm of the tongue (tongue cancer), and dysphagia (difficulty swallowing). *His physician's orders included the following medications with the route of administration identified as G-TUBE (a tube surgically inserted through the abdomen into the stomach). -Ondansetron tab (a medication given to nausea) 4mg (milligrams) every eight hours as needed. -Milk of Magnesia (a medication used for constipation)-400MG/5ML (milliliters) given 30 ML once daily as needed. -Hydrocodone/APAP (narcotic pain medication)7.5-325 give 15ML every 6 hours as needed for pain. *A progress note on 2/20/25 at 1:01 p.m. written by registered nurse (RN)/unit manager F stated, Resident's PEG tube was removed on 2/20/25 with appointment that was set up by [the resident's] niece and not communicated with [the] facility. Resident returned to [the] facility with removed PEG tube site covered with dry gauze and tegaderm [clear adhesive dressing]. No orders sent back from [the] provider, standing order [was] entered for [the] dressing. Site was clean dry and intact at [the] time of [the] observation. Review of resident 64's 2/25/25 care plan revealed: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*There was a goal to tolerate current TF [tube feeding] with no s/sx [signs and symptoms] of GI [gastrointestinal] distress and/or significant residuals. *His care plan had not been updated to reflect his feeding tube had been removed on 2/20/25 or the wound/dressing. 3. Interview on 3/5/25 at 9:30 a.m. with Minimum Data Set (MDS) coordinator I revealed: *The unit managers and the nurse managers were responsible for updating the residents' care plans. *MDS coordinators would assist the unit managers and nurse managers with care plan updates. *The care plans were updated quarterly, if there was a significant change, if there were any newly identified resident needs, and if there was any change in the resident's plan of care. *The purpose of the resident care plan was to provide adequate and appropriate care of the residents and to keep them safe. The care plan would keep the care team up to date on any changes with resident care needs. *Areas that may be addressed within a resident care plan included breathing issues, precautions such as enhanced barrier precautions, wounds and treatment of wounds, and any other care areas to address the resident's needs. *She would expect the use of oxygen to be on a resident's care plan. 4. Interview on 3/5/25 at 11:56 a.m. with director of nursing (DON) B and administrator A revealed: *Care plan updates and revisions were most often completed by the interdisciplinary team (IDT). *Nurses had the training and ability to update resident care plans. 5. Review of the provider's 9/30/24 Care Plans policy revealed: *Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay . *The personal history, habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical/diagnosis-based care considerations. *Care planning is constantly in process. *The physician's orders (including medications, treatments, labs, and diagnostics) in conjunction with the resident's care plan constitute the total 'plan of care'.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51816 Based on observation, interview, record review, and policy review, the provider failed to follow professional standards for medication administration and physician notification regarding the: *Administration of prescribed medication within the scheduled timeframe for one of one sampled resident (349). *Prompt physician notification of one of one sampled resident's (349) significant weight gain. *Prompt physician notification of abnormal vital signs (such as heart rate and blood pressure) and the holding of medications for one of one sampled resident (51). Findings include: 1. Observation and interview on 2/25/25 at 2:11 p.m. with resident 349 and his spouse in his room revealed: *He was sitting in his recliner with his feet elevated. *He had significant swelling in his lower legs. *They both stated they had concerns about resident 349 getting his Parkinson's medication on time. *Resident 349 stated there was one day when he had to ask staff three times for his dose of his Parkinson's medication. *His wife stated she didn't think the staff understood the importance of the timing of this medication for managing his symptoms of Parkinson's disease. *His wife stated she was also concerned about new swelling in his lower legs. *She pointed at his legs and stated, You don't have to be a nurse to know that is not normal. *She stated when she noticed the resident's swelling a few days ago, she had reported the swelling to his nurse, who came and looked at his legs and told them his feet needed to be elevated. Review of resident 349's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *He had a 2/17/25 Brief Interview for Mental Status (BIMS) assessment score of 13, which indicated he was cognitively intact. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*His diagnoses included Parkinson's disease without dyskinesia (involuntary movements), essential (primary) hypertension (high blood pressure), venous insufficiency (problem with the flow of blood from the legs back to the heart due to damaged valves in the veins), Type 2 Diabetes Mellitus with other circulatory complications, and paroxysmal atrial fibrillation (irregular heartbeat that occurs intermittently). *From 2/14/25 to 2/25/25, his carbidopa/levodopa (medication to treat Parkinson's disease) was not administered within 60 minutes of the scheduled administration time on 2/14/25, 2/16/25, 2/18/25, 2/22/25, and 2/25/25. *On 2/17/25 resident 349 weighed 187 pounds. *On 2/22/25 he weighed 196.7 pounds. -That was a 9.7 pound increase that equaled a 5% weight gain in five days. *A 2/25/25 Weight Change/Weight Warning Note indicated [resident 349] is triggering for significant wt [weight] gain, of approximately ten pounds since admission. -No nutrition recommendations were made by the dietitian. *A 2/28/25 IDT (interdisciplinary team) Progress Note indicated his weights had been stable since admission. *There was no documentation to support the physician was notified of his weight gain. Interview on 3/5/25 at 11:56 a.m. with director of nursing (DON) B revealed: *For a significant weight gain for a resident, he would expect the CNA to alert the charge nurse and reweigh the resident for accuracy, then notify the dietitian and provider. *When asked about a resident with a significant weight gain and without documentation of physician notification, he stated he would have expected the physician to be notified. 51472 2. Review of resident 51's EMR revealed: *She was admitted on [DATE]. *Her 2/18/25 BIMS assessment score was 9, which indicated she had moderate cognitive impairment. *Her diagnoses included: essential hypertension, orthostatic hypotension (low blood pressure after standing up from a seated or lying position), and syncope (fainting) and collapse. *She was prescribed the following medications to treat her blood pressure: -Hydrochlorothiazide 50 mg (milligrams) one time daily. (continued on next page)

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	435039	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Norton	3600 South Norton Avenue Sioux Falls, SD 57105

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Losartan 100 mg one time daily. -Norvasc 5 mg one time daily. -Metoprolol succinate ER (extended release) 50 mg one time daily. --Additional instructions for the metoprolol succinate ER were to, Hold if HR [heart rate] < [less than] 50bpm [50 beats per minute]. *There were no parameters to hold resident 51's blood pressure medications if her blood pressure was below a designated number. 3. Review of resident 51's December 2024 medication administration record (MAR) and continued review of her MAR revealed: *On 12/3/24 at 7:43 a.m. her blood pressure was documented as 95/63. *On 12/7/24 at 7:56 a.m. her blood pressure was documented as 93/60. *On 12/16/24 at 8:25 a.m. her blood pressure was documented as 95/60. -The 12/16/24 progress note in the EMR stated, Faxed PCP [primary care provider]- Resident's HR was 21 BPM. Took again at 0820 [8:20 a.m.] and it was 46 BPM. Held Metoprolol today and yesterday. Please advise. Awaiting response. --On 12/15/24 resident 51's pulse was documented in the MAR as 64 beats per minute and the metoprolol was documented as administered. --On 12/16/24 at 8:00 a.m. the metoprolol was documented as administered. -On 12/16/24 at 12:19 p.m. a progress note stated, PCP response- Hold metoprolol for next 5 days and daily HR and BP [blood pressure] monitoring for now. *On 12/18/24 at 8:09 a.m. her blood pressure was documented as 94/62. *Resident 51's Norvasc, Losartan, and hydrochlorothiazide medications were documented as administered on the above dates. Review of resident 51's January 2025 MAR and continued review of her EMR revealed: *On 1/5/25 at 10:15 a.m. her blood pressure was documented as 79/52. -The next documented blood pressure was 114/68 on 1/6/25 at 7:05 a.m. -Her 1/5/25 metoprolol succinate ER, Norvasc, and hydrochlorothiazide, were documented in the MAR as administered. -Her Losartan was documented as V which indicated Vitals outside parameters. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*On 1/11/25 at 8:12 a.m. her blood pressure was documented as 98/64. -Her next blood pressure was documented as 115/78 at 12:51 a.m. on 1/11/25. -A progress note on 1/11/25 at 11:14 a.m. stated, B/P [blood pressure] this am [a.m.] 98/64. B/P meds not administered. Will monitor B/P/pulse through the day and adm [administer] B/P [medications] when systolic > [greater than] 110. -Her 1/11/25 metoprolol succinate ER, Norvasc, hydrochlorothiazide, and Losartan were documented as administered in the MAR. *On 1/18/25 at 9:05 a.m. her blood pressure was documented as 96/55. -Her next documented blood pressure was 116/75 on 1/19/25 at 10:14 a.m. -Her 1/18/25 metoprolol succinate ER, Norvasc, and hydrochlorothiazide, were documented in the MAR as administered. -Her 1/18/25 Losartan was documented as V which indicated Vitals outside parameters. *On 1/22/25 at 10:02 a.m. her blood pressure was documented as 77/50. -Her next documented blood pressure was 114/72 on 1/23/25. -A progress note on 1/22/25 at 11:14 a.m. stated, Held metoprolol and Losartan B/P 77/50 and Pulse 67. -Her 1/22/25 metoprolol succinate ER, Norvasc, hydrochlorothiazide, and Losartan were documented as administered in the MAR. *There was no documentation to support that the physician was notified of the low blood pressures or held medications 4. Interview on 2/26/25 at 3:46 p.m. with certified nursing assistant (CNA/medication aid (CMA) Y revealed: *Each resident had parameters within their EMR that indicated what vital signs were outside the normal range and when medications were to be held. *She would consider a systolic blood pressure under 100 to be low and a pulse less than 60 beats per minute to be low. *If she held a medication due to the established parameters, she would notify the nurse and then document V in the MAR for vital signs outside the parameters, and write a progress note. 5. Interview on 2/26/25 at 3:49 p.m. with director of nursing (DON) B revealed: *He was unable to locate blood pressure parameters for resident 51 in her EMR. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*He verified that there were low blood pressures documented in December 2024 and January 2025. *He verified that there was a 12/16/24 progress note written in resident 51's EMR that stated a medication was held but the MAR indicated the medication was administered. *He expected that the MAR would have indicated the medication was held on that date. *He was unable to find documentation that the resident's primary care provider was notified each time a medication was held. 6. Interview on 2/27/25 at 8:30 a.m. with licensed practical nurse (LPN) K regarding resident vital signs revealed: *She would expect a nurse to be notified if a resident had any vital signs outside of the normal range. *She would then recheck the resident's vital signs and complete an assessment of the resident. *She would then notify the physician of the abnormal vital signs and the assessment of the resident. Interview on 3/4/25 at 10:28 a.m. with medical director BB revealed: *He would expect to be notified of a resident's abnormal vital signs. *He would expect if a resident was found to have vitals signs out of the normal range, the vital signs be repeated, and he would be updated on the vital signs and the resident's condition. *He expected to be contacted to determine if a medication needed to be held and to give an order to hold the medication if needed. Review of the provider's 9/30/24 Following Physician Orders policy revealed, The physician should be notified when an order is not followed for any reason (omission, medication not in stock, resident refusals, etc.) Review of the provider's December 2019 Medication Administration- General Guidelines policy revealed: *The individual who administers the medication dose records the administration on the resident's MAR/eMAR [electronic medication administration record] directly after the medication is given. *Procedures -Administration --Medications are administered within 60 minutes of scheduled time. Review of the provider's 2/14/24 Weighing the Resident policy revealed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Policy -The purpose of this procedure is to determine the resident's weight and height, to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident, and to provide a baseline height to determine the ideal weight of the resident. *Procedures -Report significant weight loss/weight gain to the charge nurse who will then report to the RD [registered dietitian] and physician. -The threshold for significant unplanned and undesired weight loss/gain will be based on the following criteria: --1 month- 5% weight loss is significant; greater than 5% is severe. --3 months- 7.5% weight loss is significant; greater than 7.5% is severe. --6 months- 10% weight loss is significant; greater than 10% is severe.

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F 0675 Level of Harm - Actual harm Residents Affected - Some	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52098 Based on observation, interview, record review, resident council interview, and policy review, the provider failed to ensure prompt response to call lights and necessary care and services were provided for eight sampled residents (4, 6, 12, 47, 51, 64, 65, and 349) and four additional council meeting residents (3, 10, 61, and 62) to maintain their physical, mental, and emotional well-being. Residents reported frustration, sadness, incontinence, and pain related to the delay in staff's response to their call lights and requests for assistance. Findings include: 1. Interview on 2/25/25 at 6:57 a.m. with registered nurse (RN) E regarding day shift staffing revealed: *RN E stated the halls/wings were staffed with two nurses. -One nurse was staffed on the T-wing/East-wing hall. -One nurse was staffed on the Red unit. *She stated the halls/wings were staffed with four certified nursing assistants (CNAs). -Two CNAs were staffed on the T-wing/East-wing hall. -Two CNAs were staffed on the Red unit. *She provided copies of the nursing staff report sheets for T-wing and the East-wing. -The report sheets identified residents that were to receive care and assistance with two people. -She stated the residents were identified as Pairs with Cares with pear signs posted outside of the resident rooms. 2. Observation and interview on 2/25/25 at 8:41 a.m. with resident 12 revealed: *He was sitting up in bed and watching television with his call light within his reach. *He stated there was not enough staff to help him and he started to cry. *He stated, I hate it here and the upper managers don't care about us, they just care about the money. *He had stated living here made him very depressed and he was tired of being here when no one cared. *He stated it had taken staff five minutes to three hours to answer his call light and sometimes staff had not come at all. (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Some	*The staff's response to answer the call light had been terrible and made him feel upset and mad. *He stated at different times he had to call the receptionist's desk on the phone and tell her to send staff for help. *He could not get out of bed by himself and required assistance from staff. *He would have liked to have been out of bed every day. *He thought he had not been out of bed since Wednesday 2/19/25. *He said he had not received his scheduled shower on Sunday 2/23/25 and had not yet been offered a shower since then. *He had stated, They don't have enough help, and I get infections because they don't take care of me right. *He felt the incontinent products he used did not fit him properly, leaked, and had caused him to have rashes in his groin area and made his skin sore. *The resident continued to cry and paused when he was unable to speak about his care. *He asked staff for different incontinence products, but no alternative had been offered. -He was unable to release the adhesive strips on the incontinence products by himself timely and would become incontinent and unable to use the urinal. *He became frustrated and mad and would refuse staff assistance by the time staff responded to his call light. -He had become tired of waiting and figured what was the point. -He said the staff would respond, shut the call light off, tell him they would return, leave, and not come back to assist him. Review of resident 12's EMR revealed: *He was admitted to the facility on [DATE]. *He had a 11/26/24 Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated he was cognitively intact. *His diagnoses included immobility syndrome (paraplegic), chronic pain, rheumatoid arthritis, and spinal stenosis (narrowing of the spaces within the spinal canal). -He was non-ambulatory. *He required two staff for assistance with his activities of daily living. (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Some	-He was identified as Pairs with Cares with pear sign posted outside of his room. -He required an EZ-stand lift (a mechanical lift used to assist from a seated to a standing position) for all transfers. Review of call light logs from 2/1/25 through 2/26/25 for resident 12 revealed: *He had utilized his call light 248 times. Of those: -45 times the response time was over 10 minutes. -40 times the response time was over 20 minutes. -21 times the response time was over 40 minutes. -16 times the response time was over 60 minutes. *The longest response time identified was one hour fifty-nine minutes and twenty-four seconds. 3. Observation and interview on 2/25/25 at 9:16 a.m. with resident 6 in his room revealed: *He was lying in bed with his call light within his reach. *He stated it could take staff one to two hours to respond to his call light. -Some staff would respond to the call light, shut it off, and leave his room without saying anything, and did not return to assist him. -Some staff were unable to assist him and would respond to the call light, tell him they would send someone to assist him, but no one would return. *He stated at different times he and his roommate had to call the receptionist's desk on the phone and tell her to send staff for help. Interview and observation on 3/4/25 at 10:09 a.m. with resident 6 in his room revealed: *He stated that he had pushed his call light at approximately 9:30 a.m. for assistance to get up out of bed. *The assistant director of nursing (ADON) C responded to the call light, shut it off, and told him she would send a CNA to assist him, and then left his room. *No CNA had come to assist him as of 10:09 a.m. *He stated some staff did a good job but most of them did not. *When surveyors were present staff would do better, but it would never last. (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Some	*He stated it was all about the money and that was the facility's primary concern. -He stated that made him feel sad and mad and his concerns should be important. *He stated staffing issues had always been a problem and would stay a problem and he felt the staff's pay was not enough for the hard work that was done. Observation and interview on 3/4/25 at 10:20 a.m. with resident 6 in his room revealed: *The resident pushed his call light for staff assistance. -He stated he needed his urinary catheter drain bag emptied. -Licensed Practical Nurse (LPN) L responded to his call light at 10:29 a.m. and assisted him. Review of resident 6's electronic medical record (EMR) revealed: *He was admitted to the facility on [DATE]. *He had a 1/16/2025 Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated he was cognitively intact. *His diagnoses included a history of an embolism with stroke, legal blindness, Type 1 Diabetes, neuromuscular dysfunction, tremor, and segmental and somatic dysfunction of the cervical region (impaired function of the spine). *He required two staff for assistance with his activities of daily living. -He was identified as Pairs with Cares with pear sign posted outside of his room. Review of call light logs from 2/1/25 through 2/26/25 for resident 6 revealed: *He had utilized his call light 116 times. Of those: -20 times the response time was over 10 minutes. -18 times the response time was over 20 minutes. -10 times the response time was over 40 minutes. -12 times the response time was over 60 minutes. *The longest response time identified was two hours forty-four minutes and twenty-nine seconds. 4. Observation on 2/26/25 at 11:39 a.m. of rooms on the East-wing and T-wing revealed: *Seven resident rooms had a Pairs with Cares symbol/sign posted on the outside of their doors. (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Some	-Two of 18 residents in the East-wing were to be assisted by two staff with their cares. -Six of 21 residents in the T-wing were to be assisted by two staff with their cares. 5. Interview on 2/26/25 at 2:01 p.m. with director of nursing (DON) B regarding nursing department staffing revealed he stated: *They utilized their own staff and were contracting with two to three travel nurses to staff appropriately. *They were currently orienting three new nursing staff employees. *The staffing ratio for the day shift for the facility units/halls were four nurses, two medication aides, and nine CNAs. *The staffing ratio for the evening/night shift for the facility units/halls was three nurses, and seven CNAs. *They currently had two to three CNA positions available for hire. *The units/halls would have had a shortage of CNAs on occasion related to staff callouts and illness. -Other staff on the units/halls and other licensed staff from management would have assisted during those staffing shortages. 6. Observation of call lights on 3/5/25 from 8:34 a.m. through 8:49 a.m. of the T-wing hall revealed: *Call lights for residents 313 and 325's rooms were alarming when the surveyor began observing at 8:34 a.m. *At 8:48 a.m. the assistant director of nursing (ADON) C responded to room [ROOM NUMBER]'s call light. -That was a minimum time of 14-minutes for staff to respond. *At 8:49 a.m. CNA R responded to room [ROOM NUMBER]'s call light. -That was a minimum time of 15-minutes for staff to respond. 7. Interview on 3/5/25 at 8:50 a.m. with restorative aide O revealed she stated she thought 10 minutes would be an appropriate amount of time to answer a resident's call light. 8. Interview on 3/5/25 at 9:17 a.m. with CNA R revealed an appropriate amount of time to answer a call light would be within seven to eight minutes, or as soon as possible. 43021 (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Some	9. Interview on 2/25/25 at 1:08 p.m. with resident 4 in her room revealed she: *Felt there was not enough staff to assist her with the care she needed. *Had waited 30 minutes to one hour, at times for her call light to be answered by the staff. *Felt the staff nurses and certified nursing assistants (CNAs) were really good but there was not enough of them to help the residents. Interview on 2/27/25 at 9:16 a.m. with resident 4 in her room revealed: *She stated having to wait a long period of time for staff to respond to her call light had become almost a daily event and staff response times were hardly ever within 15 minutes. *She said on 2/26/25 she had returned from physical therapy around 1:00 p.m. and had eaten her lunch in her room. *She then put on her call light for assistance to get into her bed. -After waiting quite a while, a staff member came into her room and turned the call light off and said she would be back as she left the room. -She stated they never come back and she sat in pain for a while. --She stated her pain level was at seven, nearing eight on the pain scale (a tool used to measure and describe the intensity of pain on a scale range from 0 to 10). --She stated her pain caused her physical distress. -She then put her call light on again and a staff member came in again and stated she was waiting for sheets to put on her bed, turned off the call light, and then left the room. --She waited in pain for another 15 to 20 minutes for the staff to return with the sheets to make her bed and then she was transferred into her bed by two staff using the full body mechanical lift around 2:30 p.m. *She stated the pain in her right leg caused her distress as she needed to lay down in her bed for the pain to ease. -She stated her pain was so intense she was frustrated and close to tears. 10. Interview on 3/5/25 at 10:45 a.m. with certified nursing assistant (CNA) S revealed: *She worked full-time at the facility on the day shift. *When fully staffed, she was responsible for assisting between eight to ten residents with their care needs. (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Some	*When not fully staffed, she was assigned to assist 18 to 20 residents. -She stated that not being fully staffed occurred randomly, she estimated about 25% of the time she worked. *She had worked on 2/26/25 and recalled the interaction with resident 4 that day after lunch. -She stated they were fully staffed that day. -She stated resident 4 had complained to her about not being transferred to bed timely. -The resident stated she waited too long for her call light to be answered and was in pain. --She added the resident is always in pain and recalled that the resident had requested her pain medication. --CNA S recalled she had informed the nurse of resident 4's request for pain medication. Review of the 2/26/25 call light log for resident 4 revealed: *At 1:27 p.m. the call light was activated with a response time of 15 minutes and 47 seconds. *At 1:57 p.m. the call light was activated with a response time of 1 minute and 46 seconds. Record review of resident 4's call light log from 2/1/25 to 2/26/25 revealed there were 20 of 58 call light response times were over 15 minutes which indicated 35% of the staff's response times to resident 4's call light were over 15 minutes. Interview and review of resident 4's call light log on 3/5/25 at 10:27 a.m. with director of nursing (DON) B revealed: *He stated his expectation was that staff would respond to residents' call lights within five to ten minutes. *He acknowledged resident 4's call light response times were long and stated There is much going on during the day and he was unable to provide a reason for those long response times. Interview and record review on 3/5/25 at 11:00 a.m. with DON B regarding resident 4's report of pain on 2/26/25 revealed: *He confirmed CNA S had worked that day. *In reviewing resident 4's medication administration record (MAR) no pain medication had been administered on 2/26/25. *The resident's February 2025 MAR included twice daily pain evaluations. -He noted that her pain rating on 2/26/25 was 0 during Day Shift and 0 on Evening Shift. (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Some	Further interview and record review on 3/5/25 at 12:23 p.m. with DON B regarding resident 4's February 2025 MAR, pain levels, and staff's comments revealed: *The February 2025 pain evaluations revealed 21 of 28 day shift ratings were 0 which indicated no pain. -One day shift pain level had been rated at six which indicated a moderate pain level. -There were no levels recorded of the resident having severe (rating of seven to nine) or excruciating pain (rating of 10). *Nineteen of 28 evening shift ratings were 0 which indicated no pain. -Seven times on evening shift her pain level had been rated at a four or five which indicated moderate pain. -There were no levels recorded of the resident having severe or excruciating pain during the evening shift. *MDS coordinator H's 2/25/25 progress note, provided by DON B revealed Resident states PRN Tramadol [pain medication] works to relieve their pain . States they sometimes get high pain but the Tramadol always helps to lower it to an acceptable level. *DON B was not sure of the reason why the resident's statements, CNA S's comment, and MDS coordinator H's progress note noted above were not accurately reflected in the resident's February 2025 pain evaluations. *DON B confirmed the resident's right leg caused her pain and that the staff should have responded timely to assist with her request to get into bed to relieve that pain. Review of resident 4's EMR revealed; *She had admitted to the facility on [DATE]. *Her 1/27/25 BIMS was 14 which indicated she was cognitively intact. *Her 1/27/25 Admission MDS indicated she experienced frequent pain at an intensity rating of seven on the pain scale that interfered with her day-to-day activities. *Her current care plan revealed: -She used a full body mechanical lift for transfers with an XL full body sling. -She was dependent on staff to assist her with toileting, personal hygiene, showers, dressing, footwear, bed mobility, and transfers. -She was at risk for pain . (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Some	-Interventions included that staff were to: --Evaluate efficacy of pain management. --Observe for non-verbal signs of pain. --Offer to medicate prior to therapy/treatment. --Utilize non-pharmacological intervention like talking to loved ones, watching television, resting, reposition, [and] elevate legs. 51472 11. Observation and interview on 2/25/25 at 9:04 a.m. with resident 64 in is room revealed: *He was sitting in his wheelchair with a full body lift sling under him. *He stated there were times he did not feel there was enough staff. *He stated there were times that it took a long time for his call light to be answered and when it was answered staff would tell him there were not enough people to help him. *He stated he has given up on turning on his call light. *He stated one time he was lying in bed and could not reach his urinal. He turned on his call light, but it was not answered before he had to urinate. He stated he urinated in the trash can beside his bed because he did not want to urinate on the floor. *He stated that he felt like a bother sometimes. *When he requested pain medication some staff would give him his pain medication, others would turn off his call light, walk out the door and not return. Interview on 3/4/25 at 9:38 a.m. with resident 64 regarding his call light revealed: *At times when he had to wait a long time for his call light to be answered he felt like the staff were just sitting around and did not want to help him. *He stated he did not like to have to wait for staff assistance and sometimes it made him upset. *He stated a times staff answered his call light promptly, turned off the call light, and told him they would return. -By the time they returned it was too late (he could not hold his urine anymore). *He felt if he was promised something by the staff it should be done. (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Some	*He felt like he could not do anything about the time it took the staff to answer call lights, or return to assist him, and that made him mad. Review of resident 64's EMR revealed: *He was admitted to the facility on [DATE]. *His 2/19/25 BIMS assessment score was 12, which indicated he had moderate cognitive impairment. *He transferred with a full body mechanical lift with the assistance of two staff. *He required staff to set up or assist with his activities of daily living. *He was occasionally incontinent of urine. *Staff were to Remind, offer and assist with toileting as needed. I use the urinal for voiding. Review of resident 64's call light logs from 2/2/25 through 2/25/25 revealed: *He had utilized his call light 36 times: -12 times the response time was greater than 10 minutes. -Six times the response time was greater than 30 minutes. -Three times the response time was greater than 45 minutes. -The longest wait time identified was one hour four minutes and fifty-one seconds. 12. Interview on 2/25/25 at 8:57 a.m. with resident 51 in her room revealed: *She stated when she asked for staff to do something, at times it takes a while. *She stated she had been incontinent of urine while she waited for her call light to be answered by the staff and that happened more than one time. Observation and interview on 2/27/25 at 9:47 a.m. with resident 51 in her room revealed: *She was lying in bed. *Her call light was draped over the bedside table away from her bed and out of her reach. *She requested her call light be given to her so she could call someone. *She stated she felt very restless when she had to wait for her call light to be answered. Review of resident 51's EMR revealed: (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Some	*She was admitted on [DATE]. *Her 2/18/25 BIMS assessment score was 9, which indicated she had moderate cognitive impairment. *She required staff assistance with all her activities of daily living. *She had a history of falling. Interview on 2/27/25 at 8:30 a.m. with licensed practical nurse (LPN) K revealed it was her expectation that residents' call lights be answered within ten minutes. 51816 13. Observation and interview on 2/25/25 at 2:11 p.m. with resident 349 and his wife about call light response time revealed: *The resident was sitting in his recliner and his call light was on his bed out of his reach. *His wife stated, They have some definite issues with that here. *He stated he felt frustrated. *He would put his call light on to get help from staff to go to the bathroom, and it would sometimes take forever for his light to be answered. *He said sometimes, by the time he got help, it was too late, and he would become incontinent. *He said this made him feel like an old person. *He said he knew it was because they were short-staffed and [CNA V] is great, and she is doing all she can, but there was just too much work for the staff that's here. Review of resident 349's EMR revealed: *He was admitted on [DATE]. *He had a 2/17/25 BIMS assessment score of 13, which indicated he was cognitively intact. *He required substantial/maximal staff assistance with toileting hygiene. *He was at risk for falls related to his Parkinson's disease. *Staff were to: -Keep his call light within his reach. -Remind, offer and assist him with toileting as needed. (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Some	No call light logs were available for review for resident 349's room. It was located in a part of an addition to the facility where call light audits had not been available. 45383 14. Interview on 2/27/25 at 7:30 a.m. with resident 65 regarding call light response time revealed: *One time she had to wait so long that it pissed her off so she wheeled herself over to the call buttons on the wall and pushed the emergency button. *She stated that the call light response times had been discussed as a concern in resident council meetings with no change or improvement. Review of resident 65's EMR revealed: *She had a BIMS score of 14 that had been completed on 12/17/24 which indicated she was cognitively intact. *She required the assistance of two staff and a total lift to transfer from her bed to her wheelchair. Review of call light times from 2/1/25 through 2/26/25 for resident 65 revealed: *Forty times the resident waited longer than 10 minutes for a staff response. *Three times she had waited for 50 minutes to one hour for her call light to have been answered. 15. Interview on 3/5/25 at 9:04 a.m. with administrator A regarding a staffing policy revealed: *Staffing was based on resident census and acuity. *She would have used her facility assessment to assist with staffing as well. 16. Review of the 8/2023 through 7/2024 facility assessment regarding staffing for the nursing department revealed: *Licensed nurses providing direct care needed was seven. *Nurse aides needed was 17. *Other nursing personnel (e.g., those with administrative duties) was eight. *Instructions were to consider if and how the degree of fluctuation in the census and acuity levels impact staffing. *This plan referred to CMS Minimum staffing rule. 45683 (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Some	17. Interview on 2/25/25 at 9:45 a.m. with resident 47 in her room regarding call light response wait times revealed: *She had waited long periods of time for her call light to get answered by the staff and she had experienced pain. *She required more assistance when she returned from dialysis because she felt weaker on those days. *She would be embarrassed if she had an accident related to waiting for staff to assist her. *She wore a Rooke Boot (a boot that provided redistribution of pressure along the calf to help treat and prevent lower-extremity skin breakdown) on her left foot. -The Rooke boot limited her mobility. -Staff were needed to help her transfer in and out of bed. Review of resident 47's EMR revealed: *She was admitted on [DATE]. *She had an 11/7/24 BIMS score of 15 which indicated she was cognitively intact. * Her dialysis schedule was Monday, Wednesday, and Friday. Review of call light times from 2/1/25 through 2/26/25 revealed resident 47 waited longer than 10 minutes for a staff response 51 times. 18. Resident council meeting held on 2/26/25 at 1:30 p.m. with residents 3, 10, 12, 61, and 62 regarding staff response to resident call lights revealed: *Call lights were not answered timely in the afternoon, evening, during meals, and at staff shift change. *Call lights had been brought up at resident council meetings in the past. *The staff response times would get better for a while, but then it would go back to long wait times. *They felt there was no consistency to address the call light issue. *They expressed that they were frustrated with the lack of oversight and response to the call lights. 19. Interview and resident council meeting minutes review on 3/4/25 at 9:50 a.m. with social services DD regarding resident council meetings revealed: (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Some	*If an issue was brought up during resident council meetings a grievance form was filled out and it was given to the appropriate department to be addressed. *Call light issues were normally investigated by the administrator. *She confirmed resident call lights were an issue that had been brought up at multiple meetings. *Resident council meeting minutes dated 2/12/25 revealed under old business: -Staff stating they return and not returning in a timely manner. -Nine residents agreed it was resolved. -Six residents disagreed it was resolved, indicating it was still an issue. 20. Interview on 3/5/25 at 11:56 a.m. with administrator A and DON B regarding call lights revealed: *Call light time expectations for staff answering them was 10 minutes or less. *There may be times when an incident happened that the response could take longer. *Staff had been educated about answering call lights. *Staff were to inform the resident if extra help was needed. *It was their expectation that all staff would answer call lights. *They confirmed that residents requiring staff assistance should have had their needs met in a timely manner. *They were unaware of any psychosocial or emotional distress being caused to residents. 21. Review of the provider's 9/30/24 revised Call Lights policy revealed: *It is the policy of the facility to ensure that there is prompt response to the resident's call for assistance. *1. Facility shall answer call lights in a timely manner. If immediate assistance cannot be provided and there is not an emergent need, call light may be turned off and resident informed that staff member will be back to assist them shortly. *2. Orient all new residents to the call light at bedside as well as the call light in the bathroom and in the shower or tub rooms, as applicable. *3. If a call light is not functional, notify the Administrator or Maintenance Director immediately. Evaluate and provide another means in order for the resident to call for assistance (i.e. bell) until the call light is fixed. (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Some	*4. Ensure call lights are placed within reach of residents. *5. Ensure that when the call light is triggered, it will either alert the staff visually or audibly or both. *6. For residents who are physically unable to depress the traditional call light but cognitively able to call for help, evaluate the need for alternate call system i.e., soft touch, mouth call light activator, etc.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51472 Based on observation, record review, interview, and policy review, the provider failed to ensure proper infection control practices had been followed for six of six sampled residents (6,12,22,32,54, and 62) who required respirator devices had appropriate cleaning, storage, and replacement of those devices. 1. Observation and interview on 2/25/25 at 6:49 a.m. with resident 54 in his room revealed: *There was an oxygen concentrator at his bedside. *There was a continuous positive airway pressure (CPAP) machine (a machine to treat sleep-related breathing issues) on his bedside table. *He had lived in the facility for about three weeks. *He indicated he wore the oxygen as needed. *He stated he was supposed to wear the CPAP every night, but he had only been using it intermittently at night. *He was admitted to the facility with oxygen and the CPAP. Observation on 2/26/25 at 11:14 a.m. of resident 54's room revealed: *The room door was open but resident 54 was not in his room. *The oxygen nasal cannula (tubing that delivers oxygen through the nose) was lying on the floor. *There was no date written on the nasal cannula tubing. *There was no bag or other containment device for the nasal cannula to be stored in while it was not being used. *The concentrator oxygen flow level was set at 2 L and oxygen was flowing out of the nasal cannula. *The oxygen concentrator (a machine the purifies surrounding air into breathable oxygen) filter was coated in a thick layer of gray fuzz. *The CPAP mask and tubing were draped over the oxygen concentrator and air was flowing from the mask. Observation and interview on 2/26/25 at 1:21 p.m. with resident 54 revealed: *He was sitting in his recliner. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The oxygen nasal cannula was lying on the floor. *The oxygen concentrator was running. *He stated that his nasal cannula had been replaced one time since he was admitted to the facility. *He was unsure if anyone had cleaned his CPAP tubing but thought someone might have wiped off his CPAP mask. Review of resident 54's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *His 2/2/25 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated he was cognitively intact. *His diagnoses included chronic (long term) respiratory failure with hypoxia (low oxygen levels in the blood), diabetes, and heart failure. *There was a 1/22/25 physician's order for 2L [2 liters] [of] O2 [oxygen] as needed for hypoxia. *There was no physician's order for the CPAP use. *There was no task in the MAR or TAR to replace the nasal cannula. *There was no task in the MAR or TAR to rinse or replace the filter on the concentrator. *There was no task in the MAR or TAR to clean the CPAP machine, mask, or tubing. *There was no task in the MAR or TAR to replace the CPAP mask or tubing. 2. Observation and interview on 2/25/25 at 8:54 a.m. with resident 62 while lying in her bed revealed she: *Had been wearing oxygen by nasal cannula at 2 liters per minute. *Had used oxygen at night while sleeping. *There had not been a plastic bag for storage of the nasal cannula when not in use. Observation on 2/26/25 at 11:54 a.m. of the filter on the back of the resident 62's concentrator revealed the intake grate contained dust and debris. Review of resident 62's MAR and TAR revealed there had been no documentation the concentrator filter had been cleaned or the oxygen tubing had been changed. 3. Observation on 2/25/25 from 5:55 a.m. through 6:42 a.m. of resident 32 in her room revealed: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She had been in bed asleep. *An oxygen concentrator had been running. -She was wearing oxygen via a nasal cannula at five liters per minute (5 lpm) -The extra nasal cannula tubing had been lying on the floor. *A nebulizer machine (a small machine that turns liquid medication into a mist that can be inhaled through a mask or mouthpiece) had been stored on the bottom shelf of a small wooden stand. -The nebulizer tubing had been lying on the floor. -The nebulizer mask had been assembled and stored on top of the nebulizer machine. Observation and interview on 2/25/25 at 12:16 p.m. with resident 32 revealed: *She had been sitting in her wheelchair. *The oxygen concentrator machine had been running with no humidification or filter. -The filter intake grate on the back of the concentrator had been visibly dirty with dust. *Oxygen had been running at five liters per nasal cannula. *Oxygen tubing on the concentrator had been dated 2/16/25 and initialed by staff. -The extra nasal cannula tubing had been lying on the floor. -There had been no storage bag or other containment device for the nasal cannula tubing to have been stored when not in use. *Her nebulizer tubing and mask had been dated 2/16/25 and initialed by staff. -The mask had not been stored on a barrier to protect it from contamination. *Her portable O2 tank tubing had been dated 2/16/25 and initialed by staff. -There had not been any storage bag or other containment device for the nasal cannula tubing to have been stored when not in use. Interview on 3/4/25 at 11:04 am with resident 32 revealed: *She had been sitting in her wheelchair. *Her oxygen concentrator had been running without a filter. -The filter intake grate on the back of the concentrator had been visibly dirty with dust. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She had been unsure when staff had changed her oxygen or nebulizer tubing and supplies. *She stated staff did not clean the nebulizer mask after each use. *The nebulizer mask remained assembled and stored on top of the nebulizer machine. *The extra 14-foot nasal cannula tubing was lying on the floor. Review of resident 32's EMR revealed: *She had been admitted on [DATE]. *Her 2/12/25 BIMS assessment score was 10, which indicated she had moderate cognitive impairment. *Her EMR contained orders for the following: *Order dated 5/8/24 was to change nebulizer tubing, date and initial every Saturday night shift. -This indicated her nebulizer tubing should have been replaced on 2/22/25. *Order dated 7/10/24 was to rinse the concentrator filter with warm water and let dry every Saturday night shift. *Order dated 7/10/24 was to change oxygen tubing, date and initial every Saturday night shift. -This indicated her oxygen tubing should have been replaced on 2/22/25. 4. Observation on 2/26/25 at 11:55 a.m. with resident 6 in his room revealed: *His nebulizer machine was stored on his bedside table. -The nebulizer tubing was not dated. -The nebulizer pipe was assembled, dated 2/26/25, and next to the nebulizer machine. -The pipe was stored on top of a roll of clear trash bags and a small green spray bottle of men's body spray. -No clean barrier was noted to protect the nebulizer from potential contamination. Observation on 3/4/25 at 10:46 a.m. of resident 6's room revealed the nebulizer machine remained stored on the dresser. Observation on 3/4/25 at 10:57 a.m. of resident 6's room revealed: *The nebulizer machine was stored on his bedside table. *The nebulizer tubing was now dated 2/27/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The intake grate contained dust, lint fibers and had no filter. 6. Observation on 2/25/25 at 12:50 p.m. of resident 22's room revealed: *An oxygen concentrator was running at 4L via nasal cannula tubing. -The tubing was not dated or initialed. *There was no storage bag or other containment device for the nasal cannula tubing to be stored. *Her nebulizer machine with tubing and assembled mask was stored on top of the resident's dresser. -No barrier was used. -The nebulizer tubing was dated 2/9/25 and not initialed. -The nebulizer mask was not dated or initialed. Review of resident 22's EMR revealed: *Oxygen tubing was to be changed weekly on Sunday night. -Tubing should have been changed on 2/23/25. *Concentrator filter should have been cleaned weekly on Sunday night and as needed. -Filter should be rinsed with water and allowed to dry. 7. Interview on 2/26/25 at 11:27 a.m. with registered nurse (RN)/unit manager F revealed: *Oxygen tubing, cannulas, masks, and supplies for the nebulizer devices were to be replaced weekly, usually on the night shift. *An order was entered into the resident's chart for replacing those items. *That task was to be documented on the medication administration record (MAR) or treatment administration record (TAR) according to how the order was entered. *Oxygen cannulas were to be stored in privacy covers while not in use. *He was unsure about the process of cleaning the oxygen concentrator filter. Continued interview on 2/26/25 at 12:12 p.m. with RN/unit manager F revealed the filters on the concentrators were to be cleaned by the oxygen supplier. 8. Interview on 2/26/25 at 1:33 p.m. with certified nursing assistant (CNA) U regarding the cleaning of oxygen concentrator filters revealed she had worked here four months and had not been assigned the task to clean oxygen concentrator filters. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She had been unsure of who should have been cleaning the concentrator filters. 9. Interview on 2/26/25 at 1:40 p.m. with assistant director of nursing (ADON) C revealed: *Nebulizer masks should have been disassembled, rinsed with water and placed on a barrier (clean paper towel) and air dried. *She was unsure about the oxygen concentrator and nebulizer filter cleaning. 10. Interview on 2/26/25 at 2:01 p.m. with director of nursing (DON) B revealed: *He stated the oxygen tubing should have been changed weekly on Sundays. -It was a task on the treatment administration record (TAR) completed by the nurses. *Oxygen concentrators are rented through a vendor and were scheduled every Friday to replace oxygen tanks. -He was unsure if they checked the concentrator filters. -He would need to contact the vendor about the filters. -Staff should have cleaned the filters as needed. *Nebulizer tubing and supplies should have been changed weekly on Sundays. -Nebulizer masks/pipes should have been rinsed with water, placed on clean surface (paper towel) to air dry. *He would need to refer to the policy on dating and timing of the oxygen and nebulizer tubing. 11. Interview on 2/26/25 from 3:07 p.m. through 3:17 p.m. with registered nurse (RN) G revealed: *Oxygen and nebulizer supplies should have been changed weekly. -She stated the night shift would usually complete that on Sundays. 12. Interview on 3/4/25 at 2:03 p.m. with ADON C revealed: *She was the infection preventionist for the facility. *Oxygen and nebulizer supplies were to be changed weekly on Sunday nights. *The supplies were to be dated and initialed by the person who completed the change when they were replaced. *Oxygen tubing, masks, and nasal cannulas were to be stored in a bag when they were not in use to keep them free from potential contamination. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The oxygen concentrator filters were to be cleaned with a mild detergent or changed, depending on the concentrator. *CPAP mask, tubing, and humidification chamber were to be washed with a mild detergent every morning and hung to dry. *The orders for the cleaning and changing of the supplies were to be entered by the unit managers when a resident was admitted with or began receiving oxygen therapy, nebulizer treatments, or a CPAP. *It was her expectation for nasal cannulas or other supplies to be replaced if they were on the floor or in contact with any contaminated surface. 13. Review of the providers 2/2/2024 Nebulizer Cleaning policy revealed: *Nebulizer set will be replaced and dated weekly. *After each use, the mask/reservoir will be cleaned. Rinse mask/reservoir with tap water and place upside down to dry on a paper or cloth towel. *Weekly the mask/reservoir and tubing will be replaced, and the outside of the machine will be disinfected with disinfectant wipes. Review of the provider's 11/19/24 Oxygen Administration policy revealed: *Oxygen masks and tubing will be changed weekly and as needed. Change tubing and mask should be documented in the medical record. When not in use, the nasal cannula should be stored in a plastic bag. *Oxygen concentrators will have exterior wiped down when soiled and at least weekly. If equipped with a filter, filter will be cleaned at least weekly by rinsing with water and allow to dry. If filter becomes torn, filter should be replaced. Weekly cleaning of the concentrator and filter should be documented in the medical record. Review of the provider's 2/20/24 CPAP and BiPAP Cleaning policy revealed: *After each use, the mask/reservoir will be wiped with warm soapy water per manufacturer's instructions, rinsed, and placed upside down to dry on a paper towel. *The tubing will be replaced, and the machine should be wiped down per manufacturer's instructions on a weekly basis. 45383 52098

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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. 52098 Based on observation, interview, record review, and policy review, the provider failed to follow acceptable food standards and their policies to ensure refrigerator temperatures were properly maintained and documented for safe food temperatures, food was labeled, stored, and monitored for safe consumption and to prevent potential outbreaks of foodborne illness for thirteen of thirteen observed residents' (1, 6, 18, 19, 22, 36, 37, 44, 49, 50, 63, 65, and 79) personal refrigerators. Findings include: 1. Observation on 2/25/25 from 9:15 a.m. through 12:50 p.m. of residents' personal refrigerators and review of temperature logs revealed: *The temperature logs did not indicate: -The temperature should have been in a certain range (i.e. 41 Fahrenheit (F) or lower). -What should have been done if the temperature was out of an acceptable range or higher than 41 F. *Resident 1's refrigerator was missing temperature documentation for 2/1/25, 2/2/25, 2/7/25, 2/8/25, 2/9/25, 2/15/25, 2/16/25, 2/20/25, and 2/24/25. *There was no thermometer in the refrigerator. *Resident 1 had documented refrigerator temperatures above 41 Fahrenheit (F) which allowed for the rapid growth of pathogenic microorganisms that can cause foodborne illness. -On 2/3/25, 2/4/25, and 2/17/25 the refrigerator temperatures were 42 F -On 2/5/25, 2/6/25, 2/10/25, 2/11/25, 2/12/25, 2/14/25, and 2/21/25 the temperatures were 43 F. -On 2/13/25, 2/22/25, and 2/23/25 the temperatures were 44 F. *Resident 6's refrigerator was missing temperature documentation for 2/1/25, 2/2/25, 2/7/25, 2/8/25, 2/9/25, 2/15/25, 2/16/25, 2/19/25, 2/20/25, 2/21/25, 2/22/25, 2/23/25, and 2/24/25. *Resident 6 had documented refrigerator temperatures above 41 F. -On 2/3/25, 2/4/25, 2/10/25, 2/11/25, 2/12/25, 2/13/25, 2/14/25, and 2/17/25 the refrigerator temperatures were 42 F. -On 2/5/25, and 2/6/25 the refrigerator temperatures were 43 F. *Resident 6 shared the refrigerator with resident 12. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was a small unlabeled zip-lock bag dated 2/19/25 with one to two slices of unidentified meat on the top shelf of the refrigerator. -Resident 12 stated, It's roast beef and I plan to eat it in the next day or two. -There was no use by date on it. -Other foods and beverages in the refrigerator were not labeled for each resident. *Resident 22's refrigerator was missing temperature documentation for 2/1/25, 2/2/25, 2/7/25, 2/8/25, 2/9/25, 2/15/25, 2/16/25, 2/20/25, 2/22/25, 2/23/25, and 2/24/25. *Resident 37's refrigerator had no temperature log or documentation for February 2025. *There was no thermometer in the refrigerator. *Resident 50's refrigerator was missing temperature documentation for 2/1/25, 2/2/25, 2/3/25, 2/4/25, 2/5/25, 2/6/25, 2/7/25, 2/8/25, 2/9/25, 2/10/25, 2/11/25, 2/12/25, 2/15/25, 2/16/25, 2/20/25, 2/22/25, 2/23/25, and 2/24/25. *There was no thermometer in the refrigerator. *Resident 50 had documented refrigerator temperatures above 41 F. -On 2/14/25, and 2/17/25 the refrigerator temperatures were 43 F. *Resident 65's refrigerator was missing temperature documentation for 2/1/25, 2/2/25, 2/7/25, 2/8/25, 2/9/25, 2/15/25, 2/16/25, 2/20/25, and 2/24/25. *Resident 79's refrigerator was missing temperature documentation for 2/1/25, 2/2/25, 2/3/25, 2/7/25, 2/8/25, 2/9/25, 2/15/25, 2/16/25, 2/19/25, 2/20/25, and 2/24/25. *There was no thermometer in the refrigerator. *Resident 79 had documented refrigerator temperatures above 41 F. -On 2/13/25 the refrigerator temperature was 42 F. -On 2/4/25, 2/5/25, 2/6/25, 2/14/25, 2/17/25, 2/18/25, and 2/21/25 the refrigerator temperatures were 43 F. -On 2/22/25, and 2/23/25 the refrigerator temperatures were 44 F. -On 2/11/25, and 2/12/25 the refrigerator temperatures were 45 F. -On 2/10/25 the refrigerator temperature was 46 F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on 2/26/25 from 8:35 a.m. through 11:39 a.m. of residents' personal refrigerators and review of temperature logs revealed: *Resident 18's refrigerator was missing temperature documentation for 2/1/25, 2/2/25, 2/7/25, 2/8/25, 2/9/25, 2/15/25, 2/16/25, 2/17/25, 2/18/25, 2/21/25, and 2/24/25. *Resident 19's refrigerator was missing temperature documentation for 2/1/25, 2/2/25, 2/7/25, 2/8/25, 2/9/25, 2/15/25, 2/16/25, 2/20/25, 2/22/25, 2/23/25, 2/24/25, and 2/25/25. *Resident 36's refrigerator was missing temperature documentation for 2/1/25, 2/2/25, 2/7/25, 2/8/25, 2/9/25, 2/15/25, 2/16/25, 2/20/25, and 2/24/25. *There was no thermometer in the refrigerator. *Resident 44's refrigerator was missing temperature documentation for 2/1/25, 2/2/25, 2/5/25, 2/7/25, 2/8/25, 2/9/25, 2/15/25, 2/16/25, 2/20/25, 2/24/25, and 2/25/25. *Resident 44 had documented refrigerator temperatures above 41F . -On 2/10/25 the refrigerator temperature was 42 F. *Resident 49's refrigerator was missing temperature documentation for 2/1/25, 2/2/25, 2/5/25, 2/6/25, 2/7/25, 2/8/25, 2/9/25, 2/15/25, 2/16/25, 2/19/25, 2/20/25, and 2/24/25. *There was no thermometer in the refrigerator. *Resident 49 had documented refrigerator temperatures above 41F . -On 2/10/25 the refrigerator temperature was 44 F. *Resident 63's refrigerator was missing temperature documentation for 2/1/25, 2/2/25, 2/7/25, 2/8/25, 2/9/25, 2/15/25, 2/16/25, 2/20/25, 2/22/25, and 2/24/25. *The residents' personal refrigerator log did not include accurate identifying information. -The temperature logs had the room numbers written on them. -The room numbers did not distinguish which resident's refrigerator it was or if it was a double occupant room. 3. Interview on 2/26/25 at 1:40 p.m. with assistant director of nursing (ADON) C revealed: *She was the provider's infection preventionist. *Regarding infection control guidelines for residents sharing refrigerators in their rooms, she stated: -Resident 6 was the only resident who shared a refrigerator with his roommate. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident 6 and resident 12 had been roommates for a long time. -The facility respected resident 6's decision to share his refrigerator with resident 12. *The housekeepers were responsible for the cleaning and maintenance of residents' personal refrigerators. -The residents' refrigerators should have had temperature checks completed and documented, and the food should have been monitored daily. *Refrigerator temperature logs should have been in the resident rooms. -The resident's refrigerators should have been checked for appropriate temperatures and food items being labeled, dated, and discarded based on a use-by date. *She was unsure if each resident refrigerator should have had a thermometer in it and deferred the surveyor to ask housekeeper Z. 4. Interview on 2/26/25 at 2:01 p.m. with director of nursing (DON) B regarding residents' refrigerators revealed: *The housekeepers were responsible for checking temperatures and cleaning the residents' personal refrigerators. *He would need to refer to the policy for the process but stated, I thought it was completed daily. *The residents' refrigerator temperature logs were maintained by housekeeper Z. *He stated thermometers should have been in all residents' personal refrigerators. *The resident should get permission from their roommate to share the refrigerator if they chose to do so. *The facility should respect the resident's decision and follow the policy. 5. Interview on 2/26/25 at 2:38 p.m. with housekeeper Z revealed: *Housekeeping staff were responsible for monitoring and maintaining the residents' personal refrigerators. *Resident refrigerator temperatures should have been checked and documented daily on the temperature logs. *She used an infrared thermometer laser gun to check temperatures of residents' refrigerators with no thermometers. *She thought the resident refrigerator temperatures should have been maintained between 38 F and 45 F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She stated she determined the temperature parameters for the resident refrigerators. -She was unaware of the Danger Zone temperatures above 41 F and below 135 F according to the Food and Drug Administration (FDA) for food safety. *She stated the logs had missing temperatures but did the best she could with that. *The resident's refrigerator logs were collected at the end of the month and maintained in a binder in her office. *Food and beverages in the resident refrigerators should have been checked by the housekeepers for outdated items daily. *Food should have been labeled and dated when it was opened. -Opened food items should have been thrown out after 48 hours. *Foods in resident refrigerators including food brought in to the residents by family and friends should have been labeled and dated for safety. -She was unaware of the unlabeled meat dated 2/19/25 in resident 6's refrigerator that belonged to resident 12. -She stated that residents 6 and 12 were the only residents in the facility that shared a refrigerator. -It was the choice of resident 6 if he wanted to share his refrigerator with resident 12. *The refrigerators were cleaned as needed by housekeeping. *Housekeeping did not have a policy for resident's personal refrigerators. -There were no cleaning records for resident refrigerators for February 2025. *If temperature or other problems were identified with the resident refrigerators staff should have contacted maintenance staff. -There were no work orders for resident refrigerators for February 2025. Review of the provider's 8/8/19 Record of Refrigeration Temperatures policy revealed: *A daily temperature record is to be kept of refrigerated items. *The refrigerator must be clean, and temperatures must be 41 F or less per the food code, a 1-2-degree variance is allowed for accuracy. *Temperatures greater than these areas are to be reported immediately. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Note on the temperature forms the plan of action taken when temperatures are not in acceptable range. *Have work orders in writing as proof of requested work. *Nursing unit refrigerators and freezers and any other refrigerators/freezers having resident food stored in it must be clean, have 'Use-By Dates' on food products (not outdated), and have temperatures recorded. Medications and food cannot be stored together. Employee food and resident food should not be stored together. The community designates the cleaning of the refrigerator and freezer and the recording of temperatures. Review of the provider's 8/31/18 Cultural Change in Dining Services policy revealed: *The community still has [the]responsibility to store, prepare and serve food in a manner that prevents contamination and spread of food-borne illness: -Protect food from contamination; -Ensure temperature control (hot food hot; cold food cold); *The community has [the] responsibility to: -Train and educate residents and staff; -Provide individual packaging where appropriate; -Involve residents in review of person-directed policies and procedures. *In order to preserve sanitary conditions, the community must do the following in person-centered dining: -Temperature monitoring; -Food labeling and dating; -Discarding oversight; -Monitor all dining areas for sanitary conditions. *The resident has the right to have food from outside or brought in by family. -The staff ensures that this food is: -Safely handled; -Labeled and dated; -If leftovers, store in refrigerator.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 45683 Based on observation, interview, record review, and policy review, the provider failed to ensure the facility was operated and administered by administrator A, director of nursing (DON) B, assistant director of nursing (ADON) C, and unit managers F and G, in a manner that ensured quality of life and overall well-being for all 94 residents in the facility. Findings include: 1. Observations, interviews, record reviews, and policy reviews throughout the survey on 2/25/25 through 2/27/25 and 3/4/25 through 3/5/25 revealed administrator A, DON B, ADON C, and unit managers F and G, had not ensured the quality of life and overall well-being of all the residents who lived in the facility. This was evidenced by: *A widespread system breakdown to ensure infection control practices, policies and procedures were followed regarding: -Enhanced barrier precautions. -Personal protective equipment. -Air-borne vs. droplet precautions as it pertained to Covid. -Hand hygiene. -Oxygen concentrator preventive maintenance. *The development and revision of care plans in a timely manner. *Services provided to meet professional standards as it pertained to medication administration and physician notifications. *Responsiveness to residents' concerns with call lights and staffing issues that resulted in an overall negative effect on the residents' psycho-social well-being. Refer to F656, F658, F675, F695 and F880.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 45683 Based on observations, interview, record reviews, and policy reviews, the governing body failed to ensure the facility was operated in a manner that ensured the overall quality of life and well-being for all 94 residents in the facility. Findings include: 1. During the survey from 2/25/25 through 2/27/25 and 3/4/25 through 3/5/25 deficient practices identified the provider had not been operating in a manner to ensure the residents had received quality care. Refer to F582, F656, F658, F675, F695, F812, F835, and F880.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45383 Based on observation, interview, and policy review, the provider failed to ensure proper infection control practices had been followed for: *Two of two sampled residents (5 and 70) who had wound dressings changed by two of two observed staff licensed practical nurse/wound nurse (LPN) M and certified nurse practitioner (CNP) CC. *Four of four sampled residents (29,34, 345, and 350) who required Enhanced Barrier Precautions (EBP) (an infection control strategy in nursing homes that expands the use of personal protective equipment (PPE) specifically gowns and gloves, during high contact resident care activities to reduce the transmission of multi-drug-resistant organisms (MDROs). *Four of four sampled residents (5, 6, 35, 37, and 64) who had unlabeled personal care products to identify the correct resident for usages. Findings include: 1. Observation on [DATE] at 9:13 a.m. with LPN/wound nurse M and CNP CC while they performed a dressing change for resident 70's abdominal wound revealed: *Dressing supplies had been placed on a clean barrier on the resident's bedside table by LPN/wound nurse M. *CNP CC had put on a pair of gloves prior to entering the room and then performed wound debridement (removal of dead or infected tissue) to resident 70's abdomen with a gauze pad and then cleaned the wound with Vashe wound wash. *CNP CC removed his gloves and did not perform hand hygiene (washing or sanitizing of hands) and put on a new pair of gloves. *LPN/wound nurse M put on a pair of gloves touched the resident's blanket with her left gloved hand, and used a gauze pad to wipe the wound with her right hand. *With those same gloved hands, she: -Opened a sterile tongue depressor and applied collagen powder (to help with wound healing) onto the resident's abdominal wound. -Used an ink pen from the resident's room, dated the dressing, and applied it to the resident's abdominal wound. *LPN/wound nurse M removed her gown and gloves, placed them in the garbage, and performed hand hygiene. Then she: -Left the Vashe wound wash in the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Removed the garbage. *Performed hand hygiene before leaving the resident's room. Interview with LPN/wound nurse M following the above observation revealed: *She would typically help with cueing wound care personnel about hand hygiene if they did not do that correctly. *She agreed CNP CC had missed some opportunities when he should have performed hand hygiene. 2. Observation on [DATE] at 9:40 a.m. of LPN/wound nurse M and CNP CC while they performed a dressing change on resident 5's right leg wounds revealed: *CNP CC performed hand hygiene and put on a pair of gloves. *LPN/wound nurse M had been gathering supplies for the dressing change. *CNP CC had removed his gloves in the resident's room, performed hand hygiene, and put on a new pair of gloves. *With those gloved hands he removed the resident's soiled dressing from the right leg wound. *He then removed those gloves and put on a new pair of gloves without performing hand hygiene. *CNP CC then: -Measured the resident's wound and took a picture of it. -Touched the camera and screen of the iPad. -Reached into his pocket of his jacket and grabbed a packaged scalpel and opened the package. -Removed his gloves and performed hand hygiene. *LPN/wound nurse M reminded him that they needed to wear a gown while performing the dressing change. -Resident 5 was on EBP due to his open wound to his right leg. *CNP CC then applied his gown and with those same pair of gloves he performed wound cleansing to the resident's right leg wound. *With those same pair of gloves he proceeded to the next task of wound care. He then: -Began debriding the resident's right leg wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Obtained another picture of the resident's wound. -Touched the iPad screen with his gloved hands. *Removed his gloves and performed hand hygiene. 3. Observation on [DATE] at 6:00 a.m. of resident 34's door revealed there had been one sign on the door requesting for staff/visitors to please knock on the door and wait for him to respond before entering. Continued observation on [DATE] at 6:47 a.m. of resident 34's door now revealed another sign had been added to his door that directed the staff to use EBP when assisting him with personal cares. Observation and interview on [DATE] at 8:49 a.m. with resident 34 while he was lying in bed revealed: *He had a dressing on his right leg that had been dated [DATE]. *He stated he had a skin infection to his right leg and required a dressing change to it every week. Review of resident 34's electronic medical record (EMR) revealed on [DATE] a physician's order had been given for wound care to his right lower leg abrasions. The EBP sign had not been placed on his door to direct the staff to use the appropriate PPE while assisting him with personal care and wound care until 114 days after it was identified that he had wounds on his right leg that required treatment. The initiation of that sign had not occurred until after the surveyors had entered the facility and started the survey process. 51472 4. Observation and interview on [DATE] at 9:04 a.m. with resident 64 in his room revealed: *Resident 64 shared a room with resident 35. *On the counter surrounding the sink were: -Three syringes and two graduate containers (plastic containers with markings to measure liquid). --One of those containers was labeled as resident 64's and was dated [DATE]. --There were no resident identifiers or dates on the syringes. -An opened bottle of wound cleanser without a resident's name or date on it. -Two plastic kidney-shaped basins with a toothbrush and toothpaste in each. --There were no resident identifiers or dates on those basins or toothbrushes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Roll on deodorant without a resident identifier or date when it was opened. -A bladed razor on the shelf above the sink without a resident identifier written on it. *Under the sink, lying on the floor there was a bedpan that was not in a bag and did not have a resident identifier on it or a date. *Resident 64 was able to identify the wound cleanser as something that was used to clean around his feeding tube before he had it removed. *He was unable to identify if any of the other personal supplies were his or his roommates. 5. Interview on [DATE] at 1:41 p.m. with CNA U regarding residents' personal supplies revealed: *They were changed every 14 days or if they were soiled or missing. *They were to be labeled with the resident's name, room number, and the date of the change. *The personal items for the resident in bed A were placed on one side of the sink and the personal items for the resident in bed B were placed on the other side. *The date on the items were to alert staff when the personal items needed to be changed. *There was no place to document that the personal items were changed. 6. Interview on [DATE] at 2:03 p.m. with assistant director of nursing (ADON) C revealed: *She was the infection preventionist for the facility. *Residents' personal supplies were to be changed when worn, soiled, after illness, if expired, or if a change was requested. *The residents' personal supplies were to be dated and marked with the initials of the resident to determine who the personal supply belonged to. *She felt the provider needed a better process in place for the replacement of personal supplies. *It was her expectation that nothing be stored under a sink to protect from contamination and a bedpan that was not in a bag should not have been directly on the floor. 51816 7. Observation on [DATE] at 5:59 a.m. of resident 29's room revealed: *His light was off, and his door was mostly closed. *There was no personal protective equipment (PPE) (equipment worn to minimize exposure to hazards) or sign posted that indicated staff were to use EBP when providing contact care on his door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 9:38 a.m. revealed that PPE and a sign that indicated the need for EBP had been placed on his door. Review of resident 29's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *He had a [DATE] Brief Interview for Mental Status (BIMS) assessment score of 0, which indicated he had severe cognitive impairment. *His diagnoses included unspecified dementia, unspecified severity, and presence of other vascular implants and grafts (artificial devices implanted to maintain blood flow). *A [DATE] skin evaluation indicated an open area inside right buttocks and manager on duty notified. -The presence of a wound would indicate the need for EBP. *His care plan included a [DATE] initiated focus area of EBP for wound care. The EBP sign had not been placed on his door to direct the staff to use the appropriate PPE while performing wound care until 4 days after it was identified that he had a wound that required treatment. The initiation of that sign had not occurred until after the surveyors had entered the facility and started the survey process. 8. Observation on [DATE] at 6:01 a.m. of resident 345 in his room from the hallway revealed: *He was resting in his bed. *There was no PPE or any sign indicating the need for EBP on his door. *He had a urinary catheter (a thin, flexible tube inserted into the bladder to drain urine) hanging on his bed frame. -The presence of a urinary catheter would indicate the need for EBP. Interview on [DATE] at 6:04 a.m. with certified nursing assistant (CNA) Q when she exited resident 345's room about what care she had provided for him revealed: *She stated she had just emptied his urinary catheter. *She had not worn a gown while emptying the urinary catheter. Interview on [DATE] at 6:45 a.m. with resident 345 about his catheter revealed he had been admitted from the hospital on [DATE] with a catheter in place because of an enlarged prostate and difficulty with urination. Review of resident 345's medical record revealed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*He was admitted on [DATE]. *He had a [DATE] BIMS assessment score of 15, which indicated he was cognitively intact. *He did not have a diagnosis that indicated the need for a urinary catheter. *His care plan included a [DATE] initiated focus area of EBP for catheter care. The EBP sign had not been placed on his door to direct the staff to use the appropriate PPE while performing catheter care until 5 days after he was admitted with a catheter. The initiation of that sign had not occurred until after the surveyors had entered the facility and started the survey process. 9. Observation and interview on [DATE] at 8:14 a.m. with resident 350 in her room revealed: *There was PPE and a sign that indicated the need for EBP on the door. *She said the EBP had just started yesterday on [DATE]. *She said staff told her they had to wear a gown now because of her urinary catheter. *She said she was admitted from the hospital with a catheter in place because of difficulty urinating after surgery. -The presence of a urinary catheter put her at increased risk for infection and would indicate the need for EBP. The EBP sign had not been placed on her door to direct the staff to use the appropriate PPE while performing catheter care until 7 days after she was admitted with a catheter. The initiation of that sign had not occurred until after the surveyors had entered the facility and started the survey process. Review of resident 350's medical record revealed: *She was admitted on [DATE]. *She had a [DATE] BIMS assessment score of 14, which indicated she was cognitively intact. *Her orders included: -A [DATE] order to perform catheter cares every shift. -A [DATE] order for EBP for catheter cares. 10. Interview on [DATE] at 11:56 a.m. with director of nursing (DON) B revealed: *All managers can make rounds and participate in EBP initiation for residents that should be on those precautions. *All nursing staff can initiate EBP for residents. *He would expect that staff knew how to initiate EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*His diagnoses included acquired absence of left leg above knee and acute kidney failure. *He had a history of urinary incontinence. *Staff were to provide set-up assistance and assist him as needed with toileting. Interview on [DATE] at 11:14 a.m. with registered nurse (RN) G regarding urinals in resident rooms revealed: *She stated staff were to check and empty urinals once a shift or as needed. *Urinals should have been replaced weekly. *It was her expectation that full urinals should be emptied timely to ensure they were not spilled. *The other personal care items (toothbrush, denture cup, etc.) should have been replaced monthly or as needed. Interview on [DATE] at 11:22 a.m. with resident 5 revealed: *He stated the staff did not empty or rinse his urinals unless he put the call light on and asked them to. *He stated the urinals did not get changed out on a routine basis. *He stated he would have to tell the staff to rinse them once they emptied them or that would not get completed. *He stated he would empty and rinse the urinals when staff would not. 13. Observation on [DATE] at 11:55 a.m. with resident 6 in his room revealed: *The bathroom was shared by him and his roommate. -There was a dirty empty urinal stored on the back of the toilet identified as 300A and dated [DATE]. -There was a plastic graduate container stored on the back of the toilet dated ,d+[DATE] with no other identifiers. *There was a red basket stored on the counter left of the sink with no resident identifier that contained: -A 500ml bottle of equate mouth wash with no resident identifier. -A bottle of men's aftershave with no resident identifier. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A spray bottle of clean and free peri cleanser with no resident identifier. -A white toothbrush with no resident identifier. -Three used 60cc plastic irrigation syringes were stored in opened packages. One was dated [DATE] and not initialed, one was dated [DATE] and initialed, and one was dated [DATE] and initialed. *The left counter stored an incentive spirometer (a handheld medical device used to help improve lung function) with no resident identifier. *A graduated plastic container identified as resident 6 and dated [DATE]. -It stored an unpackaged 60cc irrigation syringe with no date and initials. *A pair of scissors with no resident identifier. *A hairbrush with no resident identifier. *There was a small clear plastic bin stored on the counter to the right of the sink with no resident identifier that contained: -An opened catheter insertion tray that expired on [DATE]. -A paper bag labeled Crest that contained gauze and flossing picks with no resident identifier. -A tube of toothpaste with no resident identifier. -A clear plastic cup with no resident identifier. -A used and undated 30cc plastic syringe that contained 17cc's of unused sterile water with a printed label that read: -Contents: Sterile Water, To Inflate Catheter Only. *The right counter stored a container of floss with no resident identifier. *A small, opened bottle of mouthwash with no resident identifier. *A [NAME] Norelco electric razor with no resident identifier. *Stored on the floor under the sink was a gray plastic bedpan dated [DATE] with resident 12's initials. -It was stored on top of a pink plastic basin and was not covered or contained. -There was no barrier between the pink plastic basin and the bed pan. *The pink plastic basin was stored on top of a cardboard box. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*A dirty blue disposable glove was on the floor by the cardboard box. *A clear plastic tote with dressing supplies was stored next to the cardboard box. -The lid for the tote was under the sink against the wall and open to potential contamination. *The trash can had no liner and contained soiled trash. Review of resident 6's EMR revealed: *He was admitted to the facility on [DATE]. *He had a BIMS assessment score completed on [DATE] of 15, which indicated he was cognitively intact. *Catheter care was to be completed every shift. *His catheter bag and graduate were to be changed weekly every Sunday night and labeled with his initials and dated. Interview and observation on [DATE] at 10:09 a.m. with resident 6 revealed: *His catheter drain bag had over 2000 cc of clear, yellow urine in it and was bulging. *He stated the catheter drain bag had not been emptied for a while. *The catheter drain bag had a cover but was not dated. *The spigot was not contained in the holder and was resting on the floor. 14. Observation and interview on [DATE] at 8:41 a.m. with resident 12 in his room revealed: *He used his urinals at bedside independently. *Two dirty urinals were stored on the edge of his trash can next to his bed. -One urinal was dated [DATE] and initialed. -The other was labeled with his name, dated [DATE] and initialed. Review of resident 12's EMR revealed: *He was admitted to the facility on [DATE]. *He had a BIMS assessment score on [DATE] of 15, which indicated he was cognitively intact. 15. Observation on [DATE] at 6:16 a.m. outside of resident 22's room revealed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*A Droplet infection control precaution sign was posted on the door of the resident's door. *A personal protective equipment (PPE) supply cart with gowns, gloves, eyeglasses/shields, and N95 masks was set up outside the resident's door. Interview on [DATE] at 6:22 a.m. with LPN M revealed resident 22 had tested positive for COVID. Review of the [DATE] CDC guidelines and recommendations at www.cdc.gov revealed residents should be placed on airborne isolation for SARS COVID pathogen. Interview on [DATE] at 1:56 p.m. with assistant director of nursing (ADON)/infection preventionist C revealed resident 22 would come off the infection control COVID precautions in 10 or 14 days. Interview on [DATE] at 3:21 p.m. with registered nurse (RN) G regarding resident 22 revealed: *The resident had tested positive with COVID on [DATE]. *Staff should have been using droplet precautions with resident. Review of resident 22's EMR revealed: *She was on isolation with droplet precautions since [DATE]. *She would come off droplet precautions by ,d+[DATE].25. *Her diagnoses included chronic obstructive pulmonary disease, and chronic respiratory failure with hypoxia *Staff were to use appropriate personal protective equipment and follow droplet precautions. *Oxygen was to be continuous at 2 lpm via the nasal cannula tubing. *Nebulizer medications were to be given as ordered for shortness of breath. Observation on [DATE] at 9:34 a.m. outside of resident 22's room revealed: *The personal protective equipment (PPE) supply cart was removed. *The Droplet precaution sign had been removed from the resident's door. *The resident's had come off Droplet precautions on Friday [DATE]. 16. Interview on [DATE] at 9:59 a.m. with CNA T revealed: *When asked what process was in place for staff to determine who or when a resident should be placed on enhanced barrier precautions (EBP) or transmission-based precautions (TBP). (continued on next page)

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